STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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 - Few	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** 35787 Based on observation, interview and record review, the facility failed to ensure residents received care in a manner which upheld dignity and right to make choices in their care for three of three residents (57, 48 and 39) reviewed for dignity and resident rights. These failures had the potential to cause psychosocial harm and a diminished quality of life RESIDENT 57 Resident 57 was readmitted to the facility on [DATE]. Her primary diagnosis list included Huntington's disease (an inherited disease that causes progressive breakdown of nerve cells in the brain that causes uncontrolled movements and loss of thinking ability) and Manic Depression (a disorder with episodes of mood swings ranging from depressive lows to manic highs). Record review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had unclear speech, was rarely understood and rarely understood others. Further record review of the MDS showed the resident required extensive to total physical assist of one to two persons for all care. In an observation on 08/27/19 at 2:01 PM, the resident was observed with a blue non-skid sock on her left hand. On 08/28/19 at 10:24 AM and 08/29/19 at 2:44 PM similar observations were made of the resident with a blue, non-skid sock on her left hand. In a joint observation on 09/04/19 at 9:46 AM with the Director of Nursing Services (DNS) and Staff P Licensed Practical Nurse (LPN) the resident was observed with a blue non-skid sock on the left hand. The DNS confirmed it was a non-skid sock on her left hand. At this time, Staff P LPN stated: she has it on because she scratches herself. She usually wears a glove on that hand, not a sock. I don't know where the glove is right now, or who put that sock on her hand. In an interview on 09/04/19 at 9:58 AM the DNS said, I will get it taken care of. 40303 (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 48 Resident 48 Quarterly MDS, dated [DATE], showed the resident extensive assistance with Activity of Daily Living (ADL) and was able to make needs known to staff. Review of the resident's baseline Care Plan (CP) listed a goal of Resident will require two staff participation to dress. Interventions include: Allow Resident to choose what clothes to wear as this is important to them. Multiple observations on 08/28/19 at 09:35 AM, 11:30 AM, 1:30 PM, and 3:30 PM, on 09/03/19 at 10:10 AM, 1:45 and 2:50 PM, and on 09/05/19 at 11:02 AM, 1:45, 2:50 PM showed the resident lying in her bed dressed in a hospital gown. Resident 48 stated that she has some clothes, but staff were not helping her to get dressed. The resident also stated that a new wheelchair was on order and that why she was staying in bed. She said that she would like to be dressed in her clothes and not a hospital gown. A similar observation was made on 09/09/19 at 10:50 AM and at 1:55PM. RESIDENT 39 Resident 39's Quarterly MDS, dated [DATE], showed the resident had diagnoses to include diabetes and stroke with hemiplegia (paralysis of one side of the body), and was dependent on staff for activities of daily living. Review of the resident's baseline Care Plan (CP) showed a goal of will verbalize any changes to current to preferences/choices. Interventions include Allow Resident to choose what clothes to wear as this is important to them. Multiple observation on 08/28/19 at 09:35 AM, 11:30 AM, 1:30 PM, and 3:30 PM, on 09/03/19 at 10:10 AM, 1:45 and 2:50 PM, and on 09/05/19 at 11:02 AM, 1:45, 2:50 PM showed the resident lying in her bed dressed in a hospital gown. A friend at bedside stated he visited Resident #39 every day and she was always wearing a hospital gown. Stated that the resident had clothes, but staff don't help her get dressed up. Similar observation was made on 09/09/19 at 10:50 AM and at 1:55PM. During an interview on 09/11/19 at 10:59 AM, Staff E, RCM stated that nursing assistant were responsible to provide dressing and grooming every day. When asked if Resident 48 and 39 ware offered or provided choices of clothes at the frequency as per care plan, Staff E stated, No. During an interview on 09/06/19 at 2:45 PM, the DNS stated that nursing assistants were responsible to offer residents choices of their clothes and that any refusals should be reported to the nurses. WAC Reference 388-97-0860 (1)(a)(2)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on interview and record review, the facility failed to honor residents' bathing preferences for nine of 9 residents (45, 49, 73, 48, 17, 57, 35, 27 and 30). This failure placed the residents at risk for poor hygiene, decreased dignity, and compromised health and well-being. Findings included . RESIDENT 45 The resident admitted to the facility on [DATE] and was a two person physical assist with bathing. Review of the resident's care plan showed the residents bathing preferences were not care planned. Review of the bath reports from 07/8/19 to 09/06/19 showed the resident only received 1 shower during this period. In an interview on 09/13/19 at 11:23 AM, the Director of Nursing Services (DNS) stated if showers and Activities of Daily Living were not completed, it was related to the lack of staff. RESIDENT 49 The resident admitted to the facility on [DATE] and was able to make his needs well known. Review of the Minimum Data Set (MDS), dated [DATE], showed the resident was totally dependent for bathing. The MDS also showed he needed extensive assistance with personal hygiene. Review of the resident's care plan, revised on 05/28/19, showed the resident was a two person assist with personal hygiene and grooming needs. The care plan showed staff were to offer the resident a shave on shower days at least two times a week. Review of the bath reports from 04/24/19 to 09/06/19 (5 months and 3 weeks) showed the resident did not have any showers with 8 refusals during this period. In an interview on 09/12/19 at 02:52 PM, Staff E, Resident Care Manager (RCM) stated the reason showers had not been done was because of staffing. He stated the nursing assistants had been instructed to do bed baths for residents. RESIDENT 73 The resident admitted to the facility on [DATE] with diagnoses including stroke and left sided weakness/paralysis. The resident was able to make his needs well known. Review of the MDS, dated [DATE], showed the resident was totally dependent with bathing. Review of the Kardex (Care plan for nursing assistants/NA) showed the resident was to get a shower every Monday and Wednesday. (continued on next page)

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the bath reports from 04/28/19 to 09/10/19 showed the resident did not receive any showers and had 10 refusals during this period. In an interview on 09/12/19 at 02:52 PM, Staff E, RCM stated the reason showers had not been done was because of staffing. He stated the nursing assistants had been instructed to do bed baths. 40303 RESIDENT 48 Resident 48 readmitted to the facility on [DATE] for care needs related to a stroke. According to the 07/19/19 MDS assessment, Resident #48 was cognitively intact and able to express her needs. During an interview and observation on 08/27/19 at 9:27 AM, Resident #48 was asked if she was able to choose the frequency with which she received bathing. Resident #48 stated, No and stated that she wanted showers and not bed baths. She further stated that she has not received even a bed bath for weeks. The resident's hair was unkempt. According to the resident's Care plan (CP), revised 05/07/19: Activity of daily living self-care deficit related to stroke: Resident prefers to take shower on Tuesday and Thursday. Resident prefers female care giver for hair. Review of Resident #48's bath record in the last 30 days (August/September) showed no showers or bed bath was offered or that the resident refused showers on any other days. On the shower days, the bath record reflected Not applicable. In an interview on 09/04/19 at 11:18 AM, Staff E, Resident Care Manager (RCM), stated the resident's preferences for bathing frequency was up to two times a week. When asked why Resident #16 had not been offered showers for a month, Staff E replied, She is bed fast and she gets bed baths while bed. Staff E stated, I guess we're not meeting the resident's preferences for bathing frequency as per the CP. 35787 RESIDENT 17 Resident 17 was admitted to the facility on [DATE] with a diagnosis list that included weakness among others. Record review of the annual Minimum Data Set (MDS) assessment dated [DATE] showed the resident had clear speech, was able to understand and be understood by others. Further record review of the (MDS) showed the resident required extensive physical assist of one person for bathing. According to the care plan with a revision date of 07/03/19 the resident preferred to have bathes two times a week on Tuesdays and Fridays. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the bath report dated 08/01/19 to 09/10/19 documented the resident received showers 08/10/19, 08/14/19, 08/17/19, 08/21/19 and 08/29/19. There were no documented showers from 09/01/19 to 09/10/19. RESIDENT 57 Resident 57 was readmitted to the facility on [DATE]. Her primary diagnosis list included Huntington's disease (an inherited disease that causes progressive breakdown of nerve cells in the brain that causes uncontrolled movements and loss of thinking ability). Record review of the annual MDS assessment dated [DATE] showed the resident total physical assist of two persons for bathing. According to the bathing task report dated 08/08/18 to 09/02/19 the resident was scheduled for showers on Mondays and Thursdays. Further review of this report showed documentation of a shower on 08/19/19, one shower for one shower during this time frame. There was documentation that the resident received bed baths on 08/15/19, 08/22/19, 08/26/19 and 09/02/19. RESIDENT 35 Resident 35 was readmitted to the facility on [DATE] with a diagnosis list that included a disorder of movement, muscle tone and abnormal brain development. Record review of the quarterly MDS assessment dated [DATE] showed the resident required physical assist of one to two persons for all mobility and care. According to the bathing care plan with a revision date of 08/21/18, the resident preferred showers on Tuesdays and Fridays, per the bathing care plan with a revision date of 07/03/19 the resident was to receive a sponge bath when a full bath or shower could not be tolerated. Record review of the bath report dated 08/10/19 to 09/10/19 the resident had documented showers on 08/10/19, 08/15/19, 08/19/19, 08/22/19, and 08/26/19. There were no documented showers or refusals for the month of September 2019. In an interview on 08/29/19 at 10:34 AM the resident said: I can't remember the last time I had a shower or a bed bath. In an interview on 09/13/19 at 11:16 AM with the DNS said: The residents are scheduled for at least two showers a week. Nothing less than that, they should receive 2 showers unless their preferences are different than what is scheduled. 38430 RESIDENT 27 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 27 was a long term care resident at the facility. The resident's diagnosis list included multiple sclerosis, quadriplegia, depression, and anxiety. According to the 06/27/19 quarterly MDS, Resident 27 was cognitively intact, able to make her needs known, required extensive two-person physical assistance for activities of daily living, and total dependence of 3 staff for bathing. Review of the resident's care plan for bathing, dated 01/18/18, showed the resident was able to express her care preferences and quality of life preferences. The care plan directed staff to Be aware of resident's time for bathing preference; prefers mornings on Mondays and Thursdays. In a review of the bathing flow sheet from 08/13/19 through 09/05/19, showed, Resident 27's bath days were scheduled for Tuesday and Thursday (preference identified in care plan was Monday and Thursday), and the resident received only 4 showers. In an interview on 09/05/19 at 4:40 PM with Staff I, Certified Nurse Assistant, stated, We do not have enough staff to give more than basic care. There is no time for showers, getting some residents up and dressed. In an interview on 09/06/19 at 3:42 PM, Resident 27 stated that she had not been showered in over 10 days, and that she smelled. RESIDENT 30 Resident 30 was a long term care resident at the facility. The resident's diagnoses list included stroke, and hemiplegia. According to the 07/01/19 quarterly MDS, Resident 27 was cognitively impaired, had difficulty with communication, and required physical assistance from one staff for bathing. In a review of the resident's care plan for bathing, dated 09/27/17, the resident required assistance with bathing due to hemiplegia. The care plan directed staff to provide one person assist with showers, and showed the resident preferred to take showers on Tuesday and Thursday. Review of the bathing flow sheet from 08/12/19 through 09/09/19 showed the resident's bath days were scheduled for Monday and Thursday (preference identified in care plan was Tuesday and Thursday), and resident only received 4 showers. In an interview on 08/29/19 at 1:04 PM, Resident 30's spouse stated that sometimes the resident goes six weeks and sometimes 2 weeks without getting showered, The facility is short staffed, he is supposed to get two showers a week. I am here every day in the mornings and evenings to take care of him, not enough staff here. Reference (WAC) 388-97-0900(1)-(4)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on observation and interview, the facility failed to ensure residents had reasonable access to the use of a telephone and a place where calls could be made without being overheard by others for one of three residents (17) reviewed for telephone access. This failure placed residents at risk for inability to make telephone calls, lack of private telephone conversations and a diminished quality of life. Findings included . RESIDENT 17 Resident 17 admitted to the facility on [DATE] with a diagnoses list that included weakness and a history of falling. Review of the Annual Minimum Data Set (MDS) assessment, dated 06/19/19, showed the resident required two person physical assist for bed mobility and transfers. Further review of the assessment showed the resident had mildly impaired thinking, and was able to understand and be understood by others. An observation and interview on 08/28/19 at 2:32 PM showed the resident was in bed. She stated, I want to talk to my son, all the phones here don't work, and the one on my table is broken. You can't get a call in or out. He usually calls me from out of town, but now he can't call me and I can't call him. I have told them so many times that the phone does not work. In an interview on 08/28/19 at 2:48 PM, Staff A, Certified Nursing Assistant (CNA) stated, I tried to call for her twice on Sunday, but the phone in her room did not work. She could use the phone at the nurse's station, the same phone that the nurses use. An observation and interview on 08/28/19 at 3:04 PM showed Staff B CNA, brought a cordless phone into the resident's room for her to use. The Staff member punched the keys on the phone key pad. Staff B stated, The phone does not work, maybe it needs charging. In an interview on 08/28/19 at 3:24 PM, Staff C, Licensed Practical Nurse (LPN) stated that the residents on the other side go to the desk and use the nurse's phone at the desk, We need to find a way to charge the phones. In an interview on 09/05/19 at 10:12 AM, the resident stated, I still have not talked to my son because the phone still does not work. They bring me a black phone to use but it does not work. In an interview on 09/12/19 at 12:54 PM, the Director of Nursing Services stated the residents should have a phone available to use in privacy. Reference WAC: 388-97-0540(1)(3)

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F 0582

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 41070

Based on interview and record review, the facility failed to provide Skilled Nursing Facility Advance Beneficiary Notices (SNF ABN) for two of four residents (335 & 336) reviewed who required them. These failures limited the residents' ability to make informed choices about further treatment or services, as required by the Medicare Program.

Findings included .

RESIDENT 335

Resident 335 was admitted to the facility on [DATE] with diagnoses that included cancer of the blood and bilateral leg weakness. Review of the 30 day Minimum Data Set (MDS)assessment, dated 06/03/19, showed the resident was able to make self-understood, and able to understand others.

The resident received Medicare Part A skilled services from 03/24/19 to 06/17/19, and remained in the facility after the skilled services ended. A Notice of Medicare Non-Coverage (NOMNC- informs the beneficiary of his or her right to an expedited review of a services termination) was issued on 06/14/19.

Review of the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN - provides information to residents/beneficiaries so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial responsibility), showed it was not signed by the resident. There was no indication in the resident's clinical record that the SNF ABN notices was explained to the resident.

On 09/03/19 at 11:38 AM, a copy of the NOMNC was provided by Staff O, Minimum Data Set Coordinator (MDS)/Registered Nurse (RN), who stated the Administrator would provide the SNF ABN, but it was not given that day.

During an interview on 09/03/19 at 11:40 AM, Staff O, MDS Coordinator/RN, stated that the Business Office Manager and the Administrator were the ones responsible for issuing the SNF ABN for residents after their skilled stay. Resident 335 remained in the facility after her skilled stay, and discharged to Assisted Living Facility on 06/25/19.

On 09/03/19 at 4:04 PM, the Administrator stated that she would look for the SNF ABN for Resident 335.

On 09/04/19 at 8:51 AM, the Administrator provided a copy of the SNF ABN and it was not signed by the resident. The SNF ABN form had a written note that stated, Resident did not want to sign. The Administrator was asked why the resident refused to sign the SNF ABN, and the Administrator was unable to explain why the resident refused to sign the SNF ABN. She stated, I don't have to document why they did not sign the SNF ABN.

RESIDENT 336

(continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 336 was admitted to the facility on [DATE] with diagnoses that included Urinary Tract Infection (bladder infection) and Congestive Heart Failure. Review of the Admission/5 day MDS, dated [DATE], showed the resident was able to make self-understood and able to understand others. The resident received Medicare Part A skilled services from 04/19/19 to 05/22/19, and remained in the facility after the skilled services ended. The NOMNC was issued on 05/20/19, but there was no indication the SNF ABN was provided to Resident 336, as required. During an interview on 09/04/19 at 11:20 AM, the Administrator stated that she was unable to find the SNF ABN for Resident 336. Reference WAC 388-97-0300(1)(e)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38430 Based on observation and interview, the facility failed to ensure the resident environment was safe and had intact window screens for 14 resident rooms on the Northwest and Southwest Hallways (rooms 2, 8, 10, 12, 16, 18, 22, 23, 24, 28, 30, 34, 36, and 40). Additionally, the facility failed to provide the necessary housekeeping services to maintain sanitary resident care equipment for feeding poles and wheelchairs for one of one resident (#39). This failure placed residents at risk for potential harm related to possible insect infestations and potential infection control issues. Findings included . BROKEN WINDOW SCREENS Observations during survey showed resident rooms with broken/bent window screen frames for the following rooms: 2, 8, 10, 12, 16, 18, 22, 23, 24, 28, 30, 34, 36, and 40. An observation and interview on 08/29/19 at 9:40 AM in room [ROOM NUMBER] showed a black spider nestled in the corner of a wall and another brown spider was hanging on a thread of cobweb over the resident's bed. In an interview with Resident 30's representative, she stated that she came to visit two to three times every day, The facility has problems with bugs here because the screens don't fit right in the windows. Last night a staff member helped me get a spider out that was on the ceiling, and a few days ago another big spider was crawling on the floor. In an interview on 09/09/19 at 9:25 AM, Resident 66 indicated she was upset that there were bugs in her room sometimes. The resident made a frown with her face and a sign with her hand that something was crawling in her room. The resident then pointed to a spray bottle of pest control (bug spray) next to her bed. During a joint inspection and interview on 09/09/19 at 9:30 AM with Staff Q, Maintenance Assistant, the window screens in rooms: 2, 8, 10, 12, 16, 18, 22, 23, 24, 28, 30, 34, 36, and 40 were observed to have broke or bent window screen frames. During the inspection with Staff Q, Resident 84 in room [ROOM NUMBER] stated that he did not open the left window because the bugs came in through the gaps in the window screen frame. Staff Q stated that he will work on fixing the window screens. Reference (WAC) 388-97-0880 40303 DIRTY EQUIPMENT. RESIDENT #39 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39's Quarterly MDS, dated [DATE], showed the resident had diagnoses to include diabetes and stroke with hemiplegia, was dependent on staff for tube feeding and activities of daily living. Multiple observations on 08/28/19 at 09:35 AM, 11:30 AM, 1:30 PM, and 3:30 PM, on 09/03/19 at 10:10 AM, 1:45 and 2:50 PM, and on 09/05/19 at 11:02 AM, 1:45, 2:50 PM showed the resident lying in her bed with a tube feeding and kangaroo pump at bedside. The pump and base of pole was dirty with white yellow stains of what appeared to be tube feeding formula. More stains were on top of the night stand table, on the oxygen concentrator, and on the floor. During an interview on 09/03/19 at 12:06 PM, Staff T, LPN, stated that residents gets tube feeding from 4:00 PM to 10:00 AM (18 hours) and nurses were responsible to clean the feeding pump and pole whenever there are spills or stains. Upon observing Resident #39's tube feeding pole and pump, Staff T stated, This needs to be wiped down. During an interview on 09/06/19 at 2:46 PM, the Director of Nursing stated the nurses were responsible for cleaning residents' tube feeding pump and pole both before and after use, Nurses can request housekeeping to clean the floor and other area. Reference (WAC) [PHONE NUMBER]

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on observation, interview and record review, the facility failed to ensure residents were free from mental, physical, verbal abuse and/or neglect for four of four residents (14, 18, 75, 27). This failure resulted in verbal and emotional harm to Resident 14, neglect to provide timely care for Resident 27, and placed Residents 18, 75 at risk for mental/emotional compromise with diminished quality of life. Findings included . Review of the facility policy titled Prevention and Reporting: Resident Mistreatment, neglect, abuse including injuries of unknown source. The policy defined Abuse as the following: The willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm or mental anguish. It also listed abuse as mental, physical, sexual, mistreatment, neglect, exploitation (manipulation, intimidation, threat or coercion). The policy also stated the resident's had the right to be free from abuse and neglect. It also stated all alleged violations should be reported immediately. The policy stated the center should provide for the immediate safety of the resident upon identification for potential abuse, neglect and mistreatment. RESIDENT 14 The resident admitted to the facility on [DATE] and was able to make her needs known. In a joint interview with Staff K, Medical Records on 09/06/19 at 3:49 PM, Resident 14 stated that she was told by the Administrator to not to tell (surveyors) that the facility was running short of supplies. During the interview, the resident appeared very upset (almost crying) and stated, It was killing me to have this knowledge. Staff 14 stated that she felt she had a responsibility to the other residents to report the lack of supplies, and feared retaliation from the Administrator. At 4:02 PM, the Regional Clinical Nurse was notified of the allegations made by Resident 14 about the Administrator. The regional clinical nurse stated that she would need to talk to her corporate people and get an investigation started. The regional Clinical Nurse stated a short time later that an investigation into the allegations about the Administrator was underway and said that the Administrator not in the building pending the results of the investigation. In a follow-up interview with Resident 14 at 4:46 PM, the resident was notified that her allegations had been reported. The resident broke down in tears stating, I have never been bullied like that before, and stated that now she felt safe to speak about all of her concerns without fear. RESIDENT 18 The resident admitted to the facility on [DATE] and was able to make her needs well known. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 09/10/19 at 12:11 PM, Resident 18 stated that the facility Administrator had threatened her. When asked how or why she felt threatened, the resident stated that the administrator had demanded that the resident write a check for money owed to the facility. During an interview on 09/10/19 at 2:02 PM, the Regional Executive Director was notified regarding Resident 18's allegations about the Administrator and the Regional Director stated that he would get an investigation started. Review of the facility investigation showed the resident expressed feeling bullied by the administrator. The investigation also showed the Administrator had gone to the resident four different times demanding money and had told Resident 18, I will evict you if you don't write me a check. I need you to write a check immediately. RESIDENT 75 The resident admitted to the facility on [DATE] with diagnoses of total knee replacement and one sided weakness. The resident was able to make her needs known. However had very limited speech. Review of the resident's care plan initiated on 07/24/19 showed she was a one person assist for activities of daily living (ADL's). In an interview on 09/03/19 at 1:46 PM, the resident's family stated that Staff L, Certified Nursing Assistant (CNA) had been physically rough with her mother. The family member stated that her mother was 92, moved slowly and required a lot of patience and witnessed the incident. The family member stated that recently Staff L was transferring her mother from bed to chair. During the transfer, this CNA was impatient with her mother, as the family member watched the CNA picked up the resident's left leg with the surgical wound, shoved the left leg in to the wheelchair which caused pain to the resident. The family member then yelled at the CNA to be more gentle. She also stated that she had been texting the administrator regarding this CNA's behavior for at least 2 weeks regarding the alleged rough handling. The family member stated that the Administrator responded to her texts stating she would look into Staff L's abusive behavior. In a interview on 09/03/19 at 4:25 PM, the Administrator was notified about the allegations made by resident family member regarding Staff L's aggressive behavior towards Resident 75. The Administrator stated that she would start an investigation to look into the allegations right away. The administrator stated that she had no prior knowledge of the allegation, then stated, This is the first time I'm hearing of this and I'll call it in right away. The family member provided copies of her text messages to the Administrator with the Administrator's text responses for review. The texts messages showed the family member was at the bedside during and witnessed the incident had initially reported the alleged incident of Staff L's rough handling through texts to the Administrator on 08/31/19 with the Administrator texting back to the family member she would address and look into the matter. Further review of the text messages showed the family member had been in communication with the Administrator about Staff L's aggressive behavior for at least two weeks prior to the incident on 08/31/19. The texts messages showed the Administrator had prior knowledge of Staff L's rough handling, failed to report the incident and initiate an investigation. (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

Review of the facility's incident log for August 2019 to September 3rd 2019 showed there were no allegations or incidents documented and no investigations regarding Resident 75 initiated during this period.

Review of the facility staffing sheets for the month of August showed Staff L had been assigned to provide direct care to Resident 75 on multiple days after the text messages were initiated by the family member.

38430

RESIDENT 27

Resident 27 was a long term care resident at the facility. The resident's diagnosis list included Multiple Sclerosis, quadriplegia, depression, and anxiety. According to the 06/27/19 quarterly Minimum Data Set, Resident 27 was cognitively intact, able to make her needs known, and required extensive two-person physical assistance for activities of daily living including toileting.

A review of the toileting care plan dated, 09/27/18, stated alteration in bowel elimination r/t [related to] multiple sclerosis, paraplegia, adverse effects from medications, chronic diarrhea/constipation. The goal of the toileting care plan; resident will not develop skin breakdown related to incontinence. The care plan also identified the resident's was at risk for a pressure ulcer related to limited mobility. The care plan instructed staff to monitor, document, and report to the doctor any changes in skin status.

In a review of the resident's skin sheet dated 07/15/19 showed no skin issues. The Medication Administration Record sheets for July, August and September, 2019 showed a weekly skin check was done and showed the resident had no areas of skin impairment.

An observation on 09/04/19 at 1:45 PM showed the resident's call light was on in the hallway. Upon entering the room, Resident 27 stated that she had diarrhea and needed to be changed. Staff F, nursing assistant/NA entered the room approximately three minutes later. The resident requested that Staff F change her brief and reported she had diarrhea. Staff F stated that she had to find another NA to assist her due to the resident needing two person extensive assistance with toileting. Before Staff F left the resident's room, the resident agreed to have a state nurse be present during the brief change for a skin observation. Staff F turned off the resident's call light and went to find a second NA to assist.

In an interview at 2:10 PM, approximately 25 minutes after answering the resident's call light, Staff F stated she was still unable to find any staff to assist with changing the resident's brief. The resident's call light was not turned back on. Staff F stated that she had changed the resident 30 minutes before she turned her light on at 1:45 PM. Staff F also stated the resident's skin was checked yesterday and that no skin issues were noted. Staff F then left the facility.

Then at 2:30 PM, the resident turned her call light back on, and at 2:34 PM Staff G, RN, answered the call light. Staff G entered the resident's room, turned off the call light, and told the resident she would find someone to help her. Staff G then left the room, went down the hallway and back to the nurses station.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An observation at a 2:50 PM; approximately one hour after the resident first requested assistance, showed Staff H, NA, enter the resident's room and start changing the resident's diarrhea-filled brief (alone). The resident's skin on her buttocks had unblanchable, beefy redness that covered both buttocks There were at least four red, moist areas on both buttocks that were macerated and open. The resident's coccyx also had an approximately 1.5 centimeter circular open area. Staff H stated, Those were not there a few days ago. During a joint observation of the resident's buttocks at 3:00 PM, the Director of Nursing Services (DNS) stated that the resident had a Stage II pressure ulcer and maceration on both her buttocks with open areas. The resident complained of pain and stated she had a pain level of 7. In an interview on 09/04/19 at 5:12 PM, the Administrator and the DNS were notified of the observations of staff neglecting to provide timely services to the resident in that the resident sat in a diarrhea-filled brief for over one hour, and had new skin breakdown (redness and open areas) on the buttocks with a Stage II pressure ulcer with pain at a level of 7. Reference (WAC) 388-97-0640 (1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on observation, interview and record review, the facility failed to complete thorough investigations to rule out abuse and neglect with six of six residents (14, 75, 27, 16, 17, 18, 35). This failure placed the residents at risk for psychological harm from abuse and neglect. Findings included . Review of the facility policy titled Prevention and Reporting: Resident Mistreatment, neglect, abuse including injuries of unknown source. The policy also stated the resident's had the right to be free from abuse and neglect. It also stated all alleged violations should be reported immediately. The policy stated the center should provide for the immediate safety of the resident upon identification for potential abuse , neglect and mistreatment. RESIDENT 14 The resident admitted to the facility on [DATE] and was able to make her needs well known. An allegation of abuse was alleged by the resident against the Administrator with the facility intiated an investigation. (Please see F600 for allegation details.) In a follow-up interview on 09/09/19 at 9:18 AM, the Regional Clinical Director stated that the Administrator was back to work in the building because the investigation was completed and they could not substantiate abuse. The regional director provided the completed investigation for review. Review of the investigation completed by the Regional Clinical Director showed interviews with 23 alert and oriented residents who were asked the question, Do you feel free to speak to staff, surveyors and corporate staff? The investigation showed the residents was asked that question and answered Yes. The investigation conclusion showed the residents had not verbalized abuse, neglect or psychological harm during the investigation, and therefore abuse and neglect was unsubstantiated. However the investigation did not include the following: 1. Interviews with the resident and the Administrator regarding the allegation. 2. Interview with the Staff K who was present when the allegation was made. 3. Interviews with other staff members, residents, and family members about any concerns of verbal or physical abuse by the administrator. 4. Observations of staff to resident interactions. 5. Review of any records such as incident & grievance logs, resident council minutes or resident records. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview on 09/09/19 at 10:54 AM, Resident #14 was notified that the administrator was back in the building and she stated, Oh god, now what am I gonna do? Resident 14 stated she did not feel safe around the administrator. She stated that she would tell the Regional Clinical Director about what the administrator asked her to do and how she felt about the Administrator. She stated the facility never asked her any questions regarding the allegation. In a telephone interview on 9/9/19 at 2:50 PM, the Director of Nursing Services (DNS) and the Regional Clinical Nurse were updated about Resident 14's still not feeling safe. They stated they would escort the administrator out of the building to ensure the resident's safety (while further investigating the allegation.) In an interview on 09/09/19 at 3:17 PM, Resident 14 was informed that the administrator that the administrator was again not in the facility. Resident 14 stated, Thank God and said she felt safe now that the administrator was out of the building. The facility's failure to complete a thorough investigation allowed the Administrator back into the building which left Resident 14 vulnerable to feelings of fear, coercion, and being bullied. RESIDENT 75 The resident admitted to the facility on [DATE] and was able to make her needs well known. In an interview on 09/10/19 at 12:11 PM, the resident made an allegation that the administrator had threatened her. The facility then initiated an investigation In an interview on 09/10/19 At 2:02 PM, the Regional Executive Director stated that he would start an investigation regarding the allegation. Review of the facility investigation showed Resident #75 expressed feeling bullied by the administrator. The investigation also showed the Administrator had gone to the resident four different times demanding money and told the resident, I will evict you if you don't write me a check. I need you to write a check immediately. The investigation showed abuse was not substantiated based on the evidence collected. Review of the investigation showed it did not contain the following components: 1. Interviews with other staff members, residents family members about any observations of verbal abuse. 2. Observations of Staff to Resident interactions. 3. Record review, such as incident & grievance logs, resident council minutes or resident clinical records. 35787 RESIDENT 16 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allegation of Fall: Resident 16 was admitted to the facility on [DATE] with a diagnosis list that included a traumatic brain injury and stroke. The admission MDS assessment, dated 06/18/19, showed the resident had some moderate thinking and problems with memory, did not walk, and required extensive to total physical assistance of one to two persons for all care. Record review of a fall incident investigation, dated 08/19/19, showed the resident's family member had reported to a staff licensed nurse (LN) that the resident was in pain from a fall he had the previous night and needed a pain pill. Further review of the investigation showed Resident #16 said he had fell to the floor, then someone came to the room, helped him to bed, and told him not to tell anyone. In a second interview on 8/19/19, with the resident and a NA that spoke the resident's primary language, the resident told staff that he walked out of his room, fell in the hall way, and got up by himself. The third time the resident was interviewed, the resident denied that a fall had happened recently. The completed investigation included documentation that five residents were asked: 1. Has a staff member ever been rude to you? 2. Do you feel safe in the facility? 3. Did any staff member tell you not to report/tell anyone if you have a fall or injury? The documentation from the alleged five residents were unsigned and undated. The completed investigation included one documented staff interview from the NA that spoke the primary language of the resident. There were no other documented staff interviews. The completed investigation documentation did not substantiate the allegation of the fall or that someone had assisted the resident back to bed and told the resident not to tell anyone about the fall. The investigation included no interviews from other residents and one staff interview related to the initial report of a fall from the resident's family member. Allegation of Neglect: Resident 16 made an allegation that his call light was not being answered and he had to lay in his own feces. Review of the completed incident investigation, dated 06/17/19, showed an NA went home early due to an illness. The report showed there were three NAs and three LPN's assigned to work that evening, and that eight other resident's that lived on the same unit as Resident 16 complained that their call lights were not being answered and the residents were lying in their feces. The NA who left work had their workload was redistributed to other NAs. Per the investigation: There were no indications on the daily schedule as to which CNA had which residents other than [the residents] already assigned. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility investigation showed no resident or staff interview(s). The facility investigation ruled out abuse due to Resident 16 showed no signs or symptoms of skin breakdown. The facility investigation ruled out neglect per the investigation: There was no willful intent of not answering call lights and letting residents lay in their own feces. RESIDENT 17 Resident 17 was admitted to the facility in 2018. According to the annual MDS assessment, dated 06/19/19, she had mild memory problems, was incontinent of bowel and bladder, and required extensive physical assist of two person for incontinent care after each incontinent episode. Record review of the completed investigation dated 06/17/19 showed Resident 17 made an allegation that her call light was not being answered and she had to sit in her own feces. Review of the facility investigation showed no resident or staff interview(s). The facility investigation ruled out abuse because the resident showed no signs or symptoms of skin breakdown. The facility investigation ruled out neglect: There was no willful intent of not answering call lights and letting residents lay in their own feces. RESIDENT 35 Resident 35 was admitted to the facility on [DATE]. According to the quarterly MDS assessment, dated 07/06/19, the resident was frequently incontinent of bladder, always incontinent of bowel, and required extensive physical assist of two person for incontinent care after each incontinent episode. Review of the facility investigation dated 06/17/19 showed Resident 35 made an allegation that her call light was not being answered and she had to sit in her own feces. The investigation showed no resident or staff interview(s). Each of these facility investigations showed no documented interviews with Resident 16, 17 or 35. The facility also lacked interviews with other residents or staff. The facility did not complete thorough investigations for Resident's 16, 17 and 35's allegations of not having their call lights answered and laying in their own feces. 38430 RESIDENT 27 Resident 27 was a long term care resident at the facility. The resident was cognitively intact and able to make her needs known. There was an incident on 9/4/19 in which the resident turned on her call light and requested assistance from Staff F, Nurse Assistant (NA) with toileting. The resident sat in a diarrhea filled brief for over one hour waiting for staff to assist her. The Administrator and the DNS were notified about the observations of the staff neglecting to provide timely services to the resident. The facility then initiated an investigation. (See F600 for further information.) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility investigation (no completion date on investigation) showed the allegation of neglect was unsubstantiated by the facility. Further review of the investigation showed it was incomplete, as the facility did not interview other staff on duty at the time of the incident, no residents were interviewed regarding care they received at the facility, and the alleged staff member was not suspended pending the results of the investigation (as per facility policy). In an interview on 09/05/19 at 2:18 PM, the DNS stated the definition of neglect was when a resident did not receive the care and services based on their needs. The DNS stated she did not originally see this incident as neglect and therefore she did not suspend Staff F, but stated that she would handle it differently next time. Reference (WAC) 388-97-0640 (6)(a)(b), 0640 (6)(c)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40303 Based on interview and record review, the facility failed to ensure a system by which the Office of the State Long-Term Care Ombudsman received required resident discharge information for one of two residents (#61) reviewed for recent hospitalization s. Failure to ensure required notification was sent to the Ombudsman prevented the Ombudsman Office from having the opportunity to educate residents and advocate for them during the discharge process. Findings included . According to the facility Ombudsman Program policy, dated 05/06/19, .Notice to the Office of the State LTC [Long Term Care] Ombudsman must occur before or as close as possible to the actual time of a facility-initiated transfer or discharge. In the case of emergency transfers the notice is sent as soon as practicable. The medical record must contain evidence that the notice was sent to the Ombudsman . RESIDENT #61 Resident #61 admitted to the facility on [DATE]. In an interview on 09/05/19 at 10:31 AM, Staff L, Medical Records, stated Resident #61 had discharged to the hospital on multiple occasions: 04/03/19; 07/13/19 and 08/30/19. Staff L stated she was not responsible for notifying the Ombudsman Office of resident discharges. In an interview on 09/06/19 at 2:53 PM, Staff B, Director of Nursing (DON), was asked for information that showed staff had notified the Ombudsman office of Resident #61's discharges. The DON stated that the facility had no system in place to notify the Ombudsman Office of residents' discharges to the hospital. REFERENCE: WAC 388-97-0120(1)(2).

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40303 Based on interview and record review, the facility failed to have a system which ensured that, at the time of transfer of a resident for hospitalization or therapeutic leave, the resident and/or the resident representative received written notice which specified the duration of the bed-hold policy for one of three residents (#61) reviewed for hospitalization . Findings included . Also Refer to: CFR 483.15(c)(3)-(6)(8), F-623, Transfer and Discharge Requirements The facility policy,Bed hold/Reservation of Room, dated July 2015, showed .when a resident is transferred to hospital or for therapeutic leave, the center will provide written notice to the resident, family member or responsible party regarding the resident's bed hold rights and the center's bed hold policy . RESIDENT #61 Resident #61 admitted to the facility on [DATE] with subsequent discharges to the hospital on 04/03/19, 07/13/19 and 08/30/19. Record review showed no documented evidence that Resident #61 was provided information regarding the bed hold policy for any of the discharges. In an interview on 09/05/19 at 10:31 AM, Staff L, Medical Records, stated, Nurses are responsible to fill the bed hold paperwork and provide a copy to the resident at the time of transfer/discharge. A copy is scanned to the Resident file under the miscellaneous section. Staff L stated that there were no discharge forms or bed hold notifications in Resident #61's record for the 04/03/19; 07/13/19 and 08/30/19 discharges. Staff L was asked to provide information to support the resident and/or family were notified of bed hold for the above dates. No information was provided. During an interview on 09/06/19 at 12:47 PM, Staff H, RCM stated that for discharges, the nurses were responsible to provide bed hold notification and document on progress notes. REFERENCE: WAC 388-97-0120 (4) (a)(b)(c).

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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** 35787 Based on observation, interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 5 of 22 residents (2, 17, 16, 22, 67) . Failure to ensure dental, fall, mobility and smoking assessments were accurate placed residents at risk for unidentified and unmet care needs. Findings included DENTAL: Section L0200: Dental, check all that apply: D. Obvious or likely cavity or broken natural teeth; Z. A check mark was placed that indicated none of the above were present. RESIDENT 2 Record review of the annual MDS assessment, dated 05/22/19, oral/dental status was checked as none of the above were present. In an interview and observation on 08/28/19 at 9:34 AM, the resident stated, I have 2 front teeth the rest are barely there. The resident opened his mouth and showed the two front teeth, teeth missing from the gum line, and teeth with dark holes and spots. During an interview on 09/10/19 at 10:31 AM, Staff M (MDS/Licensed Practical Nurse) stated, When I interviewed him(Resident 2), I asked him to let me look in his mouth. I must have missed that. RESIDENT 17 Record review of the annual MDS assessment, dated 06/19/19, under dental, showed 'none of the above were present' was checked. In an observation and interview on 09/09/19 at 12:19 PM, the resident was eating lunch in bed. She stated, I can't chew too fast because I don't have too many teeth left. I am supposed to get them pulled and get my dentures pretty soon. The resident ten opened her mouth to show that teeth were missing from the bottom gum line. During an interview on 09/12/19 at 10:01 AM, Staff N, MDS Coordinator/Registered Nurse stated that the MDS was not accurate and she would modify the MDS. FALLS MDS Section J1800: Has the resident had any falls since admission or the prior assessment, whichever is more recent. The answer no was check marked on the MDS assessments. RESIDENT 16 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 16 readmitted to the facility on [DATE] with a diagnosis list that included traumatic injury to the brain and liver disease. Record review of the admission MDS assessment, dated 06/18/19, showed the resident had no falls since admission. Record review of the incident log, dated August 2018 to August 2019, showed the resident had a non-injury fall on 06/12/19 and 06/13/19. Record review of the incident log, dated August 2018 to August 2019, showed the resident had a non-injury fall on 06/24/19 and 07/01/19. Record review of the discharge MDS assessment, dated 07/08/19, showed the resident had no falls since admission or prior assessment. In an interview on 09/12/19 at 10:01 AM Staff N MDS Coordinator/Registered Nurse stated, when we code the fall section of the MDS, section J; we first interview the staff and residents, then we look at the incident log and alert charting. And based on the information we get we code the MDS. That answer should have been checked yes for both of those MDS. 37945 Smoking RESIDENT 67 The resident admitted to the facility on [DATE] and was able to make his needs known. Review of the resident's MDS, dated [DATE], showed the resident was coded as No current use of tobacco. MDS dated [DATE] also showed the resident was coded as No current use of tobacco. Review of the smoking evaluation completed upon admission, showed the resident as a smoker, smoked 2 to 5 times a day, morning, afternoon and evening. Another smoking evaluation completed on 05/06/19 showed the resident was a smoker who smoked 5 to 10 times a day morning, afternoon and evening. Review of the resident care plan for smoking showed it did not identify Resident 67 as a smoker. No goals interventions were listed in care plan. Multiple observations were made of the resident smoking curbside in front of the facility parking entrance. In an interview on 09/06/19 at 3:08 PM, the resident stated he had been smoking since he was admitted to the facility. In an interview on 09/10/19 at 10:19 AM, Staff M, MDS Coordinator was asked when she completed her MDS on smoking, did she ask the resident if he was a smoker as directed by the RAI manual. She stated she did not and it was her mistake. (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 09/13/19 at 10:34 AM, the Director of Nursing (DNS) stated she will do education to have more complete MDS assessments, safety checks and identifying concerns on admission. MOBILITY RESIDENT 22 The resident admitted to the facility on [DATE] with diagnoses to include stroke and abnormalities of gait and mobility. Review of the Occupational therapy notes showed the resident had bilateral hand contractures. Review of the MDS dated [DATE] showed the resident was coded to have no impairment to the upper extremities. Review of the resident's care plan revised on 06/13/19 did not identify the resident's contractures so there for there were no goals and interventions stated. Multiple observations of the resident showed he had bilateral hand contractures. In an interview on 09/10/19 at 2:42 PM, Staff M, MDS nurse stated the resident's contracture was not coded correctly. In an interview on 09/13/19 at 10:34 AM, the DNS stated she will do education to have more complete MDS assessments and safety checks and identifying concerns on admission. Reference (WAC) 388-97-1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38430 Based on interview and record review, the facility failed to ensure one of five residents (66) had an accurate Pre-Admission Screening and Resident Review (PASRR) on or before admission to the facility. This failure placed the resident at risk for unmet care needs and at risk for not receiving appropriate mental health support/services needed. Findings included . Resident 66 was a long term resident of the facility with an admitted [DATE]. The resident diagnoses list included unspecified psychosis, major depressive disorder, anxiety disorder and dementia without behavioral disturbance. A review of the resident's annual Minimum Data Set (MDS) assessment, dated 07/30/19, showed the resident's cognition was moderately impaired and required assistance from staff for bed mobility, transfers, toileting and personal hygiene. A review of the resident's Physician Order sheet and Medication Administration Record for August and September 2019, showed the resident received: Buspirone 7.5 milligram (MG) two times a day for anxiety, Clonazepam 0.125 MG two times a day for anxiety, Mirtazapine 15 MG at bedtime for depression and Quetiapine 12.5 three times a day for psychosis. Review of the resident's PASRR Level 1, dated 11/05/16, did not identify the resident as having any diagnoses which would require further evaluation. During a joint record review and interview on 09/10/19 at 10:06 AM with Staff D, Social Services Director, stated that the resident's PASRR was inaccurate, I completed a new one yesterday and faxed a referral for a Level II evaluation for this resident. Reference: WAC 388-97-1975 (1)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on observation, interview and record review the facility failed to review and implement resident specific care plan interventions for 3 of 22 sampled residents (17, 35 and 27) reviewed for care plans. Failure to implement care plan interventions placed residents at risk for medical complications and diminished quality of life. Findings included . RESIDENT 17 Resident 17 was admitted to the facility on [DATE] with a diagnosis list that included weakness among others. According to the care plan with a revision date of 07/03/19 the resident preferred to have bathes two times a week on Tuesdays and Fridays. Record review of the bath report dated 08/01/19 to 09/10/19 documented the resident received showers 08/10/19, 08/14/19, 08/17/19, 08/21/19 and 08/29/19. There were no documented showers from 09/01/19 to 09/10/19. RESIDENT 35 Resident 35 was readmitted to the facility on [DATE] with a diagnosis list that included a disorder of movement, muscle tone and abnormal brain development. According to the bathing care plan with a revision date of 08/21/18, the resident preferred showers on Tuesdays and Fridays, per the bathing care plan with a revision date of 07/03/19 the resident was to receive a sponge bath when a full bath or shower could not be tolerated. Record review of the bath report dated 08/10/19 to 09/10/19 the resident had documented showers on 08/10/19, 08/15/19, 08/19/19, 08/22/19, and 08/26/19. There were no documented showers or refusals for the month of September 2019. RESIDENT 17 Resident 17 was admitted to the facility on [DATE] with a diagnosis list that included weakness among others. According to the care plan with a revision date of 07/03/19 the resident preferred to have bathes two times a week on Tuesdays and Fridays. Record review of the bath report dated 08/01/19 to 09/10/19 documented the resident received showers 08/10/19, 08/14/19, 08/17/19, 08/21/19 and 08/29/19. There were no documented showers from 09/01/19 to 09/10/19. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 35 Resident 35 was readmitted to the facility on [DATE] with a diagnosis list that included a disorder of movement, muscle tone and abnormal brain development. According to the bathing care plan with a revision date of 08/21/18, the resident preferred showers on Tuesdays and Fridays, per the bathing care plan with a revision date of 07/03/19 the resident was to receive a sponge bath when a full bath or shower could not be tolerated. Record review of the bath report dated 08/10/19 to 09/10/19 the resident had documented showers on 08/10/19, 08/15/19, 08/19/19, 08/22/19, and 08/26/19. There were no documented showers or refusals for the month of September 2019. In an interview on 09/13/19 at 11:16 AM with the Director of Nursing Services (DNS) said, she needed to do some education with the staff about following the care palns. 38430 RESIDNT 27 Resident 27 was a long term care resident at the facility, the initial admitted was 02/08/14. The resident's diagnosis list included: Multiple Sclerosis, quadriplegia, depression, and anxiety. According to the 06/27/19 quarterly Minimum Data Set assessment, Resident 27 was cognitively intact, able to make her needs known, and required extensive two-person physical assistance for activities of daily living including bed mobility. In a review of the resident's care plan, dated 04/26/18, the resident was on a low air loss mattress with bolster; the goal to remain free from skin breakdown. The care plan directed staff to monitor the low air loss mattress every shift for proper functioning. Review of the physician orders, dated11/17/18, showed to check air mattress function every shift. A review of the Medication Administration sheets for the month of August and September 2019, showed staff documented the air mattress was functioning properly. Review of a progress note on 09/10/19 by Staff S, Licensed Practical Nurse (LPN) showed there was no air loss mattress in place for this resident. Observations on 08/28/19 at 12:11 PM and on 09/04/19 at 2:51 PM showed the resident was not on a low air loss mattress. In an interview on 09/10/19 at 2:37 PM with the Director of Nursing (DNS) and Staff S, LPN, the resident has not been on a low air loss mattress for approximately three weeks, she is on a regular mattress. Staff S stated that she requested one from central supply, but they are out. The DNS stated, I will order one right now. Reference (WAC) 388-97-1020(1), (2)(a)(b)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 40303 Based on interview and record review, the facility failed to provide a concise and comprehensive discharge summary/plan that included a recapitulation of stay/summary to an Adult Family Home (AFH) for one of three discharged resident (#61). The lack of a discharge summary and post discharge care plan placed the resident at risk for unmet care and services by the receiving facility. RESIDENT #61 Resident #61 was admitted to the facility 01/25/19 with multiple diagnoses including pneumonitis due to inhalation of food and vomit, acute respiratory failure, and muscle weakness. Resident 61 had intact cognition and required assistance of staff with Activities of Daily Living (ADL) including medication and treatment administration. Record review on 08/30/19 at 4:00 PM showed Resident #61 was discharged from the facility to an Adult Family Home (AFH), where the resident was to continue receiving nursing care and services. During an interview on 09/03/19 at 3:00 p.m., a WA state social worker stated that the facility had discharged Resident #61 without clear and concise documented discharge instructions to allow the AFH staff to continue care as required. In addition, there were no medication administration record (MAR) to reflect the last time(s) the resident had received medications. The social worker further stated she had made multiple attempts to telephone the facility's nurse station to talk to staff about the discharge concerns, but there were no answer. The social worker stated that the resident was transferred from the AFH to an emergency room for evaluation due to lack of discharge instructions from the facility. In an interview on 09/12/19 at 12:11 PM, Staff E Resident Care Manger, RCM stated nurses were responsible to provide a discharge summary & medication orders, and the facility social worker was to complete the recapitulation of stay. When asked if the facility had followed discharge procedures, Staff RCM stated No. In an interview on 09/12/19 at 12:11 PM, Staff K, Medical Records Director, stated that she participated with the Resident 61's discharge and stated that the Resident's MAR and discharge summary was not sent with the resident at discharge. Staff ___further stated that the discharge was arranged by the state worker, and the AFH provider was aware of the transfer and was not aware about missing documentation . In an interview on 09/12/19 at 2:30 PM, Staff E stated nurses were responsible to ensure discharge paper work was complete and sent with the resident to the next facility for continuity of care. Staff RNC acknowledged the facility staff failed to send with the resident discharge/ recapitulation/ MAR records to AFH for continuity of care. Reference: WAC 388-97-0120 (1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on observation, interview and record review, the facility failed to provide daily facial care and grooming to 3 of 3 residents (2, 39, 49) dependent on staff to carry out activities of daily living. This failure placed the resident at risk for skin infections and diminished quality of life. Findings included . Resident 49 The resident admitted to the facility on [DATE] and was able to make his needs known. Review of the Minimum Data Set (MDS) ssessment, dated 07/21/19, showed the resident was totally dependent for bathing. The MDS also showed he needed extensive assistance with personal hygiene. Review of the resident's care plan, revised on 05/28/19, showed the resident was a two person assist with personal hygiene and grooming needs. The care plan showed staff were to offer the resident a shave on shower days at least two times a week. An observation on 08/29/19 at 11:31 AM showed Resident 49 had peeling facial skin that look oily, with unshaven dishelved facial hair. An observation and interview on 09/04/19 at 12:30 PM, the resident was lying in bed. His fingernails were long with black matter embedded in them. The resident face was red with peeling skin on his forehead cheeks, around his eyes and around his neck. The resident stated he could not remember when the last time he had a shower. An observation on 09/06/19 at 10:49 AM showed the resident sleeping in bed with white patches of dried, peeling skin on his forehead, cheeks, around his eyes and nose and embedded in his neck area. His tray table was stained with a sticky substance and a strong odor was detected upon approach to the resident. In an interview on 09/09/19 at 3:40 PM, Staff V, Nurse Practitioner, was asked about the resident's facial condition. Staff V stated that the resident had the condition for a long time, but could not state what it was or what caused it and did not comment as to whether lack of bathing or showers would make the skin condition worse. An observation at 3:40 PM showed the resident lying in bed sleeping with thick white patches of dried peeling skin on his forehead, cheeks and embedded in his neck area. His tray table was stained with a sticky substance and a strong odor was detected as surveyor approached the resident. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 09/10/19 at 1:22 PM, the resident lying in bed awake. The resident's forehead appeared to be cleaner that previously with the thick white build-up. However the resident still had some of the white build-up around his eyes, nose, cheeks and face. Staff S, Licensed Practical Nurse stated the white build-up was dry skin that needed to be cleaned off. Staff S stated that all the resident needed was facial care and getting showers would have helped loosen the buildup thereby making it easier to clean off. She also stated that the lack of cleaning up his face may be related to a lack of staffing. In an interview on 09/13/19 at 11:23 AM, the Director of Nursing Services stated that if showers and Activities of Daily Living were not completed, it was related to the lack of staff. 35787 RESIDENT 2 Resident 2 was readmitted to the facility on [DATE] with a diagnosis list that included Infarction of the spinal cord and weakness. Review of the annual MDS assessment dated [DATE] showed the resident was cognitively intact and required extensive physical assistance from one to two persons for dressing and personal hygiene. Review of the progress notes, dated 06/05/19 to 08/01/19, showed the resident had no refusals of grooming or hair cuts. An observation and interview on 08/28/18 at 9:21 AM showed the resident in bed with ungroomed facial hair and dark brown material under his fingernails. The resident stated, I am not trying to grow a beard; I just have not been shaved for a long time. I been asking to have my fingernails and toenails cut too, nothing yet. I need help to get it done. An observation on 09/03/19 at 11:01 AM, the resident was in bed with ungroomed facial hair and dark brown material under his fingernails. During an observation and interview on 09/12/19 at 11:15 AM, the resident was in bed with ungroomed facial hair and dark brown material under his fingernails. The resident stated,I would not mind a shave and a haircut. I can't do it by myself. I can barely move in this bed by myself. During an interview on 09/12/19 at 11:17 AM, Staff W ,Certified Nursing Assistant (CNA) stated, He needed help with everything. He can feed himself after we set it up for him. That's about it. We do everything else for him. In an interview on 09/12/19 at 3:19 PM, Staff E, RCM, stated that the resident did not like to be disturbed in the morning and also that he needed a lot of help with shaving and grooming. During an interview on 09/13/19 at 11:16 AM, the DNS stated that the nursing assistants did nail care and shaved the resident's on their shower days and more if needed. 40303 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TOENAILS RESIDENT #39 Resident #39 admitted to the facility on [DATE]. A 02/08/19 Quarterly MDS showed the resident had diagnoses to include diabetes and stroke, was rarely or never understood, and was dependent on staff for activities of daily living. Observations on 08/27/19 at 10:31 AM, 08/29/19 at 11:45 AM, and 09/03/19 at 12:06 PM showed Resident #48 had long, thick, and untrimmed toenails to bilateral feet. During an interview on 09/03/19 at 12:06 PM, Staff T, LPN, stated that residents with diabetes were provided nail care by licensed staff weekly and as needed. Upon observing Resident #39's toenails, Staff T described them as being long and untrimmed and stated, It does not appear they have been trimmed for weeks. In an interview on 09/06/19 at 2:27 PM, Staff E, RCM, stated the residents' nail care should be done by the nursing assistants for non-diabetic residents during shower days and that nurses were responsible to trim Resident 39's nails. Reference (WAC) 388-97 -0900(1)-(4)

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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** 40303 Based on observation, interview and record review, the facility failed to allow three of seven residents (285, 39, 66) reviewed for choice of activities and the right to make choices regarding important daily routines and health care, including accommodating preferences for sleeping, frequency of bathing, and grooming. The facility's failure to accommodate residents' choices placed these residents at risk for a diminished quality of life. Findings included . RESIDENT 285 The 08/21/19 Admission Minimum Data Set (MDS assessment showed Resident 285 had moderate cognitive impairment, was able to express her needs, and showed it was, somewhat important to attend group activities, religious activities, go outside and to do favorite activities. During an interview on 08/28/19 at 10:40 AM, Resident #285 stated that the facility did not provide evening activities, All activities end at three. The resident stated that she had an activity calendar, but was not invited to attend activities. Review of the August 2019 activity calendar showed all activities were scheduled to start at 9:30 AM and end at 3:00 PM. There was only one off-hour activity, an evening movie, scheduled on Saturday. There were no listed activity times and no structured activities after 3:00 PM Sunday through Saturday, which confirmed the resident's concerns. On 09/06/19 at 10:00 AM, a review of the resident's activity participation documentation over the last 30 days showed no evening activity program participation was documented. RESIDENT 39 The 07/08/19 MDS assessment showed Resident #39 had moderate cognitive impairment, was able to express his needs, and showedit was, very important to listen to music, watch news, attend religious activities, go outside and to do favorite activities. Observations on 08/28/19 at 10:10 AM, 08/29/19 at 9:45 AM, and on 09/04/19 at 2:45 PM showed Resident 39 was in bed wearing a hospital gown. The television was not on nor was there music playing in her room. A friend at bedside stated he visited the resident every day and stated there were no one on one activities for Resident 39. Also, the friend stated that the resident spent most time in the room, no one comes to do activities, and the television did not have channels. On 09/06/19 at 10:10 AM, a review of the resident's activity participation documentation over the last 30 days showed no evening activity program participation was documented. (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 09/06/19 at 2:13 PM, Staff R, Activity Coordinator, stated that there were no one on one activities being done and no evening scheduled activities provided. All activities starts at 9:30 AM and ends at 3:00 PM. Staff R, stated that evening activities were important to the residents as it helped them to be engaged. Staff R stated that there were no activities provided when she took a day off and she did not have assistant to help with activities. When asked why she was not providing one on one activities, Staff R stated I was told by a former manager that no resident needed one on one activities. 38430 Resident 66 was a long term resident of the facility with an admitted [DATE]. The resident diagnoses list included unspecified psychosis, major depressive disorder, anxiety disorder and dementia. A review of the resident's annual MDS assessment ,dated 07/30/19, showed the resident's cognition was moderately impaired and required assistance from staff for activities of daily living. A review of the MDS section for customary routine and activities showed that it was very important for the resident to: keep up with the news, do things with groups of people, do favorite activities, get fresh air when the weather is good, and participate in religious services. A review of the resident's activities care plan, dated 05/11/18, showed Resident 66 was dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits and physical limitations. The care plan goals and interventions were: social interactions 7 days a week, two one on one activities a week, singing and reading, and have resident up for church service every Sunday. Observations throughout the survey showed that Resident 66 did not leave her room with no music playing or other (activity) stimulation provided while the resident was in her room. Resident lyed in bed with a paper napkin covering her face and no (Korean) reading materials were in the resident's room. In a phone interview on 08/28/19 at 2:19 PM, the resident's daughter stated her mom was in bed all day. During an interview on 09/05/19 at 4:15 PM, Staff R, Activities Director, stated that she was the only person in the activity department, her schedule was Tuesday through Saturday, and there were no activities after 4:30 PM. She further stated, I was told by the facility administration that no one in the building needs one to one activities and as the only person in the activities department, there is no time to see residents one to one. There are many residents here that need individual attention and activities. She stated, I have only seen this resident one time. She does not leave her room. She is not getting to church, no music and not receiving materials in Korean. REFERENCE WAC: 388-97-0940(1) (2).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Care	21400 72nd Avenue West Edmonds, WA 98026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37945 Based on observation, interview and record review, the facility failed to provide effective monitoring and splint placement and provide appropriate services and assistance to maintain mobility for residents on a restorative program for five of six residents (22, 39, 48, 61 and 73). This failure placed the residents at risk for a functional declines, joint pain and diminished quality of life. Findings included . Review of the facility policy titled Restorative Nursing Program showed the center promotes the restorative nursing program to enable resident to attain or maintain their highest practicable level of functioning. RESIDENT 22 The resident admitted to the facility on [DATE] with diagnoses to include stroke and abnormalities of gait and mobility. Review of the Occupational therapy notes dated 03/01/19 to 03/29/19 showed the resident had bilateral hand contractures with a splint that was to be worn four hours per day to prevent pain and further hand contractures. Review of the resident's care plan, revised on 06/13/19, did not identify the resident's contractures and was without goals and interventions related to contractures. During an interview on 09/06/19 at 2:49 PM, Staff AA, Certified Nursing Assistant, CNA stated that she was not aware the resident's right hand had to be splinted and stated that normally she would know to splint based on the Kardex (Care plan for CNA's). Review of the progress notes showed no restorative notes of monitoring the resident for any declines in range of motion (ROM) or progress response to therapy. In an interview on 09/12/19 at 2:25 PM, Staff E, Resident Care Manager stated that monitoring of the resident contractures had not been done related to staffing issues and would find out who was responsible. In an interview on 09/13/19 at 10:36 AM, the Director of Nursing (DNS) stated that she would work on identifying nursing staff to oversee the restorative program to monitor progress and/or decline. RESIDENT 73 The resident admitted to the facility on [DATE] with diagnoses to include stroke and left sided weakness/Paralysis. The resident was able to make his needs known. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Occupational Therapy notes, dated 09/18/19, showed the resident was to wear a left hand splint. The notes showed the resident had demonstrated how to remove splint independently, but needed one person assist to don(put on) the splint and that nursing education completed regarding the splint. Review of the resident's care plan showed the resident's upper extremity mobility goals and interventions, however did not include splint placement. Review of the look back documentation for Restorative therapy from July 2019 to August 2019, showed there were no minutes(amount of time) documented for splint placement. An observation and interview on 09/11/19 at 10:42 AM showed the resident had a left hand contracture that was not splinted. When the resident was asked about it, he stated that he had a splint that he needed assistance with, but no one had helped him even after he has asked. Resident 73 stated that he has not had the splint on for 2 months and had to exercise the hand himself to prevent the hand from getting stiff and painful. During an interview on 09/12/19 at 2:57 PM, Staff E, RCM stated that he was not sure why the splint was not placed. He stated the resident was on a restorative program managed by the Director of Nursing Services (DNS)Staff E also stated that since there had not been an (acting) DNS, Staff E stated that no one was currently managing the program. 40303 MOBILITY RESIDENT #39 The 07/08/19 Quarterly Minimum Data Set (MDS) assessment showed Resident #39 had a diagnosis of hemiplegia, had one sided functional limitations in ROM of the upper and lower extremities, and required two person physical assistance for all activities of daily living. Review of Resident 39's revised Care Plan (CP), dated 05/15/19, showed the resident had a self-care performance deficit related to stroke and left side weakness: Transfers requires Hoyer lift with two person assist with transfers. Resident to be up in her tilt-in-space wheelchair every morning. Multiple observations on 08/27/19 at 09:30 AM, 08/28/19, at 11:50 AM, 08/30/18 at 10:20 AM, and on 09/04/19 at 10:20 am, 01:30 PM and 02:45 PM showed Resident 39 lying in bed wearing a hospital gown. The resident's friend at bedside stated he visited every day and that the staff did not help the resident to get up into the wheelchair as he had requested. The friend stated that he even wrote a note by the resident's sink resident to be up on wheelchair every morning, but stated that it was not happening as the resident was always in bed when he visited her. During an interview on 09/04/19 at 2:30 PM, Staff HH, Registered Nurse, RN stated that Resident #39 did not get dressed and get up, and stated that there was a shortage of staff to help get the residents up into a wheelchair. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/06/19 at 2:27 PM, the Director of Nursing stated that the resident should be assisted to the wheelchair as per the CP and as per the family request, Nurse and Nursing assistants are responsible to assist resident to be up on the wheelchair. RESTORATIVE. RESIDENT #48. Resident #48 readmitted to the facility on [DATE]. According to the 07/19/19 Quarterly MDS assessment, the resident had diagnoses that included stroke with hemiparesis (partial paralysis affecting only one side of the body), and functional limitation of range of motion(ROM) to one side which required a Restorative Nursing Program (RNP). The resident was also assessed to have intact cognition and able to make needs known. Review of Resident #48's Revised CP, dated 05/09/19, showed the resident had limited physical mobility related stroke. The resident's Restorative program was as follows: Range of Motion (active)-right upper extremity (RUE) strengthening using 4lbs, 3 sets of 25 reps of shoulder flexion/extension, internal/external rotation ceiling pushes as tolerated. Left upper extremity strengthening using 5lbs, 3 sets of 15 reps of shoulder flexion/ extension, BUE flexion/extension as tolerated. Neck movement exercises as tolerated. Resident to participate for 15 minutes a day up to 3-4 days weekly. Review of the Restorative program for July 2019, August 2019 and September 12 2019 showed restorative service was not provided as per the CP. During an interview on 08/28/19 at 10:20AM, Resident #48 stated she did not receive the Restorative Program as scheduled because the restorative aides are pulled away to work as a nursing assistant. RESIDENT 61. According to the 07/25/19 quarterly MDS, Resident #61 had impaired functional ROM to bilateral lower extremities, and restorative services. Review of Resident #48's Revised CP, dated 09/19, showed a Restorative Program as follows: Ambulation-ambulate in hall-way 15-25 feet with FWW with contact guard and gait belt 3-4 times weekly. Review of the Restorative program for July 2019, August 2019 and September 12 2019, showed restorative service was not provided as per the CP. During an interview on 08/28/19 at 1:30 PM, the resident's daughter stated that the resident had a Restorative program to ambulate within the hallway and which was not provided. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/19 at 09:39 AM, Staff CC, restorative aide, stated that restorative services were not provided because she got pulled to work as a nursing assistant on the floor. The staff member stated that Resident 48 and 61 did not get their restorative service programs as directed in the CP. In an interview on 09/11/19 at 10:59 AM, Staff E, Resident Care Manager. RCM stated that the Restorative aides were responsible to provide restorative services. When asked if Resident #48 and #61 had been offered and provided their restorative programs at the frequency they were assessed to require, Staff E stated, No. WAC Reference 388-97-1060 (3)(d)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40303 Based on observation, interview and record review, the facility failed to assess, monitor and accurately record enteral intake for two of two residents (39, 23) reviewed for Enteral Feedings services(provision of nutrition for those residents who cannot obtain nutrition by mouth) . Additionally, the facility failed to provide enteral feeding supplies for enteral administration as ordered by the physician for one of two residents (23) reviewed for Enteral Feedings. These failures placed the residents at risk for inadequate nutritional support and adverse consequences. Findings included . FACILITY POLICY According to the undated, Nutrition/Hydration Policy, Intake and output will be monitored and documented on residents with enteral tube feeding, fluid restrictions, parental restrictions and total parenteral nutrition. Initiate electronic intake and output to document per shift intake and output of fluids and to calculate and record the daily intake and output of fluids. RESIDENT 39 Resident 39 readmitted to the facility on [DATE]. The 07/08/19 Quarterly Minimum Data Set (MDS) assessment showed the resident had diagnoses of stroke with left side weakness, hypertension, and diabetes (A chronic condition that affects the way the body processes the intake of sugar). This MDS showed the resident required extensive one person physical assistance with eating and required artificial nutrition via a feeding tube. Review of September 2019 Medication Administration Records (MARs) showed order instructions to administer, Jevity 1.2 [calories] at 70 ml [milliliters] per hour x 18 hours until 1260 ml infused (On 1600 [4:00 PM], off 1000 [10:00 AM]. There were no directions to staff to document the amount of enteral feeding infused per day or per shift. Observation on 09/04/19 at 10:42 AM showed Resident #39 lying in bed with the tube feeding (TF) infusing at 70ml/hr. total feed amount was 1923 ml. Observation on 09/05/19 at 08:44 AM showed Resident #39 was lying in bed and the TF was infusing at 70ml/hr. and total feed amount was 2994 mls Record review showed no documentation by which staff could accurately determine the amount of enteral feeding the resident received (as the observed total feed amounts were more than the amount in the physician orders). (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/05/19 at 2:15 PM, Staff HH, RN stated the resident formula was not documented by the amount consumed, but only the times the pump was turned on and off were being documented. During an interview on 09/06/19 at 12:20 PM, Staff E, Resident Care Manager, stated that nurses were expected to clear the pump each shift and document the volume the resident consumed. Staff E also stated that nurses were expected to turn off the pump as per physician orders and document any delay or missing hours. When asked whether the reading shown on the pump was accurate, Staff E stated, No. During an interview on 09/06/19 at 1:00 PM , Staff X, Registered Dietician (RD), stated that the resident's intake and weight were used to determine the formula dose adjustment. Staff D also stated that the amount consumed should be documented each shift as part of the intakes. During an interview on 09/06/19 at 3:00 PM, the Director of Nursing services (DNS) stated that nurses were expected to clear the pump each shift and document the amount consumed. The DNS stated that the facility did not monitor or document the amount consumed each shit or each day. 35787 RESIDENT 23 Resident 23 readmitted to the facility on [DATE] with a diagnosis list that included end stage kidney disease, difficulty swallowing, and diabetes mellitus type II. According to the quarterly MDS assessment, dated 06/23/19, the resident required one person total physical assistance with eating and required artificial nutrition by a feeding tube. Review of the July 2019 through August 2019 MARs showed: Enteral feed order in the evening for NPO [nothing by mouth] from 1800 [6:00 PM] to 0400 [4:00 AM]. Enteral feed order two times a day OFFER 1 CAN NEPHRO W[with]/ CARB STEADY TWICE DAILY. Nephro Carb Steady every evening and night shift for nutrition 61ml/HR [hour] X 10 HOURS FROM 1800 TO 04OO. There were no documented amount of enteral feeding to show how much of the feeding was infused per day or per shift. In an interview on 08/29/19 at 1:46 PM, Staff C, Licensed Practical Nurse (LPN) stated, We don't document the total amount that was administered. Sometimes we don't even have the right bags for the Nephro feeding. We have to use the gravity feeding bags, sometimes those are out too and we have to bolus [pour the enteral feeding into a syringe that is placed into the feeding tube that leads to the stomach] her with a syringe. I checked everywhere, the other units and the supply closet. I keep telling them they need to order more tubes to run the pump. Then a joint observation of the enteral feeding supplies with Staff C, LPN, showed there were no tubes to run the tube feeding pump. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/09/19 at 1:44 PM, the DNS stated, It (the amount of administered tube feeding) should be totaled at the end of each shift. This morning I actually was in and totaled it for the nurse. I told her I did that. I need to re-educate the staff about that, it needs to be totaled so that we know the total amount the resident received. I will make sure the supplies for the tube feeding are here. No Reference WAC

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on observation, interview and record review, the facility failed to ensure communication and collaboration with the dialysis center regarding a change in artificial nutrition for one of one resident (23) reviewed for dialysis (a procedure that substitutes for the functions of the kidneys). These failures placed the resident at risk for medical complications and unmet care needs. Findings included . Resident 23 readmitted to the facility on [DATE] with a diagnosis list that included end stage kidney disease, difficulty swallowing and diabetes. According to the quarterly Minimum Data Set (MDS) assessment, dated 06/23/19, the resident required total one person physical assistance with eating and required enteral nutrition (artificial nutrition received by feeding tube inserted into the stomach). Record review of a physician order, dated 11/22/18, showed, Nephro Carb Steady every evening and night shift for nutrition. Another physician order, dated 11/19/18, showed, ENTERAL FEED ORDER two times a day OFFER 1 CAN NEPHRO W[with]/CARB STEADY TWICE DAILY. Record review of the July 2019 through August 2019 Medication Administration Records (MAR) showed, Enteral feed order in the evening for NPO [nothing by mouth] from 1800 [6:00 PM] to 0400 [4:00 AM]. Enteral feed order two times a day OFFER 1 CAN NEPHRO W/CARB STEADY TWICE DAILY. Nephro Carb Steady every evening and night shift for nutrition 61ml/HR [hour] X 10 HOURS FROM 1800 TO 04OO. In a joint observation and interview on 08/29/19 at 1:46 PM in the resident's room with Staff C Licensed Practical Nurse (LPN), there was a bag of enteral feeding, Jevity 1.5, hung from a feeding pole positioned next to the resident's bed. Staff C LPN stated that the resident had been receiving the Jevity (type of enteral feeding) because they did not have the right supplies to administer the Nephro enteral feeding for quite some time. Staff C also stated that the resident was scheduled to go to dialysis on Tuesday, Thursday, and Saturdays and that each time she went, a dialysis communication form was filled out and sent with the resident to communicate any changes. Review of the nursing progress note, dated 06/17/19, showed, Change in formula, updated RD [Registered Dietician] of issues with nephro. Jevity 1.5 237 ml [milliliters] PFT [per feeding tube] night and day shift until nephro is in [facility]. Monitor for s/s [signs and symptoms] of n/v [nausea/vomiting] and diarrhea. Record review of the nutrition progress note, dated 06/17/19, showed, RD received referral from Nsg [nursing] r/t [related to] Nephro not available. Review of the dialysis center communication forms, dated 06/18/19 to 08/15/19, showed no documented communication of the 06/17/19 change in enteral feeding from Nephro to Jevity. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/04/19 at 1:26 PM with Staff X, RD, stated, I am the only RD that comes here. I see the residents on dialysis monthly. If there is any type of nutrition change, I see them when that change occurs. I communicate with the RD at the dialysis centers monthly. I document the communication we have in the progress notes. I will call the RD if there is a big change the same day I am notified. I was notified the other day that they were out of the Nephro and I put in a referral for the Jevity. My expectation would be ideally she should return to it [Nephro]. It is comparable in calories, but different otherwise. I did not inform her [RD at the dialysis center] because I thought it was going to be short term. My understanding was that it was going to be short term. A week is longer than I expected. In an interview on 09/09/19 at 1:38 PM with the Director of Nursing Services stated that changes should be called into the dialysis center, the dialysis center should have been informed when the change in enteral feeding had occurred. Reference (WAC): 388-97-1900 (5)(c)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 38430 Based on interview and record review, the facility failed to ensure annual performance reviews of Certified Nurse Aides (CNA) were completed for three of three (L, F, and J) CNA's files reviewed who had been employed longer than one year. This failed practice had the potential to negatively affect the competency of these CNA's and the quality of care provided to residents. Findings include . Review of Staff L, F and J employee files on 09/12/19 showed no yearly performance evaluations had been completed. In an interview on 9/12/19 at 12:48 PM, the Regional Corporate Nurse stated that the facility had not been doing employee performance evaluations and they were aware they needed to do them. Reference: WAC 388-97-1680 (2)(b)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on observation, interview and record review, the facility failed to ensure appropriate treatment, and resident-centered activities and services were provided for one of one residents (2) reviewed for behavioral and emotional care and services. Findings included . PHQ 9: an assessment tool used to score depression severity, responses can be interpreted as follows: 1-4: minimum depression 5-9: mild depression Resident 2 was readmitted to the facility on [DATE] with a diagnosis list that included Infarction of the spinal cord and weakness. Record review of the resident's annual Minimal Data Set assessment (MDS), dated [DATE], showed the resident was cognitively intact and required extensive physical assistance from one to two persons for care. According to the MDS, the resident had a PHQ 9 score of 6. The PHQ 9 assessment interview showed the resident had responded that he felt down, depressed or hopeless for 7 to 11 days out of a two-week time frame. Review of the quarterly MDS assessment, dated 08/22/19, showed the resident was cognitively intact and required extensive physical assistance from one to two persons for care. According to the MDS, the resident had a PHQ 9 score of 9. The PHQ 9 assessment interview showed the resident had responded that he felt down, depressed or hopeless for 12-14 days out of a two-week time period. The resident's PHQ 9 score increased from 6 to 9, according to the assessment the resident had an increased number of days wherein he felt down, depressed or hopeless. Review of the physician's order with a start date of 11/26/18 showed the resident had an order for Mirtazapine (a medication used to treat depression) 15 mg (milligrams) one tablet by mouth at bedtime for depression. Review of the care plan, revision date of 06/27/19, showed the resident used an antidepressant medication related to chronic depression, and that staff were to report signs of worsening depression. In an observation and interview on 08/28/19 at 9:48 AM, the resident was in bed and stated, I just lay here, there is no reason for me to get up. The activities here are not for me, they don't interest me at all. I just lay here and watch TV. I only get 2 or 3 stations. I used to get more, I told them so many times before. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/03/19 at 11:01 AM showed the resident was in bed with the TV off and the room was dark. In an interview on 09/12/19 at 11:17 AM, Staff W, Certified Nursing Assistant (CNA) stated that the resident liked to watch TV in his room and I did not see him up in his wheelchair. In an observation and interview on 09/12/19 at 11:55 AM, the resident was in bed. Resident 2 stated, They have never asked me anything about mental health services, someone came to talk to me way back when. I don't know. It was a long time ago. I don't know if the medicine helps or not. Nobody cares anyway. During an interview on 09/06/19 at 2:13 PM, Staff R, Activities Director, stated, I was told not to do room visits. I never offered him any activities. In an interview on 09/11/19 at 9:39 AM, Staff CC, Restorative Aide stated the resident had not wanted to do his restorative exercises for at least one month, maybe more. I thought he was more depressed. I told the Director of Nursing Services about it before he left, he was also in charge of the restorative programs. During an interview on 09/12/19 at 11:36 AM, Staff P, Licensed Practical Nurse, stated that the resident would like to watch certain channels on the TV, but the TVs no longer get those channels. He started to get more depressed after the TV stopped getting the channels he liked. He does not get up in his wheelchair as much anymore, I thought it had to do with his disease process. The TV was what he enjoyed the most. We already put that on the communication board for it to get fixed. In an interview on 09/12/19 at 3:10 PM, Staff N, MDS Coordinator/Registered Nurse, stated, If the [resident's] PHQ 9 score went up on the MDS we would let the Social Worker know. We did let her know, I don't think it was documented. In an interview on 09/12/19 at 3:19 PM, Staff E, Resident Care Manager/Registered Nurse statd that the increase in PHQ 9 score for depression should have been followed up on. During an interview on 09/13/19 at 11:16 AM, the DNS stated, We should have offered him mental health services again for his depression. No Reference WAC:

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NAME OF PROVIDER OR SUPPLIER Edmonds Care		STREET ADDRESS, CITY, STATE, ZIP CODE 21400 72nd Avenue West Edmonds, WA 98026	

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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** 38430 Based on observation, interview and record review, the facility failed to provide adequate indications for the use of antipsychotic medication and behavior monitoring for six of six residents (66, 15, 61, 39, 36 and 71) reviewed for psychotropic medications. Failure to adequately monitor and document behaviors and ensure there were clinical indications for the use of an antipsychotic medication placed residents at risk for receiving incorrect dose and duration of psychotropic medications and increased their risk for adverse and irreversible consequences related to the use of the medication. Findings included . RESIDENT 66 Resident 66 was a long term resident of the facility with an admitted [DATE]. The resident diagnoses list included unspecified psychosis, major depressive disorder, anxiety disorder and dementia without behavioral disturbance. A review of the resident's active physician order sheet as of 09/04/2019 and Medication Administration Record (MAR) for August and September 2019, showed the resident received: Buspirone 7.5 milligram (MG) two times a day for anxiety, Clonazepam 0.125 MG two times a day for anxiety, Mirtazapine 15 MG at bedtime for depression and Quetiapine 12.5 three times a day for psychosis. Review of the care plan, dated 08/05/19, showed the resident used anti-psychotic medication due to combative behaviors and paranoia. The target behavior (TB) listed under interventions was Physically & Verbally Abusive toward staff. The care plan for the anti-anxiety medications showed the target behaviors identified were Feeling upset, tearful, being afraid, and feeling hopeless. The care plan showed both medications had three non-pharmacological interventions to attempt with the resident when the target behaviors were present, and directed staff to enter the numerical value for each attempted and each successful intervention. Review of a progress note, dated 02/04/19, from the social services showed, We will schedule her for mental health consult to review symptoms and medications and for possible GDR [gradual dose reduction]. We will continue to monitor mood, behaviors and cognition for any changes. Observations during the survey period showed Resident 66 did not leave her room, and she often lay in bed with a paper napkin covering her face. During a phone interview on 08/28/19 at 2:19 PM, the resident's daughter stated that her mother was in bed all day. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/06/19 at 11:53 AM, Staff T, Registered Nurse (RN), stated that if a resident was on a psychotropic medication, she documented the behavior and then notified the doctor. She further stated, I document by exception, if nothing happens then I don't document. Staff T did not know what specific behaviors to look for or why the resident was prescribed the psychotropic medication. During an interview on 09/06/19 at 12:03 PM with Staff E, Resident Care Manager (RCM)/RN, stated that he was not sure where the facility documented target behaviors. During an interview on 09/06/19 at 12:06 PM, Staff U, LPN, stated, the target behaviors should be on the MAR. Together we looked for the target behaviors on the MAR, but none were listed. In an interview on 09/06/19 at 12:14 PM, Staff F, Certified Nurse Assistant (CNA), stated, I don't know any behaviors for her, she is quiet, in her room a lot, I don't see any problems. In an interview on 09/10/19 at 3:25 PM, the Director of Nursing (DNS), stated, We are not monitoring target behaviors, and we have not had psychotropic drug committee meetings for some time. The resident has not had a GDR attempt in the past year. RESIDENT 15 Resident 15 admitted to the facility on [DATE]. The resident diagnoses list included dementia without behavioral disturbance and depression. A review of the resident's active physician order sheet as of 09/04/2019 and Medication Administration Record (MAR) for August and September 2019, showed the resident received Seroquel 25 MG two times a day for psychosis, and Sertraline 100 MG for depression. Review of the mood and behavior care plan, dated 06/13/19, showed the resident had a diagnosis of depression. Staff were directed to monitor, document, and report any signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints and tearfulness. The care plan, dated 03/26/19, showed resident used an antipsychotic medication related to psychosis. The care plan identified the target behaviors: agitation, combativeness with care and aggression. Observation on 09/05/19 at 11:02 AM showed Resident 15 was in her room visiting with friends, and observation on 09/06/19 at 12:01 PM showed the resident in room eating her lunch. Other observations during the survey period showed the resident was very friendly, calm, appropriate and well mannered, and interacted well with other residents. During an interview on 09/06/19 at 11:22 AM, Staff E, RCM/RN, stated, I do not see a diagnosis of psychosis for this resident. The behaviors identified on the care plan for the use of an antipsychotic are not clinical indications of psychosis. I am not sure an antipsychotic medication is appropriate for this resident. Staff E, was not able to demonstrate how the target behaviors were monitored at this time. 37945 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 71 The resident admitted to the facility on [DATE] and was able to make his needs known. Review of the resident's Minimum Data Set, dated dated dated (MDS) 08/06/19 showed the resident was taking an antidepressant. Review of the resident Medication Administration Record (MAR) for the month of August 2019, showed the resident was taking Cymbalta and Mirtazapine for depression. In an interview on 09/12/19 at 2:36 PM, Staff E was asked about the clinical indications for both antidepressant medications. He stated that the resident was taking Mirtazapine from the hospital, but stated that he could not find where or why the resident was on anti-depressants. He also stated that there was no documented clinical reason for the antidepressant medications and that he would follow up with the interdisciplinary team (IDT). In an interview on 09/13/19 at 10:39 AM, the DNS agreed that the psychotropic meetings were not happening that would have addressed having a clinical indication for the use of psychoactive medications and effective monitoring. 40303 RESIDENT 36 Resident #36 admitted to the facility on [DATE]. A 07/07/19 Quarterly MDS showed the resident had diagnoses to include major depression and anxiety disorder, and received anti-anxiety and anti-depressant medications on seven of seven days during the assessment period. Record review showed the following medication orders: 04/25/19 order for Trazadone (an anti-depressant) for insomnia, 08/09/19 order for Zoloft (an anti-depressant) for depression, and 07/29/19 order for Lorazepam (anti-anxiety) 0.5 mg as needed for anxiety and no end date. Review of August 2019 MAR showed of Lorazepam as needed (PRN) was given 17 times and no physician clinical assessment for use after 14 days. Review of the MARs showed no TB monitoring was in place and no indication non-pharmocologic interventions were attempted prior to the administration of the PRN Ativan. Interview on 09/04/19 at 11:53 AM, Staff E, RCM acknowledged there were no TBs identified or monitored for the use of the anti-anxiety medication. When asked if there was any documentation to support the continued use Ativan PRN, Staff E, stated, No. RESIDENT 61 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #61 admitted to the facility on [DATE]. A 07/25/19 Quarterly MDS showed the resident had diagnoses to include cerebral palsy, and psychosis on seven of seven days during the assessment period. Review of a pharmacy recommendation, dated 03/27/19, showed Resident 61 had since admission received Quetiapine 25mg at hours of sleep , without psychosis. Record review showed that on 07/18/19, the Quetiapine 12.5 mg dose was increased to 25 mg, and that the resident has been receiving the 25mg dose every day at hours of sleep. There was no documented physician assessment or clinical indication for the dose increase. During an interview on 09/04/19 at 11:53 AM, Staff E, RCM stated there were no TBs identified or monitored for the use of the antipsychotic. When asked if there was any documentation to support the increased dose, such as increased or signs and symptoms of psychosis, Staff E stated, No. Increasing the Resident's antidepressant dose, in the absence of any clinical indication, constituted an unnecessary medication. RESIDENT 39 Resident #39 readmitted to the facility on [DATE]. A 07/25/19 Quarterly MDS showed the resident had diagnoses of dyspnea (shortness of breath), stroke with hemiplegia and diabetes. Record review showed a 02/22/19 order for Lorazepam (anti-anxiety) 0.5mg every 6 hours as needed for anxiety/agitation. There were no parameters in the order indicating this psychotropic drug to be limited to 14 days. Review of the MARs showed no TB monitoring was in place and no indication that non-pharmocologic interventions were attempted prior to the administration of the PRN Ativan. Review of the Resident 61's record on 09/04/19 at 2:30 PM showed no consent was signed for the medication's use. Pharmacy recommendations, dated 03/27/19, showed, Resident receives an anxiolytic medication, Lorazepam, but informed consent documentation was found in the medical record Review of the August 2019 MAR showed Resident 39 received Ativan 0.5mg every six hours PRN a total of 27 times that month. During an interview on 09/04/19 at 11:53 AM, Staff E, RCM stated there were no TBs identified or monitored for the use of the anti-anxiety medication. When asked if there was any documentation to support the continued use PRN Ativan., Staff B stated, No. The facility staff did not consistently ensure implementation of non-drug interventions prior to the administration of the PRN Ativan and obtain informed consent prior to starting the 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. 41070 Based on observation and interview, the facility failed to ensure medications were properly labeled and stored in two of four medication carts. This failure placed residents at risk to receive expired medications, or for medication errors. Findings included . Review of the facility policy titled, Storage and Expiration of Medications, biological, syringes and Needles, revised on 10/31/16, showed Once any medication or biological is package is opened, the facility should follow manufacturer guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container. MEDICATION STORAGE and LABELING: Medication Cart 1 During the survey, an observation of a resident's medication that was delivered on 07/27/19, showed it had no open date. The package read safely throw away in the trash 1 month after opening the foil pouch or when the counter reads 0, whichever came first. In a telephone interview on 08/27/19 at 3:23 PM, Staff DD, Pharmacist stated that the Advair medication had a 30 day short expiration once it was opened. She stated the facility should have a copy of the Quick Reference for Medication Expiration Dates. She stated the facility need to be dating the medication after opening to determine when to discard it, especially medications with short expirations. During an joint observation and interview on 08/28/19 at 9:38 AM with Staff E, Registered Nurse (RN), Staff E stated that there was no Quick Reference for Medication Expiration Dates. Medication Cart 3 In a joint observation and interview on 08/27/19 at 9:55 AM, with Staff T, Registered Nurse (RN), 8 tablets (Cardivelol) were observed to have an expiration date of 07/31/19. Staff T stated that those pills were being routinely administered to a resident. In an interview on 08/28/19 11:00 AM, the Regional Clinical Nurse provided the policy for Medication Storage and Labeling from the facility's Pharmacy. She stated the policy was the one the facility was using as their for Medication Storage and Labeling policy. Reference (WAC) 388-97-1300 (2)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 37945 Based on interview and record review the facility failed to ensure an on-going Quality assurance and Performance Improvement Program (QAPI) was in place. Failure to ensure this systemic proces was in place to identify quality and system deficiencies placed all residents at risk for inadequate care and services. Findings included . Review of the documentation provided by the facility regarding the QAPI plan and policy consisted of meeting minutes that were not filled out (blank form). In an interview on 09/13/19 at 10:14 AM, the Director of Nursing stated the QAA committee was not meeting on a regular basis and did not have or create plans of action to correct quality and systems deficiencies previously identified by the state survey team. She stated she was not sure if the QAA team met quarterly and did not effectively make attempts to correct the systemic and quality deficiencies. Reference (WAC) 388-97-1760 (1)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to ensure consistent infection control data had documented analysis of infection control data, trends of infections, and had follow up activities in response to trends for 6 of 6 months (January 2019 through July 2019). This failure placed residents at risk for health care associated infections and a decreased quality of life. Additionally, the facility failed to ensure staff performed hand hygiene per professional standards and changed their gloves in between tasks. Findings included . POLICY: Infection Prevention dated January 2017, the center uses prevention strategies to reduce the risk of transmission of infections including but not limited to hand hygiene and education. Infection prevention provides for a practical system of reporting, evaluating and maintaining records of infections among residents and personnel. As the result of this collection and review of data, a follow-up plan of action is prepared and implemented. Findings included . The facility's infection surveillance tracking, dated January 2019 through July 2019, did not document infection trends, analysis, interventions used, and/or infection outcomes. Record review of the January 2019 infection control log revealed there was a total of 29 infections, 20 of those infections were acquired in the facility. Record review of the February 2019 infection control log revealed there was a total of 27 infections. Twenty two of the infections were facility acquired. The majority of the infections were found to be on one documented hall. Further record review showed: will do handwashing in-servicing and will encourage residents to stay in their rooms if experiencing s/s [signs or symptoms] of URI'S [upper respiratory infections]. There was not a documented in-service and/or follow-up plan of action. Record review of the March 2019 infection control log showed a trend was identified: significant increase in facility acquired infections spread throughout the facility. There was not a documented in-service and/or follow-up plan of action. Record review of the April, May and June 2019 infection control logs did not include documented analysis of infection control data. In an interview on 09/13/19 at 11:31 AM with the Director of Nursing Services said, I don't have any further information. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HAND HYGIENE Review of the undated Hand Hygiene Policy showed hand hygiene is the most important procedure for preventing Healthcare Associated Infection. The center requires personnel to use hand hygiene to remove dirt, organic material and transient microorganisms. A plain soap and water hand wash or an alcohol hand rub may also be used: before having direct contact with residents, after contact with resident's intact skin, and after contact with inanimate objects including medical equipment in the immediate vicinity of the resident. NURSES STATION/MEDICATION CART In an observation on 09/04/19 at 2:20 PM Staff P Licensed Practical Nurse (LPN) covered her mouth with her hand (mouth touched hand) and coughed into her hand. She then used the same hand she coughed into, touched the phone receiver that was at the nurses' station, answered a phone call and placed the phone back on the cradle that sat on the desk. There were no observations of hand hygiene performed after Staff P touched her mouth with her hand, coughed and touched the phone. In an observation on 09/04/19 at 2:30 PM Staff P LPN was observed at the medication cart) covered her mouth with her hand (mouth touched hand) and coughed into her hand. Used the same hand she coughed into, touched the surfaces of the medication cart, the medication cart drawers, cards that contained resident medication (bingo cards) and drinking cups. There was no observation of hand hygiene performed. In an interview on 09/04/19 at 2:34 PM with Staff P LPN said, I should have washed my hands, I will tell them to wash everything down with disinfectant. I am really sick, I already called in for tomorrow so I won't be here. 41070 RESIDENT 71 Resident 71 was admitted to the facility on [DATE] with diagnosis to include left ankle/foot infection. Review of the Admission Minimum Data Set (MDS) dated [DATE] showed the resident had a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident was cognitively intact. Review of the August 2019 MAR and September 2019 Physician orders showed the resident was receiving Piperacillin-Tazobactam (Zosyn - an antibiotic) 4.5 GM (grams)/1 ml (milliliter) every 6 hours for Osteomyelitis (infection of bone). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and observation on 08/30/19 at 05:15 AM, Staff O, Licensed Practical Nurse (LPN), stated the resident was on contact precaution (measures that are intended to prevent transmission of infectious agents, which are spread by direct or indirect contact with the resident or the resident's environment). The resident was observed lying in bed and had a dressing on his left foot, and an IV (Intravenous - is a therapy that delivers fluids/antibiotic directly into a vein) line dressing on his left upper arm (PICC Line). Inside the resident's room was an isolation cart by the door, Staff O LPN put on her gloves, opened the isolation cart, and put on a yellow disposal gown. She was pressing and touching the IV pump machine then hooked the Zosyn 100 ml bag to an IV line tubing, she then primed the IV line tubing. While wearing the same gloves Staff O, LPN opened the normal saline solution syringe, wiped the tip of the IV line on the resident's left upper arm with alcohol wipes, pushed the normal saline solution and hooked the primed IV line, and was pressing the IV pump machine and started running it to deliver the Zosyn medication. Staff O, LPN did not do hand hygiene and she did not change her gloves in between tasks. Staff O, LPN was asked to explain the process for hand hygiene and when to change gloves. Staff O, LPN realized she did not do hand hygiene, and she did not change her gloves in between tasks, she stated, that was my fault, I should have changed my gloves and washed my hands or use the hand sanitizer. During a joint observation on 09/06/19 at 3:11 PM, the resident was observed up in his wheelchair and he was sitting by the window in his room. On the resident's left upper arm was an IV line dressing. Staff Z, LPN stated the resident had an IV midline dressing, and it should be changed every week and prn (as needed). She also stated, I don't see an order in the resident's physician order for the IV midline dressing changes. During an interview on 09/06/19 at 3:18 PM Staff Y LPN stated, there was no physician order for the IV line dressing, and it was not written in the MAR or TAR. She stated the IV midline dressing should be changed every 72 hours, and the IV line tubing should be changed every 12 hours. Reference WAC: 388-97-1320 (1)(a)

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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. 35787 Based on interview and record review, the facility failed to establish and implement an infection prevention and control program that included utilization of an antibiotic stewardship program to promote appropriate use of antibiotics and reduce the risk of unnecessary antibiotic use, including the development of antibiotic resistance and other adverse side effects. This failure placed residents at risk for potential adverse outcomes and medical complications associated with inappropriate and unnecessary use of antibiotics. Findings included . Record review of the undated Antibiotic Stewardship Program policy showed: This policy establishes directives for antimicrobial (an agent that kills germs or stops their growth) stewardship at the facility in order to develop antibiotic use protocols and a system to monitor antibiotic use. In an interview on 09/11/19 at 12:14 PM with Staff E (Resident Care Manager/Registered Nurse), Staff E stated that the nurses should fill out the surveillance form for the antibiotic use and give it to the Director of Nursing Services (DNS), I don't know how the antibiotics would be tracked from there. During an interview on 09/11/19 at 12:26 PM, the Director of Nursing Services (DNS) stated, I will make copies of the residents on antibiotics and the surveillance forms we use for the antibiotic stewardship program. During an interview on 09/12/19 at 9:38 AM, the DNS stated: We don't have it. No reference WAC