STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individual needs and preferences for 5 (Residents 77, 153, 49, 97, & 54) of 22 residents reviewed for resident rights. The failure to accommodate residents choices in their frequency and schedule of bathing, failure to provide opportunities to make health care decisions, failure to provide dignity during assistance with eating, and in labeling of clothing placed residents at risk for feelings of embarrassment, helplessness, diminished self-worth, and quality of life. Additionally, the facility failed to inform residents of their rights upon admission. The failure to follow the facility identified admission agreement process prohibited 5 (Residents 36, 13, 81, 451, & 86) of 5 residents reviewed for Advanced Directives and 2 supplemental residents (Residents 97 & 58) from receiving a copy of their rights and detracted from the residents' ability to act upon their rights. Findings included . Choices Resident 77 Review of the 03/15/2022 Quarterly Minimum Data Set (MDS - an assessment tool) showed Resident 77 was a long-term care resident, alert and oriented, The resident felt it was very important to choose between a tub bath, shower, bed bath or sponge bath. Review of the 04/08/2022 Bathing/Showering Care Plan (CP) noted the resident preference for showers during day but did not indicate which days. Review of the Kardex on 04/26/2022 showed that the resident's bathing preferences were Monday and Friday Days. Review of the Shower Schedule on 04/22/2022 showed that Resident 77 was scheduled to be showered on Thursday and Sunday Mornings. Review of the Resident's record showed the resident was offered and refused a shower on Sunday 04/24/2022. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/22/2022 at 12:23 PM, Resident 77 stated that Staff B (Director of Nursing) made a shower schedule, but it was incorrect, My showers have been Wednesday and Friday for five years. Resident 77 stated that when they asked for a shower, the nursing assistant stated that it was not on the schedule, so the resident stated that they went around Staff B and told Staff Y (Activities Director) that they needed a shower Friday. Resident 77 stated, I don't know what their schedule is, but mine is Wednesday and Friday and I'm keeping it!. Health Care Decisions Resident 153 According to the 04/07/2022 Quarterly MDS, the resident had Medically complex conditions, including Schizophrenia, and had severe cognitive impairment, and was able to make their own decisions. The MDS showed the resident received antidepressants during the assessment period. Review of Physicians Orders (PO) showed a 08/25/2021 PO for an anti-depressant daily for an appetite stimulant. Review of the resident's record showed no consent was obtained for the use of the anti-depressant and the resident was not given the opportunity to make an informed decision about using an anti-depressant for an off label use or educated on the risks and benefits. In an interview on 04/28/2022 at 9:53 AM Staff C (Chief Nursing Officer) stated they expected a consent to be obtained and risk and benefits explained before administering an anti-depressant, even if it is being used for an off-label use, it is still classified as an antidepressant. 43642 Assistance with Eating Resident 49 According to a 03/30/2022 Quarterly MDS Resident 49 was assessed to require physical assistance for eating from staff. Observations on 04/22/2022 at 12:49 PM showed facility staff holding a cell phone to their ear while standing in front of Resident 49 assisting them with eating. Similar observations were made of staff standing in front of Resident 49 and providing feeding assistance on 04/23/2033 at 8:48 AM. Resident 97 According to a 03/25/2022 Quarterly MDS Resident 97 was assessed to require physical assistance and supervision with eating. Observations on 04/22/2022 at 8:49 AM showed facility staff standing at bedside assisting Resident 97 with feeding. Similar findings were observed on 04/25/2022 at 8:38 AM of staff standing while providing feeding assistance. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 54 According to a 02/17/2022 Admission MDS, Resident 54 was assessed to require extensive physical assistance from staff for eating. Observations on 04/22/2022 at 12:56 PM showed facility staff standing at Resident 54's bedside while assisting the resident with eating. Similar findings were also noted on 04/24/2022 at 8:46 AM when facility staff was observed standing at Resident 54's bedside while providing feeding assistance. In an interview on 04/29/2022 at 7:33 AM, Staff C stated staff should not be providing residents assistance with feeding while standing and indicated their expectation is for staff to sit and provide eating assistance as needed. Labels on Clothing Resident 49 Resident 49 was admitted to the facility on [DATE]. According to the 03/30/2022 Quarterly MDS, Resident 49 was assessed with severe cognitive impairment and required physical assistance from staff for bed mobility, transfers, dressing, eating, and personal hygiene. Observations on 04/21/2022 at 11:01 AM showed Resident 49 sitting in wheelchair (w/c) and wearing light colored shoes. Resident 49's last name was written in large black writing on the outside of shoe straps and was visible to others. In an interview on 04/29/2022 at 7:33 AM, Staff C stated Resident's clothing should not be labeled on the outside and visible to others. Resident 69 Similar findings for Resident 69. According to the 03/08/2022 Significant Change MDS, Resident 69 was severely cognitively impaired, and had diagnoses including Alzheimer's Disease and non-Alzheimer's Dementia. Observations on 04/21/2022 at 10:19 AM, and on 04/27/2022 at 09:43 AM showed Resident 69 wearing pants marked with sharpie to indicate whom they belonged to. Informed of Resident Rights In an interview on 04/27/2022 at 2:47 PM, Staff DD (Administrator in Training) confirmed that the admissions agreement contains information including but not limited to resident rights in a nursing home. Staff DD stated Residents 36, 13, 81, 451, 97, 58, & 86 did not have a signed admission agreement and were not informed of their resident rights while residing in a nursing home as required. Staff DD confined the process for providing admission agreements and informing residents of their rights was not intact. REFERENCE: WAC 388-97-0860(1)(a-b)(2), -0900(1)(3). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	44295 44296

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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** 44296 Based on interview and record review, the facility failed to ensure residents were informed and provided written information concerning the right to accept, refuse, formulate an advance directive for 5 (Residents 36, 13, 81, 451, & 86) of 5 residents reviewed for Advanced Directives and 2 supplemental residents (Residents 97 & 58). The failure to review, provide, and have the resident sign the facility admission agreement prevented residents from being able to choose or refuse to formulate an advanced directive or to provide their previously formulated advanced directive documents. This placed residents at risk for not having a surrogate decision maker when unable to make their own healthcare/financial decisions. Findings included . Resident 36 The 01/25/2022 5-day Medicare Minimum Data Set (MDS, an assessment tool) showed Resident 36 admitted to the facility on [DATE], was cognitively intact, had clear speech, was able to make themselves understood and understood others. The assessment showed Resident 36 was able to participate by answering questions and making decisions about their care. In an interview on 04/26/2022 at 7:58 PM, Resident 36 stated no one from the facility spoke with them about an advanced directive. Resident 36 stated they did not have an advanced directive and needed assistance to complete this task. Resident 36 stated they never received an admission agreement and asked what it was and if they could have a copy. In an interview on 04/27/2022 at 1:56 PM, Staff R (Business Office Manager) stated there was not an admissions agreement in the resident's record for Resident 36. Staff R confirmed that the document was not completed for Resident 36. In an interview on 04/27/2022 at 2:47 PM, Staff DD (Administrator in Training) confirmed that the admissions agreement contained information including but not limited to resident rights in a nursing home, charges for services, privacy practices, consent for release of information, authorization for immunizations, smoking policy, bed hold policy, trust fund policy, grievances policy, information about resident council, care plan conferences, personal property, advanced directives, and appointing a health care surrogate decision maker. Staff DD stated residents that do not have an admission agreement did not receive this required information upon admission. Staff DD stated the admissions agreement is expected to be reviewed with and signed by the resident or resident representative, and a copy provided to the resident, within 72 hours of admission. Residents 13, 81, 451, 86, 97, and 58 had similar findings when Staff R was unable to locate an admission agreement for each resident in their records. Staff R stated there was not an admission agreement or an advanced directive completed for these residents. Refer to F550 Resident Rights (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F585 Grievances REFERENCE: WAC 388-97-0180(1-4). 42203

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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 resident rooms were free of clutter and with adequate window covering, paper towel dispensers were functioning, and walls were free of gouges and burn marks. These failures left residents at risk for a decreased quality of life and a less than homelike environment. Findings included . Blinds In Resident Rooms On 04/22/2022 at 11:25 AM, observation in room [ROOM NUMBER] revealed many missing vertical slats for the window blinds. Resident 78 stated you can see my window isn't covered. The missing slats prevented Resident 78 from closing the blind for privacy and comfort if they wished. room [ROOM NUMBER] was also noted to be missing blind slats on 04/23/2022 at 9:51 AM; on 4/28/2022 at 12:07 PM, room [ROOM NUMBER] was observed to be missing a blind slat and the mechanism to adjust the slats was not working; on 4/28/2022 at 10:08 AM the blinds in room [ROOM NUMBER] were observed to be missing a slat. Missing blind slats were observed to be missing in rooms [ROOM NUMBERS] during environmental rounds conducted with Staff D (Maintenance Director), on 04/29/2022 at 7:34 AM. During these rounds Staff D acknowledged the missing slats and stated they would be replaced. Beds In room [ROOM NUMBER] on 04/26/2022 at 11:03 AM, the foot board of Resident 69's bed was noted to be broken. The entire right third of the board was missing, and particle board was exposed along the length of the split where the missing piece was once attached. The edging laminate along the entire perimeter of the footboard was also missing, exposing more particle board which could no longer be reliably cleaned. Similar findings were noted in room [ROOM NUMBER] where the head of the bed was missing laminate trim that exposed uncleanable particle board. These findings were noted during rounds with Staff D on 04/29/2022 at 7:34 AM who stated they would be fixed. Peeling laminate on footboards were also observed in room [ROOM NUMBER] and 109. Paper Towel Dispensers On 04/21/2022 at 8:17 AM, the paper towel dispenser in the bathroom of room [ROOM NUMBER] bathroom was noted to not be in proper working order; a paper towel roll was noted to be placed on top of the toilet tank rather than in the paper towel dispenser, preventing residents and staff from washing and drying their hands in a sanitary fashion and creating an un-homelike environment. During a meeting of the facility's Resident Council on 04/28/2022 at 1:48 PM, Resident 33 stated that the paper towel dispenser in their room, room [ROOM NUMBER], was not functioning and that a roll of paper towels was left on the tank of their toilet, rather than in the paper towel dispenser. During environmental rounds on 04/29/2022 at 7:34 AM, Staff D acknowledged there were paper towel dispensers in need of repair and demonstrated they repaired the dispenser for room [ROOM NUMBER] since the observation on 04/21/2022. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cluttered Resident Rooms On 04/21/2022 at 11:21 AM, room [ROOM NUMBER] was observed to be cluttered. The floor had an area surrounding the room heater marked with a perimeter of red tape where no items where to be placed. Resident items were noted to extend into the area. During environmental rounds on 04/29/2022 at 7:34 AM, Staff D stated that the room was cluttered, and that resident property was in the taped off area, and that the resident often placed their items where they should not. Walls On 04/21/2022 at 8:06 AM, the 100 Floor Dining room was noted with heat damage on wall; streaks of darkened panels ascended on the paneling directly above a baseboard heater. A plastic panel 1 foot by 4 feet was attached to the wall, preventing observation of part of the main panel. During environmental rounds on 4/29/2022 at 7:34 AM, Staff D stated they were unaware of the damaged paneling, and that the heater and the paneling required replacement. Wall gouges were noted on 04/21/2022 at 10:31 AM in room [ROOM NUMBER]. Gouges in resident rooms were also observed in room [ROOM NUMBER] where the head of the bed (HOB) rubbed against the wall, in room [ROOM NUMBER] on the wall by the HOB, and in room [ROOM NUMBER]. On 04/29/2022 at 7:34 AM, Staff D stated the walls needed to be repaired, we're painting all the time. REFERENCE: WAC 388-97-0880 43642 44296

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure a system was in place to resolve resident grievances timely. Failure to timely resolve a grievance for 1 (Resident 60) of 7 Resident Council attendees, and failure to effectively educate residents on their right to file a grievance for 3 (Resident 81, 91 & 90) of 7 Resident Council attendees left residents at risk for unresolved grievances, missing property and frustration. Findings included . Facility Policy According to the facility's 05/13/2021 Resident and Family Grievances policy: the Grievance Official is responsible for overseeing the grievance process, grievances may be reported in various ways including verbally, in writing or during resident council. The policy stated notices of resident's rights regarding grievances will be posted in prominent locations throughout the facility. The policy did not describe how residents limited to their rooms, or with poor or no reading comprehension or who admitted during an outbreak (when residents are restricted to their rooms) would be educated on their right to file a grievance. Admissions Packet The facility's undated Admissions Packet (a collection of documents reviewed with residents upon admission) included a section titled Attachment E: Statement of Resident Rights. The Statement of Resident Rights did not include language explaining how residents could file a grievance with the facility. Resident Council During a meeting of the facility's Resident council on 04/28/2022 at 1:30 PM, residents expressed concerns about the facility's grievance process. Resident 67 (Council President) stated there were repeated concerns with missing property. Residents 67 and 33 stated they would like the Grievance Officials (Staff G, Social Services Director and Staff H, Social Services Assistant) to attend Resident Council but they had not lately. During the Resident Council meeting, of the seven resident attendees, four stated they knew how to file a grievance. Residents 81, 91, and 90 stated they did not know how to file a grievance. Resident 90, who admitted to the facility on [DATE] stated they had personal property missing the second day I was here. At 2:08 PM, Resident 60 stated they had a couple of boxes of a sports drinks delivered which were left with the receptionist. Resident 60 stated Staff G told the resident they were working on it in February, took a picture of the resident's phone screen with a delivery confirmation message, but did not resolve the resident's concern. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/28/2022 04:24 PM, Staff G stated they remembered Resident 60's missing sports drinks. Staff G was unable to provide any record the grievance was logged, investigated, or concluded. REFERENCE: WAC 388-97-0460

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review, the facility failed to implement abuse and neglect policies and procedures for 1 (Resident 65) of 2 residents reviewed for hospitalization . The failure to identify a fracture of unknown origin, investigate to rule out abuse and report to the state agency placed Resident 65 at risk for further unidentified injury and all residents at risk for unidentified abuse and injury. Findings included . The 09/2020 facility policy titled Abuse, Neglect, Exploitation, Misappropriation Resident Property Policy showed the facility policy was to investigate all injuries of unknown source. The policy showed facility staff should immediately report all such allegations to the Administrator and the (Department). The facility procedure described identification of events such as suspicious bruising that may constitute abuse and determined the direction of the investigation. Upon completion of an investigation, the facility would determine modifications to a resident's care plan to prevent similar incidents or injuries from occurring in the future. The administrator or designee would report injuries of unknown source as soon as possible but no later than 24 hours from the time the incident was made known to the staff member. Resident 65 The 03/03/2022 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 65 was admitted [DATE] with no diagnosis of a left arm fracture. A 03/16/2022 skilled nursing assessment showed Resident 65 was alert, responsive, and usually understood others, with no pain and no skin bruising on upper left arm. A 03/17/2022 nurse discharge note showed Resident 65 was sent to the hospital for unresponsiveness at 8:00 AM. The 03/23/2022 hospital discharge summary showed Resident 65 was admitted to the hospital on 03/17/2022 with the diagnosis of urosepsis (a blood infection from a bladder infection) and pyelonephritis (a kidney infection). The summary showed an x-ray was completed on 03/21/2022 for pain, bruising, and swelling on the left upper arm. The x-ray showed an upper arm fracture. A 03/22/2022 orthopedic (bone specialist) consult note showed the upper arm fracture was of indeterminate age. The color of bruising determined an injury of 6-10 days prior to 03/22/2022. Resident 65 was admitted to the facility during this timeframe of 03/12/2022 up to the hospital transfer on 03/17/2022. A 03/23/2022 7:10 PM nurse progress note showed staff readmitted Resident 65 to the facility. Resident 65 presented with left upper arm swelling, bruising, and pain associated with the fracture. Resident 65 had an arm sling in place for support. In an interview on 04/27/2022 at 2:47 PM Staff DD (Administrator in Training) stated there was no investigation report, to rule out abuse/neglect, for Resident 65's left upper arm fracture. A review of the March 2022 incident log showed no entry, and no report to the state agency as required. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/27/2022 at 3:21 PM Staff B (Director of Nursing) stated the facility assumed the left arm fracture was from the fall prior to admission on 02/24/2022. Staff B stated the admitting nurse did not identify the fracture as possible abuse/neglect or notify the DNS. Staff B stated there was no investigation upon learning of the fracture on 03/23/2022 to determine the cause or rule out abuse/neglect. Staff B confirmed the incident was not reported to the state agency as required. Staff B stated the facility should have, and did not, follow their abuse policy. Refer to F684 Quality of Care. Refer to F726 Competent Nursing Staff. REFERENCE: WAC 388-97-0640(2).

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 42203 Based on interview and record review, the facility failed to ensure a system by which the office of the State Long-Term Care Ombudsman (LTCO) received required resident transfer information for 1 (Resident 61) of 2 residents reviewed for discharges to the hospital, and failed to ensure to offer bed holds for 1 (Resident 61) of 2 residents reviewed for discharges to the hospital. Failure to ensure required notification was completed, prevented the LTCO from educating and advocating for residents regarding their rights. Failure to provide bed hold information left residents at risk for unwanted room changes upon readmission. Findings included . Facility Policy According to the facility's 05/02/2022 Transfer and Discharge Policy, in the event of an emergency transfer, the Social Services Director or their designee will notify the LTCO via a monthly list. The policy directed staff to provide the transferring resident with a bed hold notification no later than 24 hours after transfer. Resident 61 According to a 01/18/2022 progress note, Resident 61 was observed to be confused and drowsy and was sent emergently to the hospital where they were diagnosed with a respiratory infection. Review of the resident's record revealed no evidence the LTCO was notified within 30 days of Resident 61's emergent transfer to the hospital, as required. The resident record did not include any evidence Resident 61 was offered a bed hold as required, either at the time of transfer or after. In an interview on 04/28/2022 at 01:03 PM, Staff G, (Social Services Director) stated that notifying the LTCO of emergent transfers was the responsibility of another department. In an interview on 04/28/2022 at 3:15 PM, Staff W (Admissions Coordinator) was asked to provide evidence the facility provided Resident 61 a bed hold, and notified the LTCO of Resident 61's emergent transfer to hospital. After briefly reviewing Resident 61's records, Staff W stated they would look into it and provide further information. In an interview on 04/28/2022 at 3:43 PM, Staff W stated there was no record showing the facility provided a bed hold. No further information regarding LTCO notification was provided. REFERENCE: WAC 388-97-0120 (2)(a-d), -0140 (1)(a)(b)(c)(i-iii).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview and record review the facility failed to identify a significant change and complete a timely Significant Change in Status Assessment (SCSA) within the required 14-day timeframe for 1 (Residents 3) of 22 sampled residents reviewed. Failure to complete the SCSA timely placed the residents at risk for unmet care needs, decreased quality of care and diminished quality of life. Findings included . According to the Resident Assessment Instrument Manual (RAI- a document directing staff on how to accurately assess the status of residents), the SCSA must be completed when the Interdisciplinary Team has determined that a resident meets the significant change guidelines for either major improvement or decline in status or when a terminally ill resident enrolls in a hospice program and remains at the nursing home. Resident 3 The 07/30/2021 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 3 was admitted to the facility on [DATE] with a diagnosis of a non-curable progressive neurological condition and was not enrolled in a hospice program. The 08/13/2021 Hospice Notice of Election of Benefit/Consent Form showed Resident 3 started hospice services on 08/13/2021. 08/13/2021 was the date that started the assessment period for a significant change according to the RAI manual. The 11/18/2021 SCSA MDS was completed and signed on 12/01/2021, 105 days late. In an interview on 04/26/2022 at 12:55 PM, Staff J (MDS Nurse) stated the SCSA was due 14 days after hospice started on 08/27/2021 and was completed late. REFERENCE: WAC 388-97-1000(3)(b).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review the facility failed to accurately and completely assess 5 (Residents 61, 58, 59, 97, & 21) of 22 residents reviewed for assessments and failed to ensure comprehensive admission assessments were completed within the required time frames for 3 (Residents 58, 59, & 97) of 22 sample residents reviewed. These failures to ensure assessments were complete, accurate and timely placed residents at risk for unidentified care needs, delayed services, and decreased quality of life. Findings included . According to the Resident Assessment Instrument (RAI - a manual that instructs staff on timing requirements for assessments), admission assessments are required to be completed by the 14th calendar day of the resident's admission, and annual assessments are required to be completed within 14 days of the Assessment Reference Date (ARD, +14 days). Resident 61 Review of the 02/27/2022 Admissions Minimum Data Set (MDS - an assessment tool), showed the facility failed to assess Resident 61's cognition and preferences for activities and daily routine (Daily Preferences) either by resident interview or staff assessment. In an interview on 04/28/2022 at 2:57 PM, Staff J (MDS Nurse) and Staff F (MDS Nurse) confirmed the cognitive assessment and Activities and Daily Preferences were not completed either by resident interview or staff assessment. Staff F stated the assessments for cognition and preferences were important in order to ensure a resident's needs are identified and added to their Care Plan (CP) and in order to measure changes over time. 43642 Resident 58 Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's 02/23/2022 Admission /Medicare - 5 Day MDS revealed the interviews assessing the resident's Cognitive Patterns, Mood, Behavior, Preferences, and Participation in Assessment were not completed by staff. This MDS showed it was not completed during the required 14 calendar days after admission to the facility. Resident 59 Resident 59 was admitted to the facility on [DATE]. Review of Resident 59's 02/24/2022 Admission /Medicare - 5 Day MDS revealed the interviews assessing the resident's Cognitive Patterns, Mood, and Behaviors were not completed by staff. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additionally, this MDS showed it was not completed during the required 14 calendar days after admission to the facility Resident 97 Resident 97 was admitted to the facility on [DATE]. Review of the 12/14/2021 Admission /Medicare - 5 Day MDS showed that it was not completed until 12/23/2021, two days after the required completion date. In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Nursing Officer) stated resident MDS's should be complete, accurate and completed within the required completion dates. 44295 Resident 21 According to the 01/17/2022 Quarterly MDS, Resident 21 had diagnoses including Schizophrenia, anxiety, and drug induced Tardive Dyskinesia (abnormal and involuntary movements of the face, limbs, and trunk). The resident was assessed as rarely or never makes self understood, rarely or never understanding others, and had severely impaired cognition. This MDS showed the resident had no rejection of care, no wandering behaviors, and did not use a wander or elopement alarm. Review of the CP showed a 03/08/2021 the resident is an elopement risk/wanderer, with history of attempts to leave the facility unattended due to poor safety awareness and judgement. The CP interventions directed staff to check the expiration date and functioning of an elopement prevention device (Wanderguard- a device that alarms when going out a door) every week and to verify the placement of the device to the resident's right ankle every shift. Review of a 04/02/2020 CP showed the resident is resistive to care, showers, hygiene, changing clothes, MDS interviews and mental health visits. The CP directed staff to inform the LN (licensed nurse) of all continued refusals of care. Review of April 2022 Certified Nursing Assistant (CNA) documentation showed Resident 21 refused to take a shower and refused to have their vital signs taken on multiple occasions. A 09/18/2020 Physicians Order (PO) showed 1) check to ensure wanderguard device is on, not loose, or frayed, or missing, 2) Check to ensure the skin is intact beneath the wanderguard device, 3) Check wanderguard signal and expiration date, replace as needed. On 04/24/2022 at 9:01 AM a wanderguard device was observed on the resident's right ankle. On 04/26/2022 at 7:28 PM Resident 21 was observed walking out of their room, down the hall into the activity room where they sat for 10 minutes and returned to the hall, and started walking towards their room. The resident was later seen at 8:08 PM walking the hallway towards the activity room. In an interview on 04/26/2022 at 8:13 PM Staff DD (Administer in Training) stated the resident usually sticks to the same path when wandering the halls. They normally sit in the activity or dining room for a short period of time, head back to their room and repeat the path multiple times daily. (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 04/28/2022 at 2:30 PM Staff F and Staff J stated Resident 21 wanders around the facility and has a wanderguard because they had a history of elopement. Staff J stated if the resident refused care, staff would re-approach the resident after some time and explain what type of care staff were trying to provide. Both Staff F and Staff J agreed the MDS was not accurate. 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 - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on interview and record review the facility failed to ensure Pre-admission Screening and Resident Review (PASRR) Level II evaluation recommendations were implemented and incorporated into the Care Plan (CP) for 3 (Resident 21, 30, 36) of 7 residents reviewed for Level II PASRRs. Failure to incorporate and implement treatment plans into the comprehensive CP placed residents at risk for not receiving necessary mental health and counseling services and unmet psychosocial needs. Findings included . Resident 21 According to the 01/17/2022 Quarterly Minimum Data Set (MDS an assessment tool) the resident admitted to the facility on [DATE] and had diagnoses including Schizophrenia, Anxiety disorder, and drug-induced Tardive Dyskinesia (TD- abnormal, involuntary movements of the face, neck, limbs and body). Review of 02/25/2020 Level II PASRR showed Resident 21 was referred for behaviors of being resistive to care (including showers) and showing little interaction with people at the facility. The Level II PASRR instructed the facility to complete an AIMS (Abnormal Involuntary Movement Scale) assessment, repeat the AIMS every 90 days and document the progression, due to Resident 21's long term antipsychotic use and TD diagnosis. Recommendations included: establishing a lowest effective dose for the antipsychotic medication; consideration of a trial of a medication used to treat TD, and a referral for a psychiatric consult to further assess. Review of the resident's CP showed a 02/25/2020 PASRR I reviewed and sent for review due to SMI (Serious Mental Illness), PASRR II completed. The CP did not include the most current recommendations made by the PASRR II evaluator. Review of the resident's record showed AIMS assessments were completed every six months and not every 90 days or three months as recommended. Review of Physician's Orders (PO) showed no indication a trial of the medication to treat TD was initiated, and no indication a lowest effective dose for the resident's antipsychotic was determined, as the resident continued on the same dose of the antipsychotic used to treat Schizophrenia since 10/01/2019. In an interview on 04/28/2022 at 3:34 PM Staff G (Social Services Director) stated the recommendations from the Level II PASRR evaluator should be implemented and the recommendations added to the CP. Staff G acknowledged the recommendations were not implemented and the CP did not reflect the recommendations, as they would expect. Resident 30 (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 04/13/2022 Quarterly MDS the resident admitted to the facility on [DATE] and had medically complex conditions including Schizophrenia, Neurocognitive disorder, Traumatic Brain Injury, and Seizure Disorder. Review of the PO's showed a 04/18/2020 PO for 1.5 mg daily for an antipsychotic medication to treat Schizophrenia. Review of the 06/17/2020 Level II PASRR showed the the referral was completed because the resident experienced auditory hallucinations and delusions to which the resident responded. The Level II PASRR evaluator recommended completing an AIMS and repeating the AIMS every 3 months due to some mouth movements. The Level II PASRR evaluator recommended a referral for a psychiatric consult and assessment of the resident after antipsychotic medication was restarted. Review of the resident's CP showed no indication the facility incorporated the recommendations. No Level II PASRR CP was located in the resident's record. Review of Resident 30's record showed AIMS assessments were completed every six months and not every three months as recommended. On 04/21/2022 at 1:52 PM Resident 30 was observed smacking their lips and rolling their tongue around their mouth. Similar observations were made on 04/25/2022 at 9:03 AM, and 04/26/2022 at 2:45 PM. In an interview on 04/28/2022 at 3:43 PM Staff G stated the recommendations from the Level II PASRR evaluator should be carried out and added to the CP. Staff G acknowledged the recommendations were not carried out and the CP did not reflect the recommendations, as they would expect. 44296 Resident 36 A 10/19/2021 Level 1 PASRR completed by hospital staff upon discharge showed Resident 36 had Bipolar 1 (a mood disorder) without serious functional limitations or any need for mental health in the past six months. Anxiety Disorder and Psychotic Disorder were not identified on the PASRR. No Level II evaluation was checked on the form. The 10/28/2021 Admission MDS showed Resident 36 was admitted to the facility on [DATE]. Resident 36 was assessed to require antipsychotic, antianxiety, and antidepressant medications. Resident 36 was assessed to be cognitively intact, with clear speech, the ability to make self understood and understood others. The 11/02/2021 Care Area Assessment (CAA, a tool to create a care plan) showed Resident 36 required a care plan for an altered mood state. The CAA showed Resident 36 was interviewed and reported little interest or pleasure in doing things, had impaired functional mobility, and diagnoses including Bipolar Disorder with Depression, Post-Traumatic Stress Disorder (PTSD), and Anxiety. The 11/02/2021 CAA showed Resident 36 required a CP for psychotropic medication use. The CAA showed Social Services was developing a CP for the specific diagnoses. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 12/29/2021 Level I PASRR for a re-admission after hospitalization was completed by hospital staff. The PASRR showed Resident 36 had diagnoses including Bipolar 1 Disorder, PTSD, Anxiety and Attention-Deficit-Hyperactivity Disorder (ADHD) without serious functional limitations or the need for mental health services in the past six months. In an interview on 04/26/2022 at 3:30 PM, Staff G confirmed the 10/19/2021 and the 12/29/2021 PASRR forms were incorrect and should have been corrected by the facility staff at admission. Staff G stated Resident 26 needed a PASRR Level II referral and evaluation which was not completed as required. REFERENCE: WAC 388-97-1915(4).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were developed, revised, and implemented to include individualized resident-specific interventions that accurately reflected care needs, and gave adequate directions to care staff for 14 (Residents 13, 61, 67, 69, 58, 59, 97, 251, 21, 30, 76, 95, 153, & 81) of 22 reviewed for comprehensive CPs. This failure placed residents at risk for unmet care needs, adverse events and diminished quality of care/quality of life. Findings included . Resident 13 According to the 04/06/2022 Quarterly MDS (Minimum Data Set - an assessment tool), Resident 13 received anticoagulant (AC) medication daily and required extensive assistance from two or more persons for most care. Review of Resident 13's Comprehensive CP showed it did not include a CP to address AC medication, including how to manage adverse side effects associated with AC medications, such as bleeding and bruising. Resident 13's CP included an intervention dated 03/15/2022 that indicated The resident is (SPECIFY: independent/dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t (if dependent). The CP did not specify if the resident was dependent or independent. Resident 13's record Review showed the Kardex (a care directive for Nursing Aides) did not include any instructions to Aides regarding AC precautions to prevent, or actions to take in the event of potential adverse effects. In an interview on 04/28/2022 at 04:02 PM, Staff C (Chief Nursing Officer) stated Resident 13's CP should have, but did not include an AC CP, and the absence of an AC CP and Kardex instructions to the Aides put the resident at risk of AC adverse side effects/events. Staff C stated that the facility's CPs were not up to date. Resident 61 Resident 61's Admission MDS dated [DATE] showed diagnoses including depression, a gait abnormality, and a lower back pressure ulcer. Review of progress notes dated 03/01/2022, 03/10/2022, 03/11/2022, 03/16/2022, 03/19/2022, 03/25/2022, 03/26/2022, 03/28/2022, 03/29/2022 and 04/17/2022 showed that Resident 61 refused to be weighed. A progress note on 3/16/2022 indicated wound care was also refused. In an interview on 04/27/2022 at 10:07 AM, Staff KK (outside wound care provider) stated Resident 61 was very noncompliant with care and had refused treatment the last two weeks. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the comprehensive CP indicated there was no CP problem to address the resident's depression diagnosis, or rejection of care. In an interview on 04/28/2022 at 09:30 AM, Staff C stated the Comprehensive CP should include interventions to address the resident's known pattern of refusals but did not. In an interview on 04/28/2022 at 01:00 PM, Staff G (Social Services Director) stated Resident 61 had a pattern of rejection of care and the CP should include a problem with interventions to address the behavior but did not. Resident 67 According to the 03/07/2022 Quarterly MDS, Resident 67 had diagnoses including Heart Failure and depression, for which they took Antidepressant (AD) medication. The MDS indicated Resident 67 was enrolled in Hospice services. Resident 67's record review showed Resident 67's Comprehensive CP did not include a CP addressing Hospice Services. Resident 67's record Review showed the Comprehensive CP included a Resident will remain here for long term care CP with a 10/14/2019 intervention to make arrangements with required community resources to support independence post-discharge (specify: homes care, PT, OT, MD, Wound Nurse). The intervention did not specify what type of post-discharge care Resident 67 required. The AD medication CP included a 05/01/2021 goal stating the resident will show decreased episodes (SPECIFY) of s/sx of depression (SPECIFY) through the review date. The CP did not specify a number of episodes or which signs and symptoms to monitor, and was not individualized or person-centered. In an interview on 04/28/2022 at 09:36 AM, Staff C stated the CP should have, but did not, include a Hospice CP. Resident 69 According to the 03/08/2022 Significant Change MDS, Resident 69 was severely cognitively impaired with diagnoses including Alzheimer's Disease and non-Alzheimer's Dementia. Resident 69's record review showed Resident 69's Dementia CP did not include quarterly cognitive and mood assessments. In an interview on 04/28/2022 at 09:16 AM, Staff C did not identify any measurable goals on Resident 69's Dementia CP. Staff C stated the facility assessed Resident 69 for mood and cognitive function quarterly, and that all residents received the same assessments on the same schedule. 43642 Resident 58 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 58 was admitted to the facility on [DATE]. According to the 02/23/2022 Admission /Medicare - 5 Day MDS, Resident 58 was assessed to have clear speech and to be able to understand and be understood by others. According to Resident 58's 02/22/2022 AC CP staff were directed to administer AC medications as ordered and to monitor for side effects and effectiveness every shift. Review of the March 2022 Medication Administration Records (MAR) showed the AC was discontinued on 03/09/2022. According to a 03/10/2022 social needs CP, The resident is independent for meeting emotional, intellectual, physical, and social needs r/t [related to] with a listed intervention that included, .The resident likes the following independent activities: (SPECIFY). The CP did not indicate what independent activities the resident likes. Review of CP on 04/25/2022 revealed no CP related to discharge planning for Resident 58. In an interview on 04/29/2022 at 7:33 AM, Staff C stated care plans should be individualized, updated, and revised to reflect the resident's current condition. Resident 59 Resident 59 was admitted to the facility on [DATE]. According to the 02/24/2022 Admission /Medicare - 5 Day MDS, Resident 59 had multiple medically complex diagnoses and was assessed to require extensive physical assistance from staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. According to Resident 59's 03/01/2022 social needs CP, The resident is dependent on staff and family for meeting emotional, physical, and social needs r/t with a listed intervention that included to Ensure that adaptive equipment that the resident needs is provided and is present and functional. (SPECIFY). Staff did not indicate what the CP related to, or specify what adaptive equipment Resident 59 was assessed to require. Review of the 02/18/2022 constipation CP showed showed the CP included a goal for Resident 59 to have a normal bowel movement at least every (SPECIFY) day. Staff did not specify a frequency for how often the resident should have a bowel movement. According to Resident 59's 02/21/2022 nutritional CP, the resident had interventions that directed staff to provide and serve Resident 59's diet as ordered, and listed the diet as vegetarian. Review of Physician Orders (POs) on 04/22/2022 revealed no orders that reflected Resident 59 was on a vegetarian diet. In an interview on 04/29/2022 at 7:33 AM, Staff C stated Resident 59's CPs should have been individualized, updated, and revised to reflect the resident's current condition. Resident 97 Resident 97 was admitted to the facility on [DATE]. According to a 03/25/2022 Quarterly MDS Resident 97 had multiple medically complex diagnoses including Alzheimer's disease (A progressive disease that destroys memory and other important mental functions). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to a 01/03/2022 CP, staff indicated Resident 97 uses psychotropic medications. Staff identified a goal that the resident will be free of psychotropic drug related complications. Interventions indicated staff were directed to administer psychotropic medications as ordered and to monitor for side effects and effectiveness every shift. Review of Resident 97's PO's showed the psychotropic medication for the resident was discontinued on 12/21/2021. Review of CP on 04/22/2022 revealed no CP related to discharge planning for Resident 97. In an interview on 04/29/2022 at 7:33 AM, Staff C stated it was their expectation that CPs be updated and accurate to reflect the resident's current condition. Staff C indicated the CP should have been, but was not revised to reflect Resident 97 was no longer receiving psychotropic medications. Resident 251 Similar findings were noted for Resident 251 who according to a 04/15/2022 Admission MDS had multiple medically complex diagnoses and was assessed as cognitively intact with clear speech. According to the 04/20/2022 social needs CP, no goals were established for Resident 251. Review of a 04/11/2022 chronic pain CP indicated no goals were established for Resident 251. Review of a revised 04/11/2022 impaired visual function CP, showed staff identified Resident 251 wore glasses and directed staff to ensure appropriate visual aids were clean and available to support resident's participation in activities. Review of a 04/15/2022 progress note by staff indicated Resident 251 was without glasses and stated the resident indicated they forgot their glasses at home. Review of CP on 04/25/2022 revealed no CP related to discharge planning for Resident 251. In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Operating Nurse) stated Resident 251's CPs should have been individualized, updated, and revised to reflect the resident's current condition. 44295 Resident 21 According to the 01/17/2022 Quarterly MDS, Resident 21 admitted on [DATE], had severe cognitive impairment, and diagnoses including Schizophrenia, Anxiety, and drug-induced Tardive Dyskinesia. The MDS showed the resident was assessed to require one-person physical assistance with bed mobility, transfers, dressing, eating, toilet use, personal hygiene, and bathing. Review of the resident's 09/16/2019 ADL (Activities of Daily Living) self-care performance deficit CP showed the resident was independent with bed mobility and transfers, required set up assistance with dressing, and supervision from staff with personal hygiene. Review of a 04/05/2022 revised CP showed the resident is at risk for pain related to immobility. Review of the resident's record indicated the resident was mobile and ambulated independently without staff assistance. (continued on next page)

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	505202	A. Building B. Wing	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a 04/02/2020 CP showed the resident was resistive to changing their clothes and included an intervention that directed staff to inform the resident it was time to change their clothes, and to lay out new clothing for the day. On 04/24/2022 at 9:01 AM Resident 21 was observed wearing a yellow, blue, and white striped long sleeve shirt and grey sweat pants. Similar observations of the resident wearing the same outfit on 04/25/2022 at 8:40 AM, 04/26/2022 at 9:32 AM, 04/27/2022 at 10:07 AM. On 04/26/2022 at 7:28 PM Resident 21 was observed ambulating independently from their room into the hall and was observed siting in the activity room at 7:47 PM. On 04/28/2022 at 8:55 AM Resident 21 was observed wearing a t-shirt and plaid pants. In an interview on 4/28/2022 at 8:56 AM Staff NN (Certified Nursing Assistant) stated I put new clothes out for [the resident] on the bed. If you instruct them it is time to change their clothes, they will change their clothes. When asked why their clothes were not changed for the past four days, Staff NN stated they did not know because they were working on another hall. In an interview on 04/28/2022 at 9:53 AM Staff C stated the CP was not correct and needed to be updated. Resident 30 According to the 01/17/2022 Annual MDS, Resident 30 admitted to the facility on [DATE], had severe cognitive impairment, and diagnoses including Schizophrenia, Diabetes, and Seizure Disorder. The MDS showed the resident was assessed to require two-person extensive assistance with bed mobility, transfers, dressing, and personal hygiene. Review of a 02/12/2020 the resident has an ADL self-care deficit CP showed the CP included an intervention that indicated the resident was totally dependent on staff for dressing, and needed to be out of bed every shift. The CP indicated the resident preferred to be up around 8 AM and to return to bed at 12 AM. Resident 30's record review showed a 11/18/2020 resident had an actual fall without injury CP included an intervention directing staff to keep the bed in the lowest position while Resident 30 was in bed. Review of a revised 01/13/2022 Nutrition CP showed the resident was on a Carbohydrate-Controlled diet with mechanical soft textured food, with thin liquids and no straws. On 04/21/2022 at 1:52 PM Resident 30 was observed lying in a bed that was raised to hip level, wearing a hospital gown. On 04/24/2022 at 9:17 AM Resident 30 stated, I want to get up, while they were observed lying in their bed that was raised to hip level, wearing a hospital gown. A water pitcher with a straw was observed on the bedside table. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/25/2022 at 9:03 AM Resident 30 stated, It's been a while since I got out of bed. The resident was observed lying in bed that was raised to hip level, wearing a hospital gown. Similar observations were made on 04/26/2022 at 9:39 AM and 2:45 PM, and 04/27/2022 at 10:12 AM. During an observation and interview on 04/28/2022 at 8:58 AM Staff OO (Certified Nursing Assistant - CNA) stated Resident 30 never refused and preferred to stay in bed. When asked why the resident wore hospital gowns, Staff OO stated they had never tried to get the resident dressed. Observations on 04/28/2022 at 9:03 AM Staff OO asked Resident 30 if they would like to get dressed and the resident replied, yeah I want to. Staff OO proceeded to get resident dressed. In an interview on 04/28/2022 At 9:53 AM Staff C stated if a resident preferred to only wear a hospital gown or not get out of bed, it should be care planned. Staff C stated they were not aware Resident 30 could not have straws and would have to look into it. Staff C stated they expected the staff to keep the resident's bed in the lowest position, as directed by the CP. Resident 76 According to the 03/15/2022 Quarterly MDS Resident 76 admitted to the facility on [DATE], was cognitively intact, and had diagnoses including Dementia with behavioral disturbances, Diabetes, and Depression. The MDS showed the resident did not use bed rails. Review of a 08/27/2020 revised CP showed the resident had limited physical mobility and an intervention of a mobility bar to the right side of the bed to assist the resident to move themselves in bed. On 04/24/2022 at 9:04 AM Resident 76's bed was observed with mobility bars to both sides of the resident's bed. In an interview on 04/28/2022 at 9:53 AM Staff C stated they expect the mobility bars to both be care planned. Resident 95 According to the 03/25/2022 Quarterly MDS, Resident 95 admitted to the facility on [DATE], was assessed with severely impaired cognition, and had diagnoses including Stroke (brain bleed), Dysphagia (difficulty swallowing), and Dysarthria (slow or slurred speech). The MDS showed the resident required extensive assistance with bed mobility, transfers, and toileting, and limited assistance with dressing. On 04/21/2022 at 1:49 PM Resident 95 was observed sitting on the edge of the bed wearing only a brief. Similar observations were made on 04/22/2022 at 1:50 PM, 04/25/2022 at 9:00 AM and 12:18 PM, and 04/26/2022 at 9:42 AM. In an interview and observation on 04/27/2022 at 11:57 AM, a communication board was used to ask the resident who was observed wearing only a brief, if it bothered them that they had no clothes to wear. Resident 95 pointed to NO with their finger. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/28/2022 at 8:58 AM Staff OO stated the resident preferred not to wear clothes and that they take their clothes off. In an interview on 04/28/2022 At 9:53 AM Staff C stated they would expect the CP to be updated with the resident's preference of not wearing clothes. Resident 153 According to the 04/07/2022 Quarterly MDS, Resident 153 admitted to the facility on [DATE], was assessed with severely impaired cognition, and had Medically complex conditions, including Schizophrenia, Diabetes, and Parkinson's Disease. The MDS showed the resident required extensive assistance with bed mobility, transfers, toilet use, eating, and personal hygiene. Review of a 12/14/2021 revised CP showed the resident had an ADL self-care deficit and was independent for bed mobility, personal hygiene, transfers and toilet use. Review of a 12/06/2021 revised CP showed the resident was at risk for falls, and directed staff to ensure the resident was wearing appropriate footwear when ambulating. Review of a 01/14/2019 revised CP showed the resident had a communication problem related to speaking a foreign language. The CP indicated English was not the resident's primary language. The CP directed staff to utilize a communication board in the resident's room. On 04/21/2022 at 1:28 PM Resident 153 was observed lying in bed wearing a hospital gown. During an observation and interview on 04/24/2022 at 9:08 AM Resident 153 was observed lying in bed wearing a hospital gown and stated they did not like to get out of bed. Similar observations of Resident 153 in bed, wearing a hospital gown were made on 04/25/2022 at 9:13 AM and 12:26 PM, on 04/26/2022 at 9:36 AM, 1:54 PM, 2:37 PM, and 7:42 PM, and on 04/27/2022 at 10:48 AM. Observations on 04/26/2022 at 1:54 PM showed no communication board located in the resident's room. In an interview on 04/28/2022 at 8:55 AM Staff NN stated the resident used to be independent with mobility and ADL's but required more care after an acute illness. During an interview on 04/28/2022 at 9:53 AM Staff C stated they expected the CP to reflect the resident's current status, and acknowledged the CP needed to be updated. Staff C stated if the resident's CP included a communication board, it should be available in the room for staff to use. Resident 81 According to the 03/20/2022 Medicare 5 Day MDS, Resident 81 readmitted to the facility on [DATE], was cognitively impaired, able to make their own decisions and required extensive assistance with bed mobility, dressing, toileting, personal hygiene, and bathing. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 81's 03/14/2022 ADLs CP included a bed mobility intervention stating the resident was totally dependent on staff for repositioning, eating, transferring and toileting. Review of the 04/18/2022 Pressure Ulcer (PU) CP showed the resident had a Stage four PU to their sacrum (bony end of the tail bone). The CP did not include instructions for the staff regarding repositioning the resident or directions on the use of an air mattress, including functions and settings. Observations on 04/23/2022, and 04/24/2022, showed Resident 81 was able to reposition themselves in bed, able to sit on the edge of the bed during mealtimes, and was able to walk using a walker in their room and in the hallways. In an interview on 04/24/2022 at 10:08 AM, Staff B stated the CP was inaccurate, and needed to be updated. REFERENCE: WAC 388-97-1020(1), (2)(a)(b). 44296 45941

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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** 42203 Based on observation, interview, and record review the facility failed to ensure services provided met professional standards of practice for 5 (Residents 251, 30, 95 21 & 58) of 25 sample residents reviewed. Facility nurses' failure to obtain, accurately transcribe, follow, and clarify Physician's Orders (POs) when indicated, and to sign only for tasks completed, placed residents at risk for medication errors, delays in treatment, unmet care needs, and potential negative outcomes. Findings included . Resident 251 Resident 251 was admitted to the facility on [DATE]. According to a 04/15/2022 Admission Minimum Data Set (MDS - an assessment tool) Resident 251 had multiple medically complex diagnoses including Peripheral Vascular Disease (A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs.) The MDS assessed Resident 251 with two venous ulcers (wounds on the leg or ankle caused by abnormal or damaged veins). According to the April 2022 Treatment Administration Record (TAR) staff were directed to apply compression bandages (used for the management of venous ulcers) to both lower legs in the morning and to remove at night. Observations on 04/23/2022 at 9:53 AM showed Resident 251's legs partially wrapped with loose sagging woven gauze and no compression bandage. Similar observations of Resident 251 without compression bandages were made on 04/25/2022 at 8:05 AM and 04/27/2022 at 10:05 AM. Review of Resident 251's April 2022 TAR showed staff documented the compression bandages were applied in the morning on 04/23/2022, 04/25/2022, and 04/27/2022. In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Nursing Officer) stated it was their expectation that staff complete Resident 251's treatments as ordered and confirmed staff should not sign for tasks that were not performed. Resident 30 According to the 04/13/2022 Quarterly MDS Resident 30 admitted to the facility on [DATE] and had medically complex conditions, including Schizophrenia and a Seizure Disorder. Review of Resident 30's POs showed a 04/12/2020 PO for an anticonvulsant medication used to treat seizure disorder and a 02/18/2021 PO to obtain a laboratory test (lab) to assess the anticonvulsant medication's blood level every two months. Review of the resident's record showed a lab for the anticonvulsant drawn on 08/19/2021, six months after the PO, and a second lab drawn on 10/20/2021, and a third lad drawn on 04/19/2022, six months later. (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 04/28/2022 at 9:53 AM, Staff C stated the anticonvulsant blood level should be checked every two months as ordered. Resident 95 According to the 03/25/2022 Quarterly MDS Resident 95 admitted to the facility on [DATE] and had diagnoses including Stroke (brain bleed) and Dysphagia (difficulty swallowing). Review of the resident's record showed Resident 95 admitted with a Gastrostomy tube (G-tube - a surgically placed device used to give direct access to the stomach). According to a progress note, Resident 95 pulled the G-Tube out of their stomach on 10/23/2021 and it was not replaced. Review of the PO's showed on 04/21/2022, six months after the G-tube was pulled out, the PO's changed from giving medications through the G-tube to giving medications orally. In an interview on 04/28/2022 at 9:53 AM Staff C stated they would expect staff to inform the Physician and obtain an order to give medications orally when the G-tube was pulled out. Staff C acknowledged that did not occur until 04/21/2022. Resident 21 According to the 01/17/2022 Quarterly MDS the resident admitted to the facility on [DATE] and had diagnoses including Schizophrenia, Anxiety, and drug-induced Tardive Dyskinesia (abnormal and involuntary movements of the face, limbs, and trunk). Review of the resident's record showed Certified Nursing Assistant (CNA) documentation on 01/25/2022 included a skin observation that documented a red area that was not previously observed. Review of the resident's record showed no indication the facility followed up with the newly identified red area. In an interview on 04/28/2022 At 9:53 AM Staff C stated the new red area should have been reported to the nurse, assessed by the nurse, and documented. Staff C acknowledged that did not occur. Resident 58 Resident 58 admitted to the facility on [DATE]. According to the 02/23/2022 Admission /Medicare - 5 Day MDS, Resident 58 was assessed with clear speech, able to understand, and be understood by others. In an interview on 04/22/2022 at 2:10 PM, Resident 58 indicated they were having trouble with constipation and reported they spoke with their provider requesting treatment. Review of the 04/26/2022 progress note showed the Nurse Practitioner ordered a laxative daily for seven days. (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 April 2022 Medication Administration Records (MARs) showed Resident 58 did not receive the 04/26/2022 ordered laxative. No documentation was found in the resident's records explaining why it was not started. In an interview on 04/29/2022 at 7:33 AM, Staff C stated it was their expectation that staff review provider progress notes and follow up with orders as indicated. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i). 43642 44295

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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** 43642 Based on observation, interview, and record review the facility failed to ensure residents who were dependent on staff to meet their Activities of Daily Living (ADLs) needs, were consistently provided such assistance for 11 (Residents 58, 97, 251, 59, 153, 30, 95, 21, 23, 81 & 82) of 14 sample residents reviewed for ADLs, and 3 supplemental residents (Residents 57, 20 & 8). Failure to provide assistance to residents who were dependent on staff for bathing (Residents 57, 58, 97, 251 & 59), nail care (Resident 57, 58, 97, 251, 59, 153, 30, 20, 30, 8, 81 & 82), eating (Resident 95), and personal hygiene (Residents 57, 251, 153, 30 & 21) placed residents at risk for unmet needs, poor hygiene, embarrassment and diminished quality of life. Findings included . According to the facility's 05/13/2021 ADLs policy, a resident who is unable to carry out ADLs will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident 57 According to the 02/20/2022 Admission Minimum Data Set (MDS an assessment tool) Resident 57 admitted to the facility on [DATE], was assessed to have clear speech, to be understood by and understand others. The MDS assessed Resident 57 to require extensive physical assistance with bed mobility, transfers, dressing and personal hygiene, and indicated bathing did not occur during the look back period. According to a revised 04/09/2022 ADL Care Plan (CP) Resident 57 had interventions that directed staff to provide bathing twice weekly on Saturday and Tuesday. Review of Resident 57's bathing documentation for April 2022 showed no bathing was provided after 04/16/2022 until 04/26/2022, a wait of 10 days. Observations on 04/21/2022 at 11:48 AM showed Resident 57 with long, jagged fingernails on both hands, and was unshaven with greasy, uncombed hair. In an interview at this time Resident 57 indicated they asked staff for a shave and stated, they can't do it. Resident 57 reported it was about two weeks ago when they had their last shower. Observations on 04/21/2022 at 12:22 PM showed Resident 57 was upset and asked staff about getting a shower. Similar observations of Resident 57 being unshaven with greasy hair and long fingernails were noted on 04/23/2022 at 11:29 AM and 04/24/2022 at 8:46 AM. In an interview on 04/26/2022 at 2:19 PM, Staff AA (Registered Nurse), confirmed Resident 57 was unshaven with long, jagged fingernails and stated their expectation was that staff provide shaving daily as needed and for nail care to be provided with bathing. Resident 58 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 58 was admitted to facility on 02/17/2022. According to the 02/23/2022 Admission MDS Resident 58 was assessed to have clear speech, to be understood by and understand others. The MDS assessed Resident 58 to require extensive physical assistance with bed mobility, transfers, dressing and personal hygiene, and indicated bathing did not occur during the look back period. In an interview on 04/22/2022 at 2:10 PM, Resident 58 stated, showers have been a bit of a disappointment. Resident 58 stated their nails, need to be trimmed and reported staff did not trim their fingernails since admission. Observations at this time showed Resident 58 was unshaven with long fingernails to the left hand and long, thick fingernails to the right hand. According to a revised 03/22/2022 ADL CP, Resident 58 had interventions that directed staff to provide bathing twice weekly on Saturday and Wednesday with extensive assistance. Review of Resident 58's bathing documentation for April 2022 showed Resident 58 went 27 days without a shower. In an interview on 04/26/2022 at 2:19 PM, Staff AA verified Resident 58 was not shaved and their fingernails were long. Staff AA stated staff should have, but did not provide ADL's as expected. Resident 97 Resident 97 was admitted to the facility on [DATE]. According to a 03/25/2022 Quarterly MDS, Resident 97 had moderate cognitive impairment and was not able to make decisions for themselves, but was able to be understood and understand others. The MDS assessed Resident 97 to require extensive physical assistance from staff for bed mobility, transfers, personal hygiene, and to require total assistance with bathing. Observations on 04/23/2022 at 9:59 AM, showed Resident 97 with dark debris under their long, untrimmed fingernails. Similar observations were noted on 04/25/2022 at 8:53 AM. According to a revised 01/25/2022 ADL CP, Resident 97 had interventions that indicated the resident required extensive assistance with personal hygiene and directed staff to provide bathing twice weekly on Monday and Friday. Review of the ADL documentation for April 2022 showed Resident 97 only had one documented occurrence of bathing on 04/14/2022, and no documented occurrences when nail care was provided. The resident went 24 days without a shower. In an interview on 04/25/2022 at 10:41 AM, Staff AA confirmed Resident 97 had untrimmed fingernails with dark debris under the nails on both hands and stated staff should have provided nail care and bathing as directed on the CP. Resident 251 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 251 was admitted to the facility on [DATE]. According to the 04/15/2022 Admission MDS Resident 251 was cognitively intact, with clear speech, able to be understood and understand others. This MDS assessed Resident 251 to require extensive physical assistance from staff for bed mobility, transfers, dressing, personally hygiene and indicated bathing did not occur during the look back period. Observations on 04/23/2022 at 9:47 AM showed Resident 251 had long and jagged fingernails to both hands, white debris to lower teeth. In an interview at this time, Resident 251 stated they have only had two showers since admission. According to a 04/08/2022 ADL CP, Resident 251 had interventions that directed staff to provide bathing three times per week and to provide assistance with care. Review of Resident 251's bathing documentation for April 2022 showed the resident was only provided bathing twice since admission on 04/17/2022 and 04/26/2022. In an interview on 04/29/2022 at 8:13 AM, Staff DD (Administer in Training) confirmed Resident 251 was not provided oral care as directed in the CP and verified Resident 251's fingernails were been trimmed. Resident 59 Similar findings were noted for Resident 59 who was assessed to require assistance from staff and was observed with untrimmed fingernails and was not provided bathing on three out of five scheduled opportunities in April 2022. In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Nursing Officer) stated it was their expectation staff provide assistance with bathing, shaving and nail care as directed by the residents CP. 44295 Resident 153 According to the 04/07/2022 Quarterly MDS the resident admitted to the facility on [DATE], had severe cognitive impairment, was rarely understood and rarely able to understand conversation. The MDS showed the resident had Medically Complex Conditions, including Schizophrenia, Diabetes, Dementia, and Parkinson's Disease. The MDS showed the resident was assessed to require extensive assistance from staff for bed mobility, transfers, dressing, eating, and personal hygiene. On 04/21/2022 at 1:28 PM Resident 153 was observed in a hospital gown lying in bed with long beard hairs and dark debris under the resident's fingernails. On 04/24/2022 at 9:08 AM Resident 153 was observed in a hospital gown lying in bed, the resident's hair was observed as oily and greasy, the resident's teeth were coated with a whitish debris in between and coating their teeth, and their face had long beard hairs. Similar observations were made on 04/25/2022 at 9:13 AM and 12:26 PM, and 04/26/2022 at 9:36 AM. (continued on next page)

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Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 04/26/2022 at 2:37 PM Staff SS (LPN Licensed Practical Nurse) observed Resident 153 and stated the resident's nails are long and dirty, they need to be cut and cleaned. Staff SS stated the resident had a bed bath today and they should have been shaved and their hair washed. Staff SS offered to cut the resident's nails and Resident 153 stated yes. Resident 30 According to the 04/13/2022 Quarterly MDS the resident admitted to the facility on [DATE], had severe cognitive impairment, was usually understood and able to understand conversation. The MDS showed the resident had Medically Complex Conditions, including Schizophrenia, Diabetes, and Seizure Disorder. The MDS showed the resident was assessed to require extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. During an observation and interview on 04/21/2022 at 9:01 AM Resident 30 was observed lying in bed in a hospital gown, their face had very dry skin . When asked what happened, Resident 30 stated, they probably haven't washed it. The resident had long facial hairs and fingernails were observed long in length. On 04/24/2022 at 9:17 AM Resident 30 was observed lying in bed in a hospital gown, with long facial hairs and dry skin on face. The resident's nails remained long and dark debris was observed under the finger nails. Similar observations were made on 04/25/2022 at 9:03 AM and 12:08 PM, and 04/26/2022 at 9:39 AM. In an interview on 04/26/2022 at 2:45 PM Staff SS stated Resident 30 normally does not have a beard and they should be shaved. Staff SS agreed the resident's nails were long with dark debris underneath and offered to cut the resident's nails. Resident 20 According to the 01/15/2022 Quarterly MDS the resident admitted to the facility on [DATE], had mildly impaired cognition, and was able to understand and be understood in conversation. The MDS showed the resident had diagnoses including Stroke (brain bleed), Non-Alzheimer's Dementia, and Depression. The MDS showed the resident required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. During an interview and observation on 04/25/2022 at 12:13 PM Resident 20 was observed lying in bed, a hand splint was observed on their left hand. Resident 20 pointed to their left thumb and stated, this is terrible, look at this thumb nail! Resident 20's fingernails were observed to long, especially the thumb nail on the resident's left hand. In an interview and observation on 04/26/2022 at 2:48 PM Resident 20 stated as they pointed with their finger nails, they are too long, they are like razor blades. At this time Staff SS observed the resident's nails and stated they need to be cleaned and cut. Resident 95 (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 the 03/25/2022 Quarterly MDS the resident admitted to the facility on [DATE], had severely impaired cognition, was sometimes able to understand and be understood in conversation. The MDS showed the resident had diagnoses including Stroke, Dysphagia (difficulty swallowing), and Dysarthria (weakness in muscles used for speech). The MDS showed the resident was assessed to require extensive assistance with bed mobility and toilet use, required limited assistance with transfers and dressing, and required supervision assistance with eating and personal hygiene. Review of the MDS showed bathing did not occur during the assessment period. On 04/22/2022 at 1:50 PM Resident 95 was observed sitting on the edge of their bed and a contracture (a permanent tightening of the muscles, tendons, skin that causes the joints to shorten and become stiff) was observed to their right hand and wrist. Similar observations were made on 04/25/2022 at 9:00 AM, and 04/27/2022 at 11:57 PM. On 04/25/2022 at 12:18 PM Resident 95 was observed with their lunch meal tray, which consisted of beef pot roast, roasted carrots, potatoes and onions, a side salad with dressing in a small cup with a lid, frosted gelatin poke cake, and a dinner roll. The resident's meat was not cut up, or the lids taken off the salad dressing cup. The resident was observed attempting to cut the meat using a fork in their left hand without success. In an interview on 04/28/2022 at 9:53 AM Staff C (Chief Nursing Officer) stated they would expect staff to assist a resident with one sided weakness and set up their meal tray by removing lids and assisting with cutting up foods a resident would not be able to do with the use of one arm. Resident 21 According to the 01/17/2022 Quarterly MDS the resident admitted to the facility on [DATE], had severe cognitive impairment, was rarely understood and rarely able to understand conversation. The MDS showed the resident had diagnoses including Schizophrenia, Anxiety Disorder, and Drug Induced Tardive Dyskinesia (abnormal and involuntary movements of the face, hands, limbs, and trunk). The MDS showed the resident was assessed to require supervision with bed mobility, transfers, walking, eating, bathing, and toilet use. The resident required limited assistance from staff for dressing. Review of a 04/08/2021 revised CP showed Resident 21 was resistive to changing their clothes and directed staff to inform them it is time to change their clothes and lay clothing out for the resident. On 04/24/2022 at 9:01 AM Resident 21 was observed wearing a yellow, blue, and white striped shirt, and grey sweatpants. Similar observations of the resident wearing the same outfit were made on 04/25/2022 at 8:40 AM, 04/26/2022 at 9:32 AM, and 04/27/2022 at 10:07 AM. In an interview on 04/28/2022 at 9:53 AM Staff C stated they expect the resident's clothes to be changed daily and as needed. Staff C stated staff should follow the CP and assist Resident 21 by laying clothes out for the resident daily. Resident 8 (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 the 04/05/2022 Quarterly MDS the resident admitted to the facility on [DATE], had severe cognitive impairment, was usually understood and able to understand conversation. The MDS showed the resident had diagnoses including Dementia, Schizophrenia, and Bipolar Disorder. The MDS showed the resident was assessed to require staff supervision for bed mobility, transfer, walking, dressing, eating, toilet use, and personal hygiene. Review of a 12/26/2020 CP showed the resident had an ADL self-care deficit and was independent with dressing. On 04/21/2022 at 1:48 PM Resident 8 was observed lying in bed wearing a pair of plaid lounge pants and a plaid button-down shirt. The residents face had long beard hair and their nails were observed long with dark debris under the nails. Similar observations were made on 04/24/2022 at 9:21 AM (when Resident 8's closet and drawers were observed with no clothing), 04/25/2022 at 8:59 AM, and on 04/26/2022 at 9:41 AM. In an interview on 04/26/2022 at 2:51 PM Staff SS stated it is hard to cut Resident 8's nails sometimes, but agrees they need to be cut and cleaned. Staff SS was not aware resident did not have any clothes available and stated they thought Resident 8 may have one more outfit. 45941 Resident 23 According to the 01/15/2022 Quarterly Minimum Data Set (MDS, an assessment tool), Resident 23 was cognitively severely impaired, demonstrated no behaviors or rejection of care, and required extensive assistance from staff for bed mobility, transfers, dressing, toileting, eating, personal hygiene, and bathing. A review of the 03/16/2018 care plan showed Resident 23 required 1-person extensive assistance for personal hygiene and oral care. Observations on 04/25/2022 at 12:05 PM, 04/26/2022 at 08:20 AM and 12:32 PM, 04/27/2022 at 12:25 PM, and on 04/28/2022 at 08:33 AM, showed Resident 23 with no dentures in their mouth and. Resident 23 was observed with dry food on their mouth and on beard. Resident 23's hearing aid was observed on top of their nightstand on each observation. In an interview on 04/26/2022 at 12:32 PM, Staff JJ (Nursing Assistant) stated they never saw the resident wearing dentures. Staff JJ stated they would expect the resident to receive oral care every day. Staff JJ stated Resident 23 should be assisted to use their hearing aids. According to 12/07/2021 dental consultation note, Resident 23 was not in their room during the dentist's visit. In an interview on 04/27/2022 at 10:23 AM, Staff H (Social Services) stated the resident did not have dentures and were on the list to see the dentist on 05/09/2022 in the facility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/27/2022 at 11:37 AM Staff B stated the resident should have received oral care every morning and after meals and that Resident 23 should be assisted to use their hearing aids during the day. Resident 81 According to 03/20/2022 Medicare 5 Day MDS Resident 81 was assessed with impaired cognition, able to make their decisions and required extensive assistance with bed mobility, dressing, toileting, personal hygiene, and bathing. Observations on 04/23/2022 at 10:00 AM, on 04/25/2022 at 03:15 PM, and on 04/26/2022 at 10:00 AM, showed Resident 81 had long and dirty fingernails. A review of the 03/14/2022 CP showed Resident 81 required total assistance from staff for personal hygiene. In an interview on 04/25/2022 at 11:23 AM Resident 81 stated that they could not clip their own fingernails and staff had no time to clip their fingernails. In an interview on 4/26/2022 at 10:30 AM Staff Q (Licensed Practical Nurse) stated staff should be providing nail care weekly for the resident and confirmed Resident 81's fingernails were long and were not clipped weekly. Resident 82 According to 03/17/2022 Quarterly MDS, Resident 82 was assessed with impaired cognition, and able to make their decisions. Resident 82 admitted with diagnoses including Stroke, Hemiplegia (Left side weakness), Arthritis and Anxiety Disorder, and required extensive assistance with bed mobility, dressing, toileting, personal hygiene, and bathing. Observations on 4/23/2022 at 10:22 AM, 04/24/2022 at 9:13 AM, 04/26/2022 at 7:30 PM, and 4/28/2022 at 8:45 AM showed Resident 82 with toenails that were very long, both feet with very dry skin, and dry skin was all over on their bed sheet. A review of the CP initiated on 05/07/2018 and revised on 2/17/2022 showed Resident 82 required extensive assistance from staff for personal hygiene. In an interview on 04/26/2022 at 11:37 AM, Staff F RCM (Resident Care Manager), confirmed that Resident 82 had long toenails and dry skin. Staff F stated the staff should be applying lotion to the resident's feet and their toenails should have been clipped or referred to the podiatrist but were not. REFERENCE: WAC 388-97-1060(2)(c)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview and record review the facility failed to develop and implement individualized activity plans for 4 of 5 residents (Residents 61, 251, 59 and 23) reviewed for activities, and one supplemental resident (Resident 69). Failure to consistently implement group or individual activity plans left residents at risk for boredom, isolation, and a diminished quality of life. Findings included . Resident 61 According to the 11/01/2022 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 61 was cognitively intact. This MDS showed, Resident 61 stated having books, magazines, and newspapers available was very important to them. This MDS showed participating in activities with groups of people was not very important for Resident 61. According to the 01/21/2021 activities Care Plan (CP), Resident 61's goal was to actively participate in independent leisure activities of choice daily in his room. The CP stated Resident 61's activity preferences were reading [the] daily newspaper, listening to music, animals, keeping up with the news, [sic] doing his favorite activity is very important. The CP directed staff to provide 1:1 [one-to-one] bedside/in-room visits 2-3 times per week or as resident allows, target: Reminisce, Current News, Hobbies, Games. The CP stated Resident 61 prefers independent activities at this time [.] Declines most offers for supplies, does enjoys a daily newspaper when available. Review of the resident's record showed activities staff charted both Group Activities and 1:1 Activities for Resident 61. The Group Activities charting showed that from 3/27/2022 to 4/24/2022 Resident 61 was invited to participate on 19 occasions. Resident 61 was noted to refuse the activity on 16 occasions and was charted as not applicable on three occasions. Review of the the 1:1 Activities charting showed that from 3/27/2022 to 4/24/2022 Resident 61 was offered 1:1 Activities on only five occasions, three of which were recorded as not applicable and two as resident refused. In an interview on 04/23/2022 at 8:41 AM, Resident 61 stated they would like to participate more in activities. In an interview on 04/25/2022 at 10:55 AM, Resident 61 stated that currently they did not have access to a newspaper and that they used to enjoy the newspaper daily when the facility formerly provided a free copy. Resident 61 stated they inquired last week with the activities department if it would be possible for Resident 61 to buy their own newspaper, and was told activities would get back to them but did not provide a newspaper or information on how to obtain a newspaper. In an interview on 04/26/2022 at 10:53 AM, Staff X (Activities Assistant) stated they were familiar with Resident 61. Staff X stated they knew Resident 61 preferred individual rather than group activities and that Resident 61 enjoyed the newspaper, reading, and listening to music. Staff X stated the facility no longer had newspapers delivered which prevented Resident 61 from reading it. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/27/2022 at 10:55 AM, Staff X and Staff Y (Activities Director) stated they did not recall that Resident 61 asked if they could purchase a newspaper subscription. Resident 251 Resident 251 admitted to the facility on [DATE]. According to the 04/15/2022 Admission MDS Resident 251 was assessed as cognitively intact, with clear speech, understood and was able to understand others. This MDS identified that it was very important to Resident 251 to participate in their favorite activities, listen to music, and it was somewhat important to have books, newspapers, and magazines to read, and do things with groups of people. Review of a 04/15/2022 Activities/Recreation Initial Review assessment showed Resident 251 liked to read, listen to music and attended some groups including the exercise group. According to a 04/20/2022 social needs CP, it was identified that staff would need to remind the resident of different programs that were available during the day and help to escort them to the activities of interest. This CP did not have any goals established for Resident 251. In an interview on 04/23/2022 at 9:09 AM, Resident 251 indicated they would like to go to activities and stated, but they don't do anything here. Observations of Resident 251's room on 04/21/2022 at 10:20 AM, 04/22/2022 at 12:46 PM, 1:57 PM, & 2:34 PM, 04/25/2022 at 8:05 AM, 12:01 PM & 12:31 PM, and 04/27/2022 at 10:05 AM showed Resident 215 lying in bed with no radio or mechanism to play music or personalized activities at the bedside. Review of the April 2022 1:1 Activities charting revealed, Resident 215 had only one documented activity participation on 04/19/2022, four occasions were documented as refused, and six occasions documented as not applicable. According to the April 2022 Group Activities charting, Resident 215 was invited to participate in activities on nine occasions but staff documented the resident refused, and had six occasions that were coded as not applicable In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Nursing Officer) stated it was their expectation that staff offer, encourage, and assist residents to participate in activities and be provided with individual activities per preference. Resident 59 Resident 59 was admitted to the facility on [DATE]. According to the 02/24/2022 Admission /Medicare - 5 Day MDS, had multiple medically complex diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). This MDS indicated it was very important for Resident 59 to listen to music and it was somewhat important: to do things with groups of people; to do their favorite activities; to get fresh air when the weather was good; and to participate in religious services. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 03/01/2022 Activities/Recreation Initial Review assessment showed Resident 59 required assistance to get to activities and indicated staff would find appropriate activities for the resident to attend due to the resident's dementia. This assessment indicated the resident required 1:1 assistance for Activities, preferred to exercise when able, and staff would try to encourage them to do other activities. The other activities were not identified on this assessment. According to 03/01/2022 activity CP, Resident 59 had little, or no activity involvement and staff were to focus on things the resident liked to do and focus on bringing those activities to the resident. Interventions included Resident 59 needed a variety of activity types and locations to maintain interest. Resident 59's record review showed the 03/01/2022 Social Needs CP included interventions that indicated Resident 59 needed assistance with arranging community activities. This CP gave directions that Resident 59 needed 1:1 bedside/in-room visits and activities if the resident was unable to attend out of the room events. Observations on 04/21/2022 at 1:43 PM, 04/23/2022 at 8:33 AM, 04/24/2022 at 8:48 AM & 9:18 AM, 04/25/2022 at 8:11 AM, 8:54 AM & 12:03 PM showed Resident 59 either lying or sitting on bed without TV on, music, or personalized activities at bedside. In an interview on 04/25/2022 at 12:33 PM, Resident 59 asked what they should be doing during the day and expressed they were hoping to get up and do something. Observations on 04/25/2022 at 12:51 PM showed Resident 59 remained in bed without offer to attend a music activity that was scheduled to start at 1:00 PM. Similar observations of Resident 59 lying in bed were noted on 04/26/2022 at 9:52 AM, 1:19 PM, 2:19 PM, & 7:42 PM, and 04/27/2022 at 10:11 AM. Review of the April 2022 1:1 activities charting showed, Resident 59 did not have any documented participation in this activity but was coded as not applicable on 04/03/2022, 04/05/2022, 04/10/2022, 04/24/2022, and 04/28/2022. According to the April 2022 Group Activities charting, Resident 59 was invited to participate on 12 occasions but staff documented the resident refused, and on five occasions were coded as not applicable In an interview on 04/29/2022 at 7:33 AM, Staff C stated it was their expectation that Activities would be offered and encouraged for residents and that Activities programs were individualized as needed for resident's that are not able to remain in group activities settings. Resident 23 According to the 01/15/2022 Quarterly MDS Resident 23 had severe cognitive impairment, demonstrated no behaviors or rejection of care, and required extensive assistance from staff for bed mobility, transfers, dressing, toileting, eating, personal hygiene, and bathing. This MDS showed the resident was not assessed for activities this quarter. Resident 23's primary language was [NAME] but the resident was able to understand and converse with limited English. In an interview on 04/25/2021 at 11:22 AM, Resident's 23's family stated the resident enjoyed religious prayers, [NAME] music, and getting up in the chair during daytime. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the 11/26/2021 activity assessment indicated the resident liked to listen to their religious prayers on a portable player in their room. A review of the 08/25/2020 CP showed Resident 23 enjoyed activities such as watching TV, listening to [NAME] music, and religious prayers. The CP instructed staff to encourage the resident's involvement in activities of interest: Music, movies, religious prayers, [NAME] music, offer [NAME] speaking talking books, and provide individual in room activities. Observations on 04/23/2022 at 9:07 AM and 12:32 PM ; 04/24/2022 at 8:50 AM, 9:47 AM, 11:38 AM and 3:38 PM ; 04/25/2022 at 9:42 AM, 11:20 AM, and 12:05 PM, and on 04/26/2022 at 9:19 AM, 10:30 AM, 12:24 PM, and 02:01 PM, showed no TV on, no radio or mechanism to play music, and no readily available individual activities in room. Resident 23 was lying in bed in a night gown all the times. In an interview on 04/27/2022 at 11:07 AM, Staff B (Director of Nursing) stated their expectations were the resident should be dressed, up in their wheel chair and attend activities or their music/TV should be on but acknowledged it was not. Resident 69 According to the 03/08/2022 Significant Change MDS, Resident 69 had severely impaired cognition and diagnoses including Alzheimer's Disease and non-Alzheimer's dementia. The MDS showed while they were in the facility it was very important to Resident 69 to listen to music they liked, somewhat important to do their favorite activities, and not at all important to do things with groups of people. According to the 01/13/2021 Activities CP, Resident 69 had Activities Goals to participate in independent activities of choice and 1-2 special events per week as [resident] will allow and to participate in independent activities of choice and in-room activities every other day. The CP included an intervention for staff to Provide 1:1 visits 2-3 times per week as [resident] will allow, target: Reminisce, Current News, Hobbies, Travel, Games . Review of the 1:1 Activities charting revealed in March 2022, Resident 69 was offered 1:1 activities on three occasions, participated actively once, refused once and was charted as not applicable once at 5:53 AM on 03/19/2022. The April 2022 charting from 04/01/2022 to 04/24/2022, included no record of any attempt by staff to provide 1:1 activities. Review of the Group Activities charting revealed in March 2022, Resident 69 was invited to participate on 11 occasions, refused on 7 occasions and was charted as not applicable once at 5:53 AM on 03/19/2022. The April 2022 Group Activity charting from 04/01/2022 to 04/24/2022 included 13 refusals, one occasion where Resident 69 actively participated and one occasion where they observed. In an interview on 04/27/2022 at 10:55 AM, Staff Y stated that activities play an important function for residents with dementia, that 1:1 activities were appropriate and could assist with the maintenance of cognitive function and that 1:1 activities were preferred by Resident 69. REFERENCE: WAC 388-97-0940(1). 43642 (continued on next page)

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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** 44296 Based on observation, interview, and record review the facility failed to ensure 3 (Residents 36, 251 & 153) of 17 residents reviewed, received the necessary care and services in accordance with professional standards of practice and their comprehensive person-centered care plan. The failure to implement monitoring and interventions for skin care (Resident 251),and air mattress settings (Resident 153) resulted in the potential for unmet care needs and diminished quality of life. The failure to provide physician ordered treatments for 1 (Resident 36) of 3 residents reviewed for non-pressure skin issues resulted in worsening of the skin condition, discomfort, and psychological distress to the resident. Findings included . Non-Pressure Skin Resident 36 The 04/27/2022 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 36 was cognitively intact, able to make themselves understood and understand others. Resident 36 was identified as high risk for skin injuries and had moisture associated skin damage with applications of ointments and medications to the skin. A review of the Physician Orders (PO) showed: 1. 01/17/2022 an antifungal powder that directed staff to apply to skin folds topically two times a day for itching 2. 01/17/2022 a barrier paste that directed staff to apply to skin folds topically two times a day for itching 3. 01/17/2022 an anti-inflammatory ointment that directed staff to apply topically to affected area every 12 hours as needed for itching. 4. 01/17/2022 a lotion that directed staff to apply to affected area topically every eight hours as needed for itching three times a day 5. 01/19/2022 a topical solution that directed staff to apply to skin folds topically as needed for excess moisture two times a day as needed. 6. 02/23/2022 treatment for multiple areas of dermatitis (rash) in folds of skin bilateral flanks (underarm), pannus (abdomen) area, and behind knees, recommended by wound specialist: Cleans folds gently with warm water, pat dry, apply a anti-inflammatory ointment and anti-fungal powder and moisturizing cream, place sheets when available in folds (washable and reusable product) Provide treatment three times a week until resolved or new treatment needed, one time a day every Monday, Wednesday, and Friday, wound nurse provide treatment when available. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the 04/2022 Medication Administration Record (MAR) showed: 1. Anti-fungal Powder ordered for twice daily was not administered seven times on day shift and 12 times on evening shift between 04/01/2022 and 04/21/2022. 2. Barrier paste ordered for twice daily was not administered nine times on day shift and 17 times on evening shift. 3. Anti-inflammatory ointment, lotion and topical solution was not administered at all in the month of April 2022. 4. The anti-inflammatory and anti-fungal powder and moisturizing cream with bed sheets in skin fold daily on Monday, Wednesday and Friday was not administered on Friday, 04/22/2022 as scheduled. A review of the 03/02/2022 wound specialist note showed the left flank with a rash and maceration (broken skin from moisture) noted to skin fold with a treatment prescribed- anti-inflammatory ointment and anti-fungal powder followed by a moisturizer daily, place pillowcase between folds. These recommendations were not found on the physician orders to replace the 01/17/2022 and 02/23/2022 treatment orders. Review of the 04/2022 Kardex (care instructions) showed no instructions to staff to clean Resident 36's skin daily or place the pillowcases between the skin folds. A review of the weekly wound evaluation assessments for Resident 36 showed the last assessment for the left flank wound was completed on 03/10/2022 at 8:44 AM. There were no assessments of the left flank wound after 03/10/2022 to indicate the facility was managing the wound care with updated orders or ensuring daily skin hygiene. The 04/01/2022 Care Plan (CP) directed staff to administer treatments as ordered and monitor for effectiveness, if the resident refuses treatment, confer with the resident to determine why and try alternative methods to gain compliance, document alternative methods. There was no CP for the left flank skin care or hygiene. In an interview on 04/22/2022 at 2:25 PM, Resident 36 stated they had redness under the arms in the skin folds that was itchy, painful, and not being taken care of by the staff. Resident 36 stated the doctor ordered daily cleaning and an ointment and a powder. Resident 36 raised their left arm and moved the fold of skin which showed bright red, moist, bumpy skin that had patches of white. The rash spanned from the chest to the back and covered the entire inner skin fold. Resident 36 stated the area was not cleaned or a treatment applied since Monday, 3 days earlier. Resident 36 stated the nurse often came between 11:00 PM and 1:00 AM to do the treatment while they were already asleep, and they would refuse and send the nurse away. Resident 36 stated, the nurse should come when I am awake, I am tired of them waking me in the middle of the night. Resident 36 stated , with tears in their eyes, no one should have to live like this. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/25/2022 at 12:22 PM, Resident 36 stated the facility got rid of the shower aide and made the caregivers do the showers. Resident 36 stated they had not had a shower since the beginning of March and only had bed baths. Resident 36 showed under their arm and the skin was redder and flakier and had drips of moisture than what was observed on 04/22/2022 at 2:55 PM. Resident 36 stated their sheets were all wet and it was that way all night. Resident 36 said they told the staff that morning about the sheets, but the staff did not change the sheets yet. Observation showed the sheets were wet, spanning the entire width of the resident from mid back down to where the resident was sitting in the bed. Resident 36 stated, I want to have a shower, I need them to take care of my skin, I am on the low priority for wound care. When they don't do the wound treatments the rash gets worse, and it hurts, In an interview on 04/27/2022 at 12:38 PM, Staff F (RCM & MDS Nurse) stated physician orders for wound care was not obtained or administered as prescribed. Staff F stated the facility wound care nurse resigned three or four weeks ago and the position was not filled. In an interview on 04/28/2022 at 2:13 PM, Staff C (Chief Nursing Officer) confirmed the orders written by the wound specialist on 03/02/2022 was not updated in the resident's record and the prior orders were not discontinued. Staff C acknowledged the treatments were not administered when Resident 36 was awake to avoid refusal of treatments. 43642 Resident 251 Resident 251 was admitted to the facility on [DATE]. According to a 04/15/2022 Admission MDS, Resident 251 had multiple medically complex diagnoses including Peripheral Vascular Disease (A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). This MDS assessed Resident 251 to be at risk of Pressure Ulcers/Injuries and had two venous ulcers (wounds on the leg or ankle caused by abnormal or damaged veins). According to the 04/21/2022 Pressure Ulcer/Injury Care Area Assessment, Resident 251 was identified on admission with two small open skin areas on the left lower leg and was receiving treatment per the April 2022 TAR. Review of the April 2022 TARs showed an order that directed staff to apply compression bandages used for the management of venous ulcers to both lower legs in the morning and to remove at night. Observations on 04/23/2022 at 9:53 AM showed Resident 251's legs partially wrapped with loose sagging woven gauze and no compression bandage. Similar findings of Resident 251 without compression bandages was observed on 04/25/2022 at 8:05 AM and 04/27/2022 at 10:05 AM. In an interview on 04/29/2022 at 7:33 AM, Staff C stated it was their expectation that staff complete Resident 251's treatments as ordered. 44295 Air Mattress Settings (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident 153 According to the 04/07/2022 Quarterly MDS, the resident had diagnoses including Schizophrenia, Diabetes, Dementia, and Parkinson's Disease. Resident 153 was assessed at risk for pressure ulcers and required a pressure reducing device for the bed. Review of PO's showed a 10/04/2021 PO for a specialty mattress, and directed staff to check function every shift. Green light equals proper functioning. LN (Licensed Nurse) initials indicates functioning as per order. Review of a 12/31/2020 Potential for skin breakdown/pressure injury CP showed an intervention that resident requires a pressure relieving device on the bed. On 04/24/2022 at 9:08 AM the resident was observed lying on an air mattress. The air mattress settings were observed on alternating and the weight setting was at 450 lbs (pounds). Similar observations were made on 04/25/2022 at 9:13 AM and 12:26 PM, 04/26/2022 at 9:36 AM, and 04/27/2022 at 10:08 AM. Review of the resident's weight record showed on 04/25/2022 the resident weighed 107.5 Lbs. In an interview on 04/28/2022 at 9:53 AM Staff C stated they expected the air mattress to be set at the appropriate weight, and acknowledged Resident 153 did not weigh 450 lbs. REFERENCE: WAC 388-97-1060(1).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview and record review, the facility failed to provide vision services according to professional standards of nursing for 1 (Resident 67) of 3 reviewed for vision and hearing services. Failure to arrange vision services left residents at risk for impaired vision and diminished quality of life. Findings included . According to the 03/07/2022 Quarterly MDS (Minimum Data Set - an assessment tool) Resident 67 was cognitively intact, had impaired vision that required corrective lenses, and diagnoses including Myasthenia Gravis (MG - a disease affecting the immune system that can cause visual symptoms including drooping eyelids and double vision). According to the 10/13/2019 Resident Has Impaired Visual Function Care Plan (CP), Resident 67 required glasses. The CP directed staff to monitor for worsening vision/double vision (related to MG diagnosis) and to remind resident to wear glasses when up. Ensure resident is wearing glasses which are clean free from scratches and in good repair. Report any damage to nurse/family. During an interview on 04/22/2022 at 9:04 AM Resident 67 was observed not wearing glasses. Resident 67 stated that their glasses did not fit and were the wrong prescription. Resident 67 stated the facility optometrist was not professional and they wanted to see an outside optometrist. Resident 67 stated they had informed the facility they needed better glasses but felt staff were indifferent. I have to use a magnifying glass to read. Review of Resident 67's record showed they last saw the optometrist on 02/06/2020. According to a 03/06/2020 Social Services (SS) progress note Resident 67 received [their] new eyeglasses yesterday. A 04/05/2021 SS progress note showed Resident 67 received new glasses in February 2020 and should have a glasses appointment in a year or as necessary. A 03/30/2020 Activities progress note stated Resident 67 wears glasses for reading. From 03/30/2020 to 04/29/2022, there were no other progress notes that addressed Resident 67's vision or the resident's dissatisfaction with their glasses or their desire to see a different optometrist. In an interview on 04/27/2022 at 11:53 AM with Staff G (Social Services Director) and Staff H (Social Services Assistant), Staff H stated Resident 67 refused to see the optometrist on the 12th and said Resident 67 said the optometrist was no good. Staff G stated we should arrange some follow up with an outside provider. Staff H stated that a collateral contact of Resident 67 offered to assist with the arrangement of an appointment but they did not document the conversation. REFERENCE: WAC [PHONE NUMBER](3)(a).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview and record review the facility failed to ensure care is provided consistent with professional standards of practice to prevent and/or provide treatment and services for pressure ulcers for 3 of 8 (Resident 3, 97, & 76) residents reviewed for Pressure Ulcers (PU). Failure to identify and assess changes in skin condition, notify the practitioner to obtain orders for treatment, and complete weekly documentation of PU progress caused harm to Resident 3 who obtained two stage four PUs on the right hip, one stage 4 PU on the right outer ankle and one stage 4 PU on the right outer foot. Failure to implement preventative measures (Residents 97 &76) such as positioning, placed residents at risk for deterioration in skin condition. Findings included . According to the 05/17/2021 facility policy titled, Pressure Injury Risk Assessment, residents determined as at risk for developing pressure injuries would have interventions documented in the Care Plan (CP) based on specific factors identified in the risk assessment. According to the National Pressure Injury Advisory Panel (NPIAP) PU stages are defined as; Stage 1 PI: intact skin with a localized area of non-blanchable (discoloration of the skin that does not turn white when pressed), Stage 2 PI: partial thickness loss of skin with exposed dermis (second layer of skin), may present as an intact or ruptured serum-filled blister, granulation tissue (indicates healing), slough (yellow/white material in wound bed) and eschar (dead tissue) are not present. Stage 3 PI: full thickness loss of skin, in which adipose (fat) is visible, slough and/or eschar may be visible. Stage 4 PI: full thickness skin and tissue loss with exposed or directly fascia (connective tissue), muscle, tendon, ligaments, cartilage, or bone in the ulcer. Resident 3 The 02/10/2022 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 3 was admitted to the facility on [DATE] and was on hospice care. Resident 3 had diagnoses of malnutrition, dehydration, and one stage 4 PU on the low back and one stage 4 PU on the right hip. Resident 3 was assessed as high risk for PU development and the assessment only identified one PU on the MDS. Resident 3 was assessed to require extensive assistance with bed mobility and total dependence with transfers using a mechanical lift. A review of the 03/16/2022 wound specialist notes showed Resident 3 only had one PU on the low back that was a stage 4 with increased breakdown to the ulcer edges with more dead skin cells in the wound. The recommended treatment was to be completed daily. A 03/17/2022 Physician Order (PO) showed treatment orders for a Pressure ulcer (on low back) stage 4: Cleanse, pack wound and cover with foam dressing daily. Change daily by floor nurse except Wednesday when wound specialist sees the resident. The treatment was scheduled to be performed every night shift. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the 03/23/2022 nurse progress note showed Resident 3 refused wound care by the wound specialist on the 03/23/2022 weekly rounds. There is no documentation of nursing staff assessment or care provided to the PU's on 03/23/2022. The 03/23/2022 CP showed Resident 3 had a stage 4 pressure ulcer on the low back. The interventions directed staff to assess, record, and monitor wound healing weekly including measurements, status of the wound, and healing progress. The CP specified use of foam boots on both feet and an air mattress with settings to be checked every shift. The CP directed staff to refer assessments and treatment recommendations to the wound specialist. The CP directed staff to inform the resident, family, and caregivers of any new area of skin breakdown. A review of the 03/25/2022 nurse progress note showed the Resident Care Manager (RCM) called the hospice nurse to come and see Resident 3 for a new red area on the right hip. The RCM wanted the hospice nurse to help with a plan to prevent PUs. The 03/29/2022 weekly skin observation assessment identified the ankle and right outer foot pressure ulcers. The assessment showed these PU were not new and further assessment was not required. There was no documentation to show the nurse staff notified the physician on this assessment information. There was no documentation or PO for treatment for the two new PUs. A review of the 03/30/2022 nurse progress note showed Resident 3 refused wound care, a second time, by the wound specialist on the weekly rounds and the Director of Nursing and Hospice was notified. There is no documentation that the facility nursing staff provided assessment or PU care to the current five (1-low back, 2-right hip, 3-right hip, 4-right ankle, 5-right foot) PUs on 03/30/2022. A review of the 04/01/2022 nurse progress note showed the RCM called hospice to inform them the wound specialist would no longer be visiting Resident 3 because of hospice services. The RCM asked the hospice nurse to manage wounds and was waiting for a call back. A review of the 04/01/2022 hospice nurse visit notes showed the facility did not report any concerns at this visit. The hospice nurse validated and verified that the caregiver demonstrates and verbalizes understanding of the plan of care and will notify hospice with falls, uncontrolled symptoms, changes in condition, questions, concerns. The hospice nurse was still uninformed about the status of the right hip, new right ankle, and new right foot PUs. A 04/06/2022 nurse progress note showed the hospice nurse visited Resident 3 but Resident 3 did not allow the hospice nurse to assess the right hip area. The nurse note showed the plan was to continue current treatments to the low back only and reposition resident as they allow. A review of the 04/06/2022 hospice nurse visit notes showed the RCM called and requested the hospice nurse visit because a new open area on the right hip was identified. The 04/06/2022 hospice note showed Resident 3 refused to let the nurse assess the right hip PU, so the hospice nurse did not give treatment recommendations to the facility for care of the PU. Resident 3 also did not allow the hospice nurse to complete a full skin check, thus the hospice nurse did not identify the additional PUs on the right ankle or right foot. There were no recommendations for treatment of the right hip, right ankle or right foot PU provided by the hospice provider or forwarded to the facility practitioner for nursing staff to implement. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An observation on 04/21/22 at 11:18 AM showed Resident 3 was lying on their right side on the air mattress that was set to 400 pounds, and not wearing foam boots. Resident 3 did not appear to be 400 pounds. The last weight recorded on 01/24/2022 was 107 pounds. The 04/22/2022 hospice nurse visit notes showed no concerns or issues reported by the floor staff at this visit. The hospice nurse validated and verified that the caregiver demonstrates and verbalizes understanding of the plan of care and will notify hospice with falls, uncontrolled symptoms, changes in condition, questions, concerns. The hospice nurse was still uninformed about the right ankle and right foot PUs. An observation on 04/23/22 at 10:56 AM showed Resident 3 was lying on their back, no foam boots and air mattress setting at 400 pounds. An observation on 04/25/2022 at 8:59 AM showed Staff S (Registered Nurse) in the middle of providing wound care to Resident 3. Resident 3's right ankle and right foot were covered with a clean foam dressing. There was a PU at the base of the back and two PU on the right hip that had a paste surrounding the wound on the intact skin. Staff S placed the packing material in the low back wound and covered with a foam dressing. Staff S placed an ointment in both hip wounds and covered with a foam dressing. When asked, Staff S stated the right foot, right ankle, low back, and two right hips PU were all stage 4 PU. Staff S stated the wound specialist comes on Wednesdays and that is when the wounds are measured and evaluated for a change in treatment. Staff S was not aware the wound specialist was no longer directing wound care for Resident 3. Staff S confirmed there were no PO for treatments for the right hip, right ankle and right foot and there should be PO obtained. A 04/25/2022 nurse progress note identified the PU on the low back, right hip, right outer ankle, and right outer foot. The note showed staff would report the new PU to the care team, hospice nurse, and the physician. A 04/27/2022 in person physician visit note showed provision of wound care changed from the wound specialist to hospice services. The physician documented Resident 3 had a long history of a low back PU and referenced the 04/25/2022 nurse progress note. The physician did not mention changes in PU assessment or treatment plan for the hip, ankle, or foot pressure ulcers. A review of the nursing progress notes from 03/29/2022 to 04/27/2022 showed no documentation the physician was notified of the two hip, one ankle and one foot ulcers. There was no documentation the hospice nurse was notified of the ankle or foot ulcers. In an interview on 04/27/2022 at 12:38 PM, Staff F (RCM & MDS nurse) stated when the new PU was identified the physician and the hospice nurse were expected to be notified. Staff F stated a treatment order was expected to be obtained and must be in place before the nurse could provide the treatment. Staff F reviewed Resident 3's record and was not able to find any documentation that the physician or hospice nurse were notified. Staff F reviewed the POs and stated there were no treatment orders for the hip, ankle, or foot. Staff F observed Resident 3's hip, ankle, and foot and confirmed the placement of a dressing on all three areas. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 04/27/2022 at 12:36 PM Staff E (Staff Development Coordinator) stated the facility performed competency checks for all nurses who provided wound care. Staff E was unable to provide a competency evaluation for Staff S who was observed providing wound care without orders on 04/25/2022. Staff E was not able to provide a competency evaluation for wound care for Staff U (RCM) responsible for coordinating care and treatment with the wound specialist, hospice nurse, and the physician. In an interview on 04/27/2022 at 3:21 PM Staff B (Director of Nursing) stated the nurses are expected to identify and assess changes in skin condition, notify the practitioner to obtain orders for treatment, and complete weekly documentation of wound progress. Staff B acknowledged the nurses did not follow the expectation and resulted in Resident 3's PUs not being treated. 43642 Resident 97 Resident 97 was admitted to the facility on [DATE]. According to the 03/25/2022 Quarterly MDS Resident 97 had multiple medically complex diagnoses and was assessed to be at risk for developing PU. This MDS assessed Resident 97 to require extensive physical assistance from staff for bed mobility, transfers, and dressing. Observations on 04/21/2022 at 10:38 AM showed Resident 97 asleep sitting in wheelchair (w/c) next to their bed. On 04/21/2021 at 12:41 PM and 1:50 PM showed Resident 97 remained sitting up in w/c at side of bed. According to a 12/19/2021 PU Care Area Assessment (CAA) associated with Resident 97's 12/14/2021 Admission MDS, showed staff documented Resident 97 had preventative measures in place, which included repositioning and stated, .will proceed to plan of care. Review of Resident 97's CP on 04/22/2022 revealed no identified concerns or interventions related to the resident being at risk for developing PUs. In an interview on 04/23/2022 at 8:47 AM, Staff Z (Certified Nursing Assistant- CNA), indicated Resident 97 had no skin risks or concerns. Observations on 04/25/2022 at 10:41 AM with Staff AA (Registered Nurse - RN) showed Resident 97 had redness noted to bilateral buttocks. In an interview at this time, Staff AA indicated Resident 97 was at risk for developing PUs and should be repositioned frequently. In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Nursing Officer) stated staff should have but did not update and revise Resident 97's CP to include interventions to prevent the development of PU. Resident 76 According to the 03/15/2022 Quarterly MDS Resident 76 had diagnoses including dementia with behavioral disturbances, diabetes, and depression. The resident was assessed to be at to be at risk for developing PUs and currently had no PUs. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A 03/21/2022 nursing progress note showed staff identified an open and unopened blister to the right lateral thigh during the weekly skin assessment that caused Resident 76 mild pain to the area. Staff documented they were unsure how the blister developed. Review of a 03/21/2022 Weekly skin observation assessment showed no new skin issues. Additional notes showed Resident 76 had a right lateral upper thigh open skin area that measured 8 x 4.5 cm (centimeters) and a fluid filled blister on the right upper lateral thigh that measured 3.5 cm x 2.5 cm. Review of a 03/21/2022 Incident report showed, the root cause analysis presents that the resident has large friction rub and provider agreed. The investigation did not determine what caused the large friction rub. A 03/22/2022 Physician note showed the resident presented with an apparent large friction blister to the right lateral thigh. The resident informed the physician they did not experience acute trauma to the area. Review of a 03/22/2022 Potential for impairment to skin integrity related to edema, fragile skin, redness to the bi-lateral lower extremities, and an actual skin impairment of a open blister to the lateral right thigh. The CP interventions included educate resident and caregivers of causative factors and measures to prevent skin injury, and to monitor the open and unopened blister to the right lateral thigh. There were no identified interventions on the CP to prevent the wound from worsening or reoccurring. A 03/30/2022 nursing progress note showed the resident missed the wound provider visit and the PU was assessed by facility staff. Staff documented the PU measured 4.5 cm x 9 cm x 0.1 cm, had no odor but did have yellowish colored slough. A 03/31/2022 wound provider assessment showed the cause of the resident's right lateral thigh PU was an abrasion with partial thickness injury of the skin. On 04/27/2022 at 10:04 AM Resident 76 was observed in their power wheelchair, the wheelchair controls were observed on the right side of the chair, making contact with the residents right lateral thigh, where the PU was located. In an interview on 04/27/2022 at 11:12 AM the contracted wound provider stated the CAUSE may be from pressure caused by the resident's wheelchair. Refer to F849 Hospice Services. Refer to F726 Competent Nursing Staff. REFERENCE: WAC 388-97-1060(3)(b).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44296 Based on observation, interview, and record review the facility failed to ensure the residents' environment was free from accident hazards, including securing portable oxygen tanks (contains compressed oxygen). The failure to secure portable oxygen tanks in 3 (Resident 90, 84 & 66) resident rooms and in an oxygen storage room placed the residents at risk for serious adverse outcomes if oxygen tanks fell or tipped over, with the potential for an explosion and/or serious bodily injury, and constituted an immediate jeopardy (IJ). On 04/22/2022 at 10:57 AM an IJ was identified and the Provider was informed. On 04/25/2022 at 12:00 PM, the facility removed the immediacy by ensuring all portable oxygen tanks were secured, all resident rooms, offices, therapy gyms, and closets were audited to ensure oxygen tanks were properly stored and secured, and staff were trained on oxygen storage and handling. Additionally, the facility failed to identify potential accident hazards, assess potential hazards, and provide interventions for 2 (Resident 84 & 81) residents, one of whom smoked a cigarette while the portable oxygen tank flow was on, and one resident who used a heating pad. Additional accident hazards were identified in common resident areas, to include sharp metal filings in the resident activity room, unsecured stairwell door, unattended cookies and a cookie baking oven easily accessible to residents, and one (Resident 67) resident room with multiple stacked boxes, all of which had the potential to result in avoidable accidents and/or injury to the residents. Findings included . Review of the 04/22/2022 facility Oxygen Safety policy showed oxygen cylinders (tanks) would be properly chained or supported in racks or carts to prevent tanks from falling. The policy directed staff to protect tanks from damage by not storing portable oxygen tanks in locations where they could tip over. The policy showed No Smoking rules will be strictly enforced while oxygen was in use, including removal of smoking materials from residents receiving oxygen. Compressed Oxygen Tanks Unsecured Resident 90 Review of the 03/23/2022 Admission Minimum Data Set (MDS an assessment tool) showed Resident 90 had diagnoses including Chronic Obstructive Pulmonary Disease (COPD), required oxygen, and was not a smoker. Resident 90 was assessed with moderately impaired cognition, was capable of making their own decisions, and required limited assistance from staff for bed mobility, transfers, dressing, toilet use and personal hygiene. Review of Physicians Orders (PO) showed a 03/18/2022 PO that directed staff to titrate (continuously measure and adjust) oxygen (O2) 1-5 L (liters) to keep O2 saturations (indicates the amount of oxygen in blood) between 88-92%. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An observation on 04/21/2022 at 8:38 AM showed Resident 90 sitting in a wheelchair at their bedside table trying to rearrange a very long oxygen tube. There was a portable oxygen tank standing on the floor near the resident's feet. The tank was not in a cart, rack or secured in any way. In an interview on 04/21/2022 at 8:44 AM, Staff Q (Licensed Practical Nurse) stated Resident 90's oxygen tank was not secured and it should be in a cart. On 04/21/2022 at 8:45 AM Staff T verified Resident 84's oxygen tank should not be on the floor or on the seat of the walker and placed the oxygen tank in the bag under the seat to secure it from falling. Staff Q removed the immediacy of potential harm. Resident 84 Review of the 03/18/2022 Quarterly MDS showed Resident 84 had diagnoses including COPD, required oxygen, and was not a smoker. The resident was assessed with mildly impaired cognition, was capable of making their own decisions, and required staff supervision for bed mobility, locomotion on and off the unit, dressing, eating, toilet use, and personal hygiene. Review of PO's showed a 01/31/2021 PO that directed staff to administer O2 at 2 L per minute via a nasal cannula (tubing used to deliver oxygen) and remind the resident to keep it on. An observation and interview on 04/21/2022 at 8:46 AM showed Resident 84 was sitting on their bed with their four-wheeled walker observed at the foot of the bed, a portable oxygen tank was observed standing on the floor next to the wheel of the walker. Resident 84 stated they did not have an oxygen holder to secure the tank and usually laid the tank on the seat of the walker when ambulating. In an interview and observation on 04/21/2022 at 8:53 AM, Staff T (Certified Nursing Assistant) stated the oxygen tank was usually on the seat of Resident 84's walker and not on the floor. Staff T placed the tank on the seat of the walker. Resident 66 Review of the 03/17/2022 Medicare 5 Day MDS showed Resident 66 had diagnoses including Congestive Heart Failure, and did not use oxygen. The resident was assessed as cognitively intact, was able to make their own decisions, and required extensive assistance from staff for bed mobility, dressing, toilet use, and personal hygiene. Review of PO's showed a 03/21/2022 PO that directed staff to titrate O2 1-2 L to keep O2 saturations greater than 93%. Observation on 04/22/2022 at 8:42 AM and 9:22 AM showed an oxygen tank standing upright on the floor of Resident 66's room, unsecured and next to the oxygen concentrator. 200 East Hall Oxygen Storage Room Observation on 04/22/2022 at 8:52 AM showed an unsecured oxygen tank sitting on the cement floor inside the door of the oxygen storage room on the 200 East Hall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Unlabeled Oxygen In Use Signs In an interview on 04/22/2022 at 11:25 AM, Staff CC (Chief Nursing Officer) verified Resident 6, Resident 90, and Resident 84 used oxygen in their rooms. Staff CC acknowledged there was no sign at the resident's door instructing staff that oxygen was in use In an interview on 04/21/2022 at 8:50 AM, Staff BB (Certified Nursing Assistant) stated it was their second day at the facility and to ask someone else how to secure portable oxygen tanks. On 04/22/2022 at 10:57 AM Staff EE (Chief Executive Officer- CEO), Staff A (Administrator), Staff B (Director of Nursing), and Staff C were informed of the unsecured portable oxygen tanks and took immediate action to remove the immediacy and acknowledged portable oxygen tanks must be secured in a rack, cart, or holder to prevent tipping or falling over. On 04/22/2022 at 11:25 AM the Fire Marshall identified nine unsecured oxygen tanks in a crate in the back of the 200 East Hall oxygen room. At 11:45 AM on 04/22/2022 the Fire Marshall identified 12 portable oxygen tanks and an oxygen re-filling tank located in the physical therapy gym that were unsecured. On 04/22/2022 at 11:46 AM Staff DD (Administrator in Training) and Staff EE were made aware of the unsecured oxygen tanks in the physical therapy gym and started relocating the oxygen tanks to the 100 hall oxygen room. Smoking and Oxygen Use Resident 84 Observations on 04/28/2022 at 10:23 AM showed Resident 84 walked down the driveway, through parked cars to a small stairwell. At 10:30 AM, Resident 84 sat on the concrete parking curb with the oxygen tank secured to the walker and the oxygen tubing in their lap. The oxygen regulator was open, and oxygen was flowing from the tank. Resident 84 had a burning cigarette in their hand and a package of cigarettes sitting on the ground next to them. Resident 84 confirmed the oxygen was flowing and they usually turned it off, but not this time. In an interview on 04/28/2022 at 12:55 PM Staff V (Receptionist) identified Resident 84 as a smoker who went outside to smoke. Staff V could not recall if Resident 84 used oxygen or carried an oxygen tank. In an interview on 04/28/2022 at 1:01 PM Staff C and Staff B stated they were not aware that Resident 84 was a smoker or went off the facilities property to smoke. On 04/28/2022 at 1:22 PM Resident 84 stated they knew smoking while using oxygen was not allowed, knew the facility was non-smoking, and confirmed they were smoking the same pack of cigarettes since February 2022. 45941 Heating Pad Resident 81 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to the 03/20/2022 Medicare 5 Day MDS, Resident 81 had diagnoses including Acute Respiratory Failure. The resident was assesed as cognitively impaired and able to make their decisions, and required extensive assistance from staff with bed mobility, dressing, toileting, personal hygiene, and bathing. A review of the 03/14/2022 CP showed Resident 81 required extensive assistance from staff for bed mobility, dressing, toileting, and bathing. Observation and interview on 04/24/2022 at 11:02 AM, showed Resident 81 lying on their bed on their back with an electric heating pad under their neck and upper back area. Resident 81 stated their family brought the heating pad from home to relieve their back pain. In an interview on 04/24/2022 at 11:50 AM, Resident 81 stated they were independently putting the heating pad under their back. A review of the visitor sign in log on 04/24/2022 at 12:23 PM, showed Resident 81's family visited Resident 81 on 04/22/2022 at 2:57 PM. Observations on 04/24/2022 at 12:57 PM showed no skin issue on Resident 81's back. Resident 81 stated the heating pad shuts off automatically after 2 hours. The temperature of the heating pad was noted at 93 degrees Fahrenheit by thermometer. During an interview with Staff B and Staff C on 04/24/2022 at 1:23 PM, Staff C stated Resident 81 could reposition themselves in bed and the CP was inaccurate. Staff B stated they were not aware Resident 81 used a heating pad and stated the facility policy prohibited the use of heating pads by residents because they could cause burns. 42203 Activity Room Sliding Door On 04/24/2022 at 10:08 AM, the sliding door from the Activities room was noted to be bolted shut. A screw hole in the handle was noted with sharp metal filings extending from the drill hole. During environmental rounds and interview conducted on 04/29/2022 at 7:34 AM, Staff D (Maintenance Director) stated the metal filings represented a potential accident hazard to a resident trying to open the door and needed to be removed so a resident doesn't cut themselves on the sharp metal pieces. Staircase Magnetic Lock Mechanism On 04/25/2022 at 10:38 AM, the magnetic door fastener at the top of the stairway located next to the Activities Room was observed to be fastened with duct tape and was not secured. During environmental rounds and interview conducted on 04/29/2022 at 7:34 AM, Staff D stated the mechanism was not but should be secured to remove a potential accident hazard if a resident was able to go through the door into an unsupervised stairwell. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Room Storage Resident 67 On 4/28/2022 at 12:07 PM, residents' personal items were noted on top of the closet. A sign was observed on the side of the closet that stated DO NOT PLACE ANYTHING ABOVE THIS LINE PER FIRE REGULATION. During environmental rounds conducted on 04/29/2022 at 7:34 AM, Staff D stated that the items should not be there. Cookie Baking Oven On 04/22/2022 at 12:13 PM a cookie baking oven was observed in the second floor activity room, unplugged and not in use. A sticker on the front door stated, Caution Hot. Next to the oven was an unlocked clear box that contained 4 cream colored cookies, easily accessible to any resident. During an interview on 04/22/2022 at 12:34 PM, when asked about the cookie oven, Staff X (Activities Assistant) stated they never used it and When I came in the morning, I was surprised to see that, We don't usually leave food sitting out. On 04/22/2022 at 12:35 PM an empty cardboard box the size of the oven, with the name of the cookie company was observed in the Activity office. The box had a shipping label dated 04/04/2022, and was addressed to Staff FF (Food Service Manager from a sister facility). During an interview at that time, Staff X stated, It showed up in our office the other day. On 04/22/2022 at 12:39 PM Staff FF confirmed they brought the cookie oven to the facility in the box. When asked if staff training was provided, Staff FF stated that the user only needed to engage the on/off switch. Staff FF stated that the activity staff were given a diet roster two days prior to verify the residents who could eat the freshly baked cookies. Staff FF stated that they expected the cookies to be given out under staff supervision. On 04/22/2022 at 1:01 PM Staff Y (Activities Director) stated they used the oven the day before and when it was plugged in the fan broke so the cookies were baked in the kitchen oven. Staff Y stated that they passed out the cookies and did not have any cookies leftover. On 04/22/2022 the kitchen staff baked cookies again. According to Staff Y who stated, The ones I had left over, I left there in the activity room. Staff Y acknowledged that food should not be left unattended. On 04/22/2022 at 1:14 PM Staff FF plugged in and turned on the cookie oven. The oven was observed heating up, and the front door warm to touch. At 1:17 PM the oven started making loud noises and sounded like the fan was malfunctioning. REFERENCE: WAC 388-97-1060(3)(g).

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview, and record review the facility failed to ensure bowel and bladder care and catheter care was provided according to professional nursing standards for 3 (Residents 65, 13 & 67) of 7 residents reviewed. Failure to identify and provide care for diarrhea (Resident 13) and failure to provide appropriate catheter care (Resident 67) left residents at risk for dehydration, urinary tract infection, skin breakdown, and negative health outcomes. Additionally, the failure to implement catheter care and monitoring to Resident 65 according to professional nursing standards resulted in hospitalization for a blood infection, bladder and kidney infection. The harm caused to Resident 65 caused a decline in condition which may have contributed to the death of Resident 65. Findings included . Resident 65 The closed record review for Resident 65 showed they admitted to the facility on [DATE] for rehabilitation for a left lower leg fracture and a bowel infection. Other diagnosis included quadriplegia (paralysis) and use of a urinary catheter (for urination related to paralysis). The 02/24/2022 admission practitioner note showed Resident 65 had a (urinary) catheter and directed staff to change catheter and drainage bag together using aseptic technique as needed for disconnection, leakage, obstruction, bleeding, or infection. The practitioner also directed staff to continue skilled nursing care and maintenance of the catheter. The 02/24/2022 Admission Physician Orders (POs) showed no orders for Resident 65 to have an indwelling urinary catheter or instructions to monitor, change catheter tubing or nursing care for catheter maintenance. The 02/26/2022 nursing baseline Care Plan (CP), completed two days after admission showed Resident 65 had a catheter for urination. No instructions for care or monitoring were shown on the care plan. Resident 65's 02/2022 and 03/2022 Medication Administration Record (MAR), and the Treatment Administration Record (TAR) showed no directions for care and maintenance for the catheter and no documentation of nursing care and monitoring of urination or the catheter. The 02/2022 and 03/2022 Kardex (caregiver directions) and flowsheets showed no documentation of hygiene care was provided to the catheter for Resident 65. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The 03/03/2022 Minimum Data Set (MDS- an assessment tool) showed Resident 65 required a urinary catheter. The 03/03/2022 Care Area Assessment (CAA) showed the facility triggered further care planning for the catheter. The CAA provided direction to the licensed nurses to plan interventions for the care of the urinary catheter, including following physician orders and to create a catheter focused care plan. The 03/02/2022 CP for bladder dysfunction and use of a catheter was initiated 26 days after admission. The CP goal showed Resident 65 would be free of infection related to the urinary catheter. There were no interventions initiated to meet the defined goal. There were no interventions for care and monitoring of the catheter or urinary function. The daily nursing skilled progress notes on 03/13/2022, 03/14/2022, 03/15/2022, and 03/16/2022 described Resident 65's urine in the catheter bag as amber and cloudy. There was no documentation in the progress notes of notification of the provider about the assessment of abnormal urine color and clarity to identify a possible urinary tract infection. The 03/17/2022 provider note showed the nursing staff emergently contacted the provider about the resident's change in condition, including unresponsiveness, an elevated blood sugar of 400, high blood pressure 180/117 (a hypertensive crisis is greater than 180/120), and pulse was 148 (normal pulse is 60-90). There was no report to the provider of the change in urine color and clarity in the catheter bag. The provider directed staff to transfer Resident 65 to the emergency room . The 03/17/2022 hospital records showed Resident 65 presented to the emergency room with altered mental status, elevated blood sugar, abnormal heart rate and an abnormal heart rhythm. The hospital physician documented the urinary catheter contents were red, abnormal, and positive for infection. The urine lab results showed a urinary infection. The blood lab results showed a serious infection. The resident was placed on intravenous fluids and antibiotics for a diagnosis of catheter related urinary tract infection and sepsis (systemic infection). In an interview on 04/27/2022 at 12:14 PM, Staff F (RCM & MDS Nurse) stated POs for catheter care, maintenance, monitoring and care directions to staff are required for residents with a catheter. In an interview on 04/27/2022 at 3:21 PM with Staff B (Director of Nursing) and Staff C (Chief Nursing Officer), Staff B acknowledged Resident 65 did not have an order from the physician for use of a catheter, there were no interventions in place to care for and monitor the catheter which resulted in hospitalization for a blood, bladder and kidney infection. Staff B and Staff C agreed the care and monitoring interventions should have been in place to prevent infection, timely identify an infection, and prevent hospitalization and declined condition. 42203 Resident 67 According to the 03/07/2022 Quarterly MDS, Resident 67 was cognitively intact, had diagnoses including a neurogenic bladder (a condition where a person lacks bladder control due to a nerve condition) and used an indwelling urinary catheter (a device to drain urine from the bladder). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	According to the 10/13/2019 Suprapubic Catheter CP, nurses should monitor and document Resident 67's fluid intake and output (I&O) and should flush Resident 67's catheter with 30 cc (cubic centimeters) of normal saline each shift. Review of the April 2022 MAR revealed no monitoring and documentation of Resident 67's I&O. The MAR showed 3 occasions where the nurses failed to document that Resident 67's catheter was flushed. Review of the March 2022 MAR showed nurses failed to document a catheter flush on four occasions, and review of the February 2022 MAR showed nurses failed to document a catheter flush on three occasions. In an interview on 04/28/2022 at 9:36 AM, Staff C stated they expected the catheter to be flushed every shift as ordered. In an interview on 04/28/2022 at 4:02 PM, Staff C stated the facility was not but should be monitoring Resident 67's I & O. Resident 13 According to the 04/06/2022 Quarterly MDS, Resident 13 was cognitively intact. The MDS showed Resident 61 was always incontinent of bowel and bladder. In an interview on 04/22/2022 at 12:11 PM, Resident 13 stated that they sometimes experienced diarrhea and stated they believed it might be a side effect of their medications. According to the resident's records, between 03/28/2022 and 04/25/2022, Certified Nursing Assistants (CNAs) documented Resident 13 had loose stools (diarrhea) on 04/01/2022, 04/07/2022, 04/09/2022, 04/11/2022, 04/16/2022, 04/17/2022, 04/18/2022, 04/19/2022 and twice on 04/21/2022. Review of Resident 13's progress notes from 03/28/2022 to 04/25/2022 revealed no evidence CNAs reported the loose stools to the nurse. Review of Resident 13's POs showed no orders for an antidiarrheal medication or any other orders to treat Resident 13's loose stools. In an interview on 04/28/2022 at 3:59 PM, Staff C stated that CNAs should have, and did not, report the loose stools to the nurse, that this omission prevented the nurse from notifying the physician, and prevented Resident 13 from receiving the treatment they required. REFERENCE: WAC 388-97-1060 (3)(c).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44295 Based on interview and record review the facility failed to ensure 5 (Residents 153, 59, 97, 251 & 6) of 9 sampled residents reviewed for nutrition and/or hydration, maintained acceptable parameters of nutritional status or were adequately monitored for hydration status. Failure to ensure accurate intakes were documented, identified or acted on significant weight changes, and notified physicians of changes, placed residents at risk for delayed identification of interventions for continued weight loss. Findings included . According to a 05/14/2021 facility Weight Monitoring policy, a weight monitoring schedule would be developed upon admission for all residents. The policy stated weights would be monitored: weekly for four weeks for newly admitted residents; weekly for residents with weight loss; daily if clinically indicated; and monthly for all other residents. This policy directed staff to compare the resident's newly recorded weight to the previous recorded weights and identified a significant change in weight as: 5% change in 30 days; 7.5% change in 90 days; and 10% change in 180 days. This policy stated the physician should be informed of a significant weight change, meal consumption should be recorded, the registered dietician should be consulted, and observations pertinent to the resident's weight status should be recorded in the resident's records. Resident 153 According to the 04/07/2022 Quarterly MDS Resident 153 admitted to the facility on [DATE], had severe cognitive impairment, and sometimes was able to make themselves understood and sometimes able to understand others. The MDS showed the resident had Medically Complex Conditions, including Schizophrenia, Diabetes, Dysphagia (difficulty swallowing), and Anxiety. The MDS showed the resident had no or unknown weight loss in the last 6 months, had no swallowing disorder, and was on a therapeutic diet. Review of a 04/08/2022 Nutrition Care Plan (CP) showed a goal for no significant weight loss of 5% in 30 days or 10% in 180 days. The CP directed staff for RD (Registered Dietician) to evaluate and diet changes recommendations as needed. Review of Physician Orders (POs) showed a 12/09/2021 PO to weigh the resident every week. Review of the Resident 153's record showed on 06/28/2021 the resident weighed 123 lbs. (pounds) and the next weight documented on 07/27/2021 was 105 lbs. A total of 18 lb. weight loss or loss of 14.6 % of the residents body weight. Review of progress notes showed no indication the Physician or RD were notified about the weight loss. Review of the resident's record showed the resident's weight on 01/03/2022 was 106.5 lbs, on 01/17/2022 was 106.3 lbs., and on 01/31/2022 was 106.4 lbs. The resident was not weighed weekly on 01/10/22 and 01/24/2022, as the PO directed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's record showed in February 2022 the resident weighed 105.8 lbs on 02/21/2022. No other weights for the month of February were recorded in the weight record and the resident missed their weekly weights on 02/07/2022, 02/14/2022, and 02/28/2022. Review of the resident's record showed in March 2022 the resident weighed 105.5 lbs. on 03/21/2022 and 105.1 lbs. on 3/28/2022. The resident was not weighed weekly on 03/07/2022 or 03/14/2022. In an interview on 04/28/2022 at 9:53 AM Staff C stated they expect the staff to inform the Physician and RD about the weight loss, the Physician to document, and the PO's to be carried out as written. Staff C acknowledged the resident's weights were not being done weekly and stated they expected residents to be weighed as ordered. 43642 Resident 59 Resident 59 admitted to the facility on [DATE]. According to 02/24/2022 Admission /Medicare -5 Day MDS, Resident 59 had multiple medically complex diagnoses including malnutrition. This MDS assessed Resident 59 to weigh 67 lbs and required supervision with eating. According to a 03/03/2022 Nutritional Status Care Area Assessment (CAA) staff indicated Resident 59 had severe malnutrition with inadequate oral intake related to decreased appetite. Review of a 02/21/2022 nutritional CP, directed staff to monitor Resident 59's meal intake and record every meal. Review of Resident 59's February 2022 nutritional intake documentation showed staff failed to document the resident's meal intake for 7 of the 30 meals provided. March 2022 records showed staff failed to document the resident's intake for 35 of the 93 meals provided. April 2022 records showed staff failed to document the resident's intake for 33 of the 78 meals provided. Review of February and March 2022 weight records showed staff failed to obtain weekly weights on 02/26/2022, 03/12/2022, and 03/19/2022 as required by facility policy. Resident 97 According to the 03/25/2022 Quarterly MDS Resident 97 was assessed to weigh 115 lbs and required supervision for eating. Record review revealed a 01/17/2022 PO directing staff to obtain weekly weights for Resident 97. Review of weight records showed staff failed to obtain weights weekly for Resident 97 from 02/23/2022 until 04/04/2022, missing five consecutive weeks of weights. The 04/06/2022 nutritional CP directed staff to monitor and record Resident 97's meal intake every meal. Review of Resident 97's March 2022 nutritional intake documentation showed staff failed to document the resident's meal intake for 34 of the 93 meals provided. April 2022 records showed staff failed to document the resident's intake for 31 of the 73 meals provided. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 251 Resident 251 admitted to the facility on [DATE]. According to a 04/15/2022 Admission MDS, Resident 251 was assessed to weigh 220 lbs and required limited assistance from staff for eating. Record review revealed a 04/20/2022 PO directing staff to obtain Resident 251's weight weekly. According to Resident 251's weight records staff failed to obtain a weekly weight on 04/15/2022. According to a revised 04/20/2022 nutritional CP, staff were directed to monitor Resident 251's meal intake and record every meal. Review of Resident 251's April 2022 nutritional intake documentation showed, the staff failed to document the resident's meal intake for 30 of the 55 meals provided. In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Nursing Officer) stated it was their expectation that staff document meal intake with each meal, obtain weights according to physician orders, and facility policy and follow up as required with weight changes. Staff C stated having complete and accurate information allows staff to assess the resident's complete nutritional status. 44296 Fluid Restriction Resident 6 According to a 04/01/2022 Quarterly MDS, Resident 6 admitted to the facility on [DATE] with a diagnoses including end-stage kidney disease and received dialysis treatments three times a week. A 03/23/2022 PO showed Resident 6 was restricted to 1000 milliliters (ml) of fluid intake in a 24 hour period. The division of fluids showed each meal served 240 ml of fluid for a dietary total of 720 ml in 24 hours. Nursing staff were to give 180 ml on day shift and 100 ml on night shift for medications with a total of 280 ml in 24 hours. The order showed no water pitcher should be left at Resident 6's bedside. A review of the 04/01/2022 to 04/20/2022 MAR showed on 18 of 20 days nurses provided more than the 280 ml per day allotted to nursing. The MAR did not show a daily summary of fluid intake to monitor the 1000 ml per day restriction. A review of the 04/01/2022 to 04/20/2022 meal intake record showed on 20 of 20 days Resident 6's fluid intake exceeded the allotted 720 ml per day. In an observation and interview on 04/21/22 at 11:54 AM Resident 6 stated the staff just took their water pitcher and the resident did not know why, and they wanted it back. Resident 6 pointed to three cases of bottled water stacked near the wall and stated, they better not take that, it is mine. Observation of Resident 6's lunch tray showed 120 ml of red juice, 120 ml of milk and 180 ml of a hot drink. Resident 6 also had two opened bottles of water on the bedside table next to the lunch tray. The tray ticket showed dietary was to provide 720 ml of fluids per day. The ticket did not breakdown the volume per meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/26/2022 at 2:22 PM, Staff T (Certified Nursing Assistant) stated Resident 6 was on a fluid restriction but always asked for water. Staff T stated staff gave the resident water from the supply of cases on the floor when the resident requested or when the resident got mad. Staff T stated the staff were not able to keep track of the fluid intake for Resident 6. In an interview on 04/28/2022 at 2:25 PM, Staff B (Director of Nursing) stated a fluid restriction must have a 24-hour summary and the physician must be notified if restrictions were not followed. Staff B stated the process for maintaining fluid restrictions was not intact. REFERENCE: WAC 388-97-1060 (3)(h)(i).

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview and record review the facility failed to ensure intravenous (IV- in a vein) fluids were administered according to professional nursing standards for 1 (Resident 23) of 1 resident reviewed for IV services. The failure to provide IV treatments by qualified and competent trained nurses, prevented nurse staff from obtaining and/or clarifying complete orders for maintaining and monitoring IV treatments which placed Resident 23 at risk for infection and other adverse outcomes. Findings included . The ,d+[DATE] policy for Maintaining Patency of Peripheral Vascular Devices (maintenance of IV treatments) showed directions to the nurse to obtain a Physician Order (PO) for appropriate flush solutions, refer to the flush chart, the flush orders must be written as a complete medication order. The policy showed IV's were required to be flushed routinely when not in use to maintain unobstructed access. Flushes were documented in the resident's record. The policy flush chart showed directions for the nurse to flush the IV every eight hours and as needed to keep open. The ,d+[DATE] policy for Infusion Therapy Procedures Summary showed directions to the nurse to inspect the bag of solution, verify the label and expiration date prior to hanging and infusion. The ,d+[DATE] policy for Administration Set Change showed directions to the nurse to label the administration set with the date and time of starting the infusion. Resident 23 The [DATE] Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 23 had diagnoses of diabetes and Parkinson's Disease. The MDS section for cognition and mood was blank, which showed no assessment was completed for these areas. Resident 23 was assessed with clear speech in a language that was not English but was not assessed for cognition or mood. Observation on [DATE] at 8:56 AM showed Resident 23 with an IV site on the back of their right hand. An IV pole with an empty bag and tubing was next to the bed. The IV bag was labeled 5% dextrose and 0.9% NaCl (sodium chloride) and had a manufacture expiration date of [DATE]. There was not a label of the date and time the bag was hung, according to the facility policy. An observation on [DATE] at 11:27 AM showed Resident 23 with the IV site in the back of the right hand, the IV pole was removed from the room and the IV bag and tubing was in the trash can. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 11:31 AM, Staff N (Licensed Practical Nurse) viewed the IV bag and confirmed the label showed 5% dextrose and 0.9% NaCl, had an expiration date of [DATE], and did not have a date and time of administration on the bag. Staff N stated the IV solution was expired and there should be a label on the bag with the date and time it started infusing. Staff N looked the order up in the computer and stated the order was for 5% dextrose and 45% NaCl starting on [DATE] and ending on [DATE] for dehydration. Staff N stated the solution bag did not match the order. Staff N verified there were no physician orders for flushing the IV site, no order for removal and no directions for monitoring the IV site for adverse effects. Staff N stated they did not flush the IV on their shifts. A review of the ,d+[DATE] Medication Administration Record (MAR) showed no administration of IV flushes and no monitoring the IV site for adverse effects. A review of the [DATE] through [DATE] nurse progress notes showed no documentation of monitoring, or assessment of the IV treatment, IV site or Resident 23's tolerance to the IV treatment, indicating an alert was not triggered for every shift documentation. There was no follow up documentation from the practitioner for evaluation of the IV treatment. In an interview on [DATE] at 1:26 PM, Staff B (Director of Nursing) stated standard nursing practice was to place a resident on alert charting for IV monitoring every shift for complications and the IV was expected to be flushed every shift to keep the line open. In an interview on [DATE] at 11:33 AM, Staff B stated the standard of care was in the policy and nurses were expected to follow the policy. Staff B stated the current pharmacy IV policy book was located on the first floor. Staff B acknowledged Resident 23 lived on the second floor and there was no pharmacy IV reference manual on the second floor. In an interview on [DATE] at 11:54 AM, Staff B reviewed the contents of the emergency pharmacy storage room and electronic storage device. The storage room contained an empty box of Dextrose 5% and 0.9% NaCl with a manufacturer expiration date of [DATE]. The electronic pharmacy storage contained one available bag of Dextrose 5% with 0.45% NaCl with the expiration date of [DATE]. Staff B obtained a list of items checked out form the electronic pharmacy storage device and no items were removed for Resident 23 during the IV administration timeline. Staff B acknowledged the incorrect solution was administered to Resident 23 and the solution was expired. Staff B stated a medication error investigation would be initiated. In an interview on [DATE] at 12:36 PM, Staff E (Staff Development Coordinator) was asked to provide competency documentation related to IV administration for five selected nurses, including Staff N, Q, S, and U. Staff E only provided two of the five competencies requested, three nurses did not have IV competencies on file. Refer to F726 Competent Nursing Staff. REFERENCE: WAC [DATE](3)(j)(ii).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44296 Based on observation, interview and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 1 (Resident 451) of 1 resident reviewed for oxygen use. The failure to provide Resident 451 with portable oxygen to use outside of their room, placed resident at risk for decline in condition and decreased quality of life. Findings included . Resident 451 The 04/20/2022 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 451 was assessed as cognitively intact, able to make self understood, and understood others. Resident 451 was admitted for the diagnoses of lung disease, pneumonia (lung infection), and recovering from COVID-19 (Coronavirus disease 2019, a respiratory disease). According to the MDS Resident 451 was assessed to require continuous supplemental oxygen. Observations of Resident 451 not wearing portable oxygen included; 04/21/2022 at 1:01 PM at the nurse's station asking to use the phone, and no portable oxygen observed in room; 04/21/2022 at 2:14 PM at the nurse's station on the phone; 04/22/2022 at 9:06 AM at the nurse medication cart, and no portable oxygen observed in resident's room; 04/22/2022 at 11:30 AM at the doorway of room and hallway; 04/23/2022 at 9:03 AM in the elevator headed to the entrance door; 04/23/2022 at 9:10 AM back to room from lobby with staff, and no portable oxygen observed in room; 04/23/2022 at 11:45 AM in the hallway, and no portable oxygen observed in room; 04/23/2022 at 11:50 AM at the nurse's station, and no portable oxygen observed in room; 04/24/2022 at 10:01 AM at the elevator asking for the nurse to be told they were going to therapy; 04/24/2022 at 10:50 AM in the hallway, and no portable oxygen observed in room; 04/24/2022 at 10:26 AM in the hallway; 04/25/2022 at 12:04 PM sitting on bed, not wearing oxygen, concentrator running, and no portable oxygen in the room. A 04/13/2022 Physician Order (PO) showed Resident 451 was to wear continuous oxygen by nasal cannula (tubing) running at three to five liters per minute for the diagnosis of lung disease and respiratory (breathing) failure. An observation on 04/24/2022 at 10:01 AM showed Resident 451 in the hallway walking out of the activity room not wearing portable oxygen. Staff LL (Physical Therapist Assistant) greeted Resident 451 and asked them to come to the therapy gym. Resident 451 agreed and told another staff person in the hallway to tell the nurse they were going to therapy. An observation (five minutes later) on 04/24/2022 at 10:06 AM, Resident 451 was using the stairs in the therapy gym and complained of being dizzy. Staff LL had the resident sit down and tried to take their oxygen level. The device did not read an oxygen level. Staff LL tried again at 10:12 AM and could not obtain a reading on the left or the right hands. Staff LL escorted Resident 451 back to their room when an oxygen level of 77% was obtained. (A normal oxygen level is 92-100%) Resident 451 was placed back on the oxygen concentrator by nasal cannula and their oxygen level went up to 85%. When the oxygen level was checked again at 10:22 AM, it was 92%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/24/2022 at 10:20 AM, Resident 451 stated they only wore the oxygen while in bed because the tubing was not long enough to stretch any farther. Resident 451 stated they knew they were supposed to wear the oxygen all the time they were not able to walk around with the short tubing. Resident 451 stated they wore oxygen at home before admission and had a portable tank to take with them. In an interview on 04/24/2022 at 10:22 AM, Staff Q (Licensed Practical Nurse) stated they were not told that the resident went to therapy. Staff Q stated Resident 451 refused oxygen before when going to therapy, but that anyone can put oxygen on the resident including the therapist and the nursing assistant. Staff Q stated most residents are on two liters of oxygen and any staff can set it to two liters. When asked if nurses should check the order and be setting the oxygen flow rate, Staff Q stated, if they needed help from the nurse, I would help them. In an interview on 04/25/2022 at 8:47 AM, Staff U (Resident Care Manager) stated the therapists should know which residents wear oxygen and should make sure they take portable oxygen when the resident goes to the therapy gym. Staff U stated only nurses should be setting the oxygen flow rate, but anyone can help the resident put on the nasal cannula. In an interview 04/26/2022 Staff MM (Therapy Director) stated all therapists are expected to know which residents on therapy also use oxygen. Staff MM stated the therapists are expected to ensure the resident has oxygen when coming to therapy. Staff MM looked at the therapy notes for Resident 451 from 04/24/2022 and stated a 77% oxygen reading was recorded on room air and the resident was placed back on oxygen by nasal cannula in their room. Staff MM was informed the notes as written were not what was observed by the surveyor present. Refer to F726 Competent Nursing Staff. REFERENCE: WAC 388-97-1060(3)(j)(ix).

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facility failed to employ sufficient staff to provide and supervise care as evidenced by information provided by 10 (Resident 15, 28, 7, 20, 61, 67, 58, 54, 77, 33) resident interviews, and Resident Council (Residents). The facility had insufficient staff to ensure residents received assistance with Activities of Daily Living (ADL) including showers and Restorative services, accurate and timely Minimum Data Set (MDS - an assessment tool) Assessments, and call light response in accordance with established clinical standards, care plans, and preferences. These failures placed residents at risk for unmet care needs and negative outcomes. Findings included . Resident Interviews During initial screening, residents raised the following concerns with facility nurse staffing: Resident 15 & Resident 28 In an interview with residents in room [ROOM NUMBER] on [DATE] at 12:37 PM, Resident 15 and Resident 28 stated staff entered their room, turned off the call light without providing assistance, promised to return and did not. The residents identified evenings after 2 PM as the worst time. In an interview on [DATE] 9:36 AM Resident 15 and Resident 28 stated the facility is understaffed. Resident 7 In an interview on [DATE] at 1:40 PM Resident 7 stated when you need help, sometimes have to wait 2 , d+[DATE] hours, and night time is the worst. In an interview on [DATE] at 9:15 AM Resident 7 stated they wanted to get out of bed and staff never came back to get me up, if my wheelchair was closer I would try to get up myself. At 9:31 AM Staff RR (Restorative Aide- RA) was told about Resident's 7's request to get out of bed. At 11:05 AM Resident 7 was still observed in bed. Resident 20 In an interview on [DATE] at 1:57 PM Resident 20 stated sometimes it seemed like there was only 1 person in the building, usually after dinner and on night shift. Resident 61 In an interview on [DATE] at 8:54 AM Resident 61 stated they were upset because they had to wait 45 minutes for their call light to be answered. Resident 67 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 8:59 AM Resident 67 stated there was not enough staff., that residents needed to wait half an hour for assistance after using their the call light, and identified shift change as a time of particular concern. Resident 58 In an interview on [DATE] at 2:10 PM Resident 58 stated when they used their call light, no one came to assist. Resident 54 In an interview on [DATE] at 12:00 PM Resident 54 stated there is not enough staff at certain times of the day, that sometimes no one came to help when they used their call light, and that at other times it took an hour for help to come. Resident 54 stated they were concerned with CNA (Certified Nursing Assistant) turnover. Resident 77 In an interview on [DATE] at 12:26 PM Resident 77 stated there was not enough and staff and that there were delays in responding to call lights. Resident 33 On [DATE] at 9:15 AM Resident 33 stated that the week prior they were told there were only two nurses upstairs for the evening/night shift, no nurse on one of the 3 medication carts and it would take longer for people to get their medications, That happens quite a bit. Resident Council Review of minutes from the [DATE] Resident Council included the following agenda items: the wait time for CNA's [sic] is too long. Resident's [sic] state that it takes almost two hours for care; Residents would also like snacks available during the day. During a meeting of the facility's Resident Council on [DATE] at 1:30 PM, residents expressed the following concerns regarding staffing. Resident 33 stated residents were unable to get snacks and was told they don't have enough people to provide them. Resident 67 (Council President) stated there was no improvement in the 2 hour waits mentioned in the [DATE] meeting. Resident Resident 33 stated if your Aide is available it's okay, but it can take forever. Resident 81 stated I've been here for two weeks and it's worse than when I first got here [.] I am unsure what the deal is. I noticed that the CNAs are less and less. At the end of the meeting Resident 67 revisited the topic of snacks we still don't get them. There is nobody to ask. I feel that the snack issue should be addressed. Resident 91 nodded enthusiastically in agreement. Showers Unqualified Staff providing care Resident 33 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:15 AM Resident 33 stated, The Activity Director gave me a shower yesterday. Review of Point of Care documentation showed on [DATE] at 1:31 PM Staff Y (Activity Director) documented a shower given to Resident 33. Resident 77 On [DATE] at 11:57 AM Staff Y was observed exiting the [NAME] II Shower room with Resident 77 in a shower chair, with wet hair. During an interview on [DATE] at 12:23 PM, Resident 77 stated that the facility was still understaffed. Resident 77 stated, It wasn't a CNA who gave me a shower today. It was the Activity Director. During an interview on [DATE] at 1:01 PM, when asked why they were giving showers, Staff Y stated that they were trying to help the nursing assistants. On [DATE] at 2:06 PM, Staff PP (Human Resources) stated Staff Y was the Activity Director and was not a Nursing Assistant. Staff PP stated that Staff Y did not have a License, Certification or a Registration. Review of the Department of Health Credential Verification website on [DATE] showed that Staff Y's Nursing Assistant Registration expired in 2002. Resident 36 In an interview on [DATE] at 12:22 PM, Resident 36 stated the facility got rid of shower aides and currently CNAs did showers. Resident 36 stated I have not had a shower since beginning of March, only a bed bath and not very often. I want to have shower, I need them to take care of my skin. Restorative Program Resident 33 On [DATE] at 9:15 AM Resident 33 stated that the RA continued to be pulled to the floor. Signage In Facility On [DATE] at 8:55 AM, a sign titled Posted Mealtimes was observed to read Due to census and labor, times are estimated and may be served up to 15 minutes prior to or after posted times. Wound Care In an interview on [DATE] at 12:24 PM Staff F (Resident Care Manager/MDS Nurse) stated wound care including dressing changes was now managed by nurses. Staff F stated until three to four weeks prior, the facility employed a wound nurse who managed wound care including wound evaluation, treatment, and coordination with the outside wound provider. Staff F stated the wound nurse left their position unexpectedly and was not replaced at the time of the interview. Resident 36 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on [DATE] at 12:22 PM, Resident 36 stated I need them to take care of my skin and added they felt they were on a low priority list for wound care. Staff Interviews During an interview on [DATE] at 11:28 AM Staff SS (Licensed Practical Nurse-LPN) stated the CNA's sometimes had up to 18 residents and they do their best to provide good care but it can be hard with that many residents. In an interview on [DATE] 02:22 PM, Staff T (CNA) stated there was not enough staff to complete resident showers because the facility took the shower aide away. Staff T stated aides were scheduled to do showers on the daily schedule, but on days when there insufficient Aides available, showers were not completed. Staff T stated the facility typically did not have as many staff on the floor as were present during survey. In an interview on [DATE] at 8:31 AM Staff ZZ (RA) stated they usually have two RA's but that didn't happen everyday. Staff ZZ states the RA's are pulled to work the floor as a CNA and do not have time to complete all the restorative programs. Refer to F684 Quality of Care Refer to F686 Treatment/Services to Prevent/Heal Pressure Ulcers Refer to F677 ADL Care Provided to Dependent Residents REFERENCE: WAC [DATE](1), 1090(1). 44295 44296

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview, and record review the facility failed to ensure a system was in place to verify nursing staff had appropriate competencies, skill sets, and proficiencies to provide nursing and related services to residents with acute medical conditions. This failure placed all nursing staff at risk of providing unsafe, substandard quality care, and put all residents at risk for harm. The lack of a systematic approach to ensure competent nursing staff created a situation of harm for 2 (Resident 65 & 3) of 22 residents reviewed, and one (Resident 23) supplemental resident. According to the [DATE] [NAME] Administrative Code (WAC) [DATE] Continuing Competency, the Registered Nurse (RN) and Licensed Practical Nurse (LPN) shall be responsible and accountable for their practice based upon and limited to the scope of their education, demonstrated competence, and nursing experience consistent with their scope and the RN and LPN shall obtain instruction, supervision, and consultation as necessary before implementing new or unfamiliar techniques or procedures which are within their scope of practice. Findings included . Resident 65 Resident 65 was sent to the hospital on [DATE], and was diagnosed with a catheter related urinary tract infection and sepsis (systemic infection). Resident 65 died at the hospital on [DATE]. Review of the resident's record showed nursing staff failed to obtain Physician Orders (POs) to monitor, change catheter tubing, or provide nursing care for catheter maintenance, and failed to document any provision of catheter care. Review of the daily nursing skilled progress notes dated [DATE], [DATE], [DATE], and [DATE] showed Resident 65's urine in the catheter bag was described as amber and cloudy. The nursing staff failed to identify the abnormal urine quality as a possible urinary tract infection and failed to notify the provider of the change in condition. In an interview on [DATE] at 12:36 PM Staff E (Staff Development Coordinator) stated they did annual competencies (the knowledge, skills, and abilities that contribute to individual and organizational performance) on indwelling catheter management but have not been doing competencies lately. Staff E was asked to provide 5 Licensed Nurse (LN) competencies, and was able to provide 2 of the 5 that were requested. Of the 2 competencies provided; Staff Q (Licensed Practical Nurse LPN) had indwelling catheter management training on [DATE] and Staff L (LPN) had indwelling catheter management training on [DATE], over two years ago. Refer to F-684 (Quality of Care) for details related to Resident 65's hospitalization and death following signs and symptoms of a potential infection. Resident 3 (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on [DATE] at 8:59 AM showed Staff S (Registered Nurse) was in the middle of providing wound care to Resident 3. Resident 3's right ankle and right foot were covered with a foam dressing. There were two Pressure Ulcers (PUs) on the right hip that had a paste surrounding the wound on the intact skin. Staff S placed an ointment in both hip wounds and covered them with a foam dressing. When asked, Staff S stated the right foot, right ankle, and two right hips PU were all stage 4 PU. Review of the resident's record showed the resident had a total of 5 PUs, the facility identified the Stage 4 PU to the sacrum and the lack of assessments but failed to identify 4 other PUs that were acquired at the facility. In an interview on [DATE] at 12:38 PM, Staff F (Resident Care Manager (RCM) & Minimum Data Set (MDS) Nurse) reviewed the Physicians Orders (POs) and stated there were no treatment orders for the right hip, right ankle, or right foot. Staff F stated a treatment order was expected to be obtained and must be in place before the nurse could provide the treatment. In an interview on [DATE] at 12:36 PM Staff E stated the facility performed competency checks for all nurses who provided wound care. Staff E was unable to provide a competency evaluation for Staff S who was observed providing wound care without orders on [DATE]. Staff E was not able to provide a competency evaluation for wound care for Staff U (RCM) who was responsible for coordinating residents' care and treatment with the wound specialist, hospice nurse, and the physician. Refer to F- 686 (Treatment and Services to Prevent/Heal Pressure Ulcers) for details related to Resident 3's lack of PU management and care. Resident 23 Observation on [DATE] at 8:56 AM showed Resident 23 with an intravenous (IV-existing within or administered into a vein) site on the back of their right hand. An IV pole with an empty bag and tubing was next to the bed. The IV bag had a manufacture's expiration date of [DATE]. There was no label that showed the date and time the bag was hung and fluids administered, according to the facility policy. In an interview on [DATE] at 11:31 AM, Staff N (Licensed Practical Nurse) viewed the IV bag and stated the IV solution was expired and there should be a label on the bag with the date and time it started infusing. Staff N reviewed the order and stated the order for the IV solution, was due to the residents dehydration, started on [DATE] and ended on [DATE]. Staff N stated the solution bag did not match the order. Staff N verified there were no POs for flushing the IV site, no directions for monitoring the IV site for adverse effects, and no order for removal of the IV catheter. Staff N stated they did not flush the IV on their shifts. In an interview on [DATE] at 1:26 PM, Staff B (Director of Nursing-DNS) stated standard nursing practice was to place a resident on alert charting for IV monitoring every shift for complications and the IV was expected to be flushed every shift to keep the line open. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 12:36 PM, Staff E was asked to provide competency documentation related to IV administration for five selected nurses, including Staff N, Q, S, L, and U. Staff E only provided two of the five competencies requested, three nurses did not have IV competencies on file. Review of the 2 competencies provided, showed Staff Q received IV therapy training on [DATE], and Staff L received IV therapy training [DATE], over two years ago. Refer to F-694 (Parenteral/IV Fluids) for details related to Resident 23's lack of IV management and care. REFERENCE: WAC [DATE](1), 1090(1). 44295

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on interview and record review, the facility failed to ensure a licensed pharmacist's monthly Medication Regimen Reviews (MRRs) recommendations were reviewed and implemented timely for 6 (Residents 21, 30, 76, 153, 82 & 67) of 7 sample residents whose medication regimens were reviewed. This failure placed residents at risk for delays in necessary medication changes, adverse side effects and of receiving medications without required pharmacist oversight. According to the 2022 facility Addressing Medication Regimen Review Irregularities policy the facility would utilize a systemic approach for reviewing each resident's medication regimen which included preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities. The pharmacist must report any regularities to the attending physician, the facility's medical director, and director of nursing, and the reports must be acted upon. The attending physician must document in each resident's record that the identified irregularity was reviewed, and what, if any action was taken to address it. If there was no change in the medications, the physician should document the rationale in the resident's record. Findings included . Resident 21 According to the 01/17/2022 Quarterly Minimum Data Set (MDS an assessment tool) Resident 21 admitted to the facility on [DATE], and had diagnoses including Schizophrenia, Anxiety Disorder, and drug induced Tardive Dyskinesia (caused by long term use of psychiatric medications causing repetitive, and involuntary muscle movements ion the face, neck, arms, and legs). The MDS showed the resident received antipsychotic medications each day of the assessment period Review of Physician's orders (PO) showed a 10/01/2019 PO medication nightly for Schizophrenia and a 10/19/2021 PO for an NSAID (Non-Steroidal Anti-inflammatory Drug) three times daily for pain. Review of a 11/30/2021 MRR showed Staff HH (Consultant Pharmacist) recommenced a psychotropic gradual dose reduction (GDR) for the mental health medication and recommended the physician reevaluate the use of pain medications for Resident 21. A 12/30/2021 MRR showed a bolded and underlined sentence Pending a Final Response. The MRR again recommended a GDR for the mental health medication and evaluation of the chronic NSAID use in the elderly. The MRR was signed and dated on 01/28/2022, almost 2 months after the first recommendations were made. The mental health medication was marked as dose reduction clinically contraindicated at this time but did not indicate the clinical rationale for why a GDR was contraindicated. The NSAID medication was discontinued on 01/28/2022, almost 2 months after the first recommendations were made. Review of the resident's record and PO's showed no indication the facility reviewed or implemented the recommendations until 01/28/2022, almost 2 months later. Resident 30 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/17/2022 Annual MDS Resident 30 admitted to the facility on [DATE], and had diagnoses including Schizophrenia, Diabetes, and Seizure Disorder. The MDS showed the resident received antipsychotic medications each day of the assessment period. Review of PO's showed a 04/22/2021 PO for an antipsychotic medication nightly for Schizophrenia. Review of a 03/24/2022 MRR showed Staff HH recommended a GDR for the antipsychotic and the last GDR attempt was over a year ago in 04/2021. Review of the resident's record and PO's showed no indication the facility reviewed or implemented recommendations. Resident 76 According to the 03/15/2022 Quarterly MDS Resident 76 admitted to the facility on [DATE], and had diagnoses including Dementia with behavioral disturbances, Depression, and Adjustment disorder with mixed anxiety. The MDS showed the resident received antidepressant medications each day of the assessment period. Review of PO's showed a 03/30/2022 PO for an antidepressant daily for depression. Review of a 02/27/2022 and 03/24/2022 MRR showed Staff HH recommend a GDR attempt for the antidepressant and the last GDR attempt was 9 months ago in 07/2021. Review of the resident's record showed the Physician responded to the pharmacy recommendations on 03/14/2022 and agreed to decrease the antidepressant from 25 mg to 12.5 mg daily. The order to decrease the antidepressant was not carried out until 03/30/2022, 16 days after the physician had agreed to the GDR attempt. Resident 153 According to the 04/07/2022 Quarterly MDS Resident 153 admitted to the facility on [DATE], and had Medically Complex Conditions, including Schizophrenia and Anxiety. The MDS showed the resident received antidepressant medication each day of the assessment period. Review of PO's showed a 08/25/2021 PO for an antidepressant daily for appetite stimulant and an anti-convulsant for bipolar disorder. Review of a 02/27/2022 MRR showed Staff HH recommend a GDR attempt for antidepressant as there was no GDR attempts since the PO started on 08/25/2021. Review of the resident's record showed on 03/08/2022 the physician responded to the MRR and documented continue the antidepressant for appetite, there was no clinical rationale why a GDR attempt would be contraindicated. Resident 82 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to 03/17/2022 Quarterly MDS, Resident 82 was cognitively impaired, had diagnosis of anxiety disorder and Depression, demonstrated no behaviors and received antipsychotic and antidepressant medications during the assessment period. Review of the resident's record and PO's showed a 07/14/2021 order for an antidepressant daily for Depression and a 12/01/2021 order for an antipsychotic twice daily for Vascular dementia with behavioral Disturbance. Review of a 03/24/2022 MRR showed Staff HH recommended a GDR for the antidepressant and antipsychotic. Review of the resident's record showed no indication the facility followed up on this recommendation. Resident 67 Similar findings for Resident 67. According to the 03/07/2022 Quarterly MDS, Resident 67 received scheduled pain medication. Resident 67's POs at that time included a 12/10/2021 order for a narcotic medication containing an NSAID for a total of 3250 mg (milligrams) daily that was routinely administered, an 11/20/2021 order for a narcotic medication containing a NSAID every 6 hours for a total up to 1300 mg PRN (as needed), and a 06/12/2020 order for an NSAID 650 mg PRN every four hours for a total up to 3900 mg PRN. The 3 medication orders totaled 8450 mg of an NSAID, that is twice the recommended dose. Review of a 12/30/2021 MRR showed Staff HH recommended evaluating Resident 67's pain medication regimen due to a potentially toxic NSAID dose. The MRR showed that a daily maximum dose for an NSAID is 4000 MG. These recommendations were not carried out. A MMR on 02/27/2022 showed Staff HH recommended evaluating Resident 67's pain medication regimen due to a potentially toxic NSAID dose and identified the same three orders to be reviewed. On 03/01/2022, the 12/10/2021 the narcotic order was discontinued 3 months after the recommendation was made. In an interview on 04/28/2022 at 9:53 AM Staff C (Chief Nursing Officer) stated GDR's should be done on a quarterly basis, and the pharmacy recommendations should be reviewed with the physician, documented, and orders completed. Staff C acknowledged the pharmacy recommendations were not completed timely or at all, and Physicians are not documenting clinical rationales if GDR's are contraindicated, as they would expect. REFERENCE: WAC 388-97-1300 (1)(c)(iii) 44295

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42203 Based on observation, interview, and record review the facilty failed to ensure residents' remained free of unneccesary psychotropic medications for 3 of 5 residents (Residents 69, 82 & 36) sample residents whose medications were reviewed for unnecessary psychotropic medications and 3 supplemental residents (Residents 21, 30 & 451). Failure to identify the adequate indications for use, identify triggers or specific behaviors, document behaviors, attempt GDR (gradual dose reductions) or implement non-pharmaceutical interventions before administering medication and failed to obtain informed consent prior to administration of anti-psychotic medications placed residents at risk of receiving unnecessary psychotropic medications, experiencing medication-related adverse side effects (ASE), and diminished quality of life. Findings included . Resident 69 According to the 03/08/2022 Significant Change Minimum Data Set (MDS, an assessment tool) Resident 69 originally admitted to the facility on [DATE] and had diagnoses including Alzheimer's Diesease, Non-Alzheimer's Dementia and Psychotic Disorder. The Assessment showed Resident 61 experienced delusions and halucinations, and received an Antipsychotic (AP) medication regularly. Review of Resident 69's record showed an 02/23/2022 order for an AP medication 75 mg, 2x daily for hallucinations. Review of a 12/24/2020 pharmacy consult, revealed a recommendation to discontinue Resident 69's AP medication 12.5 mg at bedtime. The recomendation was not followed by the facility; the declination completed by the physician on 01/21/2020 [sic] stated will discuss at next weekly psychiatry meeting. Review of the Physician's Orders (POs) from 12/2020 to present showed: Resident 61's AP medication was increased to 25 mg at bedtime on 02/10/2021 and to 50 mg at bedtime on 02/24/2021; a second PO for the AP medication 25 mg each morning was added on 11/16/2021 and increased to 50 mg each morning for a daily total of 100 mg on 12/06/2021; on 02/24/2022, Resident 61 was prescribed the AP medication 75 mg twice daily for hallucinations for a daily total of 150 mg. This represented a 12 times dose increase from 12.5 mg in 12/24/2020 to 75 mg in 02/24/2022. Review of the resident's record revealed an 04/05/2022 AIMS (Abnormal Involuntary Movement Scale) assessment with a score of 1. The assessment indicated Resident 69 demonstrated minimal abnormal facial expressions. Prior AIMS dated 04/18/2018, 10/02/2018, 01/15/2019, 07/15/2019, 07/16/2020, 10/01/2020 and 04/01/2021 all assessed Resident 69 with a score of 0. According a 02/18/2022 progress note, Resident 69 had hallucinations at 2:00 AM that morning. According to a 02/23/2022 progress note, Resident 69 had hallucinations on the night of 02/22/2022 at 10:30 PM. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 69's Target Behavior (TB) monitoring showed no other epsiodes of halluinations in January and February 2022. In an interview on 04/26/2022 at 11:13 AM, Staff HH (Consultant pharmacist) stated that the recent AP medication dose increase was in response to the epsiodes of hallucinations. Staff HH stated given the series of dose increases that another AP medication might be considered to treat the resident. On 04/26/2022 at 01:12 PM, Staff HH provided a copy of a 03/24/2022 pharmacist recommendation that recommended evaluating the risks and benefits of Resident 69's AP medication use. The note showed Resident 69 has been on this medication for some time with escalating doses. Is it helping the hallucinations? Staff HH stated they had concerns with increased AP medication use for an [AGE] year old resident and questioned whether it was effective. In an interview on 04/28/2022 at 9:22 AM, Staff II (Nurse Practitioner) stated it would be appropriate to reevaluate Resident 69's AP medication use at that time. 44295 Resident 21 According to the 01/17/2022 Quarterly MDS the resident admitted to the facility on [DATE], had severe cognitive impairment, was rarely understood or able to understand, and had diagnoses including Schizophrenia, Anxiety Disorder, and Drug induced Tardive Dyskinesia (TD) (abnormal and involuntary movements of the face, limbs, and trunk). The MDS showed the resident received antipsychotic medication all 7 days of the assessment period. Review of the resident's record showed a 10/01/2019 PO for an antipsychotic used to treat Schizophrenia 20 mg (milligrams) nightly and a 09/13/2019 PO that directed staff to monitor the resident for any adverse side effects (ASE) related to the antipsychotic use, such as TD. On 04/21/2022 at 8:19 AM Resident 21 was observed on their bed rocking back and forth. Similar observations were made on 04/24/2022 at 11:36 AM, 04/25/2022 at 8:40 AM, and 04/26/2022 at 7:47 PM. Review of the resident's record showed a 11/30/2021 and a 12/30/21 Pharmacist recommendation for a GDR (Gradual dose reduction) for the AP medication. The form showed the last GDR attempt was in 11/2020 and was contraindicated due to history of failed GDR attempts. On 01/28/2022 the Physician signed the 12/30/2021 GDR recommendation and marked dose reduction clinically contraindicated at this time. Review of the form showed no clinical rationale for why any attempt would be likely to impair the resident's function. The resident went 17 months without any GDR attempts. Review of the February 2022, March 2022, and April 2022 MAR (Medication Administration Record) showed no ASE's documented by nursing staff. In an interview on 04/28/2022 at 9:53 AM Staff C (Chief Nursing Officer) stated GDR's should be done on a quarterly basis, and acknowledged the Physicians are not documenting clinical rationales if GDR's are contraindicated, as they would expect. Staff C stated Resident 21 had a diagnoses of TD and expect the nurses to document any ASE's they observe on the ASE monitoring. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 30 According to the 04/13/2022 Quarterly MDS the resident admitted to the facility on [DATE], had severe cognitive impairment, usually was understood and able to understand, and had medically complex conditions including Schizophrenia, Diabetes, and Seizure Disorder. The MDS showed the resident received an AP medication all 7 days of the assessment period. Review of the resident's record showed a 04/22/2021 PO for an AP medication 1 mg nightly and a 02/13/2020 PO to monitor the resident for ASE's related to the AP medication use. On 04/21/2022 at 1:52 PM Resident 30 was observed lying in bed, their lips and tongue were observed with movements of lip smacking and thrusting their tongue. Similar observation were made on 04/25/2022 at 9:03 AM and 12:08 PM, and 04/26/2022 at 9:39 AM and 2:45 PM. In an interview on 04/26/2022 at 2:45 PM Staff SS (LPN) confirmed that Resident 30 had mouth movements of lip smacking and tongue thrusting. Review of the April 2022 MAR showed no ASE's documented by nursing staff. Review of the resident's record showed a 03/24/2022 Pharmacist recommendation for the AP medication. The form showed the last attempted GDR was in April 2021, and the AP medication dose was decreased from 1.25 mg to the current dose of 1 mg. The form was not signed by the Physician and there was no indication the facility carried out the recommendations. The resident went 1 year without a GDR attempt. In an interview on 04/28/2022 at 9:53 AM Staff C stated GDR's should be done on a quarterly basis and acknowledged Resident 30 has not had a GDR attempt in the past year. 45941 Resident 82 According to 03/17/2022 Quarterly MDS, Resident 82 was cognitively impaired, had diagnosis of anxiety disorder and Depression, demonstrated no behaviors and received antipsychotic and antidepressant medications during the assessment period. Record review showed Resident 82 had a 07/14/2021 order for an antidepressant (AD medication) daily for Depression and a 12/01/2021 order for an AP medication twice daily for Vascular dementia with behavioral Disturbance. A The resident uses antidepressant medication r/t (related to) depression CP, revised 06/21/2021, directed staff to review psychotropic medications every quarter at psychotropic management meeting to evaluate the effectiveness and continued need. A 07/19/2021 order directed staff to document each shift the number of episodes for excessive worry, negative statements related to AD medication use. A 07/19/2021 order directed staff to document the number of episodes of hallucinations and suicidal ideation related to Diagnosis of dementia for the AP medication. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 82s February 2022, March 2022 and April 2022 TB's monitoring indicated no behaviors were noted. Record review showed Resident 82's 03/24/2022 monthly pharmacy review recommended a GDR for psychotropic medications. No evidence was found in Resident 82's record to indicate the facility followed up on this recommendation. Resident 82's record review showed Resident 82 received the AP medication 25 mg once daily from 06/04/2021 and on 12/02/2021 the dose was increased, and that the most recent AIMS assessment was completed on 06/29/2021. In an interview on 04/27/2022 at 10:09 AM, Staff F (Resident Care Manager) stated the facility should complete AIMS assessments every 6 months and that an AIMS should have been but was not completed in December 2021. Staff F stated the facility should have followed up on pharmacy recommendations but did not. In an interview on 04/28/2022 at 11:00 AM, Staff B (Director of Nursing) stated the facility was not consistently following the pharmacy recommendations and missed a couple of months of reviews. In an interview on 04/29/2022 at 08:02 AM, Staff G (Social Services Director) stated the facility did not have consistent meetings to discuss psychotropic medication review for GDRs. Staff G stated the facility should have reviewed Resident 82's medication for GDR but did not. 44296 Residents 36 and 451 Similar findings for Resident 36 and 451. Review of the residents' records showed the facilty did not identify individualized TB's for psychotropic medications, monitor TB's, or attempt GDRs or implement non-pharmaceutical interventions prior to administration of a PRN (as needed) medication. REFERENCE: WAC 388-97-1060(3)(k)(i).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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. 45941 Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were secured, labeled with required resident identifying information, dated when opened, and expired medications and biologicals were disposed of timely in accordance with professional standards in 1 of 4 medication carts, and 2 of 22 resident rooms reviewed. This failure placed residents at risk for not receiving medication, receiving expired medications and at risk for medication errors. Findings included . According to the 05/25/2021 facility Medication Storage policy is to ensure all medications housed at the facility will be stored in the pharmacy and/or medication rooms according to manufacturer's recommendations and sufficient enough to ensure proper security and all drugs and biologicals will be stored in locked compartments. 100 [NAME] Medication Cart Observations on the 100 [NAME] Medication Cart on 04/26/2022 at 11:00 AM, with Staff F (RCM- Resident Care Manager), showed a bottle of supplement tabs that expired on 02/23/2021, a bottle of artificial tears was opened but had no open date and was unlabeled with no resident name. During an interview on 04/26/2022 at 11:34 AM, Staff F confirmed the presence of above mentioned expired, undated, and unlabeled medications. Medication at the Bedside Resident 84 Observations on 04/26/2022 at 08:00 AM and 10:00 AM, showed Resident 84 had a bottle of nasal spray sitting on their bedside table. There was an open date 11/13/2021 on the bottle and expired date was 03/2022. In an interview on 04/26/2022 at 10:00 AM, Resident 84 stated they had the bottle of nasal spray for a long time and they used it independently. In an interview on 04/26/2022 at 10:07 AM, Staff Q (LPN- Licensed Practical Nurse), confirmed the bottle of Saline nasal spray on Resident 84's nightstand and stated medications should not be left unsecured at the bedside. Resident 8 On 04/24/2022 at 9:21 AM 3 pills were observed in Resident 8's top drawer in their bedside table. Similar observations were made on 04/26/2022 at 9:41 AM. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/26/2022 at 3:34 PM Staff SS (LPN) stated someone left the pills unsupervised with the resident and they [Resident 8] would take their pills one at a time and I stay with them to ensure they swallow all the medication. Staff SS confirmed the 3 pills by comparing the pills to the resident's medication in the medication cart, and stated they were the resident's evening medication consisting of a small oval pink pill that was confirmed a medication that treats high cholesterol, a large oval white pill that was confirmed as a supplement, and a large oval pink pill that was confirmed as medication that treats bipolar disorder. Staff SS stated they would not expect nurses to leave pills at the resident's bedside, especially with Resident 8, they will put their pills in their pockets, drawers, or stash them unsecured. REFERENCE: WAC 388-97-1300(2),-2340

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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. 43642 Based on observation, interview, and record review the facility failed to provide prompt dental services for 2 (Resident 82 & 251) of 4 residents reviewed for dental services. This failure placed the resident at risk for unmet dental needs, weight loss and a diminished quality of life. Findings included . Review of a 05/20/2021 facility Dental Services policy showed the facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location. This policy indicates that in the case of an acute dental condition or loss/damage of dentures, the facility will take measures to ensure residents are still able to eat and drink while awaiting dental services. Interventions included in this policy were, but were not limited to: Notifying the Physician of pain medications or other needs; Modifying diet consistency; Providing room temperature liquids for heat/cold sensitivity; Referral to a dietician for food preferences during the interim; and Referral to a speech therapist for chewing or swallowing problems. This policy stated all actions and information regarding dental services will be documented in the resident's record. Resident 82 According to 03/17/2022 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 82 was assessed with impaired cognition, able to make their decisions, required extensive assistance with oral care, and had obvious or likely cavities or broken natural teeth. In an interview on 04/23/2022 at 08:44 AM, Resident 82 stated they had broken teeth, that were painful, and a dentist saw them few months back but nothing happened after that visit. Resident 82's record review showed Resident 82 was seen by the dentist on 02/11/2022 at the facility. Review of the 02/11/2022 dental consult showed the resident was assessed with red irritated gums, medium plaque and calculus, broken tooth number 12, loose teeth number 11 and 13, missing upper teeth number 1, 5, 15, 16 and missing lower teeth number 17 and 32. The form was marked for referral for X-rays, evaluation and extraction of teeth # 12,13/9-11 and had a hand written note on the form stating [Resident 82] would like ext. [extractions]/rest. [restoration]. A review of Resident 82's 11/25/2020 Care Plan (CP) showed Resident had oral/dental health problems, Recommendations for Hygiene cleaning local dental company to provide outside referral. The CP revised on 03/08/2021 directed staff to Coordinate arrangements for dental care, transportation as needed/as ordered. In an interview on 04/26/2022 at 02:10 PM, Staff F (RCM) acknowledged there was no documentation that facility staff followed up with the dentist recommendations to schedule appointment. In an interview on 04/27/2022 at 10:23 AM, Staff H (Social services Assistant) stated Resident 82 was seen by the dentist on 02/11/2022 and indicated staff should have followed up on the recommendations to schedule appointments for X-rays and teeth extractions after the appointment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 251 According to a 04/15/2022 Admission MDS, Resident 251 was assessed as cognitively intact, with clear speech, and able to understand and be understood in conversation. In an interview on 04/23/2022 at 9:38 AM, Resident 251 reported they did not have their upper dentures with them and stated, that's why I eat so slow. Resident 251 indicated they forgot the dentures at home when they went to the hospitalized and were unsure how to obtain them. Observations at this time showed Resident 251 had no upper teeth and had several missing lower teeth. Review of a 04/15/2022 progress note showed staff documented Resident 251, is edentulous [without teeth] upper with few natural teeth bottom. According to a 04/18/2022 Nutrition Evaluation staff identified Resident 251 had upper dentures. Review of a dental CP initiated on 04/15/2022 showed staff identified Resident 251 was edentulous to upper and had few lower teeth. Resident 251's record review showed no indication that facility staff attempted to assist Resident 251 with contacting family and obtaining their upper dentures. In an interview on 04/29/2022 at 8:13 AM, Staff DD (Administrator in Training) asked Resident 251 about their dentures and verified the resident would like assistance to obtain them. REFERENCE: WAC 388-97-1060(1),(3)(j)(vii) 45941

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43642 Based on observation and interview the facility failed to store and prepare food under sanitary conditions. Failure to ensure food items in the dietary department were properly stored, labeled, and out-of-date foods were identified and discarded, and staff used appropriate hand washing placed residents at risk for consuming expired/spoiled foods and potential exposure to food-borne illness. Findings included . According to a [DATE] facility Food Safety Requirements policy, food would be stored, prepared and served in accordance with professional standards for food service safety. This policy defined food service safety as the handling, preparing, and storing food in ways that prevent foodborne illness. This policy indicated food safety practices should be followed throughout the facility's entire food handling process and included storage of food and employee hygienic practices. Initial Kitchen Rounds During initial observations of the dietary department on [DATE] at 8:00 AM showed the following out-of-date: a bin of fruit loops cereal that was labeled with use by date of [DATE]; a bin of white sugar labeled with a use by date of [DATE]; a bin of brown sugar labeled with a use by date of [DATE]; a bin of dry milk with a use by date that was illegible. Observations on [DATE] at 8:06 AM showed two unlabeled, undated bins, one that contained a breadcrumb like product and the other with a flour like product. Neither bin identified what the product was or was affixed with a use by date. In an interview on [DATE] at 8:10 AM, Staff UU (Dietary Supervisor) confirmed the above observations of unlabeled, illegible, undated, and/or out of date products. Staff UU stated food items should be used before the use-by date and indicated staff should place a new label on a container when/if the food product is refilled into bins. In an interview on [DATE] at 8:12 AM, Staff UU stated their process for canned food items was to label each can with an orange sticker with the date of when the product arrived. Staff UU indicated this was so staff could identify when to pull the product off the shelves. Observations at this time showed the following cans without an orange sticker: one can of [NAME] de vanilla and three cans of pineapple. In an interview on [DATE] at 8:15 AM, Staff UU stated the canned food items should have been, but were not labeled with the orange stickers. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on [DATE] at 8:35 AM showed a bucket of fluids on a shelf that staff identified as a sanitizing solution. During an interview at this time with Staff VV (Dietary Cook) and Staff UU, Staff VV stated, the solution was used to sanitize surfaces and is changed every two hours. Staff VV stated the bucket was last changed at 5:30 AM, over two hours ago. Staff VV was asked to test the sanitizing solution. Staff VV was unable to locate the test strips. Staff UU tested the solution and stated the solution needed to be changed. Observations of Tray Line Observations on [DATE] at 10:45 AM, showed kitchen staff washed their hands at the sink and was unable to obtain paper towels out of the dispenser. There was a paper towel roll sitting on the eye wash station nearby, staff reached over to grab the roll, and contaminated their hands during the process. At 10:50 AM on [DATE] Staff XX (Dietary Aide) was rinsing off dirty dishes with debris using gloves. Staff XX then rinsed the gloves off with water nozzle, loaded a tray of dirty dishes and slid the tray into the dishwasher. Staff XX went back to rinsing dirty cups until the dishwasher cycle completed. At that time Staff XX opened the dishwasher and while using the same soiled gloves, touched the clean dish tray rack and dishes while sliding them down the tray line. Observations on [DATE] at 11:00 AM, showed staff YY (Dietary Aide) wearing gloves, pulling clean dishes from the dishwasher tray line, and putting away the dishes in racks. Staff YY while still wearing the gloves, reached up and touched the front of their face mask twice. Staff YY, without changing gloves or performing hand hygiene, used the soiled gloves and grabbed another stack of clean plates to put away. On [DATE] at 11:41 AM, during tray line preparation, Staff WW (Dietary Cook) was observed wearing gloves and touched the front of their face mask several times. With the same soiled gloves Staff WW continued to prepare the next plate, scooped the food, and touched the food with the contaminated gloves as it came onto the plate. Similar findings were observed of Staff WW, during tray line preparations, wearing the same soiled gloves, touching their mask, and touching the plated food. At 12:02 PM Staff WW changed their gloves, did not perform hand hygiene, and continued to touch prepared food with contaminated gloves throughout the remainder of the meal tray service. Observations on [DATE] at 10:14 AM revealed the paper towel dispenser was still not functioning and no paper towels were available within reach after hand washing. In an interview at this time Staff UU confirmed the hand washing sink should have a functioning paper towel dispenser and paper towels should be available to staff for hand hygiene purposes. In an interview on [DATE] at 10:30 AM, Staff UU stated it was their expectation that staff changed gloves and performed hand hygiene when going from dirty to the clean side of the dishwasher. Staff UU stated staff should not use contaminated gloves and touch food during food preparations and indicated their expectation was that staff perform hand hygiene between glove changes and when hands become contaminated. REFERENCE: WAC [DATE](3), -2980.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 43642 Based on interview and record review the facility failed to ensure resident's records were complete, accurate, and readily accessible for 10 (Residents 86, 6, 36, 451 & 23) of 22 residents whose records were reviewed. The facility failed to ensure Nurse Monitoring Records (Residents 86, 6, 36, 451 & 23), Activities of Daily Living (ADL) records (Residents 59, 58, 97, 251 & 82), and nutritional intake (Residents 59, 58, 97 & 251) documentation was complete and accurate. Failure to ensure resident's records were complete and accurate placed residents at risk of for unmet care needs and inaccurate assessments. Findings included . Resident 59 Review of Resident 59's March 2022 nutritional intake documentation showed staff failed to document the resident's intake for 35 of the 93 meals provided. April 2022 records showed staff failed to document the resident's intake for 33 of the 78 meals provided. Similar findings were noted on March 2022 and April 2022 ADL documentation for bed mobility, dressing, personal hygiene, toileting, and oral care. Resident 58 Review of Resident 58's March 2022 nutritional intake documentation showed staff failed to document the resident's intake for 16 of the 93 meals provided. April 2022 records showed staff failed to document the resident's intake for 39 of the 78 meals. Similar findings were noted on March 2022 and April 2022 ADL documentation for bed mobility, dressing, personal hygiene, toileting, and oral care. Resident 97 Review of Resident 97's March 2022 nutritional intake documentation showed staff failed to document the resident's intake for 34 of the 93 meals provided. April 2022 records showed staff failed to document the resident's intake for 31 of the 73 meals provided. Similar findings were noted on March and April 2022 ADL documentation for bathing, bed mobility, dressing, personal hygiene, toilet use, bowels, and oral care. Resident 251 Review of Resident 251's April 2022 nutritional intake documentation showed, the staff failed to document the resident's meal intake for 30 of the 55 meals provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Similar findings were noted on April 2022 ADL documentation for bathing, bed mobility, dressing, personal hygiene, toileting, and oral care. In an interview on 04/29/2022 at 7:33 AM, Staff C (Chief Nursing Officer) stated their expectation was that staff document completely and accurately in the resident's records. Staff C stated accurate documentation was important to help staff assess the overall health and nutritional status of a resident. Resident 82 According to 03/17/2022 Quarterly MDS (Minimum Data Set - an assessment tool) Resident 82 was assessed with impaired cognition, able to make their own decisions. Resident 82 was admitted with diagnosis of Stroke, Hemiplegia (Left side weakness), Arthritis and required extensive assistance with bed mobility, dressing, toileting, personal hygiene, and bathing. A review of April 2022's ADL documentation from 04/01/2022 to 04/28/2022 showed the following: Resident 82 was documented as receiving assistance with personal hygiene on 32 times out of 56 shifts, on 40 out of 84 shifts for toilet use, on 39 of 84 shifts for bowel and bladder elimination, on 39 of 84 shifts for pain monitoring and 39 of 84 shifts for oral care. In an interview on 04/28/2022 at 11:00 AM, Staff B stated they would expect the ADL Tasks documentation to be part of the resident's record and acknowledged it was not documented for Resident 82 on multiple occasions. 44296 Resident 86 Review of Resident 86's April 2022 nurse monitoring of the left arm fistula (dialysis administration site) showed staff failed to document monitoring for 9 of 44 shifts. Resident 6 Review of Resident 6's April 2022 nurse monitoring of oxygen saturation showed staff failed to document monitoring for 9 of 40 shifts. The monitoring record also showed staff failed to monitor the settings and function of the specialty air mattress for 9 of 40 shifts Resident 36 Review of Resident 36's April 2022 nurse monitoring for pain showed staff failed to document a pain assessment for 9 of 40 shifts. The monitoring record also showed staff failed to monitor for signs of over sedation for 9 of 40 shifts. Resident 451 Review of Resident 451's April 2022 nurse monitoring of oxygen saturation showed staff failed to document monitoring for 4 of 22 shifts. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 23 Review of Resident 23's April 2022 nurse monitoring of hours of sleep showed staff failed to document for 9 of 42 shifts. A review of bowel monitoring (BM) records for Resident 36, 86, 6, 451 and 23 showed multiple shifts missing documentation for each resident. In an interview on 04/28/2022 at 2:13 PM with Staff B (Director of Nursing) and Staff C (Chief Nursing Officer), Staff C stated all medications, treatments and nurse monitor records are expected to be documented by staff as scheduled each shift. Staff B and Staff C acknowledged the system for staff documentation on the medication, treatment, nurse monitor and caregiver records was not intact. 45941 REFERENCE: WAC 388-97-1720(1)(a)(-iv)(b). 45987

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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** 44296 Based on interview and record review the facility failed to have a system to ensure consistent communication and collaboration of care occurred between the facility and hospice staff for 1 (Resident 3) of 1 resident reviewed for hospice services. The failure to develop and maintain a comprehensive hospice care plan (CP), collaborate with hospice for the needs and changes of the resident, and obtain hospice nurse visit notes and recommendations to implement into resident care, placed Resident 3 at risk for not receiving necessary comfort care, services, and a diminished quality of life. Findings included . The 05/12/2021 policy Hospice Services Facility Agreement showed the facility would designate a clinician responsible for collaborating with hospice staff for services provided. This designee would maintain communication to coordinate the hospice CP, obtain hospice physician orders, and visit notes to incorporate into a collaborative hospice CP. Resident 3 The 02/10/2022 Quarterly Minimum Data Set (MDS - an assessment tool) showed Resident 3 admitted to the facility on [DATE] on palliative (comfort-focused) care with a diagnosis of a non-curable progressive neurological disease. The 03/23/2022 CP showed Resident 3 chose hospice services to provide support for coping with grief/loss and maintaining the resident's comfort. The CP showed an intervention to establish a facility and hospice collaborative CP. This CP had no resident specific interventions designating hospice's role in Resident 3's care. On 04/25/2022 a copy of the hospice care plan for Resident 3 was requested from the facility. No document was readily available in the resident record, and no document was provided. A 03/29/2022 weekly skin observation assessment showed Resident 3 developed a new pressure ulcers (PUs) on the left outer ankle and the right outer foot. Review of the 04/01/2022, 04/06/2022, and 04/23/2022 hospice nurse notes showed no mention of the two new PUs. The progress notes did not demonstrate facility staff reported any concerns during the corresponding hospice visits. In an interview on 04/27/2022 at 12:38 PM, Staff F (Resident Care Manager & Minimum Data Set Nurse) stated when new PUs were identified on Resident 3, the physician and the hospice nurse were expected to be notified and a treatment order obtained prior to placing a treatment on the resident. Staff F reviewed the resident record, and did not find documentation of the physician or hospice notification of the PUs or treatment orders for the new PU. REFERENCE: WAC 388-97-1020(5)(a).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The failure to implement and correctly identify 2 (Resident 451 & 6) of 5 residents on transmission based precautions (TBP) for COVID-19 (Coronavirus- a contagious respiratory illness) placed residents and staff at risk for contracting and spreading COVID-19. In addition, the facility failed to ensure staff practiced standard hand hygiene, wore required personal protective equipment (PPE), established a process to conduct COVID-19 risk assessments and failed to implement the facility policy for fit-testing N95 respirators (a mask that filters 95% of airborne particles) for 104 of 157 staff placing residents at risk for acquiring and spreading COVID-19 and/or other contagious infections. Findings included . TBP The 03/11/2022 facility policy WA State Policy for Suspected or Confirmed COVID-19 showed residents with suspected COVID-19 would be placed on contact/droplet precautions, hand hygiene would be used before and after all patient contact, staff would use PPE including gloves, gown, mask, and eye protection for direct contact with residents, and PPE would be readily available, and specific signage (to instruct staff on what PPE requirements were necessary) would be on the door. Resident 451 Observations on 04/21/2022 at 8:55 AM showed a Quarantine Precautions sign taped to the outside of the bedroom door of Resident 451. The sign directed only essential personnel to enter the room and directed staff who entered the room they must clean hands, wear an N95 respirator, protective eyewear, gown and gloves for providing personal care. The PPE cart outside the residents room contained no hand sanitizer, gowns, gloves, masks, eyewear or N95 respirators. In an observation and interview on 04/21/2022 at 8:55 AM, Resident 451 was observed at the doorway, not wearing a mask. Staff T (Certified Nursing Assistant) was walking by and was asked why Resident 451 was on quarantine precautions. Staff T stated they were not aware that Resident 451 was on quarantine precautions and would go ask the manager. Staff T did not return with the answer to why Resident 451 was on quarantine. On 04/21/2022 at 9:00 AM, Staff E (Infection Control Nurse) confirmed Resident 451 was on quarantine precautions because they recently had COVID-19 and did not receive the booster vaccine. Staff E stated all staff are required to follow the precautions listed on the door, including use of the N95 respirator when entering the room. Staff E looked in the isolation cart and confirmed there were no N95 respirators, gowns, gloves, or hand sanitizer in the cart. Staff E confirmed there were no PPE supplies at the door to enter the quarantined room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 6 The 12/2021 facility policy WA State Policy for Preventing Transmission of [COVID-19] During Aerosol Generating Procedures showed N95 respirators would be used for any resident room where the resident used an aerosol generating procedures (AGP). Continuous positive airway pressure (CPAP) treatments were listed as an AGP with the requirement to keep door closed and continue N95 respirator use when entering the room for three hours after the treatment completion. Observations on 04/22/2022 at 10:57 AM showed room [ROOM NUMBER] with a AGP sign taped to the door. The sign directed only essential personnel to enter during the procedure, must clean hands, must wear an N95 respirator, protective eyewear, a gown, and gloves for providing personal care. There was no cart outside the door for PPE storage/availability. In an interview on 04/22/2022 at 10:57 AM outside of room [ROOM NUMBER], Staff N (Licensed Practical Nurse) was asked what PPE should be worn when entering room [ROOM NUMBER]. Staff N stated they did not know why the sign was on the door and would have to ask the manager. Staff N stated they did not notice the sign and was in the room giving medications without an N95 respirator or a gown. Staff N stated, they should have worn the PPE as the sign directed. In an interview on 04/22/2022 at 11:29 AM, Staff CC (Registered Nurse) stated they heard Resident 6 had a CPAP (breathing machine) used at night and that was why Resident 6 was on isolation. Staff CC looked at the physician orders (PO) and did not see any order for a CPAP. Staff CC looked in room [ROOM NUMBER] and Resident 6 did not have a CPAP machine that would require isolation. In an interview on 04/26/2022 at 10:26 AM, Staff E (Infection Control Nurse) stated if Resident 6 was not using a CPAP, then they would not need to be on isolation. Staff E stated they did not know why the AGP sign was on Resident 6's door. Staff E stated the protocol for isolation tracking was not being done and agreed that staff did not know or follow when to use the required PPE. Observation showed the AGP Sign was not removed from the door of room [ROOM NUMBER] until 04/28/2022, 2 days later. A PPE cart was not observed outside the room between 04/22/2022 through 04/28/2022. Hand Hygiene & PPE The 09/09/2021 facility policy titled Hand Hygiene directed staff to perform hand hygiene in the following situations: between resident contact, after handling contaminated objects, before applying and after removing PPE, including gloves, and before/after handling clean or soiled linens. Observation on 04/21/2022 at 10:52 AM showed Staff BB (Nurse Aide) and Staff T (Certified Nursing Assistant- CNA) walked in and out of room [ROOM NUMBER] without performing hand hygiene. Staff T walked down the hall, entered room [ROOM NUMBER] and put on gloves without performing hand hygiene. Observation on 04/21/2022 at 10:52 AM showed therapy staff with a gait belt, exited room [ROOM NUMBER], not wearing PPE, and did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 04/21/2022 at 1:17 PM showed a CNA enter room [ROOM NUMBER] to assist Resident 7 with toileting. The CNA did not perform hand hygiene before assisting Resident 7. The CNA did not assist Resident 7 to wash their hands after using the commode. Resident 7 stated there was no way to wash their hands. [NAME] debris was noted under Resident 7's nails. The hand sanitizer on the wall inside room [ROOM NUMBER] was empty. Observation on 04/24/2022 at 10:22 AM showed a Physical Therapist (PT) enter room [ROOM NUMBER] with a posted Quarantine Precautions sign on the door, without wearing an isolation gown or an N95 respirator. The PT did not perform hand hygiene before assisting the resident or upon leaving the room. In an interview on 04/28/2022 at 2:13 PM, Staff E (Infection Control Nurse) stated all staff are expected to perform hand hygiene before and after resident care was provided. Staff E provided a copy of the 03/25/2022 All staff meeting sign in sheet which showed a topic handwashing/ hand hygiene. There were 25 staff signatures on the sign-in sheet, out of the total 157 staff. Staff BB and Staff T were not on the attendance list. Staff E was asked if the March 2022 verbal education on hand washing for 25 staff was effective for all staff training, Staff E stated no. The 08/04/2021 facility COVID-19 Plan showed the facility would provide and ensure that employees wear facemasks or a higher level of respiratory protection. Face masks must be worn by employees over the nose and mouth when indoors. Observation on 04/21/2022 at 12:59 PM, showed a housekeeper wearing an N95 respirator with their nose exposed. The housekeeper was not wearing gloves and reached into a mop bucket, then walked into resident room [ROOM NUMBER] without performing hand hygiene. On 04/21/2022 at 1:05 PM the same housekeeper walked into room [ROOM NUMBER] without hand hygiene and still wearing the same N95 respirator they used in room [ROOM NUMBER] with their nose exposed. Staff F (Registered Nurse) confirmed the improper use of the N95. COVID-19 Risk Assessments A sample of resident's records (Residents 36, 84, 81, 451, 6, 3, and 86) were reviewed for completed COVID-19 risk assessments as required for public outings from the facility. There were no risk assessments located in any of the resident records. Resident 36 stated they went on an outing for lunch on 04/23/2022. Residents 6 and 86 stated they went out of the building three times a week for dialysis using the public transportation wheelchair bus. In an interview on 04/28/2022 at 2:13 PM, Staff E (Infection Control Nurse) explained how the process of risk assessments worked. Staff E stated the nurse would complete the form before the resident left for an outing. When the resident returned from an outing. If the resident was vaccinated, they were at low risk for transmitting viruses. If the assessment said the resident was at high risk for transmitting viruses the nurse was to place the resident on quarantine for 14 days. When asked how Staff E ensured staff followed this process on quarantine status, Staff E replied they only followed up if the nurse told (Staff E) about the quarantine. When asked who supervised the quarantine status of residents, Staff E replied, the nurses do. Staff E stated the risk assessments were not in the resident charts or readily available for review. Staff E stated they were not aware that the risk assessment was part of the resident record. Staff E was not able to provide risk assessments for Residents 36, 6, or 86. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 04/28/2022 at 2:20 PM, Staff C (Chief Nursing Officer) corrected Staff E on their description of the risk assessment process and their answers to the questions. Staff E stated risk assessments are to be completed after the resident returns, if high risk for virus transmission, the resident was placed on quarantine and the Infection Control Nurse was responsible to track and ensure the quarantine and isolation processes were followed by all staff. Staff C confirmed the system of completing risk assessments was not intact. Fit Testing and N95 Respirator Use According to the Department of Labor and Industries Division of Occupational Safety and Health: Directive 11.80 (updated September 21, 2021) regarding Respiratory Protection and Face Coverings during the COVID-19 pandemic, fit tested NIOSH (National Institute for Occupational Safety and Health) approved N95 respirators were required when caring for residents with COVID-19 or suspected of having COVID-19, and when fit tested , a worker must select and wear the same make/model/size of the respirator they were fitted to. A review of the (undated) fit testing record provided by Staff E showed fit testing was completed on only 53 of the 157 total staff. The fit testing was completed on 08/12/2021 and 09/27/2021 and 09/28/2021 for only one type of N95 respirator (Makrite). In an interview on 04/25/2022 at 1:41 PM, Staff TT (Director of Central Supply) stated there were three types of N95 respirators in the central supply closet. On observation there was BYD and 3M respirators and an unknown brand of KN95 mask. There was no Makrite N95 respirators. In an interview on 04/26/2022 at 10:26 AM Staff E stated all staff were fit tested to a N95 respirator. Staff E was not aware there was no supply of Makrite N95 respirators in the facility. In an interview on 04/26/2022 at 2:25 PM, Staff C (Chief Nursing Officer) confirmed the facility did not have any supply of the Makrite N95 respirators. Staff C stated the process for N95 fit testing and ordering was not intact to keep the required respirators in stock. The undated facility Policy for PPE Contingency and Crisis use of N95 Respirators showed the Administrator was responsible for the inventory and supply chain of PPE. The policy showed the administrator was expected to have a calculated contingency supply of PPE supplies needed for a crisis. In an interview on 04/27/2022 at 1:25 PM, Staff A (Administrator) stated the facility ordered N95 respirators through the State Department of Health (DOH) and another private supplier. The facility used a set ordering system to keep PPE in stock. Staff A stated the facility asked DOH for the Makrite N95 respirators and the DOH did not send them. Staff A acknowledged the designated N95 respirator that staff were fit tested to use were not available in the facility. Staff A stated they were not aware that each brand of N95 respirator needed to be fit tested to each staff person. Staff A was not able to confirm the current facility supply, or if there was sufficient PPE if there was a facility infection outbreak. Staff A was not able to provide information on the facility's calculations for the PPE contingency supply for a crisis. Refer to F886 COVID-19 Testing Residents and Staff. Refer to F888 COVID-19 Vaccination Tracking/Reporting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	REFERENCE: WAC 388-97-1320(1)(a-c)(2)(a-c).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44296 Based on interview and record review the facility failed to establish an infection prevention and control program that included developing an antibiotic stewardship program to promote appropriate use of antibiotics, and reduce the risk of unnecessary antibiotic use for 2 (Residents 36 & 81) of 6 residents reviewed for unnecessary antibiotics and 6 (October 2021, November 2021, December 2021, January 2022, February 2022, and March 2022) of 6 months of Infection Control (IC) documents reviewed. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate/unnecessary use of antibiotics and an increased risk for multidrug-resistant organisms (MDRO: microscopic organisms that are resistant to many antibiotics). Findings included . According to the 09/09/2021 facility Antibiotic Stewardship Program policy the Infection Preventionist (IP), with oversight for the Director of Nursing (DON), served as the leader of the Antibiotic Stewardship Program and received support from the Administrator and other governing officials of the facility. The Medical Director, Consultant Pharmacist, and Attending Physician support the program via active participation in developing, promoting, and implementing a facility-wide system for monitoring the use of antibiotics. The Consultant Pharmacist reviewed antibiotics prescribed to residents during their medication regimen review and served as a resource for questions related to antibiotics. All prescriptions for antibiotics should specify the dose, duration, and indication for use. Reassessment of empiric antibiotics (given before the specific organism is unknown) was conducted after 2-3 days for appropriateness and necessity, factoring in the results of diagnostic tests, laboratory reports, and/or changes in the clinical status of the resident. Documentation related to the IC Program was maintained by the IP, including Antibiotic Stewardship meeting minutes. Resident 36 Review of the resident's record showed the resident admitted to the facility on [DATE] and was prescribed an antibiotic twice daily for a diagnosis documented as antibiotic with no stop date. Review of the Care Plan (CP) 10/22/2021 showed no indication the resident was taking an antibiotic or the diagnosis for the antibiotic. A 11/15/2021 Physician note showed the resident had a history of rapidly progressing cellulitis in the past and was currently on an antibiotic twice a day for suppression. In an interview on 04/26/2022 at 10:26 AM Staff E (Infection Preventionist/Staff Development) stated the antibiotic was for wound infection prevention and confirmed there should be a diagnosis and stop date for the antibiotic. Staff E stated they did not have justification or documentation to continue the antibiotic without a stop date, and acknowledged the Physician should have clarified the diagnosis for the antibiotic. January 2022 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2022 line list showed Resident 36 readmitted to the facility on [DATE] from a local hospital with a skin infection. The line list showed under the symptoms box the IP documented admitted with UTI and cellulitis (skin infection), no cultures were obtained, and the infections were marked as CAI's (Community Acquired Infection). Review of progress notes showed on 12/17/2021 the Physician was notified of Resident 36's complaint of increased pain and swelling to the right lower leg and recommended the Resident 36 be seen in the emergency room to rule out a possible DVT (Deep Vein Thrombosis- blood clot). A 12/17/2021 Physician encounter note showed the resident was seen on 12/19/2021 for increased right foot swelling, fungal rash to skin folds, orange urine and URI (Upper Respiratory Infection). The note showed the resident had a history of recurrent abdominal cellulitis and right foot/shin abscess that improved after 10 days on antibiotics. The Physician noted some swelling to the right foot, but denied observing any warmth or redness. The note showed the resident had a UA (Urinalysis) done that came back negative for an infection and the orange urine could be from dehydration. The resident was sent to the emergency roiagnom on [DATE]. Review of Physicians Orders (POs) showed a 01/17/2022 PO for an antibiotic for 1 day to treat a UTI, a 01/25/2022 PO for a second antibiotic for 7 days to treat a skin infection and a 01/25/2022 PO for a third antibiotic for 10 days to treat a skin infection, the antibiotic was extended on 02/12/2022 for 7 more days. Review of the January 2022 IC documents showed no Resident Infection Report Form (used to determine if the infection met criteria) for Resident 36. Review of the resident's record showed no indication the facility attempted to obtain the urine culture results to determine if the current antibiotic being used was appropriate for the specific organism. No documentation to support the symptoms of a skin infection or alert charting to monitor the effectiveness of the antibiotic was present. Review of the January 2022 IC Summary Report showed no antibiotic stewardship reviewed. In an interview on 04/26/2022 at 10:26 AM Staff E stated the facility used McGeer's criteria (surveillance definitions of infections in long term care facilities) to determine if an infection met the criteria for treatment. Staff E stated the facility did not create a resident infection report form for CAI's, but do for Healthcare Acquired Infections (HAI). February 2022 Review of the February 2022 line list showed Resident 36 had two infections, consisting of a CAI skin infection from the previous month, and a HAI (healthcare acquired infection) urinary tract infection (UTI), and was prescribed antibiotics to treat the infections. A 02/12/2022 Nursing progress note showed the resident returned to the facility with a prescription for an antibiotic for 5 days to treat a UTI. Review of PO showed a 02/12/2022 PO for an antibiotic for 5 days to treat a UTI, and a 02/18/2022 PO for a second antibiotic for 7 days to treat a skin infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A late entry 02/13/2022 Nursing progress note written on 02/17/2022 by Staff E showed the resident was noted with dysuria, suprapubic pain, an increase in urgency, and a UA was completed at the local hospital. A 02/14/2022 Resident Infection Report Form showed Resident 36 met criteria for a UTI, and the following symptoms were marked; acute dysuria (pain with urination) , suprapubic (region of the abdomen below the belly button) pain, new or marked increase in frequency, and a urine culture (lab test to check for bacteria) containing no more than 2 species of microorganisms (bacteria, virus, or fungus). Review of the 02/12/2022 hospital After Visit Summary showed Resident 36 was found to likely have a UTI . No UA or documented symptoms were found within the hospital paperwork. Resident 81 Review of the resident's record showed Resident 81 readmitted to the facility on [DATE], and was being treated with an antibiotic upon admission for SBP (Spontaneous Bacterial Peritonitis- an infection of abdominal fluid) prophylaxis . Review of PO's showed a 03/16/2022 PO for an additional antibiotic for SBP prophylaxis. Review of a 03/14/2022 Hospital discharge orders showed two antibiotics, one to be continued and one that was discontinued. Review of a 03/14/2022 Hospital after visit summary directed Resident 81 to continue taking both antibiotic medications. Review of the resident's record should no indication facility staff clarified the discrepancy between the hospital discharge order and the hospital after visit summary orders. Review of the resident's CP showed no indication the resident was received a prophylactic antibiotics, goals of antibiotic therapy, or interventions including monitoring the resident for adverse side effects. In an interview on 04/26/2022 at 10:26 AM Staff E stated they were not aware Resident 81 was taking antibiotics and they were not included on the March 2022 line list. Monthly Summaries & IC Meetings Review of October 2021, November 2021, December 2021, January 2022, February 2022, and March 2022 IC summaries showed Staff E identified specific organisms related to infections on the line list but did not include the organisms in the analyzing of the monthly IC data summary. There was no indication the facility received monthly data from the lab about organisms identified or prevalent in the facility. Failure to identify the specific organisms or obtain lab reports deterred Staff E from analyzing the potential spread of specific organisms, trends of specific organism, and determining prevalent organisms in the facility. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2021-March 2022 IC Summary Reports showed no indication the facility thoroughly analyzed the data from each floor/wing and compiled it together to determine the prevalent types of infections (i.e. skin infection, UTI) to identify specific trends on floors/wings and the building as a total. Review of the October 2021-March 2022 IC Summary Reports showed no CAI's had a Resident Infection Report Form showing if the infection met McGeer's criteria. On 04/26/2022 at 10:26 AM Staff E stated they did not check if antibiotics meet McGeer's criteria for residents who admitted to the facility with CAI's, they just go with them and only check McGeer's criteria for HAI. The failure to identify, monitor, assess for appropriate diagnosis, and justification placed residents who admitted with antibiotics at risk for unnecessary antibiotics, and potentially adverse side effects. Review of October 2021-March 2022 Pharmacist Medication Regimen Review Reports showed under Antibiotic Stewardship, a) infection control meeting: no invitation was received, please let me know if you would like me to attend, b) antibiotic stewardship: I [the pharmacist] review antibiotic usage regarding appropriate infection criteria, proper indication, dosing, and duration with each visit. In an interview on 04/26/2022 at 10:26 AM Staff E stated they do not conduct a monthly infection control meeting with the interdisciplinary team, Staff E does it on their own. In an interview on 04/28/2022 at 2:13 PM Staff C (Chief Operating Nurse) stated the Antibiotic Stewardship Program system was not intact, as required. REFERENCE: WAC 388-97-1060(3)(k)(i).

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. 44296 Based on interview and record review the facility failed to have a system to ensure staff were accurately tested during an infectious disease, COVID-19 outbreak (Coronavirus, a highly transmissible infectious respiratory disease). The failure to identify the testing frequency criteria based on positivity rate (number of positive results in all tests completed in a designated region), document completed test results for each staff, and complete additional testing for exempted staff placed all residents at risk of infection from COVID-19 during a nationwide pandemic. Findings included . Review of the daily testing logs for April 2022 provided by Staff E (Infection Control Nurse) showed a staff list with highlighted names and a date at the top of the page. The log was unnamed and was not identifiable as a tracking log for COVID-19 testing. In an interview on 04/26/2022 at 10:26 AM, Staff E (Infection Control Nurse) stated the staff testing should be done twice a week for all staff and three times a week for the staff with exemptions. Staff E stated the testing was completed at the reception desk and a paper is completed and filed. Staff E stated there was not a system of tracking to ensure all staff were tested twice a week or that the exempt staff has tested three times a week. Staff E stated they do not have a system to track or document the community transmission rates. Staff E stated the LHJ (Local Health Jurisdiction) office was called or emailed to find out if the county is high or medium. When asked if there was a tracking log for transmission rates, Staff E said they would have to go thru their email to create a log. In an interview on 04/26/2022 at 2:25 PM, Staff V (Receptionist) stated staff will take a test kit and do their test, fill out a form and return to the reception desk indicating the testing was completed. Staff V stated there was a box under the desk to place all the completed test forms and when the stack was big enough, they were taken to the Infection Control Nurse office. The box under the desk was observed with a large stack (over 1000 pages equivalent to two packages) of testing pages. Staff V stated there was multiple days of testing in the box. Staff V stated the receptionists do not audit to ensure all staff was tested two or three times per week. On 04/26/2022 at 2:12 PM, Staff E was asked to provide the documentation for the exempt, unvaccinated staff. Staff E stated the test results were not filed and tracked and the facility would need time to sort thru the piles of testing pages to find the documentation of testing. In an interview on 04/28/2022 at 2:13 PM, Staff C (Chief Nurse Officer) acknowledged the lack of systems in infection control for ensuring testing, tracking, and documenting of COVID-19 tests. Staff C stated the system was not intact. REFERENCE: WAC 388-97-1320 (i)(a).

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure staff are vaccinated for COVID-19 44296 Based on interview and record review the facility failed to ensure a system was implemented to ensure accurate tracking and reporting of COVID-19 vaccination status of residents, facility and contracted staff (provide care, treatment, or other services to the residents under contract with the facility). The failure to accurately track vaccination status, provide timely vaccination opportunities, implement vaccination exemption mitigation, and complete accurate identification for reporting to the MSN (National Healthcare Safety Network) placed residents at potential risk of an outbreak of COVID-19 in the facility. Findings included . Vaccination Tracking Review of the facility staff list provided at the entrance conference showed 157 staff worked for the facility. The facility provided the staff vaccination matrix with 133 staff. On 04/26/2022 Staff DD (Administrator in Training) was requested to reconcile the staff list with the matrix and provide documentation of vaccination for facility staff. The findings showed one staff partially vaccinated without exemption and five staff exempt for religious accommodation. The staff vaccination list and the matrix did not include contracted staff with direct contact with residents. In an interview on 04/28/2022 at 2:10 PM, Staff E, (Infection Control Nurse (IC)) stated they did not monitor the vaccination status of facility staff or contracted staff with direct contact with residents. Staff E stated they were not aware of the requirement to verify contracted staff vaccination status. Staff C (Chief Nurse Officer) present in the interview, stated Staff E was expected to track and report the accurate data for facility staff and contracted staff. Staff C confirmed the system for tracking and reporting was not intact. Vaccinations Offered A review of the 04/25/2022 resident vaccination tracking log showed five residents signed a consent form to receive the COVID-19 booster but did not receive the booster. The tracking log showed eight residents were not offered the vaccine. Review of the MSN facility reported data (week ending 04/03/2022) prior to entering the facility on 04/21/2022 showed the facility reported only 12% staff received a COVID-19 booster. In an interview on 04/29/2022 at 2:13 PM, Staff E was asked about good faith efforts to attempt vaccinations for residents and staff. Staff E stated there was no issue obtaining vaccine from the pharmacy, staff was able to sign up for boosters, residents signed consents to receive boosters and only a date to administer the vaccines needed to be set. Staff E stated the last offering of vaccination was in February 2022. There was no future date scheduled for staff and residents at this time to receive vaccines. (continued on next page)

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F 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Exempt Staff Precautions Review of the 04/26/2022 amended vaccination matrix showed there were five unvaccinated facility staff with an approved exemption and one staff who did not complete the two step vaccination series. In an interview on 04/26/2022 at 10:26 AM, Staff E stated the facility chose additional precautions for unvaccinated/exempt staff. The staff was required to test three times per week and use an N95 respirator when in the facility, to prevent the risk of COVID-19 transmission. Staff E was not aware of the partially unvaccinated Staff OO (Certified Nursing Assistant). Staff OO (Certified Nursing Assistant) was identified on the matrix as receiving the vaccination with only one of the two steps completed. Staff OO was observed on 04/21/2022, 04/22/2022, 04/23/2022 and 04/26/2022 working in the facility providing direct resident care and was not wearing an N95 respirator. Review of the limited testing records for April 2022 showed Staff OO was not tested for COVID-19 three times a week. Staff T (Certified Nursing Assistant) was identified on the matrix as unvaccinated and exempt. Observations on 04/21/2022, 04/23/2022, 04/24/2022, 04/25/2022 and 04/26/2022 showed Staff T working in the facility providing direct care to residents and did not wear an N95 respirator. Review of the testing records for April 2022 showed Staff T was not tested for COVID-19 three times a week. Staff R (Business Office Manager) was identified on the matrix as unvaccinated and exempt. Observations on 04/21/2022, 04/22/2022, 04/25/2022 and 04/26/2022 showed Staff R working in the facility less than 6 feet from residents and was not wearing an N95 respirator. Review of the limited testing records for April 2022 showed Staff R was not tested for COVID-19 three times a week. Staff AAA (Receptionist) was identified on the matrix as unvaccinated and exempt. Observations on 04/25/2022 and 04/26/2022 showed Staff AAA working at the reception desk in proximity of less than 6 feed from residents, staff and visitors and was not wearing an N95 respirator. Review of the April 2022 testing records showed Staff AAA was not tested for COVID-19 on the week of 04/24/2022. In an interview on 04/28/2022 at 2:13 PM, Staff C stated the IC was expected to ensure unvaccinated staff were compliant with COVID testing and used N95 respirators. Staff C confirmed the system for tracking and reporting was not intact. Staff Vaccination Reporting Review of the MSN facility reported data (week ending 04/03/2022) prior to entering the facility on 04/21/2022 showed the facility reported 92.6% staff fully vaccinated, 12% staff with booster. Review of the amended matrix provided by the facility on 04/26/2022 showed a total of 153 staff. The data showed one staff (Staff OO) completed one of two steps of the vaccination without a documented reason for being partially vaccinated. The contracted staff were not identified or included on the matrix and could not be counted in the facility vaccination rate. In an interview on 04/29/2022 at 2:13 PM, Staff E stated they did not know contacted staff with direct contact for resident care was to be included into the MSN report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505202	A. Building B. Wing	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Skilled Nursing and Rehabilitation	4430 Talbot Road South Renton, WA 98055

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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 0888 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/29/2022 at 2:13 PM, Staff C (Chief Nursing Officer) confirmed the facility inaccurately reported the staff vaccination status to the MSN because they did not identify all facility staff vaccination status and had omitted the contracted staff that provided direct care and services to residents. REFERENCE: WAC 388-97-1320(1)(a)