STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505463	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Post Acute	2520 Madison Everett, WA 98203

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview and record review, the facility failed to honor the preferences of one of one resident (Resident 26) reviewed for Activities of Daily Living. Failure to provide staff to assist Resident 26 with recreational meal intake 7 days a week placed them at risk for decreased quality of life. Findings included . Resident 26 admitted to the facility on [DATE], with diagnoses to include a stroke affecting their ability to swallow and maintain adequate nutrition from oral intake. Review of current physician orders dated 04/19/2023, showed Resident 26 with an order for tube feeding (tube directly into the stomach) to meet 100% of their nutritional needs. Resident 26 had been assessed as being able to safely tolerate some oral intake daily with 1:1 (one to one staff to resident ratio) supervision related to their impaired swallowing. Review of the Speech Therapy Discharge Recommendations dated 06/21/2024 showed a recommendation to continue one recreational meal per day. Review of Resident 26's physician's orders dated 06/21/2024 showed: General diabetic diet, Pureed, Nectar thick liquids. Review of Resident 26's care plan dated 06/21/2024 showed: May only have lunch Monday through Friday with 1:1 supervision. In an interview 07/31/24 at 1:33 PM, Staff G, Nursing Assistant Certified (NAC)/ Restorative Aide (RA), stated they were the primary staff that assisted Resident 26 with their daily recreational meal. Staff G stated the reason the resident only had a recreational meal Monday through Friday was because they only work Monday through Friday and there was no staff on the weekends to supervise the resident. Staff G stated this was how the schedule was. Staff G stated Resident 26 did not usually eat very much during the meal, but they liked the socializing part of it. In an interview on 07/31/2024 at 3:36 PM, Resident 26 stated they only had lunch Monday through Friday and they had the potential for upchucking (vomiting), so the staff had to monitor them. Resident 26 stated they would go every day if they could but there were not enough aids to do that. (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/06/2024 at 2:14 PM, Staff I, NAC/Unit Clerk,/Scheduler, stated when they did the schedule, they do not schedule any Restorative staff or Bath aids on the weekends, and that was how they had been trained to do the scheduling. Staff I was not aware of any limitations with providing resident assistance such as with Resident 26's meals. In an interview on 08/07/2024 at 10:04 AM, Staff B, Director of Nursing Services stated the facility interviewed residents about their preferences related to schedules. Staff B stated they were aware of the scheduling of the staff and that the facility had ensured that the Restorative programs and resident baths were completed and if a resident had a need or request on the weekend that the staff on the floor were assigned to complete that task. Staff B did not have further information regarding Resident 26 only having their recreational meal set up for Monday through Friday, reportedly due to no staff not available to assist them. Refer to WAC 388-97-0900 (3)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on observation, interview and record review, the facility failed ensure a homelike dining environment was provided during one of one dining observations. Failure to ensure licensed nurses refrained from administration of medications during resident meals placed residents at risk for diminished dignity and decreased quality of life. Findings included . Definition: Reasonable Person Concept: a standard used to determine whether an individual's actions or responses align with what a hypothetical reasonable person would do under similar circumstances. It defines the behavior expected of an ordinary, prudent, and rational individual. Resident 5 admitted to the facility on [DATE] with diagnoses to include dementia. Review of the Quarterly Minimum Data Set assessment dated [DATE] showed the resident could not complete the interview questions related to cognition. The staff assessment for cognition showed the resident had memory impairment and impaired decision making. Review of the facility policy titled Medication Administration (revised 07/2024), on 08/06/2024 showed licensed staff were to administer resident's medications in the privacy of their room. Other rooms may be suitable if the resident was alone and privacy could be preserved, or, if the resident requested, then the staff would accommodate. Review of Resident 5's current care plan on 08/05/2024 showed the resident had cognitive impairment and there were no preferences noted that the resident had requested to have their medications administered in the dining room. Applying the reasonable person concept, a resident would not desire to have a bitter tasting spoonful of medication during their meal and in front of other residents and staff. In an observation on 07/31/2024 at 1:05 PM, Staff C, Registered Nurse (RN), entered the assisted dining room with a cup of medications and was observed to walk over to Resident 5, who was in the middle of eating their meal, placed a spoonful of crushed medications in their mouth and then left the dining room. The group dining rooms were closed after 07/31/2024 due to an infectious outbreak so no further group dining observations were possible. In an interview on 08/06/2024 at 10:40 AM, Staff C, RN stated their practice for residents that require assistance with their meals or were cognitively impaired, that the meals were the best time to give residents their medications because they would be most likely to take them. Staff C stated they waited until the food was there and then brought Resident 5's medications to them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/07/2024 at 10:17 AM, Staff B, Director of Nursing Services, was made aware of the observation and interview with Staff C which showed this was their usual practice with cognitively impaired residents. Staff B stated there needed to be further education done. Reference (WAC) 388-97-0880 (1)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890 Based on interview and record review the facility failed to ensure resident grievances were filed and addressed for 1 of 1 resident (Resident 11) reviewed for grievances. The failure to address and resolve resident grievances placed residents at risk for diminished dignity, unresolved missing property and diminished quality of life. Findings included . Review of the facility's policy on 08/02/2024 titled, Grievances, showed a grievance report would be initiated for all concerns, the resident would be communicated with, and an attempt was made to resolve the grievance within 5 days. There would be follow up with the resident or representative about the grievance to ascertain satisfaction with the resolution of the reported concern. Resident 11 readmitted to the facility on [DATE] and was alert and oriented. Review of the record showed the resident had a recent prior stay 03/21/2024 through 05/16/2024. In an interview on 07/31/2024 at 11:05 AM, Resident 11 stated they ended up back in the hospital and readmitted to the facility a couple of months ago. Resident 11 stated they had a roommate during their prior stay in March, who was inconsiderate with their loud television volume and encroaching on their space in the room. Resident 11 stated they had verbalized the concern to the staff several times and asked to move rooms which they did a few days later. Resident 11 stated they were missing a pair of plaid lounge pants that had been missing for at least a month. Resident 11 stated the laundry person was still looking for them, but they had not received any updates. Resident 11 stated there had been a nursing assistant (Staff K) that they requested not to have provide care to them because they were unsanitary and just did not like their care, but they stated that the staff member did come back and care for them on two days after they requested not to have them. Resident 11 stated Staff K confronted them about it stating, do you have a problem with me? which Resident 11 stated made them upset and they told Staff K to get out of their room. Resident 11 stated they did not say anything about Staff K coming back to their room until they were in the resident council meeting at the end of July (July 23, 2024). Review of the prior 6 months of the facility grievance logs on 08/05/2024 showed no grievances found for Resident 11 related to missing property or a roommate concern. The log showed a grievance for Resident 11 that was dated 07/01/2024 and labeled as handwashing. In an interview on 08/05/2024 at 9:20 AM, Staff D, Laundry Manager, stated they were aware of Resident 11's missing lounge pants, stating Resident 11 had told them they were missing and stated they thought maybe they got mixed up with the briefs and got thrown away. Staff D stated they had not personally ever seen the lounge pants Resident 11 mentioned and added that sometimes residents did not want their clothing labeled, so items could get lost. Staff D was able to state the process for filling out a grievance when a resident reported a concern but stated they had not completed a grievance for the missing pants for Resident 11 yet. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 07/01/2024 grievance report on 08/05/2024 showed that Resident 11 did not want Staff K to be their aid anymore because they did not wear gloves and the resident did not want to get an infection. The documented action taken was Staff K received education on infection prevention and included copies of the in-service education provided to Staff K. The grievance was signed by Staff J, Infection preventionist, and a therapy (witness) on 07/02/2024, stating that the resident could not sign due to wet nails. The grievance form did not include further follow up with the resident or a conclusion to ascertain satisfaction with the reported concern, including whether Staff K would or would not provide any further care to Resident 11. The grievance was not signed as being completed and was not signed by the Director of Nursing or Administrator. Staff K was no longer a current employee. Review of Resident 11's July 2024 care record on 08/05/2024 confirmed that Staff K had documented providing care to Resident 11 on two days following the grievance report, on 07/09/2024 and 07/11/2024. In an interview on 08/06/2024 at 10:30 AM, Staff J, Infection Preventionist, stated they had received the grievance form and completed the in-service with Staff K. Staff J stated they had verbally reviewed what they had done with Resident 11 and they were okay with the education, but they still did not want Staff K to be their aid, (Resident 11) was not comfortable, they said. Staff J stated they forgot to mark the box on the grievance that stated the resident was notified of the action taken and satisfied with the outcome. In an interview on 08/06/2024 at 2:14 PM, Staff I, Scheduler, stated they were aware that Staff K was not supposed to be scheduled to care for Resident 11, but stated sometimes staff would be assigned to a certain section, but they would just trade a resident, such as if one resident on a section preferred only female aids, they may have a male aid on that section but they would just trade one resident with another aid who was female. Staff I stated they recalled it being sometime in July that there had been an allegation and even though Staff K was assigned on that section, they knew they were not supposed to have Resident 11 and were supposed to trade with another staff. In an interview on 08/07/2024 at 10:17 AM, Staff B, Director of Nursing Services stated there should have been grievances for the missing item and noisy roommate concern but had not been aware of those issues. They reviewed grievances every day in their stand-up meeting. Staff B stated that they had not been aware that Staff K had Resident 11 on their care assignment on those dates. Staff B stated that they had provided education to Staff K related to the grievance and when they had done their investigation regarding the allegation that Staff K had come back to the room stating, do you have a problem with me?, they had denied that allegation, and they had not been able to substantiate it. Staff B stated they became aware of that allegation at the July 23,2024 resident council meeting, and it was reported as an allegation of potential abuse. Staff B stated they have been working on their grievance process but needed to continue education. Refer to WAC 388-97-0460(1)(2)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on interview and record review, the facility failed to ensure the Resident Assessment Instrument (RAI - an assessment of a resident's needs, strengths, goals, and preferences, included thorough summaries of the Care Area Assessments, - a systematic process to interpret the triggered information from the Minimum Data Set assessment to assess the potential problem and determine if the area should be care planned), holistically analyzed the plan of care for 1 of 6 sampled residents (Resident 30) reviewed for comprehensive assessments. This failure placed the residents at risk of not having appropriate services provided based on their individualized needs. Findings included . Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2023, showed the RAI consists of three basic components: the Minimum Data Set (MDS - and assessment tool) assessment, the CAA process, and the RAI Utilization Guidelines (instructions for when and how to use the RAI that include instruction for completion of the RAI as well as structured frameworks for synthesizing the MDS and other clinical information). Once a CAA has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. Resident 30 admitted to the facility on [DATE] with diagnoses to include fracture of the right upper leg. Resident 30 was admitted to hospice services on 03/15/2024. Review of Resident 30's Annual CAA assessment, dated 03/25/2024, showed they triggered for functional abilities. The CAA worksheet for functional abilities showed no evidence a comprehensive analysis of findings was thoroughly completed and did not contain Resident 30's goals, preferences, strengths, needs or input from the resident or their representative. The CAA contained a narrative that read, Continue to care plan to slow or minimize decline in ADL's (Activities of Daily Living). In an interview on 08/07/2024 at 10:28 AM Collateral Contact 2 (CC 2), contracted Registered Nurse, stated they are completing the MDS's for the facility to include the CAA and care plans. CC 2 stated they had daily telephonic meetings with the facility's Resident Care Manager (RCM) and Director of Nursing Services (DNS) to discuss the residents. CC 2 stated the process for completing CAAs included a review of information that was gathered from notes and their sources and do a shorter description to proceed to the care plan. Cross Reference to: CFR 483.21(a), (a)(1)(i)(ii), F655 - Baseline Care Plan CFR 483.21(b), (b)(1),(c)(3)(i - iv), F656 - Develop/implement Comprehensive Care Plan CFR 483.21(b),(b)(2)(i-iii), F657 - Care Plan Timing And Revision (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to WAC 388-97-1000 (1)(a)(2)(q)(5)(a)

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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** 47047 Based on observation, interview and record review, the facility failed to ensure care plan interventions were implemented for 1 of 3 sampled residents (Resident 13) reviewed for accidents. This failure placed residents at risk for injury, and decreased quality of life. Findings included . Resident 13 readmitted to the facility on [DATE] with diagnoses to include fall, high blood pressure, fracture of right upper leg. In an interview and observation on 07/31/2024 at 2:54 PM, Resident 13 stated they had fallen out of their bed around eight months ago. Resident 13 stated they had been asleep in their bed when they had moved the bed control and started to fall over to the right side and fell from their bed. During the observation a blue foam wedge was noted at the foot of Resident 13's bed. Review the incident report, dated 01/02/2024, showed that Resident 13 sustained a fall at 2:45 AM and was assisted back to bed after they refused to be sent to the hospital. The incident report showed Resident 13 voiced being disproportionate in their hip and legs which had them leaning to the right side which led to the fall while they were asleep. Resident 13's care plan was updated. The incident summary dated 01/05/2024, showed therapy assessed Resident 13 and determined the cause of the fall was related to their poor trunk control. Resident 13 was assessed by therapy, and they recommended a positioning wedge be placed under the resident's right hip/leg and secured with a strap that is attached to the bed frame. In a follow up interview and observation on 08/07/2024 at 11:15 AM, Resident 13 stated the blue wedge was to assist them in not falling out of bed. Resident 13 was observed to use their cane to pull the blue wedge from the foot of their bed to them and positioned it under their right hip/leg. There was no strap observed on the wedge. Resident 13 stated the wedge worked well as an arm rest. Resident 13 stated they had not used the wedge the night before and required no reminders from staff to use it. Review of Resident 13's care plan dated 01/04/2024 and revised 06/12/2024 showed they were at high risk for falls and they had a positioning wedge with secure strap for safety and comfort to be positioned on their right side (hip/leg). The care plan directed staff to notify the nurse if the wedge was not secured and to unstrap the wedge while Resident 13 was awake and per their request. There was no information in the care plan that addressed Resident 13's poor trunk control. Review of Resident 13's treatment administration record for July 2024 showed no information about the use of the positioning wedge. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/07/2024 at 9:14 AM Staff I, Nursing Assistant Certified (NAC), stated they would need to review the information on Resident 13's Kardex (tool that directs an NAC on specific care needs of a resident). Staff I stated Resident 13 had a positioning wedge with a strap for safety and comfort. When asked what the safety and comfort reasons were, Staff I stated Resident 13 had a wound and it was to keep them comfortable. Staff I stated Resident 13 had leaned over too far while in bed and that was scary for them. Staff I stated the staff check on Resident 13 daily and provide care and repositioning if needed. Staff I stated Resident 13 was not utilizing their wedge when last checked. When asked about the strap to the wedge, Staff I stated they did not know if there was a strap. In an interview on 08/07/2024 at 12:06 PM Staff B, Director of Nursing Services, stated they were not aware Resident 13 did not want to use the strap for the wedge. No other information was provided. This is a repeat citation from 10/16/2023. Refer to WAC 388-97-1020 (1)(2)(a)(b)(e)(5)(a)(b)

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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** 47047 Based on interview and record review, the facility failed to revise comprehensive care plans for 2 of fourteen sampled residents (Residents 3 and 20), reviewed for care plan revisions. The failure to revise care plans for dental services and discharge planning placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <RESIDENT 20> Resident 20 admitted to the facility on [DATE] with diagnoses to include above the knee amputation of the right leg, diabetes mellitus Type 2 (a condition where the body has a problem regulating blood sugar), and high blood pressure. In an interview on 07/31/2024 at 3:23 PM, Resident 20 stated they had planned to move to the Assisted Living Facility (ALF) next door. Resident 20 stated they had sold some property and were now not able to move to the assisted living. Resident 20 stated they were trying to contact someone at Home and Community Services (HCS) to work it all out. Review of Resident 20's care plan initiated 08/09/2022 and revised on 08/04/2023 showed that they wished to discharge home and would consider an Adult Family Home as a secondary option. The goal was Resident 20 would verbalize understanding of the discharge plan. Interventions included, establishing a pre discharge plan with the resident and evaluate the progress and revise the plan as needed. In an interview on 08/06/2024 at 2:25 PM Staff E, Social Services Director, stated Resident 20 was supposed to move to the ALF last month, but was over resourced and was trying to get that sorted out. Staff E stated that they email/speak with the case worker at HCS weekly and received notification that Resident 20 was over resourced on 07/17/2024 and had last spoke with the case worker on 07/31/2024. Staff E stated the last care conference for Resident 20 was on 06/13/2024. Staff E stated the care plan was not updated, however there were detailed progress notes in Resident 20's medical record. 50725 <Resident 3> Resident 3 admitted to the facility on [DATE], with diagnosis to include congestive heart failure, atrial fibrillation, morbid obesity, and sleep apnea. Review of the quarterly Minimum Date Set (MDS-an assessment tool) assessment completed on 07/12/2024 showed Resident 3 was cognitively intact. Resident 3 was not on tube feeding (a way to provide nutrition when a person cannot eat or drink safely by mouth) or a mechanically altered diet. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/31/2024 at 10:35 AM, Resident 3 stated they had partials for their upper teeth that had been sent to the dentist to be repaired. Resident 3 stated they were having a hard time chewing meat. Review of Resident 3's diet order dated 02/02/2024, showed the resident was to receive a regular diet and texture with thin liquids. Review of Resident 3's current care showed a focus area of ADL self-care performance deficit related to fatigue initiated on 04/18/2023. Interventions for oral care showed Resident 3 had an upper partial, their own bottom teeth and required assistance by staff with the task of oral care, initiated on 09/14/2023. In an interview on 08/02/2024 at 09:57 AM, Staff L, Certified Nursing Assistant (CNA) stated Resident 3 did not have a partial. Staff L reviewed Resident 3's Kardex and stated: I stand corrected, resident has an upper partial and wears it. Staff L stated Resident 3 does their own oral care. In an interview on 08/02/2024 at 10:18 AM, Staff M, Registered Nurse (RN) stated Resident 3 was wearing their upper partial when they had checked on the resident. In an interview and observation on 08/02/2024 at 10:21 AM Resident 3's mouth was observed and showed no upper partials in place. Resident 3 stated their partials were sent to a dentist to be repaired before the COVID pandemic and had not been returned. In an interview on 08/05/2024 at 11:05 AM, Staff O, Licensed Practical Nurse (LPN) stated that Resident 3 did not have their partials but was going to the dentist to get fitted with one. Staff O stated they would review the care plan. In an interview on 08/02/2024 at 11:38 AM, spoke to Staff N, LPN/Resident Care Manager, stated they were working with European Dentures and [NAME] Dental in replacing the partials. Resident 3 had an appointment scheduled on 09/24/2024 and their clerk was calling the clinic to see if they can move up the appointment and would continue to keep trying. Staff N stated they and the nurses update the care plan. Staff N confirmed Resident 3 was not currently wearing a partial. This is a repeat citation from 10/16/2023. Refer to WAC 388-97-1020 (1)(2)(a)(b)(e)(5)(a)(b)

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	505463	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Post Acute	2520 Madison Everett, WA 98203

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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** 37890 Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were implemented for 2 of fourteen residents (Residents 21 and 26) reviewed. Failure to follow physician's orders for labs and medication parameters for Resident 21 and to follow Speech Language Pathologist (SLP) recommendations for Resident 26 placed the residents at risk for delay in treatment and potentially adverse outcomes. Findings included . <RESIDENT 26> Resident 26 admitted in 2023 and had diagnoses which included a stroke affecting their ability to swallow and maintain adequate nutrition from oral intake. Resident 26 had physician's order for a tube feeding (tube directly into the stomach) to meet 100% of their nutritional needs. Resident 26 had been assessed as being able to safely tolerate some oral intake daily with 1:1 (one to one staff to resident ratio) supervision related to their impaired swallowing. Review of the Speech Therapy Discharge Recommendations dated 06/21/2024 showed the resident required verbal cues for swallow strategies and stated: Continue one recreational meal per day with the following swallow strategies to facilitate safety and efficiency: rate modification, alternate liquids/solids, bolus size modification, chin tuck, hard throat clear, resident swallow, effortful swallow and no straws. Review of Resident 26's physician's orders and care plan dated 06/21/2024 on 08/01/2024 showed: General diabetic diet, Pureed, Nectar thick, may only have lunch Monday through Friday with 1:1 supervision. The care plan and resident Kardex (care directive to nursing assistants) did not include the speech therapy strategies. In an observation on 08/01/2024 at 12:55 PM, Resident 26's tray was noted to have a piece of paper with handwriting on it that stated only (Resident 26 initials) and NTL (nectar this liquids) in mugs. There was no other information on the resident's tray. In an observation on 08/01/24 12:56 PM, Staff G, Nursing Assistant Certified (NAC) stated the Speech Therapist had given them verbal instructions about the swallow precautions for Resident 26 stating the resident had a strong cough and would cough and clear their throat or stop themself and they would remind them. Resident 26 added that they were supposed to swallow hard. In an observation 08/02/2024 at 1:19 PM, Staff H, NAC was observed sitting with Resident 26. Resident 26 was noted to accept a sip of a handled mug and was noted to swallow without tucking their chin. Staff H did not cue the resident. Resident 26 coughed and held a napkin to their mouth. Staff H asked the resident you ok? but did not cue the resident with the recommended interventions. Resident 26 accepted one more bite of a thickened food and coughed again. Staff H had not cued the resident to tuck chin or swallow hard. Staff H handed Resident 26 a box of tissues but did not say anything. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/07/2024 at 10:04 AM, Staff B, Director of Nursing Services, stated swallow precautions and recommendations should be on the resident's Kardex (care directive to nursing assistants) which they were expected to review for the residents on their care assignment. Staff B was made aware of Resident 26's swallow precautions not being found on their kardex and not consistently observed. 47047 <RESIDENT 21> Resident 21 admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus Type 2 (a condition where the body has a problem regulating blood sugar), chronic pain and high blood pressure. Review of Resident 21's Medication Administration Record (MAR) for July 2024 showed they were prescribed a medication to manage their high blood pressure. The order was for Amlodipine Besylate Tablet 0.5 milligrams (mg) by mouth for high blood pressure and to hold the medication if Resident 21's systolic blood pressure was below 100 millimeters of mercury (mm Hg). The order was dated 10/04/2023 and discontinued on 07/19/2024 and the MAR showed had documented blood pressures. The July 2024 MAR showed the same order dated 07/20/2024 with no documented blood pressures. Review of Resident 21's August 2024 MAR showed an order for Amlodipine Besylate Tablet 0.5 milligrams (mg) by mouth for high blood pressure and to hold the medication if Resident 21's systolic blood pressure was below 100 millimeters of mercury (mm Hg). The August MAR contained no documented blood pressures from 08/01/2024 through 08/05/2024. Review of Resident 21's provider progress note dated 07/18/2024 showed the provider ordered an A1C (lab test that measures the average level of blood sugar over the previous three months). Review of Resident 21's electronic medical record showed there were no labs were completed for A1C on 7/18/2024. A review of Resident 21's progress notes dated 08/02/2024 that a lab slip was completed for an A1C, 15 days after it was ordered by the provider. In an interview on 08/06/2024 at 2:00 PM Staff B, Director of Nursing Services (DNS) stated they had changed times on medications to broaden the range in which medications could be administered and the blood pressure monitor was somehow left off. Staff B stated the blood pressure monitor was placed back on after they caught the error. Staff B stated the blood pressure should have been taken prior to the administration Amlodipine for Resident 21. Staff B stated the provider for Resident 21 had placed the order for their A1C in the wrong section of the electronic health record and would not have been processed by the nursing staff as this was not their practice. In an interview on 08/07/2024 at 12:06 PM CC 3, facility consultant, stated the transition to the electronic medical record was difficult and contributed to the errors. CC 1 stated the nurse managers were responsible for ensuring provider notes were and processed. CC 1 stated the provider notes were not fully integrated and were previously scanned into the medical record, causing a delay in availability of the note to the nurse manager by a few days. Refer to 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** 47047 Based on observation, interview, and record review, the facility failed to provide assistance with activities of daily living for 2 of 2 sampled dependent residents (Residents 26 and 30) reviewed for activities of daily living (ADL's). Facility failure to provide residents, who were dependent on staff for assistance with hygiene including oral care and meal assistance placed residents at risk for diminished quality of life. <RESIDENT 30> Resident 30 admitted to the facility on [DATE] with diagnoses that included fracture of the right upper leg. Review of Resident 30's Minimum Data Set (MDS-an assessment tool) dated 06/18/2024 showed they required supervision or touching assistance with eating and partial/moderate assistance to complete their oral hygiene. In an interview on 07/31/2024 at 10:54 AM Resident 30's representative, Collateral Contact 1(CC 1), stated the resident spent most of their time in bed. CC 1 stated Resident 30 was assisted by staff with their meals, had their natural teeth (which were barely there) and had difficulty eating. Review of Resident 30's current care plan, initiated 03/14/2024 and revised/updated on 06/12/2024 showed they required set up assistance for meals. The care plan identified Resident 30's oral care routine consisted of brushing teeth and rinse every AM, PM and nightly. The care plan did not identify how much care the resident required for their oral care routine. In a continuous observation on 08/01/2024 starting at 12:33 PM observed Resident 30 in their bed, their head to right. There was a cup and a pink pitcher with straw on Resident 30's overbed table. At 12:39 PM Resident 30's meal arrived on a tray and was placed overbed table and consisted of multiple drinks in cups. On 08/01/2024 at 1:35 PM Staff V, Nursing Assistant Certified (NAC) entered Resident 30's room and asked them if they wanted something to drink or eat. Staff V stated to them that they were sleepy. Staff V asked the resident several times if wanted something to eat or drink or if they could take the tray. Staff V stated that she was going to leave the tray for a few more minutes and left Resident 30's room. During the continuous observation on 08/01/2024 from 12:33 PM until 2:24 PM Resident 30 received no assistance with their meal and received no care. Resident 30's meal tray remained in their room, untouched, and no assistance was provided to them. During an observation on 08/02/2024 at 10:15 AM, Resident 30 was observed lying in their bed, the head of their bed elevated. There was visible brown matter observed under all their fingernails, their scalp was oily with multiple dried skin debris in their hair. There were several cups on the overbed table with different liquids in them. Resident 30's teeth were covered in a film with white debris and matter visibly built up in between their teeth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/02/2024 at 10:45 AM in a continuous observation from 10:15 AM to 11:56 AM, Resident 30 had the same cups of liquid on their overhead table, untouched. At 11:13 AM Staff T, Registered Nurse, entered Resident 30's room and left with two cups of liquid. At 11:21 AM Staff T returned to Resident 30's room and stated aloud they brought fresh milk. At 11:42 AM Staff P, NAC, entered Resident 30's room, asked if they were hungry and reassured them, they had water and milk. At 11:56 AM, at the end of the continuous observation, Resident 30 was lying in bed with the water and milk on their bedside table and received no assistance with oral hygiene or drinking. In an interview and observation on 08/02/2024 at 11:45 AM observed Resident 30 in their bed, their teeth unbrushed with visible debris in between their teeth. Resident 30 stated they had not had their teeth brushed in the last two days. Resident 30 had multiple cups of liquid on their overbed table to include a full glass of brown liquid, a half a glass of amber colored liquid, a full glass of clear liquid, and three quarters full glass of white liquid. Resident 30 had white crusty like matter on their right side of their cheek/chin. In an interview on 08/07/2024 at 9:33 AM Staff T, RN, stated the NACs were to assist Resident 30 with oral hygiene every shift and every time after they eat. Staff T stated Resident 30 required set up for and oral hygiene and if they don't do it then the NACs would assist them. Staff T described Resident 30 as being super motivated at times and other times not. In an interview on 08/07/2024 at 9:37 AM Staff S, NAC stated Resident 30 does not like to get out of bed. Staff S stated Resident 30 had dementia which was getting worse. Staff S stated Resident 30 is receptive to care. Staff S stated Resident 30 was particular about what they eat and drink and enjoyed cookies, milk and juice. Staff S stated when they start their shift, they make sure to change out the milk and juice because they are not sure if they had been out for more than 24 hours. Staff S stated that Resident 30 required set up, but more supervision for oral hygiene and needed supervision for eating. In an interview on 08/07/2024 at 9:49 AM Staff P, NAC, stated Resident 30 didn't really eat, but enjoyed milk which they sometimes spilled. Staff P stated they do not do Resident 30's oral hygiene and that the nurse would do it. Staff P stated Resident 30 did not need assistance with eating, but they help them when they see the resident needs it. 37890 <RESIDENT 26> Resident 26 admitted in 2023 and had diagnoses which included a stroke resulting in impaired swallow and a gastrostomy tube (tube directly into the stomach) for nutrition, left sided weakness, blindness to the left eye and dependence of staff for activities of daily living such as oral care. Review of the current care plan on 08/04/2024 showed the resident required one person assistance for oral care using glycerin swabs and assistance with mouth rinsing. The care plan did not include a problem specific to risk for dry mouth or specify a frequency for oral care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 26's current physician orders dated 07/31/2024, showed an order for glycerin (Oral swabs coated with glycerin, which activated saliva glands and helped keep the mouth moist.) swabs for mouth care as needed. There was no documentation in the clinical record that this had been done. In an observation on 07/31/2024 at 3:18 PM, Resident 26 was in their room with their eyes closed and their mouth hanging open. The residents lips were dry and flaky and their tongue was coated in white matter. In an observation and interview on 7/31/2024 at 3:41 PM, Resident 26 was noted moving their tongue over a flaky loose piece of skin on their lower lip. Their lips were dry and flaky, and their tongue had thick white matter visible. The resident stated the staff rarely helped them with swabbing their mouth. They stated their mouth was always dry (a common occurrence in people with tube feedings who do not eat and drink normally throughout the day.) Resident 26 stated they thought there was a medication they were supposed to get for their mouth because they used to have an infection in their mouth. There was a cup of pink toothettes (oral swabs- non glycerin) noted in a cup on top of the dresser on the opposite side of the room. In an interview on 08/05/2024 at 2:00 PM, Staff P, NAC, stated Resident 26 was able to swab their mouth if they handed them the swab and stated they should offer them one every day and after they eat in case they had anything left in their mouth. They said they used the toothettes, the pink ones. In an interview on 08/07/2024 at 10:04 AM, Staff B, Director of Nursing, stated oral care should be done for resident 26 upon rising, after meals related to their swallow issues, and at night. Refer to WAC 388-97-1060 (2)(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 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** 47047 Based on observation, interview and record review, the facility failed to ensure residents 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 for 2 of 5 residents (Resident 21 and 30) reviewed. The facility failed to ensure Resident 21's alternating air mattress was set at the labeled setting and Resident 30 received routine repositioning. These failures placed the residents at increased risk of unmet care needs and potential skin breakdown. Findings included . Review of the facility policy titled Repositioning residents dated 08/2022 and revised 07/2024 showed it was the facility's policy to reposition residents for comfort and skin integrity. The policy identified repositioning was critical for a resident who was immobile or dependent upon staff for repositioning. The policy general guidelines included the following interventions: 1.A turning/repositioning program includes a continuous consistent program for changing the residents position and realigning the body. A program is defined as specific approach that is organized, planned, documented, monitored and evaluated. 2.Frequency of repositioning a bed-or chair-bound resident should be determined by: a. The type of surface used. b. The condition of the skin. c. The overall condition of the resident. d. The response to the current repositioning schedule. e. Overall treatment objectives 3. Residents who are in bed and not on an alternating air mattress should be on a repositioning schedule. <RESIDENT 21> Resident 21 admitted to the facility on [DATE] with diagnoses to include Diabetes Mellitus Type 2 (a condition where the body has a problem regulating blood sugar), chronic pain and high blood pressure. In an interview on 07/31/2024 at 8:59 AM, Resident 21 stated their mattress was an air mattress and it moved her back and forth and around to the point they are stuck in the middle of the bed. In a follow up interview at 11:58 AM Resident 21 stated their mattress makes a noise and maintenance has looked at it several times without finding a problem. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/31/2024 at 11:58 AM observed the air mattress pressure pump (a pump that inflates and deflates the mattress) hooked to the back of Resident 21's foot board of their bed. The pump was set to 450/25. There was a sticker on the pump that read 300/15. On 08/02/2024 at 10:49 AM observed the air mattress pump with the settings on 450/25. Review of Resident 21's progress notes dated 02/06/2024 showed the staff found an open area to the residents sacral area (the bone at the bottom of the spine) and an alternating pressure mattress was ordered for wound prevention. Review of a skin incident report dated 02/06/2024 showed a nursing assistant observed a skin impairment on Resident 21 and notified their nurse. The nurse assessed the resident's skin, and they were found to have an open area on the sacral region measuring 0.5 centimeters (cm) by 1 cm. Interventions initiated included ordering an alternating pressure mattress. Review of Resident 21's current care showed a focus area At risk for pressure ulcer development related to immobility and other comorbidities initiated on 05/17/2023 and revised on 06/29/2024. Interventions included an alternating pressure mattress with the setting at 300/15 (300=amount of pressure-firmness/15=cycle time), initiated on 02/08/2024, revised on 06/12/2024. The staff tasked with implementing/monitoring this intervention included nursing assistants and nurses. In an interview on 08/07/2024 at 9:14 AM Staff I, Nursing Assistant Certified (NAC), stated they do not adjust the settings on the alternating pressure mattress pump for Resident 21. Staff I stated the nurses were responsible for the adjustment of the settings. Staff I stated they ensure the pump is functioning and there are no kinks in the hose that enters the mattress. In an interview on 08/07/2024 at 12:06 PM Staff B, Director of Nursing Services, stated the required settings were marked on the pump and were they not aware the settings were not set accurately. Staff B stated Resident 21's skin was intact. <RESIDENT 30> Resident 30 admitted to the facility on [DATE] with diagnoses to include fracture of the right upper leg. Resident 30 admitted to hospice services on 03/15/2024. In an interview on 07/31/2024 at 11:00 AM Resident 30's representative, Collateral Contact 1(CC 1), stated the resident spent most of their time in bed. In an observation on 07/31/2024 at 12:24 PM, Resident 30 was lying in their bed, on their back, with pillows positioned on their sides. On 08/01/2024 at 12:33 PM observed Resident 30, in their bed, on their back, their right foot on top of a pillow and their left heel on the bed. Resident 30 had a pillow tucked under their left side and their head of bed was elevated. In a continuous observation on 08/01/2024 from 12:33 PM until 2:24 PM Resident 30 received no assistance from staff with repositioning or care. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 30's current care plan showed a focus area ADL self-care performance deficit related to impaired balance, right hip fracture and pain, initiated on 03/14/2024 and revised on 07/29/2024. Interventions included the resident required extensive assistance of one staff for repositioning and turning in bed. The care plan contained no elements of a repositioning schedule or addressed Resident 30's heels. In an interview on 08/07/2024 at 9:37 AM Staff S, NAC, stated Resident 30 is repositioned every 2 hours to keep them off their hip and buttocks. Staff S stated they rolled Resident 30 toward the window and use a pillow under their hip/upper thigh. Staff S stated they always elevate Resident 30's heels by use of a pillow under their calves to relieve pressure. In an interview on 08/07/2024 at 9:49 AM Staff P, NAC, stated they reposition Resident 30 every two to three hours. Staff P stated Resident 30 often sleeps and wants to be pulled up all the way with their feet positioned higher than their head. Staff P stated that they placed pillows on each side of Resident 30's. Refer to WAC 388-97-1060(1)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 36787 Based on interview and record review, the facility failed to ensure annual Nurse Aide Certified (NAC) performance reviews were completed for 1 of 4 NAC's (Staff K) files reviewed who had been employed at the facility longer than one year. This failed practice had the potential to negatively affect the competency of these NACs and the quality of care provided to residents. Findings included . Staff K was hired on 07/06/2023. Review of Staff K's employee file showed there was no current employee evaluation done. There was no evidence the evaluator completed this evaluation nor if it was reviewed/discussed with Staff K. Review of the staff roster printed on 07/31/2024 on the first day of survey showed various hire dates for staff beginning on 06/12/1987 to 07/26/2024. In an interview on 08/06/2024 at 12:59 PM, Staff J, Staff Development Coordinator said they would be doing new performance evaluations, but everyone's start date was May 1st and they were all new employees. In an interview on 08/06/2024 at 2:48 PM, Staff B Director of Nursing Services said all staff completed new hire paperwork on 05/01/2024 so they needed to do the performance evaluations again. In a phone interview on 08/07/24 at 10:08 AM, Staff Q, Credentialing Compliance Coordinator said they were responsible for completing new hire paperwork. Staff Q said the facility had a new owner on May 1st, but they were not sure if staff were keeping their original hire dates, or the May 1st hire date. Staff Q said the prior administrator told them to ask the new administrator, but they hadn't asked Staff A, Administrator yet. Refer to WAC 388-97-1680 (2) (a-c)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47047 Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in 1 of 1 facility kitchens, 1 of 1 snack/nourishment refrigerators and 2 of 3 halls observed. The failure to monitor and document safe kitchen refrigerator temperatures, label opened food/beverage items, discard expired food items in the kitchen and unit refrigerators, ensure dishwashing temperature were maintained at the proper temperature, and cover desserts during meal delivery. These failures placed all residents at risk for their food to be contaminated, development of food borne illnesses, and consuming spoiled food. Findings included . <KITCHEN REFRIGERATOR> On [DATE] at 8:54 AM during the initial kitchen tour, observed an undated sandwich in a bag on the first shelving unit, a thickened dairy beverage that was opened and undated, three trays of condiments, a pitcher of lemonade with a use by date of [DATE], a pitcher of iced tea prepared [DATE] with no use by date in the refrigerator. There was a stack of temperature logs taped to the front of the refrigerator door multiple areas of missing documentation. In an interview on [DATE] at Staff W, dietary staff, stated the condiments had been used for salads from the night before and should have been dated. Staff W stated when items are placed in the refrigerator they should be dated. Staff W removed the sandwich in the baggie and three trays of condiments and threw them in the garbage. In an interview on [DATE] at 9:45 AM Staff X, Dietary Manager (DM), stated the temperature logs were completed in the morning and evening. Staff X stated they were aware of the missing entries to the evening portion of the logs and had spoken to the staff responsible about it. <DISHWASHER> In a follow up visit to the kitchen on [DATE] at 9:45 AM, observed the dishwasher temperature log filled out completely with the temperature documented at 120 degrees Fahrenheit (F). Observed the dishwasher temperature after a load of dishes were washed and the temperature reached 100 degrees F, outside of the required 120 degrees F. In an interview on [DATE] at 9:45 AM, Staff X, DM, stated they were unaware the dishwasher had not been heating to the required 120 degrees F and would contact maintenance and their vendor. Staff X stated the dishwasher used a chemical sanitization process. In a follow up interview on [DATE] at 2:42 PM Staff X stated the water booster heater was adjusted which attached to the dishwasher and the temperature exceeded the 120 degrees F. <MEAL DELIVERY> (continued on next page)

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	505463	A. Building B. Wing	08/07/2024

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Madison Post Acute	2520 Madison Everett, WA 98203

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:47 PM observed meal trays being delivered to resident rooms on the 100 hall. During the observation there was Jello, uncovered, on the trays being delivered. On [DATE] at 12:33 PM observed meal trays being delivered to resident rooms on the 300 hall. During the observation there was Jello, uncovered, on the trays being delivered. In an interview on [DATE] at 12:49 PM Staff H, Nursing Assistant Certified, stated the Jello on the meal trays should have been covered. On [DATE] at 12:30 PM observed a dessert being placed on a tray uncovered. When asked Staff X, DM, if the dessert should be covered, they stated they should. 37890 <UNIT REFRIGERATOR> In an observation in the assisted dining room on [DATE] at 12:30 PM, the nourishment refrigerator was observed to contain a plastic container of oats with no name or date, a zip lock bag of cheese slices with no date, a bottle of ketchup in the door with an expiration date of [DATE], and two bags of muffins and pastries with a resident name but no date. In an observation on [DATE] at 9:28 AM, the nourishment refrigerator had been moved from the assisted dining room to the main dining room. There was a new temperature log taped to the front of the refrigerator for the month of August. Inside the refrigerator, it was observed that the same items remained from the day prior (expired ketchup in the door, unlabeled cheese slices, container of oats, muffins and pastries.) In an interview on [DATE] at 9:25 AM, Staff H, Certified Nursing Assistant, stated the kitchen brought down nourishments and put them in the refrigerator and if residents had personal snacks, the staff would label them with name and date and put them in the refrigerator. Staff H stated they did not know who was responsible to check to ensure items were labeled and to remove old or expired items but they thought it was the kitchen. In an observation on [DATE] at 8:58 AM, the refrigerator contained the same expired and unlabeled items (expired ketchup in the door, unlabeled cheese slices, container of oats, muffins and pastries.) Additionally, there was now an unlabeled, undated plastic container of white rice and there were observed to be two boxes of Capri Sun drinks in the cupboard which had expiration dates of [DATE]. In an observation and interview on [DATE] at 12:56 PM, the nourishment refrigerator was observed with Staff F, Dietary Aide, who stated they checked and logged the refrigerator temperatures, made sure the refrigerator was clean, and looked to make sure there was enough of the different types of snacks for the residents every day. Staff F stated they were supposed to check for labels and dates and if items were not properly labeled, old or expired they were supposed to throw them out. Staff F confirmed the kitchen staff were supposed to do this every day and noted the observed items needed to be thrown out. Staff F did not know why the items had remained in the refrigerator days in a row without anyone noticing they were expired or not properly labeled or dated. Reference WAC: [DATE] (3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on observation, interview and record review, the facility failed to ensure adherence to infection prevention and control practices. The facility failed to properly don (put on) and doff (take off) personal protective equipment (PPE) for 1 of 1 (Resident 23) reviewed for aerosol contact precautions related to Coronavirus Disease 2019 (COVID-19, an infectious disease-causing respiratory illness symptoms including cough, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases difficulty breathing that could result in severe impairment or death) outbreak, and failed to cover clean linens during transport. The facility also failed to properly store oxygen (O2) tubing for 1 of 1 resident (Resident 3) reviewed for O2 therapy. These failures placed residents at risk for contracting infection and diminished quality of life. Findings included . In a review of the Facility Assessment, undated, showed the facility was prepared to manage the treatment of COVID-19 infection for their residents by following the COVID-19 Protocol. The facility assessment protocol showed staff would use PPE to protect eyes, nose, and mouth and to prevent contamination of clothing and hands. The minimum PPE for care of residents with respiratory illness (suspected or known COVID-19) included, gown, gloves, N-95 respirators or masks (if available) and eye protection (goggles or face shields). <Resident 3> Resident 3 was admitted to the facility on [DATE], with diagnoses to include congestive heart failure (a condition that causes the heart not to pump blood efficiently), atrial fibrillation (irregular heart rate that effects blood flow), obstructive sleep apnea (OSA) [a sleep disorder in which breathing repeatedly stops and starts]. Review of the quarterly Minimum Date Set (MDS-an assessment tool) dated 07/12/2024, showed Resident 3 was cognitively intact and used oxygen (O2) at night due to OSA. Review of a physician's order dated 10/04/2022, showed Resident 3 had an order to receive O2 at 2 liters per minute (lpm) via nasal cannula (NC) [a tube that delivers oxygen] at night secondary to OSA. In an interview and observation on 07/31/2024 at 10:44 AM, Resident 3 stated that they used oxygen at night. An O2 concentrator machine was observed at the resident's bedside and the oxygen tubing was undated and lying on the floor. In an interview/observation on 07/31/2024 at 10:56 AM, Staff P, Nursing Assistant Certified (NAC) stated Resident 3 used O2 at night and the nurse turns the O2 off. Staff P stated the O2 tubing was not supposed to be on the floor. Staff P picked up the O2 tubing from the floor, rolled it and placed it on top of the concentrator. Staff P stated that was how the tubing was stored. In an observation on 08/01/2024 at 2:01 PM, Resident 3's O2 tubing was observed rolled and stored on top of the concentrator. The O2 tubing was dated 07/11. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 08/02/2024 at 09:41 AM, Resident 3's O2 tubing was rolled and placed on top of the concentrator. The O2 tubing was dated 07/11. In an interview on 08/02/2024 at 10:00 AM, Staff M, Registered Nurse (RN) stated, Resident 3 used O2 at night and the nurse applies and removes the O2 tubing. Staff M stated the O2 tubing was changed, dated, and initialed weekly or when visibly soiled. Staff M stated, the O2 tubing used to be stored in a Ziploc bag, but the bag disappears, so staff just rolls it and puts it on the top of the concentrator. Staff M stated it was not good practice to store O2 tubing on top of the concentrator. In an interview on 08/06/2024 at 09:55 AM, Staff B, RN/Director of Nursing Services stated, if O2 tubing was found on the floor it should be replaced and stored in a plastic bag when not in use. <Facility> In an observation on 07/31/2024 at 11:55 AM, Staff D, Laundry Manager was observed transporting clean clothing protectors and towels uncovered. In an observation on 08/02/2024 at 09:59 AM, Staff U, laundry staff, was observed walking in the hall carrying clothing protectors against their body uncovered. In an interview on 08/02/2024 at 10:04 AM, Staff U stated clean linens and clothing protectors should be covered when transported in the hallway. In an interview on 08/07/2024 at 09:25 AM, Staff D stated laundered items should be covered when being transported through the facility. 47047 <RESIDENT 23> In an observation on 08/01/2024 at 12:36 PM, Staff S, NAC was observed entering Resident 23's room. The wall next to Resident 23's door had signage posted that showed they were on aerosol contact precautions. Staff S entered Resident 23's room wearing only an N95 respirator (a type of face mask recommended for COVID-19) to deliver the resident's meal tray. In an interview on 08/01/2024 at 12:36 PM Staff S, NAC, stated they were not aware Resident 23 had aerosol contact precautions. Staff S stated they should have gowned and gloved. When asked if they should change their mask after exiting Resident 23's room, Staff S stated they were not aware they needed to change their mask. During an observation on 08/01/2024 at 1:04 PM, Staff P, NAC, was observed donning PPE they were wearing a surgical mask, put on gloves and a gown and entered Resident 23's room. Staff P exited Resident 23's room and doffed the gown outside the resident's door, rolled up the gown, removed the gloves, and threw away the gown and gloves down the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/01/2024 at 1:04 PM Staff P, NAC, stated they should wear a mask, gloves and a gown. When asked what type of mask they should wear, Staff P pointed to the PPE supply bin that contained N95 masks, next to Resident 23's door. Staff P stated they were not wearing the proper mask when they entered Resident 23's room. In an interview on 08/06/2024 at 11:56 AM Staff J, Infection Preventionist-Licensed Practical Nurse (LPN) stated the expectation for donning and doffing PPE, for staff who enter rooms with aerosol contact precautions, was to follow the instructions on the posted signs step by step. 37890 Refer to WAC 388-97-1320(1(a)(c)(2)(b(3)(4)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047 Based on observation and record review, the facility failed to ensure 6 resident rooms (107,108, 302, 305, 306, and 307) measured at least 80 square feet per resident in multiple resident rooms and at least 100 square feet in single resident rooms. Failure to ensure residents reside in rooms which met the regulatory requirements for square footage, placed them at risk for living in a physical environment too small to meet their needs. Findings included . room [ROOM NUMBER] 142 Square Feet (Sq.Ft.) (2 beds) room [ROOM NUMBER] 154 Sq. Ft. (2 Beds) room [ROOM NUMBER] 154 Sq. Ft. (2 Beds) room [ROOM NUMBER] 153 Sq. Ft. (2 Beds) Review of the facilities census showed that Rooms107, 302, 305, and 307 all had two beds in each room. Surveyor's observations of residents residing in the affected rooms determined that neither health nor safety of the residents in these rooms was compromised due to the size of the rooms. This is a repeat citation from 10/16/2023. Refer to WAC 388-97-2440(1)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 36787 Based on record review, and interview the facility failed to develop, implement and maintain an in-service training program to ensure 1 of 4 Nursing Assistant's (Staff K) reviewed for the required 12 hour of nurse aide training per year. The failure to ensure Nursing Assistants Certified (NACs) received 12 hours per year in-service training placed residents at risk for potential unmet care needs. Findings included . Review of the Facility Assessment, undated, showed the facility utilizes the following training topics during all staff in-services or department meetings at multiple times throughout the year: - Communication - effective communications for direct care staff with residents/family. Resident's rights and facility responsibilities - educate staff members on the rights of the resident and the responsibilities of a facility to properly care for its residents. - Abuse, neglect, and exploitation - educate staff on: (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or misappropriation of resident property; and (3) Care/management for persons with dementia and resident abuse prevention. - Infection control - education of staff on infection prevention and control standards, policies, and procedures, including proper hand hygiene and the use of personal protective equipment (PPE) in following isolation precautions as necessary. - Culture change (that is, person-centered and person-directed care). - Required in-service training for nurse aides (CNAs and NARs). In service training must: be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. -Include dementia management training and resident abuse prevention training. <EMPLOYEE FILE REVIEW> Review of the emplolyee file for Staff K, NAC, showed they had 6.3 hours of training rather than documented evidence of the required 12 hours of in-servicing. Review of the in-service records showed the facility failed to document how long the in-service lasted or the time it started. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/06/2024 at 12:59 PM, Staff J, Staff Development Coordinator stated they were working on the education piece to ensure the staff had the 12 hours of education. At 3:00 PM, Staff J said they were able to locate the 12 hours for the other 4 NACs requested but not for Staff K. Staff K said the expectation was for NACs to have at least 12 hours of education yearly. Refer to WAC 388-97-1680 (2)(a-c)