STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505469	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at Skyline	715 9th Avenue Seattle, WA 98104

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure informed consent for an antidepressant (medication used to treat depression) was completed before administration for 1 of 5 residents (Resident 4), reviewed for unnecessary medications. This failure placed the resident and/or their representative at risk of not being fully informed of the risks and benefits before making decisions about medications before administration. Findings included . A review of the facility's policy titled, Psychotropic Drug Use, revised on 04/01/2024, showed that residents and/or their responsible parties will be asked to make an informed choice concerning the use of a psychoactive (mind altering) drug and for an informed choice to be made, potential negative outcomes (risks) and benefits for the drug use would be explained. A review of Resident 4's face sheet printed on 08/20/2024 showed that Resident 4 was readmitted to the facility on [DATE]. A review of a physician's order dated 03/19/2024 showed Resident 4 had an order for antidepressant medication. A review of the Medication Administration Records from March 2024 to August 2024 showed Resident 4 had been taking antidepressant medication since 03/20/2024. A joint record review and interview on 08/22/2024 at 11:03 AM with Staff C, Resident Care Manager, showed Resident 4 signed a consent for antidepressant medication on 05/28/2024. Staff C stated that Resident 4's consent should have been obtained before starting the medication. On 08/22/2024 at 11:33 AM, Staff B, Corporate Director of Health Services, stated that they expected residents to have consent before taking psychotropic medications to explain the risks and benefits. Staff B further stated that the consent should have been completed before Resident 4 started taking antidepressant medication. Reference: (WAC) 388-97-0260 (2) (a-d)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to ensure the residents were evaluated and assessed, and/or a physician order was obtained for safe administration of medication for 2 of 2 residents (Residents 235 & 20), reviewed for self-medication administration. This failure placed the residents at risk for inaccurate and unsafe medication administration, adverse side effects, medical complications, and a diminished quality of life. Findings included . A review of the facility's policy titled, Self-Administration of Medications, revised on 07/01/2024, showed that the facility would provide each resident with the opportunity to self-administer medications if the resident chooses. Self-administration of medications is listed as one of the rights, the resident is given the opportunity and may choose to do so if the interdisciplinary team determines the resident is safe to self-administer. An assessment of the resident's capabilities to self-administer is performed by the IDT [Interdisciplinary Team]. Assessments will be updated quarterly. A physician order is obtained. The care plan is updated. The medication sheet states the medication and that the resident is self-administering. RESIDENT 235 A review of the face sheet printed on 08/21/2024, showed Resident 235 was admitted to the facility on [DATE]. A review of the August 2024 Medication Administration Record (MAR) showed that Resident 235 was getting enoxaparin (an anticoagulant medication used to prevent and treat harmful blood clots) injection once daily. Further review of the MAR did not show an order for self-medication administration. During Resident 235's medication administration on 08/21/2024 at 9:07 AM, Staff E, Licensed Practical Nurse (LPN), stated, I have your injection. Resident 235 cleaned their abdominal skin area with an alcohol wipe, pinched their skin, and then self-administered the enoxaparin injection, then Resident 235 handed the empty syringe with the exposed needle to Staff E. Staff E pushed the syringe plunger, and the needle retracted. Resident 235 stated that they preferred to give their enoxaparin injection themselves. On 08/22/2024 at 9:23 AM, Resident 235 stated that they had been administering enoxaparin injections themselves since June 2020, before admitting to the facility. Resident 235 stated that the facility staff had not assessed them for self-medication administration of the injection. Resident 235 stated, I won't let them give me the enoxaparin injections, I have been doing it myself for so long. On 08/22/2024 at 9:38 AM Staff E stated that Resident 235 had let them inject their enoxaparin injection one time since they were admitted to the facility and that Resident 235 had been doing it. A joint record review of Resident 235's electronic clinical records did not show an assessment, an order, and/or a care plan for self-medication administration for their enoxaparin injection. Staff E stated they did not assess the resident for self-medication administration, and that there was no order, and/or care plan for self-medication of enoxaparin injection for Resident 235. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/2024 at 10:01 AM, Staff C, Resident Care Manager (RCM), stated that when a resident wants to self-administer medications, the facility completes an assessment, obtains an order from the doctor, and then care plans the self-medication administration. A joint record review of Resident 235's clinical records did not show an assessment, an order, and/or a care plan for self-administration of their enoxaparin injection. In a follow-up interview at 10:36 AM, Staff C stated that Resident 235 should have had an assessment done, an order, and a care plan for self-medication administration for enoxaparin injection. On 08/22/2024 at 11:42 AM, Staff B, Corporate Director of Health Services, stated that if a resident wanted to do self-medication, the facility assessed the residents for self-medication administration, obtained an order for self-medication of the specific medication, and then care planned the self-medication administration. Staff B stated that Resident 235 should have had an assessment, an order, and a care plan for self-medication administration. 50891 RESIDENT 20 A review of Resident 20's face sheet showed they were admitted to the facility on [DATE]. A review of the medication administration record for August 2024 showed Resident 20 was taking the following medications: -Fluticasone Propionate Nasal Suspension (nasal spray to treat seasonal allergies) Two sprays in both nostrils one time a day for allergy. Unsupervised self-administration. -Calcium-Cholecalciferol oral tablet (a dietary supplement to maintain bone strength). Give one table by mouth two times a day for Supplement. Please give for self-med [self-medication administration]/may leave at the bedside table. -Ocean Nasal Spray Nasal Solution (used to prevent dry nasal passages). Two sprays in both nostrils twice a day to prevent the nose from drying due to nasal cannula. Leave at the bedside for self-administration. -Refresh Tears Ophthalmic Solution (used to treat dry eyes). Instill one drop in both eyes two times a day for dryness unsupervised self-administration. May keep resident at bedside per resident request. - Ponaris Nasal Solution (to help moisturize the nasal passages) in both nostrils as needed for nasal irritation four times a day as needed. (There is no self-administration order for this medication). A review of the Medication Self-Administration Safety Screen assessment, dated 10/20/2023, did not include the Fluticasone Nasal spray and Ponaris Nasal solution. A review of Resident 20's comprehensive care plan, printed on 08/20/2024, did not show a care plan for self-medication administration. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 08/19/2024 at 9:40 AM showed a medication cup containing a green tablet on the bedside table in Resident 20's room. Further observation showed the Refresh tears, Fluticasone, Ponaris nasal solution, and nasal normal saline spray were on the resident's bedside table. Resident 20 stated that the medication in the medication cup was their calcium pill. In a joint record review and interview on 08/22/2024 at 3:32 PM with Staff C, the physician orders showed no medication self-administration order for Resident 20's Ponaris Nasal solution and Fluticasone Nasal Spray. Staff C stated that they did not find a self-administration order and would have to request it. In a joint record review and interview on 08/22/2024 at 4:07 PM, Staff B, Corporate Director of Health Services, stated that the facility would make sure the residents were competent to take their medications and were able to vocalize the side effects. Staff B stated that they did not see that medication self-administration was included in Resident 20's comprehensive care plan. Reference: (WAC) 388-97-0440, 1060 (3)(j)(i)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 47218 Based on observation, interview, and record review, the facility failed to ensure a homelike dining environment was provided during 2 of 3 dining observations to 6 of 8 residents (Residents 3, 8, 235, 19, 14 & 13). The failure to ensure licensed nurses refrained from administration of medications during resident meals placed the residents at risk for diminished quality of life. Findings included . A review of the facility's policy titled, Medication Administration, revised on 04/11/2024, showed that medications were administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. EIGHTH FLOOR DINING ROOM RESIDENT 3 Observation on 08/19/2024 at 8:35 AM, Staff F, Licensed Practical Nurse (LPN), was observed assisting Resident 3 with their oral medications in the dining room during the breakfast meal. RESIDENT 8 Observation on 08/19/2024 at 8:42 AM, Staff F was observed giving Resident 8 their oral medications in the dining room. On 08/21/2024 at 11:26 AM, Staff F stated that medications were not supposed to be given in the dining room. Staff F stated they should not have given Resident 3 and Resident 8's morning medications in the dining room. On 08/22/2024 at 10:16 AM, Staff D, Resident Care Manager (RCM), stated they expected staff to provide medications to the residents in their room. Staff D stated Resident 3 and Resident 8 should not have been given their medications in the dining room. On 08/22/2024 at 11:40 AM, Staff B, Corporate Health Services Director, stated that Resident 3 and Resident 8 should not have been given their medications in the dining room. 50891 SEVENTH FLOOR DINING ROOM RESIDENT 235 Observation on 08/19/2024 at 8:56 AM, showed Staff E, LPN, checked Resident 235's blood pressure and oxygen saturation levels and then gave Resident 235 their medication in the dining room during the breakfast meal. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/19/2024 at 12:28 PM showed Staff E, administered medication to Resident 235 in the dining room during lunch meal. RESIDENT 19 Observation on 08/19/2024 at 12:34 PM, showed Staff E administered medications to Resident 19 in the dining room. RESIDENT 14 Observation on 08/19/2024 at 12:39 PM, showed Staff E administered medications to Resident 14 in the dining room. RESIDENT 13 Observation on 08/19/2024 at 12:42 PM, showed Staff E checked Resident 13's blood pressure before administering a medication in the dining room. In an interview on 08/19/2024 at 1:21 PM, Staff E stated that they try to administer medications before residents get to the dining room and did not always get to them on time. Staff C further stated that some of the medications have parameters and needed to get the vital signs before giving the medications. Staff E stated that when the facility was short-staffed, they ended up administering medications in the dining room. In an interview and joint record review on 08/22/2024 at 4:22 PM, Staff B, Corporate Director of Health Services, stated that if the resident requested to have their medication administered in the dining room, then it could be administered if it was included in the care plan. A joint record review of the comprehensive care plans for Resident 235, Resident 19, Resident 14 & Resident 13 did not show that medication administration in the dining room was included in their care plan. Reference: (WAC) 399-97-0880 (1)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident and/or their representative for 1 of 1 resident (Resident 12), reviewed for hospitalization . This failure placed the resident and/or their representative at risk for not having an opportunity to make informed decisions about transfers/discharges. Findings included . A review of the facility's policy titled, Transfer/Return, revised on 04/14/2024, showed that before facility-initiated transfer, the resident would be notified in writing the reasons for transfer in a language and manner they can understand. The policy also showed that the notice would contain the reasons for transfers and be documented in the resident's record by the facility and the physician. A review of the discharge Minimum Data Set (MDS-an assessment tool) dated 05/28/2024 showed that Resident 12 was discharged to the hospital. A review of the admission MDS dated [DATE] showed that Resident 12 was readmitted back to the facility on [DATE]. A review of the nursing progress note dated 05/28/2024 showed Resident 12 was transferred to the hospital for further evaluation. A review of the clinical health record (electronic and paper chart) did not show documentation that a written notice of transfer/discharge was provided to Resident 12 and/or their representative. In an interview on 08/20/2024 at 1:56 PM, Staff E, Licensed Practical Nurse, stated that when residents transfer to the hospital, they notify family/representatives by phone. Staff E stated that they did not notify Resident 12 and/or their representatives in writing. In an interview on 08/20/2024 at 3:22 PM, Staff C, Resident Care Manager, stated that the facility notified family/representatives about hospital transfer by phone. Staff C stated that they did not provide a written notice to Resident 12 and/or their representative. In an interview on 08/22/2024 at 11:33 AM, Staff B, Corporate Director of Health Services, stated that it was their expectation for the facility to notify resident and/or their representative in writing. Reference: (WAC) 388-97-0120 (2)(a)(b)(c)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48899 Based on interview and record review, the facility failed to ensure bed hold (the opportunity to reserve a resident's current occupied bed while out of the facility to ensure their room was available when ready to return) notice was offered for 1 of 1 resident (Resident 12), reviewed for hospitalization . This failure placed the resident or their representative at risk for lack of knowledge regarding the right to hold their bed while in the hospital. Findings included . A review of the facility's policy titled, Bed Hold, revised on 01/22/2024, showed that It is the policy of this community to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave. A review of the discharge Minimum Data Set (MDS-an assessment tool) dated 05/28/2024 showed Resident 12 discharged to the hospital. A review of the admission MDS dated [DATE] showed Resident 12 was readmitted to the facility on [DATE]. A review of the nursing progress note dated 05/28/2024 showed Resident 12 was transferred to the hospital for further evaluation. A review of the clinical health record (electronic and paper chart) did not show documentation that Resident 12 was offered a bed hold notice for their transfer to the hospital. In an interview and joint record review on 08/20/2024 at 1:56 PM, Staff E, Licensed Practical Nurse, stated that when the residents transferred to the hospital, they provided a bed hold notice to residents and /or their representatives. A joint review of the clinical health record with Staff E did not show that Resident 12 and/or their representative were provided with a bed hold notice. Staff E stated that the bed hold notice should have been provided. In a joint record review of clinical health records and an interview on 08/20/2024 at 3:22 PM with Staff C, Resident Care Manager, did not show that Resident 12 and/or their representative were provided a bed hold notice. Staff C stated that the bed hold notice should have been provided to Resident 12 and/or their representative. In an interview on 08/22/2024 at 11:33 AM, Staff B, Corporate Director of Health Services, stated that it was their expectation for the facility to provide bed hold notice to Resident 12 and/or their representative. Reference: (WAC) 388-97-0120 (4)(a)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS- an assessment tool) was completed timely for 1 of 1 resident (Resident 9), reviewed for significant change in condition. The failure to complete a SCSA within 14 days placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.18.11, dated October 2023, showed that a significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'self-limiting,' 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary [involving two or more different subjects or areas of knowledge] review and/or revision of the care plan. The RAI showed that an SCSA is required to be performed when a terminally ill resident enrolls in a hospice program or changes hospice providers and remains a resident at the nursing home. The RAI manual further showed that the assessment should be completed no later than 14 days after the determination was made (determination date plus 14 calendar days). The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). A review of the face sheet printed on 08/27/2024 showed Resident 9 admitted to the facility on [DATE]. A review of the clinical health record (Electronic Health Record [EHR] and paper chart) showed Resident 9 was admitted to hospice care on 09/22/2023. A review of the SCSA MDS with an ARD of 09/27/2023 showed it was completed on 10/10/2024, which was four days late. In an interview and joint record review on 08/22/2024 at 11:55 AM, Staff K, MDS Coordinator, stated that the SCSA MDS should be completed within 14 days of the significant change in status. A joint record review of the EHR showed Resident 9 was admitted to hospice care on 09/22/2024. In a follow-up email dated 08/22/2024 at 12:21 PM, Staff K stated that the SCSA MDS was completed late per the RAI manual. In a phone interview on 08/23/2024 at 8:45 AM, Staff B, Corporate Director of Health Services, stated they expected an SCSA MDS to be completed timely. Reference: (WAC) 388-97-1000 (3)(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure resident-centered care and treatment were provided in accordance with professional standards of practice when the facility failed to ensure consistent communication and collaboration of care occurred between the facility and hospice care for 1 of 1 resident (Resident 9), reviewed for hospice services. This failure placed the resident at risk of not receiving necessary comfort care services, unmet care needs, and a diminished quality of life. Findings included . A review of the facility's policy titled, Nursing Services-Hospice, revised on 02/13/2024, showed that the facility will ensure all documentation of hospice visit[s] are complete according to the state and federal regulations. A review of the face sheet printed on 08/27/2024 showed Resident 9 admitted to the facility on [DATE]. A review of the Electronic Health Record (EHR) showed Resident 9 was admitted to hospice care on 09/22/2023. A review of Resident 9's clinical health records (EHR and paper chart) showed the most recent hospice notes were from December 2023. A review of the August 2024 Treatment Administration Record showed an order for a left heel wound treatment and dressing change that started on 07/11/2024. In an interview and joint record review on 08/21/2024 at 12:50 PM, Staff F, Licensed Practical Nurse, stated that they would look for hospice notes about Resident 9's left heel wound but they could not find any hospice visit notes in Resident 9's EHR. A joint record review of Resident 9's paper chart showed the last hospice notes were from December 2023. Staff F stated the Resident Care Manager (RCM) would call hospice and request recent hospice notes. In an interview on 08/22/2024 at 8:47 AM, Staff D, RCM, stated they did not expect the hospice notes to be readily available in the facility, but they could request the notes if needed. Staff D further stated that they had to request the documents for Resident 9 because there were no recent hospice notes readily available to show if hospice had been following the left heel wound. In an interview on 08/22/2024 at 10:32 AM, Staff B, Corporate Director of Health Services, stated that there should be verbal and written communication to coordinate care between the facility and hospice. Staff B stated they expected that after hospice visited a resident, their notes would be readily available and on hand in the facility. Staff B further stated they would not expect the last hospice notes in the resident's chart to be from December 2023. Reference: (WAC) 388-97-1060 (1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to thoroughly assess and stage a pressure ulcer (localized damage to the skin and underlying tissue from prolonged pressure, friction, or shear, causing pain) at onset and weekly and maintain clear and accurate wound documentation for a pressure ulcer for 1 of 1 resident (Resident 9), reviewed for pressure ulcer. This failure placed the resident at risk for deterioration of their pressure ulcer and a diminished quality of life. Findings included . A review of the facility's policy titled, Pressure Ulcers and Skin Breakdown, revised on 04/11/2024, showed, The nurse shall describe and document/report the following: Full assessment of pressure sore [ulcer] including location, stage. A review of the face sheet printed on 08/27/2024 showed Resident 9 admitted to the facility on [DATE]. A review of the skin integrity care plan revised on 07/10/2024, showed Resident 9 had a left heel wound. A review of the mobility care plan revised on 08/20/2024, showed Resident 9 had a left heel pressure ulcer. A review of the facility's document titled, Skin Only Evaluation, dated 07/03/2024, showed Resident 9 had discoloration on their left heel that was not opened. A review of the facility's document titled, Skin Only Evaluation, dated 07/10/2024, showed Resident 9 had discoloration on their left heel that was not opened and was not described as a pressure ulcer. In an interview and joint record review on 08/21/2024 at 12:50 PM, Staff F, Licensed Practical Nurse, stated that they did not know if Resident 9's left heel wound was a pressure ulcer. A joint review of the Skin Only Evaluation, dated 07/10/2024, showed discoloration and did not describe the wound as a pressure ulcer or document the staging. A joint review of Resident 9's mobility care plan showed Resident 9 had a left heel pressure ulcer. Staff F stated they expected there to be documentation of the staging for Resident 9's pressure ulcer. In an interview and joint record review on 08/22/2024 at 8:47 AM, Staff D, Resident Care Manager, stated that Resident 9's left heel wound started as a blister, and opened on 07/05/2024, was called a pressure injury and treatment was started. A joint review of the Skin Only Evaluations dated 07/03/2024, 07/10/2024, and 07/21/2024, showed no documentation of staging the wound. Staff D stated, Once it [the blister] pops that should have been the start of staging. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505469	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at Skyline	715 9th Avenue Seattle, WA 98104

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 08/22/2024 at 10:32 AM, Staff B, Corporate Director of Health Services, stated that it was very important to stage [or staging of pressure ulcer - is a classification system used to describe the severity of the injury to the skin and underlying tissue caused by prolonged pressure]. pressure ulcers and they expected this to be done and should be documented. A joint record review of the Skin Only Evaluation from 07/03/2024 and 07/10/2024, showed no change and continued to describe the left heel as having discoloration. Staff B stated it doesn't look like a new assessment was done. A joint record review of the physician's order for the wound treatment that started on 07/10/2024 showed no staging. Staff B stated, I would expect the order to state the stage of the pressure ulcer. In a joint observation and interview on 08/22/2024, Staff V, Hospice Registered Nurse Case Manager, showed Staff V was cleaning dry skin from Resident 9's wound. Once the skin was removed, Staff V described the pressure ulcer on the bottom of the heel as unstageable [a type of pressure ulcer, which the depth is unknown due to a wound base that is covered by slough [moist, loose, stringy dead tissue that covers the wound, often appearing as a yellow, tan, or white fibrous material] and the open parts on both sides of the heel as Stage 2 (shallow open wound and may also present as an intact or open/ruptured blister) pressure ulcers. Staff V stated that they recommend starting a new treatment based on the observation of Resident 9's heel. On 08/22/2024 at 5:25 PM, Staff D stated, Even if a resident is on hospice there should be staging of their pressure ulcer. Staff D further stated that staging was not done for Resident 9's pressure ulcer. Reference: (WAC) 388-97-1060 (3)(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on observation, interview, and record review, the facility failed to maintain, label/date, and properly store oxygen tubing/supplies and nasal cannula (flexible tubing that sits inside the nose and delivers oxygen) for 2 of 2 residents (Residents 23 & 20), reviewed for respiratory care. This failure placed the residents at risk for unmet care needs, respiratory infections, and related complications. Findings included . A review of the facility's policy titled, Oxygen Administration, revised on 02/07/2024, showed that the facility administers oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues. The policy showed that the facility would assess the need for oxygen, obtain an order from a physician if needed longer than 24 hours, write the date on prepackaged humidifier bottles and discard the bottle after 7 days or when sterile water was gone, place nasal cannula(prongs) or mask in place with a date written on a label attached to tubing, and that oxygen tubing should be changed every week with new nasal cannula or mask. RESIDENT 23 A review of the face sheet showed Resident 23 was admitted to the facility on [DATE] with a diagnosis that included pulmonary fibrosis (scarring and thickening of the tissue around and between the air sacs called alveoli in the lungs making it harder for oxygen to pass into the bloodstream). A review of Resident 23's physician orders printed on 08/20/2024 showed no orders for oxygen. On 08/19/2024 at 11:46 AM, Resident 23 was observed to have an oxygen concentrator and a portable oxygen device in their room. The oxygen concentrator had a humidifier bottle of water that was undated (or unlabeled), and the nasal cannula was lying uncovered on top of the concentrator. The nasal cannula tubing from the portable oxygen device was on the floor, uncovered, and undated. Resident 23 stated they did not remember the last time the oxygen tubing and humidifier bottle were changed. Resident 23 stated they used their portable oxygen as needed throughout the day, and that they used the oxygen concentrator nightly all night every night. Observation on 08/20/2024 at 3:18 PM showed Resident 23's oxygen tubing from the oxygen portable oxygen device was undated, uncovered, and on the floor. Resident 23's oxygen concentrator tubing, nasal cannula, and humidifier bottle were undated. Both oxygen nasal cannulas from Resident 23's oxygen concentrator and portable oxygen were not being used and were uncovered. A joint observation and interview on 08/20/2024 at 3:27 PM with Staff G, Licensed Practical Nurse (LPN), showed Resident 23's portable oxygen nasal cannula was on the floor uncovered and undated; and the oxygen concentrator nasal cannula was uncovered and undated. Staff G stated that Resident 23's nasal cannulas should have been dated, labeled, initialed, and covered with a bag when not in use. Staff G further stated that the portable oxygen nasal cannula should have not been on the floor. (continued on next page)

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	505469	A. Building B. Wing	08/23/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/2024 at 3:36 PM, Staff D, Resident Care Manager (RCM), stated that the oxygen tubing and nasal cannula should not have been on the floor, should be in a plastic bag when not in use, and be dated. A joint record review and interview with Staff D showed Resident 23's physician orders did not have orders for oxygen and/or orders for changing the oxygen tubing and the humidifier bottle. Staff D stated that Resident 23 used a portable oxygen device during the day and that they did not see oxygen protocol orders and/or oxygen orders. Staff D stated that there should have been oxygen orders in place for Resident 23. Staff D stated Resident 23's oxygen tubing and humidifier bottle should have been labeled, and dated, not on the floor, and nasal cannulas covered with a plastic bag when not in use. Another joint record review and interview with Staff D showed Resident 23's medical provider progress note and a portable oxygen concentrator order form dated 05/10/2024 documented that Resident 23 needed oxygen and the amount they needed per minute. Staff D stated that Resident 23's protocol for oxygen orders should have been started on 05/10/2024. In another interview on 08/21/2024 at 10:05 AM, Staff D stated that Resident 23's nasal cannulas from the oxygen concentrator and portable oxygen device and the humidifier bottle should have been dated, initialed, and labeled. On 08/22/2024 at 11:53 AM, Staff B, Corporate Director of Health Services, stated they expected an order for oxygen, oxygen protocol to monitor oxygen, oxygen tubing, and humidifier water bottle should be changed, dated, and initialed, and that nasal cannula needs to be appropriately stored when not in use. Staff B stated Resident 23's oxygen nasal cannula tubing should not have been on the floor and that they should have been covered in a breathable bag when not in use. A joint record review of the clinical records showed Resident 23 oxygen orders were entered on 08/20/2024, Staff B stated that there were no orders for oxygen in place before that date. A joint record review of the portable oxygen order form and medical provider's note dated 05/10/2024 showed orders for oxygen for portable concentrator device and oxygen concentrator, Staff B stated that Resident 23's oxygen orders should have been in place since around that time. 50891 RESIDENT 20 A review of Resident 20's face sheet showed they were admitted to the facility on [DATE] with a diagnosis that included chronic respiratory failure (a long-term condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). A review of Resident 20's comprehensive care plan revised on 06/26/2024, showed an oxygen therapy care plan that directed staff to .provide extension tubing or portable oxygen apparatus. Observation on 08/19/2024 at 9:36 AM showed Resident 20 was sitting in their room wearing a nasal cannula that was connected to the oxygen concentrator. The oxygen concentrator had a humidifier bottle of water. This bottle of water did not have a date written on it to indicate when the bottle was opened, and the oxygen tubing/nasal cannula was not labeled or dated. Further observation showed Resident 20 had a portable oxygen tank with a nasal cannula that was draped over Resident 20's walker that was not labeled or dated. In an interview on 08/19/2024 at 9:36 AM, Resident 20 stated that the oxygen tubing gets changed when they ask the nurse to change it. (continued on next page)

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	505469	A. Building B. Wing	08/23/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/2024 at 1:50 PM, Staff E, LPN, stated that Resident 20's tubing gets changed weekly. Staff E stated that Resident 20 would ask for the tubing to be changed and manage their oxygen on their own. In a joint record review and interview on 08/21/2024 at 2:20 PM with Staff E, showed a physician's order for oxygen that was ordered on 08/20/2024. Staff E stated they could not find an order before 08/20/2024. In an interview and joint record review on 08/22/2024 at 4:16 PM, Staff B, Corporate Director of Health Services, stated that their expectation regarding oxygen therapy included having physician orders for oxygen and the water (for the concentrator) and oxygen tubing labeled with a date. A joint record review of the physician's order with Staff B showed no oxygen orders before 08/20/2024. Staff B stated that they were unable to find an oxygen order before 08/20/2024. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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	505469	A. Building B. Wing	08/23/2024

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48899 Based on interview and record review, the facility failed to provide the required Registered Nurse (RN) coverage for 6 of 92 days (10/07/2023, 10/08/2023, 10/15/2023, 10/21/2023, 10/22/2023 & 11/04/2023), reviewed for sufficient and competent nurse staffing. This failure placed the residents at risk for inadequate assessments, delay in care services by an RN, unmet care needs, and a diminished quality of life. Findings included . A review of the facility's policy titled, Staffing Requirement, revised on 04/01/2024, showed that the facility will ensure the staffing sufficient of accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable data in a uniform format according to specifications. The policy also showed that the standard minimum staffing will significantly reduce the risk of unsafe and low-quality care for residents. Total direct nursing care to residents of at least 0.55 hours per resident per day of care must be provided by RNs. A review of the facility's form titled, Daily Nursing Staff Posting, from 10/01/2023 to 12/31/2023, showed the following dates without (or did not have) eight-hour RN coverage: 10/07/2023 10/08/2023 10/15/2023 10/21/2023 10/22/2023 11/04/2023 A joint record review and interview on 08/23/2024 at 12:35 PM with Staff I, Staffing Coordinator, showed the Daily Nursing Staff Posting, did not have RN coverage for eight hours on 10/07/2024, 10/08/2023, 10/15/2023, 10/21/2023, 10/22/2023 and 11/04/2023. Staff I stated that they were not short of staff but I don't know what happened. On 08/23/2024 at 1:01 PM Staff A, Administrator, stated that the regulation requires the facility to have RN coverage and we should meet the requirement. Staff A stated that it was their expectation for the facility to have RN coverage. Reference: (WAC) 388-97-1080 (3)

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	505469	A. Building B. Wing	08/23/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47218 Based on observation, interview, and record review, the facility failed to appropriately label/store medications/biologicals (diverse group of medicines made from natural sources) and/or medical supplies for 2 of 2 medication rooms (Seventh Floor and Eighth Floor Medication Rooms), reviewed for medication storage. This failure placed the residents at risk for receiving compromised and ineffective medications and medical supplies. Findings included . Review of the facility's policy titled, Medication Label, revised on 04/11/2024, showed that nursing would ensure resident's medication was appropriately labeled according to pharmacy recommendation. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 30 days unless the manufacturer specifies a shorter or longer date for the open vial. SEVENTH FLOOR MEDICATION ROOM A joint observation and interview on 08/20/2024 at 1:13 PM with Staff C, Resident Care Manager (RCM), showed the Seventh Floor Medication Room's refrigerator had one multidose vial of tuberculin (purified protein derivative, is a combination of proteins that are used in the diagnosis of tuberculosis [a serious illness caused by a type of bacteria that mainly affects the lungs]) with an open date of 07/18/2024. Staff C stated that tuberculin was good for 30 days from the date it was first opened. Staff C stated that the tuberculin date was a few days past the 30 days, and it was expired by three days. Staff C further stated that the tuberculin should have been discarded. EIGHTH FLOOR MEDICATION ROOM A joint observation on 08/20/2024 at 1:24 PM with Staff N, Registered Nurse, showed the Eighth Floor Medication Room's refrigerator had one bottle of amoxicillin (an antibiotic - medication that fights infections) 400-57 10.9 milliliters (a unit of measurement) with an expiration date on 08/06/2024 for Resident 22. The Eighth Floor Medication Room also showed the following expired supplies: - One intermittent catheter (a hollow, partially flexible tube that collects urine - inserted and removed several times a day to empty the bladder) with an expiration date of 05/31/2024. - One intermittent catheter with an expiration date of 09/30/2022. - One latex Foley catheter (flexible tube used to drain urine from the bladder) with an expiration date of 07/28/2023. (continued on next page)

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	505469	A. Building B. Wing	08/23/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/20/2024 at 1:48 PM, Staff N stated that Resident 23 used intermittent catheters. Staff N stated that the amoxicillin, two intermittent catheters and Foley catheter tube were expired, and that they should have been discarded. In an interview on 08/22/2024 at 10:21 AM, Staff D, RCM, stated that they expected medications and supplies to be labeled, checked for expiration dates, and to be discarded when expired. Staff D stated that the amoxicillin, the two intermittent catheters, and one foley catheter tube found in the Eighth Floor Medication Room should have been disposed. In an interview on 08/22/2024 at 11:48 AM, Staff B, Corporate Director of Health Services, stated that the expired medications and medical supplies should be removed from the medication rooms. Staff B further stated that the expired tuberculin, amoxicillin, and the three urinary catheter tubes should have been discarded. Reference: (WAC) 388-97-1300 (2)

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	505469	A. Building B. Wing	08/23/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on observation, interview, and record review, the facility failed to ensure expired food items were discarded after the expiration date or use by date and failed to have a working thermometer in accordance with professional standards for food safety for 1 of 5 refrigerators (Kitchen Walk-In Refrigerator). These failures placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages). Findings included . A review of the facility's policy titled, Food Safety Requirement, revised on [DATE], showed that Food service safety refers to handling, preparing, and storing food in ways that prevent foodborne illness. The policy showed that expired food would be removed immediately. The policy further showed practices to maintain safe refrigerated storage included monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation and labeling, dating, and monitoring food, including, but not limited to leftovers, so it is used by its use-by date. A review of the facility's policy titled, Food Storage, revised [DATE], showed the temperatures shall be monitored in all refrigeration and freezer units, checked daily (or more often if there is a problem), and recorded. Even if there is an outside thermometer, one thermometer shall be placed in the warmest part of the unit, preferably near the door, to ensure that the proper minimum temperature is maintained. A joint observation and interview on [DATE] at 8:28 AM with Staff U, Sous Chef, showed a tray of four Impossible Burger [brand] patties with a used-by date of [DATE] was found in the Kitchen Walk-In Refrigerator. A tray of raw pork chops was also observed with a label that read, prep date ,d+[DATE] [[DATE]], use by ,d+[DATE] [[DATE]]. Staff U stated they would remove these items. In another joint observation and interview on [DATE] at 8:34 AM, with Staff U, a thermometer was observed attached to the shelf in the Kitchen Walk-In Refrigerator. Staff U was unable to read the temperature on this thermometer and stated, This is a broken one. Another thermometer was found on the same shelf but tucked on the side. When Staff U was asked to read the thermometer, they stated that it was also broken. In an interview on [DATE] at 3:53 PM, Staff A, Administrator, stated that the expectation was to have a thermometer inside the refrigerator. Staff A stated that they had expired foods that they did not discard immediately. Reference: (WAC)[DATE](3)

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	505469	A. Building B. Wing	08/23/2024

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 48899 Based on interview and record review, the facility failed to ensure that direct care staffing information was submitted timely to the Centers for Medicare and Medicaid Services (CMS), for 1 of 1 quarter (Quarter 4) for the fiscal year 2023 (which included October 2023 through December 2023), reviewed for Payroll Based Journal (PBJ- mandatory reporting of staffing information based on payroll data) submission. This failure caused the CMS to have inaccurate data related to nursing home staffing levels and had the potential to impact resident care and services. Findings included . A review of the facility's policy titled, PBJ, revised on 07/01/2024, showed it is the policy of this facility to electronically submit timely to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. In an interview on 08/21/2024 at 1:32 PM, Staff J, Staffing/Central Supply Coordinator stated that they prepared the PBJ report for the 4th quarter of 2023 and provided it to the staff that submitted it to CMS. Staff J stated that they were not certain if the 4th quarter PBJ data was submitted. On 08/23/2024 at 1:01 PM, Staff A, Administrator, stated that the PBJ data for the 4th quarter of 2023 was not submitted promptly. Reference: (WAC) 388-97-1090(3)

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	505469	A. Building B. Wing	08/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure hand hygiene practices were followed during meal tray pass for 1 of 4 staff (Staff L), reviewed for infection control. In addition, the facility failed to follow infection control practices for 3 of 10 residents (Residents 6, 235 & 18), reviewed for medication administration. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . A review of the facility's policy titled, Handwashing Policy, revised on 04/11/2024, showed hand hygiene was indicated, immediately before touching a resident .after touching a resident .after touching the resident's environment. HAND HYGIENE DURING MEAL TRAY PASS Observation on 08/19/2024 at 8:53 AM, showed Staff L, Certified Nursing Assistant, set up the meal tray for the resident in room [ROOM NUMBER] and left the room without performing hand hygiene. Staff L then touched the meal cart, removed a meal tray, entered room [ROOM NUMBER], set the tray on the bedside table and exited the room and touched the meal cart. No hand hygiene was performed before or after entering room [ROOM NUMBER]. Staff L then brought a meal tray to room [ROOM NUMBER], raised the resident's bed, touched the bedside table and then exited the room. No hand hygiene was performed before or after entering room [ROOM NUMBER]. Staff L removed the next tray from the cart and brought it to room [ROOM NUMBER] (an Enhanced Barrier Precautions [EBP] room-requiring extra precautions including washing hands before and after entering the room), touched the bed controls, the bedside table, and set up the tray for the resident. No hand hygiene was performed before or after entering room [ROOM NUMBER]. In an interview and joint observation on 08/19/2024 at 9:02 AM, Staff L stated they washed their hands prior to passing meal trays but did not wash their hands when going between resident's rooms and delivering trays. Joint observation of the EBP sign outside room [ROOM NUMBER] showed that everyone should wash hands before entering the room and when exiting the room. Staff L stated I should have washed my hands when entering and exiting room [ROOM NUMBER]. In an interview on 08/22/2024 at 1:30 PM, Staff D, Resident Care Manager/Infection Preventionist, stated they expected staff to perform hand hygiene between passing meals to residents and before and after going into resident rooms. In an interview on 08/22/2024 at 5:18 PM, Staff B, Corporate Director of Health Services, stated they expected staff to perform hand hygiene during meal tray pass. Staff B further stated they expected staff to wash hands before and after going into resident rooms. 47218 INFECTION CONTROL DURING MEDICATION PASS (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505469	A. Building B. Wing	08/23/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy titled, Medication Administration, revised on 04/11/2024, showed that medications were administered by licensed nurses as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. RESIDENT 6 On 08/21/2024 at 8:39 AM, Staff E, Licensed Practical Nurse, was observed preparing medications. Staff E donned gloves and poured Resident 6's seven medications on their hand, then placed them in a medication cup after opening the medication cart, medication bottles, and medication bubble cards (medications placed in bingo cards) with the same gloved hands. Staff E brought the medication cup and the bubble card containing metoprolol tablets (medication that lowers the blood pressure) on a medication tray to Resident 6's room. Joint observation with Staff E showed there was an EBP signage outside Resident 6's room. Staff E stated that they had to put on Personal Protective Equipment [PPE-gown, gloves and mask] prior to entering Resident 6's room. Staff E brought the vital sign machine in Resident 6's room to take their blood pressure (BP) and pulse. After obtaining Resident 6's BP and pulse, Staff E popped a tablet of metoprolol in a medication cup and gave it to Resident 6. Staff E removed their gown, gloves and mask, and took the metoprolol bubble card back to the medication cart. RESIDENT 235 On 08/21/2024 at 8:57 AM, Staff E was preparing the medications for Resident 235. Staff E put their gloves on, poured Resident 235's five oral medications into their hand, then placed them in a medication cup after opening the medication cart, medication bottles, and medication bubble cards with the same gloved hands. Staff E brought the medication cup and the lisinopril (medication that lowers the blood pressure) bubble pack in Resident 235's room. Staff E took the vital signs machine and obtained Resident 235's blood pressure and heart rate, then popped one tablet of lisinopril in the medication cup and gave it to Resident 235. Staff E took the lisinopril bubble card back to the medication cart. RESIDENT 18 On 08/21/2024 at 9:26 AM, Staff E was preparing Resident 18's oral medications. Staff E put gloves on, poured Resident 18's six medications in their hand, placed them in a plastic medication cup, and gave it to Resident 18. On 08/21/2024 at 9:35 AM, Staff E stated they took the blood pressure medications in the rooms to give to the residents after they obtained their blood pressure and heart rate while they were in the residents' rooms. Staff E stated that they wore gloves to pour residents' medications because they did not like to touch the medications. Staff E stated it was not clean and should have not placed Residents 6, 235 & 18's medications on their gloved hands after touching the medication cart, medication bottles, and medication bubble cards with the same gloved hands. On 08/22/2024 at 9:46 AM, Staff C, Resident Care Manager, stated they expected nurses to provide medications to the residents as ordered, timely, and free from contamination. Staff C stated that the nurse [Staff E] should have placed the oral medications for Residents 6, 235 and 18 in medication cups and not in their gloved hand. Staff C stated that the medications bubble/bingo cards for Residents 6 and 235 should have not been taken to their room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505469	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terraces at Skyline	715 9th Avenue Seattle, WA 98104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/22/2024 at 11:26 AM, Staff B, Corporate Director of Health Services, stated that the nurse (Staff E) should not have poured the medications for the residents [Resident 6, 235 & 18] on their gloved hands and should have put them directly into the residents' medication cup. Staff B stated that the medications should be prepared on the medication cart and that medication bubble cards should have not been taken to Residents 6 and 235's rooms. Reference: (WAC) 388-97-1320(1)(a)(c)