STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on interview and record review the facility failed to notify one of one resident's representative (2) of a down grade in fluid consistency from mildly thick fluids to thin fluids for a resident with a history of a stroke, difficulty swallowing and aspiration pneumonia. This failed practice placed the resident and resident representative at risk of not able to make an informed decision or consent to the diet change and potential risk of repeat aspiration. Findings included . Resident 2 was admitted to the facility on [DATE] with diagnoses to include a stroke affecting the resident's left side along with facial weakness and difficulty swallowing, diabetes, and anxiety. Review of the Diet Order dated 12/15/2022, showed that the resident had a regular limited potassium, soft bite sized texture diet with mildly thick consistency fluids. Review of the Diet Order dated 01/24/2023, showed that the resident's diet changed to a regular limited potassium, soft bite sized texture diet with thin consistency fluids. Review of the Hospital Admission History and Physical dated 02/01/2023, showed that the resident was assessed to have had clinical pneumonia with a high suspicion for aspiration pneumonia. Review of the resident's admission orders dated 02/03/2023, showed that the resident had a diet order for Soft &Bite-Sized texture, International Dysphagia Diet Standardization Initiative (IDDSI) Mildly Thick consistency, fluids. In an email dated 02/05/2023 at 9:02 PM, Collateral Contact 3, family member documented that Resident 2 had a swallowing test, they had not been notified of the resident's diet order change from thick liquids to thin liquids and if they had known they would have opposed the diet change. Review of the resident's diet order dated 02/10/2023 showed that the resident's diet was changed to Regular diet Soft & Bite-Sized texture, IDDSI Thin consistency, fluids. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Progress Note dated 02/12/2023, showed that the resident's diet had changed, and the liquids were now updated to thin liquids. The resident had an occasional cough and the resident's daughter was concerned and stated that they had not been aware of the diet change and wanted to discuss the change with the dietitian. Review of the resident's Progress Notes from admission on 12/15/2022 through 02/23/2023, showed no documentation that the resident's representative had been informed of the resident's diet changes from thickened fluids to thin fluids throughout the resident's stay at the facility. In an interview on 02/28/2023 at 1:40 PM, Staff D, Registered Nurse/Resident Care Manager, stated that the individual who entered the diet orders with a change in the order was responsible to notify the resident's family. Reference: (WAC) 388-97-0320(1)(c)

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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 - Immediate jeopardy to resident health or safety 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** 37035 Based on observation, interview, and record review the facility failed to prevent neglect and abandonment of one of one resident (1) who was discharged to a motel, while they were still a resident of the facility, without ensuring arrangements were made to provide care for the resident's Stage IV pressure injury (PI) to their right buttock, unstageable pressure injuries to their right heel, right lateral (to the side away from the middle) calf, and left heel along with a wound to their right knee or set up any services to address the resident's nutritional needs. Additionally, the facility failed to ensure there were services in place to assist the resident with their bowel and bladder incontinence or medical management of the resident's multiple comorbidities. This failed practice placed the resident at risk of serious adverse outcomes due to the facility's identified resident's medical care needs and subsequently sent to the hospitalization for the severe deterioration of the resident's Stage IV PI of their right buttock and hospitalized for severe protein caloric malnutrition and right gluteal sacral decubitus osteomyelitis and cellulitis. An Immediate Jeopardy (IJ) was called on 03/02/2023 at 4:21 PM, at F600- Freedom from Abuse, Neglect, and Exploitation when the facility was found to have discharged Resident 1 to a motel without ensuring arrangements were made for the resident's medical, personal and nutritional needs. The facility removed the immediacy on 03/07/2023, by the return of the resident to the facility, personal care was provided to the resident along with wound assessment and treatment. The facility in-serviced the staff on Abuse Prohibition and Neglect along with Discharge Planning. Findings included . The National Pressure Ulcer Advisory Panel (NPUAP) Pressure Injury (Ulcer) definition and stages include: -A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of the soft tissue. -Stage IV Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, (thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place), muscle, tendon, ligament, cartilage, or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic (a shortage of blood supply to a part of the body) limb should not be softened or removed. Review of a Level 1 Preadmission Screen and Resident Review (PASRR) Notice of Determination dated 02/17/2023 for Resident 1, showed a Level II evaluation referral required for significant change with diagnoses of depressive disorder, psychoactive substance use and nicotine dependence. The Level II evaluation was not completed prior to the resident's discharge. Review of a Social Service Note dated 02/22/2023, showed that Staff B, Social Service Assistant, documented that along with the Administrator they met with Resident 1 to discuss their discharge plan, refusals of therapy, suspected substance use and withdrawn behavior. The resident was noted to have stated that they had not been refusing therapy or any assistance from staff. Resident 1 was noted to have reported that they would like to discharge to a motel once therapy services were over instead of (named community homeless center). Staff B noted that they reviewed with the resident that when the resident did discharge, they would be discharged with Home Health, physician follow up, medication and [NAME] (Meals on Wheels). Review of a Nursing Home Transfer of Discharge Notice signed but undated by Resident 1 and signed and dated 02/23/2023 by the facility's Administrator with the explanation that the resident overdosed after smoking Fentanyl in their rest room and continued concerns related to drug use within the facility. The location to which the resident was to transfer, or discharge was to be determined by the Home and Community Services (HCS) caseworker and the resident. Review of an Encounter note dated 02/24/2024 at 00:00 (12:00 AM),documented by Staff A, Nurse Practitioner, noted that the resident left against medical advice (AMA) and refusal of care with discharge condition as fair/stable, discharge medication reconciliation, instructions to both the resident and resident's family to return to the emergency room if there was any change in the resident condition and to follow up with primary care provider within a week and a referral to the wound clinic as an outpatient. Review of a Social Services Note dated 02/24/2023 at 9:36 AM, Staff B documented that they went in to follow up on the list of drug rehab facilities that was provided to the resident and the resident had stated that they were not interested in going to inpatient drug rehab and preferred to go to a motel. Review of a Social Services Note dated 02/24/2023 at 10:24 AM, Staff C, Social Service Director, documented that they called the resident's sister who was not able to support the resident at discharge and was not able to get in touch with the resident's daughter. Staff B documented that they were working with the resident on discharge planning and the resident was agreeable to go to a motel with services. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Nursing Care Note dated 02/24/2023 at 11:38 AM, showed the Director of Nursing Services (DNS) documented that they were notified that Resident 1 was interested in an AMA discharge. The DNS noted that they asked Resident 1 if they wished to discharge AMA. The DNS explained what that meant, which included not being discharged with narcotics, but would be sent with all other medications. The DNS noted that the resident was informed the facility would set up a Primary Care Provider appointment, would refer them to home health, would reach out to the community homeless outreach program, and would notify HCS. The DNS noted that Resident 1 was informed that with an AMA discharge, the police would be notified for a wellness check and Adult Protective Services would be notified. The DNS documented, Resident kept saying 'Fine I'll go' but never stated [the resident] wanted to go. Due to not stating [the resident] wants to go, AMA cancelled for today. Review of the AMA-Leaving Against Medical Advice form with a date of 02/24/2023 at 12:09 PM, documented Resident 1, was not able to take care of themselves independently at that time and continued to need increased level of assistance for personal care. Further deterioration of medical conditions due to no physician follow up, lack of resources in the community to assist with personal care and no monitoring related to drug abuse issue and no mental health assistance which was signed on 02/27/2023. Review of a Social Services Note dated 02/24/2023 at 12:16 PM, Staff C documented that they spoke with HCS related to the resident leaving AMA and had wanted to go to a motel. Per review of a Nursing Care Note dated 02/27/2023 at 11:42 AM, the DNS documented that they along with the Social Service Assistant and the Resident Care Manager addressed the report that the resident had drug paraphernalia in their room. The DNS noted that the resident continued to deny that they had anything and then stated that the resident wanted to leave. The DNS documented that they asked the resident if they wanted to discharge AMA and the resident stated Yes, I want to get out of here. The DNS documented that the facility would get a motel set up along with transportation and noted that the provider was signing orders, home health referral was already sent. The DNS documented that the home health agencies had declined to see the resident due to the resident's prior history and a wound clinic referral was set up. The DNS noted that the SSA was reaching out to the Community Outreach for the homeless. The DNS noted that Resident 1 agreed and had stated they were wanting to get out of there. Review of the 02/27/2023 Discharge Minimum Data Set (MDS) assessment, showed that the facility assessed Resident 1 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene, and total dependence with bathing. Per review of an email the facility's DNS sent on 02/27/2023 at 12:17 PM, to the HCS supervisor regarding the discharge of Resident 1. A Home Health referral was sent but Home Health would not be taking Resident 1 for home care, a referral to a wound clinic was made and the resident was discharged with their medication with the exception of their narcotic pain medication. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on 03/01/2023 at 4:30 PM, Resident 1, stated that their care at the facility was, not to swift. Resident 1 stated that the staff had reported that they had refused care, but they had been ill with nausea and vomiting and was unable to eat for four days. The resident stated they felt they had been coerced to leave the facility but that they did sign the discharge paperwork as it was frustrating when the facility staff lied and complained that they were refusing care. Resident 1 stated that they just finally agreed with them and said they would go. The resident stated that one of the staff members of which they did not know their name or title had told them they would be discharged to a motel with home care, [NAME], and wound care. Resident 1 stated that they had not had any home care, wound care or any meals provided to them since they had been discharged four days ago. The resident continued to state that the facility staff had told the resident that they would have wound care treatment and meals set up, yad-da yad-da yad-da, but had received nothing. Resident 1 stated that one of the staff members at the facility knew what was going on and how it went down. The resident stated that there were staff that were saying that they did not have to leave the facility and then there were staff in the background saying that they had refused care and it was frustrating and had pissed the resident off. The resident stated that the facility had given him a 30-day thing for discharge, and it was then that they had started talking about setting them up with a motel and that they could go to the motel that day. Resident 1 stated that there were even a couple of male staff that were encouraging them to leave and had told the resident that everything was going to be good and fine. In an interview on 02/28/2023 at 1:40 PM, Staff D, Registered Nurse/Resident Care Manager, stated that the resident had been, Flip flopping, about discharging and if the discharge was not safe, they were going to keep the resident in the facility. Staff D stated that they had told the DNS that the resident would not be safe to discharge on 02/24/2023 and the resident had agreed to stay at the facility. In an observation and interview on 03/02/2023 at 4:51 PM, the resident was lying in a bed in a pair of sweatpants in an unkept motel room with items scattered on the bed, floor, and tables. The resident was observed to have excess sweat on their face and chest. The resident stated that they felt coerced to leave the facility when the staff had them sign a 30-day paper and told them that they did not have to wait the 30 days but could leave that day. Resident 1 stated that there was a staff member who was by their room at the facility that told the resident to not let the other staff do that to them when the staff were telling the resident to leave. Resident 1 stated that they were coerced to leave when a staff person told them that they would get treatment, food, [NAME] and would not have to worry about nothing. Resident 1 stated that nursing and physical therapy were supposed to come see them at the motel and that was the only reason why they had left the facility. Resident 1 stated that all the stuff they were saying would happen did not happen. Resident 1 stated that they had a bowel movement in their incontinent brief, and they had tried to use the wipes that they were sent with to clean themselves. The resident pulled their sweatpants to reveal there was no dressing to their right buttock wound, there was a dry partially adhered dressing to their right knee and the resident was unable to remove their socks to reveal their reported wounds to their heels or feet. In an interview on 03/02/2023 at 3:16 PM, Collateral Contact (CC) 1, Motel Staff, stated that Resident 1 had been begging for food from other motel guests. CC 1 stated that it was the motel's policy that they were not allowed to clean the motel rooms while they were occupied by a guest. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 03/02/2023 at 3:20 PM, CC 2, Motel General Manager, stated that the motel had been reserved and paid through 03/06/2023 by Staff E, Facility's Senior Regional Administrator. CC 2 stated that they had not seen or had any calls from any home care agencies or delivery staff for meals on wheels. CC 2 stated that Resident 1 had been calling to other guest rooms at the motel attempting to get help. In a follow up phone interview on 03/03/2023 at 12:05 PM, Staff D, stated that the Administrator had directed them to go to the motel to provide wound care to Resident 1 but did not feel comfortable as they did not have active wound care orders. Staff D stated that on Friday, 02/24/2023 that they, definitely felt, the resident was coerced to leave the facility. Staff D stated that they had told the resident that it was their right to stay at the facility and the resident had stayed on Friday, but Staff D had not worked on Monday, 02/27/2023. In an interview on 03/07/2023 at 1:38 PM, Staff M, Licensed Practical Nurse, stated that Resident 1 was sent to the hospital that morning for osteomyelitis (inflammation or swelling that occurs in the bone)and worsening of their buttock and heel ulcer. Review of the Hospital History and Physical dated 03/07/2023, showed that the resident was hospitalized for severe protein caloric malnutrition, and right gluteal sacral decubitus osteomyelitis and cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin). Reference: (WAC) 388-97-0640 (1)(3)(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on observation, interview, and record review the facility failed to thoroughly investigate one of four investigations reviewed for alleged abuse and or neglect, involving Resident 3. This failed practice placed the facility at risk of not identifying the extent and nature of the resident's allegation and placed the resident at risk of potential continued abuse and diminished quality of life. Findings included . Resident 3 was admitted to the facility on [DATE] with diagnoses to include unspecified post-traumatic stress disorder, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and depressive disorder. Review of the Admission Minimum Data Set assessment dated [DATE], showed that Resident 3 was cognitively intact with a 14 out of 15 score on the Brief Interview for Mental Status, no behaviors or rejection of care were identified, required a two-person extensive assist with bed mobility, was always incontinent of bowel and bladder and required two-person extensive assistance with toileting. In an observation and interview on [DATE] at 1:15 PM, Resident 3 was lying in bed and stated that a male caregiver had placed their hand on the resident's pubic bone twice. Resident 3 stated that they had been the victim of sexual abuse in the past and started to tear up. The resident stated that they knew what molesting was and did not like it. Resident 3 stated that on the day they were molested at the facility it was a little gray outside at the end of the day at twilight. The resident stated that the individual (who had touched their pubic bone) had brought in their meal tray twice prior to the incident. Resident 3 described the individual as a male who was short, approximately four feet tall, had black hair with a crew cut. Resident 3 stated that the individual had not touched them until that day, and they had known that their husband had just died . Resident 3 stated, How dare he, and became visibly upset with facial grimacing and crying while describing the incident. The resident stated that the male caregiver had told them that their (the resident's) husband had taught them how to change Resident 3's pants, and then said it was not time for them to go home and then they left the resident's room and did not provide personal care for the resident. Resident 3 stated that they had told the lady who worked there who was in charge about the incident. Resident 3 stated that they did not want to see the male staff anymore as they were not nice to them and should not have done that to them. Resident 3 stated that they had a couple of rough nights afterwards. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident report dated [DATE], showed that the resident reported that last night someone around twilight, a male caregiver, molested them. The resident stated that the caregiver had tapped their pubic bone and had stated, Don't worry your husband . taught me how to change your brief. The resident had stated that they felt they had been molested and no longer wanted the caregiver to provide their care. The resident described the caregiver as a male, dwarf size with a buzz cut, a little overweight and did not speak a different language. In the investigation packet there was a statement that Staff H, Nursing Assistant Certified (NAC), had written on [DATE] that documented that Resident 3 had also reported that the male caregiver had, Wiped their peri area very rough and had tossed and turned them very roughly. The report indicated that no caregivers matched the resident's description were in the building and the male caregivers were interviewed to: 1. Have thought sexually assaulted [Resident 3]? 2. Have you heard [Resident 3] stated this to you at all? Residents were interviewed if a male staff had touched them inappropriately and if they felt safe and free from intimidation. The investigation noted that the sexual assault was not able to be substantiated, residents were interviewed for inappropriate touching and male caregivers had been interviewed. The investigation did not indicate that the allegation of rough handling had been investigate nor did the investigation have the initial nurse's statement. In a phone interview on [DATE] at 3:32 PM, Staff H stated that they had just completed passing lunch trays and Resident 3 had been sleeping throughout the morning and had not eaten breakfast. Staff H stated that when Resident 3 woke up they seemed scared which was not the resident's usual state and told them that there had been a male that had sexually abused them and that the nurse knew. Staff H stated that the resident had described the male as a white male of small stature and that the male had told them that the resident's husband had told them how to change their brief but that their husband had passed away. Staff H stated that the resident had told them that their private area hurt really bad. Staff H stated that Resident 3 had already reported the incident to the nurse and had reported it to the Director of Nursing Services (DNS). Staff H stated that Resident 3 had specifically stated that the individual was not Staff I, NAC, as they had always treated the resident respectfully. Staff H stated that when Resident 3 initially told them about the incident occurred the prior night but after the resident had been awake for a bit, they then stated that the incident had occurred two days prior on the evening shift. In an interview on [DATE], at 2:05 PM, the DNS stated that Staff J, Registered Nurse, had initially reported the resident's allegations of sexual abuse. The DNS stated that they had not seen the statement that Staff H had wrote out in the incident report until that morning. The DNS stated that they had not interviewed or spoken with Staff H. The DNS stated that the allegation of rough handling was not investigated. The DNS stated that the Administrator completed the final review of the facility's incident reports. In an interview on [DATE] at 3:58 PM, the Administrator stated that they completed the review of facility investigations to see if what was done was effective. The Administrator stated that they would review the initial incident and interventions to see if they were effective. The Administrator stated that they review the initial interventions that were implemented in the moment to see if they worked or maybe the intervention was not the best option and would look at what they could put into place for an effective intervention. The Administrator confirmed that they review the investigations for appropriate interviews and if they were appropriate for the investigation. The Administrator stated that they usually get the investigations on day four or five. This is a repeat deficiency from surveys dated [DATE], [DATE], [DATE], and [DATE]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC [DATE] (6)(a)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on observation, interview, and record review the facility failed to give one of three residents (4) an appropriate and reasonable discharge notice without providing a 30-day discharge date . Additionally, the facility issued a Notice for Past Due Patient Liability Notice that stated that the resident's Medicaid benefit could be interrupted and investigated by the State Medicaid Fraud agency. This failed practiced contributed to undue emotional and psychological distress for Resident 4. Findings included . Resident 4 admitted to the facility on [DATE] after being discharged from a facility owned by the same corporation due to their closure. Resident 4 had diagnoses that included diabetes, severe morbid obesity, heart failure, lack of coordination, muscle weakness, difficulty walking, history of falling, pain, and history of mental and behavioral disturbances. Review of the Admission ADL (Activity of Daily Living) Functional / Rehabilitation Potential Care Area Assessment (CAA) dated 12/22/2022, showed that Resident 4 had a prior level of functioning where they lived in an apartment independently. The resident was independent with their ADL, medication management, had grab bars and a four-wheel walker. The resident received some volunteer assistance for cleaning, shopping, and driving. This ADL CAA noted that since admission Resident 4 required extensive hands-on assistance with bed mobility, transfers, toileting, upper and lower body dressing. The resident had weakness and deconditioning related to a previous fracture. The resident had ADL self-care deficits related to a fracture and need for assistance. The resident's goal was for improvement to functional level to enable discharge back to independent living. Review of the focus care planned anticipated discharge plan to the resident's independent home dated 12/22/2022, showed interventions which included the resident had a Department of Social and Health Services (DSHS) assessment for Community Options Program Entry System, a Medicaid Program to assist nursing home level care in individual independent homes or assisted living (COPES) caregivers and barriers to discharge was self-limiting behaviors, waiting for her Home Maintenance Allowance (HMA) to end March 2023. Review of the medical record showed no 30-day discharge notice had been issued to Resident 4. (continued on next page)

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	505296	A. Building B. Wing	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Francis of Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/13/2023 at 3:11 PM, Resident 4 was visibly emotionally upset and in tears stated that they had a discharge appeal on 01/20/2023, (an appeal of a discharge notice from the resident's prior nursing home) and no one had heard anything. The resident stated that last Thursday the Administrator and Social Services had called them into a meeting and only verbally told them that they wanted to discharge the resident on 02/14/2023. The resident stated that that was new, and they had not heard the ruling from the Judge on the prior appeal. The resident stated that the Administrator had done nothing but talk down to them, harassed them, tried to go around and behind them and retaliate against them to discharge from the facility. Review of the medical record on 02/13/2023 at 4:33 PM, showed that a Discharge Return Not Anticipated for 02/14/2023 was In Progress. In an interview on 02/13/2023 at 4:42 PM, Staff C, Social Service Director, stated that the facility had a discharge set to 02/14/2023 as the resident had reached a functional plateau and a division of DSHS had stated that the facility did not need to issue a 30-day notice on this occasion. In an interview on 02/13/2023 at 4:43 PM, Staff N, Physical Therapist, stated that the resident had not been discharged from therapy. Staff N stated that the facility had asked therapy to discharge the resident but to their understanding the resident was, .caught between a rock and a hard place. Staff N stated that the resident was not able to cleanse themselves after using the bathroom due to their obesity and the resident refused to use adaptive equipment to cleanse after using the bathroom. In a follow up interview on 02/13/2023 at 4:57 PM, the resident stated that three weeks ago they had requested to have their toilet seat changed out as they were unable to reach to complete their personal care after using the bathroom. The resident stated that they had asked to have therapy six days a week but was told they had to stretch therapy out over the month. Resident 4 stated that they wanted as much therapy as they could have in order to be as physically well as possible by the first of the month. The resident stated that the Administrator was really nasty about their portion of their monthly payments. The resident stated that the facility's Financial Director was wanting payment for the month of February. At 5:18 PM, just as the resident stated that the facility staff was wanting their monthly payment for the current month, Staff O, Business Office Manager knocked on the resident's door and requested to come in to talk with the resident about their monthly payment. The resident stated that they felt the facility's pressure for money was in retaliation of them wanting to continue to stay at the facility. The resident stated that the facility had given them a letter for Notice of Past Due Patient Liability that they felt was harassing as well. The resident stated that immediately after the Ombudsman had left the last time, Staff O had come into their room to request money. A copy of the notices the facility had issued as well as a copy of an email from the Ombudsman was obtained from the resident. Review of a facility issued Notice for Past Due Patient Liability dated 10/18/2022, which was given by the prior facility that closed, documented, Failure to pay this money, as designated by the State, can result in interruption of Medicaid benefits. In addition, failure to pay can be investigated by Medicaid and the State for fraudulent use of funds. We are obligated to report to the State for investigation of any believed inappropriate use of resident funds. If payment is not received within 7 days of the date of this letter, we will be reporting the failure to pay funds due to the State for investigation. The letter was issued by the facility's Operations, LLC (Limited Liability Company). (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the printed-out email from the Northwest [NAME] Long-Term Care Ombudsman to the facility dated 01/20/2023, documented the resident had reported that the Administrator had previously handed the resident an envelope that contained a letter of notification of impending legal action for a delinquent facility charge. The email noted that the resident was currently involved in an Administrative Hearing to appeal a facility-initiated discharge. The Administrative Hearing was held via telephone on 01/20/2023. The email noted that the resident had stated that they felt the timing of the letter was retaliatory for their filing of an appeal of their discharge. The email noted that the resident had stated that they felt harassed and threatened by the notice of impending legal action. Review of the facility issued Notice for Past Due Patient Liability dated 02/21/2023, that included the same language that was written in the previous 10/18/2022 notice. The letter was issued by the facility's Operations, LLC (Limited Liability Company). In a phone interview on 03/02/2023 at 4:42 PM, Collateral Contact (CC) 4, Former Staff Member stated that the facility's Administrator would print out a list of residents based on their reimbursement rate and would direct them to discharge the lower paying residents and to keep the higher paying residents in the facility. CC 4 stated that the facility had a contract with the hospital for five leased beds for hospital patients that the hospital had difficulty discharging. CC 4 stated that those beds had transferred over from the company's other facility when it closed. CC 4 stated that there was always a push to discharge those residents that were in the leased beds from the facility as the Administrator did not want the problem residents. CC 4 stated that Resident 4 was a resident that the facility wanted discharged , and they were told the resident was supposed to be on a do not admit list. In an interview and record review on 03/07/2023 at 4:41 PM, Staff O stated that the letter of Notice for Past Due Patient Liability that was issued to Resident 4 was a general statement letter that was used for all the company's facilities for residents who had not appropriated their funds toward their daily room rate charge. Staff O stated that if the facility had not received funds by the 10th of the month a Notice for Past Due Liability letter was issued. Staff O stated that the facility had issued 40 letters to different residents in the past three months. Reference: (WAC) 388-97-0120(1)(2)(a)(b)(c)(d)(e)(3)(a)(b)(5)(a)(b)(iii)

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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** 37035 Based on observation, interview and record review, the facility failed to provide culturally competent care identified in the resident's comprehensive person-centered care plan for the review of one of one non-English speaking resident (2). Failure to include and implement culturally competent individualized approaches and interventions placed the resident at risk for inconsistent and inadequate care along with diminished quality of life. Findings Included . Resident 2 was admitted to the facility initially on 12/15/2022 with diagnoses to include a stroke, cognitive deficits following the stroke, and anxiety disorder. Review of the Admission Minimum Data set assessment dated [DATE], showed that Resident 2 was assessed to be Hispanic or Latino and wanted a Spanish interpreter to communicate with the health care staff and had moderate cognitive impairment per the Brief Interview for Mental Status with a score of eight out of 15. Review of the Communication Care Area assessment dated [DATE], showed that the resident's, Primary language was Spanish and as such, is not always understood by others and may not always understand staff that do not speak Spanish. Review of the resident's focused care planned problem of alteration in cognition and communication related to a stroke, memory loss and Spanish speaking initiated on 12/16/2022 and revised on 02/05/2023, showed the following interventions: -01/12/2023, use the communication folder in the resident's room to allow them to point to items and care they needed. -01/12/2023, use [the] App on [the electronic device] for Spanish translator to communicate with the resident. A revision was done on 02/22/2023 that there were times the resident did not want to utilize the [electronic device]. -02/21/2022, use the [Search Engine] translation to communicate with the resident. -02/22/2023, the resident could understand some English for basic conversations. If unable to communicate with the resident utilize the communication board. Review of an email dated 02/21/2023, from Collateral Contact 3 (CC 3), family member, showed on 02/20/2023 that the nurse was communicating with Resident 2 in English and had asked the resident if they had pain of which the resident replied yes. CC 3 then asked the same question of the resident in Spanish and the resident said, Oh no, not at all. CC 3 noted that obviously the resident didn't understand the words in English. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 02/21/2023 at 2:50 PM and at 3:47 PM, Resident 2 was lying in bed with an English television program on. In an observation and interview on 02/21/2023 at 4:45 PM, Staff K, Nursing Assistant Certified (NAC), was observed speaking English to Resident 3 while the resident was sitting in their wheelchair across from the nurses station. Staff K stated that Resident 3 understood a little English and that the resident spoke Spanish. In an observation and interview on 02/21/2023 at 4:51 PM, Staff L, Activity Assistant, was observed speaking English to Resident 2 while the resident was sitting in her wheelchair outside of the solarium. Staff L stated that they did have an electronic device to use but usually it did not go that far to use the electronic device but had the option to use the translator to communicate with the resident. Staff L stated that they were not sure if the Activity electronic device had the translator application. Staff L looked on their electronic device and confirmed the device did not have the translator application installed. Staff L obtained an electronic device from the nurse's station and stated that one was not working. Staff L obtained another electronic device from the nurse's station and stated that the translator on that device was set to Vietnamese. In an interview on 02/21/2023 at 5:00 PM, the Director of Nursing Services (DNS) was asked to demonstrate how the staff used the electronic devices to communicate with Resident 2. The DNS stated that Social Services would be best to demonstrate the use of the electronic translator. In an interview and observation on 02/21/2023 at 5:10 PM, Staff C, Social Service Director, picked up an electronic device that was at the nurse's station and stated that they did not think the device had the translator on the device. Staff C then went into the Resident Care Manager's office and obtained an electronic device from behind the closed door that had the translator application available. In an interview on 02/23/2023 at 4:14 PM, Staff M, NAC, stated that they sometimes took care of Resident 2. Staff M stated that Resident 2 did not speak English, but they would talk with their body language. This is a repeat deficiency from surveys dated 01/13/2023 and 01/13/2022. Reference WAC 388-97-1020 (3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37035 Based on observation and interview the facility failed to ensure medications and biologicals were stored properly on two of two nursing units when medication and treatment carts were not properly secured and not accessible to the public or residents. These failures placed the residents at risk of potential drug misuse or loss. Findings included . In an observation on 02/23/2023 at 3:38 PM, the treatment cart located on A Wing, in the hallway next to room [ROOM NUMBER] was unlocked with no staff in the immediate area. In an observation on 03/07/2023 at 1:12 PM, the treatment cart located on A Wing, in the hallway in front of room [ROOM NUMBER] was unlocked with no staff in visual sight. The cart had various treatment creams and a bottle of witch hazel. The cart remained unlocked at 1:39 PM, at 3:40 PM, and at 4:56 PM. In an interview on 03/07/2023 at 4:56 PM, Staff F, Registered Nurse / Staff Development Coordinator, stated that the treatment cart should be locked, at which time Staff F locked the treatment cart. In an observation on 03/08/2023 at 1:51 PM, the medication cart located on B Wing, in the hallway near room [ROOM NUMBER], was unlocked with no staff in the vicinity. At 1:58 PM, Staff G, Licensed Practical Nurse stated that nursing students had worked on the cart earlier. Staff G stated that the cart was supposed to be locked and Staff G locked the cart. In an interview on 03/07/2023 at 2:11 PM, the Director of Nursing Services, stated that all the carts should be, locked at all times. This is a repeat deficiency from surveys dated 01/26/2022. Reference: (WAC) 388-97-2340