STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to honor the residents' right to make choices for the type and frequency of bathing for six of eight residents (#4, #39, #45, #456, #102 and #37) reviewed for choices. Failure to honor the resident's right to make choices for bathing placed residents at risk for poor hygiene and decreased quality of life. Findings included . The facility shower Policy, effective date 12/01/16 showed: A shower is provided for residents who wish to participate. Showers are given according to a pre-determined schedule and as needed or requested. RESIDENT #4 Resident #4 was a long time resident of the facility. Record review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed the resident was able to make self-understood and to understand others. During an interview on 02/11/2020 at 12:13 PM, the resident stated, I only get bed bathes, I would like to take showers. They never give me showers. Record review of the Kardex (a care guide for nursing assistants) documented date as of 02/13/20: it is important for me to choose between a tub bath, shower, bed bath or sponge bath. It also showed, Resident #4 prefers a shower once a week. Record review of the electronic health record under Task with a look back period of 30 days, 01/26/2020 to 02/16/2020, showed the resident had no documented baths and/or showers during that time. RESIDENT #39 Resident #39 was readmitted to the facility on [DATE]. The primary diagnosis list included cerebrovascular disease that resulted in the resident's inability to move the left side of her body. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the quarterly MDS assessment, dated 11/19/2019, the resident was cognitively intact and required assist of one to two staff members for all care related issues. During an interview on 02/06/2020 at 10:15 AM, the resident stated, I don't get showers, sometimes I get bed baths, but not very often. I would like a shower, once or twice a week would be better. They could also give me bed baths between the showers. Record review of the Kardex with documented date as of 02/13/20 showed, it is important for me to choose between a tub bath, shower, bed bath or sponge bath, offer resident daily bed baths. Record review of the activity of daily living (ADL) look back report , from 01/01/2020 to 02/16/2020, showed no documented showers, bed baths or refusals for the resident. RESIDENT #45 Resident #45 was readmitted to the facility on [DATE] with diagnoses that included stroke and diabetes. Record review of the significant change MDS, dated [DATE], showed the resident was cognitively intact and required assist of one to two staff members for care. During an interview on 02/10/2020 at 1:37 PM, Resident #45 stated, I'm lucky if I get a shower once a week. Record review of the ADL look back report dated from 12/31/2019 to 02/16/2020 showed no documented showers, bed baths or refusals. Record review of the Kardex with documented date as of 02/13/20 showed Resident #45 prefers two showers a week, provide resident with extensive assist of one person for showers. RESIDENT #456 Resident #456 was admitted to the facility on [DATE]. The diagnosis list included liver disease. During an interview on 02/18/2020 at 12:52 PM, the resident stated, if I could just get my hair washed that would help me to feel better, I have not had a shower or my hair washed since I been here. I got here February 5th. I need help to shower, I can't do it by myself. Record review of the electronic health record under task with a look back period from 02/05/2020 to 02/18/2020 showed the resident had no documented baths or showers since admission to the facility. During an interview on 02/14/2020 at 9:50 AM, Staff V, shower aide, stated, all the residents should get showers at least two times a week. When they refuse I go back and ask them again and then I let the nurse know if they still refuse, so we can reschedule the shower. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/18/2020 at 1:24 PM, Staff H Licensed Practical Nurse/Resident Care Manager (LPN/RCM) stated, If we don't have a shower aide, the aide assigned to care for the resident would give the shower. If the resident refused, I expect them to go tell the nurse and then the nurse should go talk to the resident and reassign the shower to a different day or time according to what the resident wanted. These residents are totally alert and have a lot of care needs. 37945 RESIDENT #102 The resident admitted to the facility on [DATE], with diagnoses to include spinal compression and Osteoporosis. According to the MDS, 01/23/20, showed the resident was 1 person assist for bathing. Review of the facility shower schedule showed the resident was scheduled to get a shower every Wednesday and Saturday. Review of the bathing flowsheet from 01/18/2020 to 02/13/2020, showed the resident was not marked having received a shower. No other documentation was provided upon request to show when and how often the resident received a shower. During an interview on 02/07/2020 at 9:44 AM, the resident stated that she was not getting showers. She stated she last got a shower a week ago and was supposed to be getting showers at least twice weekly. She stated she had bowel accident two nights ago and not having showers made her feel dirty and depressed. During an interview on 02/13/2020 at 10:06 AM, Staff PP, Nursing assistant (NAC), stated that there were two shower aides in the building with one on vacation. She stated that when they were short they sometimes got pulled to do regular NAC duties and that prevented them from doing the scheduled resident showers. She stated the facility could use more shower aides. During an interview on 02/14/2020 at 10:23 AM, the Director of Nursing (DNS) stated that the when the NAC's gave showers they documented the shower in the computer chart. During an interview on 02/20/2020 at 8:53 AM, Staff NN, NAC, stated that she only worked 3 days a week on Monday, Tuesday, and Wednesday. She stated she had a total of 11 showers and stated she was never able to complete all the assigned showers as she was frequently pulled to assist in dining room. She stated that some residents did not get showers. During an interview on 02/26/2020 at 2:45 PM, the DNS stated that she would staff more NAC's to do showers. 42378 RESIDENT #37 Resident #37 admitted to the facility on [DATE] for long-term care. He readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, shortness of breath, schizophrenia, bipolar disorder and anxiety. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of his most recent significant change of condition MDS, dated [DATE] showed he had intact cognition and needed supervision for all of his Activities of Daily Living (ADL) except for eating, dressing and toileting. A review of the resident's Activities of Daily Living (ADL) care plan, with revision date of 12/10/2019, showed the resident preferred showers twice a week on day shift. Review of the Kardex as of 02/12/2020 showed resident wanted showers twice a week. A review of shower schedule printed on 02/19/2020 showed resident to receive showers on Tuesdays and Saturdays. A review of the bathing log, printed on 02/19/2020, showed the bathing schedule for 02/01/2020, 02/08/2020 and 02/15/2020 (Saturdays), once a week. In addition, the bathing log was marked not applicable for type of bath the resident received for these 3 weeks. During an interview on 02/19/2020 at 10:40 AM, Staff V, NAC/Shower aide, stated that the facility offered two showers per week. Staff V stated was the only shower aide for now. The other shower aide assigned for the unit where Resident #37 resided had been on vacation. Staff V stated that an NAC help with showers on Tuesdays and Wednesdays, but when they were short, sometimes they got pulled to work on the floor. During a follow-up interview on 02/19/2020 at 01:18 PM, Staff V stated that Resident #37 was not part of her shower list; therefore, she was not able to answer if resident had refused to have a shower nor what intervention staff used for refusal. During an interview on 02/19/2020 at 01:21 PM, the DNS stated there was only one shower aide now. Furthermore, she stated for 02/18/2020, the second shower aide was pulled to work on the floor so she asked an NAC to stay over so the showers can be done or be caught up with the schedule. During an interview on 02/26/2020 at 11:37 AM, notified Staff D, Registered Nurse (RN)/Resident care manager (RCM) that Resident #37 did not have a shower for 3 weeks. Reference: WAC 388-97-0900 (1) (2)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 38430 Based on interview and record review, the facility failed to address issues raised by Resident Council for three of Seven months (July, August and September) reviewed in 2019. Failure to timely address and implement a sustained solution to call light response times/staffing issues resulted in the Resident Council process being ineffective in improving resident quality of life. Findings included . A review of the Resident Council minutes dated 07/17/2019, showed, a Grievance/concern form dated 07/17/2019 was completed by Staff VV, Activities Director, the grievance described on the form showed the following documented Instances of loud staff personal conversations, in the hallways, often louder than resident's TVs/waking some residents up The investigation section revealed that an inservice was done for staff. However, there was no reply to the Resident Council regarding the steps taken by the facility. A second grievance was reported during the July meeting that described staff using the other half of a resident's room for their own use/activities and taking the sports section from the resident's newspaper. The grievance form showed no investigation, and no reply to the complaint resident. A review of the Resident Council minutes dated 08/21/2019, showed a grievance/concern brought forward by the council, Residents have gone searching for staff, when their call lights are not being answered, & discovered them sleeping. The grievance form showed no investigation to rule out abuse/neglect of residents and the resolution section of the form was blank. A review of the Resident Council minutes dated 09/18/2019, showed resident grievances regarding: A) No staff in the dining room this past Thursday at dinner time to feed residents. B) A CNA (Certified Nursing Assistant) told a resident that there were only two CNA's for the entire upstairs on the night shift. C) A resident asked her CNA to apply lotion to her legs, and was told that the CNA did not have time. D) A majority of the residents agreed the night shift (11:00 PM to 7:00 AM) staff cannot be found when the residents try to find them for assistance. Two residents gave examples of situations to support the lack of response to their call lights and others agreed to their accountings. No response to the Resident Council was found to these grievances. In an interview on 02/13/2020 with Resident Council members: Resident #50, Resident #52 and Resident #54, all stated the facility does not always respond back to the council regarding the grievances brought forward during the meetings and the resolutions to the grievances. In an interview on 02/19/2020 at 1:03 PM, with the Administrator, together we reviewed the Resident Council minutes and the grievance log. The Administrator stated she will look into the process. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12273 The grievance log documented on 10/09/19, Residents #65, filed a grievance after staff refused to allow him to store and reheat, commercially prepared frozen meals. The facility responded to the grievance by conducting an inservice training with staff that stated ALL STAFF - we do not reheat food for residents/ visitors. and also noted food can only be kept in the refrigerator for 3 days, which conflicted with the facility policy and information provided in the admission packet. There was no evidence any one responded to Resident #65's grievance about not reheating foods. (see citation under F 565.) Reference: (WAC) 388-97-0920 (5)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on observation and interview, the facility failed to ensure the facility was maintained in a clean, comfortable, homelike environment for five sample residents (#39, #456, #101, #26 and #66) and on one of five unit halls (500) reviewed. In addition, the facility failed to ensure resident furnishings, walls, equipment and supplies were clean, pest free and linens were available. Failure to ensure the facility was free from urine odors, maintained, kept clean and supplied with linens placed residents at risk for decreased quality of life, compromised dignity and potential infection control issues. Findings included . HOMELIKE ENVIROMENT: RESIDENT #39 In an observation and interview on 02/06/2020 at 10:15 AM, Resident #39 was observed in bed, the wall at the head of her bed had multiple scratches and paint missing from the wall. The wall approximately 10 feet across from her bed had a multitude of boxes packed on top of boxes that lined the width of the wall. The room floor had various areas of dark, dried particles and stains. The room did not smell clean. At this time, Resident # 39 stated: I would love for someone to clean this room, they never come in here. If they do, they just empty the garbage. In another observation and interview on 02/19/2020 at 2:55 PM, there was no significant changes from the previous observation on 02/06/2020 at 10:15 AM. In an interview at on 02/19/2020 at 2:55 PM, the resident stated: I might be able to get rid of some of this stuff, it has been here so long, I forgot what is in those boxes. RESIDENT #456 In an observation and interview on 02/19/2020 at 12:58 PM, Resident #456 (the roommate of Resident #39) was observed sitting on the side her bed, there were multiple dried particles and stains on the floor next to her bare feet. There were a couple of full bags of clothes, empty cups and paper on the floor around her bed. The wall across from her bed also had boxes against the wall. In an interview with Resident #456 at this time stated: I would love for them to clean this mess up. Some of this is mine (points to bags on the floor), they have not unpacked me yet, I was admitted here on the 5th of the month. But, some of her stuff (points to roommate [Resident#39] is coming over her to my side. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint observation and interview on 02/19/2020 at 1:22 PM, of the multiple boxes stacked one on top of the other against the width of the wall, merging into Resident #456's side of the room, Staff H Licensed Practical Nurse/Resident Care Manager stated: I don't know anything about this, I have only been here since November. A lot of the resident rooms in this hallway are like this, I will go get and ask Administrator about this. RESIDENT #101 In an interview and observation on 02/19/2020 at 9:54 AM, the resident was observed in her room, Resident #101 stated: I wish they would paint those spots, but they never do. I get tired of looking at those spots. They don't clean this room, ever. During the observation at this time, the paint on the wall next to her bed was scratched/scuffed and had missing paint. There were two to three closed boxes that lined the wall across from her bed. The floor had dried stains and dried particles throughout the floor surface. RESIDENT #26 and RESIDENT #66 In an observation and interview on 02/11/2020 at 2:28 PM, Resident's #26 and Resident #66 shared a room, the window of their room was covered by a cracked, bent, broken covering that had parts of the covering missing. The covering was also covered in layers of dust. In an interview at this time, Resident #66 said the window covering had been broken for more than one month. Resident #26 said the housekeeper never came to the room to clean, mop or dust. 500 HALL ODORS During rounds on 02/06/20 at 10:15 AM, 02/11/2020 at 12:57 PM, 02/14/2020 at 6:40 AM, strong odors of uncleanliness was noted in the 500 hall. Similar findings during the days of the survey. In an interview on 02/14/2020 at 7:04 AM, Staff DDD Housekeeper said, we pick up the garbage dry mop, then wet mop and dust almost every day. I use the broom to sweep the hallways. In an interview on 02/19/2020 at 12:51 PM, Staff ZZ Housekeeper said, the housekeepers were supposed to dust around the room, mop the room floors and clean the bathrooms every day. He also said they cleaned the windows almost every day. After they cleaned around and under each resident's tables and bed. In a joint observation and interview on 02/19/2020 at 1:28 PM, Staff JJ Housekeeping and Laundry Supervisor observed the scratched/scuffed marks on residents room walls, dried stains and particles on the floor of residents rooms and the broken window covering. Staff JJ said, they were supposed to dust and mop the residents rooms and clean their bathrooms every day. He also confirmed a urine odor in the 500 hall. He then stated: we can do better than this. Staff JJ also said, the housekeepers were supposed to report broken items and paint that was scratched or scuffed off the walls to Maintenance. He also said Nursing was responsible too, they should make out a maintenance request form if they saw something broken or that needed to be fixed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a joint observation of the scratched/scuffed walls and broken window covering on 02/19/2020 at 2:31 PM, with Staff BBB Maintenance Director said, they are supposed to report damages and things that needed to be fixed to me, I have an assistant they can also tell him. I knew about the broken window covering, it was ordered and should be here any day now. LINEN In an interview on 02/14/20 at 06:04 AM, Staff CCC Nursing Assistant Certified (NAC) stated: we don't have enough linen at night, especially wash cloths. We always run out of wash cloths, we run out of linen too. Draw sheets, bed sheets. Sometimes we have to do the laundry ourselves at night. It is not a part of our job, but if we don't do the laundry we will have no clean linen to take care of the resident's with. We told the nurses and the nurses tell the management. It has been like this for about 3 or 4 months now, it is really bad. In an observation on 02/20/20 at 12:44 PM, of the 500 hall linen closet there was no small wash cloths present. In a joint observation and interview on 02/20/20 at 12:51 PM, Staff JJ Housekeeping and Laundry Supervisor, there were no small wash cloths present in the 500 hall linen closet. In an interview at this time he said: I don't know what happens to them, I placed an order last Wednesday or Thursday for the wash cloths. It should not take that long, I don't know why it is taking so long to get here. Today I know we are short, we went and checked all the rooms to see if there was some stored in there, we did not find any. In an interview on 02/20/20 at 1:31 PM, with Staff EEE (NAC) stated: are short sometimes. It happens like that, especially in the morning when we are trying to get the residents up, you know we need wash cloths in the morning especially. In an interview on 02/20/20 at 1:16 PM, with Staff FFF Registered Nurse (RN) stated: the aides do tell me they are short of small wash cloths, especially on the weekend. I told the management team, I can't remember how long ago it was. But, it was awhile ago. In an interview on 02/21/20 at 9:48 AM, Staff V shower aide said, we are short on wash cloths a lot. Especially on the weekends. They always tell us they are ordering more, but we never seen them. We are still short. In a joint observation and interview on 02/21/20 at 1:30 PM, with Staff JJ Housekeeping and Laundry Supervisor, there was no small wash cloths observed in the 500 hall linen closet. In an interview at this time, Staff JJ stated: the order still has not arrived yet. It is scheduled for this evening. 42378 Unclean environment: ants at nightstand, dirty feeding pump and bottle of normal saline solution (NSS). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation in room [ROOM NUMBER]-B on 02/05/2020 at 10:10 AM, found an opened but undated normal saline solution (NSS) with dried feeding formula on the outside of bottle. The cushion of the wheelchair was also dirty. During observation of room [ROOM NUMBER]-B on 02/13/2020 at 12:30 PM, the tube feeding pump machine had dried feeding formula in the back and on the front of the machine. In addition, the bottle of NSS with the dried feeding formula on outside the bottle was still on the nightstand. During observation of room [ROOM NUMBER]-B on 02/19/2020 at 08:54 AM, the feeding pump machine was dirty with dried feeding formula on the front of the machine. Moreover, the bottle of NSS with dried feeding formula on the outside of the bottle was still on the nightstand. During an interview on 02/20/2020 at 11:20 AM, Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) saw the bottle of NSS with dried feeding formula on the outside. Incidentally, observed with Staff D, RN/RCM two black ants on the top of the nightstand and Staff D, RN/RCM stated, There must be something sweet here. I will notify the housekeeping. Staff D, RN/RCM removed the bottle from the room. Furthermore, showed Staff D, RN/RCM the feeding pump dirty with dried feeding formula on the outside. She stated the facility change the syringe and the formula bottle in the afternoon but it was anybody's responsibility to clean the pump when they find it dirty. Reference: WAC 388-97-0880 (1) (2)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38430 Based on observation, interview and record review, the facility failed to ensure residents were free from mental, physical, verbal abuse and/or neglect for two of four residents (#42 and #105). This failure placed residents at risk for mental and/or emotional compromise with diminished quality of life. Findings included . Review of the facility policy titled: Abuse Prohibition revised on 08/01/2016, showed the facility shall prohibit abuse, neglect, exploitation, involuntary seclusion, and misappropriation of property for all residents through the following: 1. Screening of potential hires, 2. Training of employees (both new employees and ongoing training for all employees), 3. Prevention of occurrences, 4. Identification of possible incidents or allegations, which need investigation, 5. Investigation of incidents and allegations, 6. Protection of residents during investigations, and 7. Reporting of incidents, investigations, and facility response to the results of their investigations. The policy defined abuse as the infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish, sexual abuse or exploitation, or the willful deprivation of essential needs. RESIDENT #42 Resident #42 admitted to the facility on [DATE] for long term care. A review of the resident's quarterly Minimum Data Set, dated dated dated [DATE] showed the resident was cognitively intact and was dependent on staff for all activities of daily living. A review of a facility grievance/concern form dated 01/24/2020 showed the resident reported a grievance to Staff I, Social Services Director on 01/24/2019, the grievance stated the resident had an hour and twenty minute wait time on her call light. Further review of the grievance form showed the facility did not investigate the report to rule out abuse/neglect and the follow up section on the form stated Describe action(s) taken to investigate grievance/concern: the response was inservice, no evidence was attached that showed an investigation or identification of staff had been attempted. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/19/2020 at 1:03 PM with the Administrator, together we reviewed and discussed the missing investigation regarding the grievance to rule out abuse and/or neglect of the resident. The Administrator stated, she will look into this and start an investigation if one had not been done. In a review of the completed investigation received from the Administrator on 02/26/2020, showed abuse/neglect had been substantiated 41070 RESIDENT #105 Resident #105 was admitted to the facility on [DATE] with diagnosis to include Osteomyelitis of the vertebra thoracic region (infection of the bone). Review of the Admission/5-day MDS assessment dated [DATE], showed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating cognitively intact cognition. During an interview on 02/07/2020 at 8:58 AM, the resident stated that a female nurse refused to give him his pain medication the night before that day, unless the resident takes his Vitamin B. The resident stated that the nurse said, If that's what it takes to take your Vitamin B. The resident stated he never got his pain meds from that nurse and he had to wait from the next shift nurse to get his pain medications. According to the 02/11/2020 facility investigation summary report, Resident #105 reported that he pushed his button, and Staff H, Licensed practical Nurse (LPN), came in with a combination of vitamins. The resident stated he had asked Staff H for his pain and itch medications, and Staff H told the resident if you don't take these medications you won't get your pain medication. Staff H stated that she had entered the resident's room approximately at 10:25 PM on 02/06/2020, and woke the resident for his routine medications. The resident stated that he did not want his routine medications and only wanted the pain and itch medications. The facility then did an interview with Staff H about the incident, and Staff H made a written statement that the resident said, You're making me suffer as Staff H was leaving the resident's room. The investigation summary report showed that the resident did receive his pain medication at 11:14 PM, 45 minutes after his initial request. The facility made the determination that the resident's allegation of abuse was substantiated per Staff H statement and the time of the delivery of the pain medication. Staff H was then suspended and a written discipline was provided for Staff H for inconsiderate care of a resident with untimely delivery of pain medication request. In an interview on 02/18/2020 at 3:08 PM, with the Administrator and Staff WW, Nurse Consultant, Registered Nurse (RN), stated they reported the incident and they suspended the nurse. The Director of Nursing Services (DNS) stated they completed the investigation, and they all confirmed that the abuse allegation was substantiated per Staff H's statement, and the time of the delivery of the medication as stated on the investigation summary report. In another interview on 02/26/2020 at 1:23 PM, the DNS stated she did not get a clear direction from Management whether to call the Law Enforcement and the State Department of Health (DOH). She stated she would call the police and the State DOH, and report the substantiated abuse allegation incident. (continued on next page)

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	505042	A. Building B. Wing	02/26/2020

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0640 (1)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38430 Based on observation, interview, and record review, the facility failed to ensure one of two sample residents (#46) reviewed for physical restraints, was free from the use of a wheelchair seatbelt while in the facility. The facility failed to obtain a consent from the resident's representative, a physician order, ongoing monitoring and an assessment for the use of the seatbelt while resident is in the facility. This failed practice placed the resident at risk for unmet care needs and a decreased quality of life. Findings included . The Centers for Medicare and Medicaid Services (CMS) defined Physical Restraints as Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual Appendix PP). Resident #46 was admitted to the facility on [DATE], for long term care and received dialysis treatments three days a week outside of the facility related to end stage kidney disease. A review of the quarterly Minimum Data Set assessment, dated 12/07/2019, showed the resident had moderately impaired cognition, poor decision making, cues and supervision required. Resident #46 required extensive to total dependence with activities of daily living due to hemiplegia (paralysis) affecting the right dominant side of his body. A review of the physician order, dated 10/29/2018, showed Seatbelt to be placed for transport only, and removed upon return to facility. A review of the Restraint Evaluation dated, 10/29/2019, showed, 3. What is the restraint order-include time for use, place, duration and release instructions. The response to this question, stated used during transport for safety/positioning. A review of the resident's care plan, dated 10/29/2019, related to dependence from staff for activities of Daily Living showed, Seatbelt to tilt n space to be used during transport, for safety/positioning. A review of the Kardex (instructions to the Nursing Assistants) showed Seatbelt to tilt-in-space to be used during transport, for safety/positioning. An observation on 02/25/2020 at 02:50 PM showed the resident in his room. The resident was sitting at a slight angle in his tilt-in-space wheelchair. The wheelchair had a seatbelt attached to it and the belt was buckled across the resident's lap. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 02/25/2020 at 02:55 PM in the resident's room with Staff D, Registered Nurse, Resident Care Manager, Staff D stated that the resident was not able to self-release his seatbelt. Staff D stated, He is not able to release his seatbelt himself, staff have to do this for him. He needs the seatbelt for safety so he doesn't slide out of his wheelchair. During an interview on 02/25/2020 at 03:32 PM, Staff BB, Certified Nursing Assistant, stated, We get him out of bed for the day, we put on his seatbelt at all times for safety so he doesn't slide out of his wheelchair. During an interview on 02/26/2020 at 12:44 PM with the Director of Nursing(DNS), stated, she will readdress with therapy the appropriate use for the seatbelt, and the need for monitoring the resident's skin and ability to reposition when in the wheelchair. The DNS was not aware the resident wore his seatbelt at all times, even while in the facility. Reference: (WAC) 388-97-0620 4(a)(b)(c)(5)(a)(b)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38430 Based on interview and record review, the facility failed to implement their written abuse prohibition policies in a timely manner by failing to: identify potential abuse/neglect, report incidents of potential abuse/neglect to the State Agency, and initiate timely investigation for 6 of 6 (#66, #52, #27, #46, #97 and #26) residents reviewed for abuse/neglect and 7 of 12 months of the Resident Council minutes. This failure placed residents at risk for potential neglect/abuse. Findings included . A review of the facility policy Abuse Prohibition dated, 08/01/2016, stated Upon receiving information concerning a report of abuse, the CED [The Center Executive Director] or designee shall: Conduct an immediate and thorough investigation which shall focus on: If abuse or neglect occurred and to what extent; A clinical examination for signs of injuries, if indicated; and Causative factors. RESIDENT #66 Resident #66 admitted to the facility on [DATE] for long term care. The resident's diagnosis list included paraplegia (unable to move lower body). A review of the quarterly Minimum Data Set showed the resident had intact cognition and needed extensive assistance from staff with activities of daily. In a review of a grievance made on 11/20/2019, during a Resident Council meeting, it was documented Resident #66 reported he had been left alone by a staff member in a hoyer (mechanical device for transferring) lift for about 30 minutes, with only a sheet to cover him. In an interview on 02/11/2020 at 2:34 PM, with the Director of Nursing (DNS) and the Administrator, together we reviewed the documentation in the Resident Council minutes of the resident left alone for over 30 minutes in a hoyer lift and no communication from staff during this time. Both the DNS and the Administrator stated, they were not aware of this allegation and this should have been investigated to rule out abuse/neglect. RESIDENT COUNCIL In a review of the Resident Council Minutes the following information was documented: The Resident Council minutes on 01/19/2019, showed a grievance about staff using their cell phone and earbuds during their shift and unable to hear the residents. The Resident Council minutes on 05/15/2019, showed a resident requested assistance with eating in the dining room and the staff would not assist, they stated she needs to do it herself. The Resident Council minutes on 7/17/2019, showed a grievance about missing section of the newspaper for a resident. The resident stated staff were taking her copy from her room for their use. The Resident Council minutes on 08/21/2019, showed a grievance from residents that staff were found sleeping on the night shift and call lights were not answered. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Council minutes on 09/18/2019, showed a grievance for no staff in the dining room this past Thursday and residents did not get assistance with eating that needed it. Also, only two aides for the whole upstairs on the night shift last week, and resident smelling of feces that staff were not attending to. The Resident Council minutes on 10/16/2019, showed another grievance for night shift staff not able to be found when needed. The Resident Council minutes on 11/20/2019, showed a grievance about night staff not able to be found on the 500 hall and call lights not answered by staff during this time. GRIEVANCE LOG A review of the facility Grievance Log showed the following: Resident #52 reported on 11/18/2019, an aide with a bad attitude. Resident #27 reported on 12/02/2019, aides not answering lights during shift change. Resident #46's guardian reported on 12/14/2019, the resident was sent to dialysis without: lunch, hat, lap blanket and no hoyer sling; this happens at least 2x a month. Resident #97 reported on 12/30/2019, some staff turn off call lights without answering In an interview on 02/25/2020, with the Administrator regarding the above listed grievances, she stated, all of these needed investigations to rule out abuse and neglect. We did not identify and investigate these allegations. 35787 RESIDENT #26 Resident #26 was admitted to the facility on [DATE], the diagnosis list included Multiple Sclerosis (nerve damage that disrupts communication and coordination between the brain and the body), muscle weakness and difficulty walking. Record review of the quarterly MDS dated [DATE], showed the resident had no memory problems and was able to understand and be understood by others. Record review of the grievance/concern form dated 08/18/2019, revealed the resident went to help his roommate after waiting for approximately 30 minutes for staff to come. The form also documented the resident reported that a staff member had spoken sharply to him, denied the call light was on and told the resident: he should not have done her job for her. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/20/2020 at 11:21 AM, Resident #26 stated: I went to help my roommate, not the one that is there now, but another one. He was calling out, his call light had been on for at least 2 hours. A nurse came in and told me not to help anymore. She spoke to me rudely and very sharp. Nobody came, he was calling out. That is why I went to help him, he said his heel was hurting. So I put lotion on it and wrapped it up. Nobody else did anything. In an interview on 02/25/2020 at 2:23 PM, the Administrator stated: yes, this should have been an investigation. We should have investigated this to rule out abuse/neglect. Reference: (WAC) 388-97-0640 (2)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on interview and record review, the facility failed to identify and report to the State Hotline of unexpected death of a long-term care resident (#106) reviewed for death. The failure to report an unexpected death prevented the facility from identifying if abuse or neglect occurred placed the residents at risk for harm, and decreased quality of life. Findings included . According to Nursing Home Guidelines (Purple Book), Sixth Edition, dated [DATE] - Reporting Guidelines to be followed for nursing homes on reporting requirements Appendix D, page 27 showed that unexpected death needed to be: 1. Reported to the Department of Social Health Services (DSHS) State Hotline 2. Logged on the DSHS reporting log within five days 3. Reported to the Law Enforcement (notify the police or call 911) 4. Call or notification of the Coroner or Medical Examiner Resident #106 had been a long-term care resident since [DATE] with diagnoses that included chronic kidney disease, HTN (Hypertension or high blood pressure) and diabetes. Review of the Minimum Data Set (MDS) tracker dated [DATE], showed that Resident #106 died on [DATE]. Review of the clinical record showed no documentation in the resident's progress notes preceding the resident's death. The last documentation in the progress notes was on [DATE]. Review of the facility's state reporting log for [DATE], showed no investigation was conducted for Resident #106's unexpected death. An interview on [DATE] at 9:52 AM, the Director of Nursing Services (DNS), stated that there was no documentation in the resident's progress notes preceding the resident's death, and the resident's unexpected death was not reported to the State Hotline. An interview on [DATE] at 2:40 PM, Staff FF, Nurse Practitioner (NP), stated the resident was on comfort measures only per his POLST (Physician Orders for Life Sustaining Event), and would not expect the resident's condition to improve but the resident was relatively stable. However, Staff FF stated that Resident #106 was not actively dying, and he was not on hospice care and/or comfort care end of life. The surveyor explained to the DNS what was written in the Purple Book regarding unexpected death. The DNS then stated that she now understood that she should have reported the resident's unexpected death to the State Hotline but did not, and stated she would call it in that day and investigate the resident's death. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another interview on [DATE] at 11:29 AM, the DNS stated the facility did not have a clear policy on unexpected death, and would discuss it with the facility's management team and utilize the Purple Book. Reference: (WAC) [DATE] (5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273 Based on interview and record review the faciltiy failed to throughtly investigate unexpected incidents and or accidents for three of nine residents (#101 & #106) who had incidents or accidents which should have been investigated. Failure to ensure that an unexpected death, fall accidents a resident to resident altercation was thoroughly investigated to rule out abuse, neglect, and to determine if interventions were needed to mitigate or minumize the risk of a similar incidents occurring. Findings included . 35787 RESIDENT TO RESIDENT ALTERCATION RESIDENT #101 Resident #101 was readmitted to the facility on [DATE]. The diagnosis list included muscle weakness and difficulty walking among others. Record review of the annual Minimum Data Set (MDS) assessment dated [DATE] showed the resident did not have impaired memory and was able to understand and be understood. Record review of the facility State agency reporting log with the incident date of [DATE] showed the resident had a resident to resident altercation. Record review of the event summary report dated [DATE] showed the facility social worker went to visit another resident in the facility. During the visit the other resident stated she had a misunderstanding with Resident #101 and they yelled at each other. The other resident also said Resident #101 threatened to kill her, but she felt safe and was not afraid of Resident #101. The summary form of interviews with staff dated [DATE] revealed staff did not witness or hear an argument. Further review of the event summary report dated [DATE] did not include an interview and/or statement from Resident #101. In an interview on [DATE] at 12:39 PM with the facility Administrator said Resident #101 should have been interviewed to complete the investigation. In summary, the event summary report was incomplete due to the lack of an interview with Resident #101, and staff did not witness or hear an argument between the two residents to indicate an argument occurred. The facility failed to provide Resident #101 an opportunity to provide her statement of the alleged incident. 41070 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT #106 Resident #106 had been a long-term care resident since [DATE] with diagnoses that included chronic kidney disease, HTN (Hypertension or high blood pressure) and diabetes. Review of the Minimum Data Set (MDS) tracker dated [DATE], showed that Resident #106 died on [DATE]. Review of the clinical record showed no documentation in the resident's progress notes preceding the resident's death. The last documentation in the progress notes was on [DATE]. Review of the facility's state reporting log for [DATE], showed no investigation was conducted for Resident #106. An interview on [DATE] at 9:52 AM, the Director of Nursing Services (DNS), stated that there was no documentation in the resident's progress notes preceding the resident's death. An interview on [DATE] at 2:40 PM, Staff FF, Nurse Practitioner (NP), stated the resident was on comfort measures only per his POLST [Physician Orders for Life Sustaining Event], and would not expect the resident's condition to improve but the resident was relatively stable. However, Staff FF stated that Resident #106 was not actively dying, and he was not on hospice care and/or comfort care end of life. The surveyor explained to the DNS what was written in the Purple Book regarding unexpected death. The DNS then stated that she now understood that she should have investigated the resident's unexpected death but did not. Also Refer to: F609 Reporting of Alleged Violations Reference: (WAC) [DATE] (6)(a)(b)(c)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42378 Based on interview and record review, the facility failed to notify the Office of the State Long-Term Care Ombudsman of hospital transfers for two of two residents (#30 and #40). This failure placed the residents at risk for diminished protection from being inappropriately discharged , lack of access to an advocate who can inform them of their options and rights, and to ensure that the Office of the State Long-Term-Care Ombudsman was aware of facility practices and activities related to transfers and discharges. Findings included . RESIDENT #30 A review of the medical record showed Resident #30 admitted to the facility on [DATE] for long-term care. The resident readmitted to the facility on [DATE]. A review of the electronic medical record showed a hospitalization from [DATE] through 01/21/2020. There was no documentation found in the resident's electronic or paper medical record of the required notification to the Office of the State Long-Term Care Ombudsmen. 12273 Resident #40 The resident was admitted to the facility in 2015 with multiple medical diagnosis. On 08/19/2019, an unplanned transfer to the hospital occurred, and the resident was readmitted on [DATE]. Review of the electronic health record and/or the hard copy (containing paper documents) of the medical record found no documentation that the facility staff completed the required notification to the Office of the State Long-Term Care Ombudsmen. During an interview on 02/26/2020 at 11:30 AM, the Administrator was asked if they notified the Ombudsman when a resident were transferred to the hospital. The Administrator stated that the facility did, however asked to provide the notices for Residents #30 and #40, she acknowleded the request. During a follow-up phone call interview on 02/27/2020 at 12:28 PM with the Administrator regarding records for Ombudsman notification following hospitalization that was requested on 02/26/2020, she stated that they had no records of Ombudsman notification for the two residents that were transferred to the hospital. Reference: WAC 388-97-0120 (2) (a-d), WAC 388-97-0140 (1) (a) (b) (c) (i-iii)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on interview and record review, the facility failed to ensure comprehensive assessments (Admission) were completed timely as required for two of seven residents (#97 & #406) reviewed for comprehensive Minimum Data Set (MDS) assessments. The facility's failure in ensuring comprehensive assessments were completed timely as required placed residents at risk for delayed or unidentified care needs and a diminished quality of life. Findings included . According to the Resident Assessment Instrument (RAI) process, at a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status, and not less than once every 12 months (within 366 days) while a resident. RESIDENT #97 Resident #97 was admitted to the facility on [DATE] with diagnoses that included pneumonia and depression. Review of the Admission MDS assessment, dated 01/03/2020, showed it was completed late on 01/29/2020, 19 days late. The Admission MDS assessment was not completed within 14 days, as required. During an interview on 02/21/2020 at 2:48 PM, Staff P, MDS Coordinator, Registered Nurse (RN), reviewed the Admission MDS, and stated that it was completed late. RESIDENT #406 Resident #406 was admitted to the facility on [DATE] with diagnoses that included flu and asthma. Review of the Admission MDS assessment, dated 01/31/2020, showed it was completed on 02/10/2020, 3 days late. The Admission MDS assessment was not completed within 14 days, as required. During an interview on 02/21/2020 at 2:50 PM, Staff P, MDS Coordinator, RN, reviewed the resident's Admission MDS, and stated that it was completed late. During an interview on 02/26/2020 at 11:19 AM, the Director of Nursing Services reviewed the Admission MDS for Resident #97 and #406, and stated the completion dates were red [completed late]. Reference: (WAC) 388-97-1000 (1)(b)(c)(3)(a)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessments including Care Area Assessments were completed timely within 14 days, and after the determination was made that a significant change occurred for two of four residents (#74 & #64) reviewed for significant decline in condition (#74) and a significant change in improvement (#64). This failure placed the residents at risk for unidentified or unmet care needs and diminished quality of life. Findings included . According to the Resident Assessment Instrument (RAI) process, a Significant Change in Status Assessment (SCSA) must be completed no later than 14th calendar day after determination that significant change in resident's status occurred. RESIDENT #74 Resident #74 was readmitted to the facility on [DATE] with diagnoses that included dementia (a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities) and Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs characterized by increasing breathlessness). Review of the most recent Significant Change Minimum Data Set (MDS) assessment dated [DATE], showed it was completed late on 10/21/2019, and it was not completed within 14 days after the determination of the significant change, as required. During an interview on 02/21/2020 at 2:27 PM, Staff P, MDS Coordinator, RN looked at the Significant Change MDS and stated it was completed late. Staff P also stated that a significant change MDS should be completed within 14 days. During an interview on 02/26/2020 at 10:35 AM, the Director of Nursing Services, looked at the Significant Change MDS and stated the completion date was red [completed late]. 12273 Resident #64 Resident #64 was admitted to the facility with multiple medical diagnoses, including COPD (Chronic Obstructive Pulmonary Disease) and mental Illness in 2018. The last annual MDS, dated [DATE], showed the resident needed extentsive assistance from 1 staff for bed mobility and tolieting and identified the need limited assistance from one staff for transfers, dressing and hygiene. The assessment also noted the resident was frequently incontinent of bowel and occassionally experienced bladder incontinence. (continued on next page)

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	505042	A. Building B. Wing	02/26/2020

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Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The next quarterly MDS assessment, was dated 09/26/2019, showed the resident had a significant improvement, The resident was coded supervision and oversight for bed mobility, transfers, dressing, hygiene. The resident was independant with transfers and needed set up for eating and toileting. The assessment also noted and improvement with bowel and bladder, noting the resident was always continent of Bowel and Bladder. On 02/26/2020 at 11:45 AM, Staff P, verified that a significant change in condition, should have been completed based on the improvments noted in the residents ability to participate in activities of daily living and maintain continence. Reference WAC 388-97-1000 (3)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on observation, interview, and record review, the facility failed to accurately assess 9 of 33 residents (#74, #82, #90, #97, #105, #106, #407, #69, & #98) for whom Minimum Data Set (MDS) assessments were reviewed. Failure to ensure accurate assessments regarding resident facility admission and reentry, functional abilities and goals, brief interview for mental status, resident mood interview, behavior, pain assessment, activities of daily living (ADL) for eating and transfers, skin impairments and treatments placed the residents at risk for unidentified or unmet care needs and a diminished quality of life. Findings included . Accuracy of Assessment means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (i.e. comprehensive, quarterly, annual, significant change in status). The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods. When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS. RESIDENT #74 Resident #74 was readmitted to the facility on [DATE] with diagnoses that included dementia (a decline in memory, language, problem-solving and other thinking skills that affect a person's ability to perform everyday activities) and Chronic Obstructive Pulmonary Disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs characterized by increasing breathlessness). Review of the Resident #74's clinical records showed the resident discharged from the facility on 09/22/2019, and a Discharge Return Anticipated MDS was completed. The resident then readmitted (reentry) back to the facility on [DATE] and an Entry Tracking MDS was completed. Review of the Significant Change MDS assessment, dated 10/04/2019, showed Section A0310E (first assessment since the most recent admission/entry or reentry) was coded zero (0 - not the first assessment since the most recent admission or reentry). A0310E should be coded yes (1), since the Significant Change MDS assessment was the first MDS assessment since the most recent reentry, as required. During an interview on 02/26/2020 at 12:18 PM, Staff M, MDS Nurse, Licensed Practical Nurse (LPN), reviewed the resident's record, and stated Section A310E should have been coded yes since it was the first assessment. RESIDENT #82 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #82 was admitted to the facility for skilled care rehabilitation on 01/09/2020 with diagnoses that included MRSA (Methicillin Resistant Staphylococcus Aureus - infections caused by specific bacteria that are resistant to commonly used antibiotics) on his legs and Hepatitis C (HCV - is a viral infection that causes liver inflammation, sometimes leading to serious liver damage). Review of the Admission/5 day MDS assessment dated [DATE], showed functional abilities and goals (Section GG [admission]) was completed late on 01/17/2020, 6 days later after the admission functional abilities and goals assessment period. The admission functional abilities and goals assessment period is days 1 through 3 of the Skilled Nursing Facility [SNF] Prospective Payment System [PPS - insurance payment reimbursement] Stay starting A2400B (start of the most recent Medicare [national insurance program] stay), and it should have been completed on either 01/09/2020, 01/10/2020 or 01/11/2020, as required. During an interview on 02/21/2020 at 2:20 PM, Staff M, MDS Nurse, LPN, stated that the Admit GG should been completed by day 3 of the Skilled PPS Stay. Staff P, MDS Coordinator, RN, stated that she gets it that the Admit GG was not completed timely. RESIDENT #90 Resident #90 was admitted to the facility on [DATE] with diagnoses that included diabetes, and cancer of the throat , status post total laryngectomy (removal of the larynx [voice box]) and tracheostomy in 2017. Review of the 5-day MDS, dated [DATE], showed the BIMS (Brief Interview for Mental Status) and PHQ9 (Resident Mood Interview) were completed on 02/10/20, 5 days later after ARD. The resident's BIMS and PHQ9 should be conducted during the look-back period of the ARD, preferably the day before or the day of the ARD, as required. During an interview on 02/18/20 at 2:03 PM, Staff I, Social Services Director (SSD), stated that the interview for the BIMS and PHQ9 were completed on 02/10/2020. Staff I stated that she would check the RAI (MDS) Manual when the interview should be done. Then on 02/19/2020 at 11:21 AM, Staff I stated that the BIMS interview should be completed the day before or the day of the ARD. Staff I stated that the PHQ9 had a 14 day look back period, and she was not sure when should the interview be done for it. She stated that she did not have the information on her notes. Further review of the MDS showed that edentulous (without teeth) on Section L (oral dental status) was coded on the MDS. Observation on 02/18/2020 at 1:00 PM showed the resident with two remaining teeth, one on the upper left gum and one on the lower left gum. During an interview on 02/21/2020 at 11:44 AM, Staff K, Resident Care Manager (RCM), RN, stated that she observed the resident with two remaining teeth, one on the left upper gum and one on the left lower gum. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/21/20 at 2:40 PM, Staff P, MDS Coordinator, RN, stated that she would do an oral assessment, do a modification, and change the coding on Section L to missing teeth. RESIDENT #97 Resident #97 was admitted to the facility on [DATE] with diagnoses that included pneumonia and depression. Review of the Admission MDS, dated [DATE], showed Section E (behavioral symptoms) was completed on 01/01/2020, 2 days early. Section E (is a 7-day look back period assessment) and should be completed after the ARD. During an interview on 02/18/2020 at 2:09 PM, Staff I, SSD, stated that Section E was completed on 01/01/2020, and would find out the look back period for it. Then on 02/19/2020 at 11:27 AM, Staff I stated that Section E was a 7-day look back period. RESIDENT #105 Resident #105 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (infection of the bone) and end stage kidney failure. Review of the Admission/5 day MDS assessment, dated 01/29/2020, showed the pain assessment was completed on 02/03/2020, 5 days later after the ARD. The resident's pain interview should be conducted during the 5-day look-back period of the ARD, preferably on the day before, or the day of the ARD, as required. During an interview on 02/21/2020 at 2:42 PM, Staff P, MDS Coordinator, RN stated that the pain assessment should be done on or before the ARD, and it was completed late. RESIDENT #106 Resident #106 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and dysphagia (difficulty in swallowing). Review of the Quarterly MDS assessment, dated 11/23/2019, showed the resident was receiving nutrition via feeding tube (a medical device used to provide nutrition to people who cannot obtain nutrition by mouth, are unable to swallow safely or need nutritional supplementation). Further review of the MDS showed the resident was coded two person total assistance with eating [4/3] under Section G (ADL Care). There was no documentation in the clinical record during the look back period that Resident #106 was provided with two-person assistance with eating via feeding tube. During an interview on 02/21/2020 at 2:49 PM, Staff P, MDS Coordinator, RN, reviewed the resident's clinical record, and stated that eating should have been coded 4/2 [total assistance of one person]. Staff P stated she would modify and correct the quarterly MDS. RESIDENT #407 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #407 was admitted to the facility on [DATE] with diagnoses that included incomplete quadriplegia and recurrent urinary tract infection. Review of the Admission MDS assessment, dated 02/11/2020, showed the resident was coded two person total assistance with transfers (4/3) under Section G (ADL Care). Review of the documentation on the task list under transfers showed the resident was transferred out of bed twice on 02/08/2020 and 02/11/2020. During an interview on 02/20/2020 at 1:36 PM, Staff K, Resident Care Manager (RCM), RN, stated that the resident was bed bound, did not get out of bed, and was receiving bed baths. Then on 02/21/2020 at 11:45 AM, Staff K stated that the therapist were doing the resident's exercises in bed. During an interview on 02/21/2020 at 2:37 PM, Staff P, MDS Coordinator, RN, reviewed the resident's clinical records and stated that she did not find documentation to support the coding of 4/3 for transfers, and it should have been coded 7/3 [activity occurred only once or twice with two person physical assist]. Staff P stated that she would modify and correct the admission MDS assessment. 12273 35787 According to the MDS: Section M 1040 H of the MDS: Skin problems (a seven day look back period), steps for assessment: 1. Review the medical record. 2. Speak with direct care staff. 3. Examine the resident and determine whether skin problems are present. According to the MDS: Section M1200 of the MDS: Skin Treatments (a seven day look back period), steps for assessment: 1. Review the medical record, including treatment records during the past 7 days. RESIDENT #98 Resident #98 was readmitted to the facility on [DATE], the diagnosis list included functional quadriplegia (inability to move due to severe disability). Record review of the readmission nursing documentation form, dated 01/01/2020, showed the resident had Moisture Associated Skin Damage (MASD) on his gluteal (one of the three large muscles that form the buttocks and move to the thigh) fold. Record review of the treatment administration record (TAR), dated 01/01/2020 to 01/31/2020 showed the resident received treatments to the gluteal area of his skin on 01/02/2020, 01/03/2020, 01/04/2020, and 01/06/2020. According to the annual MDS, dated [DATE], the resident did not have skin problems or treatments during the 7 day look back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/21/2020 at 10:29 AM with Staff P, MDS Coordinator/RN, stated, Yes it should have been coded, I missed that. I will modify the assessment to show that the resident had MASD and treatments at that time. Reference: (WAC) 388-97-1000 (1)(b)

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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** 41070 Based on interview and record review, the facility failed to ensure two of nine residents (#82 & #90) received baseline care plans within 48 hours of admission to ensure continuity of care and/or to provide residents and their representative with a summary of their baseline care plan. This failure resulted in the residents not being informed of their initial plan for delivery of care services and placed residents at risk for unmet care needs. Findings included . Review of the facility policy titled: Person Centered Care Plan revised on 07/01/19, showed The Center must develop and implement a baseline person-centered care plan within 48 hours for each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. RESIDENT #82 Resident #82 was admitted to the facility for skilled care rehabilitation on 01/09/2020 with diagnoses that included MRSA (Methicillin Resistant Staphylococcus Aureus - infections caused by specific bacteria that are resistant to commonly used antibiotics) on his legs and Hepatitis C (HCV - is a viral infection that causes liver inflammation, sometimes leading to serious liver damage). Review of the Admission/5 day Minimum Data Set (MDS) assessment dated [DATE] showed the resident was cognitively intact, and required the assist of one to two staff members for bed mobility, transfer and toileting. Review of the Post Admission Patient-Family Conference form dated 01/10/2020, showed it was incomplete (section status was not completed and in error per the form), and Section E (copy given to resident and or resident representative) of the form was not marked or checked. In addition, in Section B of the form (attendees to the care conference), the only attendee was the Recreation staff, and the patient [resident] and/or the resident's family representative was not marked as present during the conference. Further review of the clinical records showed no information that a summary of the 48-hour baseline care plan was provided to the resident and/or the resident's representative. During an interview on 02/19/2020 at 2:35 PM, Staff K, Resident Care Manager (RCM), Registered Nurse (RN), stated the facility was using the post admission patient-family conference form for baseline care plan that was formulated within 48 hours of the resident admitted . Staff K stated that Section B of the form was the attendance list, and whoever was present on the care conference will be marked/checked as present. Staff K reviewed the post admission patient-family conference form dated 01/10/2020, and Staff K stated that it was incomplete. Staff K also stated that there was no indication that a copy of the baseline care plan was provided to the resident because Section E of the form was not marked, and she was not in attendance either because the Nurse UM [Unit Manager] on Section B was not marked. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT #90 Resident #90 was admitted to the facility on [DATE] with diagnoses that included diabetes, and cancer of the laryngeal cartilage (throat) with right lung and bone metastasis (spread of cancer cells), status post total laryngectomy (removal of the larynx [voice box]) and tracheostomy in 2017. Review of the Admission MDS assessment dated [DATE], showed the resident was cognitively intact and required supervision to one-person assistance with bed mobility, transfers and toileting. Review of the Post Admission Patient-Family Conference form dated 01/17/2020, showed the form was not completed, the patient [resident] or the resident's representative was not marked as present during the care conference, and the only attendee that was marked on the form was the Recreation staff. In addition, Section E of the form showed a Copy given to resident and/or resident representative was not marked or checked. Further review of the clinical records showed no information that a summary of the 48-hour baseline care plan was provided to the resident and/or the resident's representative. During an interview on 02/19/2020 at 2:41 PM, Staff K, RCM, RN, reviewed the Post Admission Patient-Family Conference dated 01/17/2020, and stated the form was not completed, and it was not provided to the resident because Section E of the form showed a Copy given to resident and/or resident representative was not marked or checked. Reference: (WAC) 388-97-1020 (3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38430 Based on observation, interview and record review the facility failed to develop and/or implement a comprehensive person centered care plan to meet the residents needs or preferences. This placed eleven of thirty three residents (#46, #84, #63 #95, #90, #97, #105, #406, #30, #37 & #75) at risk of not receiving services that would meet their desires or wants and placed all other residents at risk of not receiving wanted or needed services. Findings included . The facility policy for Person-Center Care Plan dated 11/28/16, and last revised on 07/01/19 showed: A comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient that includes measurable objectives and timetable to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs that are identified in the comprehensive assessments. RESIDENT #46 Resident #46 admitted to the facility on [DATE], for long term care and received dialysis treatments three days a week outside of the facility related to end stage kidney disease. A review of the quarterly Minimum Data Set assessment, dated 12/07/2019, showed the resident had moderately impaired cognition, poor decision making, cues and supervision required. Resident #46 required extensive to total dependence with activities of daily living due to hemiplegia (paralysis) affecting the right dominant side of his body. A review of the resident's care plan, dated 10/29/2019, related to dependence from staff for activities of Daily Living showed, Seatbelt to tilt n space to be used during transport, for safety/positioning. An observation on 02/25/2020 at 02:50 PM showed the resident in his room. The resident was sitting at a slight angle in his tilt-in-space wheelchair. The wheelchair had a seatbelt attached to it and the belt was buckled across the resident's lap. During an observation and interview on 02/25/2020 at 02:55 PM in the resident's room with Staff D, Registered Nurse, Resident Care Manager, Staff D stated that the resident was not able to self-release his seatbelt. Staff D stated, He is not able to release his seatbelt himself, staff have to do this for him. He needs the seatbelt for safety so he doesn't slide out of his wheelchair. During an interview on 02/25/2020 at 03:32 PM, Staff BB, Certified Nursing Assistant, stated, We get him out of bed for the day, we put on his seatbelt at all times for safety so he doesn't slide out of his wheelchair. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/2020 at 12:44 PM with the DNS, stated she, was not aware the resident wore his seatbelt at all times, even while in the facility. RESIDENT #84 Resident 84 admitted to the facility on [DATE], the primary diagnosis list included cerebral infarction (stroke), and hemiplegia (paralysis) affecting left dominant side. A review of the quarterly minimum data set (MDS) assessment dated [DATE], showed the resident was cognitively intact. The MDS section for Functional Limitation in Range of Motion indicated the resident had upper extremity (shoulder, elbow, wrist, hand) impairment on one side. A review of the resident's current care plan dated 04/24/2019, showed, no care plan focus related to left hand contracture. A review of the facility Nursing assessment dated [DATE], showed the resident had a contracture to her left upper extremity. In an observation on 02/14/2020 at 11:09 AM, the resident was observed propelling herself with her right hand by pumping a lever attached to her wheelchair, the residents left arm was resting in her lap and her left hand was contracted closed, no splint in place. In an interview and record review on 02/14/2020 at 11:00 AM, information was requested from the Director of Nursing Services (DNS) regarding the care and services the resident is receiving for her left hand contracture. The DNS stated, she will look into this. In an interview on 02/18/2020 at 10:02 AM, the DNS, stated, she was not able to find anything on the resident's care plan for her contracture. 12273 Resident #63 The resident was admitted to the facility in 2013, with multiple diagnosis including dementia. The most recent MDS assessment, dated 12/19/2019, noted the resident was not able to participate in a verbal interview to assessment the resident cognitive status. The assessment also noted the resident was needed extensive assistance from to complete the Activities of Daily Living (ADL's bed mobility, transfers, dressing and grooming) and used a wheelchair pushed by staff for locomotion. The care plan, dated on 02/05/2019, showed the resident was at risk for skin breakdown. The interventions were updated on 12/09/2019 to include weekly wound assessments by the licensed nurse, and directed staff to include the measurements and description of any wounds, use of lower extremity protectors (a stocking skin protector), and directed staff to float heels while the resident was in bed. On 01/18/2020 by Staff FF, a Nurse Practitioner, noted the visit was related to right lower extremity (RLE) blisters. The assessment documented last visit discussed w (with) nursing staff to place pillows under RLE to prevent friction and pressure to blisters. The note showed that staff should continue to monitor the area for infection and/or additional areas of skin breakdown. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/20/2019, Staff C, Licensed Practical Nurse, was observed to complete a dressing change for a wound located on the lateral aspect of right knee (behind the knee). During this observation, the resident spontaneously repositioned his right leg over the left which placed the open wound directly on the left knee cap (creating friction and pressure). After the right leg was positioned by the resident, a second scabbed area (unstageable pressure ulcer) was exposed on the right lower inner leg (behind the knee). When asked about the second scabbed area, Staff C, stated the ARNP was aware it was there. An assessment documented on 01/18/2020 by Staff FF, a Nurse Practitioner, noted the visit was related to right lower extremity (RLE) blisters. The assessment documented last visit discussed w(with) nursing staff to place pillows under RLE to prevent friction and pressure to blisters. The note showed that staff should continue to monitor the area for infection and/or additional areas of skin breakdown. On 02/21/2020 at 10:30 AM, Staff GG, the ARNP was interviewed, he said he was not aware of the second wound (scabbed are on the right inner lower leg.) The facility failed to ensure that weekly documentation of including the size, location and description of wound(s) were completed. Although the progress notes noted identified on 12/11/2019, the resident had developed a blister, the location and size were not clearly documented. The weekly skin evaluations lacked any further documentation concerning the wound its size and/or a description was documented weekly as the care plan directed. In addition on 01/18/2020, after the NP recommendation to position pillows to prevent friction and pressure to the blisters, was not updated on the care plan until 02/25/2020. After the interview was completed with the DNS. Not following the care plan directives and /or updating the recommendations contributed to the further deterioration of the wound(s). RESIDENT #95 Resident #95 was admitted to the facility in 2016 with multiple diagnosis including a stroke that affected with residents functional abilities, and severe cognitive deficits. The last quarterly MDS assessment, dated 01/11/2020, indicated the resident needed extensive assistance of two staff to completed Activities of Daily Living (ADL's I.e. transfers, dressing, grooming, toileting and mobility.) The care plan identified the resident was at risk for falls, and identified the following interventions should be implemented to minimize the risk for falls which included During observation on 02/12/2020 02:40 PM, Resident #95 was observed in bed wearing a hospital gown, the head of the bed was elevated and the resident was position in the center of the bed on his back. The surface of the bed was elevated from the floor (approximately 1.5 to 2 feet)from the floor. Staff B, Registered Nurse, who was seated at the nurses station, was alerted the bed was elevated from the floor surface after the staff was alerted to the position of the bed, and then repositioned the r surface ed lower to the floor, bringing the bed surface lower to the floor. (continued on next page)

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	505042	A. Building B. Wing	02/26/2020

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Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Failure to consistently implement interventions to minimize fall interventions increased the risk for falls and potential injuries. 41070 RESIDENT #90 Resident #90 was admitted to the facility on [DATE] with diagnoses that included cancer of the laryngeal cartilage (throat) with right lung and bone metastasis (spread of cancer cells), status post total laryngectomy (removal of the larynx [voice box]) and tracheostomy in 2017. Review of the 5 day Minimum Data Set (MDS) assessment dated [DATE], showed the resident required supervision to one to two-person assist with bed mobility, transfer, dressing, toileting and personal hygiene. Review of the care plan for alteration in respiratory status related to malignant neoplasm [cancer] of laryngeal cartilage initiated on 01/23/2020, directed the nursing staff to monitor for airway obstruction/thickened secretions, and to suction trach/airway as needed. A joint observation on 02/10/2020 at 12:53 PM, the resident was observed suctioning his tracheostomy without gloves. The resident stated he was not completely able to suction his tracheostomy. The resident stated that he was doing the suctioning himself and none of the nurses was assisting him. The resident started coughing, and it was observed by Staff L, Licensed Practical Nurse (LPN) and the surveyor that the resident was splashing yellow and brown discharges coming from his tracheostomy. Staff L stated that nurses should be assisting the resident with tracheostomy suctioning but they were not. An interview on 02/19/2020 at 2:17 PM, Staff K, Resident care Manager (RCM), RN, stated that there was no assessment or documentation that the resident was able to suction himself. Staff K stated that she was unable to find documentation that nursing was doing the suctioning and they were not following the care plan. In another interview on 02/25/2020 at 2:13 PM, Staff K stated that she interviewed the nurses on day shift, eve and night shift. Staff K stated that Staff E, RN, and Staff A, LPN, were her regular nurses and they stated that they were not doing the suctioning for the resident and they were not monitoring the tracheostomy site. Staff K also stated that the nurses were not monitoring the resident for any signs and symptoms of obstruction or thickened secretions, and vital signs before and/or after suctioning the tracheostomy was also not being done. The facility failed to assess, monitor, and ensure appropriate care and supervision were provided to Resident #90's tracheostomy suctioning and its' care. Refer also to F695 Respiratory, Tracheostomy and Suctioning. RESIDENT #97 Resident #97 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke) and urinary retention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission MDS assessment dated [DATE], showed the resident required one to two person assist with bed mobility, transfer and toileting. Review of the facility policy titled: Catheter: Indwelling Urinary Care revised on 11/01/2019, showed to Secure catheter tubing to keep the drainage bag below the level of the patient's [resident] bladder and off the floor. Review of the January 2020 and February 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed to keep the catheter below the level of the bladder. Further review of the MAR and TAR showed the resident received Bactrim DS 800-160 mg (Sulfamethoxazole-Trimethoprim) 1 tablet by mouth two times a day for 7 days for UTI (Urinary Tract Infection - bladder infection). During a joint observation on 02/14/2020 at 6:19 AM, the resident was lying in bed, the resident had an indwelling foley catheter draining urine into a urinary leg bag, and the resident's urinary leg bag was attached to the resident's left leg. The urinary drainage bag was not placed below the resident's bed. Staff CC, Nursing Assistant Certified (NAC), stated she did not know why the resident was not using a urinary bag that could be placed below the resident's bed. Staff CC, stated it's been that way since he was admitted . Staff DD, NAC, also observed that the urinary drainage bag was not placed below the resident's bed, and stated the urinary drainage bag should be placed below the bed to facilitate the flow of urine. During an interview on 02/19/2020 at 2:59 PM, Staff K, Resident Care Manager, Registered Nurse stated the care plan showed the urinary bag was supposed to be below the bladder and that was not happening. During an interview on 02/26/2020 at 11:23 AM, the Director of Nursing Services (DNS), stated the resident's urinary drainage bag was supposed to be placed below the resident's bladder or bed to prevent infection from urine backflow. She stated that the care plan was not followed. Refer also to F690 Urinary Catheter and UTI. RESIDENT #105 Resident #105 was admitted to the facility on [DATE] with diagnoses that included vertebral (thoracic area) osteomyelitis (infection of the bone) and peripheral vascular disease (a slow and circulation disorder caused by narrowing, blockage or spasms in a blood vessel and may affect arteries and veins). Review of nurse practitioner notes dated 01/26/2020, showed the resident had multiple small wounds noted mostly to lower extremities, most noted w/ [with] superficial & stable dry scabs. Wound of right anterior shin & right 2nd toe w/noted bleeding, otherwise w/o [without] infection. Will order to clean with NS [normal saline solution], pat dry, & cover w/non-adhesive, topical antibiotic ointment to right second toe. Will refer to Skilled Wound Care for further eval [evaluation] & management. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the care plan for discharge, risk for infection r/t dialysis access site, ADL, activities, risk for psychological harm, nutritional, risk for acute pain and hemodialysis initiated on 01/23/2020, showed they were overdue and were not completed as of 02/18/2020 at 10:31 AM. In addition, there was no care plan for the resident's right leg open wound, right fourth toe and left third toe. An observation on 02/07/2020 at 8:55 AM, the resident was in his room and sitting up in wheelchair. The resident was observed with open wound on his right anterior shin (lower leg). The wound on his right lower leg was slightly bloody, the wound edges was macerated with scattered scabs on the edges of the wound. The wound was not covered, the resident was observed picking and scratching the edges of wound and the skin surrounding it. The resident stated the wound on his right leg was scaly. An interview and joint record review on 02/19/2020 on 3:07 PM, with Staff K, RCM, RN, showed the treatment order for the resident's legs and toes were not written in the resident's January 2020 and February 2020 MAR and TAR. Staff K stated the treatment order for the resident's legs and toes were not being done by LNs because the order was not carried out correctly. An interview on 02/18/2020 at 1:15 PM, Staff F, RN stated the resident's care plans were overdue. Staff stated the RCMs should be doing the residents care plan. In another interview on 02/19/2020 at 2:48 PM, Staff K stated there was no care plan for the right leg wound, right fourth toe and left third toe. An interview on 02/26/2020 at 11:08 AM, the DNS stated the resident's skin issues should have been addressed the resident's care plan but were not. The DNS also stated that the unit managers (RCMs) was initiating the care plans and the IDTs [Interdisciplinary Team] should be completing it by day 21 per the MDS comprehensive assessment. Refer also to F684 Quality of Care (For non-pressure related skin issues). RESIDENT#406 Resident #406 was admitted to the facility on [DATE] with diagnoses that included high blood pressure and asthma. Review of the care plan initiated on 01/25/2020, showed the care plans for ADLs [Activities of daily Living], skin, respiratory, activities, and risks for falls, dehydration, and nutrition did not identify the resident's swollen legs. An observation on 02/06/2020 at 10:45 AM, the resident was up in her wheelchair, in her room, and both of the resident's lower legs were red and warm to touch. The resident stated that her legs were red and swollen. An interview on 02/19/2020 at 3:02 PM, Staff K, RCM, RN, stated the resident's lower legs were swollen. Staff K stated they did a Doppler study (ultrasound test) of the legs and there was no infection, and increased the resident's Lasix [a diuretic]. Staff K reviewed the resident's care plan and stated the resident's swollen legs were not identified or addressed in his care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 02/26/2020 at 11:18 AM, the DNS stated that Resident #406's swollen legs should have been care planned but were not. 42378 ACCIDENTS -BEDRAILS and MANUAL WHEELCHAIR RESIDENT #30 Resident #30 was a long-term care resident who readmitted to the facility on [DATE]. His diagnosis list included non-traumatic bleeding in the brain, spina bifida (a congenital defect of the spine and often causes paralysis of the lower limbs), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease) and Charcot's joint (a progressive degenerative/destructive joint disorder in patients with abnormal pain sensation and proprioception) - left elbow). A review of his significant change of condition Minimum Data Set (MDS) dated [DATE] showed resident had intact cognition and needed two people assistance for activities of daily living (ADL) except for eating and locomotion. A review of the physician's orders showed an order on 07/23/2019 for bed rails size 1/2 both sides for turning. A review of the records showed a bedrail evaluation for 01/27/2020 and showed documentation that Physical Therapy completed a power wheelchair assessment on 10/31/2019. In addition, the record showed resident had signed the risk versus benefit of continuing to go out in a power wheelchair unsupervised on 02/04/2020. A review of the care plan printed on 02/14/2020 showed the care plan for requires assistance/is dependent for ADL care and risk for falls had the goals revised on 02/05/2020 but interventions did not include use of bed rails and manual wheelchair. The ADL care plan interventions listed provide total assist of 2 for bed mobility but no mention for use of bedrail to aid with turning or repositioning. It also stated resident uses electric wheelchair but resident is currently using a manual wheelchair related to the electric wheelchair needed replacement. The fall care plan did not include the use of bed rails under its interventions. There was no care plan specific for mobility in the record. Further record review of the whole care plan printed on 02/14/2020 especially the resistant to plan of care related to diagnosis of schizophrenia, cognitive loss and daily routine preferences/activities care plans did not mention about resident signing the risk versus benefit related to preference of continuing to go out in a power wheelchair unsupervised. During an observation on 02/14/2020 at 05:29 AM, observed resident in bed and he was able to hold on to the bed rail for positioning while Staff AA, Nursing Assistant Certified (NAC) was doing morning care. During an observation on 02/14/2020 at 10:22 AM, observed resident wheeling self in his manual wheelchair. He was able to use the railing on the walls to help mobilize. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/2020 at 12:00 PM, Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) stated use of bedrails should be care planned. In addition, she stated that bedrails used in positioning or turning should be care planned, if not in mobility then in ADLs. Following a joint record review at this same time with Staff D, RN/RCM of the care plans for ADL and fall, she noted that under interventions, the bedrails and manual wheelchair were not in the interventions. Furthermore, Staff D, RN/RCM reviewed the daily routine preferences/activity care plan and noted that it did not include the resident had singed the risk versus benefit related to preference to go out to the community unsupervised. UNNECESSARY MEDS/PSYCHOTROPIC MEDICATIONS/MEDICATION REGIMEN REVIEW RESIDENT #30 Resident #30 was a long-term care resident who readmitted to the facility on [DATE]. His diagnosis list included non-traumatic bleeding in the brain, spina bifida (a congenital defect of the spine and often causes paralysis of the lower limbs), paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), schizophrenia (a serious mental disorder in which people interpret reality abnormally), unspecified psychosis, depression, anxiety and delusional disorders/hallucinations. A review of his significant change of condition Minimum Data Set (MDS) dated [DATE] showed resident had intact cognition and needed two people assistance for activities of daily living except for eating and locomotion. A review of the Medication Regimen Review (MRR) sheet for July 2019 for use of Aripiprazole (antipsychotic medication) showed a recommendation to do an Abnormal Involuntary Movement Scale (AIMS) showed a recommendation to do the AIMS test now and at least every 6 months thereafter and signed on 08/05/19. Further review of the clinical records showed an AIMS test done on 08/05/2019 but none thereafter. A review of the care plan printed on 02/14/2020 for at risk for complications related to the use of psychotropic drugs . revised on 02/08/2020 did not include doing AIMS test every 6 months per MRR to assess for involuntary movements related to use of Aripiprazole. During a joint record review and an interview on 02/26/2020 at 12:09 PM with Staff D, RN/RCM, she stated the AIMS test was overdue. Informed Staff D, RN/RCM to review the care plan for psychotropic medication to get it updated, as it did not include the every 6 months AIMS testing to address risk for involuntary movements related to use of Aripiprazole. During an interview on 02/26/2020 at12:50 PM with Staff I, Social Services director about the AIMs test not done for February and psychotropic care plan not including the AIMS test to be done every 6 months and she said nursing does the AIMS test and update the care plan for psychotropic drug use. During an interview on 02/26/2020 01:11 PM with the Director of Nursing Services (DNS) about the MRR process, she was also informed the care plan for psychotropic drug use was not updated related to the AIMS testing and Staff D, RN/RCM was notified about this. The DNS stated she would follow-up with Staff D, RN/RCM regarding this. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ACCIDENTS- SMOKING RESIDENT #37 Resident #37 admitted to the facility on [DATE] for long-term care. He readmitted on [DATE] following hospitalization . His diagnosis list included Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, schizophrenia (a serious mental disorder in which people interpret reality abnormally), bipolar disorder and anxiety. A review of his most recent significant change of condition Minimum Data Set (MDS) dated [DATE] showed intact cognition and needed supervision for all of his Activities of Daily Living (ADLS) except for eating, dressing and toileting. It was also marked Yes for tobacco use. A review of the care plan (printed on 02/12/2020) for smoking initiated on 07/19/2018 and revised on 08/06/2019, had an intervention created on 11/02/2019 that stated, Offer the cigarette device to use while smoking to protect resident finger/skin. During an observation on 02/13/2020 at 01:25 PM, resident #37 was smoking outside, had a smoking apron but noted to be smoking without the black extension device to help prevent fingers from getting burn. During this same time, in an interview with Staff U, Non-certified nurse aide/smoking tech, she stated that the black extension item was missing after she came back from lunch yesterday. She stated she was just watching resident smoke to make sure he got rid of his cigarette so he does not get burn on his fingers. During an observation on 02/18/2020 at 08:53 AM, resident #37 was smoking without the extension device and was using smoking apron. The Administrator was providing the supervision and had reminded the resident to dispose his cigarette when it was near the end of the cigarette butt. During an interview on 02/18/2020 at 03:33 PM with DNS, she was informed that the extension device was missing since 2/13/2019 and that per care plan, resident was supposed to have it during smoking to prevent burning. In addition, notified DNS that resident had been smoking without the black extension device twice, on 2/13/2020 and on that day (02/18/2020). She stated that she was not aware the device was missing. She stated that the device could easily get lost for it is tiny. She stated she would buy the cigarette device on that day and will get 2 pieces so there would be a backup if it gets missing. During a follow-up interview on 02/20/20 at 12:01 PM, Staff U, Non-certified nurse aide/smoking tech stated that resident now had several cigarette extension device and she got it like 2-3 days ago. Furthermore, Staff U, Non-certified nurse aide/smoking tech had stated that she had notified the DNS the day the device got missing on her shift (which was 02/12/2020 per 2/13/2020 interview with her) when asked if she had informed the DNS about the missing device for per DNS, she was not aware the device was missing. GENERAL - SKIN CONDITION (NON-PRESSURE) RESIDENT #37 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #37 admitted to the facility on [DATE] for long-term care. He readmitted on [DATE] following hospitalization . His diagnosis list included Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, schizophrenia, bipolar disorder and anxiety. A review of his most recent significant change of condition Minimum Data Set (MDS) dated [DATE] showed intact cognition and needed supervision for all of his Activities of Daily Living (ADLS) except for eating, dressing and toileting. A review of the physician's order showed an order on 9/20/2019 for Weekly skin check - document in PCC under Skin check UDA, every evening shift every Thursday. A review of the care plan printed on 02/12/2020 for at risk for skin breakdown which was created on 10/30/2018 and revised on 11/02/2019 had an intervention for weekly skin assessment by license nurse. A review of the February eTAR (electronic Treatment Administration Record) for weekly skin check showed it was signed as done on 02/06/2020 but there was no documentation in the progress note for result of skin check or under the assessment for skin check. A review of the skin check log printed on 02/25/2020 showed an alert that a skin check was 19 days overdue with a due date of 02/06/2020. The last skin check done was for 01/30/2020. During an interview on 02/25/2020 at 10:42 AM, the DNS stated skin check is done once per week and if it is not in the assessment, then it was not done. In addition, she stated the electronic record (PointClickCare/PCC) should prompt nurses to do skin check in the User Defined Assessment (UDA). She also stated that for any wounds, there should be a measurement. She further stated that not all nurses document even if there is a prompt and she stated this is something she is looking into for wounds. During an interview on 02/26/2020 at 11:40 AM, Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) stated that the skin check was overdue after she reviewed the skin check record in the UDA. COMMUNICATION AND SENSORY PROBLEMS RESIDENT #46 Resident #46 is a long-term care resident who readmitted to the facility on [DATE]. His diagnosis list include cerebral infarction (is an area of necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain), aphasia (loss of ability to understand or express speech, caused by brain damage), and hemiplegia (paralysis of one side of the body) affecting right dominant side. A review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] showed resident had a short term and long term memory loss, no speech and was marked as rarely/never understood for ability to make express ideas or wants and rarely/never understands for ability to understand others. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a joint observation and interview on 02/25/2020 at 02:54 PM with another surveyor and Staff D, Registered Nurse (RN)/Resident Care Manager (RCM), resident smiled at surveyors upon greeting. Observed resident to have limited ability to understand; he was able to nod head or raised his left hand when asked. During an interview on 02/25/2020 at 03:12 PM, Staff S, Licensed Practical Nurse (LPN) regarding communication like for pain, she stated that she could tell if resident is on pain or not for resident can answer yes/no thru gestures. She further added that for yes, resident will nod his head but for no, he would raise his left hand. A review of the care plan for communication initiated on 02/23/2012 and revised on 09/2019 had an intervention of can nod his head yes and no. The care plan intervention was not person-centered for it did not include the specific way resident communicate his no which according to an interview with Staff S, LPN on 02/25/2020 at 03:12 PM, resident would raise his hand for no. During a joint record review of the communication care plan and an interview on 02/26/2020 on11:40 AM with Staff D, RN/RCM, she stated that resident could say yes/no at times but mostly non-verbal or used gestures. She further stated she was not aware of the resident's way of communication for a no was a gesture of using raising his left hand but had agreed when informed about this stating that Staff S, LPN had worked with resident more. TUBE FEEDING RESIDENT #75 Resident #75 was a long-term care resident that readmitted to the facility on [DATE] following an overnight stay at the ER for G-tube displacement. Her diagnosis list include cerebral infarction (an area of necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain), hemiplegia (paralysis on right side, aphasia (loss of ability to understand or express speech, caused by brain damage0 and dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). A review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] showed resident as non-verbal, with short term and long-term memory loss. She was NPO (nothing by mouth). For the nutrition section of the MDS, it showed resident had no weight loss and was on a feeding tube. A review of the physician orders showed an order on 07/15/2019 to weigh monthly. A review of the care plan titled at nutrition risk for weight loss related to nutrition and fluid needs being provided via enteral tube feeding due to dysphagia and NPO status' with a revision date of 10/07/19 showed an intervention to weigh as ordered and alert dietitian and physician to any significant loss or gain. A review of the weigh log printed on 02/14/2020 showed the last weight was on 01/06/2020 for 155 lbs. There was no weight recorded for February 2020. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/2020 at11:31 AM, Staff D, Registered Nurse (RN)/Resident Care manager (RCM) stated the facility practice was to weigh resident monthly unless there was weight fluctuation. During a joint record review of t [TRUNCATED]

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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** 12273 Based on observation, interview and record review the facility failed to provide assistance to residents with activities of daily living (ADL I.e. dressing. grooming, hygiene and bathing (or showers) for 4 of 12 sample residents (#95, #47, #90, #37) who needed assistance to maintain personal grooming and hygiene. Failure to ensure the residents who needed assistance with personal hygiene needs placed the residents at risk for health complications associated with unmet care needs. Findings included: Failure to assist with grooming, and hygiene Resident 95 The resident was re admitted to the facility 02/22/20 with multiple diagnosis including a stroke that affected with residents functional abilities. The last quarterly Minimum Data Set (MDS) assessment, dated 01/11/20, indicated the resident needed extensive assistance of two staff to completed Activities of Daily Living (ADL's I.e. transfers, dressing, grooming, toileting and mobility). The assessment also indicated the resident was rarely understood, and had severely impaired cognition. The care plan noted self-care deficits for ADL's including, bathing, grooming, and hygiene. The interventions noted encourage the resident to be up in wheelchair daily, and noted the resident preferred showers two times a week, in the evening. The care plan note the resident had a history of severe depression, and on 01/18/19, staff added a directive noting if the resident refuses care to re-approach again. The care plan for activities noted the resident's DPOA, felt it was important the resident establish a daily routine. family On 02/05/20, on 02/07/20, on 02/10/20, Resident #95, remained in bed wearing a hospital gown. On 02/11/20 02:37 PM resident remains in bed sleeping wearing hospital gown On 2/11/20 at 12:30 PM, Staff B was interviewed about the resident care. Staff B, yes but he frequently refuses. During subsequent visits to the facility and observations (02/12, 13, 14, 18, 19, 20, 21, of 2020) Resident was always in bed and never observed out of his room. On 02/14/20 the documentation for assistance with bathing for the last 90 days (12/16/19 - 02/14/19) was provided the last shower documented Resident was assisted with a shower on 12/17/19, there was no evidence the Resident had received a shower since then. (continued on next page)

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Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/18/20, at 2:45 PM, the DNS stated the record was not accurate and she would ensure the resident was assisted with a shower as scheduled in the evening. Even though on 02/13/2020 at 1:28 pm, Staff V, a shower aide reported the position was vacated several months ago and the position remained unfilled. And Staff NN, was scheduled to provide showers but because of short staffing was reassigned on 02/18/20. RESIDENT #47 The resident was admitted to the facility, prior to 2010 with multiple diagnosis, which include anxiety and r. The last quarterly MDS assessment, dated 12/07/19, documented the resident did not transfer, walk or use a wheelchair for locomotion, and needed extensive assist from staff with other Activities of Daily Living (ADL's) including dressing, grooming and hygiene, eating and bathing. The, MDS did not identify the resident had refusals of care, however previous assessment completed, noted the resident refused care on a daily basis. The care planed noted self-care deficits related to medical diagnoses, was initiated 10/05/16, and last revised on 12/11/20. The staff also noted the resident refused care (described as repositioning, dressing changes, showers, refusal to have hair combed or washed, and nail care.) The care plan directives indicated the resident needed one person assist with grooming, frequently refusals of care. Another section of the care plan identifying preferences stated it was important to choose between a bed bath and shower. On 02/05/2020 at 2:40 PM, Resident #49 was observed lying in bed wearing a hospital gown, the resident was asked if the staff help her get up daily, and responded they don't have enough staff to help her, get out of bed. When asked about bathing, she stated she is supposed to have a bed bath on Saturday, and commented that never happens. The resident was observed long hair, disheveled, dried clumps of food and /or particulate matter was tangled into the resident's hair on both sides of the face. It appeared the resident had contractures in all four upper and lower extremities. The feet were partially exposed and had visible dry and flakey skin on them. The resident finger nails were long and the resident hands were held in partially closed fists, the toe nails partially exposed were thickened, yellowed and long. On 02/07/20 at 10:25 AM, the Resident stated staff told her to get up in her chair today, and said she told me I am too lazy. The resident's hair appeared to be in the same condition, with visible clumps of food or matter tangled in the hair on both sides of her head. On 02/10/20, the resident remained in bed throughout the day, the hair remained unkempt and uncombed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/13/20 at 3:10 PM, a follow up interview was completed with Resident #49. When asked if staff assisted her with hair care, she stated no. When asked if assistance was provided with oral care, she hesitated and said if I ask, they will set up the supplies. When asked if the staff assist her with washing her face daily, she stated no. After asking about the resident hands, which were held in a partially closed fist and finger nails, which extended a 1/2 to 1 inch long past the finger tips. The resident stated the nails were not cutting in to the skin of the palm she did state verbally staff did assist with washing them a couple of times a week with washing her palms at least a couple times a week. When asked about bathing, the resident reassured me the LN does a good job of ensuring her lower body is washed when the daily wound dressing is completed. On 02/18/20, at 1:07 PM, Staff NN, the NAC assigned to the resident care was interviewed. When asked if she ever assisted the resident with hair care, responded no. When asked if assisted with washing her face she stated only if she asks. Staff then commented the resident has a lot of behaviors due to anxiety and reported the resident was non-compliant with care. On 02/18/20 at 1:11 PM, Staff H, the Resident Care Manager and a Licensed Practical Nurse, was asked to complete a joint interview with Resident #49. When asked if anyone ever helps her with hair care, the Resident commented I have a hard time getting my brief taken care of, no aide is going to have the time to help comb out my hair. Staff H, provided the resident with reassurance and agreed she would find a staff member to help with combing out her hair. On 02/20/20 at 2:45 PM, during a follow up interview Staff H, did state she gave several combs to the resident, to see which one she liked. When asked if she had followed up with her today, she reported she had not. The RCM, agreed to go talk to the resident together, however when approached the resident was sleeping soundly. On 02/21/20, at 1:15 PM, the resident was asked, if any one assisted her with hair care. Resident 49, said, a staff member had assisted brushing on the sides. It was noted the dried food or particulate matter was no longer visible, and was not tangled, however the resident stated the hair on the back of the head was matted. In addition the facility failed to ensure the stated preference for a bed bath, was care planned. 41070 FINGERNAIL CARE RESIDENT #90 Resident #90 was admitted to the facility on [DATE] with diagnoses that included diabetes, and cancer of the laryngeal cartilage (throat) with right lung and bone metastasis (spread of cancer cells), status post total laryngectomy (removal of the larynx [voice box]) and tracheostomy in 2017. Review of the 5 day Minimum Data Set (MDS) assessment dated [DATE], showed the resident required supervision to one to two-person assist with bed mobility, transfer, dressing, toileting and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled: ADL [Activities of Daily Living]: Fingernail Care effective date 12/01/06, showed Resident's fingernails will be cleaned and trimmed as needed or requested. Allow the resident to participate as much as possible. Assist only as necessary. An observation and interview on 02/10/2020 at 1:00 PM, the resident was sitting on the edge of his bed, and the resident's fingernails were long and underneath the fingernails contained black debris. The resident stated that he needed assistance with trimming his fingernails but no one in the facility was assisting him, and there was no hand sanitizer or hand wipes to clean his hands. An observation on 02/10/2020 at 1:26 PM, the resident was sitting on the edge of his bed, and the resident's fingernails were long and underneath the fingernails contained black debris. Staff L, Licensed Practical Nurse (LPN), was in the resident's room and the resident informed Staff L that he needed assistance with trimming his fingernails. Staff L responded to the resident and told him that his nurse would cut his fingernails for him. An observation on 02/13/2020 at 9:46 AM, the resident was sitting up in bed, and the resident's fingernails were long, and underneath the fingernails contained black and dark red debris. A joint observation on 02/13/2020 at 10:24 AM, the resident was lying in bed, and the resident's fingernails were long, and underneath the fingernails contained black and dark red debris. Staff F, Registered Nurse (RN), stated the resident's fingernails were long and dirty. Staff F stated that she was not sure who should cut the resident's fingernails and stated that she would ask the facility policy on fingernail care. An interview on 02/20/2020 at 1:29 PM, Staff K, Resident Care Manager, RN, stated she was not sure who should trim the resident's fingernails. Staff K stated the podiatrist cuts the resident's toenails if the resident was diabetic. Staff K stated should be an order and monitoring in the MAR or TAR to cut the resident's fingernails if the resident was diabetic. Staff K reviewed the February 2020 Medication Administration Record (MAR and Treatment Administration Record (TAR), and stated that there was no written order for fingernail care in the resident's MAR or TAR. Staff K stated it was not there. In another interview on 02/25/2020 at 2:13 PM, Staff K stated the facility should have assisted the resident to wash his hands, and should have provided the resident hand sanitizer or hand wipes at his bedside to clean his hands when needed. An interview on 02/26/2020 at 10:39 AM, the Director of Nursing Services, stated that licensed nurses should be cutting the resident's fingernails because the resident had diabetes. 42378 NAILCARE and SHOWERS RESIDENT #37 Resident #37 admitted to the facility on [DATE] for long-term care. He readmitted on [DATE] following hospitalization . His diagnosis list included Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, schizophrenia, bipolar disorder and anxiety. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of his most recent significant change of condition Minimum Data Set (MDS) dated [DATE] showed intact cognition and needed supervision for all of his Activities of Daily Living (ADLS) except for eating, dressing and toileting. A review of the care needs/ADL log showed resident needed assistance with dressing and personal hygiene. A review of the bathing log printed on 02/19/2020 showed bathing schedule for 2/1/2020, 2/8/2020 and 2/15/2020 was marked not applicable for type of bath resident had, indicating resident did not receive a shower for 3 weeks. A review of the policy for fingernail care with effective date of 12/01/06 stated, resident's fingernails will be cleaned and trimmed as needed or as requested, allow the resident to participate as much as possible and assist only as necessary. The purpose of the policy is to promote routine hygiene of hands and nails. A review of the policy for shower with effective date of 12/01/06 stated, A shower is provided for residents who wish to participate. Showers are given according to a pre-determined schedule and as needed or requested. Allow the resident to participate as much as possible. The purpose of the policy is to provide/assist resident with routine hygiene. During an observation on 02/06/20 at 11:30 AM, resident #37 noted to have long uncombed hair, long facial hair/beard and his fingernails were short but had dark brown color under the tips of the fingernails. During an observation on 02/13/20 at 01:37 PM, resident noted to have long beard, hair uncombed and long fingernails. Also noted dark matter under fingernails of right hand. Lunch tray at bedside table - pureed food and thickened liquids, touched the pudding and had some pudding on the front of his sweater. During a joint observation and an interview with Staff Q, NAC on 02/19/20 at 09:12 AM, resident fingernails were nails are short but had gray matter under the tips. Staff Q, NAC stated that resident would let him help with combing his hair but he gets back to bed often after smoking and meals. He also stated he helped the resident shaved, as he would allow. He also stated the shower aide helps with the shaving and the nails. He stated he would ask the shower aide to give resident a shower and a shave and to do the nails. Resident #37 had agreed to have a shower, shave and have his nails done when asked by Staff Q, NAC. However, Staff Q, NAC also added that when resident gets to the shower room, he would refused. During an interview on 02/19/20 at 11:11 AM, Staff V, NAC/shower, she stated the shower for the unit where resident #37 resides was on vacation. She further stated there is only one regular shower aide for now. She stated an NAC was scheduled on Tuesdays and Wednesdays to help provide showers, however this NAC was pulled out to work on the floor on 02/18/2020. During a follow-up interview on 02/19/20 at 01:18 PM, Staff V, NAC/shower aide stated she gave resident #37 a shower and he let her cut his beard and his bushy eyebrows. She stated resident did his own handwashing and fingernails. She stated resident was not on his regular shower list but was a request for shower so she was not able to answer if resident had refused shower and what intervention as provided for refusal. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/20 at 11:37 AM with Staff D, Registered Nurse (RN)/Resident care manager (RCM) was notified that resident did not have a shower for 3 weeks related to no shower aide for shower aide was on vacation. Reference: (WAC) 388-97-1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on observation, interview, and record review, the facility failed to ensure treatment and care was provided in accordance with professional standards of practice for two of four residents (#97 & #37) reviewed for bowel management, for three of five residents (#105, #63 & #59) reviewed for non-pressure related skin issues, and for one of four (#75) reviewed for dental care services. Failure to monitor, assess, and treat constipation for Resident #97 & #37, failure to monitor and provide a thorough skin assessment and wound care treatments for Resident #105, #63 & #59, and failure to monitor bleeding gums during antibiotic treatment for Resident #75 placed the residents at risk for adverse consequences, related complications, and a diminished quality of life. Review of the facility policy titled: Standing Orders Template for Constipation revised on 11/28/2017, showed: 1. If no bowel movement in three days, give milk of magnesia 30 ml [milliliter] PO [by mouth] x one dose at bedtime. 2. If no bowel movement within next shift, give Dulcolax suppository PR [per rectum] x one. 3. If no bowel movement within two hours, give fleet enema. 4. If no results from Fleet enema, call physician/advanced practice provider for further orders. Review of the policy titled: Skin Integrity Management revised on 01/31/2020, showed to Identify patient's [resident] skin integrity status and need for prevention intervention or treatment modalities though review of all appropriate assessment information: Perform skin inspection on admission/readmission and weekly. Document on Treatment Administration Record [TAR], or in Point Click Care [PCC- software program], Perform wound observations and measurements and complete Skin Integrity, weekly, and with anticipated decline of wound. CONSTIPATION RESIDENT #97 Resident #97 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke) and heart failure. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] showed the resident was cognitively intact, and required the assist of one to two staff members for bed mobility, transfer and toileting. Review of the task for toilet/bladder/bladder for January 2020, showed the resident did not have a bowel movement for six days on from 01/24/2020 to 01/29/2020 - no PRN [as needed] bowel medication was given to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed the resident had the following PRN medication orders for constipation: 1. Polyethylene Glycol Powder (Glycol 1450) give 17 gram by mouth every 24 hours as needed for constipation. Administer with 4 to 8 ounces of water. 2. Dulcolax (Bisacodyl) suppository, insert 1 suppository rectally every 24 hours as needed for constipation, if enema is not working. 3. Docusate (Enemeez Mini 283 milligram rectal enema) give every 24 hours PRN for constipation. Further review of the January 2020 MAR and TAR, showed none of the PRN medications for constipation listed above was given to the resident from 01/24/2020 to 01/29/2020 when the resident was having constipation and did not have a bowel movement lasting for 6 days. During an observation and interview on 02/11/2020 at 1:31 PM, the resident was lying in bed, and the resident stated that he had problems with constipation and he did not have a bowel movement for more than 3 days. During an interview on 02/14/2020 at 5:03 AM, Staff FF, Registered Nurse (RN), stated that the NACs [Nursing Assistant Certified] should be reporting to the nurses if the resident was having constipation. Staff FF reviewed the resident's bowel movement for January 2020 and stated the resident did not have a bowel movement for 6 days from 01/24/2020 to 01/29/2020, and the resident was not given any prn medication for constipation. Staff FF stated their protocol was to give the medication Milk of Magnesia, and if no bowel movement or result then they would give a suppository. During an interview on 02/14/2020 at 5:31 AM, the Administrator reviewed the resident's bowel records with Staff FF, and stated that they would follow-up with the resident's constipation. During an interview on 02/14/2020 at 6:29 AM, the Director of Nursing Services (DNS), stated PRN meds should be given if there was no BM after 3 days, and were to start the bowel protocol. The DNS also stated that LNs [Licensed Nurses] were responsible for monitoring the resident's bowel movement because LNs were able to see the alert charting for the residents who had no bowel movement for 3 days in the computer. During an interview on 02/19/2020 at 3:05 PM, Staff K, Resident Care Manager, RN, stated that LNs should have followed the facility bowel protocol but were not. NON-PRESSURE RELATED SKIN ISSUES RESIDENT #105 Resident #105 was admitted to the facility on [DATE] with diagnoses that included vertebral (thoracic area) osteomyelitis (infection of the bone) and peripheral vascular disease (a slow and circulation disorder caused by narrowing, blockage or spasms in a blood vessel and may affect arteries and veins). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission/5 day Minimum Data Set (MDS) assessment, dated 01/29/2020, showed the resident was cognitively intact, and required the assist of two staff members for bed mobility, transfers and toileting. Review of the nurse practitioner notes dated 01/26/2020, showed the resident had multiple small wounds noted mostly to lower extremities, most noted w/ [with] superficial & stable dry scabs. Wound of right anterior shin & right 2nd toe w/noted bleeding, otherwise w/o [without] infection. Will order to clean with NS [normal saline solution], pat dry, & cover w/non-adhesive, topical antibiotic ointment to right second toe. Will refer to Skilled Wound Care for further eval [evaluation] & management. Review of the January 2020 Physician Order, initiated on 01/23/2020 showed a treatment order for the resident's legs: a) Cleanse bilateral [both] lower extremity wounds with normal saline, b) Apply no sting skin prep to peri-wound skin, c) Allow to dry for 30 seconds, d) Apply Xerofoam to wound bed, e) Cover with dry gauze, f) Wrap with Kerlix and secure with paper tape, g) And to change dressing daily every evening shift and PRN [as needed] if soiled. Review of the February 2020 MAR and TAR showed the treatment order for the resident's legs and toes was not written in the current MAR or TAR, and no indication that Resident #105 was receiving the treatments to his bilateral legs and toes. In an observation on 02/07/2020 at 8:55 AM, showed the resident was in his room and sitting up in wheelchair. The resident had an open wound on his right anterior shin (lower leg). The wound on his right lower leg was slightly bloody, the wound edges was macerated with scattered scabs on the edges of the wound. The wound was not covered, and the resident was observed picking and scratching the edges of wound and the skin surrounding it. The resident stated that the wound on his right leg was scaly. An interview and joint record review on 02/19/2020 on 3:07 PM, with Staff K, RCM, RN, showed the treatment order for the resident's legs and toes were not written in the resident's January 2020 and February 2020 MAR and TAR. Staff K stated that the treatment order for the resident's legs and toes were not being done by LNs because the order was not carried out correctly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 02/19/2020 at 03:18 PM, with Staff K, the resident was observed in bed, and there was an undated dressing on the resident's right frontal shin. The resident stated that he had been in the facility since December 2019, and it was the first time he received a dressing on his right leg. There was no dressing on his right fourth toe, and the right fourth toe's skin layer was almost gone exposing a 100% red open wound. On top of the resident's right foot was a small abrasion and it was bleeding. The resident stated that the wound on his right leg and right fourth toe were painful when he was itching, and it could be from worry. The resident also stated the wound doctor was worried about his left third toe. The resident's left third toe was lightly red and peeling. Staff K stated that the resident was seen for the first time that morning by the wound doctor, and she would address the resident skin issues. An interview and joint record review on 02/26/2020 at 11:02 AM with the DNS, the DNS stated there was a skin assessment completed on 02/14/2020 and 02/21/2020. The 02/14/2020 skin assessment showed, the skin assessment identified the left toe and left shin, but it did not identify the resident's open wound on his right leg and right fourth toe. The DNS stated that those were the only skin assessments completed for Resident #105 since admission. The DNS also stated that LNs should do a thorough skin assessment, and document the skin issues on the skin assessment form, and the skin assessment should be completed every week, and follow the doctor's order for wound treatments but were not. In addition, the goals, treatment interventions, and evaluation for the resident's skin issues were not addressed in the resident's care plan, as required. 42378 CONSTIPATION RESIDENT #37 Resident #37 readmitted on [DATE] following hospitalization . His diagnosis list included schizophrenia. A review of his most recent significant change of condition Minimum Data Set (MDS), dated [DATE], showed intact cognition and needed supervision for all of his Activities of Daily Living (ADL) except for eating, dressing and toileting. It also showed the resident was continent of bowel. A review of the Physician orders for February 2020 showed orders for several bowel medications, which included Glycolax powder, Milk of Magnesia, Sennosides, Dulcolax suppository and Fleet enema to be given PRN [as needed] per for bowel protocol. A review of the 30-day Bowel Movement (BM) log, printed on 02/20/2020, showed Resident #37 did not have a bowel movement for 3 days from 01/22/2020 - 01/24/2020, and for 8 days from 02/07/2020 - 02/15/2020. In addition, there was no log or charting of BM for 2/16/2020 - 2/17/2020. A review of the electronic Medication Administration Record (eMAR) January 2020 and February 2020 eMAR showed the resident did not receive any PRN bowel meds to manage/treat constipation. A review of the medical record and task log showed no documentation record of the amount of fluid intake provided to help with the constipation or to restore normal bowel function. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the 30-day toileting log, printed on 02/13/2020, showed Resident #37 as independent to supervision with toileting, and needed occasional assistance. During an observation on 02/05/2020 at 11:03 AM, Resident #37 was independent with a front wheel walker (FWW), able to toilet himself and put himself to bed after toileting. During an interview on 02/13/2020 at 01:37 PM, Resident #37 stated that he did his own toileting. During an interview on 02/14/2020 at 06:59 AM, Staff Q, Nursing Assistant Certified (NAC) stated that Resident #37 was independent with toileting including peri-care and had been continent of bladder and bowel. During an interview on 02/20/2020 at 02:02 PM, Staff Q, NAC, stated that he charts the BMs daily, at the end of each shift after he asked Resident #37 if he had a BM. However, Staff Q, NAC stated he was not sure if Resident #37 had a BM for he would just say yes/no when asked. During an interview on 02/20/2020 at 11:35 AM, Staff S, Licensed Practical Nurse (LPN) stated the process for bowel protocol were as follow: the NAC charted the BM, the electronic record (Point Click Care/PCC) would put out an alert if resident had no BM for 3 days and then the nurse start with bowel meds per protocol. During this same time, Staff S, LPN did a record review of resident #37's BM record and acknowledged the charting showed no BM from 02/07/2020-02/15/2020 and a large BM on 02/18/2020. During a follow-up interview on 02/20/2020 at 02:25 PM, Staff S, LPN stated she would assess Resident #37 if he feels constipation or if had a BM and what size was the BM, if there is a PCC alert for no BM for 3 days. Staff S, LPN stated that sometimes, it could be tricky for Resident #37 may not remember very well unless he just got out of the toilet. Staff S, LPN stated that she is personally not concern for constipation for Resident #37 is active and loves to eat apple sauce when asked about risk for constipation. She was aware there was no documentation on the assessment for constipation. During an interview on 02/21/2020 at 12:53 PM, Staff D, Registered Nurse (RN)/Resident care manager (RCM) stated the facility's process for monitoring for BM start with the PCC alerting the nurse for no BM for 3 days and then the nurse starts with the Glycolax per bowel protocol if indicated. During this time, Staff D reviewed the BM log for no BM from 1/22/2020-1/24/2020 (3 days) and from 2/7/2020 - 2/15/2020 (8 days) and no BM charting for 2/16/2020-2/17/2020 and said it was a documentation issue on the part of the NAC. Did a joint record review with Staff D, RN/RCM of the eMAR and she agreed that resident did not receive the bowel meds per bowel protocol on 1/22/2020-1/24/2020 and on 2/7/2020 - 2/15/2020. Staff D, RN/RCM was not able to provide a documentation from the PCC alert about assessment for constipation. Staff D, RN/RCM stated for independent residents such as Resident #37, there should be a documentation in the progress note that would show the nurse had assessed for constipation such as resident had no constipation. During the same said interview, Staff D, RN/RCM stated the facility has a working system in place, for assessment for constipation but the big issue was on documentation related to staffing shortage. During an interview on 02/25/2020 at11:09 AM with the Director of Nursing Services (DNS) regarding the BM log, she stated there was a PCC alert and the nurses should assess for constipation and write a progress note before they clear the alert. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview on 02/25/2020 at 03:26 PM, the DNS stated resident was alert and she assessed resident for s/s of constipation and had no pain. She stated the staff was just not documenting it. She agreed that it was a documentation issue. DENTAL CARE RESIDENT #75 Resident #75 was a long-term care resident that readmitted to the facility on [DATE] following an overnight stay at the emergency room for feeding tube displacement. Her diagnosis list included periodontitis (inflammation of the tissue around the teeth). A review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] showed the dental section marked for obvious or likely cavity/broken natural teeth but no bleeding gums. During observations between 02/05/2020 to 02/20/2020, Resident #75 lips was dry with dried brown color matter. During an interview 02/19/2020 at 09:00 AM with Staff Q, Nursing Assistant Certified (NAC), he stated oral was done every 2 hours and the bleeding was in the gums and resident had seen the dentist for it. A review of the medical records showed Resident #75 with bleeding gums since 11/26/2019, and the facility had been working on her dental insurance and getting an early dental appointment but the soonest dental appointment was for February 7, 2020. A review of the medical record showed Staff FF, Nurse Practitioner (NP) checked Resident #75 on 01/29/2020 for increased bleeding/swelling/redness to gums, multiple dental caries and foul pungent odor to mouth. Staff FF, NP ordered an antibiotic to be given one time per day per the feeding tube for 1 week for periodontitis. Further record review showed on 01/31/2020, Staff FF extended the antibiotic order to be given until 02/19/2020 or until follow-up with dentist. A review of progress notes showed documentation by Staff D, Registered Nurse (RN)/Resident Care Manager (RCM) that the dentist saw the Resident #75 on 02/07/2020 and recommended oral extraction. However, the record had no dentist notes to review if the antibiotic will continue or not, since the order had stated until 2/19/2020 or f/u (follow-up) with dentist. During an interview on 02/25/2020 at 09:30 AM with Staff S, License Practical Nurse (LPN), she stated the monitoring for bleeding gums as side effects for anticoagulant use was marked a 0[zero] for staff associated the bleeding gums with the periodontitis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview on 02/25/2020 at 10:18 AM, Staff S, LPN stated there was no documentation record for monitoring of bleeding gums related to periodontitis and also, if it was improving or worsening with antibiotic treatment. Staff S stated there was nowhere in the electronic Medication Administration Record (eMAR) to document about the bleeding gums. Staff S, LPN stated the nurses only did 72 hours documentation for Resident #75 per their software alert system, rather than for the whole course of the antibiotic therapy. During an interview on 02/25/2020 at 10:20 AM with Staff UU, RN/Nurse Consultant, a request was made for the dentist notes for the 02/02/2020 dental visit and Staff UU stated that Staff I, Social Service (SS) Director was requesting for the dental notes. In an interview on 02/25/2020 at 10:42 AM, the DNS stated the process for when a resident went out for an appointment, a report of the visit should come back with resident. Furthermore, she stated that if there was no report on the actual day of the appointment, at least the report should be available the next day. The DNS stated that for the charting for monitoring for the bleeding gums should be for the entire course of the antibiotic therapy but the Point Click Care (PCC) has a glitch where it only prompts the nurses to document for 72 hours after a significant change. She further added that nurses should document especially on antibiotic use. The DNS stated there should be a monitoring for bleeding gums if it was improving or worsening especially for resident #75 who was also on an anticoagulant. During a follow-up on 02/25/2020 at 03:30 PM, the DNS was not able to provide a copy of the dental report and stated the facility is still requesting it. During an interview on 02/26/2020 at 11:17 AM, Staff D, RN/RCM stated the antibiotic did not work, thus the referral for Resident #75 to see a dentist. Staff D, RN/RCM stated Resident #75 came back without a summary report of the visit, whether the antibiotic will continue or not. Staff D, RN/RCM stated the documentation for monitoring for bleeding gums and use of antibiotic was for 72 hours only, per alert on the PCC. Staff D, RN/RCM stated there was no failed practice despite lack of monitoring and documentation for bleeding gums and its response to antibiotic treatment for facility was doing their monitoring and charting according to their software and facility practice. Furthermore, Staff D, RN/RCM stated that if there was a need to change the monitoring or documentation, the facility had to fix the software. During an interview on 02/26/2020 at 01:25 PM, the DNS stated a copy of the dental report should have come back with Resident #75 on 02/02/2020. Following a joint record review of the dental folder in Staff D's office and the copy of the dental note with a faxed date of 02/26/2020 at 10:41:29, the DNS admitted there was no summary report that came back with Resident #75. Further record review of the dental notes for 02/07/2020 with the DNS showed the use of antibiotic was not addressed, whether to continue or discontinue following the dental visit. The DNS stated, Let me look into the details when asked if there was a failed practice with dental care since the report was not received and reviewed timely. 12273 Resident #63 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was last readmitted to the facility in 2013 with multiple medical diagnosis including dementia. The most recent Minimum Data Set (MDS) assessment, dated 12/26/2019, showed the resident needed extensive staff assistance to complete the Activities of Daily Living (ADLs) such as bed mobility, transfers, dressing and grooming, and used a wheelchair pushed by staff for locomotion. The assessment also showed the resident had severely impaired cognition. The MDS did not identify any skin issues. The care plan, dated on 02/05/2019, showed the resident was at risk for skin breakdown and the resident had bilateral lower extremity redness. The care plan was updated on 12/09/2019 to include weekly wound assessments by the licensed nurse, and showed to include the measurements and description of any wounds, use of lower extremity protectors (a stocking skin protector), and directed staff to float heels while the resident was in bed. The physician orders for February 2020, included a wound treatment three times a week was initiated on 01/24/2020. The treatment included cleanse, pat dry, cover with hydrocolloid dressing (a treatment used to debride a wound with eschar) and ensure leg protectors are in place when up and identified the wound as an abrasion. During an observation on 02/11/2020 at 10:28 AM, showed Resident #63 sleeping on top of the bed. The resident did not have any pillows in place for positioning. During an observation on 02/11/2020 at 01:28 PM, showed Resident #63 was sleeping in the common area in a wheelchair. His right leg was crossed over the top of his left knee (creating friction and pressure to the area behind the right knee where the open wound was located). There were no pillows in place for positioning. During an observation on 02/13/2020 at 1:30 PM, showed the resident was in the common area sitting in the wheelchair with his right knee crossed over the left knee. There were no pillows in place for positioning. During an observation on 02/21/2020 at 3:15 PM, showed Resident #69 seated in the common area in the wheelchair within a small group of residents. The resident had pulled the right pant leg up above the knee, and the wound was exposed, the dressing was on the arm trough on the left side of the wheelchair and the adhesive bandage was on the floor next to the wheelchair. The leg protector was not in place and no staff were present. The DNS was alerted to the resident's condition and assisted the resident back to his room to replace the wound dressing. During an observation on 02/20/2020 at 10:45 AM, showed Staff C, a Licensed Practical Nurse, preparing to do a wound dressing change. The resident was wearing a leg protector in place on the right leg which extended from above the knee to the mid shin. After removing the leg protector, Staff C then removed an adhesive bandage and dressing which had yellow-brown tinged stain on it. The lateral lower leg wound (behind the knee) appeared as a shallow crater and the wound base showed a white-colored material adhered to it. The tissue surrounding the wound (peri-wound) was reddened. The resident called out in pain while the nurse repeatedly attempted to wipe the wound base. Staff C stated it started as a dry scab (an unstageable pressure ulcer) when asked what stage the wound was. Staff C, said it was caused by the resident picking at the skin. Although the staff reported the wound was caused by scratching, the resident's nails were well groomed short and had smoothly rounded tips. The Staff C then measured the wound, noting it was 1.8 centimeters (cm) x 1.9 cm x 0.1 cm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this observation, Resident #63 crossed his right leg over the left which placed the wound directly on the left knee cap. After the right leg was positioned by the resident, a second scabbed area (unstageable pressure ulcer) was exposed on the right lower inner leg (behind the knee). The scab was the size of a nickel, Staff C stated that the area was not new and stated the ARNP was aware of the wound. During an interview on 02/20/2020 at 12:25 pm, Staff D, a Registered Nurse and Resident Care Manager, stated that the knee wounds were not related to pressure. Staff D stated the wound on the lateral aspect of the knee started as a blister, and reported the skin team did not following the resident. A progress note entry, dated 12/09/2019, showed the resident had scattered scabs on the right lower extremity (RLE). However, no specific description of the location(s) and size of the scabs was noted on the skin checks or in the progress notes. A progress note, dated 12/11/2019, showed a blister was found on the right lower extemity (RLE), but the exact location and size were not documented. A weekly skin check, dated 12/23/2019, showed no skin injuries or wound were identified. A weekly skin check, dated 12/30/2019, showed there was a wound was below the right knee on the lateral side, however there was no measurements or description of the wound. The December 2019 MAR and TAR showed an order to place the leg protectors upon awakening and remove at HS (bed time) was initiated 11/25/2019. The MAR/TAR had not been initialed by the staff to show that the directive was done. The January 2020 (MAR) and (TAR) showed an 12/26/2019 order to place a non-adhesive dressing to dry scab/ wound to right medial and lateral wound to upper lower leg. On 01/25/2020, a wound treatment was initiated for an abrasion on the lateral right knee. Both treatment orders directed staff to place leg protectors when up and in the wheelchair. An assessment documented on 01/18/2020 by Staff FF, a Nurse Practitioner, noted the visit was related to right lower extremity(RLE) blisters. The assessment documented last visit discussed w(with) nursing staff to place pillows under RLE to prevent friction and pressure to blisters. The note showed that staff should continue to monitor the area for infection and/or additional areas of skin breakdown. Further review of the care plan on 02/20/20 showed no directives concerning the use of pillows to position the right lower extremity to prevent friction and pressure to the back of the knee. A 01/24/20 an assessment was completed by Staff GG, an Advanced Registered Nurse Practitioner (ARNP) showed the presence of a wound an abrasion. The note showed the size and description of the wound which measured 1.5 cm across and 0.2 cm deep with a dry wound, pink wound base; and peri-wound unremarkable. The treatment recommendation included a dressing, a thigh high leg protector(s), and a directive to provide nail care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/21/20 at 10:30 AM, Staff GG, the ARNP was interviewed. He stated the wound on the right lateral knee was an abrasion. The ARNP stated that the resident did scratch at the wound and the leg protectors were used to deter the behavior. When asked about the second scabbed area (scabbed area on the inner right leg (behind the knee), the ARNP stated, he was not aware of the second wound and commented he thought the skin wound team was monitoring and measuring the wound weekly. The facility did not ensure care plan directives to complete weekly skin checks and document the size and description of any wounds was consistently followed. The facility did not ensure leg positioning devices (pillows), and leg protectors were consistently implemented which resulted in Resident #63 developing a second unstageable wound on the medial aspect of the right knee. RESIDENT #59 The resident was admitted to the facility in 2017 with multiple medical diagnoses including failure to thrive. The most recent quarterly MDS assessment, dated 12/19/2019, showed the resident needed extensive assistance from 1-2 staff members to complete ADLs, including bed mobility, transfers, walking, mobility, dressing, grooming, and hygiene. The resident's care plan showed the resident was at risk for skin breakdown related to incontinence, limited mobility, psychotropic medications and diabetes. The care plan was updated on 12/23/2019 with a notation stating resident has multiple small wound on coccyx area. The care plan showed interventions to include position changes every two hours, use of barrier cream after each episode of incontinence, observe skin daily during ADL care and report abnormalities, and use pillows for positioning to off-load the coccyx area. A progress note, dated 12/23/2019, documented DOR (Director of Rehab) reported during visit today the resident has wound impairment on coccyx area On 02/26/20 at 3:00 PM, the DNS, provided additonal documentation, that included wound measurements. An Event Summary Report, noted the coccyx wound measured 1.5 x 1 cm, and 3 wounds measing 1 x1 cm were on the right buttock and a 1 x 1 cm open area was on the left buttock. On 12/23/2019, an order to off load (pressure from) coccyx area with pillows was initiated and placed on the treatment sheet(TAR). On 12/24/2019, a nurse progress note showed open areas on coccyx. Resident was educated not to lay down on his back in bed to prevent pressure sores. A skin check, completed 12/24/2019 at 11:24 AM, showed no skin impairments were identified. The physician order sheet showed a 12/24/2019 order: five small coccygeal wound(s) clean with NS (normal saline) and apply barrier cream day and evening shift. On 12/25/2019, a progress note showed the care plan included reposition q (every) 2 hours open area on coccyx. On 12/31/2019, a progress note showed that the resident's coccyx area had redness with small open area on bottom due to diarrhea. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A skin check, completed on 12/31/2019 at 9:24 PM, had the same information redness with small open area on bottom due to diarrhea. There was no evidence the wound was measured nor was there a description of the wound base or skin surrounding the open area. On 01/07/2020, a wound consult note showed the coccyx wound measured 2.0 cm x 1.0 cm with no depth with mild serous exudate, and the peri-wound area was raw. The wound consultant noted they would follow-up weekly. A skin check, completed on 01/14/20 at 9:24 AM, showed there were no new wounds identified, but that the skin was open on buttocks left and right which was not consistent with the one previously identified coccyx area. The next wound consultant visit note, dated 01/21/2020 (2 weeks later), showed that an additional wound had developed on the right buttock that was 1.5 cm x 0.5 cm. The assessment also noted the coccyx wound had deteriorated and measured 2.5 cm x 1.5 cm with no depth. The consultant note showed there was mild exudate, and described the peri-wound area was raw. During an interview on 02/25/2020 at 10:45 AM, the DNS was asked about the facility policy for assessment and monitoring of wounds. The DNS stated that the facility's expectation was to measure and document the size, location, and description of the wound weekly. The facility staff did not ensure the location, size and description of the wound(s) were consistently documented weekly. This left the facility without information needed to assess the effectiveness of the treatments and/or interventions care planned, and ensure the wounds were healing. Refer to: F656 Develop, Implement Comprehensive Care Plan Reference (WAC) 388-97-1060 (1)(3)(vii)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on observation, interview and record review, the facility failed ensure a resident with a hand contracture received appropriate hand splint placement to prevent worsening contractures with 3 of 6 residents (#70, #156). These failures placed Resident #70 at risk for worsening contractures, pain related to contractures and decreased quality of life. Findings included . Reveiw of the facility policy titled Restorative Nursing revised on 11/01/19, stated the purpose was to help the patient attain and maintain optimal physical, mental and psychosocial functioning. RESIDENT #70 The resident admitted to the facility on [DATE] with right and left hand contractures. According to the residents most recent Minimum Data Set (MDS) dated [DATE], showed the resident had impairment to both upper extremities. Review of the resident's most recent Occupational Therapy (OT) Discharge Summary with service dates from 06/27/2019 to 08/22/2019, showed the resident had right and left hand contractures. The document showed the resident was to wear bilateral hand roll splints for contracture management at least 4 hours daily upon discharge from OT. Review of the resident's care plan initiated on 11/17/2019, showed the resident was to wear a splint palm guard to her left and right hands. The goals listed were to maintain current function and skin integrity. In an observation on 02/06/2020 at 9:40 AM, the resident was observed to have bilateral hand contractures. Observation of her right hand showed a splint in place, however a cloth was placed in the palm of resident's left hand with no device splinting. In an observation on 02/14/2020 at 5:55 AM, The resident was observed wearing a splint on her right hand but had a cloth in her left hand contracture. In an interview on 02/25/2020 at 1:51 PM, Staff OO, Restorative Aide, stated she reported to the DNS any issues with restorative, got restorative care plans and documented restorative events in the computer. She stated she was the only restorative person and saw 17 to 18 residents daily. She also stated she was constantly pulled to the floor often for other NAC duties and stated when she was pulled to the floor, no one was available to do restorative. She stated the resident had a right and left hand splint the resident was to wear daily. She stated she had not seen the resident for the day, however in a joint observation of the resident's hands with Staff OO, showed the resident was wearing a splint to her right hand but her left was fully contracted to a fist with no splinting. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/25/2020 at 2:02 PM, Staff KK, Nursing Assistant Certified (NAC) stated the resident was supposed to wear a left hand splint but did not know where the left hand splint was and stated I don't know where it is. When asked if she had reported the splint missing she stated it had been missing for a while and she reported this to the Restorative Aide. In an interview on 02/26/2020 at 2:43 PM, the DNS stated the staff should have reported the splint missing and stated she would provide more education. 38430 RESIDENT #84 Resident #84 admitted to the facility on [DATE], the primary diagnosis list included cerebral infarction (stroke), and hemiplegia (paralysis) affecting left dominant side. A review of the quarterly minimum data set (MDS) assessment dated [DATE], showed the resident was cognitively intact. The MDS section for Functional Limitation in Range of Motion indicated the resident had upper extremity (shoulder, elbow, wrist, hand) impairment on one side. A review of the resident's current care plan dated 04/24/2019, showed, no care plan focus related to left hand contracture. A review of the facility Nursing assessment dated [DATE], showed the resident had a contracture to her left upper extremity. In an observation on 02/14/2020 at 11:09 AM, the resident was observed propelling herself with her right hand by pumping a lever attached to her wheelchair, the resident's left arm was resting in her lap and her left hand was contracted closed, with no splint in place. In an interview on 02/14/2020 at 11:00 AM, information was requested from the Director of Nursing Services (DNS) regarding the care and services the resident is receiving for her left hand contracture. The DNS stated, she will look into this. In an interview on 02/18/2020 at 10:02 AM, the DNS, stated, she had looked into the resident's left hand contracture and was not able to find any therapy evaluation that addressed the contracture at its baseline from her admit. She further stated, I am not sure why this did not get addressed but we are addressing it now. We have an order for therapy to document her baseline and recommend a restorative program. Reference (WAC) 388-97-1060 3(d)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on observation, interview, and record review, the facility failed to assess and implement effective interventions to reduce accidents for one of eight (#102) residents reviewed for fall hazards, four of five residents (#39, #66, #84 and #104) reviewed for smoking, and one of three residents (#64) for oxygen use hazards. These failures caused harm for Resident #102 due to fracture re-injury related to a fall, and placed the other residents at risk for serious injury and diminished quality of life. Findings included . Review of the facility policy titled Falls Management initiated on 09/15/01 and revised on 02/18/20, stated, Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will recieve appropriate interventions to reduces risk and minimize injury. The purpose of the policy was to reduce risk for falls and minimize the actual occurance of falls. Practice standards stated in the policy included communicating patient's fall risk status to caregivers. RESIDENT #102 The resident admitted to the facility on [DATE] with diagnoses to include Cervical Myelopathy (A condtion that results in loss of balance and trouble walking), Osteoporosis (chronic condition that causes bones to become weak and brittle, thus prone to fractures). Prior to admission, the resident ambulated using an assistive device related to weakness to her legs and impaired imbalance. Review of the a Nurse Practitioner progress note, dated 01/20/2020, showed the resident was admitted to the facility for rehabilitation after a right arm fracture she sustained from a fall at home on 01/11/2020. The note showed the resident had sustained re-injury to her fracture from a second fall that occurred few hours after admission (01/18/2020) while trying to ambulate without an assistive device to the bathroom. The documentation showed the resident sustained worsening displacement with deformity from the fall. Review of the Admission Nurse to Nurse Report that was done before a resident was admitted to the facility, dated 01/18/20, showed the resident had a right arm fracture with pain, and was non-weight bearing to the right arm (not to exceed the weight of a coffee cup). The report also showed the resident was a one person assist, walked with a cane, had a history of osteoporosis, and was continent for bowel and bladder function. The report showed the facility had knowledge that the resident used an assistive device and was at risk for falls and fractures. (continued on next page)

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	505042	A. Building B. Wing	02/26/2020

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility admission assessment, completed on 01/18/2020 at 11:12 AM, by Staff K, showed the resident had a fall with a fracture in the last month prior to admission. The assessment showed the resident's mental status was alert with no change in mental status. It also showed the resident had limited/non weight bearing to the right upper extremity, and that the current toileting method assessed for bowel and bladder was bathroom. However, the assessment section for mobility devices needed was left unchecked for cane, crutch, wheelchair and walker. The assessment did not show that the resident's ability to ambulate was assessed nor showed whether there was the need for any assistive devices such as cane, wheelchair or bedside commode were assessed for fall safety. The assessment showed the facility had knowledge of the resident's cognitive status to know her preference of toileting was to use the bathroom, was a 1 person assist, and that the resident used an assistive device. The assessment showed the resident walked every 2 hours while awake, even though her ambulation status at that point of admission had not been assessed and was not mentioned on the nurse to nurse report. Review of the nursing progress notes from 01/18/2020 to 01/19/2020 showed the resident's ambulation needs were never assessed or communicated to direct care staff for safety. The progress notes also did not show that any education was given to the resident or staff regarding fall safety precautions and prevention. Review of the resident's care plan, initiated and revised on 01/20/2020 (2 days after the resident's fall with reinjury), showed the resident was identified as fall risk related to impaired mobility, balance and history of falls. The care plan showed the resident's fall occurred on the day of admission 01/18/20. The care plan included the following interventions: 1. Provide resident extensive assist of 1 person for toileting, 2. Provide resident, limited assist of 1 person for ambulation using a FWW (Front wheel walker) 2. Assist the resident getting in and out of bed with I person extensive assistance. 3. Provide verbal cues for safety and sequencing when needed 4. Monitor for and assist toileting needs. Review of the Kardex (Care plan for nursing assistants[NAC] that was derived from the care plan) dated 02/12/20, showed the same interventions. No baseline care plan was developed upon admission or provided by the facility. Review of the PT (Physical Therapy) Evaluation, completed from 01/20/2020 to 02/18/2020, showed the resident needed contact guard assist (hand contact to help steady or help with balance) and a cane for ambulation. The resident was assessed to be independent with wheel chair use. There was no documentation that showed a wheelchair, cane or contact guard assist were provided upon admission, prior to her fall that reinjured her fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation, dated 01/19/20, showed the only fall preventative measures that were in place prior to the fall was the call light. The investigation showed the resident was attempting to transfer self to bathroom when she fell without use of any assistive devices. The investigation showed the resident tried to use a bedside (wheeled) table to assist herself with ambulation to the bathroom. It also showed the resident had a history of quadriplegia, unsteady gait, decline in function, and general weakness. The investigation showed the fall was reasonably related to and resulted from poor safety awareness, use of bedside table to assist with ambulation to the bathroom, impulsive behavior and general weakness. During an interview on 02/07/2020 at 9:22 AM, Resident #102 stated that she initially came into the facility for rehabilitation therapy on her fractured right arm that she sustained after a fall at home. Resident #102 stated that she had a neuro-muscular problem and stated that she had asked the facility for a walker on the day of admission and was told by Staff KK, Nursing Assistant Certified (NAC) that the facility did not have one. The resident then tried to get to the bathroom without a walker, fell , and re-fractured her right arm. The resident stated that she did not have any assistive devices to help her with ambulation. She stated that she had told Staff KK about the fall, and when a nurse looked at her arm two days later, the arm to be fractured with the bone sticking out. The resident stated that she was sent out to the hospital which prolonged her recovery and her stay in the facility. An observation showed the resident's right arm was bluish-black in color. Resident #102 stated that the fall in the facility occurred before she had been assessed by PT, and she did not have any assistive devices or assistance to help with toileting. The resident stated that a cane was given to her after she was assessed by PT on 1/20/2020. The resident stated that the walker that was currently observed in her room was brought in by her family after she got back from the hospital from reinjuring her arm from the fall. During an interview on 02/12/2020 at 3:50 PM, Staff LL, PT Director stated that when a resident was admitted on the weekend, the therapy assessment was usually done 3 days after admission and the initial nursing assessment was done at a lower level. He stated that he would expect to see maximum precautions in place. He stated that the mobility assessments done by PT would have determined what functional interventions or assistive devices would have been appropriate for the resident. During a follow-up interview on 02/13/2020 at 9:59 AM, Resident #102 stated that she was scheduled to have surgery the following week due to the re-injury that occurred in the facility. During an interview on 02/13/2020 at 11:10 AM, Staff MM PT stated that she was involved with the resident's initial assessment after she admitted . She stated that the facility had enough information from the hospital to determine the resident's mobility needs. She stated that the resident had a spinal injury that compromised her lower extremity mobility which placed her at high risk for falls and was the reason the resident sustained the initial injury. Staff MM stated that the resident had the call light on for 30 minutes whereby the resident then made the decision to assist herself to the bathroom, lost her balance, fell and re-fractured her right arm. She stated this could have been prevented if staff had responded to the resident's call light or properly assessed the resident's mobility needs after admission. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 02/28/2020 at 10:29 AM, the Director of Nursing (DNS) stated that she understood that the resident's fall and reinjury could probably have been avoided if there was better safety precautions in place, better mobility assessment upon admission, and placement of an assistive device such as a wheel chair or bedside commode for safety until a more thorough assessment was done by PT. The DNS stated that to prevent this from happening again, she would work on including better mobility assessments upon resident admission. 35787 SMOKING RESIDENT #39 Resident #39 was readmitted to the facility on [DATE]. The primary diagnosis list included cerebrovascular disease (disease of the blood vessels and arteries that supply the brain and can lead to a stroke) that resulted in the resident's inability to move the left side of her body. According to the quarterly MDS assessment, dated 11/19/2019, the resident was cognitively intact. Record review of the quarterly smoking evaluation, dated 11/08/2019, showed all residents that wanted to smoke required staff to observe them while they smoked prior to the evaluation decision. The evaluation showed that when staff observed the resident smoke, the resident did not properly dispose of ashes/butts and did not safely smoke without use of a smoking apron. The evaluation decision showed supervised smoking was required. Record review of the care plan, with a review date of 01/02/20 showed, Patient [Resident] may smoke with supervision per smoking assessment due to history of non-compliance with safer smoking policies. Refuses to wear smoking apron. Interventions included: Supervise patient with smoking in accordance with assessed needs; maintain patients smoking materials at nurse's station. During an observation and interview on 02/10/20 at 12:08 PM, the resident was returning to the building from the designated smoking area. She had an open package of cigarettes and a lighter. The resident stated, I am not supervised, I can smoke anytime I want to smoke, and she also said there was no staff member with me, I just finished smoking. A staff member was not observed in the designated smoking area at this time nor was a staff member observed to return to the building with the resident. During an observation on 02/13/2020 at 10:53 AM, the resident was in her wheelchair in the hallway. She had an open package of cigarettes and a lighter. Observation on 02/19/2020 at 2:55 PM showed the resident was in her wheelchair in her room with an open package of cigarettes and a lighter. During an interview on 02/25/2020 at 9:52 AM, the resident stated, I keep my cigarettes with me all the time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 02/25/20 at 10:33 AM, Staff U, nurse assistant, stated, She (the resident) is a supervised smoker, she keeps he own cigarettes and lighter, we never keep her cigarettes or lighter. We should keep the cigarettes and lighter for the supervised smokers. During an interview on 02/26/2020 at 1:23 PM, the facility Admininstrator stated, We need to be more careful and consistent with our smokers. 38430 RESIDENT #84 Resident 84 admitted to the facility on [DATE], the primary diagnosis list included stroke, paralysis affecting left dominant side, and schizophrenia. A review of the quarterly MDS assessment, dated 10/10/2019, showed the resident was cognitively intact. A review of the resident's quarterly smoking evaluation, dated 12/13/2019, showed the resident required staff supervision when smoking. In addition, the resident acknowledged the facility's smoking policy and acknowledged that not following the smoking policy may result in the loss of privileges to smoke. A review of the resident's care plan, dated 01/06/2020, related to smoking stated, Monitor patients compliance to smoking policy. A review of the facility's policy on Smoking, revision date 07/24/2018, showed If the patient is cognitively and physically able to secure all smoking materials, the Center may allow him/her to maintain his/her own tobacco or electronic cigarette products in a locked compartment. During an observation and interview on 02/14/2020 at 9:55 AM with Resident #84, the resident was in the hallway with her cigarettes and a lighter. The resident stated that she kept her cigarettes and lighters in her room on top of her dresser. Resident #84 further stated that she did not have a lock box in her room. Observation on 02/14/2020 at 9:58 AM in the resident's room showed there were packs of cigarettes and lighters on top of the night stand. During an interview and observation on 02/14/2020 at 10:02 AM with the DNS showed that in the resident's room on top of the dresser, there were six lighters and several cigarette packs. The DNS stated, Smoking materials, if kept by residents must be locked up. There was no lock box in the resident's room. The DNS stated that she will keep the resident's smoking materials until there is a lock box in her room. 42378 SMOKING RESIDENT #30 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #30 was a long-term care resident who readmitted to the facility on [DATE]. His diagnosis list included non-traumatic bleeding in the brain, a congenital defect of the spine, paralysis of the legs and lower body, and a progressive degenerative/destructive joint disorder with abnormal pain sensation. A review of his significant change of condition MDS, dated [DATE], showed the resident had intact cognition and needed two people assistance for activities of daily living, except for eating and locomotion. He was also coded a yes for tobacco use. Review of the resident's most recent smoking care plan, initiated on 10/27/2019 and revised on 12/03/19, showed the resident was a supervised smoker per smoking assessment. The interventions showed that the resident required supervision during smoking and staff were to offer smoking apron, however resident refused at this time and will keep offering. Review of the smoking evaluation, dated11/06/2019, showed for smoking decision: supervised smoking is required for resident exhibits times of poor safety awareness and non-smoking areas. Observation on 02/11/2020 at 01:16 PM showed Resident #30 was smoking by himself in the gazebo. He was using a smoking apron, but there were no staff present. Observation on 02/14/2020 at 05:29 AM showed the resident was in bed and observed a lighter at the bedside table. During an interview on 02/14/2020 at 07:19 AM, Resident #30 stated smoking staff keeps his cigarettes and lighter but observed a lighter at his bedside table. During this same time, observed a lighter at the bedside table and Staff Q, Nursing Assistant Certified (NAC) who was in the room stated that sometimes resident did not listen. Resident #30 then agreed that sometimes he kept the lighter with him. Staff Q then removed the lighter and brought it to designated smoking staff for safekeeping. Resident #30 stated that he was told that it was ok for him to keep the lighter, but not the cigarettes. Observation on 02/14/2020 at 10:04 AM showed the resident had a new pack of cigarettes. He stated that he could keep his cigarettes. During an interview on 02/20/2020 at 09:28 AM, Staff U, nurse aide, stated that smoking staff kept the smoking materials for the residents. She further stated that Resident#30 would go out to community during outings and would buy his cigarettes/lighter and would give it to the smoking technician (tech). Record review of the smoking list on 02/20/20 at 09:30 AM showed Resident #30 listed under residents that required supervision. In addition, facility practice for supervision was that the smoking staff/tech kept the smoking materials. During an interview on 02/26/2020 at 11:57 AM with Staff D, Registered Nurse (RN)/Resident Care Manager (RCM), Staff D stated that the resident was supervision with smoking per smoking assessment. In addition, she stated that the smoking tech should be keeping the smoking materials. She further added that for Resident #30, it was difficult to do as the resident would go out and buy his smoking materials. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	UNSAFE ENVIRONMENT - RAZORS AT BEDSIDE RESIDENT #30 Resident #30 was a long-term care resident who readmitted to the facility on [DATE]. A review of his significant change of condition MDS, dated [DATE], showed the resident had intact cognition and needed two people assistance for activities of daily living, except for eating and locomotion. A review of the resident's care plan for Activities of Daily Living (ADL), created on 01/03/2019 and revised on 12/20/2019, showed the resident required extensive assist with hygiene. Observation on 02/07/2020 at 09:51 AM showed Resident #30's nightstand had personal items for grooming on it, including four razors with caps. Observation on 02/14/2020 at 05:29 AM showed there were four disposable razors (capped) on the nightstand. During observation and interview on 02/14/2020 at 10:22 AM with Resident #30, the resident had facial hair. When asked who shaved him, the resident stated that he shaved himself, but staff watched him do it. During an interview on 02/14/2020 at 11:39 AM, Staff Q, Nurse Assistant Certified (NAC) stated that the resident usually shaved in the shower, but sometimes, the resident would ask to be shaved and staff would help. During this time, observation with Staff Q showed three razors in the night stand, two were capped/covered and one was without cover. There was one razor that was a facility stock, and the two other razors that were not the facility type razor. Staff Q stated that their practice was to discard used razors in the sharps container. Staff Q discarded the razors in the sharps container located in the nurse's medication cart. Staff Q was told that the razors had been observed in the room since last week. Also during this time, the DNS was informed that razors were found at the bedside and that Staff Q had disposed them in the sharps containers. During an interview on 02/26/2020 at 11:57 AM with Staff D, Registered Nurse (RN)/Resident Care manager (RCM), Staff D was notified that razors were found at the bedside. She stated that it was hard to monitor for this, as the resident would go out to the community and buy his supplies (such as razors, smoking materials). There were no resident observed wandering in the unit. Resident #30 was not using a lock box. 12273 Failure to store oxygen tank safely. Resident #64 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident was admitted to the facility with multiple medical diagnoses, including chronic lung disease and mental illness. The last quarterly MDS assessment, dated 12/27/2019, showed the resident needed supervision from staff for activities of daily living and used a wheelchair for locomotion. Observation on 02/05/2020 at 2:30 PM showed Resident #64 lying on the top of the bed with a nasal cannula in place that was attached to a oxygen cylinder (an aluminum tank of compressed oxygen) which was also lying on top of the bed surface. The top of the tank, the neck and gauge, was pointed toward the foot board of the bed and the resident's legs were positioned next to the tank. The resident stated he had been on oxygen for the last four years and stated that he always kept the cylinder on the bed surface. During an interview on 02/05/2020 at 3:00 PM, the Administrator and the Director of Nursing (DNS) were asked about the cylinder. They stated that the resident refused to allow the staff to remove it or secure it. During an interview on 02/05/2020 at 3:05 PM, Staff B, a Registered Nurse was asked if any alternative to the oxygen tank had been discussed with the resident. Staff B stated that the resident had refused to use an oxygen concentrator because it was too noisy. When asked if they offered the resident a stand (or cart) to secure the oxygen cylinder, she stated no. Observation on 02/05/2020 at 3:07 PM showed both the Administrator and the DNS entered the resident's room, and observed the oxygen cylinder lying on top of the bed surface. After a few minutes of discussion, Resident #64 agreed to place the cylinder in a stand (or cart) next to the bed. Not ensuring the oxygen tank was secured in a stand placed this resident and other residents at risk for traumatic injury if the tank were to fall off the bed surface. Reference: WAC 388-97-1060 (3) (g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12273 Based on observation, interview and record review the facility failed to ensure catheters were managed in a manner consistent with standards of practice for 2 of 4 residents (#103, #97) reviewed for catheters. Failure to ensure Resident #103 had a medical justification for the continued use of a urinary catheter and ensure a catheter was positioned below the bladder for Resident #97 increased the risk for a urinary tract infection. Findings included . Resident #103 The resident was admitted to the facility on [DATE] with multiple diagnosis including Benign Prostrate Hyperplasia (BPH, an enlarged prostrate). The most recent Minimum Data Set (MDS) assessment, dated 01/17/2020, indicated the resident was alert and oriented and needed assistance from the staff with ADL's (i. e. transfers, dressing, grooming and hygiene.) On 02/11/2020 at 10:50 AM, during an interview Resident #103 was asked about the use of a catheter. Resident 103 said he went to a physician's appointment and was told they could take it out in 5 or 6 days and said he did not know why it was still in place. The resident was asked but could not recall if he was evaluated by an urologist. The clinical record, found a urology consult, dated 06/17/2019. The consult noted the resident had memory problem and it is not clear why the catheter was in place and documented Resident #103, stated he would like to get rid of it (the catheter). The urologists consult stated the catheter because his bladder does not empty. Noted a medication was in place to treat urine retention. It also noted Since he cannot get up and walk to the toilet, a catheter may be his best option. They concluded Follow up for consideration of the catheter removal when rehabilitation has progressed enough for him to walk, may consider voiding trial. On 02/26/2020 at 10:20 AM, the Resident's Representative was interviewed. The Representative stated he did not know why the catheter was not removed, and acknowledged he attended the urology appointment with the Resident. On 02/26/2020 at 10:30 AM, Staff GG, the Advanced Registered Nurse Practitioner (ARNP) was interviewed about the resident's catheter. When asked why the catheter was in place he stated it was for convenience. When asked if a voiding trial had been attempted, he stated yes, and reported it failed. Staff explained that he added a medication to manage the prostrate problem prior to the voiding trial that was initiated on 10/31/19, but the resident refused the voiding trial, and commented, the resident became extremely anxious. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician orders verified a voiding trial was ordered on 10/21/2019 at 5:00 AM. It directed staff to check the resident for residual urine after voiding (PVR) every 12 hours, and contact the ARNP, if the residuals urine was greater than 350cc's. In addition, an order to implement a toileting program was also in place. The progress note, dated 10/21/2019 at 12:10 PM, documented the following; Foley catheter was taken out this morning. Around 9:30 resident complained of urinary retention. LN (Licensed Nurse) reported to NP (Nurse Practitioner). NP ordered a bladder scan and straight cath. LN reported to NP the I was meeting resistance and could not straight cath. Bladder scan showed 138cc. NP order to Foley Cath instead and report if any trouble. Foley was a success. The order for the voiding trial was not implemented as written. A bladder scan, completed found 138 cc's of urine, but did not indicate if this was obtained after the resident urinated (PVR), as the orders instructed. Resident #103 did not resist the removal of the catheter but was resistive to the use of a straight catheter to drain the 138cc of urine found after the bladder scan was completed. There was no information documenting the staff attempted to assist the resident to use the bathroom, after he complained about urine retention. Not ensuring there was a medical justification for the use of the catheter, increased the risk for infections. 41070 RESIDENT #97 Resident #97 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke) and urinary retention. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], showed the resident required one to two person assist with bed mobility, transfer and toileting. Review of the Urinary Care Area Assessment (CAA) dated 01/29/2020, showed the resident had a foley catheter due to urinary retention and had at least two failed voiding trials. The Urinary CAA also showed that Catheter places him at risk for infection, as well as skin breakdown r/t [related to] f/c [foley catheter] tubing, and Will proceed to care plan with the goal being to avoid complications r/t foley catheter. Review of the facility policy titled: Catheter: Indwelling Urinary Care revised on 11/01/2019, showed to Secure catheter tubing to keep the drainage bag below the level of the patient's [resident] bladder and off the floor. Review of the care plan for indwelling Foley catheter secondary to neurogenic bladder initiated on 12/28/2019, directed the staff to Keep the catheter below the level of bladder and drainage bag off the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the February 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed to offer and provide leg strap to anchor catheter tubing as resident allows, and Keep catheter below the level of the bladder and drainage bag off floor. Further review of the MAR and TAR showed on 01/27/2020, the resident received Bactrim DS 800-160 milligram (Sulfamethoxazole-Trimethoprim - an antibiotic) one tablet by mouth two times a day for 7 days for UTI (Urinary Tract Infection - bladder infection). During an observation on 02/06/2020 at 10:16 AM, the resident was lying in bed, the resident had an indwelling foley catheter draining urine into a urinary leg bag, and the resident's urinary leg bag was attached to the resident's left leg. The urinary drainage bag was not placed below the resident's bed. During a joint observation on 02/14/2020 at 6:19 AM, the resident was lying in bed, the resident had an indwelling foley catheter draining urine into a urinary leg bag, and the resident's urinary leg bag was attached to the resident's left leg. The urinary drainage bag was not placed below the resident's bed. Staff CC, Nursing Assistant Certified (NAC), stated she did not know why the resident was not using a urinary bag that could be placed below the resident's bed. Staff CC, stated it's been that way since he was admitted . Staff DD, NAC, also observed that the urinary drainage bag was not placed below the resident's bed, and stated the urinary drainage bag should be placed below the bed to facilitate the flow of urine. During an interview on 02/19/2020 at 2:56 PM, Staff K, Resident Care Manager (RCM), Registered Nurse (RN), stated the urinary drainage bag was supposed to be placed below the bladder to facilitate the flow of urine. Staff K, stated there was no documentation or information in the resident's clinical health record regarding resident education to identify the risk and benefits, and the clinical implication and the risks associated with placing the urinary drainage bag at the level of the resident's bladder in bed. During an interview on 02/26/2020 at 11:21 AM, the Director of Nursing Services, stated the resident's urinary drainage bag was supposed to be placed below the resident's bladder or bed to prevent infection from urine backflow. Reference: (WAC) 388-97-1060 (3)(c)

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	505042	A. Building B. Wing	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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F 0692 Level of Harm - Minimal harm or potential for 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** 37945 Based on observation interview and record review the facility failed to assess, monitor resident hydration status for 1 of 3 residents (70). This failure placed the resident at risk for dehydration related complications and diminished quality of life. Findings included . The resident admitted to the facility on [DATE] with right and left hand contractures. According to the residents most recent Minimum Data Set (MDS) dated [DATE], showed the resident had impairment to both upper extremities. The MDS also showed the resident showed signs of symptoms of a swallowing disorder by loss of liquids from mouth when eating or drinking, needed extensive, one person physical assist with eating and drinking. Review of the resident's diagnosis sheet showed she had Dysphagia (difficulty swallowing). Review of the resident's nutritional assessment dated [DATE] showed the resident was ordered to have thickened liquids and need one to one extensive feeding assistance. The nutrition plan documented in the assessment addressed nutritional needs and risks, but did not identify the resident's increased risk for dehydration given the resident's current physical and functional status. Review of the resident's care plan initiated on 01/15/2019 showed the resident was identified having a nutritional risk related to altered diet texture and one to one feeding assistance. Goals included the resident would consume 75% of meals and would maintain stabilized weight. Interventions included the following: 1. Provide consistent puree, nectar thick liquids as ordered. 2. Encourage 100% consumption of all fluids provided. Review of the resident drink snack flowsheet from 01/24/2020 to 02/14/2020, showed the resident was on altered liquids (nectar thick) and that the resident accepted a drink during meals and snack time. The flowsheets also showed the percentage of how much the resident ate but did not show any intake percentages or amount of the resident's fluid intake for meals and snacks given. The facility would not know if the resident was getting adequate hydration given her limitations such as bilateral contractures, Dysphagia and being dependent for staff to meet her hydration needs. In an observation on 02/06/2020 at 9:38 AM, the resident was observed to have dry chapped, peeling lips with a reddened area above her lips. The resident was being fed by a nursing assistant during the observation. In an observation on 02/21/2020 at 11:02 AM, the resident was lying in bed and had, dry cracked lips. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/21/2020 at 11:36 AM, Staff Y, Nursing Assistant Certified (NAC) stated he had worked with the resident before. He stated the resident needed assistance with eating and drinking because of her hand contractures. He also stated she was on thickened fluids, ate and drank well. He stated they were not tracking fluid amounts but were documenting other nutritional information in the computer. In an interview on 02/21/2020 at 1:04 PM, the DNS stated residents on fluid restrictions were put on fluid monitoring initiated by nursing if there was poor oral intake. In a joint review of the chart showed there was no tracking for fluid intake. Given the resident's high risk for dehydration she stated she was not sure why the resident was not being tracked for fluid intake and understood the risk. She stated the resident should have been tracked and went ahead and added the tracking in the computer. She stated she would talk to her cooperate office to have all resident's who were at high risk for dehydration tracked for fluid intake. Reference (WAC) 388-97-1060 (3)(i)

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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** 42378 Based on observation, interview and record review, the facility failed to monitor and accurately record the amount of tube feeding administered for one of three residents (#75) reviewed for tube or enteral feeding services (provision of nutrition for those residents who cannot obtain nutrition by mouth). These failures placed the resident at risk for inadequate nutritional support and adverse consequences. Findings included . RESIDENT #75 Resident was a long-term care resident that readmitted to the facility on [DATE] following an overnight stay at the ER for feeding tube displacement. Her diagnosis list includes dysphagia (difficulty or discomfort in swallowing, as a symptom of disease). A review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] showed resident was NPO (nothing by mouth), needed total assist for eating (tube feeding) and on a feeding tube. A review of the February 2020 Physician's Orders showed an order instruction on 09/04/2019 to administer: Jevity 1.2 (calories) at 75 ml (milliliters) per hour x 19 hours via pump to feeding tube until 1425 ml total volume provided, run at 12pm (on) until 7am (off). A review of the electronic Medication Administration Record (eMAR) showed an order with an instruction, every shift document ml (milliliter) Jevity 1.2 tube feeding provided during the shift. For 02/06/2020, the documentation showed 1050 ml of total volume for the day, 375 ml less than ordered volume limit of 1425 ml. Moreover, for 02/07/2020, 02/08/2020 and 02/09/2020, the record showed an 1800 ml total volume for each day, 375 ml more than the ordered total volume limit of 1425ml. A review of the medical record showed a change condition on 02/10/2020 for Resident #75. Staff GG, Advanced Registered Nurse Practitioner (ARNP) documented on 02/10/2020 that Resident #75 was non-responsive with moist chest congestion, irregular rapid heart rate of about 110 beats bpm (beats per minute) and no low oxygen volume. The ARNP documented about holding the feeding and elevating the head of the bed (HOB). The ARNP documented, pneumonitis while tube-feeding running, resolved with hold of tube feed and HOB elevated further. During an observation on 02/07/2020 at 09:00AM showed Resident #75 had her Jevity feeding running at 75ml/hour, 2 hours passed the scheduled off time. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a joint record review of the medical record and an interview on 02/26/20 at 11:26 AM, Staff D, Registered Nurse (RN/Resident care manager (RCM) acknowledged that Resident #75 received more fluid per documentation. In addition, Staff D, RN/RCM stated that when nurses chart the total given on their shift, they would click on documentation and the total volume amount (like 600ml) would carry over. Staff D, RN/RCM stated that nurses should enter the actual number. Furthermore, Staff D, RN/RCM stated it was more of a documentation issue and nurses need to change the actual number when they chart the amount. Staff D, RN/RCM stated, sometimes, not always there might be half to an hour delay related to not turning off on time, for nurses only turn the feeding off when giving medication when asked if the extra volume administered can be related to the feeding not turned off on time. Reference: WAC 388-97-1060 (3) (f)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on observation, interview, and record review, the facility failed to ensure appropriate care and services were provided for one of three resident (#90) reviewed for tracheostomy/respiratory care. Failure to assess, monitor, supervise and assist the resident with tracheostomy, and failure to change tracheostomy tubing per professional standards of practice placed the residents at increased risk for respiratory infection and/or related complications. Findings included . Tracheostomy is a surgically created hole through the front of the neck and into the windpipe [trachea] that provides an air passage to help breath when the usual route for breathing is obstructed or impaired. Review of the facility policy titled: Tracheostomy Suctioning revised on 11/01/2019, showed to Cleanse hands, Establish need for suctioning by evaluating patient for breath sounds, respiratory rate, and pulse oximetry, Put on PPE [Personal Protective Equipment] including gloves. Attempt to time catheter insertion with inspiration. With sterile hand and without applying suction, insert catheter into tracheostomy stoma/trach tube to equal the length of the tracheostomy tube, with non-sterile hand, apply suction and gently withdraw catheter, slowly rotating catheter with fingertips. Do not apply suction for longer than 10-15 seconds, during suctioning observe amount, color, and consistency of secretions, Observe need to repeat suctioning, and with sterile hand, rinse catheter in sterile water and repeat procedure until breath sounds clear and no more mucus returns, Rinse connecting tube, Evaluate heart rate, respiratory rate, breath sounds, and cough reflex. The policy also stated to Document amount, color, and consistency of secretions; evaluation of heart rate, respiratory rate, pulse oximetry, and breath sounds pre-and post-procedure; patient [resident] response to suctioning. Resident #90 was admitted to the facility on [DATE] with diagnoses that included cancer of the laryngeal cartilage (throat) with right lung and bone metastasis (spread of cancer cells), status post total laryngectomy (removal of the larynx [voice box]) and tracheostomy in 2017. Review of the 5 day Minimum Data Set (MDS) assessment dated [DATE], showed the resident required supervision of one to two-person assist with bed mobility, transfer, dressing, toileting and personal hygiene. Review of the care plan for alteration in respiratory status related to malignant neoplasm [cancer] of laryngeal cartilage initiated on 01/23/2020, directed the nursing staff to monitor for airway obstruction/thickened secretions, and to suction trach/airway as needed. Review of the February 2020 physician order showed to change the Yankauer (an instrument used for suctioning) suction PRN (as needed). There was no indication in the February 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) that the Yankauer suction tubing was being changed by the nursing staff, and there was no indication that the resident's heart rate, pulse oximetry, and breath sounds were evaluated after tracheostomy suctioning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the laboratory results for nasal swab collected on 02/07/2020, showed the results came back with presumptive positive for MRSA (Methicillin Resistant Staphylococcus Aureus - infections caused by specific bacteria that are resistant to commonly used antibiotics). In an observation on 02/10/2020 at 9:15AM, the resident was observed coughing with yellowish mucus coming out from his tracheostomy stoma. The skin around the resident stoma had an open wound with 100% beefy red tissue. In a joint observation on 02/10/2020 at 12:53 PM, the resident was observed suctioning his tracheostomy without gloves. The resident's fingernails were long and underneath the fingernails contained black debris. The resident stated he was not completely able to suction his tracheostomy. On the bedside table, there was a suction machine, and there was no saline to rinse the Yankauer suction tubing from the resident's secretions, after suctioning himself. The Yankauer suction tip was bloody. The canister on the suction machine was 3/4 full of secretions. There was no hand sanitizer or hand wipes to clean the resident's hand after suctioning his tracheostomy. The resident stated that he was doing the suctioning himself and none of the nurses was assisting him. Staff L, Licensed Practical Nurse (LPN), stated the skin around the resident's stoma looked open and red, and the Yankauer tubing was not dated, and the tip of the Yankauer looked brown and bloody. Staff L stated the Yankauer suction tip tubing should be changed every 24 hours and PRN, but it was not dated. Staff L stated that he was not sure when the Yankauer suction tubing was changed. The resident then started coughing, and it was observed by Staff L and the surveyor that the resident was splashing yellow and brown discharges coming from his tracheostomy. Staff L stated that nurses should be assisting the resident with tracheostomy suctioning but they were not. In an observation on 02/10/2020 at 1:26 PM, the resident asked Staff L, LPN, that he needed assistance to cut his fingernails, Staff L then responded to the resident and told the resident that his nurse would cut his fingernails for him. The resident's fingernails were not trimmed that day. (Refer to F677 regarding ADL Care/Fingernail Care). In an interview on 02/10/2020 at 2:08 PM, Staff F, Registered Nurse (RN), stated the results of the nasal swab came back presumptive positive for MRSA. During an observation and interview on 02/18/2020 at 12:57 PM, the resident was observed suctioning his tracheostomy. He stated that no one in the facility showed him how to suction his tracheostomy. Observed the Yankauer suction tip was bloody, and there was no saline water in the resident's room to clean the Yankauer suction tip after each use. The resident placed it in the bag hanging by the resident's drawer. He stated there was no clean cloth or hand wipes to clean his hands after suctioning his tracheostomy. In an interview on 02/19/2020 at 2:06 PM, Staff E, RN, stated the open wound around the resident's tracheostomy was red, and it was about 2.0 x 2.0 centimeter. Staff E stated the open wound was due to suctioning. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/19/2020 at 2:17 PM, Staff K, Resident Care Manager (RCM), RN, stated the open wound around the resident's stoma was from suctioning, and that was the direction when the resident was admitted that the resident was able to suction himself. Staff K stated the Yankauer suction tubing was supposed to be changed every night. Staff K reviewed the completed assessment forms for the resident and stated that there was no assessment or documentation that the resident was able to suction himself, and there was no documentation in the February 2020 MAR/TAR that the Yankauer was being changed every night. She also stated that there was no mirror in the resident's room to aid the resident when suctioning himself, and stated the resident was not able to follow the suctioning protocol per facility policy. Staff K stated the Yankauer suction tubing should be dipped in saline water after use but there was no saline water in the resident's room. Staff K also stated she agreed that there was no hand sanitizer or disposable hand wipes in the resident's bedside to clean his hands after suctioning, and it should be available for the resident. Staff K stated that she was unable to find documentation that nursing was doing the suctioning, or the necessary monitoring such as vital signs and for airway obstruction, or thickened secretions per the resident's plan of care. Staff K stated that the resident's care plan for tracheostomy care was not followed. In another interview on 02/25/2020 at 2:13 PM, Staff K stated that she interviewed the nurses on day shift, eve and night shift. Staff K stated that Staff E, RN, and Staff A, LPN, were her regular nurses and they stated that they were not doing the suctioning for the resident and they were not monitoring the tracheostomy site. Staff K stated the order was to change the Yankauer suction tubing prn, and stated it was a problem because no one knew when the last time it was changed. Staff K stated that she checked the manual for instruction or direction when the Yankauer suction tubing was supposed to be changed, and stated that it should be changed daily and prn. Staff K stated the physician order was written to change the Yankauer suction tubing PRN, instead of daily and PRN. Staff K also stated that the facility should have supervised the resident with suctioning his tracheostomy and prompting the resident to wash his hands, and should have provided the resident hand sanitizer or hand wipes at his bedside to clean his hands before and after suctioning but were not. Reference: (WAC) 388-97-1060 (3)(j)(iv)

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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** 12273 Based on observation, interview and record review, the facility failed to ensure adequate pain management was provided for two of three residents (#63, #105) who were reviewed for pain management. Failure to ensure that Resident #63, who displayed symptoms of pain, consistently received care and treatment for management of his pain resulted in the resident experiencing unrelieved pain, which was actual harm. In addition, failure to complete a comprehensive pain assessment and include non-pharmacologic interventions in Resident #105's plan of care increased the risk of unnecessary medications. Findings included . The policy for Pain Management, revised on 11/01/2019, showed the goal was to maintain the highest possible level of comfort for patients by providing a system to identify, assess, treat, and evaluate pain. The policy showed that if the assessment triggered pain, a pain evaluation would be completed. The nurse would notify the physician, obtain orders for treatment, and develop an individualized care plan to address and/or treat the underlying cause of pain to the extent possible; with non-pharmacological and pharmacological interventions; using specific strategies for preventing or minimizing pain. RESIDENT #63 Resident #63 was admitted to the facility in 2014, with multiple diagnoses including dementia. A quarterly Minimum Data Set assessment (MDS), dated [DATE], showed the resident was not able to participate in a verbal interviews, to assess for cognition and mood, and that the resident was rarely and/or never understood. The MDS section for assessment of pain showed no pain medications were administered routinely or as needed, and showed that the resident reported no issues with pain. The most recent annual MDS, completed 09/25/2019, showed the same information, and a Care Area Assessment (CAA) for pain was not completed. The resident's care plan, initiated in 2014 and updated 01/08/2020, showed the resident exhibits or is at risk for alteration in comfort related to chronic pain and DJD (Degenerative Joint Disease). The interventions directed staff to Monitor for non-verbal signs/ symptoms of pain and medicate as ordered. The care plan also contained directives for staff to monitor and treat pain. Observation on 12/12/2020, at 1:20 PM, found Resident #63 was in the common area seated in the wheelchair. When greeted, the resident responded in non sensical manner (work salad), and responded, in the same way to basic questions., when asked. On 02/13/2020 at 1:30 PM , 02/14/2020 at 1:50 PM, and 02/18/20 at 2:30 PM, the resident was greeted and asked basic questions, a similar response was obtained. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Observation on 02/19/2020 at 10:43 AM, during a transfer from the bed to the wheel chair, by two Nursing Assistants (NA's) via a mechanical lift device, Resident #63 was grimacing and moaning during the transfer and when repositioned in the chair. Staff R, one of the NA's present attempted to place a hand splint on the resident's left hand. However, when Staff R attempted to open the resident's partially closed fist to place the splint, Resident #63 cried out in pain and refused to wear the splint device. Observation on 02/20/2020 at 10:45 AM showed Staff C, Licensed Practical Nurse, preparing to do a wound dressing change. Staff C, removed a leg protector from the resident's leg, and then removed an adhesive bandage and dressing. Resident #63 cried out in pain and retracted his leg when the bandage was removed. The leg wound was a shallow crater in which the wound base had white colored slough adhered to it. When asked if the wound bed was visible, Staff C repeatedly attempted to wipe the slough from the wound bed while Resident #63 called out in pain, despite the non verbal and verbal symptoms of pain displayed. After applying the dressing, Staff C, then applied lotion to the resident lower legs feet and toes. The resident also called out in pain as the lotion was applied to the lower legs and toes. When asked about the resident's symptoms of pain, Staff C stated the resident did not need to be medicated for pain. Review of the Medication Administration Records (MAR) for 01/01/2020 through 02/20/2020, showed an order for an analgesic pain reliever (Acetaminophen) which could be administered every four hours if needed for pain and listed non-pharmacological interventions that staff could attempt to relieve pain. On 02/19/2020 and 02/20/2020, the licensed staff documented the resident was repositioned, for pain relief which was documented consistently for each shift through out the month of February. Despite the pain symptoms displayed while providing care, the analgesic medication was not administered. Review of the Treatment Administration Record (TAR) between 01/01/2020 and 02/20/2020 showed a directive to ask the resident each shift, Are you free of pain or hurting? It directed staff to document Yes or No. The staff consistently documented Yes, indicating the resident was free of pain, despite the resident having severely impaired cognition. The facility staff did not assess and/or identify pain and did not treat the resident's pain. This resulted in the Resident # 63 experiencing unrelieved pain while care was provided. 41070 RESIDENT #105 Resident #105 was admitted to the facility on [DATE] with diagnoses that included vertebral (thoracic area) osteomyelitis (infection of the bone) and end stage kidney failure. Review of the Admission/5 day Minimum Data Set (MDS) assessment, dated 01/29/2020, showed the resident was cognitively intact. Review of the February 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed the resident received the following routine and PRN (as needed) medications for pain: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	1. Camphor-Menthol lotion 0.5-0.5% apply to bilateral (both) legs topically two times a day for muscle pain. 2. Lidocaine patch 4% apply to site patient requests topically one time a day for pain. 3. Cyclobenzaprine HCl tablet 10 mg (milligram) give one tablet by mouth every 8 hours as needed for pain management. 4. Hydromorphone HCl tablet 2 mg give 0.5 mg tablet by mouth every 4 hours as needed for pain. Further review of the February 2020 MAR and TAR showed no documentation that non-pharmacological pain management interventions were developed and implemented for Resident #105. Review of the history and physical conducted by the resident's nurse practitioner, dated 01/26/2020, showed Patient reports increased pain to the area [lower back] does have history of this in the past, during admission was managed for ongoing pain. This is what largely causes agitation and reluctance to care and examination. Review of the care plan, initiated on 02/12/2020 for alteration in comfort related to acute and chronic pain due to osteomyelitis, intra-spinal abscess, and multiple chronic conditions directed the nursing staff to complete pain assessment per protocol. The care plan also directed nursing staff to evaluate pain characteristics, quality, severity, location, precipitating/relieving factors and to evaluate pain characteristics: such as precipitating/relieving factors. Further review of the resident's clinical records showed no comprehensive pain evaluation or assessment in the resident's assessment list. Factors such as activities, care, or treatment that precipitate or exacerbate pain as well as those that reduce or eliminate pain was not assessed and documented by nursing. During an interview on 02/18/2020 at 1:09 PM, Staff F, Registered Nurse (RN), stated that non-pharmacological intervention for pain were not offered to the resident, and were not identified and documented in the current MAR or TAR. During an interview on 02/20/2020 at 1:58 PM, Staff K, Resident Care Manager, RN, reviewed the completed assessments in the resident's clinical health records, and stated that there was no pain evaluation or assessment, and there was non-pharmacological interventions in the current MAR or TAR. During an interview on 02/26/2020 at 11:26 AM, the Director of Nursing Services stated that nursing staff should have offered a non-pharmacological intervention prior to giving the resident's PRN medications, and should have done a comprehensive pain assessment that included pain threshold. See also F600 regarding the resident's complaints for not getting his pain medications timely. Reference: (WAC) 388-97-1060 (1)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38430 Based on interview and record review, the facility failed to ensure sufficient number of nursing staff to provide care and services as evidenced by information provided by 12 of 12 (#39, #83, #101, #102, #105, #406, #156, #97, #456, #38, #26 and #66) resident interviews, Resident Council interview and staff interviews. These failures placed residents at risk for unmet care needs, diminished quality of life and potential negative outcomes Findings included . RESIDENT INTERVIEWS RESIDENT #39 In an interview on 02/06/2020 at 10:15 AM, the resident stated, sometimes it can take up to an hour or more to get assistance. It happens all the time, I hate it. I am waiting now to get up into my wheelchair, they told me they can't do it until 11 am today. RESIDENT #83 In an interview on 02/06/2020 at 11:25 AM, the Resident's family member stated, on 01/27/2020 from 10:00 AM to 11:00 AM (60 minutes) they waited for staff to come help the resident. The family member stated Their problem is lack of staff. RESIDENT #101 In an interview on 02/07/2020 at 10:06 AM, the resident stated, They are short all the time, thank God I can help myself. The resident further stated, there are others who can't. It happens all the time, I can remember waiting up to 2 hours or more for help, it is so bad here. I can't even get showers. There is no one here to give showers. RESIDENT #102 In an interview on 02/07/2020 at 09:53 AM, the resident stated at least two nights ago, her neighbor, who she shares a bathroom with, was on the toilet for over half hour. At that time she needed to have a bowel movement but could not go because of her neighbor was on the toilet with no help. The resident stated, she ended up soiling her pants and felt humiliated and dirty. RESIDENT #105 In an interview on 02/07/2020 at 09:16 AM, the resident stated staff would come in, turn off his call light, and walk out. This happens two to three times a day. RESIDENT #406 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/06/2020 at 10:43 AM, the resident stated gets antsy when she had to wait for a long time over an hour, it happens during change of shift. RESIDENT #156 In an interview on 02/10/2020 at 01:41 PM, the resident stated, sometimes it takes a long time early morning or evening time to get help. RESIDENT #97 In an interview on 02/06/2020 at 10:16 AM, the resident stated, he waits up to an hour and half to get help. The resident stated, it is not good to wait for a long time. RESIDENT #456 In an interview on 02/11/2020 at 10:06 AM, the resident stated, the staff take more than an hour to answer a call light. She further stated, I try to use it only when I really need to. I push the button and just wait. RESIDENT #38 In an interview on 02/21/2020 at 1:21 PM, the resident stated, the staffing here is nothing short of neglect. He further stated, he is a two person transfer but he has to do it with one person because there is not enough staff. RESIDENT #26 In an interview on 02/06/2020 at 10:00 AM, the resident stated, sometimes they have three aides to work the entire upstairs floor at night, it is horrible. It is the last bit of dignity we are clinging to. He further stated, he has laid there for two and 1/2 hours before, just smelling himself after pushing his call light. It happens all the time. RESIDENT #66 In an interview on 02/06/2020 at 10:42 AM, the resident stated I had to call 911 one day last week, my roommate needed help, he used his call light; he was just lying there for hours waiting for someone to come and help. His colostomy bag broke and he had messed all over himself. So I called 911 to get help for him. RESIDENT COUNCIL During an interview on 02/13/2020 at 10:26 AM, with some of the Resident Council member the following was stated: Resident #52 stated weekend staffing is very bad and they need to do something about it. The resident further stated, due to low staffing in housekeeping there is no one to clean rooms regularly and laundry does not get done timely. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #54 stated staffing on the overnight shift is terrible; a few days ago I was told there were only six aides for the whole building. He further stated, there is only one shower aide for the whole building, the other shower aide has been on vacation for the past two months. A review of the Resident Council Minutes showed the following documented regarding staffing problems: August 21, 2019 Night shift found sleeping by residents in the TV room and in empty resident rooms. September 18, 2019 1) Laundry problems; timeliness and missing items 2) No one in the dining room, this past Thursday at dinner time to feed residents 3) A CNA (Certified Nursing Assistant) told a resident that there were only two CNA's for the entire upstairs on the night shift last week sometime. 4) A resident stated that there are residents who smell of urine and feces in their wheelchairs and are not being checked on or changed unless other residents report it to nursing staff. A couple other residents agreed with this statement. October 16, 2019 Night shift staff complaints from 11:00 PM to 7:00 AM residents are unable to find staff. November 20, 2019 Short staffing reported, no night shift staff on the 500 hall. STAFF INTERVIEWS In an interview on 02/14/2020 at 05:03 AM with Staff TT, Licensed Practical Nurse, stated on the night shifts they have been so shorthanded that the Administrator has come in to answer call lights; she is not able to provide care but can get water or help with nonresident care needs. In an interview on 02/14/2020 at 5:11 AM, Staff [NAME], Registered Nurse (RN), stated more than half of the time the 500 hall is short staffed and it is very difficult to all the residents that need help. In an interview on 02/14/2020 at 5:27 AM, Staff Amsalu, CNA, stated, there are about 14 resident right now on the 500 hall that are two person hoyer (mechanical device) lift and usually they have four CNA's on the day shift to assist residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/19/2020 with Staff V, CNA, Shower Aide, stated right now I am the only shower aide in the building. I get backed up on showers, I have quite a few residents that are 2 person assist with hoyer transfers. She further stated I get frustrated because I can't get to all the residents that need showers, so they go without, and then they get upset and call the state. In an interview on 02/21/2020 02:32 PM, an anonymous Staff member, stated, in my opinion we need 5 aides on the 500 hall, this week on the day shift we had only four aides, except one day we had five, and there are times we have had only three aides. It is very hard because most of our residents on this hall need two person assist, so when two of us are helping one resident, and two of us are helping another resident; then there is no one to answer the call lights. The Staff member further stated, during meal times we help serve. No one from management has ever asked me about staffing concerns. In an interview on 02/19/2020 at 1:03 PM, the Administrator stated, we discussed how staffing levels were determined using the data from the Facility Assessment. The Administrator was not able to provide the information. See also F561 - Self Determination related to Showers. See also F565 - Resident/Family Group and Response. See also F584 - Safe/Clean/Comfortable Homelike Environment See also F677 - ADL care Provided to Dependent Residents. See also F684 - Quality of Care. See also F686 - Treatment/Services to Prevent/Heal Pressure Ulcers. See also F688 - Increase/Prevent Decrease in ROM/mobility. See also F689 - Free of Accident Hazards/supervision/devices. See also F690 - Bowel/Bladder Incontinence, Catheter, UTI. See also F697 - Pain Management. Reference (WAC) 388-97-1080 (1)(9) 12273

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 38430 Based on interview and record review, the facility failed to ensure annual Nurse Aide (NA) performance reviews were completed for four of four (W, X, Y and Z) NA's files reviewed who had been employed longer than 1 year. This failed practice had the potential to negatively affect the competency of these NAs and the quality of care provided to residents. Findings included . Review of the NA's (W, X, Y and Z) personnel files revealed they did not have current annual performance reviews. In an interview on 02/19/2020 at 9:49 AM, Staff G, Registered Nurse/Infection Control, stated there are no performance evaluations for any of the facility staff. Reference: (WAC) 388-97-1680(2) (a-c)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on interview and record review, the facility failed to effectively assess for clinical indications for the use of an antipsychotic medication Seroquel for one of four residents (70) reviewed for unnecessary medications in the presence of Dementia and Alzheimer's. This failure placed the resident at risk for avoidable side effects from the medication and diminished quality of life. Findings included . An article issued by the National Institute of Health (NIH) dated 01/07/2020, stated, Indications for the use of Seroquel included Schizophrenia, Bipolar Disorder, and Major Depressive Disorder. The article stated, elderly patients with dementia-related psychosis treated with antipsychotic drugs were at an increased risk of death. The article further stated Seroquel was not approved for the treatment of patients with dementia-related psychosis. Review of the facility policy titled Psychotropic Medication Use, initiated on 12/01/2007, revised on 05/01/2010, 01/01/2012 and 11/28/2016 stated the following: Antipsychotic medication used to treat behavioral or psychological symptoms of Dementia, must be clinically inidicated, be supoorted by an adequate rational for use and may not be used for a behavior with an unidentified cause The resident admitted to the facility on [DATE]. According to the resident's most recent Minimum Data Set (MDS) dated [DATE] showed the resident had diagnoses to include; Alzheimer's Disease, Dementia, Depression (other than Bipolar) and Psychotic Disorder. Review of the Medication Administration Record from 02/01/2020 to 02/20/2020, showed the resident was administered the antipsychotic medication Seroquel twice daily during this period. The MAR showed the antipsychotic medication had a start date of 11/29/2019 and was given for as stated in the MAR; Give 12. 5mg by mouth two times a day for m/b calling out related to other psychotic disorder not due a substance or known physiological condition. No other documented information was found to specify why the resident was initially prescribed the medication. Review of the Treatment Administration Record from 02/01/2020 to 02/29/2020, showed the facility was monitoring the following resident behaviors related to the antipsychotic use. 1. Number of episodes of calling out Review a Psychiatric progress note dated 06/16/2019, showed target issues that were being addressed were verbal and physical aggression, refusal of care, depressed mood, delusions associated with Alzheimer's. A nursing progress note dated 06/26/2020 showed the Seroquel was increased as a result of Dementia with associated behavior symptoms as recorded on behavior monitoring flow record. No other information. No other documented indications for the use of the antipsychotic medication were given upon request. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan initiated on 01/14/2019, identified the resident as having multiple Mental Health diagnoses such as Psychotic disorder, anxiety depression. The care plan stated the resident had a history of disrobing and smearing of feces. Further review of the progress notes did not show evidence of these behaviors and upon request. In an observation and interview on 02/14/2020 at 6:00 AM, the resident was observed lying in bed yelling out loud. The resident had her feet hanging off the right side of the bed with her head hanging off to the left. The resident had told the surveyor earlier she needed help repositioning. Staff TT, Licensed Practical Nurse (LPN) who was getting ready to administer medications to the resident was asked why the resident was yelling and he stated Oh she does that and has mood problems. She gets Seroquel for that. In an interview 02/25/2020 at 9:27 AM, documents were requested from the facility administration to provide resident accounts of the episodes such as feces smearing and disrobing. Staff SS, Regional administrator provided documents and stated there was no documentation of an event that warranted the use of the medication. She stated she understood what was needed by the surveyor but could not provide that. Reference (WAC) 388-97-1040(1)(a-c)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 39651 Based on observation, interview and record review, the facility failed to consistently provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for one of three sample residents (#88) reviewed for narcotic medication records. This failure placed Resident #88 at risk for not receiving an accurate dose of medication and drug misuse. Findings included . A review of Resident #88's Physician order sheet and Medication Administration Record for February 2020, showed the resident was currently receiving Phenobarbital (anticonvulsant/hypnotics) related to seizure disorder. A review of the narcotic log for Resident #88 showed, the resident had a total of 1025 milliliter (mL) of the medication stored and kept in the narcotic box, as of 02/05/2020. During a joint observation and interview on 02/06/2020 at 9:42 AM with Staff C, Registered Nurse (RN) stated the narcotic log showed the resident should have at least 1025mL of the medication left on the bottle. However, the medication bottle/drug on hand only showed a total of 265mL. Staff C stated, she was not sure where the rest of the medication was and she was not sure what happened to the rest of the medication. During a joint interview and observation on 02/06/2020 at 10:03 AM, Staff D, Resident Care Manager (RCM)/RN and Staff C, RN both staff members stated they were not sure what happened to the rest of the medication and whether it was just an error with the receiving and/or documentation of the medication when it was first delivered by the pharmacy. Both Staff C and Staff D stated, they had looked in the medication room and was not able to identify what happened to the medication. Staff D further stated, she had notified the Director of Nursing and they would immediately conduct an investigation. In a follow-up interview on 02/06/2020 at 10:30 AM, Staff D RCM/RN stated the error was related to the inaccurate acquiring/documentation of the medication when it was first received by the licensed nurse on duty. Staff D also stated, the medication label and stickers on the narcotic log was also inaccurate because it did not show the actual amount of the medication when it was first received by the facility. According to Staff D, they would immediately review this process and re-educate nurses about this process. Reference (WAC) 388-97-1300 (1)(b)(ii)(c)(ii)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42378 Based on interview and record review, the facility failed to implement and follow-up on the nurse practitioner's (NP) response to the Medication Regimen Review (MRR) for one of five residents (#30) reviewed for pharmacy recommendations. This failure placed the resident at risk for adverse side effects and receiving unnecessary medications. Findings included RESIDENT #30 Resident #30 was a long-term care resident who readmitted to the facility on [DATE]. His diagnosis list included Hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), Diabetes Mellitus Type 2, Schizophrenia (a serious mental disorder in which people interpret reality abnormally), Depression, anxiety and delusional disorders/hallucinations. A review of his significant change of condition Minimum Data Set (MDS) dated [DATE] showed resident had intact cognition and for behavioral symptoms, had been rejecting care for 1-3 days of 14-day assessment window. A review of the medical record showed orders for antipsychotic medication (AP), antidepressant medication (AD) and Atorvastatin (a cholesterol-lowering medication). It also showed orders for two types of insulin (medicine that helps the blood sugar level from getting too high [hyperglycemia] or too low [hypoglycemia]): a long-acting insulin and a rapid-acting form of insulin used for the treatment of high blood sugar level before meal time and as sliding scale (dose is based on pre-defined blood glucose ranges). A review of the MRR for 07/24/2019 showed Staff FF, NP signed on 08/05/2019 the recommendation to monitor for involuntary movements now and at least every 6 months for AP medication may cause involuntary movements including tardive dyskinesia (a neurological disorder characterized by involuntary movements of the face and jaw). Further review of the medical record showed an Abnormal Involuntary Movement Scale (AIMS) Assessment done for 08/05/19 but none six months after (due February 2020). A review of the NP's orders and the care plan showed no order to do the AIMS test at least every 6 months from August 2019 related to continued use of AP medication. A review of the MRR issued on 08/28/2019 showed on 09/09/2019, the NP's written response on the form for the goal less than 8% and need referral to endocrinologist (a medical practitioner qualified to diagnose and treat disorders of the endocrine glands and hormones) for insulin pump, will write. However, the medical record did not show documentation for a referral or consultation with an endocrinologist. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the MRR for 12/11/2019 showed a recommendation to increase the Atorvastatin from 40 mg [milligram] to 60mg at bedtime related to elevated triglyceride (are the main constituents of natural fats and oils, and high concentrations in the blood indicate an elevated risk of stroke) level of 454 (normal was (20-200). Furthermore, the MRR form showed on 12/18/2019, Staff FF, NP agreed to the recommendation: if therapy is changed, order a fasting lipid panel (a test that measures fats and fatty substances used as a source of energy in the body. Lipids include cholesterol and triglycerides) in 4 weeks and every 12 months thereafter. A review of the medical records showed an order for Atorvastatin 60mg since 01/21/2020 but no order to do the lipid panel four weeks from increasing the dose and 12 months after. A review of the laboratory results showed 11/13/2019 was the last time the lipid panel test was done. During a joint record review and an interview on 02/26/2020 at 12:09 PM, Staff D, Registered Nurse (RN)/Resident care manager (RCM) stated the AIMS test was overdue for it was due February 2020. Staff D, RN/RCM stated she was not aware about the referral to the endocrinologist for insulin pump. Staff D, RN/RCM acknowledged the laboratory for December 2019 did not include a lipid panel. Furthermore, the medical record showed no orders for lipid panel for January/February 2020 and for every 12months after January/February 2020. During an interview on 02/26/2020 at 01:11 PM, the Director of Nursing Services (DNS) stated MRR was monthly and she would ask for an email copy of the MRR list monthly and it would come in a bulk email for all residents reviewed. In addition, the DNS stated for nursing related MRR, they would just follow the recommendations. However, if it involved the provider, then they put the MRR form in the provider binder to review and after the provider reviewed it, they follow the provider's recommendation and file the completed MRR form in the MRR binder. The DNS stated she will follow-up with Staff D, RN/RCM regarding the lack of follow through for the MRR recommendations for July, August and December 2019. Reference: WAC 388-97-1300 (4) (c)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on interview and record review, the facility failed to ensure adequate monitoring for adverse side effects (ASE) was in place related to the use of anticoagulants (blood thinners) for one of three (#105) residents reviewed for unnecessary medications. This failure placed the residents at risk for potential serious ASE and complications and a diminished quality of life. Findings included . Resident #105 was admitted to the facility on [DATE] with diagnoses that included vertebral (thoracic area) osteomyelitis (infection of the bone) and end stage kidney failure. Review of the Admission/5 day Minimum Data Set (MDS) assessment dated [DATE] showed the resident required the assist of two staff members for bed mobility, transfers and toileting. Review of the February 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed the resident was receiving Heparin Sodium Solution 5,000 unit/milliliter (ml), injections, 1 ml subcutaneously, two times a day for anticoagulation therapy. Further review of the February 2020 MAR and TAR, physician orders, and progress notes showed no evidence of adequate monitoring and/or documentation for potential adverse side effects (ASE) of anticoagulant use, such as excessive bleeding which may manifest as red or tarry stools, red or brown urine, or headache in case of a bleed in the brain. Other examples of excessive bleeding includes excessive bruising, prolonged nosebleed, bleeding gums, and vomiting and/or coughing up blood. During an interview on 02/18/2020 at 1:15 PM, Staff F, Registered Nurse (RN), reviewed the resident's February 2020 MAR and TAR, and stated the ASE related to the use of anticoagulant was bleeding, and there was no monitoring for it in the resident's current MAR or TAR. During an interview and record review on 02/20/2020 at 2:01 PM, Staff K, Resident Care Manager, RN, reviewed the resident's February 2020 MAR and TAR, and stated the resident should be monitored for signs and symptoms of bleeding, but there was no monitoring for it in the resident's current MAR or TAR. During an interview on 02/26/2020 at 11:12 AM, the Director of Nursing Services, stated the resident should have been monitored for signs and symptoms of bleeding, and that was the expectation for nursing staff to monitor ASE for residents on anticoagulant medication. Reference: (WAC) 388-97-1060 (3)(k)(i)

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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** 12273 Based on interview and record review the facility failed to 1 of 5 residents (40) reviewed for unnecessary drugs, the adequate documentation to justify not implementing a Gradual Dose Reducation (GDR) documented. Failure to ensure the physician documented the clinical justification to decline a GDR recommended by the pharmacists placed Resident 40 at risk for an unnecessary drug. Findings included . Resident #40 readmitted to the facility on [DATE], after treatment in the hospital for a gastrointestinal illness. A significant change in condition Minimum Data Set (MDS) assessment, dated 09/02/2019, was completed. It identified two different psychotropic medications, an anti-depressant (AD) and anti-anxiety (AA) medication, were administered. The assessment did not identify any behaviors that interfered with care, or were disruptive to the environment. The next quarterly MDS assessment, dated 12/03/2019, documented the same information identifying no behaviors were displayed. The Care Area Assessment (CAA), dated 09/02/2019, for psychotropic medication noted, Continues to have increased anxiety, is forgetful and has memory issues r/t to dementia. The facility concluded they will continue with present plan of care. The last CAA completed in coordination with an annual assessment, dated 08/29/2018, documented the following: Resident does not want changes in her AA or AD medication and noted attempted GDR in past which wasn't successful. The care plan noted a risk for complications related to the use of an antianxiety and antidepressant drugs related to insomnia and depression. The care plan was initiated on 08/22/2016. It documented the resident exhibits or is at risk for anxiety/fear caused by changes in functional ability and on-going adjustment, was initiated 03/11/2018. A pharmacy review, dated 10/22/2019, indicated Resident #40 was on Alprazolam 0.5mg, (Xanax- a benzodiazepine), three times a day and recommended a gradual dose reduction (of 25% every two weeks). The pharmacy consult recommended monitoring target behaviors and/or withdrawal symptoms. If an alternate (medication) is clinically indicated, it recommended starting Buspirone (a different AA) if symptoms reoccurred. The rational for the change was documented in the consult as follows: Benzodiazepines . are generally reserved for short term management of anxiety based disorders, especially in the elderly. The physician declined the recommendation and responded, Will taper Trazadone (the AD medication). No signs and symptoms of ADE (adverse drugs effects) of Xanax, stable dose for many years. Risk of adverse effect of taper. On 11/13/2019, the pharmacist's recommendation documented although the physician agreed to a dose reduction of Trazadone, no change to the medication was initiated. It also noted the resident had been on Xanax since 2015, and commented all of my GDR requests have been denied. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facilities Interdisciplinary Team (IDT) review for psychotropic medications, dated 11/12/2019, reported there was no change in behavior, noting, Resident keeps calling out for help at times, and repeatedly asks the same questions with different staff. The next IDT review, dated 12/06/19, noting the resident had not shown any behaviors, during September, October or November. In addition, the behavior monitor, dated 02/01/2020, lacked specific information to identify what symptoms of anxiety were displayed by Resident #40. The behavior indicated staff monitored for verbalization of feelings of anxiousness. On 02/25/2020 at 2:30 PM, Staff D, a Registered Nurse and a Resident Care Manager, was interviewed. When asked how the resident's anxiety is displayed, she stated the resident is obsessive and described she yells, when she is anxious for something, asks or says the same thing over and over again. When asked for an example, Staff D responded, Can you scratch my back, repeatedly. (A non-pharmacological intervention would be to provide a back scratcher.) Staff D was asked to review the record and provide any evidence to verify a GDR was attempted and failed, no additional information was provided. A readmission assessment, dated 08/26/2019, documented by Staff GG, an Advanced Registered Nurse Practitioner (ARNP) noted a GDR was initiated while in the hospital, which was successful, noting the dose scheduled at 8:00 PM reduced from 1 mg (milligram) to 0.5 mg. Despite the documentation that a successful GDR occurred, lack of behavior monitor showing resident verbalized anxiety, the physician still declined the pharmacy recommendation for the GDR. In addition, response to recommendation, (of 10/22/2019) documented by the physician did not provide the clinical rational and/or justification to continue use of the medication. This left the resident at risk for unnecessary drugs. Reference WAC 388-97-1060 (3) (k) (i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39651 Based on observation, interview and record review the facility failed to ensure multi dose vials/medications were dated after initial use and maintained accordingly based on the manufacturers recommendation for one of two medication rooms and three of three medication carts reviewed for medication storage and labels. These failures placed the residents at risk for harm in receiving expired medications. Findings included . MEDICATION ROOM During a joint observation of the unit 600 medication room on 02/06/2020 at 9:06 AM, Staff A, Registered Nurse (RN) observed an undated multi-dose vial of Humalog (Insulin) that was open. In an interview at the time of the observation, Staff A stated the vial was half way gone and the vial should have been dated when it was first opened. Staff A further stated, multi-dose vial insulins were only good for 28 days from the day it was opened but there's no way to find when to discard this particular insulin. MEDICATION CART #1 During a joint observation of Medication Cart #1 on 02/06/2020 at 9:11 AM, Staff A, RN found an undated Latanoprost (medicated eye drops) on the top drawer of the cart. In an interview at the time of the observation, Staff A stated the eye drops was almost empty and it should have been dated when it was first opened. Staff A further stated, eye drops were only good for 28-30 days from the day it was opened but since the medication was not dated, there's no way to find when to discard this particular medication. MEDICATION CART #2 During a joint observation of Medication Cart #2 on 02/06/2020 at 9:19 AM, Staff B, RN found an expired medicated eye drops for Resident #11. The eye drops had an opened date of 10/03/2019. In an interview at the time of the observation, Staff B stated this particular eye drops was expired for almost 3 months and should have been discarded 28-30 days after it was first used/opened. MEDICATION CART #3 During a joint observation of Medication Cart #3 on 02/06/2020 at 9:42 AM, with Staff C, RN the following items were observed: A. An open can of a liquid supplement with no open date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. An undated medication cup with 4 pills with no labels and/or resident identifier. In an interview at the time of the observation, Staff C stated the canned supplement should have been labelled and dated when she first opened it. Staff C also stated she should have not pre-poured any medications and she should have at least labeled the cup with a resident identifier to ensure that it will not be given to a wrong resident. In an interview on 02/06/2020 at 10:03 AM, Staff D, Resident Care Manager/RN stated multi dose medications, including insulin and eye drops should all have open dates and should have discarded 28 days after it was first used. Staff D also stated, nurses should not pre-pour any medications because this practice was not acceptable based on professional standards of practice. Reference (WAC) 388-97-1300(1)(2)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 12273 Based on observation, interview and record review the facility failed to ensure the pre planned menus were followed. Failure to ensure the portion serving sizes on the preplanned menu (and or the recipe) were followed, placed the residents at risk for malnutrition and weight loss. Findings included . On 02/19/20 between 12:15 PM and 1:10 PM, Staff RR, the cook and Staff QQ, the Food Services Director were observed serving food for the noon meal. After the meal was served, the serving sizes were verified and compared to the menu extention (a guideline, identifying the portion serving size and what foods were served for each diet). It was discovered that the menu extension, documented the cole served with the meal was intended to be 1/2 a cup. However the staff had used a 1/3 cup scoop, to portion the salad into dishes for serving. In addition, on 02/25/20, during the noon meal a test tray was obtained, the entree served was gumbo. Although the entree was served in a soup cup, which can hold 6 ounces, a scoop of rice or potatoes (depending on the diet had been place in the bowl) was placed into the bowl, then the gumbo was ladled over the top. At 2:00 PM, a recipe for the entree was provided. The FSD and the Regional Dietitian explained the resident had planned the menu for the meal for fat Tuesday. The staff then provided a copy of the recipe used for chicken and shrimp gumbo that identified the serving size should have been six ounces. The recipe recommended a tablespoon of rice be placed on top of the serving. The Regional Dietitian, who was present during the survey, stated the rice (or potatoes) were intended to be served on the side and when asked about the menu extension for the meal, said the did not have one. Staff RR was contacted by phone, and verified a scoop of rice or potatoes was served, and the gumbo was ladled over it in the bowl. Not ensuring the preplanned menu and portion serving sizes were followed, and ensuring a menu extension was developed for a special meal planned by the residents, placed then at risk for malnutrition. Reference WAC 388-97-1160 (1)(a)(b) 35787

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 12273 Based on observation interview and record review the facility failed to ensure the meals served were palatable, attractive, and at a safe and appetizing temperature. Failure to ensure meals served were at a palatable and appetizing temperature resulted in 8 of 22 (#82, #39, #101, #46, #406, #456, #103, #40) residents interviewed asked about food complaining about the taste, quality and temperature the of meals served. Findings included . Residents comments concerning the food included the following several resident's commented it food was awful, terrible, cold. Other residents described the food as does not have any taste, does not taste good, taste good, carrots are not cooked. Other resident's reported they routinely buy food outside the facility and/or order carry out foods. Staff YY, the Registered Dietitian provided meeting minutes from the Menu meeting. Staff YY, reported the purpose of the meetings included review of the menu and to get feed back about the food/ meals serviced. The meeting minutes, were provided for the last six months. The notes recorded the meetings scheduled for September of 2019, and October of 2019 lack did not occur, due to lack of resident interest. On August of 2019, residents complained about lack of sufficient protein being served, lack of variety in the diet, lack of condiments, and watery soup. On November of 2019, the resident's complained not getting condiments with meals. On 12/11/2019, the same issue with condiments was reported, as a continuing problem. The notes for 01/08/2020 and 02/04/2020, it residents report the menu was not followed. One month reporting the omission of gravy and whipped cream from their meals the menu identified they should be served. The grievance log found 26 individual grievances concerning the food were documented during the last 6 months. Review of 11 of the grievances found complaints about a variety of issues were documented. The issues included: under cooked foods, not meeting preferences, not providing a diabetic diet and grievances about not having a system in place to safely handle foods brought into the facility by visitors and /or families. On 02/21/2020, during observation of the meal service, the Regional Dietitian, was asked about the preplanned menu, used by the facility. Staff XX, the Regional Dietitian, said the facility utilized a 3 week cycle which was rotated. When asked how many times a year the menu changed, Staff XX said two and commented several alternates available for each meal. Serving the same meals a three week cycle, which was changed every six months could limit the variety of foods offered. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It was noted that heated pallets, were not consistently used, to assist in maintaining temperatures. When asked about their use, Staff XX stated they heated pallets were not used in the main dining room. After pointing out that the trays sometimes remain on the cart in the dining room, for an extended period of time, if a resident change the location for the meal. Staff XX commented it would be a good ideal to start using them in the main dining room. On 02/25/2020, at 1:10 PM, three non sample Resident's remained in the dining room, one of them complained the food taste burnt and had refused the meal. A second resident also refused the meal, and left the dining area shortly after looking over the tray. The third Resident agreed with their table mate that the food tasted burnt, and said she ate it anyway. It was also noted a tray, remained on the cart, but not heated pallet was observed. On 02/25/2020 at 1:25 pm, the trays arrived in the 200 hallway Staff Q an NAC, was the only staff in the area to deliver and assist residents with meal set up. The last was taken from the cart and served at 1:50 PM, the temperatures of the food were obtained from a test tray. The vegetable had been portioned into a small glass dish that had been placed on a dinner plate, the temperature was 119 Degrees Farhreneit (DF), the other item on the plate was a corn muffin. The temperature of the entree, chicken and shrimp Gumbo, was only 124 DF. On 02/25/2020 at 2:15 PM, during a follow interview, was completed with the Staff QQ, the Food Service Director and Staff XX , said they were disappointed to hear the residents comments and the results of the temperature testing. They contacted the Cook, who had prepared the meal, and discovered the portion serving sizes for the mail entree was not followed. Staff XX, reported the resident helped plan the menu and said that a menu extension was not provided to staff because it was a special meal and when asked acknowledged the facility did not have enough of the heated pallets to use for all the meal trays. Not ensuring the meals served maintained a palatable temperature, ensure the preplanned menus and resident preferences were consistently followed, ensure the menu variety, and ensure a the facility responded to concerns expressed by residents contributed to residents expressing dissatisfaction with the meals served.

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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. 12273 Based on observation, interview and record review the facility failed to ensure food was stored, prepared and distributed under sanitary conditions. Failure to ensure foods were stored at the appropriate temperature, food preparation equipment, was kept in a clean and sanitary condition, and ensure foods were labeled and dated as needed increased the risk for a food borne illness for all residents residing in the facility. Findings included . Main kitchen and food service area On 02/05/2020, during the initial tour of the kitchen between at 9:15 AM, the handwashing station in the main kitchen was out of paper towels to dry your hands after washing. There were two whole turkey roasts, found on the shelf in the walk in refrigerator. There was no date to identify when they were placed in the refrigerator. Staff QQ, the Food Service Manager, stated the roasts were cooked the previous evening and were intended to be used for the meal that day. When Staff QQ tested the temperature and found the roasts were at a temperature of 44 degrees Fahrenheit. When asked if staff monitored the temperature during cooling, Staff QQ, explained the roast was placed in the refrigerator at the end of the evening, and no staff was available to monitor the cooling process. Approximately 3-4 boxes of health shakes were found in the service kitchen refrigerator. When asked how they monitor the shelf life of the supplements, which are delivered frozen and needed to be used within 14 days of thawing. Staff QQ stated the delivery date was on the boxes, and are used with-in a week of delivery. He stated individual cartons are not dated when they leave the kitchen, because they are intended to be consumed when served. The juice machine, a commercial dispenser, appeared soiled, along with the rack holding the juice boxes and spigots. When asked how the equipment was maintained and cleaned, Staff QQ, reported he was new to the facility and was not certain how it was cleaned and/or maintained. During a follow up interview on 02/05/2020, at 10:00 AM, Staff QQ, stated they had discarded the turkey roasts, because the temperatures were not monitored while cooling. (Cooked foods must reach 41 degrees within 6 hours of cooling.) In an observation on 02/05/2020 at 10:00 AM, in the hallway between the service kitchen (where a steam table for holding of hot food and tray assembly occurred) and the main kitchen (where food preparation occurred) the exterior windows were open. The screens covering the windows were loose fitting and had gaps, leaving the area, susceptible to bugs and other undesirable vermin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/14/2020 at 5:30 AM, during a follow up tour in the main kitchen, the handwashing station in the main kitchen did not have any paper towels available. One unnamed dietary aide was present, and Staff RR, the cook arrived within the next few minutes. The blade on the can opener had built up grim adhered to it. The bases of both the blender, and a commercial food processor were soiled with food spills and splash. The grill, was soiled with food spills, crumbs and dried food splash. The counters were observed with food particulate matter and spills, in various places throughout the food preparation area. A white colored dried spill was observed in a sink (located next to the handwashing sink.) The floor in the dish-room was soiled with bit of paper and other garbage scattered on the surface. At 5:40 AM, Staff RR, who entered the kitchen to begin preparing the breakfast meal, acknowledged the equipment and areas in the kitchen had not been properly cleaned and provided reassurance the area would be cleaned, before preparing the meal. Resident food storage areas on units The facility policy entitled Food: safe Handling for Foods From Visitors which was updated on 07/2019. The policy noted that if food not intended for immediate consumption was brought to the facility staff would label the item with the resident's name and date, and would be stored for 7 days. On 02/05/2020, a refrigerator was observed in basement floor (near the elevator). The refrigerator was found to have three food items, only one of the items was labeled with a name but no date. The two other items in the refrigerator did not include a name or identify the date they were placed in the refrigerator. One was a partially eaten rack if ribs, the other was tub of humus that identified a sell by date of 12/09/2019. The refrigerator, had a large dried spill in the drawer, which was visible in the clear plastic drawer. On 02/07/2020, the foods were no longer in the refrigerator, however the dried food spill in the drawer remained visible. On 12/21/2020, at 11:20 AM, another refrigerator was observed in the nurse's station in the basement. Ten undated unlabeled health shake supplements, were observed. Three carry out packages of food were found, but they were undated and did not identify the name of the resident they belonged to. Two additional dishes of food were found in plastic containers with no labels or dates. A peanut butter sandwich dated, 02/14/20, but did not identify who it was intended for. At 11:30 AM, Staff K, a Registered Nurse and Resident Care Manager verified the items should be labeled with the resident name and date the item was placed in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/21/2020 at 2:34 pm, two refrigerators were found on the main floor. The refrigerator were located across the hallway, in a utility room, between the 400 and 500 hallway. Three bags of raw fresh vegetables were observed, that included a name and were dated for, 01/14/20. The items had been in the refrigerator more then 30 days. Two of the bags contained celery that was browning on ends, and another bag had whole fresh peppers that were soft and mushy. On 02/21/2020, the other refrigerator located in the medication storage room, at the nurses station, between the 200 and 300 hallway. There were two carry out cartons of food, restaurant style found. They did not identify the resident nor were they dated. A bag contained a piece of fried chicken, dated 02/12/2020. It identified a current resident, but had been in refrigerator for 10 days. Staff D, who was in the medication room at the time of the observation, reported all the food items, belonged to the same resident and acknowledge they were not labeled or dated. Reference WAC 388-97-1100 (3), & WAC 388-97-2980

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 12273 Based on observation, interview and record review, the facility failed to ensure a policy for sanitary storage, handling and consumption of foods brought to residents by family or visitors, was implemented for two of seven residents (#65, #92) who filed grievances with the facility. Failure to ensure the facility policy was implemented could negatively impact quality of life and nutritional intake for Residents #65 and #92. Findings included The facility policy, which was last revised 07/2019, entitled Food: safe Handling for Foods From Visitors documented if the food items were intended for immediate consumption a staff member would assist with ensuring the appropriate utensils and dishware, and assist in reheating the items. If not intended for immediate consumption, the staff would label the item with the resident name and date, and store for 7 days. The policy directed staff responsible for reheating the food items in the unit microwave, to 165 degrees for 15 seconds. Review of the facilities admission packet, included a booklet entitled 2019 welcome Packet, noted on page 5, food brought by family / visitors will be handled and stored in a safe and sanitary manner. Resident # 65 The grievance log showed on 10/09/2019, Resident #65, filed a grievance after staff refused to allow him to store and reheat, commercially prepared frozen meals. The facility responded to the grievance by conducting an inservice training with staff that stated ALL STAFF - we do not reheat food for residents/visitors. and also noted food can only be kept in the refrigerator for 3 days, which conflicted with the facility policy and information provided in the admission packet. There was no evidence any one responded to Resident #65's grievance about not reheating foods. (see citation under F 565) Resident #92 On 11/03/2019, a similar grievance was filed from Resident #92. The form documented Family bring food and want to be reheated in the facility. An undated document attached to the grievance noted a meeting, with the Registered Dietitian, Food Service Manager, and the resident, who reported typically has food brought in from home . The facility contacted the spouse who had reiterated the resident prefers to have food brought in from home. Another document attached, was dated 11/06/2019, which indicated the DNS, called the spouse and advised them the facility not able to warm up food for the residents and suggested she bring it to the facility at noon . and serve it while it's warm. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/2020 at 10:20 AM, the Administrator was asked about reheating foods for residents that had been brought in by visitors. She stated, the facility did not reheat foods brought in, and stated it took too much time for the staff to reheat foods and they needed training on reheating foods. When asked if they had considered an alternate system to reheat foods such as allowing families or residents access to a microwave, she stated No as there was no microwave available to re-heat foods. After asking if the residents were informed of the change in facility policy, the administrator stated that she did not know and would look for additional information, however no further information was provided. No Reference WAC available.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38430 Based on interview and record review, the facility failed to put in place, conduct, and document a facility-wide assessment with the necessary information as required to meet the needs of each resident of the facility. This failures placed all residents of the facility at risk for unmet care needs. Findings included . A review of the facility assessment, dated 02/07/2019, showed it was missing the following information and documentation as required: A) The staff training/education and competencies that are necessary to meet the needs of each resident. B) The physical environment, equipment, services, and physical plan consideration to meet the needs of the residents/resident population. C) Pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resource needs (e.g. residents' preferences with regard to daily schedules, waking, bathing, activities, naps, food, going to bed, etc.) D) Contract memorandum of understanding, or other agreements with third parties to meet the needs of the resident during normal operations and emergencies. During an interview and record review on 02/19/2020 at 1:03 PM with the Administrator, the facility assessment showed sections that were missing required information. The Administrator stated, Okay. No associated WAC reference

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41070 Based on observation, interview, and record review, the facility failed to follow an effective infection control practices for two of two residents (#82 & #63) reviewed for wound care observations. In addition, the facility failed to dispose biohazard waste appropriately for Resident #82, appropriately care and document use of intravenous tubing for Resident #105, and failed to perform hand hygiene for three of three residents (#406, #408 & #82) reviewed during medication pass. The facility also failed to provide education and training to staff regarding highly contagious diseases and isolation precautions. These failures placed the residents at risk for acquiring facility acquired or healthcare-associated infections, related complications, and a diminished quality of life. Findings included . Review of the facility policy titled: Infection Control Policies and Procedure revised on 01/06/2020, showed In addition to Standard Precautions, Enhanced Barrier Precautions and Contact Precautions will be used for novel or targeted multi-drug resistant organisms (MDROs) per the Centers for Disease Prevention & Control (CDC) guidance. To reduce the risk of transmission of epidemiologically [plan/evaluate strategies to prevent illness] important microorganisms by direct or indirect contact. The policy also stated to follow the CDC guidelines below: 1. Standard Precaution - applies to all patient [resident], use PPE [Personal Protective Equipment - gloves, gown, or face protection] for any potential exposure to blood, body fluids, mucous membranes and non-intact skin, and potentially contaminated environmental surfaces or equipment. Change PPE before caring for another patient. 2. Enhanced Barrier Precautions - applies to resident with known infected or colonized with a novel or targeted MDRO. Use of PPE (gloves and gown) prior to high contact care activity (ADL Care [dressing, bathing/showering, transferring, providing hygiene, changing linens, briefs or assisting with toileting, device care or use such as central line [intravenous lines], urinary catheter, feeding tube, tracheostomy, and wound care [any skin opening requiring a dressing]. 3. Contact Precautions - applies to resident with known infected or colonized with a novel or targeted MDRO in any of the following situations: presence of diarrhea, draining wounds, or other sites of secretions that are unable to be covered or contained. Use of PPE [gloves and gown - don before room entry, doff before room exit; change before caring for another patient; and face protection may be needed if performing activity with risk of splash or spray. According to CDC, the Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately before touching a patient, before performing an aseptic task (placing an indwelling device) or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. DRAINING WOUNDS with MRSA [Methicillin Resistant Staphylococcus Aureus] RESIDENT #82 Resident #82 was admitted to the facility on [DATE] with diagnoses that included MRSA (Methicillin Resistant Staphylococcus Aureus - infections caused by specific bacteria that are resistant to commonly used antibiotics) on his legs and Hepatitis C (HCV - is a viral infection that causes liver inflammation, sometimes leading to serious liver damage). An observation on 02/05/2020 at 11:00 AM, the resident was up in his wheelchair, in his room, the resident had wounds on his upper and lower legs, and the wounds on the resident's legs were draining on his pants and shoes. An observation on 02/06/2020 at 10:05 AM, the resident was up in his wheelchair, in his room, the wounds on the resident's bilateral [both] upper and lower legs were covered with dressings, and the dressings on the resident's upper and lower legs were soaked with fresh blood. The blood coming from the resident's wounds were draining to his pants and shoes. The resident was also observed touched his wounds, wheeled himself out of his room, touched the handrails in the hallway, the elevator button, and went up to the main level to the smoking area. The resident was not reminded or cued to wash his hands prior to leaving his room. An interview on 02/06/2020 at 1:33 PM, Staff O, Nursing Assistant Registered (NAR), stated she was not aware what kind of infection precaution was being observed for Resident #82's roommate (Resident #90 who tested positive for nasal MRSA, and had tracheostomy). Staff O stated she would ask the nurse for the most specific reason for Resident #90's infection control precaution. Staff O, stated they did not need to gown up or watch other precautions for delivering trays for Resident #82 because the resident was independent. An interview on 02/06/2020 at 1:38 PM, Staff F, RN, stated she was not sure about the precaution for Resident #82 and Resident #90. Staff R stated she was an agency nurse and it was her very first shift that day. Staff R stated the resident's roommate (Resident #90) should be on contact precaution because he had a tracheostomy, and she would use gloves, wear a mask, and gown up. However, for Resident #82, Staff F stated she was not sure because the night shift nurse did not tell her anything about the two residents, and did not know what kind of infection the residents have. An observation on 02/06/2020 at 2:29 PM, Staff JJ, Housekeeping and Laundry Manager, and Staff HH, Nursing Assistant Certified went in and out of the residents room and did not do hand hygiene and they did not wear a mask, and were not aware of what other precautions to observe. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint observation with Staff II, Certified Occupational Therapy Assistant on 02/07/2020 at 10:22 AM, observed with the surveyor that Resident #82 was wheeling himself in the 600 hallway and all the way to the elevator with his left leg wound uncovered and actively bleeding. The blood was draining from the resident's leg wounds to his socks and shoes, the carpet and on the elevator floor while wheeling himself. A joint observation on 02/07/2020 at 10:34 AM, with Resident #82's doctor, Resident #82 was wheeling himself in the 600 hallway, and all the way to the elevator with his left leg wound uncovered and actively bleeding. The blood was draining from the wound, to his socks and shoes, to the carpet and the elevator floor. The resident's doctor stated the wound should be covered because the resident had an active infection related to MRSA of the wound on his legs, and stated the likelihood of spreading the infection was very high because there was no plan to contain the infection and the resident was mobile [independent with wheelchair mobility]. An observation and interview on 02/10/2020 at 12:43 PM, Staff L, Licensed Practical Nurse (LPN), and the surveyor found a soiled dressing on top the resident's bedside drawer, and in the resident's garbage. The soiled dressing was bloody with slight yellowish and dark brown drainage. Staff L stated the soiled dressings should have been disposed to a biohazard container. An observation on 02/10/2020 at 1:39 PM, the resident was observed touching the roommate's bed (Resident #90) while walking towards his bed to get a cigarette. The resident then wheeled himself out of his room, touching the handrail in the hallway, touched the elevator button, and went up to the main level to the smoking area. The resident did not wash his hands when he left his room. An interview on 02/10/2020 at 3:39 PM, the Director of Nursing Services (DNS), stated the Staff G, Infection Control Nurse informed her that Resident #82 was on Enhanced Precaution and Resident #90 should be on Standard plus Contact Precaution, and both signs should be posted by the residents' room but the Standard plus Contact Precaution fell off. The DNS stated that she was aware that staff were not following the precautions, and should be assisting the residents to wash their hands but hand hygiene was not happening. The DNS also stated that they would need to train their staff with infection control program and practices. In another interview on 02/26/2020 at 10:29 AM, the DNS stated the expectation for disposing bloody or soiled dressings should be disposed in the biohazard container because it was an infection control issue, she also stated that nurses should be assisting and reminding the residents to wash their hands. USE OF INTRAVENOUS [IV] LINE SET RESIDENT #105 Resident #105 was admitted to the facility on [DATE] with diagnoses that included vertebral (thoracic area) osteomyelitis (infection of the bone) and peripheral vascular disease (a slow and circulation disorder caused by narrowing, blockage or spasms in a blood vessel and may affect arteries and veins). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the February 2020 Medication Administration Record (MAR) and Treatment Administration Record (TAR) showed the resident was receiving Ceftriaxone (an antibiotic) Sodium Solution reconstituted 2 gram [GM], use 2 gram intravenously [IV] every 24 hours for Osteomyelitis secondary to Group B Strep Bacteremia until 03/26/2020 [this medication was started on 01/30/2020]. Further review of the MAR and TAR showed no documentation that the IV line tubing set was being changed every 24 hours per pharmacy recommendation and guidance. An observation on 02/07/2020 at 9:25 AM, the resident was up in his wheelchair in his room, in the resident's room there was an IV pole, hanging in the IV pole was an empty bag of Ceftriaxone. The IV line was not dated. The resident stated he had shivers after dialysis. A joint interview and record review on 02/19/2020 at 3:07 PM, Staff K, Resident Care Manager (RCM), Registered Nurse (RN), stated the resident was receiving Ceftriaxone until 03/26/20 for Osteomyelitis to Group 3 Strep Bacteria in his vertebrae T5-T6 complicated by epidural access. A joint observation on 02/19/2020 at 3:18 PM, Staff K observed an IV pole in the resident's room, hanging in the pole was an empty bag of Ceftriaxone with an IV line attached to the bag. The IV line was not dated. Staff K stated that there should be an order to change the IV line every evening [every 24 hours] but she could not find it in the physician order or in the February MAR and TAR. Staff K also stated she was unable to prove that licensed nurses were changing the IV line every evening because there was no order for it and it was not written in the MAR or TAR. An interview on 02/26/2020 at 11:10 AM, the Director of Nursing Services stated the expectation was to change the IV line every 24 hours, and it should be dated. 39651 MEDICATION ADMINISTRATION An observation on 02/07/2020 at 8:44 AM, Staff E, Registered Nurse (RN), was passing Resident #406's morning medications, no hand hygiene observed before and after the medication pass, before and after resident contact and after providing a subcutaneous injection (a shot given into the fat layer between the skin and muscle), no hand hygiene was performed. An observation on 02/07/2020 at 8:57 AM, Staff E, RN, was passing Resident #408's morning medications, no hand hygiene observed before and after the medication pass, before and after resident contact, and after administering the resident's inhalation medications, no hand hygiene was performed. Enhanced Barrier Precautions and Standard plus Contact Precautions were posted for most of the residents in the 600 hall, and Staff E was not following the precautions posted on the residents' door with Enhanced and Standard/Contact Precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 02/07/2020 at 9:18 AM, Staff E, RN, stated she was not sure about the precautions and was surprised that almost all residents were on enhanced precaution and standard/contact precautions. Staff E stated she did not understand why because the residents' care plan was not showing any information about the precautions, and she did not get any education or information by anyone in Management, and did not get a good report from the night shift nurse. Staff E stated she should have washed her hands in between patient contact during medication pass, especially for Resident #406 who received a subcutaneous injection. An observation on 02/07/2020 at 9:11 AM, Staff F, RN, was passing Resident #82's morning medications, no hand hygiene observed before and after the medication pass, before and after resident contact, and after administering the resident's inhalation medication, no hand hygiene was performed. Resident #82 who had wounds with MRSA on his legs was on Standard plus Contact Precautions, and Staff F, did not follow the resident's infection control precaution. An interview on 02/07/2020 at 9:18 AM, Staff F, RN, stated that she was not sure about the Resident #82's infection control precautions, and she should have washed her hands in between patient contact, especially for Resident #82 who had MRSA precautions. Staff F stated that it was not clear to her either on why almost all residents in the 600 hall were on enhanced precautions. An interview on 02/07/2020 at 9:21 AM, Staff G, Infection Control Nurse (ICN), RN, confirmed that she had not trained or educated Staff E, RN, on infection control program and/or about the infection precautions that were not followed during medication pass observations that day. MDRO [Multi-Drug Resistant Organisms] in the URINE Resident #407 was admitted to the facility on [DATE], with diagnoses that included MDRO [are commonly spread by direct contact between people or with contaminated surfaces in the environment] and incomplete quadriplegia (paralysis of all four limbs) with cervical spine injury. An observation on 02/05/2020 at 1:10 PM, the resident was lying in bed and needed the assistance with adjusting his call light and his pocket talker. Staff E, RN was observed answered the resident's call light and adjusted the resident's call light pad located on the left side of the resident's head. The resident was using his head to press his call light pad because he was unable to use his hands. Staff E assisted the resident with his call light and pocket talker but did not wash her hands before and after contact with the resident and the resident's call light button. Other staff were also observed going in and out of the room without following any infection control precaution. There was no posted precaution or sign on Resident #407's door to guide the nursing staff on how to handle the resident's diagnosis of MDRO when providing care to the resident. An interview on 02/07/2020 at 9:21 AM, Staff G, ICN, RN, stated that all residents who had lines and/or break in the skin, and draining wounds should have been on Enhanced Precautions per facility policy. Staff G, also stated they only found out on 02/05/20, that Resident #407 was admitted with MDRO Pseudomonas UTI [Urinary Tract Infection - bladder infection]. However, Staff G stated the facility had only put in the precautions in the afternoon of 02/06/20, and just started informing the staff about the precautions, and they were working on updating the resident's care plan. Staff G was aware that not all rooms had isolation carts and they were working on getting some more. 12273 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NOT FOLLOWING INFECTION CONTROL PRECUATIONS On 02/05/20 at 2:10 PM, Staff G the facilities Infection Control Preventionist (ICP) was interviewed about what the staff were trained to do if precautions were posted outside the room. She stated they should read and follow them. Staff G said if Personal Protective Equipment (PPE's) is needed it should be discarded when exiting the room, then complete hand hygiene, using a hand sanitizer or washing with soap and water. On 02/11/20 at 12:04 PM, Staff AAA, an NAC was observed in room [ROOM NUMBER], an enhanced barrier precautions sign was posted outside the door. Staff was observed exiting the room wearing a face mask, she then entered room [ROOM NUMBER], placed gloves on, and entered the bathroom to emptying urinals. After completing the task the staff was heard to wash her hands in the bathroom, and exit room [ROOM NUMBER], however the face mask remained in place. When asked about care provided in while in room [ROOM NUMBER], the Staff AAA, stated she the resident with incontinent care. Staff AAA, reviewed precautions posted, and acknowledged the face mash should have been discarded in the room, prior to exiting. 02/14/19 at 5:10 AM, Staff W, an NAC entered room [ROOM NUMBER], the sign outside the door noted the resident was on contact precautions. Staff W placed a gown, gloves, and face mask, then exited the room, and entered room [ROOM NUMBER]. Staff W, obtained supplies from the closet, then went back to room [ROOM NUMBER], still wearing the same gown, gloves and mask that they put on in room [ROOM NUMBER]. The staff then closed the room door and exited at 5:17 AM. Staff W was interviewed, and what when asked what are you supposed to do when you exit the room, the only response was it is not my room. On 02/14/20 at 9:51 AM, Staff ZZ, a housekeeper was observed to come to the door, empty garbage into a barrel. The garbage can was returned to the room and the staff exited the room wearing gloves and face mask. The gloves and face mask were discarded in the barrel in the hallway. A gown or clothing protector was not used by the staff. The contact precautions, posted at the door of the room, directed staff to wear gown, gloves and a mask, remove the PPE in the room, in the room and complete hand hygiene. The resident was not observed wearing a gown and when exiting the room, placed the face mask and gloves in the barrel in the hallway, put the lid back in place and push it to the next room, in the 400 hallway. Before entering the room, the staff was asked what were you trained to do when gloves were removed, Staff ZZ, stated they should have washed his hands but did not. On 02/14/20 10:20 AM, Staff JJ, the housekeeping manager was interviewed about the training provided to the housekeeping staff. Staff JJ reported they are trained to remove their gloves in the bathroom, and wash their hands prior to exiting the room. When asked how staff are trained if special precautions in place, Staff JJ, said they should be following the signs posted outside the room, discarding the PPE's in the room then washing before exiting. On 02/20/20 at 10:45 AM, Staff C, was observed completing a dressing change. While completing the task Staff C was observed to remove gloves and placed new ones on multiple occasions, including after handling the soiled dressing and before handling the clean supplies. After she completed the dressing change Staff C, acknowledged she should have washed her hands, after removing soiled gloves and placing new one on. 37945 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection control Program Review of the State Operations Manual stated Standard and transmission-based precautions to be followed to prevent spread of infections. In an interview on 02/26/20 at 12:56 PM, [NAME] RN was notified of the concerns identified during the Survey. She stated she was aware of the issues however had just taken over the facility infection control program and would educate staff on infection control, with an emphasis on educating on wearing masks, gloves with isolations. She stated she would implement training and education in different languages, so the staff who spoke limited English could understand the differences of the modes of transmission such as contact, airborne and droplet. Reference (WAC) 388-97-1320 (2)(a)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 41070 Based on interview and record review the facility failed to provide abuse and dementia care training for one of six staff (Staff H) hired in 2019, before unsupervised access to vulnerable residents. This failed practice had the potential of not identifying and preventing abuse and/or neglect. Findings included . Review of the facility policy titled: Abuse Prohibition revised on 08/01/16, showed the facility shall prohibit abuse, neglect, exploitation, involuntary seclusion, and misappropriation of property for all residents through the following: 1. Screening of potential hires, 2. Training of employees (both new employees and ongoing training for all employees), 3. Prevention of occurrences, 4. Identification of possible incidents or allegations, which need investigation, 5. Investigation of incidents and allegations, 6. Protection of residents during investigations, and 7. Reporting of incidents, investigations, and facility response to the results of their investigations. Staff H, Licensed Practical Nurse (LPN), was hired on 11/22/2019, and Staff H had not completed the abuse or dementia training. An interview on 02/26/2020 at 10:43 AM, the Director of Nursing Services (DNS), stated that Staff H had not completed the abuse training and dementia training. An interview on 02/26/2020 at 12:25 PM, Staff G, Infection Control Nurse, Registered Nurse, stated there was no abuse or dementia training, and Licensed Nurse Skills check for Staff H's employee file. Reference: (WAC) 388-97-1680 (2)(a)(b)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 38430 Based on record review and interview the facility failed to develop, implement and maintain an in-service training program to ensure 4 of 4 Nursing Assistants (W, X, Y and Z) received the required 12 hours of nurse aide training and required dementia training per year. The failure to ensure Nursing Assistants (NA's) received 12 hours per year in-service training and dementia training placed residents at risk for potential unmet care needs. Findings included . Review of the Staff Members W, X, Y and Z employee files showed the NA's did not have documented evidence of 12 hours of in-servicing each year. Additional review of the NA's files showed no documented evidence of dementia specific in-servicing each year. In an interview on 02/19/2020 PM, with Staff G, Infection Control/Staff Training Coordinator, stated the NA's reviewed for the required trainings did not have the 12 hours needed and none of the staff have dementia training. Reference: WAC 388-97-1680(2)(a-c)