STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	12/06/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review the facility failed to ensure an appropriate delegation of resident rights for decision making and informed consent was completed and followed for 1 of 4 residents (Resident 53) reviewed for Advance Directives. This failure placed Resident 53 and their representative at risk for lack of knowledge related to risks, benefits and alternatives to proposed health care and for financial or other exploitation related to lack of capacity to make informed decisions. Findings included . Review of the facility's policy titled Resident Rights- Advance Directives dated ,d+[DATE] showed the facility would identify the primary decision-maker which included assessing the resident's decision-making capacity and identifying or arranging for an appropriate representative for a resident assessed as unable to make relevant health care decisions. Resident 53 was admitted to the facility on [DATE] with diagnoses which included traumatic brain injury following a fall. Review of Resident 53's clinical record on [DATE] showed no Advance Directives, no decision-making hierarchy, and no legal or medical documents that addressed decision making capacity or competency. The available scanned records only included a POLST (Physicians orders for Life Sustaining Treatment) form dated [DATE] showing a selection of No CPR, and Comfort measures only, which was hand signed by the resident on [DATE]. Review of Resident 53's Admission Minimum Data Set (MDS- an assessment tool) dated [DATE] showed the resident's decision making was severely impaired and showed the Brief Interview for Mental status (BIMS- a 15-point test to determine memory recall and cognition) was scored at 99 indicating the resident received no score (the resident did not respond to the questions.) The care area assessment (CAA) related to cognition stated the resident had experienced a significant cognitive decline following a fall with head injury and loss of consciousness and the resident had difficulty processing information. Review of a progress note dated [DATE] Showed Resident 53's daughter was the resident's POA (Power of Attorney) and they had requested a copy of the paperwork. (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 53's care plan dated [DATE] showed the resident's designated POA, who was a family friend, not the daughter, had, in fact, passed away and the resident had not designated a secondary POA. The care plan stated the daughter was the next of kin. In an attempted interview on [DATE] at 11:38 AM, Resident 53 was not able to respond to questions and made only repetitive verbal vocalizations. Review of Resident 53's clinical record showed the residents signature in the form of a single initial was on the facility legal admission agreements (dated [DATE]), and arbitration agreements (dated [DATE]) (agreement to settle disputes through an arbitrator, rather than court.) Review of Resident 53's clinical record showed the resident was sent to the emergency department for a fall and change of condition on [DATE]. Review of a hospital palliative care note dated [DATE] showed Resident 53 was unable to make complex medical decisions and per WA state law, the patients next of kin was the daughter. The resident readmitted to the facility on [DATE] and review of the resident's medical record showed again, the resident's initial was hand signed at the bottom of the facility readmission agreement dated [DATE] and signed by Staff M, Admissions. In an interview on [DATE] at 12:20 PM, Staff M stated they reviewed Advance Directives during the admission process/paperwork. Staff M stated that they reviewed paperwork with the resident or the responsible party if the resident was not able to sign. Staff M stated they were not the one who determined if the resident was competent to sign the admission paperwork and they were not as familiar with the new paperwork since the change of ownership. Staff M stated they could not recall reviewing paperwork specifically with Resident 53. In an interview on [DATE] at 10:16 AM, Staff G, Registered Nurse/Unit Manager, stated that Resident 53 was at their baseline. Staff G stated the resident could not make decisions or sign their own documents. Staff G stated Resident 53 was able to communicate some needs, will say yes/no and staff have become familiar with them, and they must anticipate Resident 53's needs. Staff G stated the resident had declined further in their cognitive ability since their hospitalization and readmission and the goals were comfort focused. Staff G stated they had been told to contact Resident 53's daughter for consents but stated they were not aware of what the process was when a resident did not have clear Advance Directives and there were concerns that the resident did not have capacity to give consent for care or treatment. In an interview on [DATE] at 11:27 AM, Staff L, Social Services, stated they had called Resident 53's daughter who stated they would come in and sign something saying they were willing to assume decision making. Staff L stated they were not aware of whether the resident's provider had been or needed to be involved or not, stating there was probably a process, but they did not know what it was. On [DATE] the facility provided a letter dated [DATE] signed by the facility medical director stating that the resident lacked the capacity to make health care decisions due to their inability to understand the nature and consequences of a health condition, the proposed treatment, including non-treatment and reach an informed decision. Reference: (WAC) [DATE]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 3 residents (Residents 51 and 215) reviewed for discharge planning, 1 of 1 resident reviewed for Rehab and Restorative Services (Resident 54) and 1 of 2 residents (Resident 6) reviewed for skin issues. Failure to develop and implement individualized goals or approaches placed residents at risk for decreased quality of care and unmet care needs. Findings Included . Review of the facility policy titled Comprehensive Care Plans, dated 11/2017, showed the facility Interdisciplinary Team (IDT) will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, physical, mental, and psychosocial needs that are identified in the comprehensive assessment. <RESIDENT 6> Resident 6 admitted to the facility on [DATE] with diagnoses to include chronic congestive heart failure. In an observation on 12/02/2024 at 9:38 AM, Resident 6 was observed to have swelling (edema) in both feet and wearing tight fitting slippers. In subsequent observations on 12/03/2024 at 9:07 AM, 12/04/2024 at 8:43 AM, 12/05/2024 at 8:37 AM and 12/06/2024 at 9:29 AM, the resident was observed to have edema with TED hose (stockings/socks that help prevent blood clots) and tight-fitting slippers on. Record review of Resident 6's care plan dated 06/01/2023 and revised on 07/31/2024 showed there were no specific interventions noted to address the resident's congestive heart failure (CHF) and edema. The care plan had one intervention to monitor/document/report to the physician any signs of CHF such as dependent edema of legs and feet, periorbital edema, shortness of breath (SOB) upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation. In an interview on 12/06/2024 at 9:11 AM, Staff C, Licensed Practical Nurse (LPN)/Unit Manager stated they would update Resident 6's CHF care plan to include interventions. In an interview on 12/06/2024 at 10:45 AM, Staff B, DNS stated that Resident 6 had edema, and they had adjusted their diuretics (medication to help with edema). Staff B stated that Staff C would be updating the care plan to include the interventions. 37890 <RESIDENT 51> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 51 admitted to the facility on [DATE] with diagnoses to include heart and liver problems and a history of alcohol use disorder. Review of the Admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE] showed the resident had intact cognition, resident was at facility for a short stay, with a goal to return to community, and that they had an active discharge plan. Review of Resident 51's care plan on 12/02/2024 through 12/05/2024 showed no focus area for discharge planning. In an interview and observation on 12/02/2024 at 10:09 AM, Resident 51 was ambulating throughout the facility with a walker, at a quick pace, observed to be steady on their feet, observed to ambulate from one end of the facility to the other multiple times. Resident 51 stopped in the hallway, said hello and wanted to talk, stating they did not know why there were not able to discharge home. The resident stated that they were no longer receiving any therapy and felt they were ready to go home. Resident 51 stated they had some stairs at their apartment, but they could do the stairs and they were agreeable to some help at home if that was what they needed. Resident 51 stated they were stressed out because they wanted to know what the plan was. <RESIDENT 54> Resident 54 admitted to the facility on [DATE] with diagnoses to include COVID 19 illness, history of falls, and diabetes. Review of the Admission MDS dated [DATE] showed Resident 54's discharge was unknown and there was an active discharge plan in place. In an interview on 12/02/2024 at 11:46 AM, Resident 54 stated they were working with therapy, and they knew they needed to improve their strength. The resident stated they had requested to have a predictable schedule for things like therapy because it helped them be productive with other things they needed to do, stating I like to have an organized day. Resident 54 stated they were not sure when they would discharge or if they were going to have to move or not. Review of Resident 54's care plan on 12/02/2024 through 12/05/2024 showed no focus area for therapy goals or discharge planning. In an interview on 12/05/2024 at 9:51 AM, Staff L, Social Services Director (SSD), stated they did care conferences with residents within 48 of their admission and they talk about goals, it starts on day one. Staff L stated they encourage residents to have a plan B. Staff L stated Resident 51 was ready to go, but the family had been in favor of an adult family home or other assisted option instead of the previous apartment and the resident needed a new bed. Staff L stated the process was changing and the notes, which had been in the progress notes, will now be found in the assessments section under discharge plan. Staff L stated this information should be on the care plan and acknowledged that the prior progress notes and care plans were lacking for some residents including Resident's 51 and 54. 44110 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<RESIDENT 215> Resident 215 admitted to the facility on [DATE] with diagnoses to include left arm fracture, high blood pressure, and muscle weakness. The Admission MDS dated [DATE] showed Resident 215 had intact cognition, was at facility for a short stay, with a goal to return to community, and that they had an active discharge plan. Review of Resident 215's care plan on 12/02/2024 through 12/05/2024 showed no focus area for discharge planning. In an interview on 12/02/2024 at 2:23 PM, Resident 215 stated they have not talked to any facility staff regarding their discharge plan, and it was stressing me out a bit. Resident 215 stated it will be a big change, so they hope there was a good plan. In an interview on 12/05/2024 at 9:51 AM, Staff L stated the expectation was to meet with the newly admitted resident within 48 hours to review their plan of care. Staff L stated that was when the care plan was updated to reflect the discharge plan and would build from there throughout their stay. Staff L confirmed that the discharge plan had not been developed in Resident 215's care plan. In an interview on 12/06/2024 at 11:05, Staff B stated their expectation was discharge planning started on the day of admission, and that the SSD was updating the care plan to reflect the resident's current goals and preferences. Reference WAC 388-97-1020(1)(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** 36787 Based on observation, interview and record review, the facility failed to assist 1 of 3 dependent residents (Resident 6) with routine activities of daily living. Failure to provide routine grooming and clothing changes placed residents at risk for poor hygiene, discomfort, dignity issues, and diminished quality of life. Findings included . Review of facility policy titled, Quality of Life-Activities of Daily Living (ADL's), revised on 11/2017, showed A patient who is unable to carry out ADL's will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal and oral hygiene. In the case of a resident with cognitive impairment who refuses care, the facility staff are responsible to attempt to identify the underlying cause of the refusal/declination of care. Resident 6 admitted to the facility on [DATE] with diagnoses to include stroke with hemiplegia (paralysis to one side of the body) and hemiparesis (a condition that causes weakness or partial paralysis on one side of the body) affecting their right dominant side, congestive heart failure, dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and depression. Review of Resident 6's Quarterly Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], showed the resident had impaired range-of-motion to both sides of their upper and lower extremities and they did not refuse care. Review of the ADL Care Area Assessment (CAA) dated 01/24/2024 showed Resident 6 had chronic weakness and deconditioning with some right sided deficits along with cognitive impairments secondary to dementia with limited activity tolerance are primary factors contributing to self-care and mobility deficits. Resident 6 continues to require primarily supervision/touching assistance with most cares due to their cognitive deficits with limited insight/awareness of their care needs with occasional partial/moderate assistance r/t balance deficits and/or fatigue. Review of Resident 6's care plan initiated on 04/28/2016 directed staff to assist the resident in choosing clothing and provide one person partial or moderate assistance to dress. The care plan directed staff that if they noticed facial hair to assist Resident 6 twice a week with shaving. In an observation on 12/02/2024 at 9:38 AM, Resident 6 was observed in the hallway wearing a pink shirt with a white cross on it. The resident was observed to have 3/4 inch long white chin hair. In an observation on 12/03/2024 at 9:47 AM, Resident 6 was observed in the hallway wearing a pink shirt with a white cross on it. There were multiple food and/or fluid spills on the upper chest area of the shirt. The resident was observed to have 3/4 inch long white chin hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 12/04/2024 at 8:43 AM, Resident 6 was getting assistance back to their room wearing the same pink shirt with a white cross on it. There were multiple food and or fluid spills on the upper chest area of the shirt. Their blue slacks had some food or fluid particles on both thighs. The resident was observed to have 3/4 inch long white chin hair. In an observation on 12/05/2024 at 8:37 AM, Resident 6 was in the hall outside their room wearing the same pink soiled shirt. Their blue sacks were heavy soiled with white and tan spots on both thighs. The white chin hair remained. In an observation on 12/06/2024 at 9:29 AM, Resident 6 was in the hallway outside their room with two streaks of chocolate running down their mouth to their chin. Resident 6 was wearing the same pink soiled shirt since Monday (12/02/2024). Their blue sacks were heavily soiled with white and tan spots on both thighs. The long white chin hair remained. Review of the progress notes beginning 09/01/2024 through 12/05/2024 did not contain any documentation that Resident 6 refused ADL care. In an interview on 12/05/2024 at 10:22 AM, Staff N, Social Services stated Resident 6 refused denture care, but they were not aware of any other care refusals. In an interview on 12/05/2024 at 1:17 PM, Staff O, Nursing Assistant Certified (NAC) stated Resident 6 needed help with ADL's including grooming, and changing clothes and they did not refuse care. In an interview on 12/05/2024 at 1:18 PM, Staff P, NAC stated Resident 6 got finicky with oral care and no longer walked to dine. Staff P stated staff have to assist the resident with changing their clothing. Staff P stated the resident needed assistance with ADL's including shaving. In an interview on 12/06/2024 at 9:11 AM, Staff C, Licensed Practical Nurse/ Unit Manager stated their expectation was that grooming be provided and the aides will change residents' clothing daily. In an interview on 12/06/2024 at 10:45 AM, Staff B, Director of Nursing stated they had heard about Resident 6 wearing the same shirt for five days. Staff B stated Resident 6 would wear the same thing over and over and their care plan did not reflect the resident's refusals of care. Reference: WAC 388-97-1060 (2)(c).

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 44110 Based on record review and interview, the facility failed to ensure the facility's activity program was directed by a trained and qualified activities professional for the ongoing assessment, development, and/or revision of individualized activity programs for the current activities scheduled in the facility for 1 of 1 Recreation/Activity Directors (Staff S) reviewed for activities professional qualifications. This failure placed residents at risk for unmet recreation needs, boredom, and decreased quality of life. Findings included . Review of a facility document titled, Job description: Recreation Director, dated 2022 showed the role was to ensure the development, organization and coordination of facility and community resources to provide comprehensive Therapeutic Recreation Services and programs that fulfill the basic psychological, physical, social, cultural, emotional, spiritual and recreational needs and interests of each resident .with required education and experience to have certification as a Therapeutic Recreation Specialist or as an activities professional by a recognized accrediting body; or have two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting; or was a qualified Occupational Therapist or Occupational Therapy Assistant; or have completed a training course approved by the state. In an interview on 12/02/2024 at 11:21 AM, Resident 34 stated they prefer to not leave their room for activities. Resident 34 stated they only have three staff and no time to spend with residents that prefer to have activities in their room. Resident 34 stated they only have time for quick visits, and on the weekends sometimes it never happens. In an interview on 12/02/2024 at 1:54 PM, Resident 19 stated they were bored a lot, they had some magazines to look at but that was all. Resident 19 stated they missed their cat at home, and they wished the facility had animals that visited. In an interview on 12/02/2024 at 2:24 PM, Resident 215 stated they felt like they were going stir crazy. They stated there was nothing ever to do but watch television. In an observation on 12/03/2024 at 3:20 PM, there was a scheduled activity of flower arranging occurring in the activity room, there were only 3 residents that participated out of 64 residents. In an observation on 12/04/2024 at 10:33 AM, there was a scheduled exercise group activity occurring in the dining room. There were 6 residents that attended the group out of 64 residents. The staff directing the group followed a self-made video on the television screen, no engagement was observed with the residents, the music was faint to hear, and during the session 1 resident left the group. In an observation on 12/04/2024 at 1:52 PM, there was a scheduled activity of Christmas crafts occurring in the activity room, there were only 3 residents that participated out of 64 residents. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/05/2024 at 12:23 PM, Staff T, Recreation Assistant stated they have a set routine every day. They will do one-to-one visit with residents that do not wish to attend activities. Staff T stated they attempt to see everyone, but that's not possible most days. Staff T stated the one-to-one visits will usually consist of offering magazines, books, puzzles and handing out the daily chronicle. In an interview on 12/05/2024 at 1:49 PM, Resident 47 stated during resident council meeting that there are usually only 3 to 4 resident that show up for the activities in the facility. In an interview on 12/05/2024 at 2:33 PM, Staff S, Recreation Director stated they have been in the role as the director for about six months. Staff S stated they have an associate's degree in arts and science and worked at a memory care facility for a year and half where they helped with activities. Staff S stated they had not been told they needed to have any type of certification or certain qualifications for this position. Staff S stated when a resident refused to participate in an activity, that was the residents right to refuse, Staff S stated they did not usually pressure or inquire with the resident as to why they did not want to participate. Staff S stated they had noticed that the attendance for the activities was low, and that the residents did not seem to be interested in what was offered. Staff S stated they had not brought this issue up in the Quality Assurance and Improvement Committee (QAPI) meeting. In an interview on 12/06/2024 at 11:05 AM, Staff A, Administrator stated they were aware that Staff S was not qualified to fill the role as Recreation Director. Staff A stated they were supporting Staff S and had a plan that they were going to get them into a program at some point, but at this time there was no active plan. Reference WAC 388-97-0940 (3)(a-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** 36787 Based on observation, interview and record review, the facility failed to ensure 5 of 6 resident's (Resident 6, 23, 24, 29 and 53) received care and treatment in accordance with professional standards of practice and received the necessary care and services to attain or maintain their highest practicable level of well-being. This placed residents at increased risk of unmet care needs, medical complications and decreased quality of life. Findings included . <RESIDENT 6> Resident 6 admitted to the facility on [DATE] with diagnoses to include congestive heart failure, and cerebral infarction (stroke). Review of Resident 6's physician order dated 10/19/2023 directed staff to apply a dot bandage to the right side of the resident's nose to cushion their skin and prevent skin breakdown. Review of Resident 6's physician order dated 05/16/2024 directed staff to weigh the resident every Monday and Thursday day shift related to edema. Review of Resident 6's Medication Administration Records (MAR) for September, November and December 2024 showed there were no weights obtained as ordered on 09/09/2024, 11/04/2024, 11/28/2024 and 12/02/2024. In an observation on 12/02/2024 at 9:38 AM, Resident 6 was observed in the hallway with no bandage on their nose. In subsequent observations on 12/03/2024 at 9:47 AM, 12/04/2024 at 8:43 AM, and 12/05/2024 at 8:37 AM, the resident did not have a bandage on their nose. Review of the December MARS showed the nurses initialed the daily bandage to the nose had been completed. In an interview on 12/05/2024 at 10:22 AM, Staff N, Social Services stated Resident 6 refused denture care, but they were not aware of any other care refusals. In an interview on 12/06/2024 at 9:11 AM, Staff C, Licensed Practical Nurse (LPN)/Unit Manager stated the expectation was that nurses weighed the residents as ordered. Staff C stated that they are supposed to obtain the weight, attempt to re-weigh if the resident refuses and if they refuse, they are to attempt the next shift and day until the weight is obtained. In an interview on 12/06/2024 at 12:00 PM, Staff B, Director of Nursing (DNS) stated the nurses should not initial treatments as completed when they did not complete them. <RESIDENT 24> Resident 24 admitted to the facility on [DATE] with diagnoses to include kidney disease. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 24's physician order dated 01/24/2023 directed the staff to obtain a Depakote (medication used to treat seizures) level and Complete Metabolic Panel every three months on the 25th. Review of Resident 24's clinical record on 12/06/2024 showed the last Depakote level and CMP were obtained on 07/25/2024. In an interview on 12/06/2024 at 9:06 AM, Staff C was asked about the missed CMP and Depakote level on 10/25/2024. Staff C was unaware of the missed labs and stated they would notify the provider. Staff C stated the expectation is the nurses get the order, then print the slip and it goes into their lab book and the lab tech would draw the sample. Staff C stated the lab comes up on our dashboard in the computer system until the process is completed. Staff are to view it, print it and notify the doctor of the results. In an interview on 12/06/2024 at 10:00 AM, Staff B stated they changed lab providers but were able to utilize their prior lab as needed during the transition. Staff B stated they were unaware of missed labs, and they would complete an audit and get a better system going. Review of Resident 29's physician orders dated 01/15/2023 showed the resident was to have a Depakote level and CMP lab obtained every three months. The physician directed staff to administer Divalproex Sodium/Depakote two times a day for bipolar disorder since 05/09/2024. Review of Resident 29's progress note dated 12/01/2024 at 12:27 PM showed the resident refused their Depakote capsule that morning and stated, I don't want it until they check my level explained risk and benefits. The note showed the resident had a lab draw scheduled for tomorrow to check their Depakote level. Review of Resident 29's progress note dated 12/01/2024 at 8:05 PM, showed the resident accepted only one capsule of medication. Review of Resident 29's progress note dated 12/03/2024 at 8:34 AM showed the resident refused Depakote medication and stated, I don't want to take this capsule; it gives me tremors explained risk and benefits. Still refused. Provider aware. In an interview on 12/04/2024 at 2:28 PM, Staff C was asked about Resident 29 refusing their Depakote medication or asking for a decreased dose until they had a lab drawn to check their levels. Staff C stated they were going to ask the provider about a Depakote level but had forgotten. In a follow up interview on 12/04/2024 at 2:54 PM, Staff C stated they met with Resident 29 who said they had been taking Depakote for years after a psychiatrist ordered it but they had only been on one pill a day. When Staff C was asked about the progress note from 12/01/2024, that showed the resident would have a Depakote level drawn the next day, but the level was not drawn. Staff C said they would look into it but did not know if there was an order for a lab draw. Staff C was unaware the resident had multiple other labs except Depakote drawn on 12/02/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/04/2024 at 3:20 PM, Staff C said the provider was going to taper the Depakote to 125 milligrams (MG) daily for 7 days and then evaluate. Staff C stated they would check a level to see how the resident does on the lower dose. Staff C stated the lab was ordered for 12/01/2024 but when the nurse transferred the order to the lab slip, they missed selecting the Depakote box and that lab was missed. Staff C stated they would draw the lab now. In an interview on 12/05/2024 at 10:07 AM, Resident 29 stated they would be getting their Depakote level lab drawn this morning. Review of Resident 29's clinical record on 12/06/2024 at 9:00 AM showed the Depakote level had not yet been drawn. In an interview on 12/06/2024 at 9:06 AM, Staff C stated the provider did not want the Depakote level drawn for Resident 29 now. 37890 <RESIDENT 53> Resident 53 admitted to the facility on [DATE] with diagnoses to include a traumatic brain injury and pressure ulcers. Review of the Minimum Data Set (MDS- an assessment tool) dated 10/15/2024 showed Resident 53 had an unstageable pressure injury to the sacrum and pressure injuries to both heels, present on admission. The resident was documented as being seen weekly by the wound specialist consultant and received daily wound treatments with goals and recommendations to increase nutrition for wound healing. Review of the Registered Dietician's (RD) assessment dated [DATE] showed Resident 53 was assessed as a nutritional risk related to weight loss, diminished ability to feed themself and pressure ulcers with recommendations to add nutritional supplements which included Prosource (a protein supplement drink) twice a day which was initiated on 11/04/2024. Review of Resident 53's clinical record on 12/04/2024 showed the resident had a hospital stay on 11/09/2024 and readmitted on [DATE]. The resident had experienced significant weight loss upon re-admission; however, goals of treatment focused on overall comfort and weights were ordered monthly. The resident would continue with weekly visits from the wound specialist consultant with goals continuing to be consistent with increasing nutritional support for wound healing. Review of Resident 53's note titled Skin and nutrition dated 11/19/2024 showed Prior recommendations had fallen off, will continue with previous RD recommendations. Review of Resident 53's skin and nutrition note dated 12/03/2024 showed Prior recommendations had fallen off, will continue with previous RD recommendations. Review of Resident 53's administration records on 12/04/2024 showed that the prior RD recommendations for Prosource twice daily were not resumed until 12/03/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 53's record showed no documentation of weekly wound visit notes from the consultant wound specialist. In an interview on 12/06/2024 at 9:40 AM, Staff G, Registered Nurse/Unit Manager, stated that there should be notes in the clinical record from the wound specialist and the facility wound nurse (Staff Q, LPN) assisted the wound specialist with rounds and made a note. Staff Q would update the orders and recommendations at the same time. Staff G stated they did not know where the wound notes were located in the record and had not reviewed them. In an interview on 12/06/2024 at 9:43 AM, CC2, wound specialist consultant- stated they were aware their notes were no longer appearing in the facility records stating, Since the new company took over. CC2 stated they had notified their IT department and were told that the facilities new ownership had to request access again and they have been made aware. CC2 stated the primary goal for Resident 53 was to maximize comfort, but we are still treating with antibiotics and continuing treatments, seeing them weekly, there are still daily wound treatments and we continue to make changes and recommendations, but it makes no sense that we are sending notes that don't go anywhere (since August). Staff Q stated they did not have access to the wound notes in the system but believed that the Director of Nursing (Staff B) and another one of the unit managers were able to access them. Staff Q stated they made a summary note in the progress notes and updated the treatment orders. In an interview on 12/06/24 at 9:49 AM, Staff B stated there are notes in the system titled skin and nutrition which is like our nutrition at risk notes. The system should work for the wound notes. (Resident 53) has been seen weekly by the wound consultant. Staff B stated the wound notes should be in the resident's charts. In a joint interview on 12/06/2024 at 9:55 AM, Staff B questioned Staff R, Medical Records asking if they had been receiving wound consultant notes for residents. Staff R stated that since the transition, they had not seen any. Staff B stated they were not aware that the wound consultant notes had not been received for residents which included wound recommendations, nutritional recommendations, etc. Staff B stated Staff Q also wrote a note and would input the recommendations at the time of the visit. Staff B stated they had talked about Resident 53 and their goals of care had changed but had not been aware the resident's nutritional recommendations had not resumed upon re-admission, which had been noted by facility staff and documented in wound round notes as well as potential for other missed recommendations related to lack of review of the notes by facility staff and discrepancies in the orders. 47047 <RESIDENT 23> Resident 23 admitted to the facility on [DATE] with diagnoses that included lung cancer, cirrhosis of the liver (a chronic liver condition where scar tissue replaces healthy liver tissue and prevents the liver from functioning properly), chronic obstructive pulmonary disease (COPD-a common lung disease that makes it difficult to breathe), and a condition where fluid builds up in the body's tissues, causing swelling. Review of Resident 23's Quarterly MDS dated [DATE] showed the resident was cognitively intact and had no refusals of care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 23's care plan dated 06/17/2024 showed the residenty had a left heel ulcer which resolved 06/25/2024. Review of Resident 23's Treatment Administration records for October and November 2024 showed: 1) an order dated 10/04/2024 for Resident 23 to have knee high TED hose (stockings/socks that help prevent blood clots) on in the am and off at night every day and evening shift for lower extremity edema. 2) an order dated 06/25/2024 for Resident 23 to have their heels offloaded when in bed with 2 pillows in one case. Heels should be hanging over the pillow every shift for prevention. Review of Resident 23's progress notes for November 2024 showed they had refused to wear their TED hose on 11/30/2024, no other instance found. In observations on 12/03/2024 at 9:25 AM, 12/04/2024 at 8:30 AM, and 12/05/2024 at 12:58 PM Resident 23 was in bed not wearing TED hose nor had their feet offloaded, their feet were uncovered and bare. In an interview on 12/05/2024 at 1:00 PM Resident 23 stated they had told the staff they will not wear the TED hose provided by the facility because they make their legs itch and then they scratch causing sores. Resident 23 stated there was no alternatives offered besides what was initially offered. Resident 23 stated they wore TED hose at home routinely, prior to coming to the facility. In an interview on 12/05/2024 at 1:30 PM Staff D, LPN stated Resident 23 has edema and their legs are elevated, and they have TED hose as interventions. Staff D stated the provider should be notified of Resident 23's refusals to wear the TED hose. Staff D stated they reposition Resident 23 throughout the day. In an interview on 11/06/2024 at 8:58 AM Staff C stated they expected staff to complete and follow physician orders as prescribed. Staff C stated they had not discussed any other options with Resident 23 for TED hose preference and was planning on speaking with the provider that day. Refer to WAC 388-97-1060(1), (2)(3)(b)(h)

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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** 47047 Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (Resident 49) reviewed for incontinence, received the care and services necessary to maintain and avoid loss of bowel and bladder functions. This failure placed the resident at risk for continued decline in bowel and bladder function, skin issues, and feelings of frustration and embarrassment. Findings included . Review of the facility policy titled, Quality of Care Incontinence Urinary Incontinence dated 11/2017 showed residents would receive necessary care and services to maintain continence. The policy contained guidelines which included an assessment at admission and ongoing. Resident 49 admitted to the facility on [DATE] with diagnoses that included stroke, history of heart attack, post-polio syndrome (a condition that can affect people who have had polio). Review of Resident 49's Quarterly Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], showed the resident was cognitively intact, did not exhibit behaviors, had not had any refusal of cares and was dependent on staff for toileting needs. Review of Resident 49's care plan initiated 06/21/2024 showed they required two-person maximum assistance using a Hoyer (a patient lift used by caregivers to safely transfer patients) for toilet use. Interventions included a toileting schedule and referred to Nursing Assistant Certified (NAC) tasks. Review of Resident 49's Kardex (a reference guide, derived from the care plan that provides direction on how to care for a specific resident) dated as of 12/03/2024 showed they had a toileting schedule which was toileting upon rising, by 8 am, dressing personal hygiene and breakfast, toilet at 10 am, lunch, toilet at 2:30 PM and 4:30 PM and toilet as needed at night and throughout the night. In an interview on 12/02/2024 at 11:17 AM Collateral Contact 1 (CC1), Resident 49's representative, stated toileting Resident 49 has been an issue in the facility. CC1 stated they will sit for an hour before getting assistance, was recently moved to a different room to get better attention, and they had made multiple complaints. CC1 stated the staff turn off the call light which ensures the system does not register the hour Resident 49 is waiting. CC1 stated Resident 49 is continent of urine and was able to identify when they need to urinate and have a bowel movement. In an observation on 12/02/2024 at 11:17 AM there was a noticeable smell of urine in Resident 49's room. In continuous observations on 12/03/2024 from 2:34 PM through 3:31 PM the following occurred: -At 2: 34 PM Resident 49 was in their room with CC1. Resident 49 was sitting upright in their wheelchair. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 2:40 PM met with Resident 49 and CC1 and they stated they had not had any care or toileting since around 12-12:30 PM and had not been offered any care since. -At 3:03 PM CC1 asked Staff H, Licensed Practical Nurse (LPN) to help Resident 49 with toileting. Resident 49's call light was on, and Staff H used the walkie talkie to call for assistance with Resident 49's toileting needs. -At 3:08 PM Resident 49's call light was turned off. -At 3:10 PM Resident 49's call light was turned on. -At 3:15 PM Resident 49's call light was turned off and not provided any care. -At 3:18 PM Resident 49's call light was turned on. -At 3:19 PM Staff I, NAC, entered Resident 49's room and turned off the call light. When asked why Resident 49's call light was on, Staff I stated they needed to use a bed pan and they were waiting for their colleague to get the Hoyer lift. Staff I stated they had answered Resident 49's call light not that long ago and they had turned the call light off then left to go find someone to help them. -At 3:25 PM Resident 49's call light was turned on. -At 3:26 PM Resident 49's light was answered by Staff J, NAC, who stated they would be right back to assist resident and left their call light on. -At 3:30 PM Staff H, LPN used their walkie talkie to call for Staff K and was told they were in another room assisting another resident and would be an additional ten minutes. -At 3:31 PM Staff C, Unit Manager-LPN, entered Resident 49's room and asked them what they needed. Resident 49 explained to Staff C they were waiting to use the bed pan and the aides kept turning their light off and they had been waiting. Staff C told Resident 49 let's do this and did not address Resident 49's verbalizations. Staff J reentered Resident 49's room with the Hoyer lift and Staff C remained to assist in the process of placing them on the bedpan. In an observation on 12/04/2024 at 8:22 AM Resident 49 was in their bed, laying on their back, with their eyes closed. On 12/04/2024 at 8:33 AM Staff C. LPN entered Resident 49's room and woke them up asking them if they wanted to have breakfast. In an interview on 12/04/2024 at 12:51 PM Staff F, NAC, stated they had assisted Resident 49 with getting dressed after breakfast to include use of the bed pan around 9:30 AM. Staff F stated they know how to care for a resident by reviewing their care plan and Kardex as well as information provided by other staff and the family. When asked if Resident 49 was on a toileting program, Staff F stated for them they use the bedpan before and after every meal and when they call. Staff F stated Resident 49 was mostly continent and at times had small accidents. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/06/024 at 8:46 AM Staff C, LPN, stated Resident 49 had transitioned to their unit just recently. Staff C stated the times noted on the Kardex for Resident 49's toileting was by direction of CC1 and they did not go back and have a discussion with CC1 about time frames versus specific times. Staff C stated they expected their staff to answer call lights within 10 minutes and preferred staff to leave the call light on when finding equipment or another staff to assist. Staff C stated they had not conducted a bladder assessment on Resident 49. Reference WAC 388-97-1060 (3)(c)