STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505206	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Timberline	400 East 33rd Street Vancouver, WA 98663

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to ensure residents were treated with respect and dignity to enhance their quality of life when a resident called out for help and a licensed nurse told the resident they could not help for 1 of 2 sampled residents (38) reviewed for resident rights. This failure placed residents at risk of not meeting their highest practical psychosocial well being, unmet care needs, and a diminished quality of life. Findings included . Resident 38 was admitted to the facility on [DATE] with diagnoses including depression and anxiety. The Quarterly Minimum Data Set assessment, dated 08/05/2024, indicated Resident 38 was moderately cognitively impaired. The care plan interventions/task, dated 09/06/2024, documented, [Resident 38] has increased anxiety when other people are angry or aggressive. Staff to speak calmly to her when communicating with her. Resident 38's care plan, dated 09/06/2024 and revised 01/08/2025, documented, Focus:[Resident 38] is at risk for depression/low mood r/t [related to] diagnosis of Depression. Review of Resident 38's progress notes, dated 01/18/2025 at 1:55 PM, documented Resident on alert r/t [related to] psychological distress. Resident displayed mild distress first thing this morning when I went in to see her to check blood sugar. She asked what I was doing here, and I told her I worked here. She seemed a little upset and requested to check her own blood sugar and I let her. I also explained to her that I wanted to get her pain meds on board before her shower. I went back in to talk with her about being upset and asking why I was here. She spoke with me a little bit. Then I went about the morning routine as usual and she was pleasant and cooperative with me the rest of my shift without any issue. A progress note, dated 01/19/2025 at 2:54 PM, documented LN [License Nurse] followed up with resident. She states that she is feeling much better today. Resident states that she received the care that she needed and denies any harm. However, she prefers to not have specific nurse [Staff G, Licensed Practical Nurse-LPN] tend to her. LN asked resident if she feels safe. Resident states that she feels safe and enjoys the nurse on shift today, and is not in any distress at this time. Care plan reviewed and updated. (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	On 01/21/2025 at 11:40 AM, Resident 38 said she had an incident with a nurse (Staff G, LPN), approximately a week ago. Resident 38 said she almost fell out of her bed and yelled out for help. Resident 38 said Staff G responded to Resident 38's call for help saying she was giving out medication. Resident 38 said Staff H, Certified Nursing Assistant (CNA), came into her room to help her and then another CNA (Staff J, CNA) came into the room to assist. On 01/24/2025 at 11:07 AM, Resident 38 stated, I lost my balance trying to sit up on the side of the bed. I just know that I said help help, I am falling. I have fallen many times before, but I have never called out that frantic before. I didn't know what else to do. I know I was going to land on the floor. Resident 38 stated, It made me feel like crap. I am already planning on stopping dialysis and slowly die. Having that happen made me feel like its okay for me to leave. I didn't feel like that before. Resident 38 said Staff G was in another section in the building the next day. When asked how Resident 38 knew Staff G was in another section of the building, Resident 38 stated, I asked one of the CNAs and they told me she was on another cart. In my mind I was nervous that she was going to be here that day. Resident 38 stated, After that incident, [Staff G] worked with me. I didn't like that she was here. It was uncomfortable. [Staff G] came in the room and asked is there was a problem that she should know about. I asked why are you here. I asked if you had a patient in distress would you help, and [Staff G] said she would. I didn't like the way I was feeling and I just stopped. Resident 38 stated, I told [Staff I, Infection Preventionist and Staff Development Coordinator] about what I had said to [Staff G]. I told [Staff I] if I was not able to get out of bed, if the building was burning, I don't think she [Staff G] would help. I told [Staff I] I don't feel comfortable with her [Staff G's] care. [Staff G] could have put the medication in a basket and come in to help [when Resident 38 was falling and called out for help]. At 3:04 PM, Staff I said on 01/16/2025, Staff H reported a concern saying she was not sure how to address it. Staff H told Staff I she heard Resident 38 yelling for help and Staff G yelled at Resident 38 that she could not help. Staff I stated, [Staff H and I] said that was abuse and needed to report it to [Staff A, Administrator]. Staff I said it was the expectation that Staff G should have locked the medication she had in the cart and went to assist Resident 38. On 01/27/2025 at 10:20 AM, Staff A said she was immediately made aware of the incident that occurred on 01/16/2025 in relation to Resident 38's interaction with Staff G. Staff A stated, The investigation completed was unsubstantiated. Staff A said Staff G had narcotics on the cart and called Staff H to assist Resident 38. At 10:49 AM, Staff H stated, On the 16th [01/16/2025] around 1:00 PM we were doing lunch. I pushed the cart down the hallway. I grabbed one tray and heard the nurse screaming a little bit. She had yelled a little bit. [The nurse] said I am busy. I have meds right now. My [Staff H's] plan was to deliver the tray I had. Then I heard another yell, and they [the person yelling] had yelled help me please two or three times. I walked into the room [room [ROOM NUMBER]] and Resident 38 was tangled in her oxygen tubing and a little bit frantic. The resident said I don't feel safe here with this nurse [Staff G]. I [Staff H] immediately went to report to a manger. When asked if Staff G had asked Staff H to go into Resident 38's room and assist her, Staff H stated, The nurse [Staff G] did not ask me to come and help the resident [Resident 38]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:11 PM, Staff J stated, I heard the nurse [Staff G] say to Resident 38, I can't come. I have narcotics out. [Staff G] asked me to assist Resident 38. I went into room [ROOM NUMBER] and saw [Staff H] trying to assist Resident 38 get untangled. Staff J said she did not recall seeing Staff H going into Resident 38's room and she found Staff H in the room already assisting Resident 38. Additional documentation provided by the facility on 01/29/2025 included SSD (Social Services Director) follow up note, dated 01/28/2025, documented Resident 38's recount of her interaction with Staff G. Per the follow-up note, Resident 38 stated, After yelling for help several times, [Staff G] screamed at me that she couldn't help me right now because she was holding medications . Per SSD follow-up note, Resident 38 indicated she did not trust Staff G with her care and seeing Staff G on the day SSD followed up, triggered Resident 38's PTSD (Post-traumatic Stress Disorder) and anxiety. Additional documentation provided by the facility on 01/29/2025 included a Primary physician progress note, undated, with a print date of 01/29/2025, documented a conversation between the provider and Resident 38. The progress notes highlighted Resident 38's past medical and psychosocial history and documented, Unfortunately, [Resident 38] feels that she was inappropriately treated by the nurse who noted she was busy at the time, and subsequently feels that she cannot trust this nurse to have her care as a top priority in her day to day operations . The progress note documented Resident 38's personal history of abuse and panic attacks and the event that occurred on 01/16/2025 triggered her response. On 01/30/2025 at 10:56 AM, Staff G said she was standing at her medication cart and had liquid medication and narcotics belonging to the resident in room [ROOM NUMBER] in her hand. Staff G stated, Resident 38 was calling my name as she usually does, and I had a CNA go check on her. When asked which CNA she asked to check on Resident 38, Staff G stated, I asked [Staff H] to go check on Resident 38. When asked if Resident 38 was calling out saying help, Staff G stated, Resident 38 did not call out for help. Reference WAC 388-97-0180 (1-4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was completed accurately to reflect a resident's health status and/or care needs for 1 of 4 sampled residents (3) reviewed for assessment accuracy. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included . Resident 3 was admitted to the facility on [DATE] with diagnoses including diabetes mellitus. The Admission MDS, dated [DATE], showed Resident 3 was alert and oriented, had diabetes mellitus, and did not receive insulin (a medication used to help regulate blood sugar levels and treat diabetes) injections in the last 7 days. Review of Resident 3's November 2024 Electronic Medication Administration Record (EMAR), documented Resident 3 received Insulin Lispro (a type of rapid-acting insulin) on 11/11/2024, 11/12/2024, 11/13/2024, 11/14/2024, 11/15/2024, 11/16/2024, and 11/17/2024. The November 2024 EMAR also showed Resident 3 received Insulin Glargine (a type of long-acting insulin) on 11/12/2024, 11/13/2024, 11/14/2024, 11/15/2024, 11/16/2024, and 11/17/2024. On 01/23/2025 at 10:43 AM, Staff B; Interim Director of Nursing Services, MDS Coordinator, and Registered Nurse; said they looked at the Electronic Health Record (EHR), including the EMAR, to gather information to complete the MDS. After looking at Resident 3's EHR, Staff B said Resident 3 received insulin that was not coded correctly on the MDS. Staff B stated, Yes, we will need to modify it [MDS]. Staff B said it was her expectation the MDS was completed accurately to reflect the resident and the care received. Reference WAC 388-97-1000 (1)(b), (2)(n)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47518 Based on interview and record review, the facility failed to ensure the recommendations of the Level II Preadmission Screen and Resident Review (PASARR) were implemented upon receiving recommendations for 2 of 8 sampled residents (55 & 38) reviewed for coordination of PASARR and assessments. This failure placed residents at risk of not receiving the necessary mental health services and a diminished quality of life. Findings included . 1) Resident 55 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder, Post-Traumatic Stress Disorder, and Suicide Attempt. The Admission/Medicare 5-day Minimum Data Set (MDS) assessment, dated 11/30/2024, indicated Resident 55 was alert and oriented. Review of Resident 55's Level I PASARR, dated 11/24/2024, showed, Level II evaluation referral required for SMI [serious mental illness]. Review of Resident 55's Level II PASARR, dated 11/25/2024, documented: Recommendations for Plan of Care . B. Recommendations for Nursing Facility 1. Environment Encourage him to focus on his goals for the future, purposeful activities, and DC plans. 2. Staff approaches/training [Resident 55] reported being irritated when others assist him. Encourage him to complete tasks on his own when he is able and avoid doing things for him that he can do on his own. Provide support and reassurance when assistance is needed. 3. Behavioral supports Monitor for symptoms of depression and anxiety as evidenced by social withdrawal, agitation, anger, negative statements, irritability, and overall mood presentation. Document changes when observed and update care plans as needed. 4. Activities Encourage daily activities for mental stimulation and improved emotional well-being. 5. Other (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident 55] has a history of suicidal ideation when frustrated or overwhelmed. Listen and validate his concerns without being dismissive before providing support or reassurance. Avoid multitasking or rushing to reduce risk of frustration when completing tasks. Contact emergency services if he appears at increased risk of self-harm, as evidenced by increased statements of hopelessness. Review of Resident 55's Level II PASARR care plan, initiated 12/26/2024, 31 days after admission, did not show Interventions/Tasks related to numbers 2, 4, and 5 referenced above as Recommended for Plan of Care on the Level II PASARR. Review of Resident 55's Impaired Cognitive Function/Thought Processes care plan, dated 11/25/2024, showed Interventions/Tasks including PASARR Level II Recommendations as initiated on 01/21/2025, 57 days after admission. On 01/24/2025 at 11:11 AM, Staff C, Regional Patient Advocacy Resource, said a resident should be seen at the hospital for the Level II PASARR evaluation, if identified as required, prior to admission. Staff C said the recommendations for the facility would then be incorporated into the care plan from the Level II PASARR evaluation. When asked how soon the recommendations are incorporated into the care plan, Staff C said it depended on when they received the summary for the Level II PASARR. When asked about when the Level II PASARR was received for Resident 55, Staff C said she did not know, and stated, Let me check on that. When asked if Resident 55's care plan recommendations for the Level II PASARR were not added until 01/21/2025, Staff C nodded her head, indicating yes. At 11:26 AM, Staff C said the facility received Resident 55's Level II PASARR evaluation and recommendations on 12/20/2024 and were not completed in the care plan until 01/21/2025. Staff C stated, It should have been incorporated sooner than that. I agree with that, yes . It should be as soon as possible. On 01/27/2025 at 10:45 AM, Staff A, Administrator, said they received Level II PASARR recommendations for Resident 55 on 12/20/2024. Staff A nodded her head, indicating yes; and indicated they should have been implemented into the care plan prior to 01/21/2025. 50416 2) Resident 38 was admitted to the facility on [DATE] with diagnoses including Depression and Anxiety Disorder. The Quarterly MDS assessment, dated 08/05/2024, indicated Resident 38 was moderately cognitively impaired. Review of Resident 38's Level II PASARR evaluation, dated 06/11/2024, and reviewed by Psychiatrist on 07/25/2024 and 07/27/2024, documented: Recommendations for Plan of Care . B. Recommendations for Nursing Facility 1. Environment (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Resident 38] reported a history of night terrors. Encourage her to avoid watching television prior to bedtime. Provide support and reassure her that she is safe if she wakes from a nightmare. Quickly ask her to think about her current environment, including sights, smells, and textures. 2. Staff approaches/training [Resident 38] reported increased anxiety or depression when other people are angry or aggressive. Attempt to assign her to a room that is not near the entrance or nursing station to reduce risk of loud noise. Speak calmly to her when communication with her. 3. Behavioral supports Monitor for symptoms of depression and anxiety as evidenced by social withdrawal, agitation, disinterest in activities, tearfulness, changes in sleep, and overall presentation. Document changes when observed and update care plans as needed. Provide female staff for personal care. Male caregiver should identify themselves prior to entering the room and should not attempt to provide personal care. 4. Activities Encourage daily activities for mental stimulation and improved emotional well-being. 5. Other Provide female staff for personal care. Male caregiver should identify themselves prior to entering the room and should not attempt to provide personal care. Review of Resident 38's care plan showed PASARR Level II Recommendations were initiated 01/20/2025, seven months after Level II PASARR evaluation was completed. On 01/23/2025 at 11:36 AM, when asked what the facility's process was for following up on Level II PASARR evaluations, Staff C said the facility did monthly follow ups. Staff C said the evaluation was completed in 07/2024 and was updated to the care plan on 01/20/2025. Staff C said Social Services was responsible for updating Level II PASARR recommendations into Resident 38's care plan. Reference WAC 388-97-1975 (10)

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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** 46751 Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASARR) assessment accurately reflected the resident's mental health diagnoses and Level II PASARR evaluations were referred and completed timely for 1 of 8 sampled residents (15) reviewed for PASARRs. This failure placed residents at risk for inappropriate placement, not receiving timely and necessary mental health services to meet their mental health needs, and a diminished quality of life. Findings included . Resident 15 was admitted to the facility on [DATE] with diagnoses including Adjustment Disorder (psychiatric diagnosis characterized by unhealthy reaction to a stressful event), and Bipolar Disorder (psychiatric diagnosis characterized by extreme mood and emotional states). The Admission Minimum Data Set assessment, dated 11/13/2024, documented the resident was moderately cognitively impaired. A Level I PASARR, dated 11/07/2024, documented Resident 15 had a diagnosis of Adjustment Disorder, with no indicators of Serious Mental Illness (SMI) requiring a Level II PASARR. Per the Level I PASARR, a Level II must be completed if scheduled discharge does not occur. The Electronic Health Record (EHR) documented Resident 15 had a diagnosis of Bipolar Disorder and physician's order for Ripiprazole (an antipsychotic medication). The EHR did not include a Level II PASARR, or a referral for Level II PASARR for Resident 15. On 01/24/2025 at 9:36 AM, Staff C, Social Worker and Patient Advocacy, said residents' Level I PASARR should be sent for a Level II within 30 days if there is was not a discharge. Staff C said the facility received an inaccurate Level I PASARR prior to Resident 15's admission from the hospital and was unable to provide documentation of a Level II referral. Staff C stated, It should be marked and sent in for a Level II. At 11:10 AM, Staff A, Administrator, said she would expect accurate completion and referral of PASARR for residents. Reference: WAC 388-97-1915 (1)(2) (a-c)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50416 Based on interview and record review, the facility failed to provide care and services according to professional standards of practice when insulin was not held as per physician orders for 1 of 5 sampled residents (54) reviewed for care provided meeting professional standards. This placed the residents at risk for medical complications and a diminished quality of life. Findings included . Resident 54 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus (a chronic condition that affects how the body uses sugar (glucose) for energy). Review of Resident's 54's record showed a physician order, dated 12/05/2024, for Insulin Lispro Injection Solution (Insulin Lispro) Inject 2 unit subcutaneously with meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS (E11.9) HOLD for CBG (Capillary Blood Glucose-blood sugar) < (Less than) 100. Review of Resident 54's January 2025 blood glucose summary documented CBG level of 91.0 mg/dL (milligrams per deciliter) on 01/07/2025 at 8:10 AM and 90mg/dl on 01/14/2025 at 1:25 PM. Review of Resident 54's January 2025 Medication Administration Record (MAR) documented Insulin Lispro Injection Solution was administered to Resident 54 on 01/07/2025 morning and 01/14/2025 afternoon. On 01/23/2025 at 11:26 AM, Staff D, Resident Care Manager and Licensed Practical Nurse, said the expectation was if Resident 54's CBG was less than 100mg/dL, the medication would have been held per the physician's order. After reviewing Resident 54's January 2025 MAR, Staff D said the MAR showed Lispro Injection Solution had been administered on 01/07/2025 morning and 01/14/2025 afternoon. Reference WAC 388-97-1620 (2)(b)(i)(ii) .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37934 Based on observation, interview and record review, the facility failed to ensure activities of daily living (ADLs) were provided for dependent residents including nail care for 1 of 2 sampled residents (25) reviewed for ADLs. This failure placed residents at risk of not receiving the care and services needed for which they cannot perform themselves and a diminished quality of life. Findings included . Resident 25 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment, dated 12/04/2024, indicated Resident 25 was alert and oriented, and needed substantial/maximal assistance with shower/bathe and needed supervision or touching assistance with personal hygiene. The nail care, care plan for Resident 25, dated 06/23/2022, noted avoid scratching and keep hands and body from excessive moisture. Keep fingernails short. The Tub/Shower task documented Resident 25's had a shower on 01/14/2025 and on 01/18/2025. On 01/21/2025 at 11:05 AM, Resident 25 was observed with fingernails that appeared to be about 1/3 of an inch long. Resident 25 said he liked his fingernails short. On 01/23/2025 at 9:09 AM, Resident 25 said his last shower was on 01/18/2025. The resident's fingernails were observed to be about 1/3 of an inch long. At 2:33 PM, Staff K, Staffing Coordinator and Certified Nursing Assistant Supervisor, said resident showers included nail care. Staff K said Resident 25's Kardex (nurse assistants' reference for patient information) indicated to keep fingernails short. At 2:43 PM, Staff L, Resident Care Manager and Licensed Practical Nurse, said nail care was a part of resident showers. Reference WAC 388-97-1060 (2)(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** 46751 Based on interviews and record review, the facility failed to ensure bowel management interventions were initiated for 2 of 6 sampled residents (15 & 45) and failed to ensure dental care was completed for 1 of 2 sampled residents (20) reviewed for quality of care. These failures placed residents at risk for discomfort, health complications and a diminished quality of life. Findings included . <Bowel Management> The facility's policy entitled, House Bowel Protocol/Constipation, updated 04/02/2024, documented to implement the following interventions: -- Miralax [laxative]- Give 17 grams PRN for no BM [bowel movement] x3 days --Dulcolax Suppository 10mg- Insert one suppository daily PRN (if Miralax ineffective) --Fleet Enema 7-19 GM/118 ML QD PRN (if Miralax and suppository ineffective) --May administer Miralax up to three times daily PRN until BM. May schedule Miralax up to three times daily. 1) Resident 15 was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 11/13/2024, documented the resident was moderately cognitively impaired. The January 2025 Bowel Movement task sheet documented Resident 15 had a BM (bowel movement) on 01/12/2025 at 1:59 PM, and did not have another BM until 01/17/2025 at 11:09 AM, over 117 hours (over 4 1/2 days) since her last BM. Resident 15's January 2025 Medication Administration Record (MAR), and January 2025 Progress Notes, did not show the bowel protocol was initiated. 2) Resident 45 was admitted to the facility on [DATE]. The Admission 5-Day MDS assessment, dated 11/30/2024, documented the resident was moderately cognitively impaired. The December 2024 Bowel Movement task sheet documented Resident 45 had a BM on 12/27/2024 at 11:59 PM, and did not have another BM until 12/31/2024 at 5:48 PM, over 89 hours (over 3 1/2 days) since her last BM. The December 2024 and January 2025 Bowel Movement task sheet documented Resident 45 had a BM on 12/31/2024 at 5:48 PM, and did not have another BM until 01/04/2025 at 6:21 PM, over 96 hours (over 4 days) since her last BM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505206	A. Building B. Wing	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Timberline	400 East 33rd Street Vancouver, WA 98663

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The January 2025 Bowel Movement task sheet documented Resident 45 had a BM on 01/15/2025 at 11:53 AM, and did not have another BM until 01/19/2025 at 2:06 PM, over 98 hours (over 4 days) since her last BM. Resident 45's December 2024 and January 2025 Medication Administration Record (MAR), and December 2024 and January 2025 Progress Notes, did not show the bowel protocol was initiated. On 01/23/2025 at 10:57 AM, Staff E, Licensed Practical Nurse (LPN), said if a resident did not have a BM in over three days, they would be started on Miralax on the very next shift. If that was not effective, the resident would be given a suppository, and enema. Staff E stated, We are charting what was given in MAR, even refusals. On 01/24/2025 at 9:50 AM, Staff D, LPN and Resident Care Manager (RCM), said the BM protocol should have been initiated per facility bowel policy for both residents. Staff D was unable to provide additional documentation showing how the bowel protocol was initiated. Staff D said BM interventions should have been given on 1/15/2025 in the PM for Resident 45. At 11:10 AM, Staff A, Administrator, said the BM protocol should have been started at day 3 per policy. Staff A was unable to provide further documentation. 51254 <Dental> Resident 20 was admitted to the facility on [DATE] for long term care placement. The Quarterly MDS assessment, dated 12/31/2024, indicated Resident 20 was moderately cognitively impaired. Review of the Electronic Health Record (EHR) for Resident 20 showed a referral was sent for an emergency appointment for teeth extraction on 11/30/2023. Resident 20 was seen by a local dental office on 12/07/2023, with teeth extractions arranged with another dental office on 01/10/2024, and subsequent denture fitting and placement at the first local dental office on 02/07/2024. No further documentation was found in the EHR indicating that Resident 20 attended the appointments on 01/10/2024 or 02/07/2024. On 01/21/2025 at 10:20 AM, Resident 20 said he would like to get his teeth pulled and some dentures made as his teeth were all rotten. Resident 20 said he was unsure what was taking so long but would still like to pursue denture placement. On 01/23/2025 at 2:33 PM, Staff C, Social Services and Patient Advocacy Resource, said she was unsure about specific resident dental concerns, but would review the EHR for documentation. Staff C was unable to provide documentation related to dental care for Resident 20. At 4:09 PM, Staff D, Licensed Practical Nurse and Resident Care Manager, said she was not sure why the appointment for Resident 20 was not rescheduled after 01/10/2024. Staff D was unable to provide documentation as to why Resident 20 was not seen for the teeth extraction and denture fitting as planned. (continued on next page)

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	505206	A. Building B. Wing	01/27/2025

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The Oaks at Timberline	400 East 33rd Street Vancouver, WA 98663

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/24/2025 at 10:20 AM, Staff B, Registered Nurse and Interim Director of Nursing Services, indicated she looked for communication from Resident 20's guardian to determine why the dental appointments had not been attended or rescheduled. Staff B was unable to provide documentation to support why the dental procedure had not been rescheduled. At 1:36 PM, Staff A, Administrator, said there was generally documentation in the EHR to support why the resident did not go to an appointment, or why it had not been rescheduled in the last year. Staff A said 12 months was longer than it should take to have a new appointment arranged. Reference WAC 388-97-1060 (1), (3)(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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46751 Based on observation and interview, the facility failed to ensure food items were labeled and had when opened dates in 1 of 1 kitchen walk-in refrigerators reviewed for food storage in a sanitary manner. This failure placed residents at risk for cross-contamination, food borne illness, and a diminished quality of life. Findings included . On [DATE] at 10:21 AM, the kitchen walk-in refrigerator was observed with the following expired, undated, and unlabeled opened items: 1. Jar of Maraschino Cherries- labeled with use by date of [DATE] 2. Jar of Peeled Garlic- labeled with use by date of [DATE] 3. Jar of Worcestershire Sauce- labeled with use by date of [DATE] 4. Jar of Raspberry Vinaigrette Dressing- not labeled or dated 5. Bag of shredded [NAME] Cheddar Cheese- not labeled or dated On [DATE] at 10:29 AM, Staff F, Dietary Supervisor, said the facility had a three day policy for opened items, and use-by-date for unopened items. Staff F was observed throwing away the identified items, and stated, These should not be there. On [DATE] at 11:10 AM, Staff A, Administrator, said she expected food items in the refrigerators and freezers to be dated and labeled per facility practice. Reference WAC [DATE] (3) & -2980