STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505195	A. Building B. Wing	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42203 Based on observation, interview, and record review the facility failed to provide care and services that ensured privacy in a manner that maintained and promoted resident rights and resident dignity for 1 of 18 (Residents 50) sampled residents. Failure to communicate with residents in a dignified manner placed residents at risk for diminished resident rights, feelings of institutionalization, embarrassment, frustration, disrespect, and diminished self-worth. Findings included . Resident 50 On 12/08/2022 at 7:30 AM Resident 50 was observed to approach an unattended beverage cart left in the dining room. Staff Y (Certified Nursing Assistant) called out loudly to Resident 50 from the nurse's station outside the dining room directing the resident to get off the cart twice. Staff Y then approached Resident 50 and asked the resident if they wanted a drink. Resident 50 left the dining room in frustration and went to the resident lounge. In an interview on 12/09/2022 at 3:53 PM Staff C (Licensed Practical Nurse, Unit Manager) stated they expected staff to treat residents with courtesy. Staff C stated Staff Y should have approached Resident 50 and offered a drink without raising their voice from a distance. REFERENCE: WAC 388-97-0180(1-4). 43642 46479 45941

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

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview and record review, the facility failed to provide advanced written notice for room changes, to include the reason for the move, for 3 (Residents 2, 6 & 41) of 3 residents reviewed for room changes. These failures placed the residents at risk for feelings of powerlessness and decreased quality of life. Findings included . Facility Policy According to the facility's undated Change in Room/Roommate Assignment policy, the facility was to provide reasonable notice of the room/roommate change, including oral or written explanation of the reason of the change. The policy stated a resident had the right to refuse the room change if the purpose of the transfer was to relocate the resident from the skilled (short term) section of the center to the non-skilled (long term care) section of the center. The room move was to be documented in the medical record and include the reason for the move, effective date of proposed change, location of new room, discussion with the resident/family, and discussion with current and new roommate. Resident 6 According to the 11/02/2022 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 6 admitted to the facility on [DATE] and was cognitively intact, able to make themselves understood and understood others. The MDS showed Resident 6 was able to participate by answering questions and making decisions about their care. Observation on 12/02/2022 at 10:54 AM showed Resident 6 moving down the hallway in their wheelchair wearing a hospital gown while staff moved Resident 6's belongings to another room. In an interview on 12/02/2022 at 10:57 AM, Resident 6 stated staff told them an hour ago they would be moving them to a different room. Resident 6 stated they did not know why staff had to move them. Resident 6 stated they liked their bed by the window in the previous room. Resident 6 stated they did not want to move and did not want to be in a bed by the door. In an interview on 12/02/2022 at 11:00 AM, Staff Y (Certified Nursing Assistant) stated they were told by Staff A (Administrator) to move Resident 6 to a different room and were following the boss's order. Resident 2 In an interview on 12/02/2022 at 2:53 PM, Resident 2 (Resident 6's new roommate) stated no one told them they were receiving a new roommate and just started moving someone's stuff into their room. Record Review showed no documentation of notification or monitoring of a new roommate. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/06/2022 at 1:55 PM, Staff C (Licensed Practical Nurse, Unit Manager) stated the facility's process was to notify the resident and the roommate prior to the room move. Staff C stated alert charting was expected to be initiated immediately after a resident moved to a different room and monitoring was documented in the resident's record. Review of Resident 6's record showed no documentation the resident was notified about the room move. Resident 6 was not placed on alert charting related to room move until 12/05/2022, three days later. There was no documentation of monitoring Resident 6's acceptance, settling in or interactions with the new roommate. In an interview on 12/09/2022 at 3:08 PM, Staff B (Director of Nursing) stated nursing staff was expected to notify the resident and their roommate about room moves and document in their records, but they did not. Resident 41 According to a 10/15/2022 MDS, Resident 41 was assessed as cognitively intact, had kidney failure, joint swelling and pain, and loss of sensation in their feet. In an interview on 11/20/2022 at 11:45 AM, Resident 41 stated they were required to move rooms by staff without notice or warning. Resident 41 stated on 11/29/2022 staff entered their room around 4:00 PM and started moving their bed. Resident 41 asked staff what was happening and was told it was time to move rooms. When Resident 41 asked why, staff informed the resident it was because they were no longer considered a short stay resident. Resident 41 stated their new room was not set up correctly as the bed was on the opposite side which made it more difficult for them to get in and out of bed. Resident 41 stated it took staff a couple days to get the TV and bathroom in the new room arranged to meet their needs. In an interview on 12/06/2022 at 1:55 PM, Staff C stated the facility's process was to notify the resident or family prior to a room move. Staff C stated alert charting was initiated immediately after a resident moved rooms and was documented in the resident's record. Review of Resident 41's record showed no documentation the resident was notified about the room move. There was no documentation noting Resident 41's toleration of the room move. Resident 41 was not placed on alert charting related to the room move. REFERENCE: WAC 388-97-0580(b)(i)(ii).

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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** 44296 Based on interview, and record review the facility failed to ensure residents had the ability to exercise self-determination related to aspects of life in the facility that was significant to the resident including the frequency and type of bathing for 3 of 3 residents (Residents 51, 6, & 65) reviewed for choices. The facility's failure to identify and/or honor resident preferences related to bathing placed residents at risk for feelings of un-cleanliness, powerlessness, decreased self-worth and diminished quality of life. Finding included . Resident 51 According to a 09/29/2022 Admission Minimum Data Set (MDS - an assessment tool), Resident 51 was cognitively intact, with clear speech, able to understand others, and be understood. This MDS indicated Resident 51 reported it was very important to choose between a tub bath, shower, bed bath or sponge bath. In an interview on 12/02/2022 at 10:44 AM, Resident 51 stated they get bathing, one time a week if you're lucky. The resident stated they preferred to have showers at least twice weekly. Review of a 09/28/2022 Activities of Daily Living Care Plan (CP) showed no preferences for bathing were identified for Resident 51. According to the November 2022 shower log documentation, Resident 51 only received four showers in 30 days. In an interview on 12/12/2022 at 8:16 AM, Staff C (Licensed Practical Nurse, Unit Manager) stated their expectation was for staff to follow Resident 51's preferences and provide bathing twice weekly. Resident 6 According to the 11/02/2022 Quarterly MDS, Resident 6 admitted to the facility on [DATE], was cognitively intact, and able to be understood and get understand in conversation. The MDS showed Resident 6 required extensive assistance with personal hygiene and showers. In an interview on 12/01/2022 at 11:21 AM, Resident 6 stated they did not get to make choices about bathing, and they did not receive a shower for a month. Resident 6 stated they preferred showering at least twice weekly but never got a shower. Observations on 12/02/2022 at 8:09 AM, 12/05/2022 at 11:33 AM, and 12/08/2022 at 10:01 AM showed Resident 6's face was not shaved and their hair was greasy. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's records showed no documentation of their preference of showers vs. bed baths, or frequency of bathing. Review of Resident 6's bathing records showed from 11/01/2022 through 12/01/2022, the resident received four bed baths in 30 days, but no showers. In an interview on 12/07/2022 at 12:04 PM, Staff C stated Resident 6's CP should have, but did not, reflect Resident 6's preferences for bathing. Staff C stated staff was expected to assist Resident 6 with showers according to the shower schedule twice a week, and per the resident's preferences. Staff C stated staff should shave Resident 6 daily or as the resident preferred. Resident 65 According to the 11/02/2022 Admission MDS Resident 65 readmitted to the facility on [DATE] and was cognitively intact, able to be understood and to understand conversation. The MDS showed it was very important to Resident 65 to choose between a tub bath, shower, bed bath or sponge bath. In an interview on 11/30/2022 at 11:30 AM, Resident 65 stated they did not get to make choices about bathing. Resident 65 stated they wanted a shower twice a week but only received bed baths. Review of Resident 65's Preference CP showed instructions for bathing (SPECIFY). The CP did not indicate Resident 65's preference for frequency or type of bathing. Review of Resident 65's bathing records showed they received one shower on 11/27/2022 and bed baths on 11/19/2022 and 11/23/2022 since their 10/27/2022 admission. In an interview on 12/07/2022 at 12:04 PM, Staff C stated resident 65 should receive bathing at least twice a week and the CP should specify the resident's preferences. REFERENCE: WAC 388-97-0900(1)(3).

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review the facility failed to ensure funds were reimbursed to the state Office of Financial Recovery (OFR), within 30 days of resident discharge or death, for 3 (Residents 221, 223, 222) of 3 discharged residents reviewed. This failure caused delay in reconciling resident accounts within 30 days as required. Additionally, the facility failed to notify 2 (Residents 38 & 2) of 28 residents reviewed, who were Medicaid recipients, when their personal fund account balances reached $1800 (i.e. within $200 of the $2,000 resource limit beneficiaries could possess, without their Medicaid coverage being impacted). This failure placed residents at risk for personal financial liability for their care. Findings included . According to a 12/01/2017 facility Personal Funds- Your Rights policy, the facility would notify a resident who receives Medicaid benefits when the balance of the resident trust account is 200 dollars less than the resource limit. The facility would advise the resident they may lose eligibility for Medicaid if the amount in the account was to reach the limit. OFR Fund Disbursement Resident 221 Record review showed Resident 221 was discharged on [DATE]. Review of trust records showed the resident a balance of $2060.00, which was not transferred to the OFR until 11/23/2022, two months after discharge. Resident 223 Record review showed Resident 223 was discharged on [DATE]. Review of trust records showed the resident had a balance of $600.02, which was not transferred to the OFR as of 12/12/2022. Resident 222 Record review showed Resident 222 was discharged on [DATE]. Review of trust records showed the resident had a balance of $440.00, which was not transferred to the OFR as of 12/12/2022. In an interview on 12/12/2022 at 11:14 AM, Staff G (Business Office Manager) stated the accounts were not closed timely and the money should be sent to the OFR within 30 days of a resident's discharge. Staff G stated, as of today, the checks have not been written. Notice of Medicaid Balances (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's Trial Balance report showed, as of 12/06/2022, the trust account balance for Resident 38 was 2297.71 dollars and for Resident 2 was 11,165.19. This was over the resource limit beneficiaries could possess. In an interview on 12/12/2022 at 11:14 AM, Staff G stated they had not provided notification to Resident 38 or Resident 2 regarding being over their resource limits. Staff G stated notification was important as the residents are at risk of losing their benefits if they are over the resource limit. REFERENCE: WAC 388-97-0340(4)(5).

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure the security of all personal funds of residents deposited with the facility. 43642 Based on interview and record review the facility failed to ensure 15 of 28 residents who had a Trust Account with the facility had their funds covered by a surety bond. This failure placed residents at risk to be unable to recover their money in the event of loss of funds from their account. Findings included . Record review of the facility's Trial Balance report showed 28 residents had trust accounts. The trust account report showed a current balance of 25,984.29 dollars on 12/06/2022. Review of the facility's surety bond, effective July 2021 showed the bond amount covered a trust account balance of $21,000 which did not cover the total trust account balance. In an interview on 12/12/2022 at 11:14 AM, Staff G (Business Office Manager) stated, Yes, the surety bond should be more than the amount in trust. REFERENCE: WAC 388-97-0340(6).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on interview and record review the facility failed to ensure residents were informed and provided written information concerning their rights to accept, refuse, or formulate an Advance Directive (AD) for 9 (Residents 6, 35, 45, 52, 20, 32, 65, 12, & 40) of 18 residents reviewed for ADs. This failure placed residents at risk for not having a surrogate decision maker when unable to make their own healthcare decisions. This failure placed the residents at risk of losing their rights to have their stated preferences/decisions regarding end-of-life care followed. Findings included . Resident 6 According to the 11/02/2022 Quarterly Minimum Data Set (MDS, an assessment tool) Resident 6 admitted to the facility on [DATE] and was cognitively intact, able to make themselves understood and understood others. Review of Resident 6's record on 11/30/2022 at 1:03 PM, showed no AD documentation. In an interview on 12/01/2022 at 7:48 AM, Resident 6 stated no one from the facility spoke with them about an AD. Resident 6 stated they needed assistance to complete an AD. In an interview on 12/06/2022 at 10:09 AM, Staff L (SSD, Social Service Assistant) stated the admission coordinator completed an AD task at admission, the SSD would discuss the AD in the resident's care conference if it was not initiated at admission. Staff L stated the facility documented an AD in the resident's record. If AD documentation was not in the resident record, then it was not done. In an interview on 12/12/2022 at 11:00 AM, Staff G (Business Office Manager) stated the admission coordinator completed the admission agreement upon admission and offered an AD to the residents or their representatives using the form in the admissions packet. Staff G reviewed Resident 6's admission agreement papers and confirmed an AD should have been completed but was not. Residents 35, 45, 52, 20, 32 & 65 Similar findings were identified for Residents 35, 45, 52 and 65 for whom Staff G was unable to locate AD documentation in the resident's admission agreement records, and there was no documentation an AD was offered to these residents. 44296 Resident 12 & 40 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Similar findings were identified for Resident 12 and 40 who were assessed to require a legal guardian related to cognitive loss. Resident 12 and 40 each had a petition for guardianship on 06/20/2022 and there was no further follow up after 09/22/2022. There was no documentation in the resident record that the residents or the resident's representative were offered assistance with an AD. In an interview on 12/09/2022 at 2:33 PM, Staff B (Director of Nursing) stated the corporate staff who submitted the guardianship application no longer worked for the company. Staff B stated the SSD facility staff who followed up also does not work for the facility any longer. Staff B stated follow up should have been ongoing through changes in staff. Staff B provided documentation that no follow up occurred after 09/22/2022. Staff B verified there was no documentation found in the record regarding guardianship follow up after 09/22/2022. REFERENCE: WAC 388-97-0280(3)(a-c),(i-ii). 46472 46471 42203

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 46472 Based on interview and record review the facility failed to provide timely notice, in writing, of changes in payment status and potential charges for services not covered by Medicare/Medicaid for 2 of 3 (Residents 27 & 371)residents reviewed for Advanced Beneficiary Notices (ABN, a notification of costs when services provided may not be paid by Medicare) and assist residents or their representatives to understand these notices or assist with the appeal process placed residents at risk for insufficient information to make informed decisions about care and finances. Findings included . Resident 27 On 05/21/2022 Resident 27 began skilled nursing/therapy services under their Medicare A benefit. Resident 27 was issued a Notice of Medicare Non-Coverage (NOMNC) on 06/15/2022 showing their last day of Medicare A coverage was 06/17/2022. In a 12/07/2022 10:30 AM interview, Staff G (Business Office Manager) stated Resident 27 should have been issued the federally required ABN because they no longer qualified for skilled nursing services under their Medicare A benefit and continued to reside at the facility. Staff G was not able to locate the ABN document and stated staff should have but did not issue the required ABN to Resident 27. Resident 371 Resident 371 began skilled nursing/therapy services under their Medicare A benefit on 06/16/2022. The 07/26/2022 NOMNC showed Resident 371's last covered day under their Medicare A benefit was 07/27/2022. The NOMNC was electronically signed on 07/27/2022, less than 48 hours from the required 48-hour timeframe for issuance of a NOMNC. In a 12/07/2022 10:30 AM interview, Staff G stated the NOMNC was not issued timely. Staff G stated no signed ABN was found in the record for Resident 371. Staff G could not confirm that an ABN was issued as required. REFERENCE: WAC 388-97-0300(1)(e)(5)(6).

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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** 42203 Based on observation and interview, the facility failed to ensure a clean, comfortable, homelike environment for 4 of 4 Wings (Wings A, B, C & D) reviewed. Facility failure to ensure a sufficient supply of linens in adequate condition, hallways were clean and homelike, resident rooms were free of wall gouges and damaged furniture, hand sanitizer dispensers were intact, call lights were within reach, clocks in resident rooms were accurate, and Blood Pressure cuffs were kept clean left residents at risk for a diminished quality of life and a less than homelike environment. Findings included . Linens On 11/30/2022 at 8:53 AM Staff Y (CNA, Certified Nursing Assistant) reported to surveyors that the facility did not have an adequate supply of fitted sheets. Staff Y stated the CNAs told the facility about it for months. Observation on 11/30/2022 from 8:56 AM to 9:01 AM showed the linen cart in Wing D had four flat sheets and some pillowcases but no other bed sheets, the linen cart in the hallway in Wing A had no bed sheets of any kind available, the linen cart in Wing B had no bed sheets, and the linen cart in Wing C had over 20 pillowcases and no other bed sheets. In an interview on 11/30/2022 at 9:16 AM Staff LL (Laundry Assistant) stated the facility was short on flat and fitted sheets. On 11/30/22 at 8:10 AM, Resident 21 was observed lying on an uncovered mattress with no bottom sheet. On 11/30/2022 at 9:45 AM, Resident 22 was observed to be lying on a bare mattress with no sheet. On 11/30/2022 at 11:07 AM Resident 28 was observed to be lying on a bare mattress with no sheet. On 12/01/2022 at 9:56 AM Resident 8 was observed lying on a bare mattress without a sheet. On 12/02/2022 at 11:06 AM Resident 55 was observed in room [ROOM NUMBER] lying on a bare mattress. The following observations were made of residents lying on beds with flat sheets instead of fitted sheets: on 12/06/2022 at 10:03 AM in room [ROOM NUMBER]; on 12/06/2022 at 10:04 AM in room [ROOM NUMBER], both residents had flat sheets on their mattresses and the sheet on the window bed was threadbare in two areas over 5 inches in length; on 12/06/2022 at 10:14 AM both beds in room [ROOM NUMBER] had flat sheets on both beds; on 12/06/2022 at 10:17 AM a resident was observed lying on a mattress with a flat sheet; on 12/06/2022 at 10:19 AM a resident was in bed with a flat sheet on the mattress; on 12/06/2022 at 10:32 AM a resident was observed in room [ROOM NUMBER] lying in bed with a flat sheet on their mattress In an interview on 12/12/2022 at 3:46 PM, Staff A confirmed residents should have fitted sheets in good repair on the bed for comfort, dignity, and safety. In an interview on 12/05/2022 at 12:11 PM Staff MM (Laundry Assistant) stated the facility did not have an adequate supply of fitted sheets. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/06/2022 at 9:26 AM showed Staff Y trying to find bed linens from the linen cart. Staff Y was unable to find the linens they required. In an interview on 12/08/2022 at 10:45 AM Staff Y stated the supply of linens showed no improvement and was the same for over a year. Staff Y stated having an available supply of linens was important for CNAs to perform their responsibilities. In an interview on 12/05/2022 at 11:20 AM, Staff A (Administrator) stated Staff I (Maintenance Assistant) was the person responsible for ordering linens. Review of the linens purchase order showed from 10/5/2022 through 11/29/2022 showed the facility had purchased a total of 48 extra wide fitted sheets and 36 regular fitted sheets. Hallway Fans and Trim Observation on 12/01/2022 at 11:50 AM showed a fan installed in a window at the end of the East Hall, next to Emergency Exit 2. The fan was attached to the window at eye level with two layers of plastic paneling that were not flush and were attached crookedly. The panels were screwed to the frame using unfinished wood. The screws used to attach the panels were not screwed in flush. Plexiglass was used to cover the horizontal window panels and was also attached to the unfinished wood. There was a layer of dust and cobwebs on the plexiglass, in the corners of the window, and on the fan. The fan had two hinged legs attached that indicated it was intended as a standing fan, not a window fan. Observation of the window to the right of Emergency Exit 3 on at 12/01/2022 at 11:52 AM showed a square, white, plastic panel was installed at eye level. The panel had one-foot diameter white tubing that dangled from the window to the floor. The square, white, plastic panel was attached to a secondary white panel with two black screws that were not flush, and mounted on unfinished wood, screwed to the window frame. There was a layer of dust in and around the window. Observation on 12/02/2022 at 10:49 AM showed a fan mounted high on wall outside room [ROOM NUMBER] encrusted with a thick layer of dust on the blades. In an interview on 12/02/2022 at 10:50 AM Staff C (Resident Care Manager) stated the fans were used to cool the hall in the summer. Staff C stated they couldn't begin to tell when the last time the fans were cleaned. In an interview on 12/12/2022 at 10:03 AM Staff H stated the windows near the Emergency Exits 2 and 3 were dirty, and unkempt. Resident Rooms The following observations were made in resident rooms: On 11/30/2022, a large triangular hole was noted at the bottom of the closet in room [ROOM NUMBER]; On 11/30/22 at 8:20 AM the night stand for bed 3 was noted with broken drawer and the walls was noted to have significant wall gouges in room [ROOM NUMBER]; On 11/30/2022 at 8:49 AM torn wallpaper was observed behind bed 1 in room [ROOM NUMBER]; On 11/30/2022 at 9:31 AM foot long wall gouges were noted behind bed 2; On 12/01/2022 at 10:48 AM similar wall gouges were noted in room [ROOM NUMBER] behind bed 1; On 12/06/2022 at 9:21 AM the light chain over Bed 2 in room [ROOM NUMBER] was observed to be too short for the resident to use. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During environmental rounds on 12/12/2022 at 10:37 AM, Staff H took note of the concerns with resident rooms and stated they would be addressed. Hand Sanitizer Dispensers On 12/01/2022 at 10:19 AM the hand sanitizer dispenser by room [ROOM NUMBER] was observed not to be working. On 12/01/22 at 11:55 AM, the hand sanitizer dispenser outside was observed to be removed outside room [ROOM NUMBER], leaving a mark on the wall. Call Lights Observations on 11/30/2022 at 1:06 PM, on 12/01/2022 at 10:34 AM, on 12/01/2022 at 12:11 PM, on 12/06/2022 at 8:23 AM, and on 12/08/2022 at 2:32 PM showed Resident 6's call light was inaccessible to them, either on the floor, or on a table beyond their reach. In an observation and interview on 12/08/2022 at 2:33 PM, Staff D (Registered Nurse, Unit Manager) confirmed the call light was on the floor. Staff D stated the light should be but was not reachable at that time. Wall Clocks On 12/05/2022 at 11:23 AM the wall clock in room [ROOM NUMBER]-1 showed a time of 5:32. On 12/07/2022 at 8:32 AM the wall clock in room [ROOM NUMBER] showed a time of 11:25. During environmental rounds on 12/12/2022 at 10:37 AM, Staff H stated the clocks should be accurate and stated they would fix them. Blood Pressure Cuffs In an interview on 12/06/2022 at 9:12 AM, Resident 45 stated they were concerned the facility's blood pressure cuffs did not fasten well because the Velcro was matted with hair. Resident 45 stated they were concerned whether their Blood Pressure measurements were accurate as the cuffs did not fasten well. Observation on 12/06/2022 at 9:40 AM showed a layer of hair enmeshed in the cuff's Velcro and the fabric of the cuff was frayed. The layer of hair and fraying fabric prevented the cuff from staying attached as required. Two other cuffs were noted in similar condition. Refer to F835 Administration. REFERENCE: WAC 399-97-0880. 43642 45941 46471 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46472

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 42203 Based on interview and record review, the facility failed to implement a system to ensure resident concerns were identified and addressed timely and the outcome communicated to residents, including concerns brought up during Resident Council meetings. Facility failure to identify, address timely, and provide residents with the outcome of the grievance investigation left residents at risk for unresolved concerns, feeling unheard, frustrated, diminished self-worth and decreased quality of life. Findings included . On 12/07/2022 at 12:58 PM, Staff M (Life Enrichment Director) provided all available Resident Council Meeting Minutes from the last 6 months. Meeting minutes were provided for meetings on 10/25/2022 and 11/16/2022. Staff M stated they were unable to provide any other meeting minutes, the two sets of Minutes provided were the only ones available. Staff M stated they held the position of Life Enrichment Director since 10/04/2022 and did not know if/where their predecessor stored meeting minutes. Staff M stated their predecessor didn't leave me any records. Staff M stated they reached out but couldn't make contact to establish where the previous records were kept, if anywhere. Staff M stated they would provide previous months' Life Enrichment calendars which should include the dates of any Resident Council Meetings. Review of the Life Enrichment Calendars from July 2022 through December 2022 provided by Staff M showed the Resident Council met on 9/20/2022 at 2:30 PM and was scheduled to meet on 12/14/2022. The calendars showed no evidence the Resident Council met in July or August 2022. Staff M stated they expected their predecessor to keep and file the previous Resident Council Meeting Minutes, but it appeared they did not. The 10/25/2022 Resident Council Minutes identified seven residents by name who attended the meeting. The Minutes included an Old Business section that listed the following past resident concerns: the building was too cold, and residents wanted to be able to use headphones when they watched television. The meeting minutes did not make clear which residents shared which concerns, what if anything facility staff did to fix the concerns, or whether residents were satisfied with the outcome. Under New Business, the 10/25/2022 Minutes identified the following concerns: the building was too cold, residents suggested quiet hours after 10:30 PM, resident wanted to be able to use headphones when they watched television, residents were not happy with the TV service and wanted to switch back to the former provider, and residents felt staff spoke too loudly at night. Under Nursing, the Minutes identified resident concerns with sugar being served to residents with diabetes, and call light wait times were too long. Under Housekeeping, the Minutes identified resident concerns with the timing of floor cleaning. Under Dietary, the Minutes identified resident concerns with staff rushing when serving meals, residents receiving foods they did not like or that was too cold, and the menu was repetitive. According to the Minutes, Staff EE (Dietary Manager) attended the meeting and informed the residents in attendance they intended to meet individually with residents to address dislikes, and was working to change the menu up and have an alternate menu available. Under Maintenance, residents identified concerns with clocks around the building being set to the wrong time. The 10/25/2022 Resident Council Minutes did not identify which residents had which concerns. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/16/2022 Resident Council Minutes identified four residents by name who attended the meeting. The Minutes included an Old Business section that listed the following past resident concerns: the building was too cold, residents suggested quiet hours after 10:30 PM, resident wanted to be able to use headphones when they watched television, residents were not happy with the television service and wanted to switch back to the former provider, and residents felt staff spoke too loudly at night. The meeting minutes did not make clear which residents shared which concerns, what if anything facility staff did to fix the concerns, whether residents were satisfied with the outcome. The New Business section of the 11/16/2022 Resident Council Minutes included concerns the building was now warmer, staff were no longer having loud conversations outside resident rooms, and residents wished to change television provider. The Minutes did not indicate if residents were satisfied with, or agreed with these outcomes, or whether the residents who identified the concern the previous month were in attendance that month (and if not, how they were informed). The Nursing section of the 11/16/2022 Resident Council Minutes included concerns that floor staff can be loud first thing in the morning contradicting the earlier claim that staff noise was addressed, and ongoing dissatisfaction with call light waiting times. The Housekeeping section included no concerns. The Maintenance section included a request for more snack options. The Maintenance section included the same concern from October 2022 that clocks around the building were set to the wrong time, and would like the Garden Room cleared out so they could use it. The Minutes did not indicate which residents shared which concerns. Review of the October 2022 and November 2022 Grievance Logs showed no indication the resident concerns identified during the 10/25/2022 and 11/16/2022 Resident Council Meetings were processed as grievances. From 10/26/2022 through 12/07/2022 only one new grievance of any kind was logged facility wide on 11/13/2022. This grievance pertained to missing property and was not related to concerns raised at Resident Council. In an interview on 12/09/2022 at 11:14 AM, Staff M stated some matters raised at Resident Council were handled informally and others referred to the correct department for handling. Staff M stated Staff A (Administrator) received a copy of the minutes, but they were unsure if Staff A was the facility's grievance officer. Staff M stated they did not process any of the concerns raised in the October 2022 Resident Council Meeting as a grievance including resident concerns with the choice of television channels but asked Staff I (Maintenance Assistant) about changing back to the old television provider. Staff I stated to Staff M it was not possible. Staff M stated there was no way to establish from the minutes which residents had which concerns. Staff M stated no concerns from the November 2022 Resident Council Meeting were processed as Grievances. Staff M stated they could not locate Resident Council Meeting Minutes from May 2022 through September 2022. In an interview on 12/09/2022 at 11:38 AM, Staff A stated L (Social Services Assistant) was the grievance officer. A copy of a sample of three grievances from the Grievance Log was requested from the facility: the 11/13/2022 missing property grievance, a 09/30/2022 grievance regarding missing medication, and an 08/08/2022 grievance related to call lights, cold food and other dietary issues. In an interview on 12/09/2022 at 1:59 PM, Staff L stated they were only the Grievance Officer since 12/01/2022 after the former Social Services Director (SSD) left on 11/30/2022. Staff L stated they assisted the SSD with grievances but were unsure how grievances should be processed in total as they did not complete the process by themselves. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	REFERENCE: WAC 388-97-0460.

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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 46471 Based on observation, interview, and record review the facility failed to ensure a Significant Change in Status Assessment (SCSA), including Care Area Assessments (CAAs), were completed within 14 days from the date of determination for 3 of 3 residents (Residents 27, 42, & 19) reviewed for significant changes in status. The failures to identify the need for a SCSA for: decline in cognition, eating abilities, new swallowing disorder, and repeated falls for Resident 42; decline in ability to feed self, decline in mood, and significant weight loss for Resident 19; and a terminal prognosis with initiating hospice services for Resident 27 placed the residents at risk for further decline, diminished quality of life/quality of care, and unmet care needs. Findings included . Resident 27 According to the Resident Assessment Instrument manual (a document directing staff when assessments of resident status is required) a . SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains a resident at the nursing home. Record review of the 07/07/2022 Hospice Notice of Election Benefit/Consent Form, Resident 27's hospice start of care date was 07/28/2022. The 07/28/2022 Hospice Plan of Care information showed Resident 27 was admitted to hospice services due to a severe heart condition. Review of Resident 27's Minimum Data Set (MDS- an assessment tool) assessments showed a 08/18/2022 SCSA was completed for Resident 27, 22 days after the date of determination on 07/28/2022, which is the hospice provider's start of care date. In an interview on 12/09/2022 at 1:03 PM, Staff NN (MDS Specialist, Licensed Practical Nurse) confirmed the completion of Resident 27's SCSA did not happen within 14 days as required. Staff NN stated, Unfortunately, the communication [with billing services] is very poor . as the correct hospice start of care date was not made known in a timely manner that led to the late SCSA completion. Resident 42 According to the 09/12/2022 modified Admission MDS, Resident 42 had no cognitive deficits. Resident 42 was assessed to require assistance for bed mobility, transfers, toileting, and eating. Resident 42 did not have a swallowing problem and was on a regular textured diet. On 09/14/2022, the resident choked on a hot dog and required the Heimlich maneuver (an emergent procedure to clear the airway of obstruction) prior to being sent to the hospital. On 09/26/2022 the resident returned to the facility with a new diagnosis of dysphasia (difficulty chewing/swallowing), on a physician ordered soft textured diet with thickened liquids, and required 1:1 feeding assistance for eating. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing and provider progress notes showed Resident 42 was having an increase in confusion and decline in cognition which was identified as the root cause for several of the resident's falls. Review of the resident's MDS record showed the facility failed to identify and conduct a SCSA related to the residents decline in cognition, decline in swallowing requiring altered texture diets, requirement for 1:1 feeding assistance, fluctuating diabetic management, and repetitive falls after the resident readmitted to the facility. In a 12/09/2022 1:10 PM interview, Staff NN said they should have identified the need for a SCSA and should have completed it within 14 days of the change, but did not. Resident 19 The 12/29/2021 SCSA showed Resident 19 had moderate to severe cognitive impairment, indicators of depression, was receiving an antidepressant (AD), only required supervision with set up assistance to eat, and weighed 103 pounds. The 03/31/2022 Quarterly MDS showed Resident 19 had further decline in their cognition, an increase in indicators of depression, was not receiving an AD, showed a decline in their ability to eat independently, and had a significant weight loss of 14.5% of their total body weight in three months. In a 12/09/2022 1:10 PM interview, Staff NN validated the facility failed to identify this as a significant change for the resident and did not complete a SCSA when they should have. REFERENCE: WAC 388-97-1000(3)(b). 46472

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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** 42203 Based on observation, interview, and record review the facility failed to ensure Minimum Data Sets (MDS - an assessment tool) were complete and accurate for 6 of 20 (Residents 35, 55, 51, 6, 27, & 49) sample residents reviewed. Facility failure to complete accurate MDS assessments prevented the facility from transmitting accurate information to the Centers for Medicare and Medicaid Services (CMS) for facility quality ratings, and left residents at risk for unidentified and/or unmet needs. Findings included . Resident 35 According to the 10/31/2022 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 35 had diagnoses including debility (physical weakness), respiratory failure, and malnutrition. The MDS showed Resident 35 had no falls while a resident of the facility. According to the 09/16/2022 progress notes, Resident 35 was found on the floor of their room after a fall at 10:00 AM on 09/16/2022. Resident 35 was noted to have a 3 x 3 inch hematoma (build up of blood under the skin secondary to trauma) on their forehead. In an interview on 12/07/2022 at 10:33 AM, Resident 35 stated they recalled falling in the facility. In an interview on 12/09/2022 at 2:33 PM, Staff B (Director of Nursing) confirmed the MDS was inaccurate and the fall with injury was not, but should be, included on the MDS. 43642 Resident 55 According to a 11/18/2022 Quarterly MDS, Resident 55 had clear speech, was understood, and able to understand others. The MDS showed Resident 55 had no dental concerns. In an interview on 12/01/2022 at 10:22 AM, Resident 55 stated they only had two lower teeth. In an observation at this time, the resident opened their mouth, moved their two teeth back and forth, and stated look at this. Review of a 05/13/2022 Care Plan (CP) showed Resident 55 had an oral/dental health problem related to having no teeth or dentures. Review of a 11/02/2022 dental consult showed Resident 55 had active an dental disease and the two remaining teeth were very loose. In an interview on 12/12/2022 at 8:16 AM, Staff C (Licensed Practical Nurse, LPN Unit Manager) stated if a resident had dental concerns, they should be coded accurately on the MDS so the CP and follow up can be addressed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 51 According to the 10/06/2022 Admission MDS, Resident 51 was cognitively intact with clear speech, was understood, and able to understand others. The MDS showed staff assessed Resident 51 with no dental concerns. In an interview and observation on 12/02/2022 at 10:49 AM, Resident 51 stated they had broken teeth. Resident 51 opened their mouth and showed a broken tooth to the upper left side and a broken tooth to the lower ride side of mouth. In an interview on 12/12/2022 at 2:00 PM, Resident 51 stated they had the broken teeth for years. In an interview on 12/09/2022 at 1:03 PM, Staff NN (MDS Specialist, LPN) stated the MDS was inaccurate and should have identified the broken teeth. 45941 Resident 6 According to the 11/02/2022 Quarterly MDS Resident 6 admitted to the facility on [DATE] and was cognitively intact. This MDS showed Resident 6 had no broken or missing teeth, and no weight loss in last quarter. Resident 6's weight record showed Resident 6 lost more than five percent weight in 30 days. Resident 6's weight on 10/05/2022 was 270.3 pounds (lbs) and on 10/30/2022 was 250 lbs (down 20 lbs in 25 days). Observations on 11/30/2022 at 11:04 AM and on 12/05/2022 at 10:25 AM, showed Resident 6 had a front broken tooth and multiple missing teeth. Resident 6 stated they had been broken tooth for a while. In an interview on 12/6/2022 at 11:22 AM, Staff C stated the MDS was incorrect as Resident 6 had broken and missing teeth and experienced a significant weight loss. 46471 Resident 27 On 11/30/2022 at 11:14 AM, Resident 27 stated they had trouble hearing in both ears. Resident 27 stated staff provided them with hearing aids. Resident 27 stated they kept the hearing aids in a box located on the bookshelf across from the bed and they preferred not to wear them since they stick out. According to the 08/18/2022 Significant Change MDS, no hearing aids or other hearing appliance were used when completing Resident 27's hearing assessment. The 03/29/2022 revised communication CP showed a goal of care for Resident 27 was to improve their hearing with the use of hearing aids. The CP intervention directed staff to ensure Resident 27 wore hearing aids on both ears. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/09/2022 at 1:03 PM, Staff NN acknowledged they should have validated the presence of Resident 27's hearing aids and used them during the hearing assessment, but did not. Staff NN stated the MDS assessment was inaccurate. Resident 49 According to the 11/17/2022 Admission MDS, Resident 49 received an antibiotic during the assessment period. Record review of Resident 49's November 2022 Medication Administration Record (MAR) did not show any antibiotic use. In an interview on 12/09/2022 at 1:03 PM. Staff NN stated Resident 49 did not take any antibiotic during the assessment period. Staff NN stated the Admission MDS was inaccurate. REFERENCE: WAC 388-97-1000 (1)(b).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level 2 comprehensive evaluations were obtained, and/or implemented and incorporated into the Care Plan (CP) for 2 of 5 (Residents 55 and 32) residents and 1 supplemental resident (Resident 18) reviewed for PASRR. This failure placed residents at risk for not receiving necessary mental health care and services. Findings included . Resident 55 According to a Quarterly Minimum Data Set (MDS - an assessment tool), Resident 55 had medically complex diagnoses including depression and required the use of an antidepressant medication. Review of Resident 55's records revealed a 05/31/2022 Level 1 PASRR completed by facility staff that identified the resident with a serious mental illness indicator of depression. Staff identified Resident 55 required a Level 2 evaluation referral for the serious mental illness diagnosis. Record review showed a social services progress note on 06/02/2022 at 11:32 AM that identified a plan to update Resident 55's Level 1 PASRR screen and request a Level 2 evaluation based on depression with secondary diagnosis of dementia. No further documentation was found in Resident 55's records of a Level 2 evaluation being obtained or implemented into the resident's CP. 44296 Resident 32 The 10/19/2022 Annual MDS showed Resident 32 admitted to the facility on [DATE] from another skilled nursing facility. The MDS showed Resident 32 had a PASSR Level 2 completed. Record review showed a PASRR Level 2 dated 05/31/2019 prior to admission to a previous skilled nursing facility. Review of Resident 32's CP showed no interventions identified by the Level 2 PASRR evaluator were implemented. Resident 18 According to a corrected 05/23/2022 PASRR completed by Staff L (Social Services Assistant), Resident 18 had diagnoses of schizophrenia, mood disorder, anxiety, and evidence of serious functional limitations during the previous six months related to a serious mental illness. PASRR Section IV showed a Level 2 evaluation referral was required. There was no Level 2 evaluation found in Resident 18's record. On 12/06/2022 at 2:15 PM Staff L provided a 05/31/2022 social services progress note that showed a PASRR Level 2 evaluation referral was made. Staff L said they did not follow up to see if the Level 2 evaluation was completed. (continued on next page)

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North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2022 at 3:13 PM, Staff L stated Level 2 evaluation referrals should be obtained timely with recommendations implemented and incorporated into the resident's CP so staff know how to provide day to day care when a resident is affected by mental health illness. REFERENCE WAC: 388-97-1915(4). 46472

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities 43642 Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments accurately reflected residents' mental health conditions for 3 of 5 (Resident 51, 34, and 49) residents and 1 supplemental (Resident 18) resident reviewed for PASRR. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included . According to an undated facility MI [mental illness]/MR [developmental disability] Preadmission Screening policy, staff were to determine if a new resident had a Level 1 screen, directed staff to review the Level 1 screen, at least quarterly, ensure the Level 1 screen was filed in the resident's record, and accurately reflected the resident's current status. This policy stated the state mental health authority, as applicable, upon admission, annually, promptly after a significant change in mental or physical condition of a resident who had a mental disorder for resident review, or upon learning of an MI/MR diagnosis which was previously unknown. Resident 51 According to the 10/06/2022 Admission Minimum Data Set (MDS, an assessment tool), Resident 51 had multiple medically complex diagnoses including depression and required the use of an antidepressant medication. Review of Resident 51's records revealed a 09/28/2022 Level 1 PASRR that was incomplete. This form had sections one through three blank and did not identify that Resident 51 had a diagnosis of depression. Resident 34 According to a 09/14/2022 Quarterly MDS, Resident 34 had multiple medically complex diagnoses including dementia and bipolar disorder (a mental health condition that causes extreme mood swings) and required the use of psychotropic medications. Review of Resident 34's records revealed an 11/04/2021 Level 1 PASRR that identified Resident 34 with a bipolar disorder. This PASRR did not identify Resident 34 also had diagnoses that included hallucinations and anxiety according to the resident's records. Staff failed to ensure Resident 51 had an accurate Level 1 PASRR completed in their resident records. Resident 49 According to the 11/17/2022 Admission MDS, Resident 49 had multiple medically complex diagnoses including depression and required the use of an antidepressant medication. Review of Resident 49's December 2022 physician order summary showed an order for an antianxiety medication dated 11/10/2022 for a diagnosis of anxiety. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 49's records showed an 11/10/2022 Level 1 PASRR that was inaccurate. The form did not identify the presence of Resident 49's mental illness diagnoses of depression and anxiety. In an interview on 12/12/2022 at 3:13 PM, Staff L (Social Services Assistant) stated timely and accurate Level 1 PASRRs are important to know if a resident required a Level 2 assessment and to know how mental health can affect day to day care. Staff L confirmed Resident 51, Resident 34, and Resident 49's Level 1 PASRR should have, but did not accurately reflect the resident's mental health condition. REFERENCE: WAC 388-97-1915(1)(2)(a-c). 46471

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46471 Based on observation, interview, and record review the facility failed to develop and/or implement comprehensive, person-centered, and/or individualized care plans for 5 of 18 residents (Resident 12, 27, 45, 49, & 51) whose care plans were reviewed. Failure to establish care plans that were individualized and accurately reflected care needs, placed residents at risk of unmet care needs due to inaccurate or absent direction to staff. Resident 12 According to the 11/20/2022 Quarterly Minimum Data Set (MDS, an assessment tool) Resident 12 required total assistance during transfers from the bed to the chair and the support was provided by two staff during the assessment period. The MDS showed Resident 12 did not reject care from staff. Review of the 06/20/2022 Care Plan (CP) indicated Resident 12 would sit in chair for 2-3 hours a day every day for the rehabilitation of their weakened muscles and for trunk control. The CP stated staff would ensure Resident 12 was sitting in the chair for meals and that staff would assist Resident 12 into their chair. Observations on 12/01/2022 at 12:11 PM, 12/05/2022 at 1:10 PM, 12/08/2022 at 7:49 AM, and 12/08/2022 at 12:22 PM showed Resident 12 was eating their meal in bed. In an interview on 12/08/2022 at 12:29 PM, Resident 12 stated staff served their meals in bed. Resident 12 was asked if they had ever sat up in a chair during meals, Resident 12 stated, No, not yet I haven't. Resident 12 was asked if they recall staff asking them if they want to get up and sit in the chair for meals, Resident 12 stated, No. In an interview on 12/08/2022 at 12:41 PM, Staff S (CNA, Certified Nursing Assistant) stated they have served Resident 12's meal tray only in bed. In an interview on 12/08/2022 at 12:46 PM, Staff Q (LPN, Licensed Practical Nurse) was asked if they had seen Resident 12 sitting up in the chair during meals as instructed in the CP for the past three days, Staff Q stated, No. In an interview on 12/09/2022 at 11:04 AM, Staff B (Director of Nursing) stated the expectation from staff was that they follow the CP and whatever is written. Resident 27 According to the 08/18/2022 Significant Change in Status MDS, Resident 27 was transferred to the wheelchair once or twice during the seven day look back period. The assessment showed Resident 27 was cognitively intact and did not reject care from staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 05/04/2022 revised Activities of Daily Living (ADL) CP showed Resident 27 had decreased ADL function due to a severe heart condition and difficulty of breathing. The CP indicated Resident 27 required stand-by assist, assist of two persons for transfers from the bed to the wheelchair. Observation on 11/30/2022 at 11:14 AM showed Resident 27 was in bed reading a book. The same observation was noted on 12/06/2022 at 8:47 AM and on 12/08/2022 at 11:28 AM. Record review of Resident 27's transferring task from 11/09/2022 until 12/08/2022 did not show Resident 27 refused transfer assistance from staff. In an interview on 12/08/2022 at 11:58 AM, Resident 27 confirmed staff did not offer transfer assistance to get them out of the bed since their facility return from the hospital on 07/28/2022. Resident 27 stated, I should be getting up but was not. Resident 49 According to the 11/17/2022 Admission MDS, Resident 49 had multiple medically complex diagnoses including diabetes. The assessment showed Resident 49 received insulin (a medication used to treat diabetes) for seven days during the assessment period. The 11/10/2022 CP did not include any monitoring of Resident 49's current insulin use. Review of Resident 49's November 2022 and December 2022 Medication Administration Record (MAR) did not show staff were monitoring Resident 49 for any signs and symptoms that would indicate worsening diabetes. In an interview on 12/12/2022 at 11:33 AM, Staff C (LPN Unit Manager) validated the importance of monitoring high-risk medications including insulin. Staff C stated there was no insulin monitoring in place for Resident 49. 43642 Resident 51 According to the 10/06/2022 Admission MDS, Resident 51 had multiple medically complex diagnoses, was cognitively intact, had clear speech, was understood, and able to understand others. In an observation on 12/07/2022 at 1:04 PM, Resident 51 was lying in bed when a nurse brought their medications into the room. The nurse attempted to do a blood pressure check to the resident's right arm and Resident 51 stated, no, no, remember you have to do my blood pressure on my left arm because I had a mastectomy [surgical removal of one or both breasts,]. In an interview on 12/07/2022 at 1:12 PM, Resident 51 stated they were instructed by their doctor to only have blood pressures done on the left arm. The resident stated they took medications for severe low blood pressure and often could not get out of bed due to feeling dizzy. Review of an 11/30/2022 provider progress note showed Resident 51 had a history of cancer, had a mastectomy to both sides, and was taking medications for low blood pressure. Review of Resident 51's CP on 12/02/2022 revealed these concerns were not addressed and no direction was given to staff with interventions needed for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/2022 at 8:16 AM, Staff C stated having accurate and complete CPs was important so staff would know what care and interventions to provide to the residents. Resident 45 According to the 11/12/2022 5-Day MDS, Resident 45 their own natural teeth and had obvious or likely cavities and broken or natural teeth. The MDS history of the dental assessment showed this was also identified on five previous assessments (07/07/2021, 09/16/2021, 12/17/2021, 03/19/2022, and 06/19/2022). The 09/23/2022 revised CP showed no focus problems for dental concerns and no interventions for dental problems. In an interview on 12/12/2022 1:35 PM interview, Staff B, Director of Nursing said the resident's CP should of had interventions and a plan to address the resident's dental issues, but did not. The 09/17/2022 Annual MDS showed Resident 45 had medical diagnoses including heart failure, anemia, high blood pressure, and kidney disease. The resident had a significant weight gain and received a diuretic (water pill) 3 of 7 days during the observation period. Review of the 09/23/2022 revised CP showed there were no interventions or CP problems to address the resident's comprehensive care needs and management of heart failure, fluid balance / diuretic use, edema, and kidney disease. In the 12/12/2022 1:35 PM interview, Staff B said the resident's CP should of had problems/interventions to direct staff to care and monitor the residents issues related to anemia, edema, cardiac problems and kidney disease, but did not. REFERENCE: WAC 388-97-1020(1),(2)(a)(b). 46472 45941 46479

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were revised and implemented for 9 (Residents 35, 51, 34, 55, 42, 6, 52, 65, & 22) of 20 sample residents reviewed. The failure to include residents and/or their resident representatives participation in the CP process prevented residents from exercizing their rights in developing person-centered care plans and deterred the facility from providing individualized resident informaiton to staff caring for residents placing residents at risk for unmet needs, feeling institutionalized, depersonalization, and diminished quality of life. Findings included . Facility Policy According to an undated Care Plans facility policy, the facility was to review and revise care plans. The care plans were written to be consistent with the services provided. The policy identified care plans were not only driven by resident issues or conditions but also by their unique characteristics, strengths, and needs. The facility was to re-evaluate the resident's status at prescribed intervals and modify the individualized care plan as appropriate and necessary. Resident 35 According to the 10/31/2022 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 35 had diagnoses including debility (physical weakness), bipolar disorder, Post Traumatic Stress Disorder (PTSD), and a nightmare disorder. According to progress notes, Resident 35 had an unwitnessed fall with injury on 09/16/2022. The fall caused a 3 x 3 inch hematoma on Resident 35's forehead. Resident 35's comprehensive CP included a revised 05/03/2022 high risk for falls CP. The CP included a 05/03/2022 intervention for floor mats to be placed on both sides of Resident 35's bed to reduce the risk of injury from a fall., and a 05/03/2022 intervention for a perimeter mattress for safety. The CP did not reflect Resident 35's 09/16/2022 unwitnessed fall with injury. Observations on 12/05/2022 at 12:02 PM and on 12/06/2022 at 1:53 PM and 3:31 PM showed no fall mats in place by Resident 35's bed. In an interview on 12/07/2022 at 10:33 AM Resident 35 stated they did not recall fall mats being placed on both sides of their bed. In an interview on 12/08/2022 at 3:09 PM Staff C (Licensed Practical Nurse - LPN/Unit Manager) stated the CP should have been revised to reflect the 09/16/2022 fall. Staff C stated new interventions should be implemented after a fall. Staff C stated the facility no longer utilized fall mats after a previous Administrator discontinued their use facility wide, and the Fall CP required revision. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed a 09/18/2022 intervention for Bolsters to mattress added to Resident 35's revised 05/03/2022 Edentulous (Lacking Teeth) CP. Resident 35's Kardex (a set of care instructions for Aides generated from the CP) did not include the bolsters and included an intervention for floor mats to reduce the risk of injury should a fall occur. Resident 35's comprehensive CP included a revised 05/10/2022 CP for a antihypertensive (blood pressure reducing medication) used to treat nightmares, and a revised 05/10/2022 for a hypnotic medication prescribed as a sleep aid related to Resident 35's PTSD and nightmares. Record review showed Resident 35 had no current orders for the antihypertensive medication or the hypnotic medication. Both medications were discontinued on 09/15/2022. In an interview on 12/08/2022 at 3:14 PM Staff C stated that both medications were discontinued, and the CP needed revision to reflect the medication changes. 43642 Resident 51 Review of Resident 51's Physician Orders showed a 10/05/2022 order for a regular diet. Review of Resident 51's 09/28/2022 nutrition CP showed interventions that directed staff to provide diet as ordered and identified the resident's diet as carbohydrate controlled, with no added salt. Review of a 10/18/2022 alteration in neurological status CP showed Resident 51 had a persistent vegetative state with no detectable consciousness. This CP had a goal to maintain quality of life within limitations imposed by their neurological deficits. In an interview on 12/12/2022 at 8:16 AM, Staff C (Licensed Practical Nurse - Unit Manager) stated the nutritional CP for Resident 51 needed to be revised. Staff C stated they were unsure why the CP regarding Resident 51's neurological status was in place and confirmed the resident was cognitively intact with clear speech, able to understand others, and be understood. Resident 34 Review of Resident 34's 08/11/2022 COVID-19 CP showed the resident had tested positive for COVID-19 on 08/11/2022 and gave directions to staff to implement precautions as indicated. Review of an 08/22/2022 progress note showed staff documented Resident 34 had completed their 10-day isolation and the resident would be removed from precautions at that time. In an interview on 12/12/2022 at 8:16 AM, Staff C stated Resident 34's CP needed to be updated and revised. Resident 55 Review of Resident 55's 08/11/2022 COVID-19 CP showed the resident had tested positive for COVID-19 on 08/11/2022 and gave directions to staff to implement precautions as indicated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an 08/22/2022 progress note showed staff documented Resident 34 had completed their 10-day isolation and the resident would be removed from precautions at that time. Review of a 05/13/2022 pain CP showed Resident 55 had chronic pain as described or exhibited by, there was no further information provided as to why the resident had chronic pain. In an interview on 12/12/2022 at 8:16 AM, Staff C stated their expectation was that resident CPs should be updated and revised with changes to reflect the current resident conditions. Staff C stated Resident 55's CP needed to be updated and revised. 46472 Resident 42 The 09/12/2022 modified Admission MDS showed Resident 42 had no cognitive deficits and diagnoses including multiple falls, fracture related to falls, and had experienced 2 or more falls after admission to the facility. Review of the revised 09/26/2022 CP directed the staff to make sure the call light was within reach, encourage the resident to use the call light, proper non-skid footwear, provide safe environment, increase supervision, and refer to therapy as needed. The CP failed to include person-centered interventions to address the resident's fall history with fractures, care needs, and was not updated with new interventions after the first two falls sustained after they admitted . Review of the facility Reporting log showed Resident 45 had fallen a total of 10 times since admission. Review of the facility Incident Reports showed the facility consistently failed to update the resident's care plan with new fall interventions to prevent further falls. Review of the most recent 09/26/2022 CP showed only one fall intervention CP update. In an interview on 12/12/2022 at 1:30 PM interview Staff B confirmed the care plan was not updated to address new careplan interventions to prevent falls or address the resident's identified blood pressure concerns and change in cognition and orientation, but should of been. 45941 Resident 6 According to the 11/02/2022 Quarterly Minimum Data Set (MDS-an assessment tool) Resident 6 admitted to the facility on [DATE] and was cognitively intact, able to be understood and understand conversation. This assessment indicated Resident 6 had no broken or missing teeth and no weight loss in last quarter. Observations on 11/30/2022 at 11:04 AM and on 12/05/2022 at 10:25 AM showed Resident 6 had broken and missing teeth. Resident 6 was also observed eating meals in their bed. Resident 6 stated they had broken teeth for a while and had no problem eating their meals after tray set up. Review of Resident 6's record showed no care plans (CP) about Resident 6 missing teeth or losing weight. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to a 07/27/2022 Activities of Daily Living (ADL) CP, staff interventions included totally dependent on staff for eating. In an interview on 12/05/2022 at 1:23 PM, Staff C stated Resident 6 was able to eat meals by themselves after tray set up. Staff C stated the care plans should have been revised but was not. According to a 07/27/2022 CP Resident receiving IV antibiotics for Sepsis (body's response to an infection), had a PICC line (a thin tube inserted into the vein to give intravenous medicine or fluids) in left arm. Review of Resident 6's record showed no physician order for any intravenous antibiotic medication. Observation on 12/02/2022 at 10:23 AM showed no PICC line in Resident 6's left or right arm. In an interview on 12/06/2022 at 1:23 PM, Staff C stated the CP was not accurate, and it should be updated. In an interview on 12/09/2022 at 3:08 PM, Staff B (Director of Nursing) confirmed multiple CPs were not updated but they should be updated on time. Resident 52 According to the 11/08/2022 Quarterly MDS Resident 52 readmitted to the facility on [DATE], was assessed as cognitively intact, and had diagnoses including stroke with right side weakness, seizure, anxiety, and depression. This assessment identified it was very important for Resident 52 to participate in religious activities and go outside in the fresh air. Review of Resident 52's record showed an activity evaluation completed on 06/21/2022. This evaluation indicated activities that were very important to Resident 52. In an interview on 12/05/2022 at 1:02 PM, Resident 52 stated they wanted to participate in activities in their room. A review of Resident 52's comprehensive CP showed no CP was developed indicating activities of Resident 52's interest. According to a 06/28/2022 ADL CP, staff interventions included required 1:1 feeding and get resident out of bed for all meals. Observations on 11/30/2022 at 12:23 PM, 12/01/2022 at 8:07 AM, 12/02/2022 at 11:45 AM, and 12/07/2022 at 8:03 AM showed Resident 52 was eating their meals in their bed without assistance. In an interview on 12/05/2022 at 11:23 AM, Resident 52 stated they did not need help with feeding. In an interview on 12/09/2022 at 3:08 PM, Staff B confirmed multiple care plans were not updated and they should have been updated on time. Resident 65 According to the 11/02/2022 Admission MDS Resident 65 readmitted to the facility on [DATE], was assessed cognitively intact, and had medically complex diagnoses including Bullous Pemphigoid (a skin condition causing large fluid filled blisters), asthma and diabetes. The 10/27/2022 Skin Concern CP showed location (SPECIFY) and Goal included Areas of concern will resolve (SPECIFY). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Another 10/27/2022 Resident Preferences CP showed interventions included bathing preferences (SPECIFY: morning or evening), go to bed (SPECIFY: time), wake up at (SPECIFY). In an interview on 12/06/2022 at 1:23 PM, Staff C confirmed there were multiple CPs with issues, goals and interventions which included (SPECIFY) that should be updated, and individualized but were not. In an interview on 12/09/2022 at 3:08 PM, Staff B confirmed multiple CPs were not but should be updated on time. 46479 Resident 22 According to a 10/27/2022 Quarterly MDS, Resident 22 was assessed to have impaired memory, multiple medically complex conditions, lack of bladder control, and was at risk for developing pressure injuries. Resident 22 had no rejection of care. Observations on 11/30/2022 at 9:45 AM, 12/02/2022 at 10:14 AM, and 12/05/2022 at 9:42 AM, showed Resident 22 lying in bed, on their back. An observation on 12/08/2022 at 11:26 AM, showed Resident 22 receiving a bed bath. At that time, Resident 22 was noted to have a suprapubic catheter (a tube surgically placed in the belly to drain urine from the bladder). Record review of an 11/07/2022 physician's note showed Resident 22 had a partial thickness (loss of some skin) pressure ulcer to their tailbone. The physician's note indicated staff were to off-load pressure from the tailbone every two hours as tolerated by Resident 22. Review of the active Potential for Pressure Ulcer CP dated 01/07/2020, showed no goals or interventions related to Resident 22's current pressure ulcers. The CP did not identify Resident 22 had current pressure ulcers. Review of Resident 22's Kardex (a tool directing staff on the type of care a resident needs) did not identify Resident 22's pressure ulcers. It did not direct staff to off-load pressure from Resident 22's tailbone every two hours as indicated by the physician. Review of Resident 22's bladder CP dated 05/07/2020, directed staff on the care of Resident 22's urethral catheter (a tube inserted into the urethra to drain urine from the bladder and does not require surgical placement). The CP did not address Resident 22's current suprapubic catheter. In an interview on 12/12/2022 at 11:20 AM, Staff C (LPN - Licensed Practical Nurse, Unit Manager) stated Resident 22 obtained the wounds during a recent hospitalization . Staff C stated pressure ulcers and wounds should be care planned so staff know what care to provide. Staff C verified Resident 22 had a suprapubic catheter and the CP should match the appliance Resident 22 currently had. REFERENCE: WAC 388-97-1020(5)(b) 44296

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation, interview, and record review the facility failed to ensure nursing services were provided within professional standards of nursing for 6 of 18 (Residents 45, 51, 34, 6, 40 & 41) residents reviewed. Nursing staff failed to follow physician orders (Resident 45, 51, & 34), clarify physician orders (Residents 45, 51, 6, & 40), and signed for tasks not performed (Residents 51), which placed the residents at risk for medication and treatment errors and adverse outcomes. Findings included . Follow Physician Orders (PO) / Edema Monitoring Resident 45 Professional Standard: According to the American Heart Association, the monitoring of fluid balance status in the management of a resident with heart failure (which usually directly affects the kidney function) is to weight the resident at the same time of the day, everyday. For a weight increase of three pounds in two days or five pounds in a seven days, the nurse should notify the provider of the increase and the resident most recent labs / lab trends, vital signs including oxygen saturation, edema assessment, and symptoms observed (shortness of breath with physical exertion, when lying flat, or at rest), lung sounds, intake and output. The resident lab values should be monitored routinely at frequent intervals. The resident should be under the care of a cardiac and / or kidney specialist if the resident's fluid balance and lab values are not easily stabilized or progressively worsening. The 11/12/2022 5-Day/Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 45 had a diagnosis of heart failure and kidney disease. Resident 45 was assessed as cognitively intact and capable to make decisions about their daily care. Review of Resident 45's physician visit notes showed a 08/23/2021 provider note and the provider referred the resident to a kidney specialist. A 05/03/2022 Physician order (PO) showed Resident 45 was again ordered to be referred to a kidney specialist because the facility failed to get the resident scheduled an appointment between 08/23/2021 and 05/03/2022. Resident 45's record showed they went to the Emergency Department on 07/17/2022, due to worsening fluid balance status and worsening kidney function lab values. The hospital scheduled Resident 45 for an appointment with the kidney specialist for 08/23/2022. Resident 45 was ill on 08/23/2022 and was unable to attend the kidney specialist appointment and the appointment was rescheduled for 10/04/2022. The facility failed to ensure the resident's transportation was established and the resident missed the 10/04/2022 appointment; the appointment was rescheduled for 11/01/2022. Resident 45 was unable to attend the 11/01/2022 appointment because they were in the hospital due to acute respiratory failure and acute kidney injury. The were evaluated by a hospitality kidney specialist to stabilize their condition, and received another referral for Nephrology with an appointment for 11/28/2022. Resident 45's first appointment with the kidney specialist was 11/28/2022, 15 months from the first referral. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 45's POs showed orders for daily weights on 07/20/2022, 07/27/2022, and 09/17/2022. order to obtain daily weights. POs dated 08/31/2022 and 09/01/2022 directed staff to weigh daily and notify the provider of weight gain of three pounds in one day or five pounds in seven days. Review of the 07/2022, 08/2022, 09/2022, 10/2022, 11/2022, and 12/2022 Treatment Administration Records (TAR) and weight logs showed daily weights were not documented for Resident 45. According to the facility 12/2022 Edema Monitoring policy, residents with edema are monitored weekly, by measuring the grade of pitting of the affected area and documented on the TAR. Review of Resident 45's TARs for 07/2022, 08/2022, 09/2022, 10/2022, 11/2022, and 12/2022 showed no edema monitoring was assessed or monitored. In an interview 12/12/2022 at 1:30 PM, Staff B (Director of Nursing) stated the facility monitors edema and document the findings on the TAR. Staff B stated staff is expected to monitor edema according to the PO or at least weekly. Staff B said the resident should have been weighed daily after the provider ordered daily weights. Staff B looked in the resident's record and confirmed there was no edema monitoring or daily weights completed or documented. Staff B stated Resident 45 should have followed up with the kidney specialist within a month of the first referral, dependent on the availability of the specialist. Staff B confirmed 15 months to finally see a specialist was not acceptable timeframe, and the resident should have been seen as soon as possible after the first request in August 2021. Resident 51 The 10/06/2022 Admission MDS showed Resident 51 had multiple medically complex diagnoses. The MDS showed Resident 51 had a recent history of multiple falls with one fall resulting in a fracture. Review of Resident 51's October 2022 Medication Administration Records (MAR) showed a 10/19/2022 order instructing staff to administer a medication for low Blood Pressure (BP) three times daily and to hold if the resident's systolic (a measure of the pressure in the arteries when the heart beats) BP was greater than 120. According to the October 2022 MAR nursing staff administered this medication on 11 occasions when the BP was greater than 120 and outside of parameters to be administered. The November 2022 MAR showed nursing staff administered this medication on 12 occasions when it should have been held. Review of December 2022 MAR showed nursing staff failed to hold this medication when outside of BP parameters on eight occasions in the first eight days of December. In an interview on 12/12/2022 at 8:16 AM, Staff C (Licensed Practical Nurse, LPN Unit Manager) indicated nursing staff should have followed the POs and held the medications when the BP was outside ordered parameters for Resident 51. Resident 34 According to a 09/14/2022 Quarterly MDS, Resident 34 had multiple medically complex diagnoses including high blood pressure. Review of November and December 2022 MARs showed Resident 34 had an 08/25/2020 order for a high blood pressure medication to be given once daily. This order gave parameters to hold medication if systolic BP was less than 100. No documentation of daily BP monitoring was found on the MARs prior to staff administering the blood pressure medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2022 at 8:16 AM, Staff C stated their expectation was for staff to obtain Resident 34's BP prior to the administration of the medication and hold as directed in the order based on results. Staff C confirmed staff should have, but did not obtain Resident 34's BP daily. Clarify Physician Orders (PO) Resident 45 The 06/01/2021 revised Pharmacy Policy titled Peripheral Intravenous (IV, tube into a vein) Catheter showed specific flush orders must be obtained, documented, and submitted to the pharmacy that include the flushing agent, volume to use to flush, and frequency of flushing. An 11/28/2022 PO from the kidney specialist showed Resident 45 was to have an IV access placed for administration of an iron solution. An observation on 12/02/2022 10:00 AM showed Resident 45 had an IV access catheter (tube for intravenous infusion) in their left forearm dated 12/02/22. An observation on 12/08/2022 at 12:19 PM showed the same IV access catheter in place in the left forearm. The dressing was dated 12/4/22 and the dressing was hanging off the arm, not secured. On 12/08/2022 at 12:20 PM, Resident 45 said since the IV had been placed on Friday 12/02/2022, only one nurse had come in to flush the IV and changed the dressing on 12/04/2022, the IV site had not been moved. In an observation and interview on 12/08/2022 at 12:24 PM Resident 45 asked the nurse if they were going to flush the IV to keep it from getting clogged and secure the dressing. When interviewed, Staff Q (Licensed Practical Nurse) said there was no orders for on the TAR for IV maintenance, including flushes to keep open and securing the line to keep clean and prevent dislodgement. Staff Q said it was important to make sure the line was flushed and not clogged, and that the dressing was clean, dry and intact otherwise the resident could get an infection or a clot could be dislodged. Review of Resident 45's POs and December 2022 TAR (Treatment Administration Record) showed no instructions for flushing or maintaining the IV. In a 12/08/2022 12:30 PM interview, Staff Q stated they had not flushed the IV since it was placed and they should have received an order from the physician to flush the IV. In an interview on 12/09/2022 at 2:45 PM, Staff C said the nurses should follow the pharmacy policy for IV management, have orders for flushing the IV that include what to flush the IV with, should have orders when to change the IV site or when to discontinue, and confirmed there were no orders for Resident 45. Resident 51 According to the 10/06/2022 Admission MDS, Resident 51 had multiple medically complex diagnoses including fractures and required the use of pain medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of November 2022 MAR showed Resident 51 had two orders for pain medications to be used as needed for pain. The first order was an Over-The-Counter (OTC) medication to be given every six hours as needed for pain and the second order was for a narcotic pain medication to be given every four hours as needed for pain and rib fractures. There were no parameters given to nursing staff to identify which pain medication should be administered when Resident 51 was having pain. According to the November 2022 MAR, no OTC pain medication was administered by staff and the narcotic pain medication was administered 24 times. Each time the narcotic pain medication was administered, staff documented Resident 51's pain level ranged from zero to eight on a scale from zero to ten. In an interview on 12/12/2022 at 8:16 AM, Staff C stated each pain medication should have, but did not have parameters that directed nursing staff on which pain medication to administer. Staff C stated the OTC medication should be given for mild pain from zero to five and the narcotic pain medication for severe pain from six to ten on the pain scale. 45941 Resident 6 The 11/02/2022 Quarterly MDS showed Resident 6 was admitted to the facility on [DATE] and had diagnoses including Neurogenic Bladder and Bowel (lack of bladder and bowel control), and Pressure Ulcers (open wounds caused by pressure). This MDS showed Resident 6 had a foley catheter (a tube inserted in the bladder to drain the urine) and required extensive assistance with catheter care. Observations on 11/30/2022 at 9:10 AM, 12/01/2022 at 11:40 AM, 12/02/2022 at 3:12 PM, 12/05/22 at 8:17 AM, and 12/08/2022 at 4:52 PM showed Resident 6 had a foley catheter in bladder continuously. Review of Resident 6's December 2022 Physician Orders (POs) showed no orders related to the foley catheter size, care, when to change the catheter or monitor for functioning. In an interview on 12/09/2022 at 1:01 PM, Staff C stated Resident 6 had the foley catheter in since admission for neurogenic bladder. Staff C stated POs were required to provide any treatment to the residents. Staff C stated they should have received the physician orders for foley catheter size, care and when to change but they did not. 44296 Resident 40 The 10/13/2022 Quarterly MDS showed Resident 40 was unable to complete a cognitive assessment, had chronic pain and received medication to treat their pain. The assessment showed Resident 40 was to receive more than 51 percent of their nutrition requirements via tube feeding (a process that carried liquid nutrition through a flexible tube into the body). A 05/19/2022 PO showed Resident 40 was to receive a topical pain gel to their left shoulder and knees every shift. The order did not specify how much of the topical pain gel was to be applied to each area. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2022 at 11:33 AM, Staff F (Infection Control Preventionist) confirmed the PO needed clarification and any nurse administering the gel should have identified the order needed to be clarified. A 07/12/2022 PO for Resident 40 directed the nurse to turn the tube feeding off at 9:00 AM and turn back on at 1:00 PM. An observation on 12/02/2022 at 2:37 PM showed Resident 40 did not have the tube feeding connected and running. In an interview on 12/02/2022 at 2:47 PM, Staff C acknowledged the order to start the tube feeding at 1:00 PM and Resident 40 did not have the tube feeding running. Staff C stated they forgot to turn the tube feeding back on. In an interview on 12/02/2022 at 3:15 PM, Staff B stated nurses are expected to follow PO and the tube feeding should have been started at 1:00 PM and was not. 46472 46479 Resident 41 According to a 06/2022 Respiratory Practice Manual facility policy, the facility required a physician's order be obtained prior to the administration of oxygen. The orders were to include how much oxygen was to be given to the resident and the duration of use. The oxygen tubing was to be placed in a plastic bag, labeled with the date and resident's name when not in use. Tubing was to be changed weekly. According to a 10/15/2022 Quarterly MDS, Resident 41 was assessed to have no memory impairment, diagnoses of heart failure, kidney failure, and respiratory failure. In an observation and interview on 12/01/2022 at 9:46 AM, an oxygen machine and oxygen tubing were observed in Resident 41's room. The oxygen tubing was draped over the resident's bed and not contained in bag. There was no date on the tubing. Resident 41 stated they only used the oxygen at night, and they kept the flow at two liters per minute. In an observation and interview on 12/05/2022 at 11:26 AM, Resident 46's oxygen tubing was draped over the resident's bed. No date was observed on the tubing. Resident 41 stated they were not sure the last time the tubing had been replaced. Similar observations were noted 12/06/2022 at 9:42 AM. A 07/08/2022 Care Plan (CP) indicated Resident 41 was to receive oxygen therapy as ordered by Resident 41's physician. Review of Resident 41's records showed no orders instructing staff the resident required oxygen therapy. The record contained no instructions for the amount or duration of oxygen the Resident 41 was to receive. There were no orders instructing staff to change the oxygen tubing every week as the facility policy indicated. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/08/2022 at 2:44 PM, Staff C stated they expected Resident 41 to have oxygen orders in their record if they are receiving oxygen. Signed for Tasks Not Performed Resident 51 The 10/06/2022 Admission MDS showed Resident 51 had multiple medically complex diagnoses including malnutrition, diabetes, and a thyroid disorder. A physician's order was written on 11/16/2022 for staff to obtain lab work for monitoring of Resident 51's diabetes and thyroid disorder. Review of Resident 51's November 2022 MAR showed nursing staff signed the order for lab work was completed on 11/16/2022. Record review showed lab work was not completed in November 2022. In an interview on 12/12/2022 at 8:16 AM, Staff C stated staff should not sign for orders when not competed. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review the facility failed to implement effective discharge planning processes to transition residents to post-discharge care for 2 of 3 (Residents 161 & 69) residents and 1 supplemental resident (Resident 51) reviewed for discharge planning. The failure to identify and plan for the individual discharge needs of each resident placed residents at risk for unmet needs after discharge, lack of medical equipment, distress about plans to go home, unsafe discharge location, and rehospitalization . Findings included . Resident 121 According to the 10/28/2022 Admission Minimum Data Set (MDS, an assessment tool) Resident 121 admitted to the facility on [DATE], was cognitively intact, and made their own decisions. Resident 121 had medically complex conditions, including Atrial Fibrillation (A-fib, abnormal heart rhythm), Coronary Artery Disease (damage in the heart's major blood vessels), and Hypertension (high blood pressure). Resident 121 received a blood thinning (anti-coagulant) medication during the assessment period. Review of a 10/28/2022 Social Services Admission/Discharge evaluation showed Resident 121 was projected to stay in the facility three to four weeks and the plan was to discharge home independently with a walker. Review of a Resident 121's 10/21/2022 comprehensive care plan (CP) revealed the facility did not create a discharge care plan with goals and interventions. Review of a 11/17/2022 Nurse Practitioner (NP) telephone encounter note showed the facility staff called the NP about abnormal blood test results regarding Resident 121's blood thinning medications, values elevated indicated blood required extensive time to clot (prolonged bleeding that can be life-threatening). The NP ordered a coagulate medication (assists with blood clotting to stop bleeding) due to Resident 121's ongoing elevated blood test results. The NP directed staff to obtain a blood test on 11/18/2022 and monitor the resident closely for any signs of bleeding or bruising. Review of the 11/17/2022 blood test results showed the results were flagged and the report contained critical results. Review of the November 2022 Medication Administration Record (MAR) showed Resident 121 did not receive the coagulate medicate on 11/17/2022 when the NP ordered the medication. Resident 121 received the coagulate medication on 11/18/2022 at 7:49 AM. A 11/18/2022 NP note showed that Resident 121 received the coagulate medication and directed staff to re-check the blood test on 11/19/2022 and continue to monitor the resident for bleeding. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 11/18/2022 Social Services discharge summary showed Resident 121 discharged from the facility on 11/18/2022 at 2:15 PM with a collateral contact for transportation. Home health services, for healthcare follow up at home, were set up to start on 11/22/2022, 4 days after the resident discharged from the facility. Review of a 11/18/2022 Interdisciplinary resident discharge note showed the facility provided no supporting education to the resident. The note showed Resident 121 required post-discharge treatments including lab tests for blood clotting monitoring. The summary was minimally completed with only three sections filled out; all other areas of the discharge summary were left blank. The form was not signed by Resident 121 or staff confirming that discharge instructions were provided to the resident or allowed the resident the opportunity to ask questions. An 11/18/2022 Nursing progress note showed discharged home with orders and belongings. Review of a 11/19/2022 NP discharge summary note showed that home health was arranged for Resident 121, and they are discharged in fair/stable condition. The NP documented for Resident 121 to obtain the blood test on 11/19/2022 in an outpatient setting and monitor the resident for bleeding. Resident 121 had already discharged from the facility without discharge instructions or the ability to ask questions about follow up medical needs. In an interview on 11/29/2022 at 10:29 AM with Resident 121's collateral contact (CC) stated they picked up the resident from the facility and was not provided any education or information about a medication that could cause bleeding, or information for an appointment for a blood test. The CC stated Resident 122 was having some shortness of breath and the CC decided to take Resident 121 to the emergency room where the resident was admitted for low blood pressure. The CC stated Resident 121 passed away five days being admitted to the hospital. During an interview on 12/6/2022 at 3:17 PM, Staff L (Social Services Assistant) stated Resident 121's discharge plan was to return home and acknowledged there was not a discharge CP in place for the resident. In an interview on 12/06/2022 at 3:27 PM Staff B (Director of Nursing) confirmed the NP placed orders on 11/18/2022 for Resident 121 to have a blood test completed and to monitor the resident for any signs or symptoms of bleeding. When asked who oversaw monitoring Resident 121 for bleeding, Staff B replied staff should have provided education to the Resident and the CC before discharge including signs and symptoms to monitor for bleeding and what to do if symptoms were observed. Staff B stated Resident 121's blood tests were unstable while the Resident resided in the facility and if the NP ordered blood tests for 11/19/2022 facility staff should have, but did not, set the Resident up with an appointment or information on how or where to get the blood test completed. When asked why home health was set up to start four days after the resident discharged , Staff B stated discharge was before a weekend, but it was a little long for the resident to wait. Resident 69 (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/20/2022 Admission MDS showed Resident 69 was admitted to the facility on [DATE] with the diagnoses of Urinary Tract Infection (UTI), new nephrostomy catheter (implanted urinary tube for draining urine) and received intravenous (IV, through a vein) antibiotics. Resident 39 was assessed as cognitively intact and able to make daily care decisions. The MDS showed Resident 69 discharged to an acute hospital, return not anticipated on 10/20/2022. In an interview on 12/08/2022 at 12:07 PM, the designated Resident Representative (RR) stated Resident 69 did not speak English, would not be able to make medical decisions if spoken to in English. The RR stated Resident 69 could understand simple English for easy daily task decisions. The RR stated there was not a translator used to help Resident 69 to make discharge plans or make decisions about their care. The RR stated they were not called about any care planning or discharge planning discussions, and did not talk to any social workers, nurses, or physicians. The RR stated Resident 69 called (the RR) on 10/20/2022 and asked to be picked up from the facility to go home. The RR was told by Resident 69 they were not getting the care they expected and wanted to leave. The RR stated they arrived to pick up the resident and the facility made the RR sign a form that Resident 69 was leaving against medical advice. The RR stated when Resident 69 left the facility, they wanted to go straight to the hospital to see a doctor, then was admitted for medical issues. A review of Resident 69's medical record showed no progress notes, assessments or discussions regarding discharge planning was completed with the resident or the RR. A 10/19/2022 progress note showed the interdisciplinary team discussed Resident 69's skilled care provided and current status. The note showed Resident [69] discharge plan is to return home . resident will not likely be available to safely discharge home . will continue to work with therapy on strengthening, social services director will speak with resident on discharge plan and may need to discuss palliative care needs. There was no further follow-up documentation from facility staff about discussion with the resident or the RR. In an interview on 12/09/2022 at 2:36 PM, Staff B stated Resident 69 should have had a discharge planning discussion with the social worker just a couple days after admission, then ongoing until discharge. Staff B stated the facility can provide translator services but did not provide for Resident 69's discharge planning. Staff B reviewed Resident 69's records and stated there was no discharge planning notes with the resident or the RR, there was no discharge CP, and there was no discharge summary from the physician as required. Staff B stated these items were not done by the facility staff as required. 43642 Resident 51 According to a 10/06/2022 Admission MDS, Resident 51 was cognitively intact, had clear speech, was understood and able to understand others. This MDS indicated Resident 51 did not have an active discharge plan for the resident to return to the community and no referral to a local contact agency was needed. In an interview on 12/02/2022 at 10:48 AM, Resident 51 reported staff had not involved them in discussions regarding their care and stated they wanted to know if they had a discharge plan in place. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 09/28/2022 discharge CP showed Resident 51 wished to discharge to their apartment where they lived alone with scheduled caregiver assistance, and wished to administer their own medications. This CP directed staff to ask resident their preferences of outside services post-discharge, complete a referral from the county if needed, discuss discharge goals/prognosis with the resident, provide with written instructions regarding their medications/exercise/nutrition, and plan family meetings as needed. Record review showed a 10/14/2022 provider progress note that stated Resident 51's discharge plan was to return home with family support and to continue follow up by facility social worker for discharge planning. On 11/09/2022 a provider progress note stated Resident 51 had participated in physical and occupational therapy, had been discharged from skilled Medicare services due to lack of progress, and was to have continued follow up by facility social worker for discharge planning. Record review revealed no documentation from social services that a discharge plan was in place or any plans had been discussed with Resident 51 since their readmission on 09/28/2022. In an interview on 12/12/2022 at 3:13 PM, Staff L stated their expectation is social services staff would meet with residents to discuss discharge planning and assist them as needed to obtain the referrals and equipment needed for a safe discharge. Staff L stated a resident's CP should be updated and revised if discharge plans change. The discharge expectations were not met for Resident 51. REFERENCE: WAC 388-97-0080.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 46471 Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) for 5 of 18 residents (Resident 12, 51, 6, 41, & 46) reviewed for ADL care to dependent residents. The failure to provide dependent residents with bathing, nail care, oral care, and overall grooming placed them at risk for poor hygiene, embarrassment, and diminished quality of life. Findings include . Resident 12 According to the 05/13/2022 Admission Evaluation, Resident 12 had a full upper denture and natural bottom teeth. The 12/02/2022 Kardex (a care guide) showed Resident 12 required set up and standby assistance with oral care. A 07/08/2022 Sound Dental Care consultation showed Resident 12 needed help to remove and clean their upper denture. Observation on 11/30/2022 at 1:16 PM showed Resident 12's was wearing their upper denture. The upper denture was noted with food residue outlining the teeth and in between the gum line. When asked if they have rinsed their mouth or brushed their teeth yet, Resident 12 stated, No, not really. Observation on 12/08/2022 at 7:19 AM showed Resident 12 was sleeping in bed. At 7:49 AM, Staff S (CNA, Certified Nursing Assistant) came in the room with a meal tray, woke up Resident 12, and stated it was breakfast time. Staff S set up the resident to eat breakfast and left the room. Resident 12 was not provided any oral care assistance. On 12/08/2022 at 12:07 PM, before the lunch trays were served, Resident 12 was observed in bed, with the same obvious food residue wedged in between their teeth. Record review of Resident 12's personal hygiene task (dental/oral care including dentures) from 11/03/2022 until 12/08/2022 showed no documentation of oral or dental care was documented that staff provided oral care. The 09/23/2022 revised Care Plan (CP) did not have any care interventions listed for Resident 12's oral and denture care needs. In an interview on 12/09/2022 at 3:33 PM, Staff D (Registered Nurse, RN Unit Manager) stated the expectation was for staff to provide oral care and document accurately. Staff D confirmed there was no documentation of oral care provided, Staff D could not confirm staff provided oral care for Resident 12 as directed. 43642 Resident 51 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to an 10/06/2022 Admission Minimum Data Set (MDS, an assessment tool) Resident 51 was cognitively intact with clear speech and had no rejection of care during the assessment period. This MDS assessed Resident 51 to require extensive physical assistance from staff for bed mobility, transfers, and personal hygiene and was totally dependent on staff for bathing. In an interview on 12/02/2022 at 10:44 AM, Resident 51 stated they get bathing, one time a week if you're lucky and stated, they [staff] wont cut my toenails, my fingernails and toenails are too long. Resident 51 explained they used to get weekly nail care due to their diagnosis of diabetes and reported it was only done once since September. Observation on 12/02/2022 at 10:58 AM, showed Resident 51 had long thick toenails that extended beyond the tip of both of their big toes and the rest of the toenails were long and curled over to the tip of the toes. Review of revised 09/28/2022 ADL CP showed Resident 51 required extensive assistance with bathing. A 09/28/2022 diabetic CP showed directions to staff to refer Resident 51 to a podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. According to November 2022 ADL Documentation, Resident 51 was scheduled for twice weekly bathing on Tuesday and Saturday but only received four showers in 30 days. Review of Resident 51's 09/28/2022 Physician Orders showed directions to staff to complete weekly hair and nail assessments every Tuesday and the resident may see podiatrist as needed. In an interview on 12/12/2022 at 8:16 AM, Staff C (Licensed Practical Nurse, LPN Unit Manager) stated staff is expected to provide bathing twice weekly as scheduled, provide nail care weekly, and refer residents to podiatry as needed. 46479 Resident 6 According to the 11/02/2022 Quarterly MDS, Resident 6 admitted to the facility on [DATE], was cognitively intact, and able to be understood and get understand in conversation. The MDS showed Resident 6 required extensive assistance with personal hygiene and showers. In an interview on 12/01/2022 at 11:21 AM, Resident 6 stated they did not get a shower for a month. Resident 6 stated they preferred showering at least twice weekly but never got a shower. Review of Resident 6's bathing records showed from 11/01/2022 through 12/01/2022, the resident received four bed baths in 30 days, but no showers. Observations on 12/02/2022 at 8:09 AM, 12/05/2022 at 11:33 AM, and 12/08/2022 at 10:01 AM showed Resident 6 was not shaved and had greasy hair. In an interview on 12/07/2022 at 12:04 PM, Staff C stated staff is expected to assist Resident 6 with showers and hair washing according to the shower schedule twice a week, and per the resident's preferences. Staff C stated staff should shave Resident 6 daily or as the resident preferred. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 41 A 10/15/2022 Quarterly MDS showed Resident 41 was assessed with no memory problems, was frequently incontinent of bowels, had mobility impairment, and used a wheelchair for mobility. The assessment showed Resident 41 did not reject care and depended on staff for bathing assistance. In an interview on 12/01/2022 at 9:49 AM, Resident 41 stated they had not received a shower in three weeks. In an observation at that time, Resident 41 had long thumb nails, large peeling flakes of dry skin on their left foot, and their hair was unkempt, sticking out in different directions. In an interview on 12/12/2022 at 11:07 AM, Staff C stated they used shower sheets (documentation signed and dated by staff indicating a resident had received a shower) to verify when residents received showers. Staff C stated if a resident refused a shower, it would be documented in the record. Record review showed the most recent shower sheet was dated 10/30/2022. There were no shower sheets found for the month of November or December. Review of Resident 41's progress notes from 11/01/2022 to 12/12/2022 showed no notes indicating the resident refused a shower. Resident 46 A 09/28/2022 Admission MDS, showed Resident 46 was assessed to have memory impairment, no speech, sometimes understood, and usually understands others. Resident 46 had history of a stroke (blockage or bleeding of vessels in the brain) and had limited range of motion with one side of their body. Resident 46 did not reject care and required assistance from staff for dressing and hygiene. A 09/21/2022 care plan indicated Resident 46 would be neat, clean, and well-groomed daily. An observation on 12/01/2022 at 2:44 PM, showed Resident 46 with long fingernails and facial stubble to their cheeks and chin. Similar observations were noted on 12/02/2022, 12/05/2022, and 12/06/2022. On 12/07/2022 at 12:30 PM, Resident 46 was observed lying in bed and was wearing a night gown. Resident 46 had long facial stubble. In an interview on 12/07/2022 at 12:39 PM, Resident 46 was shown a typed question Do you prefer to have your face shaved?. Resident 46 said Yeah!. When Resident 46 was asked if they preferred to wear clothes, their eyes got very big, and the resident loudly stated Yeah! while nodding their head. In an interview on 12/08/2022 at 11:34 AM, Staff Y (CNA) stated sometimes Resident 46 had a long beard and sometimes it was shaved. In an interview on 12/12/2022 at 11:18 AM, Staff C stated orders were in the Medication Administration Record (MAR) for nurses to check resident's nails and hair daily. This check was for the nurse to determine if a resident needed their nails trimmed or hair washed. Record review showed no orders for nursing staff to monitor Resident 46's nails or hair daily. The record did not indicate Resident 46's preferences for shaving or dressing. REFERENCE: WAC 388-97-1060(2)(c).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to ensure 1 of 18 residents (Resident 45) received necessary care and services in accordance with professional standards of practice related to hospitalization , significant change in condition, edema management, and medically related appointments. The facility's failure to recognize, accurately assess, and provide ongoing monitoring for worsening heart failure and kidney function; assess and adequately monitor progressively significant weight gain and edema; implement repeated physician orders for daily weights and multiple referral requests to Nephrology (kidney specialist); and ensure reliable transportation was established for appointments resulted in harm to Resident 45 who sustained avoidable acute kidney injury and acute respiratory failure, required two likely avoidable hospitalization s and one emergency room visit, avoidable psychological stress, and significantly diminished quality of life. Findings included . Resident 45 According to the The Fundamentals of Nursing -The Art and Science of Person-Centered Care, 9th edition (pages 1554-1578), alterations in fluid balance and electrolytes (potassium) are commonly caused by a malfunction of the kidneys ability to excrete excess fluids and heart failure that results in fluid accumulating (edema/swelling) in the lungs and dependent parts of the body (lower legs). Accurate assessment of fluid and electrolyte balance when symptoms occur is critical because such imbalances can have serious negative outcomes and could even be life-threatening. The Care Plan (CP) should include monitoring of fluid intake and output, daily weights- at the same time every day preferably in the morning, and routine labs. Daily weighing is the most accurate way to depict changes in fluid volume. A rapid increase or loss of 2.2 pounds is equal to one liter of fluid. Edema is graded from 1+ to 4+ and brawny (swelling that is so significant it will no longer show pitting) edema by pressing on the affected area and evaluating the level or pitting. A more accurate way to measure edema is measuring the affected body part, in the same area each day or routinely. A physical assessment should include an assessment of the skin, oral membranes, vital signs, oxygen saturation, respiratory and cardiac assessment - including lung sounds, edema grade and location, and weight changes. Moist crackles heard in the lungs is an indication of fluid in the lungs and may indicate fluid volume overload. According to the 09/17/2022 Annual Minimum Data Set (MDS, an assessment tool), Resident 45 had no cognitive deficits and had diagnoses including heart failure, kidney disease, high blood pressure, and diabetes. Resident 45 required supervision with ambulation and bed mobility and required limited assistance with transfers and toileting. Resident 45 did not have breathing difficulty. The MDS showed a weight of 258 pounds, which triggered a significant unplanned weight gain. Review of the 09/23/2022 revised CP showed no identification of problems related to heart failure, kidney disease, edema / weight gain, respiratory problems, or dental problems. There were no interventions to direct staff how to care for Resident 45 related to these medical care areas identified in the MDS assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 11/30/2022 at 11:10 AM, Resident 45 stated they were very unhappy with the physician services provided by the facility and believed the provider did not know how to manage their care and was incompetent. Resident 45 stated they would have to start dialysis (treatment for filtering blood when the kidneys no longer functioned) much sooner than expected due to the medical mismanagement they experienced. Resident 45 said they were hospitalized several times over the past year because they did not receive the care they needed. Resident 45 stated their quality of life was severely impacted by the medical complications experienced in February 2022 when they were hospitalized for an oral gum infection after requesting to see the dentist and hospitalized again in October 2022 when they had such bad edema they had to go to the hospital, resulting in respiratory failure and diuresis (removal) of 74 pounds of water weight. Resident 45 said their medical circumstances had caused a considerable decline in their mood and made their anxiety almost unmanageable at times. According to record review, Resident 45 admitted to the facility on [DATE] and weighed 218 lbs. An 08/23/2021 Physician note showed Resident 45 was referred to Nephrology due to multiple abnormal kidney function labs and recurrent high potassium (an electrolyte) levels. The note showed Resident 45 weighed 220 lbs. A 12/10/2021 Physician note showed Resident 45's lower leg edema worsened over the past week and the provider adjusted Resident 45's medications to help decrease their edema. The provider failed to identify Resident 45 was not seen by Nephrology as ordered. Resident records showed on 12/10/2021 Resident 45 weighed 237 pounds. A 12/21/2021 Physician note identified the resident had edema but did not address the status of the Nephrology appointment or question why it was not followed up on. A 12/21/2021 document of blood work results showed Resident 45's kidney function had worsened. According to a 02/21/2022 hospital history and physical note, Resident 45 was admitted to the hospital due to an oral gum infection. The hospital admission weight showed Resident 45 weighed 252 lbs, an increase of 15 pounds. Resident 45's kidney function labs were abnormal, and Resident 45 received treatment to stabilize their kidney function. According to Resident 45's census record, they returned to the facility on [DATE]; they weighed 241 lbs. Review of the Physician Progress Notes showed from the date of the first Nephrology referral request on 08/23/2021 to 05/03/2022 (over 8 months), Resident 45 was evaluated by or received consult by facility Physician (or designee) providers 100 times. Facility staff and Physician providers failed to identify or question why Resident 45 had not been referred to a Nephrologist as ordered. On 05/03/2022, Staff II (Physician) placed another order into the electronic record, saying, Refer to Nephrology. A 06/02/2022 nutrition note identified Resident 45 weighed 258 lbs., an increase of 12 lbs. in two days. The note showed the interdisciplinary team (IDT) felt the weight was miscalculated and they would re-weigh Resident 45. The note indicated Resident 45 had a pending Nephrology referral for end stage renal disease (a condition in which the kidneys cease functioning on a permanent basis) and did not address issues with the residents's fluid balance or abnormal lab values. Resident 45's weight record showed the next weight assessed was 11 days later, on 06/13/2022, they weighed 242 lbs. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A 07/06/2022 Physician note showed Resident 45 was seen for fluid volume overload, lower leg edema, and high blood pressure. The note showed there were no new labs drawn and no current weight. The plan for Resident 45's worsening chronic kidney disease was to avoid medications toxic to the kidneys, encourage the resident to increase fluids, and referenced abnormal labs drawn on 05/17/2022, which were not current labs. On 07/07/2022 Resident 45 weighed 266 lbs. (a 24-pound weight gain in 24 days). This weight gain triggered a significant increase alert to the nursing staff in the electronic medical record. There was no nursing assessment of the weight gain. There was no re-weight conducted and no evidence the provider was notified. A 07/17/2022 nursing note showed Resident 45 had significant edema to both legs, hips, low back, and now crackles were heard in the resident's lungs (an indication of increase fluid volume overload, worsening heart failure and/or kidney function). A 07/17/2022 after hours physician provider note showed nursing staff notified the provider of Resident 45's elevated blood pressure, severe edema from their hips to lower legs, and crackles heard in both lungs and that Resident 45 requested to go to the hospital. The provider noted they [Provider] did not think Resident 45 needed to go to the hospital and ordered an additional dose of their diuretic and lab work again. Resident refused the order and insisted to go to the hospital. According to the 07/17/2022 hospital notes, Resident 45 was treated for edema and was scheduled for a follow up with a Nephrologist on 08/23/2022 as the previously ordered Nephrology consults were never implemented by the facility. According to a 07/20/2022 Physician order (PO) staff were directed to obtain daily weights. Review of Resident 45's weight record showed staff failed to implement the daily weights, only weighing the resident on one day between 07/20/2022 to 08/31/2022. A 08/31/2022 Physician provider note showed Resident 45 had edema to both lower legs and had a newly identified heart murmur (abnormal heart sound). The provider again wrote refer to nephrology, encouraged increased fluid intake, and repeat the blood work. The provider documented, start daily weights if greater than 3-pound weight gain in 1 day or 5 pounds in 1 week, notify provider. The provider said to continue current medications. The provider note did not address the lack of daily weights in the resident's record or delay in obtaining the nephrology appointment. On 08/23/2022 Resident 45 had a Nephrology appointment scheduled. Resident 45 was ill that day and the appointment was rescheduled for 10/04/2022. Resident 45's weight record for September 2022 showed staff failed to obtain daily weights on six of 30 days. A 09/28/2022 Physician provider note repeated the order to, Refer to Nephrology. On 10/04/2022 Resident 45 missed their appointment to Nephrology due to the facility's failure to ensure transportation. The appointment was re-scheduled for 11/01/2022. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident 45's October 2022 weight record showed facility staff failed to obtain daily weights on five days between 10/01/2022 and 10/13/2022. Weight record showed on 10/04/2022 (281 lb.), on 10/02/2022 (288 lb.), and on 10/13/2022 (292 lb.- a 37 lb. weight gain in 30 days, a 51 lb. weight gain in 120 days, and 72 lb. weight gain in 245 days - the date of the first Nephrology referral request). Resident 45 was subsequently sent to the hospital related to significant edema from their lower legs to their abdomen, causing the resident breathing complications. According to the 10/13/2022 emergency room Physician note: Resident 45 had chest tightness and shortness of breath, lower leg swelling and abdominal edema. Their labs indicated acute kidney injury. The hospital physician stated Resident 45's declining kidney function was concerning. The physician note identified the resident never received the Nephrology referral recommended from the July 2022 emergency room visit. The physician documented, now today [their] renal function continues to decline, and [their] swelling has worsened significantly. The resident was admitted to the hospital with acute respiratory failure and acute kidney injury. According to a 10/14/2022 hospital Nephrology consultation, Resident 45 had acute kidney injury with chronic disease and Nephrotic Syndrome (a kidney disorder that caused the body to excrete too much protein). According to this Nephrology consult, the diuretic medication prescribed by the facility physician did not help control Resident 45's ongoing and worsening fluid overload. The kidney specialist prescribed a plan to use medication and fluids to remove the excess fluid from the resident's body and manage their recurrent critical electrolyte imbalance. Review of hospital documents showed on 11/05/2022 Resident 45 readmitted to the facility weighting 204 lbs. ; a decrease in weight of 88 pounds in 23 days. According to the 11/12/2022 5 day Quarterly MDS, Resident 45 had diagnoses of acute respiratory failure and kidney disease. Resident 45 required extensive assistance with their bed mobility, transfers, walking, and toileting, which was a decline in function from the previous assessment. Resident 45 required oxygen therapy which was new for the resident. Resident 45 had a newly acquired Foley catheter (flexible tube inserted in the bladder to drain urine). Resident 45 weighed 229 pounds (lb.) and had a significant planned weight loss. The revised 09/23/2022 CP showed no new updates related to respiratory failure, oxygen, kidney disease, heart failure, edema, or daily weights. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 12/09/2022 at 3:45 PM with Staff B (Director of Nursing) and Staff KK (Corporate Clinical Nurse), Staff B stated they were not aware of the initial Nephrology referral ordered August of 2021. Staff B stated the process for referrals was the provider wrote a referral order and/or notified the nurse. The nurse notified transportation staff who would schedule the appointment and transportation. Staff B and Staff KK were not aware of transportation concerns or residents missing appointments due to transportation problems. Staff B stated, once referred, it was their expectation residents were evaluated by specialists as soon as possible, depending on the specialist availability. Staff B stated 15 months of repeated requests for referral was not an acceptable timeframe for Resident 45 to wait and other avenues should have been explored to obtain the referral but were not. Staff B stated they would call to other provider groups, get on cancellation lists, and do whatever it took to make sure the referring provider was aware of what the facility was doing to meet the residents' needs. Staff B stated if a resident had heart failure or problems with edema, their expectation was the resident would be weighed routinely according to the frequency ordered by the provider. Staff B expected nursing to monitor Resident 45's level of edema, skin condition, respiratory, and urinary status, and to document their findings and notify the provider as soon as possible of any changes or abnormalities identified. Staff B verified Resident 45 should have been seen by a specialist in a timely manner but was not. Staff B verified Resident 45 should have daily weights but did not. Staff B stated nursing staff should have notified and documented their communication to the provider when Resident 45's weight gain was outside the parameters of professional standards for fluid volume management and the provider's order, but they did not. In an interview on 12/13/2022 at 2:40 PM, Staff II (Physician) stated they were not aware of Resident 45's extent of referral requests for Nephrology because they didn't start seeing the patient until recently. Staff II stated they did not necessarily follow up with the nursing department management after daily weights were ordered for Resident 45 because they just expected to order it and it be done. Staff II stated there were some problems with transportation regarding Resident 45's appointments. Staff II stated they put orders for nephrology in the electronic ordering system and that is the process providers should be following. Staff II stated they will even print out the orders and deliver to the nurse on duty and provide a list of the residents seen for that day and orders to implement. REFERENCE: WAC 388-97-1060(1)(2)(a)(3)(i)(4). 44296

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to ensure weekly skin assessments, documenting and monitoring of wounds for infection, and wound treatment supplies were available for 1 of 3 (Resident 6) residents reviewed for Pressure Ulcers (PUs). Failure to complete weekly skin checks as ordered, assess and document wound progress, and/or ensure the availability of ordered skin care and treatment supplies placed residents at risk for deterioration in skin condition, and diminished quality of life. Findings included . According to the facility's undated Wound Prevention and Treatment policy, pressure injuries would be monitored weekly, and documentation of the size, color, odor, healing progression, notifications, and other information related to skin condition would be documented in the medical record, including physician and resident/responsible party notifications. Resident 6 According to the 11/02/2022 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 6 admitted to the facility on [DATE], had multiple medically complex diagnoses including PUs (open wounds caused by pressure), bone infection of their spine and tail bone area (sacrum), and loss of movement and sensation of their lower body. The MDS showed Resident 6 was at risk for PUs, had two Stage Three (wound gone through all skin layers to the fat tissue) and one Stage Four (deep wound reaching to the muscles and bones) PU, and required extensive assistance with all activities of daily living. Observations on 11/30/2022 at 11:03 AM, 12/01/2022 at 8:02 AM, 12/02/2022 at 10:07 AM, and 12/05/2022 at 9:20 AM showed Resident 6 lying in bed, on an air mattress with a wound vac (a device to promote wound healing using negative pressure) on the tail bone wound. Observation on 12/06/2022 at 7:42 AM, showed no wound vac dressing on Resident 6's tail bone wound. In an interview on 12/06/2022 at 7:45 AM, Resident 6 stated they were unsure why the staff removed the wound vac pump. Resident 6's Physician Orders (POs) included a 10/17/2022 PO to clean the tail bone wound with Dakins (wound cleaning solution to prevent infection) cover with a foam dressing, set the wound vac to 70-75 mmHg (mmHg - millimeters of mercury), and change the wound vac dressing three times per week. A 07/27/2022 PO for weekly skin assessments directed nurses to Document (-) for No area of impairment; Document (+) for ANY area of impairment whether new or old. IF NEW complete A and I (accident and investigation), and document in progress note and notify MD . In an interview on 12/06/2022 at 11:59 AM, Staff C (Licensed Practical Nurse - LPN/Unit Manager) stated they did not have wound vac canisters available (container to hold the wound drainage) for the dressing change. Staff C stated they told Staff A (Executive Director) last week to order the canisters, but they were still out of stock. POs were directed to continue with the wound vac. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/06/2022 at 12:23 PM showed the outside wound care provider completing the wound treatment for Resident 6 in their room. In an interview on 12/06/2022 at 1:02 PM, the outside wound care provider stated the facility ran out of wound vac supplies, and they did not have canisters for the wound vac pump. The wound care provider stated they provided wound assessment documentation to the facility weekly after wound rounds. Observations on 12/07/2022 at 2:49 PM, 12/08/2022 at 9:02 AM, and 12/09/2022 at 5:52 PM showed Resident 6 had no wound vac dressing on their tail bone. Review of Resident 6's October and November 2022 MARs showed nursing staff failed to complete the weekly skin assessments as directed by the Physician. Review of Resident 6's outside wound provider documentation showed no documentation after 10/25/2022. In an interview on 12/07/2022 at 12:08 PM, Staff C confirmed weekly skin documentation was not completed as ordered and the outside wound provider's documentation after 10/25/2022 was not in Resident 6's record. Staff C stated weekly nursing skin check documentation and the wound provider's wound assessment documentation should be in Resident 6's record but was not. In an interview on 12/07/2022 at 1:26 PM, Staff B (Director of Nursing) stated the facility should follow POs and document in the resident's record. Staff B stated if documentation of care was not in the record, the care was not completed. REFERENCE: WAC 388-97-1060(3)(b).

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North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42203 Based on observation, interview, and record review the facility failed to assess falls timely, identify cause of falls, and implement fall interventions to prevent recurrent falls for 4 (Residents 35,42, 51 & 20) of 8 residents reviewed for accidents, failed to provide required supervision while eating for 1 of 8 (Resident 66) and 4 supplemental (Residents 24, 46, 42, & 40) residents reviewed for nutrition and swallowing difficulty, failed to provide supervision of unsecured emergency exits, failed to maintain handrails in safe condition, and failed to secure construction materials and tools in the resident environment. These failures left residents at risk for falling, choking, aspiration, elopement, injury, and/or death. Findings included . Falls Resident 35 According to the 10/31/2022 Quarterly Minimum Data Set (MDS, an assessment tool) Resident 35 had intact cognition. The MDS showed Resident 35 had diagnoses including debility (physical weakness) and malnutrition. Review of the facility's September 2022 incident log showed Resident 35 had a fall on 09/16/2022. According to the facility's investigation of the 09/16/2022 fall, Resident 35 was found on the floor of their room at 10:00 AM on 09/16/2022 after crying out for help. The incident description showed Resident 35 sustained a 3 x 3-inch hematoma on their forehead, and that neurological checks (neuros - periodic evaluations to establish the presence of a neurological injury after a fall) were started. The 09/16/2022 investigation did not include any evidence neuros were completed. The 09/16/2022 investigation included a 09/15/2022 fall risk evaluation completed after Resident 35 returned to the facility after a stay at the hospital and did not reflect the fall Resident 35 had on 09/16/2022. No fall risk evaluation was found in the resident's record or included in the investigation to demonstrate Resident 35's risk for falling was reassessed after an actual fall. In an interview on 12/09/22 at 2:33 PM, Staff B (Director of Nursing) stated for an unwitnessed fall resulting in a forehead hematoma, neuros should be completed. Staff B stated evidence of the neuros should be included in the investigation. Resident 42 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 09/12/2022 modified Admission MDS showed Resident 42 had no cognitive deficits and diagnoses including multiple falls, fracture related to falls, and had experienced 2 or more falls after admission to the facility. Review of the revised 09/26/2022 Care Plan (CP) showed the basic standard of care interventions used for all residents; directed the staff to make sure the call light was within reach, encourage the resident to use the call light, proper non-skid footwear, provide safe environment, increase supervision, and refer to therapy as needed. The CP failed to include person-centered interventions to address the resident's fall history with fractures, interventions for cardiac / medication related factors that commonly cause falls, care needs, or updated with new interventions after the first two falls sustained after admission. According to the facility Reporting log showed as of 12/09/2022, Resident 42 fallen 10 times since admission. Review of the 10 facility fall Incident Reports (IRs) showed the facility consistently failed to either identify new interventions to help manage falls, update the CP with planned fall interventions, and/or implement the interventions according to the IRs. After Resident 42's fall on 09/09/2022, the 09/11/2022 facility IR showed the new intervention was to encourage the door to be open to the room. The CP showed the new intervention had not been added to the CP until 09/15/2022. In a 12/12/2022 1:30 PM interview, Staff B stated the update was not timely and should have been added on 09/11/22. On 09/11/2022 at 12:45 AM, Resident 42 fell again. The facility IR showed a plan to have the pharmacist review the resident's medications. In a 12/12/2022 1:30 PM interview, Staff B stated they had not gotten the pharmacy review done and the CP was not updated, but should have been. Resident 42 fell on [DATE] at 8:28 AM and the facility IR showed the root cause of the fall was orthostasis (significant drop in blood pressure upon standing, often causing the resident to fall or faint). The plan was for orthostatic blood pressure review. The facility failed to complete neurological assessments, include orthosatic blood pressures, implement the plan, or update the CP. Similar findings for the falls on 10/05/2022, 10/12/2022, and 10/22/2022. Resident's sixth fall was on 10/24/2022. The facility IR showed the plan was for therapy to assess for the placement of anti-roll back brakes (a device placed on the back of the w/c to prevent it from rolling back if the resident stood up from the chair) on the wheelchair (WC). The CP was not updated and the interventions were not implemented. A 12/12/2022 12:38 PM observation showed the resident's wheelchair did not have anti-roll back brakes attached to the back of the wheelchair. On 10/30/2022, Resident 42 fell during a self-transfer without locking the WC brakes. The resident sustained a long abrasion on the middle of their back. The facility IR said the root cause of the fall was orthostasis. The IR showed no consideration or review of the effectiveness of previous planned interventions, identify they were not implemented, and/or care planned. On 12/12/2022 at 1:30 PM, Staff B agreed if the facility had implemented the anti-roll back brakes on the resident's WC, the resident may not have fallen on 10/30/2022 or 11/02/2022. Resident 42's ninth fall was on 11/10/2022. The facility IR showed the root cause was increase confusion, but no investigation into the reason Resident 42 was having increased confusion, or consider if the resident was having a change of condition. The plan was to place a sign on the bedside table to remind the resident to call for help before trying to self-transfer. During observations on 11/30/2022 at 1:30 PM and 12/12/2022 at 2:28 PM showed no sign on the bedside table. The CP was not updated and the interventions were not implemented. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 42's tenth fall was on 11/20/2022. The facility IR showed the resident had rolled from the bed and the plan was to place the resident on a mattress that had raised perimeter. An observation on 11/30/2022 at 1:30 PM showed the resident was lying on a perimeter mattress. An observation on 12/12/2022 at 11:30 AM showed resident 42 had moved to another room, but the perimeter mattress was not on the residents bed, it was left on the bed in the previous room. In the 12/12/2022 1:30 PM interview, Staff B stated the perimeter mattress should have been moved with the resident and should have been updated on the CP, but was not. Staff B said the investigations lacked witness statements and were not all thorough, the CP was not consistently updated as it should have been placing the resident at continued risk for falling and significant injury. Staff B said the post fall alert monitoring by the nurses was not consistently documented but should have been. Resident 51 According to the 10/06/2022 Admission MDS, Resident 51 had multiple medically complex diagnoses including fractures. This MDS assessed Resident 51 with falls prior to admission that resulted in fractures. Review of the facility incident log showed Resident 51 had a fall on 08/10/2022. The incident report completed by staff showed the resident stated, help me, I fell and was found on the floor with a bump on her forehead. This incident report showed, at the time of the incident, Resident 51 had a bruise to their face and left shoulder. On the incident report staff left the following sections blank: Level of pain; level of consciousness; mobility; mental status; injuries post incident, predisposing environmental factors; and predisposing physiological factors. Review of progress notes showed a late entry note for 08/10/2022 for nursing communication to therapy. This note indicated Resident 51 showed a possible change in condition regarding falls and safety/judgement and requested the resident be evaluated and treated by therapy. No further progress notes by nursing staff regarding the fall were found in the Resident 51's records until 08/20/2022 at 4:11 PM, at which time staff documented a left shoulder x-ray completed on 08/11/2022 was placed in the provider file. Review of Resident 51's records revealed no alert monitoring or neuro assessments were completed by nursing staff after the residents fall on 08/10/2022 with injury to their head. In an interview on 12/09/2022 at 2:33 PM Staff B (Director of Nursing) stated nurses are expected to start the investigation by collecting information for the fall report at the time of the fall. The physician and family must be notified and all documentation of the fall is required to be in the progress notes. Resident 20 The 09/17/2022 Quarterly MDS showed Resident 20 was cognitively impaired, had diagnosis of dementia and at risk for falls. The MDS showed Resident 20 had no falls since the prior assessment. Resident 20 was assessed to require supervision with walking, transfers, and bed mobility and extensive physical assistance with toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's November 2022 incident log showed Resident 20 had a fall on 11/17/2022. Review of the 11/17/2022 investigation report showed Resident 20 had an emergency room (ER) visit and broken scapula (collar bone). Record review showed a 12/05/2022 7:55 PM progress note Informed resident family of fall that took place today with the information at hand. Family is going to meet resident at [NAME] ER. State report complete, DNS ADON AND ED notified of fall with Major injury - suspected fracture. The next progress note dated 12/05/2022 9:31 PM showed Nursing communication to Therapy. Resident is showing a possible change in condition in the following areas: Personal hygiene, Toileting/Continence, Falls. A 12/06/2022 5:23 AM progress note showed Resident came back from the hospital alert and verbally responsive. Resident arrived at the facility around 11:45 pm . went to hospital for non-witnessed fall. Resident sustained some injury on the nose . had displaced bilateral nasal bone fractures . periorbital hematoma. Resident continues neuros and on alert for three days [resident representative] informed about the discharge from the hospital. The progress note did not show cause of fall, notification of the physician, interventions put into place immediately. Review of progress notes 12/06/2022 day, evening, and night shift, 12/07/2022 day, evening shift showed no ongoing monitoring of Resident 20 after the fall with a nose fracture. In an interview on 12/06/2022 at 9:35 AM Staff B stated the nurses are expected to start the investigation at the time of the fall, make a progress note describing what happened and who was notified. Staff B stated the physician should have been notified immediately and it should be documented in the record. Staff B was told the information was missing from the progress notes and replied, It should be in there by now. In an interview on 12/09/2022 at 2:30 PM, Staff B was asked to provide a copy of the investigation that had been completed so far on the 12/05/2022 fall, 5 days prior. No documents were provided. In an interview on 12/12/2022 at 11:33 AM, Staff F (Infection Control Preventionist) stated they were the person on duty at the time of the fall and helped the nurse with the investigation and transferring Resident 20 to the ER. Staff F reviewed the progress notes and stated they were incomplete, missed the assessment of the resident after the fall, missed the initial findings of the cause of fall, missed the notification of the physician, and did not place the resident on alert monitoring upon return from the ER. Staff F stated the investigation had not been completed but had been given to the DNS. In an interview on 12/12/2022 at 2:32 PM, Staff B was asked to provide a copy of the investigation for the 12/09/2022 fall, 8 days prior. The document was not provided until the end of survey. Review of the 12/05/2022 fall investigation showed an intervention of a physical therapy evaluation which the resident refused. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2022 at 2:32 PM, Staff B stated a complete fall investigation included interviews with the resident, staff, and other residents to rule out abuse and neglect, have a root cause analysis with interventions on the care plan to prevent future incidents. Alert charting is required after any incident and continues for three days or until stable. Neuro monitoring is required for any head injuries and should be documented in the investigation. Eating Supervision Resident 66 According to the 11/04/2022 Admission MDS, Resident 66 had diagnoses including stroke and difficulty swallowing. The MDS showed Resident 66 required an altered texture diet and required supervision during. According to an 11/04/2022 Physician's Order (PO) Resident 66 should eat all their meals in the facility's dining room for supervision. The PO showed Resident 66 required aspiration precautions be in place. According to the 11/04/2022 Activities of Daily Living (ADL) CP Resident 66 had a self-care deficit related to weakness and deconditioning. The CP indicated Resident 66 required extensive assistance with eating. Observation on 12/06/2022 at 12:23 PM showed Resident 66 eating alone in their room. On 12/07/2022 at 12:17 PM Resident 66 was observed receiving their lunch tray from Staff S (Certified Nursing Assistant - CNA) who then left the room to a pass more trays. Resident 66 was left unattended to eat their lunch. On 12/08/2022 at 7:49 AM Resident 66 was observed eating their breakfast in their room without supervision. In an interview on 12/07/2022 at 12:22 PM Staff S stated they were unsure what level of supervision Resident 66 required. Staff S stated they usually worked the other side of the building. Staff S stated they could use the CP, the resident's tray ticket, or ask a colleague when working with residents they were less familiar with. Resident 24 According to the 09/14/2022 Quarterly MDS, Resident 24 had difficult chewing / swallowing, significant weight loss, received a mechanically altered texture diet, and required supervision for eating. The 07/13/2022 Nutrition CP directed staff to provide 1:1 (one-to-one) feeding assistance / supervision with meals and report to the nurse any signs of chewing or swallowing problems. The CP failed to include information for staff related to the residents' risk for aspiration and physician ordered diet textures for food/fluids. A constant observation on 12/08/2022 from 7:31 AM to 7:54 AM showed Staff PP (CNA) delivered the breakfast tray to Resident 24 who was lying in bed, with their head of bed at a 30 degree angle. Staff PP set the tray on the bedside table, did not elevate the residents head to ensure the resident was sitting upright for swallowing safety, then left the room. During the observation, Resident 24 was observed slowly feeding themselves and no staff ever came to the room to provide the 1:1 eating assistance and supervision the resident was required to receive. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a 12/08/2022 8:05 AM interview, Staff PP said Resident 24 could feed themselves and only required set up. When Staff PP was asked what the resident's care plan said for eating assistance required, they said the resident required supervision, but that did not always mean 1:1 -all the time. They said staff just needed to check on the resident often. Staff PP said they had not returned to check on the resident because they continued passing the hall trays for the unit and the nurse or other CNAs would need to help check on the residents. In a 12/08/2022 07:55 AM interview, Staff E (RN Unit Charge Nurse) reviewed Resident 24's CP and verified the resident is at risk for nutritional decline and is care planned to need 1:1 feeding assistance and supervision for eating. When Staff E was asked what does 1:1 mean, they said the resident normally eats in their bed and the CNAs are expected to sit with the resident during the entire meal, and not leave the resident alone with food because the resident is at risk for choking and aspiration (inhalation of food into the lungs). When asked who ensures the residents receive the 1:1 assistance they require and they are positioned safely for eating, Staff E said the nurses on the floor mainly, but its everyone's responsibility. Staff E said Resident 24 should have been sitting upright in the bed for eating and provided 1:1 assistance / supervision during the entire meal. Resident 46 According to a 09/28/2022 Admission MDS, Resident 46 was assessed to have poor memory, limited mobility in one arm, and a history of a stroke (a blockage or rupture of blood vessels in the brain). In an observation on 12/07/2022 at 12:30 PM, Resident 46 was sitting up in bed with lunch on the bedside table, over the resident's lap. The plate contained pureed chicken, pureed cornbread, pureed French green beans and kidney beans. Resident 46 ate all the chicken and bread. No staff were observed in or around Resident 46's room while they were eating. A 12/05/2022 Kardex (a tool directing staff on the type of care/assistance a resident requires) showed Resident 46 required extensive assistance and supervision with meals. Record review showed a 09/21/2022 diet order for dysphasia (difficulty swallowing food), pureed texture, thin consistency. In an interview on 12/07/2022 at 12:45 PM Staff M (Nursing Assistant Registered - NAR) stated they used a tablet which showed how much assistance a resident required. Staff M stated Resident 46 only needed set up help and could eat independently. Resident 42 According to the 09/06/2022 admission MDS, Resident 42 did not have a swallowing problem. The resident was assessed to require assistance with eating. On 09/14/2022, the resident choked on a meal and required the Heimlich maneuver (an emergent procedure to clear the airway of obstruction) prior to being sent to the hospital. On 09/26/2022 the resident returned to the facility with a new diagnosis of difficulty chewing/swallowing and on a physician ordered soft textured diet and thickened liquids. The 09/26/2022 CP showed the resident required 1:1 feeding assistance and supervision for meals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an ongoing observation on 12/08/2022 from 12:23 PM to 1:16 PM showed Resident 42 was set up at the edge of the bed with their meal by the CNA without checking the meal tray for accuracy, then left the room without identifying the meal they delivered to the resident had three incorrect food textures and the wrong liquid consistency. (Refer to F803) After the correct meal was provided to the resident, staff left the room, and did not return to supervise the resident for their meal. During a 12/08/2022 1:23 PM interview, Staff T (Licensed Speech Therapist) said the resident should be supervised for meals due to their risk of choking and aspiration. Resident 40 The 10/13/2022 quarterly MDS showed Resident 40 was assessed with dysphagia (a swallowing problem) and was on a mechanically altered diet, requiring supervision and one person assistance for cueing for eating. A 07/11/2022 PO showed Resident 40 should be up in a wheelchair and in the assisted dining room for lunch. The 08/12/2022 diet order showed Resident 40 required a dysphasia mechanical soft diet with nectar thick liquids and supervision during meals for standard aspiration (inhaled food/fluids into lungs) precautions. Observation on 12/08/2022 at 12:21 PM showed Resident 40 was in bed, the head of the bed was at 30 degrees, too low for eating position, lunch tray was on the overbed table, holding a fork and eating holding head up from the mattress. There was no staff present providing supervision to prevent aspiration. In an interview on 12/09/2022 at 2:33 PM Staff B stated Resident 40 should eat in the assisted dining room, or if eating in their room, should have the required supervision for swallowing safety. Unsecured Building Materials On 12/06/2022 at 10:21 AM the door to room [ROOM NUMBER] was observed to have a sign hung indicating the room was under construction. The door was observed to be unlocked. Inside room [ROOM NUMBER] the following was observed: an open container of a putty-like compound, a half-full, 5-gallon paint can, a drill, a hammer, assorted hardware, painting supplies, a box of ceiling tiles on a cart, a second cart with box of all-purpose joint compound, a can of wall texture spray, and a step ladder. There was a large hole observed to be cut into the ceiling to provide access to water pipes. The bathroom inside room [ROOM NUMBER] was shared with room [ROOM NUMBER] which allowed the occupants of room [ROOM NUMBER] to access room [ROOM NUMBER] through the bathroom as well as from the hallway unsecure both from hallway and through bathroom to room [ROOM NUMBER]. In an interview at 12/06/2022 at 10:48 AM, Staff A (Administrator) stated it was their expectation that construction materials and tools were stored securely. Staff A stated room [ROOM NUMBER] should have been, but was not secured for resident safety. Handrails (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/30/2022 at 8:03 AM showed the handrail fixture next to storage room and opposite room [ROOM NUMBER] had a broken plastic bracket that was potentially sharp enough to tear the skin of residents using it. On 11/30/2022 at 8:39 AM the handrail outside room [ROOM NUMBER] was fractured and had exposed, sharp edges. On 12/09/2022 at 12:54 PM the handrailing on the corner of the office between the shower room and activity room near rooms [ROOM NUMBERS] was detaching from the brackets and wobbly. A 3x3 inch corner piece was not securely fastened and could be detached manually. The second bracket from the corner was missing. In an observation and interview on 12/12/2022 at 10:37 AM, Staff H (Maintenance Director) stated the rails needed to be repaired. Staff H stated they were unsure if they had the parts available but could order them. 44296 Emergency Exit Doors During a life safety inspection on 12/01/2022 from 8:45 AM to 9:50 AM, a [NAME] State Fire Marshal identified the two EE doors (door 2 and 3) on the east side of the building did not function as required. The Fire Marshal determined the EE doors were locked and could not be opened, which prevented residents and staff from exiting emergently. In an interview and observation on 12/01/2022 at 11:51 AM, Staff I (Maintenance Assistant) stated they took the door pins to their private home and needed to collect the pins before they could get the EE doors open. Staff I stated they removed pin from each of the push-bars for EE doors 2 and 3 after a resident wandered through the doors outside to the patio area, unsupervised. Staff I was unable to recall the name of the resident or the date they removed the pins from the door but stated that it was a while ago. Staff I was observed using multiple tools to install the pin into the push-bar and 11 minutes later EE Door 2 was unlocked and opened. At 12:08 PM, Staff I installed the pin into the push bar for EE Door 3 and it was unlocked. Both doors 2 and 3 were locked and non-functional for a total of two hours and 12 minutes after the Fire Marshal determined both doors were locked and not functioning as required by federal regulations. Observations on 12/01/2022 1:07 PM showed the EE doors were unlocked but no alarm sounded when opened, which allowed residents to exit the facility without staff knowledge. There was no staff present at the EE doors to watch for residents exiting through the unlocked EE doors. Observation on 12/01/2022 at 2:31 PM showed the facility tested the audible fire alarm system. The fire alarm response by staff cleared the hallways and all staff responded to the nurse's station preventing staff from monitoring the EE doors for residents exiting. The fire alarm sounded for 34 minutes while surveyors monitored the EE Doors for staff supervising for residents exiting. In an interview on 12/01/2022 at 2:48 PM Staff A, while the alarm was sounding, stated staff would be assigned to watch the unlocked/unsecured EE Doors 2 and 3 during the fire alarm testing. Observations of the EE doors 2 and 3 at 2:54 PM, 3:11 PM and 3:23 PM showed no staff present to prevent resident exit/elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/01/2022 at 2:48 PM showed Staff H and Staff FF (Corporate Maintenance) attempting to reset the EE doors connection to the fire alarm system. Staff H and Staff FF put the fire system in test mode and established that EE doors 2 and 3 did not open as they should when the alarm sounded. At 3:05 PM the facility concluded the test of the fire system and the alarms silenced. The EE doors 2 and 3 remained unlocked and staff was not present to supervise the doors. Observation on 12/01/2022 at 4:32 PM showed magnetic door alarms mounted to EE doors 2 and 3. The alarms were designed to sound when the magnet on the alarm attached to the door and the magnet attached to the frame separated. The alarms were designed to activate and deactivate with a key sticking out of the device. The alarms were noted to be installed and function as intended when a surveyor opened EE door 2 and the magnet alarm sounded. EE doors 2 and 3 remained disconnected from the main system so the main fire alarm did not sound. Observation on 12/02/2022 at 9:13 AM showed both EE doors 2 and 3 still with magnet alarms attached, with the key sticking out, and not connected to the fire alarm system. In an interview on 12/01/2022 at 3:13 PM Staff FF stated they were unsure why or when Staff I disabled the doors. Staff FF stated the EE doors should never be locked. Staff FF stated they would seek more information on the EE door functioning so they could assure the EE doors were fully functional and compliant with fire codes. REFERENCE: WAC 388-97-1060(3)(g). 46472 46479

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure 4 (Residents 19, 66, 51, & 20) of 8 residents reviewed for nutrition maintained acceptable parameters of nutritional status. Failure to ensure consistent and timely weights, notify physicians of changes, and implement interdisciplinary interventions and physician ordered nutritional supplements, placed residents at risk for weight loss and/or delayed implementation of interventions to prevent continued weight loss. Findings included . Facility Policy According to a revised 11/2022 facility Nutrition Assessment policy the facility was required to measure and record food intake three times daily with meals for all residents in the electronic medical record (EMR). If changes in intake or an intake less than 50% was noted, the resident's condition would be evaluated during the clinical meeting to determine if there were new risk factors for nutrition. This policy provided recommendations for consideration to develop individualized interventions for implementation based on IDT (interdisciplinary team) assessments that would promote the highest level of function and dignity, some recommendations included: implement pharmacological interventions to decrease depression and/or anxiety, offer replacements of similar nutritive value for uneaten food items, monitor lab values, obtain pharmacy and psychological consults, and obtaining weekly weights. According to the policy, CNAs (Certified Nursing Assistants) were responsible for weighing each resident within 24 hours of admission and weekly for four weeks and/or until the weight is determined to be stable by the IDT team, then monthly if stable. The weight was to be reported to the Licensed Nurse who was responsible for verifying accuracy. For residents who had a weight change of 5% or greater, the Licensed Nurse was responsible to supervise the re-weight; report verified weight loss/gain of 5% or greater to the immediate nursing supervisor, dietician, physician, and resident representative; review at the clinical meeting; review and revise the Nutritional Risks Care Plan as needed; monitor the resident's response to interventions; and re-evaluate interventions to determine effectiveness/need for Care Plan (CP) revisions. Resident 19 The 12/29/2021 Significant Change Minimum Data Set (MDS - an assessment tool) showed the assessment was initiated related to a discharge from hospice care, Resident 19 was [AGE] years old. The MDS showed Resident 19 had diagnoses of dementia and depression. Resident 19 was assessed with cognitive impairment, indicators of depression including poor appetite and weight loss with weight of 103 lbs. Resident 19 was prescribed an antidepressant (AD) and nutritional supplement. Resident 19's nutrition care plan (CP) was not updated after the 12/29/2021 significant change assessment. The 10/26/2020 nutrition CP showed Resident 19 had a nutrition risk due to inadequate intake, dementia, and a history of unplanned weight loss. The CP interventions included monitor weight and provide nutrition supplements. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 01/06/2022 provider note showed Resident 19 had severe protein calorie malnutrition and had increased risk of mortality (death) and morbidity (suffering from a disease or medical condition). The provider recommended Resident 19 remain on the AD for appetite stimulation and depression. Review of the AD order showed the diagnosis for use of the AD was not updated to use for appetite stimulation. On 01/20/2022, Resident 19's AD medication, with the diagnosis of depression only, was discontinued by a psychiatrist with the notation on the order no longer indicated. Review of the progress notes showed no mention of the AD being discontinued, no notification of nursing and no monitoring was initiated for mood, appetite, or weight loss. A 01/26/2022 primary physician progress note showed Resident 19 continued with severe malnutrition and was at increased risk for further malnutrition and weight loss, which would affect all aspects of their care, increase their risk of further decline, mortality, and morbidity. The physician's progress note showed to continue the AD for appetite stimulation. Review of the January 2022 physician orders showed no order to re-start the AD medication. On 01/31/2022 the weight log showed Resident 19 weighed 101 lbs. A 02/03/2022 psychiatry progress note showed no review of the discontinuation of the AD and no evaluation or assessment for increase in indicators of depression or decreased appetite. The 02/07/2022 weight log showed Resident 19 weighed 99.6 lbs. Review of the March 2022 Medication Administration Record (MAR) showed an order for a high calorie/high protein liquid supplement. Resident 19 was to receive 120 milliliters (mL) of the supplement four times daily. The MAR showed on 03/15/2022 the supplement was not given twice with a progress note it was not available and was on order. Of the 124 doses of the supplement prescribed in March 2022, 53 doses were not administered, and 24 doses showed only 90 mL was administered. A 03/24/2022 dietary progress note from the Registered Dietician (RD) showed a weight loss warning for Resident 19 with a significant weight loss. The note showed Resident 19's food and fluid intake was not enough to meet minimum nutrition or hydration requirements. The 03/10/2022 weight was 88 lbs. The RD note stated they questioned the accuracy of the weight and requested a re-weight. The RD evaluation did not identify the recent discontinuation of the AD as a possible contributing factor of the trending weight loss. There was no evaluation of the missed nutritional supplements and no change made to the CP. The weight log showed the next weight obtained was a month later, on 04/23/2022 Resident 19 was 96.0 lbs. A 03/31/2022 Quarterly MDS showed Resident 19 had a decline in their cognition and an increase in depression indicators from the previous assessment and was not receiving an AD. Resident 19 was assessed to have a decline in their ability to feed themselves and had a significant weight loss of greater than 10% of their total body weight in three months. The nutrition CP was not updated after the assessment. A 04/28/2022 dietary progress note showed a recommendation to provide one-to-one feeding assistance, add cocoa and fortified orange juice to the meal trays. The RD goal showed Resident 19's weight to return to greater than 100 lbs. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 07/22/2022 PO showed a change in nutritional supplement to 240 mL twice a day. Review of August 2022 MAR showed of 62 doses only 44 doses were given and only 60 mL were taken by Resident 19, two doses were not administered without a progress note, and 16 doses were not administered with progress notes showing the supplement was not available. The nutrition CP was not revised until 09/13/2022 and then included a goal of comfort care. The interventions were monitor weight, monitor intake, 1:1 feeding assistance with a mechanically altered texture, and provide nutritional supplements of high calorie/high protein and fortified orange juice. The 09/12/2022 weight log showed Resident 19 was 92.6 lbs. On 12/04/2022 the weight log showed Resident 19 weighed 91 lbs. On 12/05/2022 during a continuous dining room observation from 11:54 AM to 12:18 PM, Resident 19 was observed facing the wall with no other residents nearby. Resident 19 was sitting on the edge of the standard wheelchair, laying against the backrest, with their head rested on the top of the backrest of the wheelchair, an improper position for safe eating. There were no fluids on the table, including no cocoa or fortified orange juice supplement. Staff RR (CNA) was observed sitting next to Resident 19 repetitively placing the fork in front of their mouth and stated, take a bite. Staff RR removed the plate and utensils from the table and at 12:35 PM, Resident 19 had eaten less than 25% of their meal. In an interview on 12/07/2022 at 10:00 AM, Staff Q (Licensed Practical Nurse) confirmed Resident 19 did not have an order for an AD, required one-to-one assistance for eating, had and order for 120 mL of liquid supplement and a fortified orange juice at each meal. Staff Q stated CNAs are expected to report to the nurse when residents did not consume all the supplements, so it could be offered later. Staff Q was not informed of Resident 19 not receiving the fortified orange juice. In a 12/09/2022 3:00 PM interview Staff B (Director of Nursing) stated when an AD was discontinued, the practitioner is expected to report to nursing and complete a progress note, nursing was required to monitor and document for mood and meal intake, the RD is required to monitor weights, identify medication changes and nutritional supplement intake, update the CP, and put interventions in place related to the residents assessed dietary needs. Staff B stated Resident 19 was expected to be weighted weekly based on the identified weight loss trend. Staff B stated residents are expected to receive nutritional supplements as ordered and supplements are expected to be available. Resident 66 According to the 11/11/2022 Admissions MDS, Resident 66 admitted to the facility on [DATE]. The MDS showed Resident 66 had intact cognition, diagnoses including swallowing difficulties, a history of stroke, failure to thrive, and depression, and required a mechanically altered diet. The MDS showed Resident 66 required supervision while eating. The 11/08/2022 PO directed staff to provide an altered texture diet to Resident 66, and to provide all Resident 66's meals in the facility dining room. There was no POs regarding weight monitoring. According to the 11/07/2022 Nutrition Risk CP, Resident 66 was at risk nutritionally due to their swallowing difficulty, a history of stroke, failure to thrive, and depression diagnoses. The CP directed staff to provide Resident 66's diet as ordered and to collect weights per orders/policy. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 12/05/2022 at 12:17 PM showed Resident 66 received their lunch tray in their bedroom from an unidentified staff member who then left the room, leaving the resident unattended to eat. Observations on 12/06/2022 at 12:23 PM and on 12/07/2022 at 12:37 PM showed Resident 66 eating in their room without the supervision they were assessed to require. Review of the November 2022 TAR (Treatment Administration Record) showed Resident 66 weighed 150 lbs. on 11/5/2022. Resident 66 was not weighed on 11/12/2022 or 11/19/2022, as scheduled on the TAR, and there was no documented refusal. The next recorded weight showed 146.5 lbs. on 12/4/2022. In an interview on 12/12/2022 at 1:02 PM Staff C (Resident Care Manager) stated Resident 66 was assessed to be at nutritional risk upon admission. Staff C confirmed Resident 66's weekly weights were not obtained per facility policy. 43642 Resident 51 According to the 10/06/2022 Admission MDS, Resident 51 was cognitively intact, had multiple medically complex diagnoses including a thyroid disorder, diabetes, and malnutrition. This MDS assessed Resident 51 with weight loss of 5% or more in the last month, or 10% or more in the last six months and not on a physician-prescribed weight-loss program. In an interview on 12/02/2022 at 10:37 AM, Resident 51 stated they had, a lot of weight loss. The resident indicated they were not happy with the food and reported they would sometimes have food delivered from outside sources. According to a 10/11/2022 Nutritional Care Area Assessment (CAA), staff documented Resident 51 had weight loss in the last six months, the CP would address the nutritional goals/interventions, and nursing was to monitor intake every shift daily. Review of a 09/28/2022 nutrition CP showed the Resident 51 had inadequate oral intake, malnutrition, and recent hospitalization . This CP showed a goal the resident would consume at least 75% of meals and snacks, directed staff to offer preferred foods when possible, and to monitor weight weekly. Record review showed Resident 51 readmitted to the facility on [DATE] and according to the resident's weight records, was not weighed until 10/04/2022, five days after admission. Resident 51's weight on 10/04/2022 was documented as 113.4 pounds. A 10/05/2022 Nutrition Evaluation showed Resident 51 was at risk for severe malnutrition and the resident had unintended weight loss in the last six months related to inadequate oral intake. The evaluation identified new interventions for Resident 51 to start on a high protein health shake twice daily, directed staff to monitor weight and oral intake with a goal to have no significant weight changes for 90 days, and for oral intake to be at least 50% of most meals provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/13/2022 a weight of 111.9 pounds and a weight of 105 pounds was documented for Resident 51, a difference of 6.9 pounds. The resident did not have another weight documented until 10/20/2022 (seven days later) at which time Resident 51 was at 106 pounds, a weight loss of 6.53% since the re-admission weight less than 30 days prior. In an interview on 12/12/2022 at 8:16 AM, Staff C stated the resident should have been re-weighed to verify the weight discrepancy and follow up as needed. Review of a 10/21/2022 nutrition progress note showed staff would continue with weekly weights to determine stability. Record review showed a weight was obtained on 10/26/2022 which reflected Resident 51 weighed 107 pounds, a significant weight loss of 5.98% in less than 30 days. A 11/03/2022 nutrition note reflected Resident 51 appeared to be having true weight loss, indicated the protein supplements would be increased, and weights would continue to be obtained. Resident 51 was not weighed again until 11/28/2022 (over four weeks later) and was 109.9 lbs. In an interview on 12/12/2022 at 10:27 AM, Staff C stated the reporting of weight discrepancies by the CNA's to nursing staff was not consistent. Staff C indicated they expected weekly weights to be done if residents were losing or gaining weight and monthly weights if they were stable. Staff C stated staff should follow the facility policy regarding weights and resident CPs should be followed, updated, and revised as needed with changes. 44296 Resident 20 The 09/17/2022 Quarterly MDS showed Resident 20 had an unplanned significant weight loss of 10% in last six months. Resident 20 had medically complex conditions with diagnoses including malnutrition, dysphasia, Vitamin D deficiency, thyroid disorder, and dementia. The MDS showed Resident 20 had no issues with swallowing, had no natural teeth, did not wear dentures and was on a mechanically altered diet. Resident 20 was assessed to require supervision with oversight, encouragement and cueing while eating. A 12/18/2018 CP showed Resident 20 required staff set up and staff participation to eat meals generally eaten in the main dining room, sometimes meals in room. The CP was not updated after the 09/217/2022 MDS to direct staff for Resident 20's required supervision, oversight, encouragement, or cueing. Review of Resident 20's recorded weights showed 02/07/2022 weight 126.3 pounds, 04/28/2022 weight 119 pounds, 07/07/2022 weight 115 pounds, 08/02/2022 weight 112 pounds, 10/04/2022 weight 109 pounds, 11/28/2022 weight 103 pounds, total of 23.3 pounds (18.45%) weight lost over nine months. A 09/23/2022 nutrition evaluation from the dietician showed resident was to be on weekly weight monitoring, have labs and monitor meal intake to prevent further weight loss and goal of intake at least 50% for all meals. Review of the 2022 weight log showed no weights were obtained in September 2022, only two weights obtained in October 2022 and only one weight obtained in November 2022. This did not follow the dietician recommendations for weekly weight monitoring. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 11/30/2022 at 8:39 AM, 10:57 AM, and 11:20 AM showed Resident 20 in bed with the breakfast tray on the bedside table next to the bed not set up and not eaten, no supervision or cueing from staff was provided. In an interview at 11:24 AM, Staff Y (CNA) checked on Resident 20 and stated they are usually awake all night and sleeps through meals during the day. At 12:04 PM, the lunch tray was delivered to Resident 20 in their room. Observations at 12:17 PM, 12:21 PM, 1:33 PM showed Resident 20 was lying in bed and not eating lunch. At 1:56 PM, Resident 20 was sitting on the side of the bed, lunch untouched and eating a chocolate cupcake. During these observations Resident 20 did not have staff supervision, encouragement or cueing to reach the dietician goal of 50% intake each meal. Similar observations for Resident 20's meal trays served in the room on 12/05/2022 breakfast, 12/06/2022 breakfast, 12/07/2022 breakfast and lunch, 12/08/2022 breakfast and lunch. Observation on 12/06/2022 at 12:19 PM showed Resident 20 sitting on the side of the bed with the lunch tray in front of them. Resident 20 was cutting a brownie with a piece of cardboard from the tissue box and eating the main dish with their fingers. There was no staff present to assist with set up, supervision or cueing. In an interview on 12/01/2022 at 1:44 PM, the Resident's Representative (RR) stated they were concerned about weight loss and wanted Resident 20 to gain some weight. The RR stated Resident 20 needed more help from staff to help eat so they would gain weight. The RR stated when they visit, they provided help to Resident 20 to eat ice cream or something else. The RR stated the weight loss did not seem right if the staff was assisting the resident with eating. In an interview on 12/09/2022 at 2:36 PM, Staff B stated there is not an interdisciplinary team approach to review of weight loss. Behaviors identified by nursing are not discussed with the dietician for collaborative interventions to stabilize or improve intake. Staff did not identify Resident 20's sleep schedule in relation to eating and weight loss and put interventions in place to mitigate further weight loss. REFERENCE: WAC 388-97-1060(3)(h). 46472 45941

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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** 44296 Based on observation, interview, and record review the facility failed to ensure residents that can eat enough orally is not fed by enteral (feeding by tube into body) methods for 1 of 1 resident (Resident 40) reviewed for tube feeding. The failure to complete on-going interdisciplinary team (IDT) assessments of the clinical indications and rationale to continue tube feeding and to identify the residents wishes and requests for oral intake placed Resident 40 at risk for possible unnecessary artificial tube feeding and diminished quality of life. Findings included . Resident 40 The 10/13/2022 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 40 admitted to the facility on [DATE] from another skilled nursing facility. Resident 40 had diagnoses including recent stroke, aphasia (difficulty speaking), dysphasia (difficulty swallowing), unable to take food or fluids by mouth and had a tube into the stomach for administration of nutrition and fluids. A 09/24/2022 speech therapy discharge summary showed Resident 40 could safely tolerate two meals per day with an altered food texture and thickened liquids. The discharge summary recommended Resident 40 eat one meal per day in the supervised dining room. Staff was instructed to supervise, prevent aspiration (food or fluids inhaled into the lungs), and provide cueing precautions for rate of eating, bite sizes and alternation of bites of food and sips of liquids. The 07/11/2022 physician order directed staff to stop the tube feeding at 9:00 AM and Resident 40 to be out of bed and in the assisted dining room every day for lunch. The 08/12/2022 diet order showed a mechanically altered texture and thickened liquids with standard aspiration precautions and supervision during meals. Review of November 2022 meal intake records showed 20 of 30 days the staff documented Resident 40 was able to eat by mouth between 25-100% of the meal. An additional 3 days showed Resident 40 attempted to eat, but intake was under 25%. In an observation and interview on 12/05/2022 at 12:30 PM, Resident 40 was in bed watching a video on a tablet. When asked if they were going to have lunch, Resident 40 stated want pizza then stated kung [NAME] chicken. The more Resident 40 talked, it was more difficult to understand. Resident 40 confirmed they were hungry and wanted lunch. Observation at 12:45 PM showed Resident 40 was eating in bed using a fork and eating independently without staff supervision. Resident 40 was observed to eat lunch in the room independently on 12/06/2022, 12/07/2022, 12/08/2022, 12/09/2022 and 12/12/2022. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/09/2022 at 2:33 PM, Staff B (Director of Nursing) stated there has not been an IDT assessment or discussion between nursing, speech, and dietician about Resident 40's oral intake, requests for oral intake or the continued necessity for the artificial tube feeding. Staff B confirmed an IDT assessment of Resident 40's oral intake and tube feeding was necessary to determine if the tube feeding should continue. Staff B stated if the IDT team could determine Resident 40 could eat on their own, it would be very impactful on Resident 40's quality of life. REFERENCE: WAC 388-97-1060(3)(f).

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observations, interview, and record review the attending physician failed to ensure and/or adequately supervise the complete medical care for 1 of 20 (Resident 45) residents reviewed. The failure to follow up on the status of repeated orders given to nursing staff for a referral to a kidney specialist, address the omission of daily weight monitoring, and facility failure to follow Physician orders (POs) resulted in Resident 45 not being evaluated for worsening fluid balance status by a kidney specialist for over 12 months, required a possibly avoidable hospitalization with the removal of a significant amount of water weight, experienced acute kidney injury and acute respiratory failure. Findings included . Resident 45 According to the 08/23/2021 provider visit note, the resident was referred to Nephrologist (kidney specialist) due to recurrent abnormal and worsening kidney function lab values and critical potassium levels. A 05/03/2022 nurse note showed the Physician ordered repeat labs due to worsening kidney function labs and repeated Refer to Nephrology as the resident had not been set up for a Nephrology appointment yet. A 08/01/2022, 08/31/2022, 09/14/2022, 09/20/2022, 09/28/2022 provider note showed refer to nephrology. The first Nephrology specialty appointment was finally scheduled for 08/23/2022, one year after the first request for referral. Resident 45 was ill that day and unable to attend and the appointment was rescheduled for 10/04/2022. A 10/05/2022 provider note showed Resident 45 missed the 10/04/2022 appointment due to facility's failure to establish reliable transportation. The provider said the resident's potassium level was at a critical level and ordered a medication to help bring the potassium level back to normal. The provider reviewed the resident's medication to manage edema because the resident was complaining of increased edema to the lower legs and abdomen. The provider said the resident's current weight was 287.5 pounds (a 29-pound weight gain in 30 days) and they questioned the current weight trend but did not elaborate as to why. The provider assessed the resident as having pitting edema to both lower legs and up to the trunk (abdomen) and addressed labs values from 10/03/2022 that had significantly worsened. The provider adjusted the residents' medications and said, Refer to Nephrology ASAP (As soon as possible). On 10/13/2022 the Resident was sent to the hospital due to breathing complications related to fluid volume overload. The 10/13/2022 hospital records showed the resident was admitted to the hospital weighting 292 pounds and diagnoses acute respiratory failure, acute kidney injury, high potassium level, and protein in the urine (nephrotic syndrome). The resident was transferred back to the facility on [DATE] and weighed 204 pounds (a loss of 88 pounds in 18 days). (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a 12/13/2022 2:30 PM interview, Staff II, facility Physician, said they did not recall reviewing the weight list and had not had any conversations with facility administration regarding the facility's failure to obtain daily weights as ordered. Staff II said they write the order and expect the nurses follow the order. Staff II said they were not aware the request for Nephrology referral was first initiated in August of 2021 because they started seeing the patient around May of 2022. They were unsure of the reason it was taking the facility so long to obtain the appointment and was only made aware of a transportation issue. Staff II said a resident waiting 12 to 15 months for a nephrology referral was not acceptable. Staff II said they did not have any conversations with the facility administration regarding the resident not getting into the specialist as ordered or that orders were not followed thru to monitor Resident 45's fluid balance status. Staff II was asked if there was anything else that could have been done to get the resident into the specialist sooner for specialized kidney treatment and possibly slow the progression of kidney failure, need for hospitalization , and now the need for life altering hemodialysis (for instance a provider to provider call to expedite the waiting period, calling other specialists, getting on cancellation lists) and Staff II said they have in the past, but was unsure if it would have been helpful for this situation, and they were not from this area or familiar with the specialists in this area. Refer to F684 Quality of Care Refer to F658 Services Provided to meet Professional Standards REFERENCE: WAC 388-97-1260(3)(a).

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North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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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. 44296 Based on observation, interview, and record review the facility failed to ensure residents with dementia receive the appropriate treatment and services for 1 of 2 (Resident 20) residents reviewed for dementia care. The failure to assess residents individualized care needs through an interdisciplinary approach and implement a person-centered care plan prevented the facility from supporting residents to maintain their highest practicable physical, mental, and psychosocial wellbeing. Findings included . Resident 20 The 09/17/2022 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 20 had clear speech, was able to make self-understood and was able to understand others. The MDS showed Resident 20 was not able to complete a cognitive interview and had a diagnosis of dementia. The MDS showed Resident 20 had no adverse behaviors, no wandering, and no refusals of care. Resident 20 was assessed to require extensive physical assistance with toileting, supervision, encouragement and cueing for eating. The MDS did not match the comprehensive care plan (CP) for Resident 20. A 09/19/2022 wandering assessment showed Resident 20 had a history of elopement, impaired cognition, was restless, independent with ambulation, unable to locate their room and had a wander guard device (mobility tracker) on the left ankle. The 11/10/2022 CP for wandering directed staff to allow for safe wandering, use of a wander guard device at all times, collect data on elopements, intervene as appropriate with conversation, reassurance, and redirection. The CP did not show individualized wandering behaviors of Resident 20, such as time of day, location of wandering, triggers, or interventions for staff to provide to support safe wandering. An 11/17/2022 incident investigation showed Resident 20 was wandering without supervision and had a fall. Resident 20 was diagnosed in the emergency room with a scapula (shoulder) fracture. A subsequent incident investigation on 12/05/2022 for an unwitnessed fall, showed Resident 20 tripped over a rug in the hallway. Resident 20 was diagnosed in the emergency room with a nose fracture. Review of the 11/18/2022 fall CP and the 11/10/2022 wandering CP showed no updates or new person-centered interventions were added after the investigations to prevent falls or increase supervision during times of wandering. A 09/23/2022 nutrition monitoring and evaluation assessment showed Resident 20 had a weight loss of 14 pounds in six months. The assessment showed food preferences were obtained but were not listed on the assessment. The 09/23/2022 CP for nutrition directed staff to enhance diet to increase calorie intake, offer alternate food choices when meals were refused, offer Resident 20 preferred foods when possible. There were no person-centered food items listed on the CP. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/10/2022 CP for activities showed Resident 20 had supplies to participate in activities in their room independently, remind resident of activities occurring daily, invite/escort to group activities as needed including religion, bingo and music, events, and socials. There were no person-centered interventions specific for Resident 20, with dementia, to engage in activities. The 03/30/2022 CP for Activities of Daily Living showed Resident 20 was independent with nail care, independent with oral care, independent with eating after set-up, independent with toilet transfers, hygiene, clothing management and ambulation. This CP was not updated after the 09/17/2022 MDS to accurately direct the person- centered care for Resident 20. An observation on 11/30/2022 at 10:57 AM, Resident 20 was in their room lying in bed, feet were exposed from the blankets with long, thick toenails. Fingernails observed long and debris under nails. Breakfast tray was observed on the table next to the bed. No food was eaten from the tray, more than two hours after breakfast was served. An observation on 12/06/2022 at 1:20 PM showed Resident 20 eating lunch sitting on the side of the bed at the bedside table. Resident 20 was cutting the brownie with a piece of cardboard. Resident 20 had eaten the main dish with their hands. The silverware on the tray was untouched. The resident was not supervised while eating to provide An interview on 12/06/2022 at 1:22 PM, Resident 20's roommate reported that Resident 20 had used the shared toilet and it was now backed up and needed attention. Observation of the toilet showed that it had been used, the bowl was filled with toilet tissue, there was brown debris on the toilet seat and toilet tissue on the floor. In an interview on 12/12/2022 at 2:44 PM, Staff B (Director of Nursing) stated the CP should be updated to reflect individual person-centered care needs. Staff B reviewed Resident 20's CP and stated it was not updated to include person-centered dementia care interventions. Staff B was asked to provide the Dementia Care policies or procedures, none were provided. REFERENCE: WAC 388-79-1040(1)(a-c).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43642 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assured timely acquiring, receiving, and administering of all drugs) to meet the needs of each resident for 8 of 10 residents (Resident 51, 23, 2, 42, 49, 4, 65, and 32) reviewed. The facility failed to implement a system of medication records that ensures accurate reconciliation and accounting of all controlled medications for 4 of 5 inventory of controlled substance books reviewed from 3 of 3 medication carts. This failure resulted in residents not receiving their medications as ordered, placed residents at risk for adverse effects from not receiving prescribed medications, at risk for misappropriation of property, and drug diversion. Findings included . Unavailable Medications Resident 51 According to the 10/06/2022 Admission Minimum Data Set (MDS - an assessment tool), Resident 51 had multiple medically complex diagnoses including depression and fractures and required the use of an antidepressant and scheduled pain medication. In an interview on 12/05/2022 at 9:29 AM, Resident 51 stated, I got my [pain] patch finally. The resident stated they had not received their pain patch for about a week and indicated the facility had none available. Review of Resident 51's November 2022 Medication Administration Records (MAR) showed staff failed to administer the resident's: antidepressant medication on 11/05/2022 or 11/06/2022; and pain patch to lower back and chest wall on 11/13/2022, 11/14/2022, 11/15/2022, 11/18/2022, 11/20/2022, 11/21/2022, 11/23/2022, 11/24/2022, 11/25/2022, 11/26/2022, 11/27/2022, 11/28/2022, 11/29/2022, and 11/30/2022. According to 11/05/2022 and 11/06/2022 progress notes, staff documented the antidepressant medication was not in stock. Progress notes reviewed between 11/13/2022 and 11/30/2022 showed staff documented the pain patch was not administered due to awaiting delivery, unavailable, awaiting arrival, not given none available, medication not on hand. Review of Resident 51's December 2022 MAR showed staff failed to administer the resident's pain patch to lower back and chest wall on 12/01/2022, 12/02/2022, 12/03/2022, 12/04/2022, 12/08/2022, and 12/09/2022. Review of progress notes between 12/01/2022 and 12/09/2022 showed staff documented the pain patch was not administered due to not given none available, not available, and facility out of patches. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/12/2022 at 8:16 AM, Staff C (Licensed Practical Nurse- LPN- Unit Manager) stated there were currently concerns regarding the facility supply of medications. Staff C stated residents should get medications as prescribed by their doctor. 46471 Resident 23 Review of Resident 23's MAR showed a physician order for a constipation medication. The medication should be given two times daily according to the MAR. Observation of Resident 23's morning medication pass on 12/06/2022 at 9:28 AM, Staff Q (LPN) found an empty bottle of the constipation medication inside Hall A medication cart. Staff Q proceeded to the medication room, looked at the supply of over-the-counter medications, and did not find the constipation medication. Staff Q asked Staff N (LPN) if they had the constipation medication in their medication cart but Staff N did not have the constipation medication either. Staff Q finally stated the constipation medication was not available and marked Resident 23's MAR as not given. Residents 2, 42, 49, 4, 65, and 32 Similar findings were revealed for Residents 2, 42, 49, 4, 65, and 32 with staff not administering the physician ordered pain patches consistently between November 1 through December 10. Review of these resident's progress notes for the dates when the patch was not administered revealed the facility had no supply of the pain patches. In an interview on 12/07/2022 at 10:23 AM, Staff Q was asked how often the supply of medications ran out, Staff Q stated, to be honest, it happens quite often. Staff Q was asked to quantify the statement quite often, Staff Q stated, this is not the first time for sure. Inventory of Controlled Substances Books Observation of Hall A medication cart on 12/05/2022 at 12:47 PM with Staff Q showed two inventory of controlled substances books with missing signatures on the shift count sheet. The first controlled substance book labeled August 2022 showed staff did not sign the book for seven of 30 opportunities for the month of November 2022 and one of four opportunities for the month of December 2022. The second controlled substances book labeled September 2022 showed staff did not sign the book for eight of 30 opportunities for the month of November 2022 and one of four opportunities for the month of December 2022. Observation of Hall B-C medication cart on 12/05/2022 at 11:26 AM with Staff N showed one inventory of controlled substances book with missing signatures on the shift count sheet. The book showed staff did not sign for three of 30 opportunities for the month of November 2022. Observation of Hall D medication cart on 12/05/2022 at 12:12 PM with Staff C showed one inventory of controlled substances book with missing signatures on the shift count sheet. The book showed staff did not sign for six of 15 opportunities for the month of November 2022 and four of four opportunities for the month of December 2022. Two consecutive days in December 2022 (12/01/2022 and 12/02/2022) showed staff did not sign the book for all shifts. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/05/2022 at 12:55 PM, Staff Q validated they were accountable for the controlled substances during their shift. Staff Q stated it was important to sign the inventory of controlled substances book to ensure that the count received was correct. In an interview on 12/05/2022 at 12:18 PM, Staff C stated the expectation from staff was to sign the inventory of controlled substances books every shift per facility protocol. Staff C acknowledged multiple signatures were missing and stated, I cannot argue with that. Refer to F835 Administrtion. REFERENCE: WAC 388-97-1300(1)(a)(b)(i-ii)(c)(ii).

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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. 42203 Based on interview and record review, the facility failed to ensure resident's drug regimens were free from unnecesary psychotropic medications for 2 (Residents 32 & 49) of 5 residents and one supplemental resident (Resident 66) reviewed for unncessary medications The failure to obtain consent and review the risks and benefits of psychotropic medicaitons and failure to monitor for Adverse Side Effects (ASEs) left residents at risk for use of unnecessary psychotropic medications, adverse side effects and diminished quality of life. Findings included . 44296 Resident 49 According to the 11/17/2022 Admission Minimum Data Set (MDS, an assessment tool) Resident 49 had multiple medically complex diagnoses including depression and required the use of an antidepressant medication. Review of Resident 49's December 2022 Physician Order (PO) summary showed an order for an antianxiety (AA) medication dated 11/10/2022 for a diagnosis of anxiety. The November 2022 Medication Administration Record (MAR) showed Resident 49 started receiving the AA medication on 11/10/2022 and started receiving the antidepressant (AD) medication on 11/11/2022. Review of Resident 49's medical records showed the consent form for the AA medication use was completed on 12/06/2022, 26 days after Resident 49 started receiving the AA medication. The consent form for the AD was completed on 12/06/2022, 25 days after Resident 49 started receiving the AD medication. Resident 32 Similar findings for Resident 32 who was prescribed three AD medications and one AA medication, did not have timely consent forms signed and did not have medications and behaviors monitored or reviewed by an IDT team to determine ongoing need for these AD and AA medications. In an interview on 12/09/2022 at 2:33 PM, Staff B (Director of Nursing) when asked about psychoactive medication review, consents, and audits, Staff B stated consent forms are required to be signed prior to the psychotropic medication being administered. Staff B stated audits of psychotropic medications were not being completed and there was no IDT monthly reviews of residents using psychoactive medication. Resident 66 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 11/11/2022 Admissions MDS Resident 35 was cognitively intact. The MDS showed Resident 35 had diagnoses including a history of stroke, difficulty swallowing, and depression. Record review showed Resident 66 had a 11/26/2022 PO for an AD medication. The PO stated the AD medication was prescribed for for depression, appetite stimulant. Resident 66's Comprehensive Care Plan (CP) included an 11/18/2022 Antidepressant CP. This CP included an 11/18/2022 goal for Resident 66 to remain free from discomfort or adverse reactions related to antidepressant therapy . The CP did not identify which ASEs to monitor for the AD medication. Record review showed no documentation of monitoring for ASEs. Resident 32 Similar findings for Resident 32. The CP did not identify ASEs to monitor for the AD and AA medications and record review showed no documentation of monitoring for ASEs. In an interview on 12/12/2022 at 1:02 PM, Staff C stated the facility was not but should be monitoring for ASEs from the AD medication. REFERENCE: WAC 388-97-10603)(k)(i). 43642 46471

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 46471 Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than five percent (%). Failure of 1 of 3 nurses (Staff Q) to properly administer 3 of 26 medications for 1 of 8 residents (Resident 23) observed during medication pass resulted in a medication error rate of 11.54%. This failure placed residents at risk for adverse side effects due to improper medication administration. Findings included . Facility Policy The undated facility policy titled, Medication Administration, showed the licensed nurse and/or medication assistant would document administration of medication on the Medication Administration Record (MAR) as soon as medications were given. The policy instructed nursing staff to remove a dose from the back-up supply when medications were not available. Resident 23 Observation of the medication pass on 12/06/2022 at 9:28 AM showed Staff Q (Licensed Practical Nurse-LPN) prepare medications for Resident 23. Staff Q went to Resident 23's room, administered one type of eye drops, handed Resident 23 the medicine cup containing oral medications, and left the room. No other medications were administered to Resident 23. Review of the December 2022 MAR showed a second type of eye drop and a medication for constipation were to be administered to Resident 23 but were not given on 12/06/2022. The MAR showed Staff Q documented administration of a topical pain gel to Resident 23 but was not administered during medication pass. In an interview on 12/06/2022 at 9:32 AM, Staff Q was asked to recheck the availability of the second type of eye drops for Resident 23 in the medication cart. Staff Q found the second type of eye drops and stated the generic names of the two types of eye drops created the confusion. Staff Q stated the second type of eye drops was not administered during medication pass. In an interview on 12/06/2022 at 9:43 AM, Staff Q was asked about the documentation of administration of the pain medication gel noted in the MAR. Staff Q stated, I must have clicked it [pain medication gel] by accident. Staff Q confirmed the pain medication gel was not provided to Resident 23 and should have been during medication pass. In an interview on 12/07/2022 at 3:25 PM, Staff U (LPN) stated a bottle of the constipation medication was found at the back of the cabinet in the medication room. Staff Q acknowledged the constipation medication for Resident 23 was not administered during medication pass on 12/06/2022. REFERENCE: WAC 388-97-1060 (3)(k)(ii).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46471 Based on observation and interview, the facility failed to ensure expired medications, liquid feeding supplement, and medical supplies were disposed of timely in accordance with current accepted professional standards of practice for 1 of 1 medication room, 1 of 3 medication carts, and 1 of 2 emergency crash carts reviewed. These failures placed residents at risk for receiving compromised supplies and medications with decreased or no potency. Findings included . Medication Room Observation of the medication room on 12/02/2022 at 10:06 AM with Staff E (Registered Nurse-RN Unit Manager) showed five bottles of Iron supplement that expired 10/2022, five bottles of liquid feeding supplement that expired 12/01/2022, six anti-nausea suppositories that expired 10/2022, two boxes of alcohol swabs that expired 08/2022, nine swab collection tubes, two urinary catheters (tube that drains urine from the bladder) that expired 07/10/2021 and one urinary catheter that expired 10/11/2022. In an interview on 12/02/2022 at 10:33 AM, Staff E validated the dates of the expired medications, liquid feeding supplement, and medical supplies found. Staff E stated expired medications and supplies should not be kept in the medication room for resident safety. Medication Cart- Hall D Observation of the medication cart in Hall D on 12/05/2022 at 12:12 PM with Staff C (Licensed Practical Nurse-LPN Unit Manager) showed one bottle of pain reliever that expired 11/2022. In an interview on 12/05/2022 at 12:18 PM, Staff C confirmed the expired date and stated it should not be kept in the medication cart. Emergency Crash Cart- Dining Room Observation of the dining room emergency crash cart on 12/07/2022 at 8:45 AM showed one suction catheter (a device used to clear oral and nasal secretions) that expired 03/02/2022, one suction catheter tip that expired 10/28/2022, and one disposable syringe (a device used to draw liquid medications) that expired 07/31/2022. In an interview on 12/07/2022 at 9:07 AM, Staff C confirmed the dates of the expired supplies. Staff C stated the facility should check the crash cart every night to ensure no expired supplies were kept, but they did not. Medication Room Refrigerator (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Refrigerator Temperature Log form on 12/06/2022 on 3:25 PM with Staff E showed the refrigeration temperature should be kept at 41 degrees Fahrenheit (F) or below. Record review of the November 2022 medication room refrigerator log showed 19 of 60 opportunities the refrigeration temperature was 42 F and above. Record review of the December 2022 medication room refrigerator log showed 3 of 12 opportunities the refrigeration temperature was 42 F and above. In an interview with Staff C and Staff B (Director of Nursing) on 12/12/2022 at 1:05 PM, stated the temperature readings documented above 42 F on both the November 2022 and December 2022 refrigerator temperature logs were out of range. REFERENCE: WAC 388-97-1300(1)(b)(ii),(2). .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 43642 Based on interview and record review, the facility failed to obtain timely laboratory services to meet the needs of 3 (Residents 51, 49, and 32) of 5 residents reviewed for unnecessary medications. Failure to obtain physician ordered blood tests for residents who were assessed to require this service, placed residents at risk for delayed treatment and services. Findings included . Review of an undated facility Laboratory/Diagnostic Test Values- Monitoring policy showed the facility strived to ensure each resident's laboratory/diagnostic test order requested was ordered. This policy identified the daily nurse manager's responsibility was to ensure all scheduled labs were drawn and if a test was missed, make arrangements for the lab/diagnostic test to be completed that day or have it rescheduled. This policy stated the unit manager must notify the provider and Director of Nursing. Resident 51 According to the 10/06/2022 Admission Minimum Data Set (MDS - an assessment tool), Resident 51 had multiple medically complex diagnoses including malnutrition, diabetes, and a thyroid disorder. Review of November 2022 Medication Administration Records (MAR) showed Resident 51 had physician ordered medications for diabetes and the thyroid disorder. According to this MAR, a new order was added on 11/16/2022 for staff to obtain lab work including a CBC (Complete Blood Count - a comprehensive blood test), CMP (Comprehensive Metabolic Panel - a comprehensive blood test), TSH (Thyroid Stimulating Hormone - a test to determine thyroid function), and Hemoglobin A1C (a test that reflects long term blood sugar levels). Record review showed these labs were not drawn in November 2022 as ordered. According to a provider note on 12/01/2022, As of today still no labs as ordered. Recommend this be evaluated. Review of Resident 51's physician orders (POs) showed new orders on 12/01/2022 for CMP, CBC, TSH, Hgb [Hemoglobin] A1C .Have been ordered 2x [two times] already and no results. Please do today . Record review showed these labs were not drawn until 12/05/2022, five days after the 12/01/2022 order and 19 days after originally ordered by the provider on 11/16/2022. According to the 12/05/2022 lab results, the TSH was not performed due to not having enough of a blood sample and the facility staff were notified. On 12/07/2022 new orders were given to obtain a Hemoglobin A1C and TSH. The physician order was not signed as completed by staff until 12/08/2022 (21 days after originally ordered by the provider on 11/16/2022). In an interview on 12/07/2022 at 1:04 PM, Resident 51 was talking with staff about their lab work and stated, I'm kinda worried about my thyroid, so I'm glad they are checking it. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/2022 at 8:16 AM, Staff C (Licensed Practical Nurse - Unit Manager) stated their expectations were for staff to follow physician orders and ensure lab work was completed as ordered. Staff C stated lab work was important so staff and providers could monitor residents' lab values and make changes as needed to their care. 46471 Resident 49 The 11/17/2022 Admission MDS showed Resident 49 had multiple medically complex diagnoses including chronic lung disease, a heart problem, and diabetes. Review of the November 2022 MAR showed three POs for staff to obtain lab work for Resident 49, including a CMP and CBC. Review of November 2022 MARs showed lab work was not signed as completed by staff. The MAR showed four opportunities (11/17/2022, 11/18/2022, 11/21/2022, and 11/28/2022) where lab work was scheduled, but not obtained. According to the 12/02/2022 provider note, CMP, CBC order for 11/21 [2022], STILL pending. REORDERED AGAIN for 11/28 [2022] and is still pending today. In an interview on 12/12/2022 at 8:16 AM, Staff C stated the expectation was for staff to follow physician orders and ensure lab work was completed as ordered. Staff C was asked if the facility had documentation of Resident 49's lab work results. Staff C stated they would look into Resident 49's medical records. No further information was provided by Staff C. 44296 Resident 32 Record review showed a 07/24/2022 PO for lab services including a CBC, CMP, Hgb A1C, Vitamin D and Lipid panel for Resident 32. Record review showed no lab results from the 07/24/2022 physician order. In an interview on 12/09/2022 at 2:33 PM, Staff B (Director of Nursing) confirmed the lab results were not in the record. Staff B stated nurses were expected to order labs according to physician orders, receive the lab results, report to the physician and document actions in the record. Staff B stated there was not a system to reconcile orders with lab services and receipt of lab results with report to the physician. Staff B stated a system needed to be implemented. REFERENCE: WAC 388-97-1620 (2)(b)(i).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interviews, and record review the facility failed to ensure 1 of 6 residents (Resident 45) reviewed for dental services was assisted in obtaining emergent dental care. The facility's failure to follow through with the resident's request for outside emergent dental care, failure to follow a hospital transfer order for dental services follow-up, failure to follow up on two separate dental exam recommendations for emergent dental care placed resident at risk for an oral infection, hospitalization , pain, and diminished quality of life. Findings included . According to the undated facility dental policy, when residents require emergency dental service for acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; any problem requiring the immediate attention of a dentist, the facility would schedule an appointment and arrange transportation. Resident 45 According to the 11/12/2022 5 Day Minimum Data Set (MDS, an assessment tool) Resident 45 had their own natural teeth and had obvious or likely cavities and broken or natural teeth. The MDS history of the dental assessment showed this was also identified on five previous assessments (07/07/2021, 09/16/2021, 12/17/2021, 03/19/2022, and 06/19/2022). The CP showed no focus problems for dental concerns and no interventions for dental problems. A 12/13/2021 social services note showed Resident 45 last saw dental services on 08/21/2021 and a six month follow up was recommended. According to the 12/13/2021 social services note, Resident 45 requested to see the dentist and the writer said, will add to dental list. A 01/24/2022 nurse communication note showed nursing notified the physician of Resident 45's complaints of tongue swelling and mouth pain. The provider was notified, and the resident was ordered treatment for an oral yeast infection. In a 11/30/2022 11:10 AM interview, Resident 45 said the doctor came to see her when her mouth was hurting, and her tooth had been hurting for several weeks. Resident 45 said the doctor ordered a medication for an oral yeast infection and the resident said they told the provider, Are you kidding me? What about my bad tooth?. Resident 45 said they felt the provider was not listening to them and they were concerned they were not getting the care they needed. On 02/11/2022, Resident 45 was seen by the in-house denture specialist. The exam notes showed Resident 45 had red and irritated gum tissue. There was no evidence the facility followed up on the abnormal exam. A 02/19/2022 nursing progress note showed Resident 45 had complaints of weakness, dizziness, and felt shaky. The nurse stated the right side of Resident 45's face was swollen. The Provider was notified and according to a 02/19/2022 provider note (an eight-minute non-face-to-face visit via phone call) showed Resident 45 had right facial edema, acute pain of their right face/cheek, and swollen lymph nodes (an indication of infection). There were no new order changes. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 02/21/2022 health status note, on 02/20/2022 Resident 45 had worsening weakness, began to have respiratory complications, and increased confusion, so the nursing staff sent the resident to the hospital. Resident 45 was admitted for an abscess (confined pocket of pus usually due to an infection) of the mouth and right cheek. According to the 02/21/2022 hospital provider notes, Resident 45 went to the emergency department with a temperature of 101.9 and had elevated white blood cell count indicating infection. A scan of Resident 45's head and neck showed soft tissue swelling of their right face which extended down their neck. Resident 45's kidney function was abnormal, and their potassium level was high. Resident 45 was admitted to the hospital and required intravenous antibiotics, fluids, and medication changes stabilize their kidney function and treat the infection of the infection. A 02/25/2022 operative report showed Resident 45 required a surgical procedure to have the abscess of their right face drained. A drain was attached to Resident 45's face after surgery to allow the abscess to continue to drain and heal. Record review showed Resident 45 was transferred back to the facility on [DATE]. According to the 03/01/2022 facility transfer discharge orders; Resident 45 was referred to the Ear-Nose-Throat (ENT) specialist and the Dentist. A 03/08/2022 Registered Dental hygienist cleaning visit note showed Resident 45 was examined and their teeth were cleaned. The hygienist checked the box that said, Refer to Dentist and wrote the resident requests to see the Dentist to evaluate #32 fractured tooth for treatment options. Has a large lesion on it too. Finished antibiotics yesterday for right side abscess - monitor healing. A 09/14/2022 Registered Dental hygienist cleaning visit note showed Refer to Dentist for a large hole inside one of their teeth causing nerve pain and follow up for the lower right lesion and abscess noted in their 03/08/2022 visit. They would like to have it evaluated soon by outside dental. Between 12/13/2021 and 11/30/2022, the facility failed to obtain a dentist appointment for Resident 45 after resident request, the hospital physician referral for Dentist, and two separate dental hygienist exam recommendations. In an interview on 11/30/2022 at 11:10 AM, Resident 45 stated they had their own natural teeth, and they have lots of problems with them. Resident 45 stated they saw a dental hygienist a couple of times at the facility for cleaning, but that is all they were allowed to do. I have asked to see the dentist, but it has not happened yet. I am from Seattle, and I just don't know where to start to find a dentist in this area. Resident 45 said the facility did not help with setting up a dentist appointment. Resident 45 said they had to go to the hospital in February of 2022 because they had a horrible oral and cheek infection that went from their gum to their whole right cheek. Resident 45 said they had been asking to see the dentist since sometime in December of 2021 and now it has been almost a year, and I (Resident 45) still have not seen the dentist. In an interview on 12/06/2022 at 1:33 PM, Staff L (Social Services Assistant) stated they managed the routine dental exams in the facility and when there are recommendations / requests for dentist needs, Staff JJ (Certified Nursing Assistant) handled the appointment setting and transportation. Staff L stated they are notified by verbal notifications, written on exams, and orders. Staff L stated an acceptable timeframe for getting an emergent dental visit scheduled and for the resident to attend would be a couple weeks. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/2022 at 3:12 PM, Staff JJ (Certified Nursing Assistant responsible for transportation and appointments), stated they took over the transportation responsibility several months ago. Staff JJ stated they were recently made aware of Resident 45's request to see a dentist. Staff JJ stated Resident 45 had an appointment scheduled. Staff JJ stated they were not notified of any out-lying appointments that had not been finished when they took over the duties. Staff JJ had a system that provided adequate communication and tracking of appointments on a computer system that management had access to. Staff JJ stated it was important for residents to make it to their appointments, so their care needs were met to prevent bad outcomes. REFERENCE WAC: 388-97-1060 (3)(j)(vii).

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45941 Based on observation, interview, and record review the facility failed to provide foods according to the resident's preferences for 1 of 2 (Resident 52) residents reviewed for food preferences. The failure to accommodate a resident's religious dietary preferences placed residents at risk for inadequate nutrition and well-being. Findings included . Resident 52 According to the 11/08/2022 Quarterly Minimum Data Set (MDS, an assessment tool), Resident 52 readmitted to the facility on [DATE], was assessed as cognitively intact, able to make themselves understood and understood others. The MDS showed Resident 52 was able to participate by answering questions and making decisions about their care. The MDS showed it was very important to Resident 52 to have snacks available between meals. In an interview on 11/30/2022 at 9:10 AM, Resident 52 stated they did not get to make choices about food. Resident 52 stated they did not eat pork or beef according to their religion but the facility kept serving them bacon with breakfast. Resident 52 stated they told the staff multiple times, but no change happened, and they had to ask their family to bring food from home. In an interview on 12/05/2022 at 1:11 PM, Staff C (Licensed Practical Nurse, LPN Unit Manager) stated the dining system for managing resident dietary needs and preferences did not show Resident 52's pork and beef religious restrictions. In an interview on 12/06/2022 at 10:09 AM, Staff NN (Registered Dietitian - RD) stated they were not able to locate any documentation about Resident 52's religious food preferences in the resident's record. Staff NN stated the facility should have obtained the religious dietary preferences and put the information in the kitchen's diet orders and on the CP. REFERENCE: WAC 388-97-1100(1). 44296

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46472 Based on observation, interview, and record review the facility failed to ensure food was prepared according to the required menu for modified food textures and thickened liquid consistencies and as ordered by the physician for 3 of 3 (Residents 42, 40, & 66) residents. This failure placed 27 total residents assessed to require altered food textures and/or thickened liquid consistencies, for safe swallowing, at risk for choking while eating, aspiration (inhalation of food/fluids into the lungs), pneumonia, and/or death. CFR 483.60 (c)(3)(5)(6) F-803 Menus meet Resident Needs/Prep in Advance/Followed. On 12/08/2022 at 5:31 PM, an Immediate Jeopardy was identified, and the Administrator was informed. On 12/09/2022 the immediacy was removed. The facility completed speech therapy swallowing screens of residents, reviewed and corrected breakout menus, updated recipes for altered textures, completed a crosswalk for dietary and facility diet types, reviewed resident diet orders and compared with the tray ticket system and care plans, educated dietary and nursing staff, and completed audits on the delivery of altered texture foods to the 27 residents. Findings included . Resident 42 According to the 09/06/2022 admission MDS (Minimum Data Set - an assessment) Resident 42 did not have a swallowing problem and was on a regular diet and thin liquids. The resident was assessed to require assistance with eating. The 09/26/2022 care plan (CP) showed Resident 42 required assistance for set up but could eat independently. According to a 09/14/2022 nursing progress note, Resident 42 choked (blocking of airway to prevent breathing) on a hotdog and required abdominal thrusts (a life-saving emergency procedure to remove an obstruction from a person's airway). Resident 42 was sent to the hospital, and treated for aspiration pneumonia (lung infection from inhaling food into lungs). The resident was newly diagnosed with a decline in their ability to chew and swallow, and discharged back to the facility on [DATE]. The resident's 09/26/2022 Physician Orders (PO) included a speech therapy evaluation for swallowing, a mechanically altered diet, thickened liquids, and one-to-one feeding assistance/supervision. Review of the December 2022 POs showed Resident 42's diet texture order was dysphagia (altered texture of foods and liquids that make swallowing safer) mechanical soft diet and nectar thick liquids. The 12/08/2022 lunch menu for dysphagia mechanical soft texture showed: ground sweet and sour pork (no pineapple), seasoned cream of rice, ground green beans, and a pureed roll. Residents who were on nectar thick liquids were designated a cup of nectar thick orange juice. Observation of the tray line on 12/08/2022 at 12:00 PM, showed Staff O (Cook) placed chopped broccoli on the plate for Resident 42. The tray ticket for Resident 42 showed ground green beans, dysphagia mechanical diet, nectar thick liquids. (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a 12/08/2022 12:23 PM observation, Staff S (Certified Nursing Assistant) served Resident 42 their lunch tray. After setting the resident up at the edge of the bed, they did not remove the cover from the plate to observe what was being served or if the food matched the diet order on the tray ticket. Staff S left the room. On 12/08/2022 at 12:24 PM Resident 42 removed the cover from the plate where chopped broccoli was observed. The tray included a cup of thin milk and a bowl of un-chopped mandarin orange slices. On 12/08/2022 12:27 PM, Staff Q, LPN (Licensed Practical Nurse) in an interview, confirmed the chopped broccoli and thin milk was not the correct diet texture, removed them both from the tray, and took them to the kitchen for correction. An observation on 12/08/2022 at 12:32 PM showed Staff Q was provided nectar thickened milk, minced broccoli, and pureed orange slices from the kitchen staff, and delivered to Resident 42. Observation on 12/08/2022 at 12:39 PM showed Staff Q returned to Resident 42 who was found with a coffee mug of thin cocoa. Staff Q removed the thin cocoa and gave Resident 42 the correct broccoli, correct milk, and pureed oranges. Resident 42 began to consume the pureed oranges. Staff Q left the room, during ongoing observation no other staff provided one-to-one supervision for the meal as listed as an intervention on the CP. At 1:16 PM Staff Q reported that Staff S brought the thin cocoa to Resident 42. During a 12/08/2022 at 1:23 PM interview, Staff T (Licensed Speech Therapist) confirmed Resident 42's prescribed diet was dysphagia mechanical soft, nectar thick liquids, and supervision was required using strict precautions to prevent aspiration/choking. Staff T stated the only time it was safe for Resident 42 to consume thin liquids was during their speech treatment with the speech therapist. Staff T looked at the consistency of the chopped broccoli that was served to Resident 42 and stated the chopped broccoli pieces were not an appropriate substitution for ground green beans or a dysphagia mechanical soft diet. Staff T stated pureed mandarin oranges were not appropriate for Resident 42 because the consistency would be too thin for the resident to safely consume due to their swallow problem. Staff T said they would expect staff to supervise Resident 42 while eating as they would for any resident on altered texture diets due to chewing / swallowing problems. Staff T said the risk of not receiving the prescribed diet texture or liquid consistency placed the resident at risk for aspiration of food/fluids into the lungs and/or choking again. In a 12/08/2022 at 1:53 PM interview, Staff S stated they did not look at the tray ticket and compare it to the food on the plate when serving Resident 42. Staff S stated it was important that the resident received the diet ordered by the physician because they could choke and die if not served the correct diet. On 12/08/2022 at 4:15 PM Resident 42 said that sometimes they are served thin milk, cocoa, and coffee and sometimes it is thickened. They just drink drank what they were served. 44296 Resident 40 (continued on next page)

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F 0803 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 08/12/2022 PO showed Resident 40 was prescribed a regular diet with dysphagia mechanical soft texture, and nectar thick consistency fluids. The PO showed Resident 40 required implementation of standard aspiration precautions by staff to supervise size of bites, pace of eating, and alternating solids and liquids. Observation of the tray line on 12/08/2022 at 12:08 PM, showed Staff O placed chopped broccoli on the plate for Resident 40. The tray ticket for Resident 40 showed ground green beans, dysphagia mechanical diet, nectar thick liquids. Observation on 12/08/2022 at 12:21 PM showed Resident 40 sitting in bed with the head of bed at 30 degrees. The tray table was in front of the resident. The plate of food showed broccoli cut into one-inch pieces. Resident 40 was poking at the broccoli with the fork. No staff was observed in the room with Resident 40 while they were eating as directed in the CP. Resident 66 The 11/08/2022 PO showed Resident 66 was prescribed a regular diet with dysphagia advanced texture and thin consistency fluids. Resident 66's PO required supervision eating in the dining room to assist with aspiration precautions. Observation of the tray line on 12/08/2022 at 11:57 AM, showed Staff O (Cook) placed chopped broccoli on the plate for Resident 66. The tray ticket for Resident 66 showed ground green beans and dysphagia mechanical diet. In an interview on 12/08/2022 at 12:27 PM, Staff Q stated the chopped broccoli was not the correct texture for a dysphagia mechanical diet. Staff Q stated it should not be served to residents with swallowing problems due to risk of choking. Observation and interview during the tray line on 12/08/2022 at 12:10 PM showed Staff O began plating food for the room tray carts. Review of the 12/08/2022 menu for the lunch meal showed green beans as the vegetable of the day. When asked about the chopped broccoli instead of the green beans, Staff O stated, We don't have any [green beans]. Staff EE (Dietary Manager) was present and when asked if the broccoli was the right texture, Staff EE stated, Yeah. In an interview on 12/08/2022 at 1:27 PM, Staff T (Licensed Speech Therapist) looked at the chopped broccoli and stated it was not an appropriate substitution for ground green beans on the menu. Staff T stated the chopped broccoli was not the correct texture for a dysphagia mechanical diet and the broccoli should be minced into small pieces. Staff T confirmed Residents 42, 40 and 66 were assessed to require altered textured food and/or liquids. Staff T stated residents with swallowing problems are at high risk for choking if served the incorrect diet textures. REFERENCE: WAC 388-97-1160(1)(a)(b)(c)(iii-iv), -1180(1), -1200(1)(2). 42203

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure food was stored, prepared and served in a sanitary manner and in accordance to professional standards for food service safety. The failure to ensure food: had cold storage temperature was maintained at or below 41 degrees; was stored in a clean refrigerator, was free of expired, unlabeled and undated food products for one of one unit refrigerators; failure to ensure staff performed adequate hand hygiene during food preparation and food service; and ensure food was prepared in a kitchen free of potential food contamination placed residents at risk for food-borne illness and unsavory food. Findings included . Facility Policy According to the facility's revised [DATE] Handwashing/Hand Hygiene policy, facility staff should perform Hand Hygiene (HH) using Alcohol Based Hand Rub (ABHR - hand sanitizer) before and after direct contact with residents. The policy showed staff should perform HH after contact with objects in the immediate vicinity of residents, and before and after handling food. Meal Service Observations Observation of breakfast service on [DATE] showed the following: At 8:29 AM Staff OO (Certified Nursing Assistant - CNA) removed a dirty tray from room [ROOM NUMBER], placed the tray on the cart, and entered room [ROOM NUMBER] without performing HH. The ABHR dispenser on the wall was noted to be broken. At 8:35 AM Staff OO was observed returning a dirty breakfast tray to the cart. Staff OO then entered room [ROOM NUMBER] without performing HH. Staff OO left room [ROOM NUMBER] with another dirty tray and entered room [ROOM NUMBER] without performing HH. Staff OO removed a dirty tray from room [ROOM NUMBER], placed the tray on the cart and reentered room [ROOM NUMBER]. Observation during lunch service on [DATE] at 11:50 AM in the dining room showed Staff Y (CNA) exit from a resident's room to the dining room with a dirty tray. Staff Y placed the dirty tray in the cart, and grabbed a clean meal tray for another resident without performing HH. At 11:59 AM Staff Y was observed bringing a dirty tray from a resident room to the cart in the dining room. Staff Y did not perform HH after placing the tray on the cart before taking Resident 20 their tray. At 12:00 PM Staff PP (CNA) was observed to exit room [ROOM NUMBER] without performing HH, before taking a tray from the cart to room [ROOM NUMBER]. Staff PP then adjusted a resident's bed using the bed controller and helped the resident sit up with the assistance of an unidentified staff member. Staff PP left room [ROOM NUMBER] and, without performing HH, took a lunch tray to room [ROOM NUMBER]. At 12:06 PM in the dining room, Staff X (CNA) was observed to rub their eye while feeding a resident. After rubbing their eye Staff X continued feeding the resident without performing HH. At 12:11 PM, an unidentified CNA was observed setting up a lunch tray for a resident on the over-the-bed table. The CNA left room [ROOM NUMBER] without performing HH, took another tray from the cart and entered room [ROOM NUMBER]. At 12:14 PM Staff X was observed feeding Resident 19 in the dining room. Staff X repositioned Resident 19 and continued to provide feeding assistance without performing HH. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Kitchen Observations On [DATE] at 2:10 PM, Staff QQ (Dietary Aide/Dishwasher) was observed washing dishes without wearing a hairnet. In an interview at that time, Staff EE (Dietary Manager) stated dietary staff must wear a hairnet when in the kitchen. During kitchen observations on [DATE] at 10:45 AM, two window fans located over 12 feet in height on opposite sides of the window were noted to be covered in dust and cobwebs. On [DATE] at 11:26 AM, dust was noted to have accumulated on the wall behind refrigerator 6. Streaks of dust stretched up the wall behind the fridge, extending above the height of the fridge by at least one foot. Similar accumulations of dust were noted behind Refrigerators 3 and 4 at that time. In an interview on [DATE] at 10:53 AM, Staff EE stated the fans in the kitchen needed cleaning. Staff EE stated the fans probably were not cleaned since the summer and stated the dust on the fans had the potential to contaminate the food prepared in the kitchen. In an interview on [DATE] at 11:27 AM, Staff EE stated the walls behind the refrigerators were not clean. Staff EE stated cleaning behind the refrigerators was the responsibility of the maintenance department, and the maintenance department experienced a lot of turnover recently. Staff EE stated the dust behind the refrigerators had the potential to contaminate food. 45941 46472 Unit Refrigerator A [DATE] 8:03 AM observation of the refrigerator (fridge) at the nurse's station showed the inside was unclean with dried debris on the bottom of the fridge. The thermometer showed the fridge temperature was 42 degrees. There was no temperature log observed on or near the fridge. Inside the fridge were two pints of sour cream that both had expired use by dates, were not dated when opened, and did not have names on them indicating who they belonged to; a large opened bottle of coffee creamer with no open date, no name, and had an expired used by date; a container of fast food with potatoes that had green mold on them visibly seen through the lid of the container, unlabeled and undated; an uncovered clear plastic cup with molding and rotting green grapes; a clear plastic dietary bin with a sticky note on it that said ,d+[DATE] and undated sandwiches and re-packaged pudding cups with lids, not dated with the repackage date; a container of what appeared to be egg salad with a resident's name on a piece of tape and a date from [DATE]. On [DATE] at 8:28 AM Staff E (Registered Nurse Charge Unit Manager), stated housekeeping was responsible for cleaning the fridge and temperature monitoring. They were unsure where the temperature log was kept. An observation on [DATE] at 9:53 AM, the nurse's station refrigerator temperature showed 42 degrees. The refrigerator contained the same contents as observed on [DATE], except the clear plastic bin from the dietary department was removed, and there was a new fast food container with no name or date on it. (continued on next page)

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North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A [DATE] 10:32 AM observation showed the refrigerator temperature was 42 degrees and the fridge had the same contents as observed on [DATE]. A [DATE] 8:59 AM observation showed the refrigerator temperature at 42 degrees and contained the same items observed on [DATE] and [DATE], with the addition of soda cans labeled with a resident's name. In a [DATE] 9:00 AM interview, Staff SS (Housekeeping Manager), stated housekeeping was not responsible for cleaning the fridge or checking the daily temperature and did not know who was. In a [DATE] 9:04 AM interview, Staff TT (Corporate Nurse), confirmed the fridge temp was 42 degrees which was not cold enough, was unclean, the moldy potatoes and rotting grape should have been labeled with the person who they belonged to, dated, and removed from the fridge after 5 days, but were not. Staff TT confirmed the unlabeled and expired food products should have been removed but were not. Staff TT was unsure which department the facility designated responsible for cleaning the fridge, temperature monitoring, and documenting daily on a temperature log, but would find out. REFERENCE: WAC [DATE] (3), -2980.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview, and record review the facility administration failed to act swiftly and effectively to ensure the Emergency Exit (EE) doors were operable and in compliance with federal regulatory requirements. The failure to prioritize the life safety component of repairing the EE doors when found locked and inaccessible in emergent situations placed residents' health and safety at risk for serious harm including death and resulted in Immediate Jeopardy (IJ) on 12/01/2021. Administration failed to ensure supplies, including linens, wound care supplies, and over-the-counter medications were available to staff to provide care in a clean and comfortable manner and according to physician orders. This failure led to residents having inadequate linens on the beds, medication errors and alternate wound treatments. Administration failed to ensure an ongoing Quality Assurance and Performance Improvement (QAPI) program existed, was comprehensive, and sustainable through changes in facility management. This failure of administration detracted from the facility's responsibility to ensure quality care was provided to residents, identify areas for improvement and implement performance improvement plans to meet federal and state regulation compliance which placed residents at risk for decreased quality of care. CFR 483.70 Administration, F-835: A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. On 12/01/2022 at 4:55 PM, the Administrator was informed of an Immediate Jeopardy identified related to two locked, non-functioning EE doors. On 12/02/2022 the immediacy was removed. The facility unlocked the EE doors and installed magnetic door alarms to both doors. The EE doors remained disconnected from the fire alarm system when the immediacy was removed on 12/01/2022. Findings included . Emergency Exit Doors During a life safety inspection on 12/01/2022 from 8:45 AM to 9:50 AM, a [NAME] State Fire Marshal identified the two EE doors (door 2 and 3) on the east side of the building did not function as required. The Fire Marshal determined the EE doors were locked and could not be opened, which prevented residents and staff from exiting the facility in an emergency. The Fire Marshal found the EE doors were not connected to the fire alarm system and the keypad controllers which connected the doors to the fire alarm system were not functioning. The Fire Marshal called an IJ in Life Safety for K-222; the facility failed to maintain egress doors free of locks or latches requiring special knowledge or equipment. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 12/01/2022 at 12:10 PM with the Fire Marshal present, Staff A (Administrator) stated they discovered the two east hallway EE doors did not open during a building walk through last Friday (11/25/2022). Staff A stated they asked maintenance to repair the doors. Staff A stated they did not follow up with maintenance to ensure the two EE doors were repaired and functional. Staff A did not know how long the doors were locked but did acknowledge they were locked from 11/25/2022 to 12/01/2022, seven days. In an interview on 12/01/2022 at 3:13 PM Staff FF (Regional Maintenance Director) stated they were unsure why or when Staff I (Maintenance Assistant) disabled and locked the doors Staff FF stated the EE doors should never be locked. A 2022 12-month work order history log showed Staff I completed a test of the doors, locks, and alarms on 11/08/2022. The 11/08/2022 work order showed Emergency doors are not operational due to code alarm issues. The Director has been notified. In an interview on 12/12/2022 at 4:03 PM, Staff A stated they did not know Staff I had locked the doors. Staff A stated they interviewed Staff I and received information that Staff I locked the doors because the alarm kept going off and kept being set off. According to Staff A, Staff I also stated the keypad stopped working. Staff A acknowledged the work order history log which showed Staff I reported the non-functioning doors to a director on 11/08/2022. Staff A stated no staff reported the non-functioning door to them. Wound Supplies Observations on 11/30/2022 at 09:10 AM, 12/01/2022 at 11:02 AM, 12/02/2022 at 3:11 PM showed Resident 6 had a wound vacuum (equipment used for wound healing) in place on a sacral (lower back) wound. On 12/05/2022 at 10:07 AM Resident 6 was observed with no wound vacuum on their sacral wound. During an observation on 12/06/2022 at 10:46 AM, the wound team completed a wound assessment and treatment with Resident 6 and did not apply a wound vacuum. In an interview on 12/06/2022 at 10:49 AM, the wound care provider stated Resident 6 needed the wound vacuum and they did not know why the wound vacuum was not available from the facility. In an interview on 12/06/2022 at 1:37 PM, Staff C (Licensed Practical Nurse, LPN Unit Manager) stated Resident 6 required the wound vacuum treatment, but the facility ran out of the canisters for the wound vacuum. Staff C stated the wound vacuum treatment was discontinued because of no supplies. Staff C stated they notified the Administrator there were no more canisters last week on Friday (12/02/2022). Staff C stated there were no canisters ordered, and the wound care provider had to change the treatment orders until the supplies were received. In an interview on 12/12/2022 at 2:33 PM, Staff B (Director of Nursing - DNS) stated they were not informed of the wound vacuum treatment change or the canisters being out of supply. Staff B stated the supplies should always be available for the wound vacuum and should not run out. Staff B stated the Administrator oversees supply ordering. In an interview on 12/12/2022 at 3:46 PM, Staff A stated a nurse reported the canisters were out on Monday (12/05/2022) and they were ordered. Staff A stated a shipment was received on 12/12/2022, but Staff A did not know if the canisters were received in the shipment. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Linens During an interview on 11/30/2022 at 8:53 AM Staff Y (Certified Nursing Assistant) stated the facility did not have enough fitted sheets and they told management for months there were not enough sheets. Observation at that time, of the linen carts, source of available linens to the caregivers, showed two of four linen carts had no sheets and one linen cart had four flat sheets. Observations on 11/30/2022 from 8:10 AM to 11:06 AM showed five residents (Residents 21, 33, 28, 8, & 55) lying on a bare mattress without any sheets. Observations on 12/06/2022 from 10:03 AM to 10:32 AM showed eight residents (Rooms 3, 6, 43, & 20) were lying on flat sheets instead of fitted sheets. In an interview on 12/05/2022 at 12:11 PM, Staff MM (Laundry Assistant) stated the facility did not have an adequate supply of fitted sheets. Staff MM showed the facility logs, dated August thru December 2022, documenting dates of when sheets were discarded due to holes, rips, and tares. Staff MM stated the facility had a new contracted laundry provider and the facility had not purchased linens in three months. In an interview on 12/12/2022 at 3:46 PM, when asked about the frequency of ordering sheets and other linens, Staff A stated the caregivers took all the linen and stored it in the resident rooms so there was none on the carts. Staff A stated there was plenty of linens if staff did not hide them. Staff A stated an order was placed and should be delivered soon. Staff A confirmed residents should have fitted sheets in good repair on the bed for comfort, dignity, and safety. Over-the-Counter Medications Review of November and December 2022 Medication Administration Records for seven sampled Residents (2, 42, 49, 4, 51, 65, & 32) showed Lidocaine (for pain) patches were not given consistently between November 1 thru December 10. Review of the resident progress notes for the dates a patch was not administered revealed the facility had no Lidocaine patches. In a medication pass observation and interview on 12/06/2022 at 09:28 AM, Staff Q (Licensed Practical Nurse) stated they were not able to administer two over the counter supplements because the facility supply was out. Staff Q stated if the medication was not on the cart, then the nurse checked the medication room, then went from cart to cart to see if there was any supply to give the resident. Staff Q stated the facility ran out of medications quite often, when asked to define quite often, Staff Q stated, this is not the first time. In an interview on 12/12/2022 at 2:33 PM, Staff B stated when they were informed about one of the over-the-counter medications being out of supply, a staff person was sent out to buy some from the local store. Staff B was not aware of the other supplement or the Lidocaine patches being out of stock. Staff B stated the nurses just need to ask for supplies or put a note under the DNS office door and the supplies would be ordered. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	In an interview on 12/12/2022 at 3:46 PM, Staff A described a par level system for ordering supplies and stated the staff responsible had been trained but was not keeping items in supply. Staff A stated they were not informed of being out of Lidocaine patches or other over the counter meds. Staff A stated there was an order form staff had to fill out to request supplies. Staff A was aware that prior to September orders were canceled by the corporate office but they had not been canceled since Staff A was doing the ordering. Quality Assurance Performance Improvement Program (QAPI) In an interview on 12/12/2022 at 3:46 PM Staff A stated since starting employment in September 2022 they held two monthly QA meetings on 09/29/2022 and 10/30/2022. Staff A stated in September 2022 the QA team discussed psychotropic drugs, survey readiness, recent citations, weight loss/gain and nursing documentation of showers. In October 2022 the QA team discussed administrative, pharmacy, Minimum Data Set assessments, business office items, ancillary items, staffing and nursing call lights, competency, citations, and discharges against medical advice. When asked if the QA team had any PIP's (Performance Improvement Plans) in place for identified areas, Staff A stated, No. When asked about QAPI documents or PIPs implemented prior to September 2022, Staff A stated there were no documents from any prior monthly or quarterly QAPI committee meetings. When asked if the Administrator was trained to facility and corporation policies and procedures, systems and expectations, Staff A stated they were not provided any training about the facility QAPI processes from the corporate staff or provided information on any current PIPs in place from prior administration. Refer to 689 Free of Accident Hazards/Supervision/Devices Refer to 584 Safe/Clean/Comfortable Homelike Environment Refer to 755 Pharmacy Services Refer to 736 Governing Body REFERENCE: WAC-388-97-1620(1). 42203

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46471 Based on interview and record review, the facility failed to identify a designated interdisciplinary team member appointed as the responsible party for coordinating care and communication with hospice services, and to ensure the development of a coordinated plan of care for 1 of 1 residents (Resident 27) reviewed for hospice care services. These failures placed the resident at risk for not receiving necessary hospice services, lack of continuity of care, and unmet care needs. Findings included . Facility Policy The undated facility policy titled, Hospice Residents- Admission and Discharge of and Care and Treatment Provided to, showed the Center would designate a Registered Nurse (RN) from the interdisciplinary team to be responsible for working with hospice representatives in coordinating care for hospice residents receiving facility and hospice services. The policy showed Hospice and the Center would jointly develop and agree upon a coordinated plan of care and the description of the services furnished by the Center to attain or maintain the hospice resident's highest practicable, physical, mental, and psychosocial well-being. The policy showed the facility would obtain the Physician Certification of Terminal Illness (CTI) and the names and contact information for hospice personnel involved in hospice care for each hospice resident. Resident 27 According to the [DATE] Hospice Notice of Election of Benefit/Consent Form, Resident 27's hospice start of care date was [DATE]. Review of Resident 27's hospice documentation did not show Resident 27's CTI. Review of Resident 27's medical records did not show a designated RN by the facility to be responsible for coordinating care and communicating with hospice services. In an interview on [DATE] at 5:07 PM, Staff C (Licensed Practical Nurse- LPN Unit Manager) stated they were instructed by Staff A (Executive Director) to direct all hospice services questions to Staff G (Business Office Manager- BOM), who was not a registered nurse. In an interview on [DATE] at 5:18 PM, Staff G was asked if the facility had or obtained a copy of Resident 27's CTI from the hospice provider. Staff G stated they did not have Resident 27's CTI but would inquire about the matter from Resident 27's hospice provider. Staff G was asked about the facility's hospice designee for care and services collaboration for Resident 27. Staff G stated, Honestly, I do not know. Staff G was asked if they had any written documentation that indicated the facility had designated a member from the interdisciplinary team, Staff G stated, No, I do not. Record review of the [DATE] Hospice Plan of Care information showed Resident 27 was admitted to hospice services due to complex medical diagnoses including a severe heart condition. The hospice plan listed Resident 27's care and service needs, but the plan showed no information available regarding the hospice interdisciplinary group members. The undated How and When to Call Hospice communication form was entirely blank. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [DATE] Care Plan (CP) showed the facility initiated a hospice care plan on [DATE], 35 days after Resident 27's hospice start of care on [DATE]. The CP goal target date [DATE] was expired. The CP did not show a coordinated plan that addressed Resident 27's pain needs. The CP did not identify the facility's designated person responsible for coordinating care and services with hospice. In an interview on [DATE] at 11:01 AM, Staff G stated, I do not even really know what to show you. Staff G acknowledged the review of Resident 27's medical records did not show any coordinated plan of care with hospice. REFERENCE: WAC [DATE] (1).

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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** 45941 Based on observation, interview, and record review the facility failed to establish and maintain infection control practices that provide a safe and sanitary environment to help prevent the transmission of communicable diseases. The facility failed to ensure the availability of hand sanitizer, and failed to ensure staff: performed hand hygiene during medication administration, and performed wound care without wearing gloves in accordance with the Centers for Disease Control (CDC) recommendations. These failures placed residents at risk for the development and transmission of communicable disease and infections. Findings included . The facility's Infection Prevention and Control Program (IPCP) policy revised in October 2018 showed that IPCP was established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Hand Hygiene The facility policy Handwashing/Hand Hygiene revised in August 2019 showed that staff were required to perform hand hygiene before and after direct contact with residents, before preparing and handling medications, after contact with medical equipment, Before and after entering the isolation precautions settings, before and after assisting the residents with meals or handling foods, and after removing PPE. The policy showed, unless hands were visibly soiled, an alcohol-based hand rub (ABHR) was preferred. Review of the undated facility policy titled, Medication Administration, showed procedural guidance that licensed nurse and/or medication assistant must wash their hands before and after medication administration. On 12/06/2022 at 8:59 AM, Staff Q (LPN, Licensed Practical Nurse) was observed for medication administration for Resident 49. Staff Q took one pain patch from the medication cart and proceeded to Resident 49's room. Staff Q put on gloves and applied the patch to Resident 49's left side without washing their hands before application. On 12/06/2022 at 9:28 AM, Staff Q was observed for medication administration for Resident 23. Staff Q entered Resident 23's room and set the medicine cup with pills and a glass of water mixed with medication for constipation on top of the over-bed table. Staff Q held Resident 23's hand, handed the medicine cup to the resident, and provided the glass of water without washing their hands before medication administration. Staff Q then put on gloves and instilled Resident 23's eye drops without washing their hands before administration. On 12/06/2022 at 10:19 AM, Staff Q pumped some pain gel for Resident 23 from the house supply bottle. Staff Q went to Resident 23's room, put on gloves, and applied the gel to Resident 23's shoulders. Staff Q took off their gloves and left the resident's room without washing their hands after providing treatment and proceeded to prepare another resident's medications at the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/06/2022 at 10:25 AM, Staff Q confirmed they did not perform hand hygiene on three occasions when administering medications and treatments. Staff Q stated hand hygiene should be done before and after medication administration. Observations on 12/07/2022 at 12:49 PM showed Staff DD (CNA, Certified Nursing Assistant) performing incontinence care for Resident 55 after a bowel movement. Staff DD was wearing gloves and used wipes for cleaning during care provided. Staff DD, without changing gloves or performing hand hygiene, picked up a new brief and began positioning the brief into place under the resident. Staff DD used the same soiled gloves and opened the top drawer of the resident's nightstand, picked up a bottle, moved several other items around in the drawer, and touched Resident 55's left hip and knee. After providing care Staff DD removed the gloves, and without performing hand hygiene, put on a new pair of gloves, picked up the garbage, carried it down the hallway, and used a key to open the biohazard room to throw the garbage away. In an interview on 12/09/2022 at 3:53 PM, Staff F (ICP, Infection Control Preventionist) stated all staff were expected to perform hand hygiene before and after providing care to the residents including medication administration. Wound Care Resident 41 Review of a 10/15/2022 Quarterly MDS showed Resident 41 was being treated for a Stage Four pressure ulcer (breakdown of skin and underlying tissue caused by constant pressure) on their left heel. Review of Resident 41's December 2022 Medication Administration Record showed the resident recently finished a course of antibiotics for a bacterial skin infection on their right leg. Record review showed Resident 41 had several open areas on their right lower leg and were being followed by an outside wound team. An observation on 12/06/2022 at 9:24 AM, showed Staff E (Registered Nurse Unit Manager) used their bare hands to remove a soiled dressing from Resident 41's right lower leg. Four open areas were observed on Resident 41's right lower leg. Staff E washed their hands and exited the room to obtain gloves. At 9:27 AM, Staff E applied a solution to cleanse wounds to a gauze pad and proceeded to wipe the gauze pad around each different open area on Resident 41's right leg. Staff E did not use a separate gauze pad for each open area or get new gauze during the wound cleaning. An observation on 12/06/2022 at 9:45 AM, showed the soiled wound bandages removed from Resident 41's leg were lying on the floor, uncontained, next to the resident's bed. Staff E stated to Resident 41, they would pick up the soiled bandages. Sanitizer Dispensers According to Housekeeping Services and Agreement signed on September 12, 2022, the facility would be responsible for the supply and materials including all hand sanitizer. Observations on 11/30/2022 at 7:58 AM, 12/01/2022 at 10:19 AM, and 12/05/2022 at 9:27 AM showed the sanitizer dispenser in the hallway by room [ROOM NUMBER] was empty. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 11/30/2022 at 7:58 AM, 12/01/2022 at 10:19 AM, and 12/05/2022 at 9:27 AM showed a broken sanitizer dispenser on the wall between room [ROOM NUMBER] and 30. Observations on 11/30/2022 at 8:47 AM and 12/05/2022 at 9:27 AM showed the sanitizer dispenser was empty in the hallway on the wall between room [ROOM NUMBER] and 34. Observations on 11/30/2022 at 9:22 AM showed hand sanitizer containers were empty in the [NAME] hallways wall for the staff to use. On 11/30/2022 at 12:18 PM observations showed Staff Y attempted to sanitize their hands using an empty dispenser on the wall, stated. Staff Y stated, it's empty, and proceeded to enter a resident's room. On 12/05/2022 at 9:27 AM the sanitizer dispenser was observed to be empty in the hallway on the wall between room [ROOM NUMBER] and 37. Observations on 12/05/2022 at 11:43 AM showed hand sanitizer dispensers in the hallway in front of room [ROOM NUMBER] and 36 was empty, staff had to walk to the end of the hallway to sanitize their hands. In an interview on 12/12/2022 at 11:33 AM, Staff F stated a few weeks ago they removed broken and empty sanitizer dispensers and as far as they knew, every dispenser was now working. Staff F indicated housekeeping staff was responsible for keeping them filled and expected them to be checked daily and replaced as needed. Staff F stated not having the dispensers functional and available to use could lead to staff not performing hand hygiene as needed. REFERENCE: WAC 388-97-1320(1)(a)(c), (5)(a) 44296 46471 43642 46479

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	505195	A. Building B. Wing	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Auburn Rehab & Health Center	2830 I Street Northeast Auburn, WA 98002

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 44296 Based on interview and record review the facility failed to establish an infection prevention and control program that included developing an antibiotic (ABO) stewardship program to promote appropriate use of antibiotics; failed to analyze and complete monthly surveillance effectively for 4 of 4 months (July 2022 to October 2022) reviewed; failed to have an effective Infection Control Committee to meet regularly and analyze/review Antibiotic usage in the facility. These failures placed residents at risk for potential adverse outcomes associated with the inappropriate/unnecessary use of antibiotics and an increased risk for multi-drug resistant organisms (MDRO). Findings included . The October 2018 revised facility policy named Infection Prevention and Control Program showed the facility would use surveillance tools to recognize the occurrence of infections .and detecting unusual pathogens with infection control implications. The facility would use culture reports, sensitivity data and antibiotic usage reviews for surveillance activities, data gathering, and analysis and medical criteria is used to recognize and mange infections as part of the antibiotic stewardship program. In an interview on 11/30/2022 at 2:07 PM, Staff F (ICP, Infection Control Preventionist) stated they were new to the position starting in September 2022 and the first month of infection control data gathering and analysis they had completed was October 2022. Staff F did not have any other prior months of infection control surveillance, analysis, or data reports. On 11/30/2022 at 2:17 PM, Staff F was asked to provide the line list surveillance that was in place for November 2022. Staff F was not able to print the document from the cloud program at the time and asked to provide it later. (It was received on 12/02/2022, two days later.) At 2:28 PM Staff F asked the DNS where to find the infection control data from the prior months. The DNS stated they did not have them and to check in another office. On 11/30/2022 at 2:28 PM, Staff F was asked to provide the monthly infection control surveillance tools used to recognize and track infections including pathogens, antibiotic guideline criteria used, infection maps, analysis summaries and MDRO list. Staff F stated they would need to talk to the Director of Nursing (DNS) to obtain the monthly documents and summaries for June, July, August, September 2022 that were completed by the prior ICP. The data analysis from July, August, and September 2022 was not provided during the time of the survey investigation. A review of the October and November 2022 line list of antibiotic use cases in the facility showed the type of bacteria was not identified to ensure the prescribed antibiotic was appropriate for each infection, the line list did not show infections were reviewed with a nationally recognized stewardship tool to verify requirements of antibiotic use prior to treating infections. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 12/20/2022 at 10:12 AM, Staff KK (Chief Nursing Officer) when asked about the prior months of infection control reports and surveillance data, stated they were kept in another office in the facility and Staff F and B should have been able to provide them easily. Staff KK was asked to send the infection control surveillance tools, analysis reports, infection mapping and any other documents the facility used for antibiotic stewardship processes from July August, and September of 2022. Only an antibiotic case list was received from Staff KK. The case list did not show each infectious pathogen in relation to the antibiotic treatment, the antibiotic criteria used to determine antibiotic use criteria was met. The analysis of antibiotic use, monthly analysis summaries, pharmacy reports, laboratory reports and other documents were not provided to support an ongoing antibiotic stewardship program was in effect in the facility for the past five months. REFERENCE: WAC 388-97-1320(1)(a)(2)(a-c).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review, the facility failed to ensure influenza and/or pneumococcal vaccines were offered and/or provided for 4 of 5 residents (Residents 32, 34, 51, and 49) reviewed for immunizations/unnecessary medications. These failures placed residents at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from influenza and pneumococcal disease. Findings included . The revised October 2019 facility Influenza Vaccine policy showed all residents who have no contraindications to the vaccine would be offered the influenza vaccine annually between October 1 and March 31 of each year. For those who received or refused the vaccine, documentation would be placed in the resident's records. The revised October 2019 facility Pneumococcal Vaccine policy showed all residents would be offered the vaccine series within 30 days of admission. Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. Staff would document in the resident's records if the vaccine was administered or refused. The policy stated administration of the pneumococcal vaccines would be made in accordance with current Centers for Disease Control (CDC) recommendations at the time of the vaccination. The CDC website titled Pneumococcal Vaccination: Summary of Who and When to Vaccinate, indicated . CDC recommends pneumococcal vaccination for all adults [AGE] years or older .and adults 19 through [AGE] years old who have certain risk factors. The tables below provide detailed information .For adults [AGE] years or older who have not previously received any pneumococcal vaccine, CDC recommends you . Give one dose of PCV15 or PCV20 [Pneumococcal conjugate vaccine] .For adults [AGE] years or older who have only received PPSV23 [Pneumococcal polysaccharide vaccine], CDC recommends .Give one dose of PCV15 or PCV20 .For adults 19 through [AGE] years old .who have only received a PCV13 [Pneumococcal conjugate vaccine] with or without PPSV23, CDC recommends .Give PPSV23 . The CDC guidelines went into effect on 10/21/2021 per recommendations from the Advisory Committee on Immunization Practices (ACIP). Resident 34 According to a 09/14/2022 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 34 received their 2021 influenza vaccine in the facility and the pneumococcal vaccine was not up to date due to being declined. Review of Resident 34's immunization record showed the resident received the influenza vaccine previously on 10/08/2021. Another entry for the influenza vaccine stated, consent refused, there was no date or staff listed to indicate when this occurred. There were three other entries that showed, consent refused for the pneumococcal vaccines with no dates or staff identified. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 10/08/2019 Pneumococcal and Annual Influenza Vaccine Information and Request form (a form that addresses, risks, benefits, and consent) showed Resident 34 requested the influenza vaccine annually and refused the pneumococcal vaccine. A 10/17/2022 Pneumococcal, COVID-19 and Annual Influenza Vaccine Information and Request form (PCAIVIR) was blank for the sections offering the Influenza and Pneumococcal vaccines. Record review revealed no documentation Resident 34 or the resident's representative received information regarding the risks and benefits of receiving the influenza vaccine since 2021 or the pneumococcal vaccines since 2019. Resident 32 The 10/19/2022 Annual MDS showed Resident 32 admitted to the facility on [DATE] from another skilled nursing facility and was assessed with up-to-date pneumococcal vaccinations. Review of Resident 32's record showed the PPV23 vaccination was received twice prior to admission on 08/13/2013 and 09/09/2014. There was no documentation Resident 32 was offered the PCV15 or PCV20 vaccination per CDC recommendations. A 10/04/2022 and 10/17/2022 PCAIVIR form for Resident 32 showed the pneumococcal vaccine sections were blank. Record review showed no documentation that Resident 32 was offered, received or refused any additional pneumococcal vaccinations after admission to the facility. Resident 51 According to the 10/06/2022 Admission MDS Resident 51 admitted to the facility on [DATE], had clear speech, was understood, and able to understand others. This MDS indicated Resident 51 was offered and declined the Pneumococcal Vaccine. A 10/06/2022 PCAIVIR form showed Resident 51 was offered and refused the annual influenza vaccine but the section for the pneumococcal vaccine was blank. Review of 10/05/2022 and 11/09/2022 provider progress notes showed directions to staff to provide influenza and pneumococcal vaccines as indicated and tolerated by patient. In an interview on 12/09/2022 at 11:10 AM, Resident 51 stated they were interested in receiving their vaccines. Resident 51 stated staff had talked with them a long time ago but reported it was not brought up since the resident was readmitted to the facility on [DATE]. In an interview on 12/09/2022 at 3:53 PM, Staff F (Infection Preventionist) stated residents should be offered the influenza and pneumococcal vaccines on admission per CDC recommendations and facility policy. Staff F stated if a resident refused, staff should provide education on the risks and benefits, make further attempts to offer, and document in the resident's record. 44296 46471 Resident 49 (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/17/2022 Admission MDS showed Resident 49 had multiple medically complex diagnoses. The assessment showed Resident 49 was less than [AGE] years old, cognitively intact, able to make decisions and had clear speech. Review of Resident 49's immunization record showed Resident 49 received the PCV13 on 01/22/2013 but did not receive the PPV23 as recommended by the CDC for people under [AGE] years old. An 11/16/2022 physician progress note showed an order for staff to administer the pneumococcal vaccine to Resident 49, as indicated and tolerated. Record review showed no documentation that Resident 49 was offered and/or declined the PPSV23 vaccination while they were in the facility. In an interview on 12/07/2022 at 1:06 PM, Resident 49 confirmed staff did not offer or administer any follow-up pneumococcal vaccination since their facility admission on 11/10/2022. In an interview on 12/09/2022 at 3:54 PM, Staff F stated the facility did not have a system in place for tracking resident's pneumococcal vaccinations per the CDC recommendations. REFERENCE: WAC 388-97-1340 (1)(2).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on interview and record review the facility failed to ensure 2 of 5 residents (Resident 51 and 49) were offered the COVID-19 (a highly transmissible infectious virus that causes respiratory illness, in severe cases can cause difficulty breathing and could result in impairment or death) vaccination and had education on the benefits and potential risk associated with COVID-19. These failed practices placed the residents at risk of COVID-19 infection and placed residents at risk for not having their medical records reflect complete and/or accurate information to be considered when making a medical decision. Findings included . Review of a revised November 2021 facility COVID-19 - Vaccination of Residents policy showed each resident would be offered the COVID-19 vaccine unless the immunization was medically contraindicated, or the resident had already been immunized. This policy stated the resident had the opportunity to accept or refuse a COVID-19 vaccine, and to change their decision. The policy stated the resident's records would include documentation that indicated, at a minimum, the following: the resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine; signed consent; and each dose of COVID-19 vaccine that was administered to the resident. If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination or refusal, appropriate documentation would be made in the resident's records. Resident 51 According to the 10/06/2022 Admission Minimum Data Set (MDS - an assessment tool), Resident 51 admitted to the facility on [DATE], had multiple medically complex diagnoses, clear speech, was understood, and able to understand others. Record review showed a 09/29/2022 physician order for Resident 49 to have the 2-step COVID vaccine but no information regarding if the resident had received the COVID-19 vaccination. A 10/06/2022 Pneumococcal, COVID-19 and Annual Influenza Vaccine Information and Request (PCAIVIR) form showed Resident 51 was offered and refused the annual influenza vaccine but the section for the COVID-19 vaccine was blank. Review of a 06/22/2022 PCAIVIR form showed Resident 51 was offered and declined the COVID-19 vaccine during their previous admission. In an interview on 12/09/2022 at 11:10 AM, Resident 51 stated they were interested in receiving the COVID-19 vaccine. Resident 51 stated staff had talked with them a long time ago but reported it was not brought up since the resident was readmitted to the facility on [DATE]. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/12/2022 at 1:55 PM, Staff F (Infection Control Preventionist) stated staff should educate and offer COVID-19 vaccinations to residents upon admission or readmission and re-approach those residents who previously refused. 46471 Resident 49 According to the 11/17/2022 Admission MDS, Resident 49 admitted to the facility on [DATE], presented with clear speech, and was cognitively intact. The assessment showed Resident 49 had a personal history of COVID-19 infection. Record review showed an 11/10/2022 physician order for Resident 49 to have the 2-step COVID vaccine but no information regarding if the resident had offered or received the COVID-19 vaccination. On 12/07/2022 at 1:06 PM, Resident 49 was asked if the facility offered them the COVID-19 vaccine since their admission to the facility on [DATE]. Resident 49 stated, No and stated they would like to receive the COVID-19 vaccination. In an interview on 12/12/2022 at 1:55 PM, Staff F confirmed the facility should, but did not, educate and offer COVID-19 vaccinations to residents per guidelines upon admission. REFERENCE: WAC: 388-97-1780(1)(2)(a)(i)(b).