STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505096	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Post Acute	802 West Third Avenue Toppenish, WA 98948

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 39652 Based on observation, interview, and record review, the facility failed to ensure residents that required assistance with eating received a dignified meal service, related to timely assistance with meals, for 2 of 4 residents (Residents 14 and 3) reviewed for dignity. This failure placed the residents at risk for unmet care needs and a deterioration in their quality of life. Findings included . <Resident 14> Review of the resident's medical record showed they were admitted to the facility with diagnoses including dementia (a progressive disease that destroys the memory and other important mental functions), dysphasia (impaired ability to swallow) and legal blindness. Resident 14's comprehensive assessment, dated 08/28/2024, showed the resident was severely cognitively impaired and required substantial assistance (a considerable amount) with eating. Review of Resident 14's care plan, dated 09/03/2024, showed the resident's legal blindness and cognition status was the reason they required substantial assistance from staff with their meals. During an observation on 10/22/2024 from 11:50 AM to 1:16 PM, showed Resident 14 sitting in the dining room alone at a table. At 1:00 PM, meal trays arrived, and Resident 14's meal tray was placed on the table in front of them. The three staff in the dining room were assisting other residents to eat their meals at other tables. Resident 14 waited until 1:16 PM (16 minutes after their meal arrived) for Staff T, Nursing Assistant (NA) to come from the west hall to assist the resident with their meal. During an interview on 10/22/2024 at 1:35 PM, Staff T stated they tried to come to the assisted dining room as soon as they could to help but were required to pass trays and assist other residents in the west hall first. During an observation on 10/24/2024 from 1:00 PM to 1:48 PM, showed Resident 14 sitting at a table alone. At 1:12 PM, the resident's meal tray was placed in front of them. Resident 14 stated Are you going to help me or what? The staff who had delivered the tray stated, someone will be with you soon. Resident 14 was observed leaning forward and attempting to smell their food. At 1:35 PM Staff U, NA, came into the dining room and assisted Resident 14 with their food. Resident 14 waited 17 minutes to eat after their meal tray had been served. (continued on next page)

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 3> Review of the resident's medical record showed they admitted to the facility with diagnoses including deafness and dementia. The most recent comprehensive assessment, dated 08/18/2024, showed the resident was severely cognitively impaired and required substantial assistance for activities of daily living to include assistance with meals. During an observation on 10/22/2024 from 11:50 AM to 1:16 PM, showed Resident 3 was sitting in the dining room with another resident at the table. At 1:00 PM, Resident 3 had their meal placed in front of them. Staff assisted the other resident at the table to eat, however Resident 3 just sat there with untouched food. At 1:30 PM (30 minutes after their meal was served), Staff S, NA, placed the resident's hand on their cup to cue them to start eating. During an observation on 10/24/2024 from 1:00 PM to 1:48 PM, showed that Resident 3 was served their lunch tray at 1:17 PM. At 1:48 PM (31 minutes after their meal had been served), Staff S who had been assisting residents at another table, approached the resident and assisted them with their meal. During an interview on 10/30/2024 at 9:50 AM, Staff L, Licensed Practical Nurse, stated the NA working on the west hall was assigned to go to the assisted dining room to help residents with their meals after passing out the room trays. Staff L stated the reason the NA was late going to the dining room was because they also had to assist the residents who dined in their rooms and required help with their meals prior to heading to the dining room, which often put them behind. During an interview on 10/30/2024 at 12:50 PM, Staff A, Administrator, stated it was not appropriate for residents to be waiting with their meal trays in front of them for assistance while other residents were already eating. Reference: WAC 388-97-0180(1-4)

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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** 43280 Based on interview and record review, the facility failed to review and validate the Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) were corrected on/after residents admission to the facility and had the required Level II referral sent if residents had a positive Level I PASARR for 2 of 8 residents (Resident 29 and 56) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, Clarification to the Pre-Admission Screening and Resident Review (PASARR or PASRR) Level I Screening Process, dated 07/06/2024, showed that nursing facilities will ensure residents with a positive Level I PASARR screen have been evaluated by the designated state-authority through the Level II PASARR process and approved for admission prior to admitting to the nursing facility. <Resident 29> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including Post-Traumatic Stress Disorder [PTSD, a mental health condition that's caused by an extremely stressful or terrifying event) and depression. The 09/12/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Review of a Level I PASARR screening form dated 08/30/2024, showed Resident 29 was pending an admitted ASAP (as soon as possible) and had anxiety disorders checked for their PTSD in the SMI indicators section. No other SMI indicators were checked, and a Level II referral evaluation was required for Residents 29's SMI indicators. During an interview on 10/28/2024 at 9:28 AM, Staff H, Social Service Director (SSD), stated they were responsible for reviewing the accuracy of the PASARR Level I screenings and Level II referral prior to the resident admitting into the facility. Staff H stated Resident 29's PASARR Level I screening was not accurate with their diagnosis of depression. Additionally, the residents PASARR was not sent for a Level II referral prior to their admission into the facility. 45117 <Resident 56> Review of the medical record showed Resident 56 was admitted to the facility on [DATE] with diagnoses including PTSD and anxiety. The 08/26/2024 comprehensive assessment showed Resident 56 required partial/moderate assistance of one staff member for activities of daily living. The assessment also showed the resident had an intact cognition. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Level I PASARR screening form, dated 08/20/2024, showed Resident 56 was pending an admitted [DATE] and had no serious mental illness indicators. Review of a Level I PASARR screening form, dated 09/02/2024, showed Resident 56 was a current nursing facility resident, with an admitted [DATE]. The form showed serious mental illness indicators of an anxiety disorder and PTSD. Further review of the form showed No Level II evaluation indicated. During an interview on 10/28/2024 at 11:38 AM, Staff H, SSD, stated they were responsible for reviewing the PASARR Level I screenings prior to the resident's admission to the facility. Staff H stated Resident 56's PASARR Level I screening was incorrect and should have been referred for a Level II screening. During an interview on 10/29/2024 at 1:42 PM, Staff B, Director of Nursing Services, stated Staff H was responsible for reviewing the PASARR Level I screenings prior to admission. Staff B stated if a PASARR Level II screening was indicated, Staff H was responsible for completing the referral. Staff B stated Resident 56's PASARR Level I initial screening was incorrect. They stated Staff H completed a second PASARR Level I with the correct diagnoses and that should have been sent for a Level II referral. Reference: WAC 388-97-1915(1)(2)(a-c)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to develop and implement an effective discharge planning process that addressed the resident's goals and needs, that involved the resident and the interdisciplinary team [(IDT) a group of healthcare professionals from different disciplines to help residents receive the care they need] for 1 of 3 residents (Resident 264) reviewed for discharge planning process. The failure to develop and implement a discharge plan consistent with the resident's needs and expressed discharge goals, placed the resident at risk for decreased self-worth and dissatisfaction with their living situation. Additionally, the facility failed to ensure a safe discharge when 1 of 2 residents (Resident 61) discharged against medical advice (AMA) with a peripheral inserted central catheter line [(PICC) a thin, flexible tube that is inserted into a vein in the arm and threaded into a large vein above the heart used to deliver fluids and medications]. This failure placed the resident at risk for infection and poor outcomes. Findings included . <Resident 264> Review of the medical record showed Resident 264 was admitted to the facility on [DATE] with diagnoses including fainting and collapse, heart failure, and dehydration. The 10/15/2024 comprehensive assessment showed Resident 264 required partial/moderate assistance of one staff member for activities of daily living (ADLs) and was cognitively intact. The assessment also showed Resident 264's goal for discharge was to return to the community. Record review of a care plan dated 10/01/2024, showed no documentation of discharge planning for Resident 264. Record review of a social services progress note dated 09/27/2024 at 2:38 PM, showed Resident 264 requested to discharge that day. Staff H, Social Services Director, documented they had explained the discharge process to Resident 264, who became upset and stated they wanted to return home. Staff H contacted the provider who addended their previous visit note dated 09/19/2024 that showed Resident 264 was ok to d/c from facility. Record review of a nursing progress note dated 09/24/2024 at 3:44 PM, showed Resident 264 discharged home AMA with their family. <Resident 61> Review of the medical record showed Resident 61 was admitted to the facility with diagnoses including cellulitis (a serious bacterial skin infection) of their left lower limb, osteomyelitis (a serious bone infection), and paraplegia (paralysis that makes it impossible to stand or walk). The 08/02/2024 comprehensive assessment showed Resident 61 required substantial/maximum assistance with ADLs. The assessment also showed Resident 61 had an intact cognition. Review of a Medication Administration Record (MAR) dated 08/2024, showed Resident 61 was receiving an antibiotic through their PICC line that started on 07/27/2024 and was to end on 09/02/2024. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a nursing progress note dated 08/29/2024, showed the licensed nurse had placed a call to Resident 61, who stated they would not be returning to the facility for their treatment cares, including their antibiotic medication through their PICC line. Review of the medical record showed no documentation that Resident 61's provider was notified of the AMA discharge with their PICC line in place. There was no documentation that showed Adult Protective Services (APS), or law enforcement had been notified. During an interview 10/29/2024 12:00 PM, Staff H stated the process for discharge planning started upon admission. They stated they reviewed the resident's goals for discharge and entered them into the care plan. Staff H stated they were required to have the initial goals documented in the care plan in the first 72 hours after admission, then re-evaluate and update the care plan within the first two weeks after admission. Staff H stated thought they had documented discharge planning in the progress notes for Resident 264. They stated their normal process was add that information to the care plan. Staff H stated, after reviewing the medical record, there was no documentation addressing Resident 264's discharge plans. During an interview on 10/29/2024 at 1:43 PM, Staff B, Director of Nursing Services, stated the process for discharge planning started on admission and was constantly reviewed. They stated Resident 61 left the facility AMA with their PICC line in place. Staff B stated it was unsafe to discharge a resident with a PICC line in place. They stated the facility should have notified the provider and other entities (law enforcement/Adult Protective Services) when Resident 61 did not return to the facility. Reference: WAC 388-97-0080(3)(a)(5)(7)(a-c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care of their type two diabetes mellitus (a disease that causes inadequate control of the body's blood levels of sugar, which can lead to abnormally high or low levels of the body's blood sugar) in accordance with professional standards of practice for 1 of 2 residents (Resident 218) reviewed for insulin (a medication that assists in control of blood sugar levels) therapy. This failure placed residents at an increased risk for unmet care needs, emergent situations, and poor health outcomes. Findings included . Review of a policy titled, Nursing Care of the Older Adult with Diabetes Mellitus, dated November 2020, showed blood glucose (sugar) monitoring of diabetic residents were needed to detect hyperglycemia (high levels of blood sugar in the body, greater than 150 milligrams/deciliter [mg/dL, units of measure]) and hypoglycemia (low levels of blood sugar in the body, less than 70 mg/dL) complications associated with diabetes. The policy showed that residents who were receiving sliding scale insulin ([SSI], a scale that increases the amount of pre-meal insulin that is administered to a resident based on their blood sugar level before the meal) should be monitored three to four times a day. Review of a policy titled, Obtaining a Fingerstick Glucose Level, dated September 2014, showed the fingerstick glucose device was used to determine a diabetic resident's blood sugar level. The policy showed that staff were to ensure the device was working properly as instructed by the manufacturers recommendations. <Resident 218> Review of the medical record showed Resident 218 was admitted to the facility on [DATE] with diagnoses including aftercare for surgery on their left lower leg, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and type two diabetes. The 10/17/2024 comprehensive assessment showed the resident was cognitively intact, able to make their needs known, and received daily insulin injections. During an interview on 10/23/2024 at 11:07 AM, Resident 218 stated the nursing staff utilized the residents own blood glucose monitor called FreeStyle Libre 2 (a sensor placed on the skin that continuously tracks and records blood glucose levels throughout the day and night) before administering their SSI. The resident stated their blood glucose levels had been different since they admitted to the facility and were sometimes going higher than they expected with readings at 230 mg/dL and other times going lower than they expected with readings in the 80's mg/dL. Resident 218 stated the fingerstick glucose monitoring device had not been used to check the residents blood glucose due to them having the FreeStyle Libre 2 sensor since they had admitted to the facility. Additionally, Resident 218 stated they changed out their blood glucose monitoring sensor on 10/22/2024, sometime in the morning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer's recommendations titled, FreeStyle Libre 2 Flash Glucose Monitoring System, revised August 2024, showed failure to use the System according to the instructions for use may result in you missing a severe low blood glucose or high blood glucose event and/or making a treatment decision (like administering more insulin when blood sugars values are high and/or administering sugar in the form of food or medications when values are low) that may result in injury. If your glucose reading alarms and reading from the System do not match symptoms or expectations, use a fingerstick blood glucose value from a blood glucose meter to make diabetes treatment decisions. The recommendation stated that during the first 12 hours after changing out the sensor, the sensors blood glucose values should not be used to make treatment decisions and the values needed to be confirmed with another blood glucose monitor before deciding what to do or what treatment decisions to make. Review of Resident 218's Medication Administration Record for October 2024, showed the resident's blood glucose checks were four times a day .before meals and at bedtime . The resident was administered a scheduled insulin injection in the morning and, in addition to that, a SSI based on the resident's blood glucose levels, .if 131 - 180 = 2 units (a unit of measure for insulin medication); 181 - 240 = 4 units; 241 - 300 = 6 units . On 10/22/2024 Resident 218 was administered their scheduled insulin in the morning and SSI of six units, one time in the afternoon for a 246 mg/dL blood glucose value by Staff E, Registered Nurse (RN). During an interview on 10/25/2024 at 8:18 AM, Staff E, RN, stated they had been administering Resident 218's SSI based on the FreeStyle Libre 2 sensors blood glucose readings. Staff E stated they were unaware of the FreeStyle Libre 2 sensors manufacturer's recommendations of not utilizing the blood glucose values for the first 12 hours after changing the sensor without confirming the values with another glucose monitor. Staff E stated they had never used the facility's fingerstick glucose device for reading Resident 218's blood glucose levels, nor to confirm the FreeStyle Libre 2 sensors readings. During an interview on 10/28/2024 at 3:29 PM, Staff D, Resident Case Manager, stated they did not have a policy for Resident 218's continuous blood glucose monitoring system and would refer to the FreeStyle Libre 2 sensors manufacturer's recommendations. Staff D stated Resident 218 informed them that the FreeStyle Libre 2 sensor was changed out on 10/22/2024 but was unaware of what time it was changed. Staff D stated they were unaware of the manufacturer's recommendations to not utilize the blood glucose sensors readings for the first 12 hours after it was changed out. Staff D stated that on 10/22/2024 Resident 218's blood glucose readings should have been confirmed with the facility fingerstick glucose device during the first 12 hours of changing the sensor. During an interview on 10/30/2024 at 11:13 AM, Staff A, Administrator, and Staff B, Director of Nursing Services, stated the facility did not have a process in place for confirming the FreeStyle Libre 2 sensor's blood glucose levels for Resident 218 after the sensor was changed out, per the manufacturer's recommendations. Reference: WAC 388-97-1060(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on observation, interview, and record review, the facility failed to ensure residents environment remained free of accident/hazards with: A) a resident that required a smoking apron for safety when smoking for 1 of 2 residents (Resident 29) reviewed for accident/hazard of smoking, B) the securement of compressed oxygen cylinder storage for 1 of 2 storage rooms (East/West storage room) reviewed for accident/hazards of oxygen cylinder storage, and C) that toxic cleaning chemicals were safely stored away from residents for 2 of 3 hallways (East/West and Central Hall) reviewed for accidents/hazards of chemicals. This failure placed residents at an increased risk for avoidable accidents, significate injury, and unmet care needs. Findings included . Review of the facility's policy titled, Smoking Policy for Independent and Supervised, revised December 2017 showed that residents who wished to smoke would be assessed for their risks with smoking and the ability to smoke safely. Residents who did not meet the criteria to smoke independently would be provided assistance with their smoking materials and supervision when smoking. Review of an Office of Congressional Workplace Rights document titled, Compressed Gas Cylinder Storage, dated 08/2019, showed compressed gas cylinders should be treated as potential high energy projectiles and should be secured at all times to prevent tipping. All cylinders should be chained or secured to prevent them from falling. <Smoking> <Resident 29> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including Post-Traumatic Stress Disorder [(PTSD) a mental health condition that's caused by an extremely stressful or terrifying event], depression and paralysis following a stroke that affected the residents left side of the body. The 09/12/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Resident 29 need partial/moderate facility staff assistance with their oral hygiene (a resident's ability to use suitable items to clean their teeth) and substantial/maximal facility staff assistance with upper body dressing (resident ability to dress/undress themselves above the waist and use of hands/fingers to work things like buttons). Review of facility smoking observation/assessment, dated 09/06/2024, showed Resident 29 had dexterity (the ability to perform difficult actions quickly and skillfully with the hands) issues related to Resident 29's stroke, was unable to light their own cigarette, required supervision of staff when smoking and needed a smoking apron (a protective flame retardant garment that prevents burning of clothes and keeps hot cigarette ashes from burning the skin) as an adaptive equipment (any kind of tool or device that can simplify caregiving or make the resident's environment safer) when smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/23/2024 at 8:34 AM, showed Resident 29 in their room with two cigarette burn marks on the black sweater they were wearing. When inquired about the burn marks the resident stated they were a hazardous smoker before admitting into the facility. Resident 29 stated they actively went outside to smoke during the facility designated smoking times, needed to be supervised by the facility staff when smoking, but had not been required to wear a smoking apron. During a concurrent observation and interview on 10/24/2024 at 9:34 AM, showed Resident 29 being taken out to smoke during one of the designated smoking times. The resident was in/out of falling asleep in their wheelchair saying pretty dam sleepy .make sure I don't burn my clothes . when given a cigarette and helped to light it by Staff U, [NAME] Clerk/Nursing Assistant. Resident 29 was not offered nor wore a smoking apron. Staff U stated the facility had recently got smoking aprons but was unaware of residents that required a smoking apron when smoking. When asked about facility staff training on being a supervisor during resident smoking times, Staff U stated had not taken the safety training like other staff had. Observation on 10/28/2024 at 1:48 PM showed Resident 29 outside during the afternoon's staff supervised smoking time. The resident was observed smoking and was not wearing the required smoking apron. During an interview on 10/28/2024 at 1:53 PM, Staff V, Activities Director, stated they were one of the staff that supervised residents during the smoking times. Staff V stated that Resident 29 was shaky sometimes and the residents had dexterity complications, so they were required to wear a smoking apron. During an interview on 10/28/2024 at 3:02 PM, Staff D, Resident Case Manager, stated they completed the initial smoking assessment/evaluation on Resident 29. Staff D stated the resident needed staff supervision and a smoking apron due to the history of cigarette burns in their clothing/history in conjunction with the resident dexterity issues. Staff D stated the resident had never refused to wear the smoking apron. During an interview on 10/29/2024 at 9:26 AM, Staff A, Administrator and Staff B, Director of Nursing Services (DNS), stated that Resident 29 should have been wear a smoking apron with their dexterity complications and history of burns in clothing form smoking. <Oxygen Storage> An observation on 10/22/2024 at 12:16 PM, showed the Central oxygen storage closet, located in the main hall of the East/West wing of the facility, contained 24 full oxygen cylinders; four cylinders were not secured. There was a sign posted on the inside of the closet door that showed O2 (oxygen) tanks are not to be left freestanding, please put them in the holder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 10/22/2024 at 3:35 PM, Staff G, Maintenance Director, stated the process for storing oxygen cylinders included performing a weekly check of the oxygen storage rooms to ensure the cylinders were in holders or chained to the walls. Staff G opened the storage room door and observed four oxygen cylinders that were not secured. They stated all cylinders needed to be in the rack and placed one in the rack. Staff G picked up the remaining three freestanding cylinders and carried them to the North wing oxygen storage room. Staff G stated they did not know why the four cylinders were not in a rack. They stated their process was to check the storage rooms weekly for safety, and with finding the four unsecured, the process is not working. During an interview on 10/29/2024 at 2:18 PM, Staff A, Administrator, stated the process for oxygen storage was to ensure they were stored in a secure area to prevent them from falling over. They stated the oxygen delivery driver had placed the oxygen cylinders in the storage closet and left them unsecured. Staff A stated that was not the normal process and the facility needed to ensure the cylinders were safely stored. <Chemicals> Review of the 12/06/2022 Safety Data Sheet [(SDS) a document that contains information about the hazards of a chemical or product and how to handle it safely] for Medline MicroKill Two Germicidal 1 Wipes (a brand of sanitizing wipes used on hard surfaces to kill germs, bacteria, and viruses), showed the chemical could cause serious eye damage and severe skin burns. Review of the 04/05/2024 SDS for PDI Super Sani-Cloth Germicidal Wipes (a brand of disinfecting wipe used for cleaning and disinfecting) showed precautions for safe handling included avoid contact with eyes and skin. An observation on 10/23/2024 at 11:36 AM, showed a container of Super Sani-Cloth Germicidal Wipes on a side table in the puzzle room. There was one resident, unsupervised, in the puzzle room area. An observation on 10/24/2024 at 11:32 AM, showed an unattended cart containing wound care supplies in the central hallway. There was a container of MicroKill Two wipes on top of the cart within reach of residents. An observation on 10/29/2024 at 9:19 AM, showed a container of MicroKill Two germicidal wipes on the East/West nurses' station, within reach of residents. There were three residents present. During an interview on 10/29/2024 at 2:08 PM, Staff B, DNS, stated the wipes could be left out, the residents like to use them to wipe down their own wheelchairs. Reference: WAC 388-97-1060(3)(g)

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	505096	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Post Acute	802 West Third Avenue Toppenish, WA 98948

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to identify and utilize an implanted bladder stimulator device [(InterStim) - an implantable device that treats urinary incontinence and overactive bladder by sending electrical pulses to the sacral nerves] used to treat urinary incontinence for 1 of 2 residents (Resident 5) reviewed for urinary incontinence (a loss of bladder control or involuntary urination). This failure placed the resident at risk for poor self-esteem related to dignity, skin impairments, continued urinary incontinence, and other health complications. Findings included . Review of the Medtronic InterStim guidance titled, Sacral Neuromodulation (the use of electrical or chemical stimulation to change nerve activity), dated 10/2024, showed the InterStim system was an implanted neurostimulator (a device that uses electrical stimulation to treat neurological disorders). The leads (wires) from the implanted device stimulate the sacral nerves that control normal bladder and bowel function. The InterStim device was indicated for the treatment of urinary retention and symptoms of an overactive bladder, including urinary urge incontinence. The InterStim device may be affected by or adversely affect cardiac devices, electrocautery (electric current to destroy abnormal tissue or control bleeding), defibrillators (a device that applies an electric charge or current to the heart to restore a normal heartbeat), ultrasonic equipment (a device that uses sound waves to detect and measure objects), radiation therapy, MRI [(Magnetic Resonance Imaging) - a test that produces detailed images of the internal structure of the body], and theft detectors/screening devices. <Resident 5> Review of the medical record showed Resident 5 was admitted to the facility on [DATE] with diagnoses including osteoarthritis (a condition that causes the breakdown of cartilage in the joints of the body, leading to pain and stiffness), muscle weakness, and need for assistance with personal cares. The 09/07/2024 comprehensive assessment showed Resident 5 required substantial/maximum assistance of one staff member for activities of daily living and was dependent on two staff members for transfers. The assessment also showed Resident 5 was frequently incontinent of urine and was cognitively intact. Record review of a hospital discharge summary dated 03/01/2023, showed Resident 5 had a history of urinary incontinence after InterStim device placement. Record review of a care plan, dated 08/24/2024, showed a focus area for bladder incontinence related to impaired mobility with overactive bladder. The interventions showed Resident 5 had some bladder control and wore briefs. There was no documentation that Resident 5 had a urologist (a medical doctor specializing in condition that affect the urinary tract) or an InterStim device for urinary incontinence. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/22/2024 at 10:27 AM, Resident 5 stated they had an implanted device to control their bladder incontinence. They stated it was not working because they did not have the remote to control it. Resident 5 stated they had not seen a urologist since they were admitted to the facility. Resident 5 stated the staff had not asked them about their implanted device or about seeing a urologist. During an interview on 10/28/2024 at 9:21 AM, Staff P, Nursing Assistant, stated they had worked at the facility for about six years and was responsible for daily cares for Resident 5. They stated Resident 5 had always been incontinent but did know when they needed to be changed. Staff P stated there was no scheduled toileting plan in place for the resident's incontinence, except for incontinent care as needed. During an interview on 10/28/2024 at 10:03 AM, Staff K, Resident Case Manager, stated they had worked in the facility for eight years. They stated Resident 5 would sometimes ask for a bedpan for toileting. Staff K stated Resident 5 had no cognitive impairments that would limit a bladder retraining program. Staff K stated they had not done a retraining program for Resident 5. Staff K stated they were not aware that Resident 5 had an implanted device for urinary incontinence. They stated Resident 5 did not have a urologist but was taking a medication to help with the incontinence. Staff K stated they would have expected to see the implanted device identified in the medical record, specifically on the care plan. During an interview on 10/29/2024 at 1:31 PM, Staff B, Director of Nursing Services, stated the process for accuracy of medical records on admission to the facility, included reviewing the referral and hospital discharge summary. They stated they listed out the identified medical concerns to ensure they have the means to care for the resident, prior to admission. Upon arrival, they performed a physical assessment of the resident to identify additional needs. Staff B stated the implanted device was something we would catch on admit. Staff B stated they did not see any urology appointments in Resident 5's medical record and there was no care plan for the device. They stated they were unsure why this was missed. Reference: WAC 388-97-1060(3)(c)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma informed care, complete with identified experiences and preferences regarding potential triggers (a stimulus that could prompt a recall of a previous traumatic event even if the stimulus itself is not traumatic or frightening) that may cause re-traumatization (a reliving of the traumatic experience) for 1 of 4 residents (Resident 29) reviewed for trauma informed care. This failure placed the resident at risk for unidentified triggers and re-traumatization. Findings included . Review of the policy titled, Trauma Informed Care, dated 08/01/2024, showed, Trauma-informed care is an approach aimed at identification of individuals with a trauma history and the development of care approaches that are sensitive to the individual needs . The policy showed identifying potential triggers and making modifications to care approaches and strategies would be a focus to order to avoid resident re-traumatization. <Resident 29> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including Post-Traumatic Stress Disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event), traumatic brain injury (TBI, a violent blow, jolt, or external force to the head or body), partial traumatic amputation of right great toe (a partial loss of the big toe due to a severe accident or injury), nightmare disorder (a sleep disorder characterized by repeated intense nightmares that most of center on threats to physical safety and security) and depression. The 09/12/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. During an interview on 10/23/2024 at 9:26 AM, Resident 29 stated they were injured overseas on a deployment in the military and there were potential triggers they knew of. They stated no staff member had talked with them about it. During a follow-up interview on 10/24/2024 at 9:59 AM, Resident 29 stated they had been blown up (involved in an explosion) overseas and was easily startled when woken from sleep/loud noises. Review of Resident 29's hospital history and physical report, dated 08/26/2024, and sent to the facility on [DATE], showed the resident was involved in multiple military war zone deployments, an explosion, and was a prisoner of war ([NAME]). Review of Resident 29's care plan, dated 09/09/2024, showed the resident was at risk for emotional trauma due to a history of .combat or exposure to a war zone . and PTSD. No care plan approaches or interventions were identified or made regarding Resident 29's combat, exposure to a war zone and/or their diagnosis of PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 29's social history assessment (which reviewed traumatic events), dated 09/13/2024, showed the resident had a transportation accident (for example, car accident, boat accident, train wreck, plane crash) that was marked and happened to Resident 29. Other traumatic events, Combat or exposure to a war zone (in the military or as a civilian) .Fire or explosion .captivity (for example, being kidnapped, abducted, held hostage, prisoner of war) were not checked for the resident and no other traumatic events were documented. During an interview on 10/28/2024 at 9:37 AM, Staff H, Social Services Director, stated they oversaw trauma informed care assessment on residents, documented the information under the social history assessment tab in a resident's record, and developed a care plan regarding identified triggers. Staff H stated Resident 29 was at war, saw a lot of people die in combat, and was deployed to different places/war zones. Staff H stated they remembered Resident 29 informing them about having flash backs and memories of times at war. When reviewing Resident 29's trauma informed care assessment and care plan, Staff H stated no triggers were identified or care planned. During an interview on 10/28/2024 at 11:09 AM, Staff E, Registered Nurse, stated Resident 29 had PTSD from events while being deployed overseas in the military. Staff E stated Resident 29 startles awake and will talk in (Resident 29's) sleep and had some nightmare's .have to be careful on how you wake (Resident 29) up . Staff E stated the resident was injured as a [NAME], did not get a lot of sleep, and had been known to stay up in a wheelchair all night. During an interview on 10/28/2024 at 3:02 PM Staff D, Resident Case Manager (RCM), and Staff C, Infection Preventionist/RCM, stated that Resident 29 had nightmares and did not like loud noises, you have to be careful not to startle (Resident 29) or catch (Resident 29) by surprise because the resident got upset and would start yelling. Staff D stated the known potential triggers for Resident 29 should be on the resident care plan and the correct process was not followed. During an interview on 10/29/2024 at 9:26 AM, Staff A, Administrator, and Staff B, Director of Nursing Services, stated they were aware of Resident 29's history of PTSD and being in a war zone, but did not know of any triggers that were identified. Staff A and Staff B stated that Resident 29 should have been accurately assessed for potential triggers with the resident's diagnosis of PTSD/known deployments to a war zone, being easily startled when sleeping and by loud noises, and an individualized care plan should have been implemented so all staff were aware of triggers that could cause re-traumatization. Reference: WAC 388-97-1060(3)(e)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent for 2 of 5 residents (Residents 218 and 1) observed during 27 medication administration opportunities that resulted in an error rate of 7.41 percent. This failure placed the residents at risk of not receiving the full therapeutic effect of the medication and potential adverse side effects. Findings included . Review of the Basaglar KwikPen (a pre-filled disposable device containing an insulin medication) instructions for use, dated ,d+[DATE], showed the insulin pen needed to be primed (removing air from the needle and cartridge that may have collected during normal use) before each injection. If the pen was not primed before each injection, too much or too little insulin could be delivered. Review of a policy titled, Medication Administration, dated ,d+[DATE], showed check expiration date on package/container .no expired medication will be administered to a resident. <Resident 218> Review of the medical record showed Resident 218 was admitted to the facility with diagnoses including aftercare for surgery on the skin, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and type two diabetes (a group of diseases that result in too much sugar in the blood) with a foot ulcer (an open sore or wound). The [DATE] comprehensive assessment showed Resident 218 required partial/moderate assistance with activities of daily living (ADLs). The assessment also showed the resident had an intact cognition. Review of the [DATE] Medication Administration Record (MAR), showed Resident 218 was to receive 20 units (a measurement) of Basaglar insulin, injected with an insulin pen, every morning. A concurrent observation and interview on [DATE] at 8:18 AM, showed Staff E, Registered Nurse, preparing an insulin pen for Resident 218. Staff E scrubbed the hub of the pen with an alcohol swab, attached the needle, and dialed up 20 units of Basaglar insulin on the insulin pen. Staff E cleaned the resident's skin with an alcohol swab then injected the 20 units of insulin into Resident 218's lower abdomen. Staff E did not prime the pen prior to administering the insulin. Staff E stated they did not know the insulin pen needed to be primed before dialing up the correct amount of insulin. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and heart failure. The [DATE] comprehensive assessment showed Resident 1 required set-up assistance from one staff member for ADLs. The assessment also showed Resident 1 had a severely impaired cognition. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent observation and interview on [DATE] at 8:51 AM, showed Staff L, Licensed Practical Nurse, preparing medications for Resident 1. Staff L obtained a package of medication from the medication cart, removed one tablet, placed it into the medication cup with other medications, and locked the medication cart. Staff L stated they were going to give the medications to Resident 1. Staff L was asked to review the expiration date on the medication prior to going into the resident room. Staff L stated the medication package showed the medication had expired on ,d+[DATE]. Staff L removed the medication from the medication cup and obtained a new package of medication with an expiration date of ,d+[DATE]. Staff L stated they were responsible for checking the expiration dates of all medications on their cart. Staff L stated they did not check the medication package because it had just arrived from the pharmacy, so they assumed it was good. During an interview on [DATE] at 1:54 PM, Staff B, Director of Nursing Services, stated the process for administering medication involved reviewing the physician order, the medication, the route of delivery, ensuring administration was to the correct resident, and checking the expiration date. Staff B stated the nurses on the medication carts were responsible for reviewing medication expiration dates. Staff B stated the process for administering insulin with a pen involved cleaning the hub of the pen, putting a needle on the pen, dialing up the correct amount of insulin, then injecting the insulin. Staff B stated they were not aware that the insulin pen needed to be primed. Reference: WAC [DATE](3)(k)(ii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39652 Based on observation, interview, and record review, the facility failed to consistently provide appetizing and palatable food for 4 of 7 residents (Residents 44, 34, 21, and 57) reviewed for food quality. Additionally, observations in the kitchen showed a delay in meal service which resulted in cold food served to the residents. These failures placed residents at risk for less than adequate nutritional intake and dissatisfaction with meals. Findings included . <Resident 44> Review of the resident's record showed they were admitted to the facility with diagnoses including diabetes (high levels of sugar in the blood), and chronic obstructive pulmonary disease (COPD, a chronic lung disease). Review of the comprehensive assessment, dated 08/01/2024, showed the resident was cognitively intact with no memory impairment. Review of Resident 44's physician orders for October 2024 showed their diet was a consistent, constant, controlled, carbohydrate (CCHO) diet with regular texture, which was commonly ordered for people with diabetes. During a concurrent observation and interview on 10/23/2024 at 1:29 PM, Resident 44 was sitting up in their bed with their lunch tray on the over bed table in front of them. Their lunch consisted of mushy tortellini pasta with a red sauce and some wilted spinach on the side. The resident looked at their lunch and stated it was not very good, as they had tasted it and discovered there was something wrong with it. The resident stated the food often tasted bad and was served cold. An observation on 10/30/2024 at 8:56 AM, showed Resident 44 sitting up in their bed with their breakfast on the over bed table. The meal consisted of leathery like eggs which were hard and cold. Additionally, there was a piece of plain bread with no butter or any other topping on it. Resident 44 stated, how do you like my toast, it's just a piece of dry bread they could have at least toasted it. The resident stated they would have eaten their cereal but there was too much sugar on it as they were diabetic. <Resident 34> Review of the resident's record showed they were admitted to the facility with diagnoses including dysphagia (impaired ability to swallow) and COPD. Review of the comprehensive assessment, dated 09/22/2024, showed the resident had mild cognitive impairment however was able to make their needs known. Review of Resident 34's October 2024 physician orders showed they were on a general (regular healthy meal plan) diet with mechanical soft (foods that are easy to chew and swallow) texture cut into bite sized pieces. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/2024 at 10:41 AM Resident 34 stated, the food is terrible, I have to use barbeque sauce to cover the taste and smell. The resident stated, something needs to be done about it. During a concurrent observation and interview on 10/23/2024 at 1:23 PM, Resident 34 was sitting up in their bed with their food tray on the over the bed table in front of them. The resident's meal consisted of a brownish red sauce and bite sized pieces of a light brown meat. The resident stated, I can't eat this stuff, I don't even know what it is. The resident pointed to two cans of tuna fish and a loaf of bread and stated, people from church brought me in some food to eat because the food here is so bad. <Resident 21> Review of the resident's medical record showed they were admitted to the facility with diagnosis including diabetes. The comprehensive assessment, dated 09/01/2024, showed the resident was cognitively intact with no memory impairment. Review of Resident 21's October 2024 physician orders showed they were on a CCHO diet with regular texture. During an interview on 10/23/2024 at 2:32 PM Resident 21 stated they were not happy with the food they were being served at the facility, as it was often cold and unappetizing. The resident further stated they disliked beets, and it was on their list of food dislikes, however every time we have beets I get served them. Resident 21 stated they also had concerns about too much sugar and carbohydrates served to them related to their diabetes. I have complained many times, but nothing gets done about it. <Resident 57> Review of the resident's record showed they were admitted to the facility with diagnoses including diabetes. The resident's comprehensive assessment, dated 09/04/2024, showed they were cognitively intact and required no assistance with eating except for meal set-up. Review of the October 2024 physicians' orders showed they had orders for a CCHO diet regular texture. During an interview on 10/23/2024 at 2:24 PM Resident 57 stated they were diabetic and were often served sugar products with their meals. They do not follow my diet restrictions at all. The resident stated they went to the kitchen themselves related to their food concerns, and no matter how often they complain nothing changed. 45117 <Kitchen> (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 10/24/2024 at 12:20 PM, showed Staff O, Cook, and Staff N, Dietary Aide, starting the lunch meal serve out, 20 minutes after the posted lunch meal start time. The first cart of lunch trays was sent out of the kitchen at 12:28 PM, the second at 12:36 PM, the third at 12:45 PM, and the fourth at 12:54 PM. At 1:01 PM, Staff O informed Staff M, Dietary Manager, that there were not enough pellet inserts (a warmed disc placed in the base of a plate holder to retain heat) for the plate warmers. There were six lunch meals that were placed in the meal tray cart that did not have pellet inserts, including the surveyor test tray. Staff M stated they frequently ran out of silverware and pellets for the warmers. They stated they go out on the meal trays but don't come back. At 1:06 PM, the final meal tray cart was sent out, one hour and six minutes after the posted mealtime. During a continued observation and interview on 10/24/2024 at 1:14 PM, showed a pureed meal, the noodles were a translucent, white, gel-like substance, with a scoop of a brown pureed substance (beef) on top. The meal included a scoop of pureed green peas on the plate. Staff M, stated the puree foods for the lunch meal was not appetizing and they would not eat it. At 1:14 PM, a surveyor test tray was removed from the last tray cart. Staff M took the temperature of the lunch meal surveyor test tray, which resulted as follows: beef stroganoff with noodles - 130.2 degrees Fahrenheit (F, a unit of measure). green peas - 106.4 F. Staff M stated those temperatures were not good and continued to take the temperature of the glass of milk, which measured 45.5 degrees F. Staff M stated the overall temperatures of the test tray were not good. Staff M stated they were aware of food temperature issues, and they needed to work on how the kitchen staff communicated with nursing staff to get trays to residents faster. Staff M stated they had extra pellet warmers and would need to get them into service. Staff M stated the posted time for the lunch meal of 12:00 PM meant the kitchen would start serve out at 12:00. They stated meal serve out was late due to kitchen staff taking their lunch breaks and cleaning the kitchen prior to the residents' meal serve out. During an interview on 10/29/2024 at 2:33 PM, Staff A, Administrator, stated the process for serving hot meals included following the times set for meal service. They stated kitchen staff needed to ensure there were enough pellets for the plate warmers to keep the food warm. Staff A stated they needed to fix the process. Reference: WAC 388-97-1100(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure periodic testing of sanitizing agents used for proper sanitation of food preparation surfaces in accordance with professional standards for food service safety, appropriate labeling of open foods, and that food delivery carts were clean, for 1 of 1 kitchen reviewed for safe food service. This failure placed residents, staff, and visitors that ate from the facility's kitchen at risk for food borne illnesses and the spread of infectious diseases. Findings included . Review of the policy titled, Food Preparation and Service, dated ,d+[DATE], showed food and nutrition services staff would prepare, distribute, and serve food in a manner that complied with safe food handling processes. Appropriate measures used to prevent cross contamination (the spread of chemical or disease-causing organisms transferred to food by hands, food contact surfaces, sponges, cloth towels, or utensils that were not adequately cleaned) included using sanitizing towels or cloths for wiping surfaces in a container filled with an approved sanitizing solution and at the concentration of sanitizer specified by the manufacturer of the solution. All food service equipment and utensils would be sanitized according to current guidelines and manufacturer's recommendations. Review of the policy titled, Discard Date, dated [DATE], showed foods were dated and prepared for storage to prevent deterioration, dehydration, or food borne illnesses. Leftover food that was to be served at a later date, would be wrapped, covered with plastic wrap or an approved plastic container, and stored in the appropriate manner. Leftover food would be labeled with the discard date which included the month and day. <Sanitation Buckets> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505096	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Post Acute	802 West Third Avenue Toppenish, WA 98948

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 8:35 AM, Staff N, Dietary Aide, was observed with a red bucket at the sink. Staff N stated the bucket contained a sanitation solution that was used to wipe countertops and food service carts. The staff member stated they had just changed the solution in the bucket. Staff N obtained a container of test strips to test the solution. They opened the container, obtained a strip and placed it into the bucket of solution for 15 seconds. Staff N removed the strip from the solution and stated, it did not pass. Observation of the container of test strips showed the strip needed to turn green to pass the test; the strip remained yellow. The expiration date on the container showed the strips expired in 2023. Staff N obtained a new container of test strips with an expiration date of 2026 and retested the solution. Observation showed the strip remained yellow. Staff N stated, it did not pass either. Staff N obtained a round container of testing strips and tested the solution again (no color change on the test strip), and stated it still did not pass. Staff M, Dietary Manager, tested the solution with the round container of strips, and had failed results. At 8:37 AM, Staff O, Cook, dumped their bucket of solution, filled the bucket with the premixed sanitation solution and tested the solution with the round container of testing paper and had passing results. Staff N then dumped their bucket of solution and tested with the round container of strips with passing results. Staff N stated they were trained on changing and testing the sanitizing solution when they were hired four years ago. They stated they changed the solution every hour and retested and logged the results on the log sheet posted on the walk-in refrigerator door. During an interview at 8:56 AM, Staff M stated they personally tested the sanitation buckets once weekly. They stated the process for staff was to test the sanitation solution in the buckets after each change and log the result on the form. They stated they were unsure if staff were testing the solution properly and I believe some are not doing it correctly. Staff M stated the sanitation log was probably not accurate and did not know what the sanitation solution instructions were. Staff M stated they did not have documentation of training or return demonstration for testing the sanitation solution. They stated there was no process in place regarding the safe use of the sanitation solution. <Food Storage> During an initial kitchen tour observation and interview on [DATE] at 8:55 AM with Staff M, Dietary Manager, showed a one-gallon pitcher of pre-made health shake in the refrigerator dated [DATE]. Staff M removed the pitcher from the refrigerator and stated they could not serve it to residents as it was no longer safe for resident consumption after three days. Further review of the walk-in refrigerator with Staff M, showed a plastic bag with yellow fluid and three hard boiled eggs, a small bowl with chopped ham and cheese that was near empty, covered with no label or date. Staff M stated the eggs and bowl of ham/cheese should have been labeled with the date opened or made. Observations of the dry goods area of the kitchen showed a brownie in a plastic bag, no label or date, on the shelf with the dry cereals. Staff M stated the brownie should not have been there and threw the brownie in the trash. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview with Staff M on [DATE] at 9:38 AM, showed the walk-in refrigerator contained a plastic bag of ham lunch meat in a bag. The bag was not sealed and was not labeled or dated. There were two half bags of lettuce mix that had been opened. One bag was dated [DATE] and the second bag was undated. There was a plastic bag of baby carrots that was previously opened, not sealed, and not labeled or dated. There was an opened plastic bag of shredded carrots that was twisted/tied in a knot with a date on the bag (under the knot). Staff M stated the date was [DATE]. There was a plastic bag of cilantro that had portions of it that were black and slimy/mushy. There was no label or date noted on the bag, and it was not sealed. Staff M stated the process for storing leftovers and/or open packages of food included placing the food in a plastic bag and label/date the package. Staff M stated the cooks were responsible for maintaining the foods in the refrigerator. Staff M stated that was not happening consistently. <Food Delivery Carts> During an observation on [DATE] at 12:20 PM through 1:09 PM, showed five food delivery carts were used for meal serve out. Each cart was made of stainless steel with two doors/four wheels and a gray rubber bumper around the base of the cart. The carts had white streaks on the outside, towards the base of the carts. The gray rubber bumpers were sticky with gray dust/debris stuck to the rubber and the wheels were rusty. At 1:09 PM, Staff M observed the carts with visible debris and rusty wheels. Staff M stated the carts looked dirty. They stated the staff were supposed to be wiping out the insides of the carts daily. Staff M stated the outside of the carts did not get wiped and needed to add the cleaning of the outside of the carts to the cleaning list. During an interview on [DATE] at 2:37 PM, Staff A, Administrator, stated there was a training issue in the kitchen for food safety. Reference: WAC [DATE](3)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45117 Based on observation and interview, the facility failed to properly dispose of kitchen refuse for 1 of 1 kitchen, reviewed for refuse disposal. This failure placed the facility at risk for attracting insects, rodents, and an unsanitary environment. Findings included . During an observation on 12/24/2024 at 12:38 PM, showed a fly in the kitchen, walking on the lipped plates that were being used during serve out. At 12:42 PM, a second fly was noted resting on the plates. An observation on 10/28/2024 at 12:41 PM, showed two black trash bags containing kitchen food garbage, on a cart located outside of the emergency exit of the kitchen/laundry hallway with snow peas scattered on the ground. There were flies, bees, and gnats swarming around the trash bags and snow peas. During an interview on 10/29/2024 at 12:47 PM, Staff O, Cook, stated they put the kitchen trash outside the door until later. During an interview on 10/29/2024 at 12:55 PM, Staff M, Dietary Manager, stated the process for removing trash from the kitchen included taking it to the dumpster right away and not leaving it outside the kitchen/laundry hallway door. Staff M stated the trash had been outside on the cart for at least 45 minutes. During an interview on 10/29/2024 at 1:04 PM, Staff G, Maintenance Director, stated they had a pest control program to control the flies in the building. They stated the process for trash included immediate disposal in the dumpster; not leaving it outside the door in the entry way. During an interview on 10/29/2024 at 2:34 PM, Staff A, Administrator, stated there were pest control measures in place. They stated the process for removing trash from the kitchen needed dealt with. Reference: WAC 388-97-1320(4)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39652 Based on interview and record review the facility failed to ensure a resident had the cognitive capacity to understand the nature and implication of entering into a binding arbitration agreement used to settle disputes without a jury trial for 1 of 3 residents (Resident 39) reviewed for arbitration. This failure placed the resident at risk for a lack of understanding of the legal contract they had signed and their right to make a choice for a jury trial in the event of a dispute with the facility. Findings included . <Resident 39> Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including, congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should) and bipolar disorder (a mental disorder that causes changes in mood and energy). Review of the comprehensive assessment, dated 10/09/2024, showed the resident had severe cognitive impairment with their Brief Interview of Mental Status (BIMS, a numerically scored test used to screen for cognitive impairments, a zero to seven score indicates severe cognitive impairment, an eight to 12 score indicates moderate cognitive impairment and a 13 to 15 indicates that a residents cognition is intact) scored at a three of 15. Review of the residents initial BIMS score dated 01/23/2024 showed a score of 6 which also indicated severe cognitive impairment. Record review of a three-page facility arbitration document in Resident 39's medical record titled Alternative Dispute Resolution Agreement, showed the agreement was between the resident and the facility, which stated that in the event of a dispute the resident would waive their right to a jury by trial in the federal or state court system. The document further showed the agreement would be explained in terms that Resident 39 would understand. The document showed the resident signed the agreement on 01/19/2024 when they admitted to the facility with two circles and two lines indicating their signature as they were unable to sign their name. During an interview on 10/22/2024 at 10:00 AM, Resident 39 indicated they lacked understanding of the facility arbitration agreement process. During an interview on 10/28/2024 at 11:00 AM, Staff H, Social Services Director, stated they presented the facility arbitration agreement during the admission process as a part of the admission paperwork to Resident 39. Staff H stated the resident did not have a power of attorney or legal guardian to sign for them and therefore the agreement was presented to the resident for their signature. When asked if Resident 39 had the capacity to understand the agreement when they were signing it, Staff H stated they had explained it to the resident however was not sure if Resident 39 had understood it. Reference: WAC 388-97-1620(2)(b)(i)