STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505217	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation at Ridgemont	2051 Pottery Avenue Port Orchard, WA 98366

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 42960 Based on interview and record review, the facility failed to ensure residents with personal funds/resident trust accounts had ready access to their accounts during evenings and weekends for 11 of 11 residents reviewed for person funds accounts. This failure placed residents at risk of not having access to their accounts during non-banking hours, a decreased sense of autonomy and a diminished quality of life. Findings included . On 08/21/2024 at 1:02 PM, Resident 3 said they had a family member open another bank account for them because they could not withdraw money from their personal funds account on the weekends. On 8/26/2024 at 9:37 AM, Staff H, Licensed Practical Nurse (LPN), said she did not know the process if a resident wanted to withdraw money from their personal funds account over the weekend or after hours. At 9:40 AM, Staff C, LPN Resident Care Manager, said she did not know how a resident could withdraw funds from their Personal Funds account on the weekends and she said she would contact the business office to find out. At 9:50 AM, Staff I, Receptionist, said residents could withdraw money from their Personal Funds account through activities on the weekends but did not now know how they could withdraw money from their account if activities was not there. At 9:51 AM, Staff G, Business Office Manager, said there was a sign for residents with personal funds that said, Front Desk Resident Banking Hours 8:00 AM - 4:30 PM Monday - Friday Saturday & Sunday See Activities and when asked what the residents should do when activities was not in the building she acknowledged the sign needed to be changed. On 8/27/2024 at 11:42 AM, Staff A, Administrator, said they would educate staff on how residents could withdraw money from their personal funds account on the weekend and after hours. Reference (WAC) 388-97-0340 (1)(2)(3)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37044 Based on observation and interview, the facility failed to provide a clean, comfortable and homelike environment on 1 of 4 hallways (200 hall). The failure to ensure hallway carpeting was clean and in good repair and resident rooms were mopped and free of sticky substances, placed resident at risk for a diminished quality of life, and resulted in a less than homelike environment. Findings included . On 08/21/2024 at 10:28 AM, observation of the 200-hall carpet showed an approximately 30-foot-long vertical cut right down the middle of the hallway carpet, and multiple five to eight feet long, horizontal cuts in the carpet running side to side across the hallway. Each of the vertical and horizontal cuts were covered with duct tape. At 10:30 AM, when asked about the state of the carpet, an anonymous staff member stated, oh you noticed that [carpet in disrepair]. I can't stand it. The staff member indicated the carpet had been in that state for a few years. On 08/22/2024 at 11:55 AM, when asked about the environment, Resident 65 stated, [The hallway carpet] is disgusting. I find it insulting. Do I find it homelike? What? No! When I first saw it, I thought they must be replacing it, but no. At 3:12 PM, Staff D, Maintenance Director, explained that for greater than two years prior, the carpet on the 200 hall had been bunching up resulting in potential tripping/safety hazards. Staff D said he had to cut the carpet to try and stretch the carpet in the areas where it was bunching up. After the bunched-up areas were addressed, the cuts in the carpet were covered with duct tape and bids were obtained for replacement of the carpet. According to Staff D, the facility then went through several Administrators. Staff D said with each change in administration, Staff D had to obtain a new bid for replacement of the carpet which had continuously set the project back. Staff D stated, I know I have told the [state] survey team for a few years that the carpet was going to be replaced because it was, but like I said then the administrators would change, and the carpet [replacement] quote process would start over. At 3:21 PM, when asked if the facility had a work order or had moved beyond just obtaining bids Staff D, stated, No. Reference WAC 388-97-0880 (1)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46793 Based on interview and record review, the facility failed to provide residents a written notice detailing the reasons for discharge/transfer and to provide a copy of the notice to the state Ombudsman office as required for 2 of 2 sampled residents (Resident 27 & 75) reviewed for hospitalization s. This failure placed residents at risk for inappropriate transfers and a lack of information regarding their rights and options related to bed-holds. Findings included . Facility policy, titled, Transfer or Discharge Notice, dated March 2021, documented Residents and/or representatives are notified in writing, and in a language and format they understand, at least thirty (30) days prior to a transfer or discharge. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. Resident 27 was admitted to the facility on [DATE]. The Admission Minimal Data Set, (MDS, an assessment tool) date 07/23/2023, documented Resident 27 was severely cognitively impaired. Resident 27 was hospitalized from 07/23/2024 until their return on 07/29/2024. The Electronic Health Record (EHR) showed no documentation of a transfer notice or Ombudsman notification. Resident 75 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 75 was cognitively intact. Resident 75 was hospitalized from 06/08/2024. The EHR showed no documentation of a transfer notice or Ombudsman notification. On 08/26/2024 at 1:15 PM, Staff C, Resident Care Manager, said they did not have a copy of the transfer notice or Ombudsman notification for either resident. When asked if a transfer notice/Ombudsman notification should have been completed, Staff C said yes. At 1:18 PM Staff N, Social Services Director, stated, I am responsible for the Ombudsman notification, and provided a copy of the Ombudsman notification list of transferred residents for June and July 2024. Resident 27 nor Resident 75 were on the list. Staff N said both residents should have been on the transfer list to the Ombudsman. Reference WAC 388-97-0120 (2) (a-d) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to provide Care Conferences (a conference where staff and residents/families talk about life in the facility, review the progress of resident and make adjustments, as needed, to their care), for 1 of 2 sampled residents (Resident 13) reviewed for provision of care conferences, and failed to ensure care plans were reviewed, revised, and accurately reflected resident care needs for 4 of 21 sample residents (Residents 16, 48, 63, & 8) reviewed for care plan timing and revision. These failures placed residents at risk of not feeling involved in the development of their plan of care, unmet needs, and a diminished quality of life. Findings included . <Care Plans> 1) Resident 48 admitted to the facility on [DATE]. Review of the 5-day Minimum Data Set (MDS, an assessment tool), dated 07/22/2024, showed the resident had intravenous (IV) access via a midline and received IV medications. A 07/27/2024 re-admission nurse's note documented the resident had a midline (a tube that is placed into a vein, usually in the arm. The catheter is then moved through the vein until the tip sits at the level of your armpit and away from the shoulder) to their left upper arm and were to receive IV Daptomycin (an antibiotic). Resident 48's comprehensive care plan (CP) showed no care plan was developed that addressed the presence, or type and location of the Resident 48's IV access. No interventions were developed and/or implemented that directed staff how to assess, monitor, and care for the IV access. On 08/26/2024 at 3:27 PM, Staff B, Director of Nursing Services (DNS), said the location and type of IV access and maintenance and monitoring instructions should be care planned. When asked if they were Staff B stated, No. 2) Resident 16 admitted to the facility on [DATE]. Review of the 5-day MDS, dated [DATE], showed the resident had IV access via a midline and received IV medications. An Admission Nursing Database assessment, dated 08/07/2024, documented Resident 16 had IV access via a midline to their right upper arm for antibiotic therapy related osteomyelitis (bone infection) of the left tibia and fibula (lower leg bones). Resident 16's comprehensive CP showed no care plan was developed that addressed the type and location of the Resident 16's IV access. On 08/26/2024 at 3:27 PM, when asked if the type and location of Resident 16's IV access was care planned Staff B, DNS, stated, No. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) Resident 63 admitted to the facility on [DATE]. Review of the 5-day MDS, dated [DATE], showed the resident had a diagnosis of obstructive sleep apnea (OSA, a sleep-related breathing disorder where people repeatedly stop and start breathing while they sleep) and did not use a continuous positive airway pressure (CPAP, a machine that uses mild pressure to keep the breathing airways open during sleep) machine or Bilevel Positive Airway Pressure (BiPAP, a non-invasive ventilation therapy used to treat sleep apnea, respiratory failure, and other breathing disorders) machine. On 08/06/2024 an order directed staff to apply CPAP at bedtime per set settings and remove in the AM. A CPAP therapy CP, revised 08/06/2024, directed staff to encourage resident to use their CPAP or BiPAP, but failed to identify which one the resident was to receive. The CP did not identify the CPAP settings or provide instruction for the cleaning and maintenance of the CPAP mask and machine, or identify the CPAP had a humidifier chamber, which needed to be checked and filled. On 08/26/2024 at 3:31 PM, Staff B, DNS, said Resident 63's CP should have identified the type of non-invasive ventilation the resident was to receive (CPAP vs. BiPAP) and provided resident specific care instructions related to their CPAP machine. 4) Resident 8 admitted to the facility on [DATE]. Review of the Significant change MDS, dated [DATE], showed the resident had impaired functional Range of Motion (ROM) to one upper and one lower extremity and did not receive restorative nursing services. Review of a self-care deficit CP, revised 06/13/2024, showed staff were to provide passive ROM to both upper and lower extremities, times fifteen repetitions and perform hand hygiene and gentle stretching of the resident's left hand, before applying a left-hand splint in the am. The care plan did not identify what joints and planes should be ranged or the frequency at which staff should provide the programs (e.g. daily, six times a week etc.) On 08/27/2024 at 2:38 PM, Staff B, DNS, stated the frequency at which the ROM program was to be provided, should have been care planned but was not. 42960 <Care Conferences> Resident 13 was admitted to the facility on [DATE] with diagnoses including Parkinson (neurodegenerative brain conditions that causes motor symptoms) and bipolar disorder (characterized by both manic and depressive episodes). The Quarterly MDS, dated [DATE], documented the resident was cognitively intact and felt it was very important to have family involved in discussions about their care. On 08/22/2024 at 10:55 AM, Resident 13 said they had not had a care conference recently. Review of the electronic health record (EHR) showed a care conference was conducted on 08/03/2023. On 8/26/2024 at 2:36 PM, Staff K, Social Services Coordinator, said Resident 13's last care conference was over a year ago in August 2023. Staff K said Resident 13's care conferences did not happen as often as they should have and Staff K said they had no excuses. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/2024 at 11:11 AM, Staff B, DNS said the expectation was for the care conferences to be done quarterly. Staff B said there was a note contacting the family to set up a care conference on 03/14/2024 but no further documentation after that. Reference WAC 388-97 -1020(2)(c)(d)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure 1 of 2 residents (Resident 63) reviewed for communication and sensory and who required assistive devices for vision or hearing were assisted with application of their glasses. Failure to ensure their glasses were in good repair and applied to the resident daily precluded the resident from reading the activity calendar and menus independently and placed them at risk for feelings of diminished self worth and decreased quality of life. Findings included . Resident 10 admitted to the facility on [DATE]. Review of the 07/09/2024 Quarterly Minimum Data Set (MDS, an assessment tool), showed the resident's vision was adequate with the use of corrective lenses. A self care deficit care plan, revised 08/24/2023, showed the resident wore glasses during waking hours, as well as at night as the resident would often wake up and read. Staff were directed to keep the resident's glasses within reach for independent use, and make sure the glasses were clean. On 08/22/2024 at 11:30 AM, Resident 10 was observed lying in bed without their glasses in place. The resident's glasses were observed in a kidney basin on a three drawer chest located on the other side of a divider curtain. The glasses were not in the resident's sight or reach. The glasses were observed to only have one lens in place. The other lens was lying in the bottom of the basin. Resident 10 said they did not know where their glasses were currently at but indicated they had been broken. Resident 10 said staff were aware but No one does anything! When asked if they required their glasses for activities of daily living, the resident said they used them for reading. Similar observations were made on 08/23/2024 at 1:41 PM, 08/26/2024 at 11:19 AM and 1:43 PM and 08/27/2024 at 12:09 PM. On 08/27/2024 at 1:05 PM, Staff C, Resident Care Manager, confirmed Resident 10's glasses were in a kidney basin on the other side of the divider curtain, not within the residents field of vision or within reach. Staff C then looked around the room and found two more sets of glasses, each pair also only had one lens. Staff C said they had not been informed that the resident's glasses were broken. When asked if facility staff should have identified this when they performed the daily cleaning of the glasses, Staff C said yes. Reference WAC 388-97-1060 (2)(a)

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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** 37044 Based on observation, interview, and record review the facility failed to provide assistance with activities of daily living (ADLs) to include providing oral care and assistance with shaving for 2 of 2 residents (Residents 63 and 10) reviewed for ADL's. The failure to assist dependent residents with oral care and shaving, placed residents at risk for embarrassment, dental caries, powerlessness and a diminished quality of life. Findings included . 1) Resident 63 admitted to the facility on [DATE]. Review of the 05/09/2024 Admission Minimum Data Set (MDS, an assessment tool), showed the resident was dependent on staff for oral hygiene and had no obvious or likely cavities or broken natural teeth. An ADL self-care care plan, initiated 05/20/2024, showed staff were directed to set Resident 63 up to self-brush, and staff were to assist to complete. On 08/21/2024 at 1:52 PM, Resident 63's family member said the resident was always clean shaven prior to admitting to the facility and systematically cleaned his hands and face after meals and brushed his teeth after breakfast. The resident's family member said they had informed staff on multiple occasions but stated, they are not doing it. Resident 63 was observed with a very short facial hair (beard/mustache.) When asked if he was assisted to brush his teeth after breakfast as requested, Resident 63 stated, Never. At 1:58 PM, Staff J, Certified Nursing Assistant (CNA) entered the room. Resident 63's family member asked if they had been brushing his teeth after breakfast and shaving him daily. Staff J, CNA, stated, No, not as often as I would like to honestly, but I try [to]. On 08/27/2024 at 1:41 PM, Staff C, Resident Care Manager (RCM), said facility staff should be assisting Resident 63 with brushing his teeth after breakfast and shaving daily, per Resident 63's preference. 2) Resident 10 admitted to the facility on [DATE]. On 08/22/2024 at 11:30 AM, Resident 10 was observed with several long curly hairs on their chin and a significant amount of hair on their upper lip. Similar observations were made on 08/23/2024 at 1:41 PM, 08/26/2024 at 11:19 AM and 1:43 PM. On 08/27/2024 at 12:09 PM, when asked it was their preference to have hair on their upper lip and chin, Resident 10 stated, No, I just don't have anything to remove it with. On 08/27/2024 at 1:05 PM, Staff C, RCM, confirmed staff should have been offering/assisting Resident 10 with shaving as needed, but had not recently done so. 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 - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on interview and record review, the facility failed to provide the necessary care and services to maintain residents' highest practicable level of well-being for 5 of 8 residents (Residents 65, 32, 25, 10 and 13) reviewed for bowel management. The failure to initiate bowel care in accordance with physician's orders placed residents at risk for pain/discomfort, nausea, decreased appetite and a diminished quality of life. Findings included . Review of the Avamere Living Bowel Care Protocol, dated 10/2020, showed if a resident had not had a bowel movement (BM) for three consecutive days (must be medium or large), Evening shift would administer: a) milk of magnesia (MOM) b) if no results from MOM, day shift would administer a bisacodyl suppository. c) if no results from the suppository, a fleets enema would be administered. If no results from the enema a focused examination of the abdomen and a digital exam and notify the physician. 1) Resident 65 admitted to the facility on [DATE]. On 08/22/2024 at 12:02 PM, Resident 65 reported a long history of constipation and stated, It's one of those things I have to deal with. Review of the July and August 2024 bowel record showed the resident went the following periods without a BM: 7/11/2024 - 07/21/2024 (11 days) and 8/10/2024 - 08/12/2204 (4 days.) Review of the July and August 2024 Medication Administration Record (MAR) showed facility staff failed to administer as needed bowel medication after three days of no BM as ordered. On 08/27/2024 at 2:28 PM, when asked if on the above referenced occasions facility nurses provided as needed bowel care as ordered Staff B, Director of Nursing Services (DNS), stated, No. 2) Resident 32 admitted to the facility on [DATE]. On 08/22/2024 at 2:02 PM, Resident 32 said they struggled with periodic constipation. Review of the August 2024 bowel record showed the resident went from 08/08/2024 - 8/12/2024 (4 days) without a BM. Review of the August MAR showed facility staff failed to administer Resident 32's as needed bowel medication after three days of no BM as ordered. On 08/27/2024 at 2:36 PM, when asked if on the above referenced occasion facility nurses provided as needed bowel care as ordered Staff B, DNS, stated, No. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident 10 admitted to the facility on [DATE]. Review of the July and August 2024 bowel record showed the resident went the following periods without a BM: 07/27/2024 - 7/29/2024 (3 days), and 08/07/2024 - 08/11/2024 (5 days). Review of the July and August 2024 MAR showed facility staff failed to administer Resident 10's as needed bowel medication after three days of no BM as ordered. On 08/27/2024 at 2:36 PM, when asked if on the above referenced occasion facility nurses provided as needed bowel care as ordered Staff B, DNS, stated, No. 4) Resident 25 admitted to the facility on [DATE]. Review of the June 2024 bowel record showed the resident had no BM from 06/19/2024 - 06/22/2024 (4 days.) Review of the June 2024 MAR showed facility staff failed to administer as needed bowel medication after three days of no BM as ordered. On 08/27/2024 at 2:37 PM, when asked if facility nurses provided as needed bowel care to Resident 25 as ordered Staff B, DNS, stated, No. 42960 5) Resident 13 was admitted to the facility on [DATE] with diagnoses including Parkinsons (neurodegenerative brain conditions that causes motor symptoms) and bipolar disorder (characterized by both manic and depressive episodes). The Quarterly Minimum Data Set (MDS), an assessment tool, dated 08/06/2024 documented the resident was cognitively intact and was dependent to needing moderate assistance with activities of daily living (ADLs). Resident 13's physician orders showed to give 2 tablets of Bisacodyl (a stimulant laxative) 5 MG (miligrams) by mouth every 24 hours as needed for constipation and no bowel movement (BM) on the 3rd day. The Bowel Record for 07/24/2024 - 08/22/2024 documented Resident 13 did not have a BM on 08/03/2024, 08/04/2024, 08/05/2024, and 08/06/2024. The Medication Administration Record for August 2024 documented Resident 13 received a Dulcolax Suppository (a stimulant laxative suitable for the fast relief of occasional constipation) 10 MG on 08/07/2024. On 08/26/2024 at 1:04 PM, Staff C, Resident Care Manager, said Resident 13 went 4 days without a BM and the bowel protocol should have been implemented on 08/06/2024. On 08/27/2024 at 11:11 AM, Staff B, DNS, said his expectation was for the staff to follow the bowel protocol and the resident receive a bowel medication on the 4th day without a BM or document in a progress note that the resident refused. Reference WAC 388-97 - 1060 (1)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure intravenous (IV) access devices were assessed, maintained and monitored in accordance with professional standards of practice for 3 of 3 residents (Residents 16, 48 & 74) reviewed for IV therapy. The failure to ensure IV orders included routine monitoring of IV insertion sites, flush orders, weekly changes of IV dressings and needleless injection caps, and initial and then weekly measurements of IV catheters external length and the residents arm circumferences, placed them at risk for loss of vascular access, infection, and other potential negative health outcomes. Findings included . <Facility Policy> Review of the facility's Vascular Access Device (VAD) Dressing Change, Needleless Connector Change, Flushing and Locking, and Peripheral Midline Catheter policies, dated 08/2021, showed VADs included PICCs, non-tunneled catheters (subclavian, jugular, femoral), Tunneled catheters, and implanted venous ports. Staff were directed to: a) Perform VAD dressing changes every seven days and as needed. b) Measure VADs external length upon admission/during the initial assessment, weekly with dressing changes, upon suspicion of a change in length or if signs or symptoms of complications were present. c) Measure the upper arm circumference of residents with Peripherally inserted central catheters (PICCs) or peripheral midline catheters, upon admission and/or with the initial assessment and then at least weekly. d) Change needleless connectors upon admission; at least every seven days; after blood draws; and any time the integrity of the needleless connector is in question. e) Specific flush/lock orders must be obtained, documented, and submitted to the pharmacy. f) Monitor the IV insertion site for signs and symptoms of infection or infiltration each shift. 1) Resident 16 admitted to the facility on [DATE]. Review of the 5-day Minimum Data Set (MDS, an assessment tool) showed the resident had a diagnosis of osteomyelitis (bone infection), had IV access via a midline, and received IV antibiotic therapy. An Admission Nursing Database assessment, dated 08/07/2024, documented Resident 16 had IV access via a midline (a tube that is placed into a vein, usually in the arm. The catheter is then moved through the vein until the tip sits at the level of your armpit and away from the shoulder) to the right upper arm for antibiotic therapy related osteomyelitis of the left tibia and fibula (lower leg bones). (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 16's comprehensive care plan showed the type and location of the resident's IV access, goals of antibiotic therapy and care instruction for management of the IV site were identified or addressed in the plan of care. Review of Resident 16's physicians' orders showed a 08/08/2024 order for Ceftriaxone (an antibiotic) two grams IV daily, infuse over 30 minutes for osteomyelitis. No IV maintenance and monitoring orders were in place. The August 2024 Medication and Treatment Administration Records (MAR, TAR) showed there was no documentation that facility staff had: a) Monitored the IV insertion site for signs and symptoms of infection or infiltration. b) Performed weekly midline dressing changes. c) Measuring the midline external length weekly. d) Measured the resident's right arm circumference weekly. e) Performed midline flushes. There was no direction related to the type, amount and frequency of midline flushes. f) Changed the resident's needleless injection caps at least weekly. 2) Resident 48 admitted to the facility on [DATE]. Review of the 5-day MDS, dated [DATE], showed the resident had a wound infection, IV access and received IV medications. A 07/27/2024 re-admission nurse's note documented the resident had a midline to their left upper arm and were to receive IV Daptomycin (an antibiotic). Resident 48's comprehensive care plan (CP) showed it did not address the presence, type, and location, of the Resident 48's IV access. No instruction was provided to staff about how to assess, monitor, and care for the resident's IV access. Review of Resident 48's physicians' orders showed the following 07/30/2024 IV orders: -IV Daptomycin daily. - Midline IV catheter: replace administration sets for intermittent use every 24 hours. - Midline IV catheter: Check placement sterile transparent dressing every shift. The August 2024 MAR and TAR showed there was no documentation to show facility staff had: a) Monitored the IV insertion site for signs and symptoms of infection or infiltration. b) Performed weekly midline dressing changes. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) Measuring the midline external length weekly. d) Measured the resident's right arm circumference weekly. e) Performed midline flushes. Nor was there direction related to the type, amount and frequency of midline flushes. f) Changed the resident's needleless injection caps at least weekly. On 08/26/2024 at 3:27 PM, Staff B, Director of Nursing Services (DNS), said Resident 16's and 48's IV orders were incomplete and should have included the maintenance and monitoring orders identified in the facility's IV policy. Staff B said facility nurses should have identified the IV orders were incomplete and clarified them but failed to do so. 46793 Resident 74 admitted to the facility on [DATE]. The Admission MDS, dated [DATE], documented Resident 74 was cognitively intact. Resident 74 was admitted to the facility with a PICC line. The Electronic Health Records shows no order for monitoring and maintenance of the PICC line. On 08/26/2024 at 3:27 PM, Staff B, DNS, said Resident 74's IV orders were incomplete and should have included the maintenance and monitoring orders identified in the facility's IV policy. Staff B said facility nurses should have identified the IV orders were incomplete and clarified them but failed to do so. Reference WAC 388-97-1060 (3)(j)(ii)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37044 Based on observation, interview and record review, the facility failed to ensure non-invasive mechanical ventilation via continuous positive airway pressure machines (CPAP, an external device that provides a fixed pressure to keep breathing airways open while you sleep) was provided in accordance with accepted professional standards of practice for 2 of 2 residents (Resident 25 & 63) reviewed for respiratory care. The failure to ensure active CPAP orders were in place and complete, to include the prescribed pressure settings, type of mask (e.g. nasal pillows, nasal mask, full face mask) to be used, direction to check and refill the humidifier reservoir, and the solution to be used to refill it, placed residents at risk for ineffective assisted ventilation and unmet respiratory needs. Findings included . 1) Resident 25 admitted to the facility on [DATE]. Review of the 01/17/2024 Annual Minimum Data Set (MDS, an assessment tool), showed the resident was cognitively intact, had diagnoses of chronic lung disease and obstructive sleep apnea (OSA, refers to apnea syndromes due primarily to collapse of the upper airway during sleep) and required non-invasive mechanical ventilation via a CPAP machine. An alteration in respiratory status care plan (CP), with a target date of 10/02/2024, showed the resident was to wear their CPAP during hours of sleep. The CPAP pressure settings should be set at 12-20 cm H2O per the 04/28/2023 pulmonologist recommendations. On 08/22/2024 at 10:32 AM, Resident 25 was observed with a CPAP machine and an opened and undated gallon, container of distilled water. The gallon container was approximately two thirds full. On 08/26/2024 at 9:03 AM, the opened and undated gallon container of distilled water remained present on the bedside table but was now only 1/2 full. Resident 25 stated, They poured it into the [CPAP] machine, it moistens the air. Review of Resident 25's physician's orders and August 2024 Medication and Treatment Administration Records showed there was no order for Resident 25 to use a CPAP, or any direction to staff to clean the machine, validate the pressure settings or assist with its application. Review of Resident 25's order history showed there was a CPAP order in place from 11/05/2023 - 05/13/2024, at which time it was discontinued. Review of the electronic health record showed no documentation was present that indicated an order was received to discontinue the CPAP. Provider notes, dated 05/23/2024 and 06/28/2024, showed they documented Resident 25's CPAP remained in use. On 08/26/2024 at 2:53 PM, when asked if Resident 25 had an order to wear a CPAP during hours of sleep Staff B, Director of Nursing Services (DNS), stated, No. When informed the resident's CPAP order fell off on 05/13/2024, despite the provider notes documenting it was still in use Staff B, DNS, said they would look into it. No further information was provided. Additionally, Staff B confirmed when staff opened a container of distillied water, it should be dated, as it should be discarded 2-4 days after opening. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident 63 admitted to the facility on [DATE]. Review of the Admission/ 5-Day MDS, dated [DATE], showed the resident had a diagnosis of obstructive sleep apnea and required non-invasive mechanical ventilation via a CPAP machine. A CPAP/BiPAP therapy related to obstructive sleep apnea CP, revised 08/06/2024, showed staff were to encourage CPAP/BiPAP use during hours of sleep. The CP did not identify whether Resident 63 used a CPAP or a BiPAP, nor did it identify the what the pressure settings should be, direct staff on when, how and what to use for cleaning the machine. Resident 63 had 06/08/2024 orders for: a) CPAP therapy per set settings at bedtime for OSA. Place at bedtime and remove in AM. b) Wash CPAP mask, reservoir, and machine every morning after removal. Let air dry. c) Clean and Wash CPAP tubing every Week. The orders did not identify what the prescribed pressure settings were for the CPA, identify what the CPAP mask and tubing were to be cleaned with daily, or on a weekly basis (e.g. soap and water, a vinegar mixture etc.), nor was there instruction to staff to check or refill the CPAP humidifier reservoir. Additionally, the solution staff was to refill the humidifier reservoir with was not identified. On 08/26/2024 at 2:53 PM, Staff B, DNS, said the CPAP orders should have identified what the CPAP mask and tubing was to be cleaned with, provided direction to staff to check and refill the humidifier reservoir as needed and identified that the reservoir should be filled with distilled water only. Staff B acknowledged the CPAP orders were incomplete and indicated facility nurses should have identified the incomplete order set and clarified the orders but failed to do so. Reference WAC 388-97-1060(3)(j)(vi)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 37044 Based on observation, interview and record review, the facility failed to assure residents received foods in the appropriate form and/or nutritive content as prescribed by a physician for 5 of 36 sampled residents (Resident 57, 22, 10, 52 & 74) reviewed for diet requirements. Failure to ensure residents' received physician ordered therapeutic diets or portion sizes placed residents at risk for medical complications or nutritional deficits. Findings included . Review of the breakout menu for the lunch meal on 08/26/2024 showed residents on a: a) Regular diet was to receive an #8 scoop of apple crisp. b) Residents on a soft bite sized diet (SB6) or minced and moist diet (MM5) were to receive a #12 scoop of apple crisp. c) Residents on a pureed diet (PU4) were to receive a #10 scoop of apple crisp. d) Residents on limited carbohydrate, limited fat, limited salt, or limited potassium/phosphorus diets, were to receive a #16 scoop of apple crisp. Additionally, residents on a low potassium/phosphorus (renal) diets were to receive lemonade in lieu of milk and spiral pasta in lieu of cubed steak. <Prepping> On 08/26/2024 at 10:22 AM, Staff L, Cook, was observed preparing pureed chicken. Staff L poured an un-measured amount of chicken from a metal container into the robot coupe blender and pulsed the blender five times. Staff L then obtained an un-measured amount of hot water from the spigot and proceeded to pour an unmeasured amount into the blender with the chicken. The mixture was then blended for 1 minute. Staff L, then stopped and looked and added an unmeasured amount of thickener to the mixture and blended it for 30 seconds. Staff L again observed the mixture and added an additional unmeasured amount of thickener before pulsing the mixture. The mixture was then poured from the blender into a strainer to remove any excess fluid. The chicken mixture was then poured into a metal steam table bin and placed it on the steam table. At 10:35 AM, Staff L followed a similar process when preparing the pureed asparagus. An unmeasured amount of asparagus was put into the blender and blended for 10 seconds. Staff L then added an unmeasured amount of thickener from an un-graduated plastic cup and blended the mixture for an additional 10 seconds before pouring it into a metal steam table bin and placing it on the steam table. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:32 PM, when asked if dietary staff were to follow a written recipe when preparing pureed foods, Staff E, Food Service Director (FSD) stated, Yes, and indicated staff were expected to follow the recipe and measure out the amount of thickener, seasoning, etc. as directed in the recipe to maintain nutritional content, palatability, and appropriate texture. <Plating/Serving> On 08/26/2024 at 10:46 AM Staff M, Dietary Aide, was observed plating peach crisp (substituted for apple crisp). Staff M placed one #16 scoop of peach crisp into each desert container and covered them with lids. Staff M then placed a desert on each of the staged trays in preparation for tray line. At 11:45 AM, observation of the steam table showed dietary staff failed to prepare spiral pasta for the residents on renal diets, garlic green beans which was to be served with the alternative meal of lemon pepper chicken and wild rice; apple crisp as it was unavailable and replaced with peach crisp; and no butter was available to provide residents with their vegetables. At 11:46 AM, Staff E, FSD, confirmed the facility was out of the following lunch menu items- butter, garlic green beans, apple crisp and failed to prepare spiral pasta, which was to be served to residents on renal diets in lieu of the cubed steak. <Lunch Tray Line> Observation of lunch tray line from 11:47 AM - 12:32PM, showed Staff O, Cook, prepare the following: 1) Resident 57's was on a regular, limited carbohydrate diet, with additional instruction to provide extra sauce and gravy. Staff O, failed to provide extra sauce/gravy. 2) Resident 22 was on a regular, limited salt, soft and bite sized diet, with small portions. Staff O served the resident a regular large protein diet. 3) Resident 10 was on a regular, soft and bite sized diet, with small portions. Staff O served the resident regular portions. 4) Resident 52 was on a regular, limited phosphate, sodium and potassium (Renal) diet. Staff O did not provide the resident spiral pasta as none was prepared. Additionally, the menu showed residents on renal diets were to receive lemonade in lieu of milk. However, beverages were not provided by dietary staff and floor staff provided beverages when delivering the tray. Observation on 8/26/2024 at 12:47 PM, Resident 52's room tray was observed with an open, empty container of 2% milk on their tray. No lemonade was present. 5) Resident 74 was on a regular high calorie, high protein diet. Staff O served a regular diet. The resident was not provided whole milk or butter (the facility was out of butter). At 12:15 PM, Staff O explained that a high calorie diet usually entailed providing whole milk, extra butter etc. to maximize caloric intake. When asked if the facility had whole milk or butter available, Staff O stated it was not available. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:17 PM, Staff E, FSD, acknowledged the serving size of the peach crisp was incorrect for all residents on regular, regular texture diets, as well as for residents on minced and moist, soft and bite sized, and pureed diets, which called for a #12 and #10 scoop of peach crisp respectively. When asked about the above referenced deviations from resident's ordered diets Staff E, FSD, checked the dietary computer and confirmed the list of diets that was provided remained accurate and confirmed the above observed errors. Staff E said it was the expectation that residents' therapeutic diet orders be followed. Reference WAC 388-97-1200(1)