STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50A181	A. Building B. Wing	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Basin Hospital	200 Nat Washington Way Ephrata, WA 98823

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure residents were given the opportunity to formulate an Advanced Directive (AD) and/or periodically reviewed/notified residents of their right to formulate an AD for 1 of 4 residents (Resident 2) reviewed for ADs. This failure denied residents the right to make an informed decision regarding formulation of an AD and placed residents at risk for losing the right to have their preferences and choices honored regarding emergent/end-of-life care. Findings included . Review of the facility's policy titled, Advance Directives, dated 02/06/2020, showed upon admission, and periodically thereafter, residents would be informed of their right to make health care decisions and advance directives. Additionally, if a resident wished to formulate an AD, then social services would assist in the process. <Resident 2> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including respiratory failure, and a lung infection. The 01/05/2024 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Additionally, the medical records showed no documentation that Resident 2 had an AD nor that a discussion about formulating an AD had taken place with the resident. During an interview on 01/30/2024 at 10:49 AM, Staff E, Social Service Director (SSD), stated that during the resident admission a social service assessment would be completed and that was where residents were given the opportunity to formulate an AD if they did not already have one. Additionally, Staff E stated that ADs were also reviewed during the resident's first quarterly care conference (a meeting with the resident, nursing staff and/or their representative), and with a significant change in a resident. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a continued interview on 01/30/2024 at 10:59 AM, when reviewing Resident 2's medical records, Staff E stated they did not see where ADs were discussed with Resident 2. Staff E stated that Resident 2 was going to provide an AD from their last stay at the facility but that it was never obtained and should have been followed up on, .that will be something that I will be asking (Resident 2). Additionally, after reviewing resident records, Staff E stated that the facility had not been discussing or providing residents' the opportunity to formulate an AD after the first quarterly care conference. During an interview on 01/30/2024 at 1:51 PM, after explaining what ADs were, Resident 2 stated that no staff had discussed AD with them, maybe that is something I should fill out while I'm still able to. During an interview on 01/31/2024 at 11:50 AM, Staff B, Acting Director of Nursing Services, stated that the AD's were to be discussed with Resident 2 when they were admitted . Staff B stated the process should have been to provided Resident 2 the opportunity to formulate an AD when they were admitted . Additionally, Staff B stated that all residents should be periodically given the opportunity, during their quarterly care conferences, to formulating an AD if they want to. Reference: WAC 388-97-0280 (1)(3)(a)(d)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46722 Based on interview and record review the facility failed to develop an abuse prohibition policy and procedures regarding the incorporation of Quality Assurance and Performance Improvement program (QAPI). This failure disallowed the QAPI committee determination regarding abuse investigations. Findings included . Review of the facility's policy titled Protection of Residents from Mistreatment, Neglect, and/or Misappropriation of Property, revised 03/03/2020, showed the facility did not develop written policies/procedures related to coordination with QAPI. During an interview on 02/02/2024 at 12:50 PM, Staff A, Administrator, stated QAPI should be included in the Abuse policies. Reference: WAC 388-97-0640

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on interview and record review, the facility failed to report alleged violations related to abuse to include injuries of unknown source within the required time frame to the State Agency (SA) for 1 of 1 resident (Resident 10), reviewed for abuse and neglect. This failure placed residents at risk for unidentified abuse and neglect and the continued exposure to abuse and neglect. Findings included . Review of the facility's policy titled, Guidelines for Staff Reporting Resident Abuse or Neglect-Long Term care, revised on 4/28/2022, showed all employees are considered mandated reporters. According to the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition), a nursing home employee (or other mandated reporter) is required to make a report immediately where there is a reasonable cause to believe abuse, neglect, abandonment, mistreatment, personal and/or financial exploitation, or misappropriation of resident property has occurred. Substantial injuries of unknown source must be reported within 24 hours, if through the process of a thorough investigation, the injury is not reasonably related to a disease process or known sequence of events. <Resident 10> Review of Resident 10's medical record showed they were admitted to the facility on [DATE] with diagnoses including heart failure (a condition where the heart cannot pump enough blood to meet the body's needs) and an intact cognition. Review of the facility's Incident Reporting Log, dated 09/14/2023, showed Resident 10 had a substantial injury of bruising deep in color of unknown origin. Further review of the log showed the incident happened on 08/28/2023 and was not reported to the SA. Review of nursing progress notes, dated 08/29/2023, showed Resident 10 had a three-centimeter bluish in color mark on their right upper breast. The progress notes also showed this was an unwitnessed event. During an interview on 02/02/2024 at 10:41 AM, Staff B Acting Director of Nursing Services, stated Resident 10's incident was not reported to the SA. Staff B further stated the incident should have been reported. During an interview on 02/02/2024 at 12:50 PM, Staff A, Administrator, stated alleged abuse and neglect were mandated to be reported to the SA by staff. Staff A stated due to the location of Resident 10's bruise, the facility should have ruled out sexual abuse. Reference: WAC 388-97-0640(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on interview and record review the facility failed to conduct a thorough investigation regarding allegations of abuse and/or neglect for 1 of 1 resident (Resident 10) reviewed for investigations. The failure to complete a thorough investigation placed residents at risk for abuse, neglect, and unmet care needs. Findings included . Review of the facility's policy titled, Guidelines for Staff Reporting Resident Abuse or Neglect-Long Term care, revised on 04/28/2022, showed the facility will follow the Purple Book for investigating reported incidents of resident abuse, neglect, injuries of unknown source. According to the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition), all incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. A thorough investigation is a systematic collection of review of evidence/information that describes and explains an event or a series of events to determine what occurred and make necessary changes to resident's plan of care and services to prevent reoccurrence. The investigation should include the who, what, when, where, why and how, of the incident and establish a reasonable cause within 24 hours of the incident. <Resident 10> Review of Resident 10's electronic medical record showed they were admitted to the facility on [DATE] with diagnoses including heart failure and had an intact cognition. Review of the facility's Incident Reporting Log, dated 09/14/2023, showed Resident 10 had a substantial injury of bruising deep in color of unknown origin. Review of the facility's investigation report, dated 09/05/2023, showed Resident 10 was found to have an unwitnessed event and unknown cause that resulted in a three-centimeter bluish purple mark on their right breast. There was no documentation that showed the facility thoroughly investigated the cause of the unwitnessed event. During an interview on 02/01/2024 at 4:29 PM, Staff A, Administrator, stated this investigation was not a thorough investigation and did not even contain witness statements. During an interview on 02/02/2024 at 10:41 AM, Staff B, Acting Director of Nursing Services, stated they received the investigation report and read what the nurse wrote about the incident. Staff B stated they believed that Resident 10 bumped their area with the bruise. Staff B stated if they felt the incident needed to be reviewed more, they would talk to staff and residents, but that it was situational based on the incident reported. Reference: WAC 388-97-0640(6)(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45117 Based on observation, interview, and record review, the facility failed to develop and implement a person-centered comprehensive care plan that addressed the resident's medical, physical, mental, and psychosocial needs for 5 of 7 residents (Resident 3, 2, 112, 6, and 7) reviewed for urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) use, medication use, and transfers. These failures placed the residents at risk for not receiving care and services to meet their individualized needs. Findings included . <Urinary Catheter Use> <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including a stroke with right sided weakness, atrial fibrillation (an irregular heart rate that causes poor blood flow), obstructive uropathy (a disorder of the urinary tract that occurs due to obstruction in urinary flow), neurogenic bladder (a number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem) and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland). The 11/21/2023 comprehensive assessment showed the resident was dependent on assistance of two staff members for activities of daily living (ADLs - activities related to personal care such as bathing, dressing, using the toilet, and getting in and out of a chair or bed). The assessment also showed the resident was cognitively intact. An observation on 01/29/2024 at 9:46 AM, showed Resident 3 lying in bed, a urinary catheter tube exiting their left pant leg, connected to a drainage bag that was hanging on the side of the bed. Resident 3 stated the urinary catheter had been in place for about five to six years. Review of the Resident 3's comprehensive care plan, last updated 11/07/2023, showed there was no problem area, goal, or interventions related to the use of Resident 3's urinary catheter. <Medication Use> An observation on 01/30/2024 at 10:08 AM, showed Resident 3 lying in bed. They had dark purple bruising to their right elbow area and left forearm. Record review of Resident 3's physician orders, dated 11/07/2023, showed the resident received a blood thinning medication used to treat and prevent blood clots and lower the risk of stroke, that can cause excessive, unwanted bruising or bleeding. Review of the Resident 3's comprehensive care plan, last updated 11/10/2023, showed it did not reflect the resident's current use of, or interventions related to the use of the blood thinner. <Resident 2> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 2 was admitted on [DATE] with diagnoses including respiratory failure with a lung infection, seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements), a heart condition that required a blood thinning medication, depression, and anxiety. The 01/13/2024 comprehensive assessment showed the resident was cognitively intact, able to make their needs known. Review of Resident 2's physician medication orders, dated 01/05/2024, showed the resident was being administered apixaban (a blood thinning medication used to treat and prevent blood clots and strokes), paroxetine (a medication used to treat depression and anxiety disorders), lamotrigine [a medication used to treat seizures and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and remeron (a medication used to treat depression). Review of Resident 2's care plan, last updated 01/12/2024, showed there was no problem area related to the resident's use of the apixaban, paroxetine, lamotrigine, and remeron medications or diagnoses connected to them. During an interview on 02/02/2024 at 11:17 AM, Staff B, Acting Director of Nursing Services, stated that Resident 2 should have been care planned with goals and interventions for their seizures, heart condition, depression, anxiety, and the high-risk medications being administered with the diagnoses. <Resident 112> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including dementia with behavioral disturbances (an impairment of brain function, which causes memory loss, forgetfulness, impaired thinking abilities and can be accompanied with mood/behavior change) and chronic (long term) right hip pain. The 01/26/2024 comprehensive assessment showed the resident was cognitively impaired but was able to communicate and make their needs known to staff. Additionally, the comprehensive assessment showed the resident was taking Cymbalta (high-risk psychotropic medication used to treat certain mental/mood disorders) medication for their dementia. Review of Resident 112's physician medication orders, dated 01/15/2024, showed the resident was being administered Cymbalta for their dementia with behavioral disturbances and an analgesic (a medication used for pain management) medication for their chronic right hip pain. Review of Resident 112's care plan, last updated 01/22/2024, showed there was no problem area, goals, or interventions related to the resident's high risk psychotropic medication or chronic right hip pain. During an interview on 02/02/2024 at 11:26 AM, Staff B, stated that Resident 112 should have been care planned with goals/interventions for their dementia with behavioral disturbances, with high-risk medication, and chronic right hip pain. <Transfers> <Resident 6> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed Resident 6 was admitted to the facility on [DATE] with diagnoses including arthritis and muscle weakness. The 11/07/2023 comprehensive assessment showed Resident 6 required maximum assistance/dependent on one staff member for ADLs. The assessment also showed the resident had an intact cognition. An observation on 01/29/2024 at 1:17 PM, showed Staff K, Nursing Assistant, transferring Resident 6 from their wheelchair to their recliner using a sit-to-stand (a mechanical lift that assists individuals with limited mobility to a standing position from a seated position) mechanical lift. Review of Resident 6's comprehensive care plan, last updated 1/22/2024, showed no interventions related to transfers or the use of the sit-to-stand lift. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and trigeminal neuralgia (a type of chronic pain disorder that involves sudden, severe facial pain). The 12/18/2023 comprehensive assessment showed the resident required partial to maximum assistance of one staff member for ADLs. The assessment also showed Resident 7 had a moderately impaired cognition. During an interview on 01/31/2024 at 2:52 PM, Staff I, Registered Nurse stated the resident used a front wheeled walker and assistance of one staff member for transfers, unless their condition (trigeminal neuralgia) flared up (a worsening of the disease process) then they would need to transfer with staff assistance and the use of the sit-to-stand. Review of Resident 6's comprehensive care plan, last updated 12/11/2023, showed no interventions related to the use of the sit-to-stand lift, including when staff were to use it for safe transfer of the resident. During a follow up interview on 02/02/2024 at 12:23 PM, Staff I stated the care plans were created based on the comprehensive assessments and were individualized from there. Staff I stated they adjusted the care plans quarterly to ensure accuracy. They stated the comprehensive care plan should contain information such as their ADLs, mobility, toileting requirements, and medication use. Staff I stated they were able to individualize the care plan for each resident's needs. Staff I stated all current resident care plans were comprehensive and up to date, with exception of the resident who was recently admitted (01/15/2024). During an interview on 02/01/2024 at 3:40 PM, with Staff B and Staff A, Administrator, Staff B, stated the resident's care plans needed to be comprehensive, up to date, and reflect the current needs of the resident. Staff A, stated they agreed with Staff B. Reference: WAC 388-97-1020(1)(2)(a)(b) 43280 46722

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident (Resident 3), reviewed for care and use of a urinary catheter (a hollow, partially flexible tube that collects urine from the bladder and leads to a drainage bag) received appropriate care and services by positioning the catheter drainage bag below the level of the bladder to prevent infection. This failure placed the resident at risk for additional urinary tract infections (UTI) and serious medical complications. Findings included . Review of the Centers for Disease Control and Prevention Guidelines titled, Prevention of Catheter-Associated Urinary Tract Infections 2009, dated 06/06/2019, showed the Proper Techniques for Urinary Catheter Maintenance, included the catheter drainage bag must be kept below the level of the bladder. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including a stroke with right sided weakness, obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), neurogenic bladder (a number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem), benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland) and chronic UTI's. The 11/21/2023 comprehensive assessment showed the resident was dependent on assistance of two staff members for activities of daily living (ADLs - activities related to personal care such as bathing, dressing, using the toilet, and getting in and out of a chair or bed). The assessment also showed the resident was cognitively intact. An observation on 01/30/2024 at 3:23 PM, showed Staff J, Nursing Assistant (NA), and Staff N, NA, transferring Resident 3 from their wheelchair to their bed using a mechanical lift. Staff J removed the catheter drainage bag from below the seat of the wheelchair and hung it on the mechanical lift at the height of the resident's chest. The catheter drainage bag was higher than the level of the bladder. An observation on 01/31/2024 at 7:14 AM, showed Staff L, NA, and Staff O, NA, assisted Resident 3 with their morning personal cares and then transferred the resident to their wheelchair from the bed. While Resident 3 was lying flat in bed, Staff L and Staff O placed the sling (for the mechanical lift) under Resident 3 and attached the sling to the lift. Staff O removed the catheter drainage bag from the side of the bed and, with Resident 3 still lying flat, hung the catheter drainage bag above the resident's chest (higher than the level of the bladder) and proceeded to transfer the resident to their wheelchair. During a concurrent interview on 01/31/2024 at 9:47 AM, Staff L and Staff O stated they were trained to hang the catheter drainage bag below the level of the bladder to prevent the urine from flowing back into the bladder. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/01/2024 at 3:45 PM, Staff B, Acting Director of Nursing Services, stated the staff were not following the process with correct placement of Resident 3's catheter drainage bag during transfers. Reference: WAC 388-97-1060(3)(c)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma-informed care in accordance with professional standards of practice for 2 of 2 residents (Resident 2 and 9) reviewed for trauma informed care. The facility failed to assess, monitor, and care plan residents' experiences and preferences regarding potential triggers (a stimulus that could prompt a recall of a previous traumatic event even if the stimulus itself is not traumatic or frightening) that may cause re-traumatization (a reliving of the traumatic experience). This failure placed the resident at risk for unidentified triggers and re-traumatization. Findings included . <Resident 2> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including respiratory failure with a lung infection, Post Traumatic Stress Disorder (PTSD, a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event), depression and anxiety. The 01/13/2024 comprehensive assessment showed the resident was cognitively intact, able to make their needs known. Review of Resident 2's care plan, dated 01/05/2024 and 01/12/2024, showed that a plan for the resident trauma history and PTSD was not developed, nor potential triggers identified. During an interview on 01/31/2024 at 4:00 PM, Resident 2 stated specific historical traumatic events that had taken place and lead to their diagnosis of PTSD. Additionally, Resident 2 stated that based on their experiences there were key triggers that could lead to them reliving the traumatic event that they had been working on with counselor from outside of the facility. During an interview on 01/31/2024 at 4:14 PM, Staff E, Social Service Director, stated they did not know about Resident 2's trauma history, why they had been diagnosed with PTSD, or if they had potential triggers. Staff E stated it was not their process to complete a trauma informed care assessment (an approach to care delivery that assesses signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, procedures, and practices to avoid re-traumatization) when residents were admitted to the facility. During an interview on 01/31/2024 at 4:35 PM, Staff I, Registered Nurse, stated they did not complete a trauma informed care assessment on any resident and was not aware that Resident 2 had traumatic experiences or was diagnosed with PTSD. During an interview on 02/01/2024 at 3:34 PM, Staff J, Nursing Assistant, stated they were not aware that Resident 2 had a history of traumatic events or of specific triggers to monitor for. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/02/2024 at 11:17 PM, Staff B, Acting Director of Nursing Services, stated they would have expected nursing staff to have assessed and monitor Resident 2's traumatic history and PTSD. Additionally, Staff B stated that Resident 2's PTSD and trauma triggers should have been care plan. During an interview on 02/01/2024 at 5:01 PM, Staff A, Administrator, stated the process should have been for Resident 2 to have a trauma informed care assessment completed when they were admitted to the facility. <Resident 9> Review of the medical record showed Resident 9 was admitted to the facility on [DATE] with diagnoses including dementia (a group of symptoms affecting memory, thinking and daily life) and depression. The 12/06/2023 comprehensive assessment showed Resident 9 had a severely impaired cognition. Review of Resident 9's 06/22/2023 progress note, showed the resident required two staff members for their shower due to Resident 9's behaviors of screaming and anger. The progress note further showed Resident 9 was combative during the shower and staff were unable to complete the shower for the resident. During an interview on 01/30/2024 at 1:28 PM, the Resident Representative stated the facility had attempted alternatives to showering, however Resident 9 would continue to be combative. The Resident Representative informed staff that Resident 9 had a traumatic event in their life that caused Resident 9 to be terrified of water. During an interview on 01/30/2024 at 1:54 PM, Staff K, Nursing Assistant (NA), stated they showered Resident 9 on 01/29/2024 and the resident screamed, yelled, and hit them throughout the shower. Staff K further stated Resident 9 did not like to be wet. During an interview on 01/30/2024 at 1:55 PM, Staff I, Registered Nurse (RN), stated they were aware the resident almost drowned when they were younger and getting wet was a trigger for Resident 9. During an interview on 01/31/2024 at 10:04 AM, Staff L, NA stated when Resident 9 was showered it took two staff members and must be done quickly. Staff L stated Resident 9 hated showers and screamed during the process of showering. Staff L stated they were aware of a near drowning when the resident was younger. During an interview on 01/31/2024 at 2:52 PM, Staff B, Acting Director of Nursing Services, stated the facility did not admit residents with behavioral issues. Staff B stated they were unaware of any residents who experienced trauma or had behavioral issues. Staff B stated there was no assessments for trauma or behaviors that was conducted when residents were admitted to the facility. Staff B continued to state that Resident 9 would become very distressed during showers and their behavior had become worse. Reference: WAC 388-97-1060(3)(e) 46722

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure nursing staff had the appropriate competencies (a series of knowledge, abilities, skills, experiences and behaviors, which leads to effective performance of staff regarding resident cares), and skill sets, which included an assessment of the staff's demonstration of competency in the skills needed to provide care and services for the facility's resident population, for 5 of 5 nursing staff (Staff I, K, O, P and Q) reviewed for staff competencies. This failure placed residents at an increased risk of adverse effects regarding the quality of care provided to the residents and unmet care needs. Findings included . Review of the facility's document titled, Facility Assessment Tool, dated 01/17/2021, showed the Facility Assessment [(FA) a tool used to determine the resources necessary to care for residents during both day-to-day operations and emergencies] had not been completed for the 2023 to [AGE] year. Additionally, the document showed the type of care the resident population would require included, .indwelling or other urinary catheter .pressure injury prevention and care, skin care, wound care .identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/post-traumatic stress disorder (a disorder that develops when a person has experienced or witnessed a scary, shocking, terrifying, or dangerous event) .identification and containment for infections, prevention of infections .resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process .prevent abuse and neglect .identify hazards and risks for residents .person-centered care planning and advance care planning ., but did not include what staffing competencies would be needed to provide the level of care/services regarding the resident population. Review of the facility's skills fair documentation, dated 12/12/2023, showed that Staff I, Registered Nurse, Staff K, Nursing Assistant (NA), Staff O, NA, Staff P, NA and Staff Q, Licensed Practical Nurse, obtained skills fair training, which included review of restraints, sepsis (a serious condition that happens when the body's immune system has an extreme response to an infection), and resident transfer devices. Additionally, the training did not include an evaluation of the Staff I, K, O, P and Q's competences regarding the training and/or through a form of return demonstration for the training activities that were reviewed. Review of Staff I, K, O, P and Q's personnel education and training records, dated 01/01/2023 to 12/31/2023, showed that no staff had completed any competencies. During an interview on 02/01/2024 at 12:21 PM, Staff B, Acting Director of Nursing Services, stated the facility did not complete competencies or skills check offs every year with nursing staff. Staff B stated they had facility staff complete trainings through an online platform, then attended a skills fair which was held by the facility on 12/12/2023, and that no other trainings were conducted. Staff B stated that the skills fair did not include skills check offs or an assessment of staff demonstration of competencies. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refer to F656, F699, F880 for additional information. Reference: WAC 388-97-1680(2)(a)(b)(i-ii)(c)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview, and record review, the facility failed to consistently offer substantial nutritional snacks in the evening for 6 of 9 residents (Residents 112, 8, 9, 3, 6, and 7) reviewed for evening snacks. This failure placed the residents at risk for hunger and unmet nutritional needs. Findings included . Review of an undated, facility provided document titled, Service Cart Delivery Times, showed the dinner meal for Dining Room B was scheduled for 5:00 PM and the breakfast meal was scheduled for 8:00 AM (15 hours between the evening and breakfast meal). <Resident 112> Review of the medical record showed Resident 112 was admitted to the facility on [DATE] with diagnoses including dementia with behavioral disturbances (a disease that effects a person's personality and habits that may lead to changes in their behavior including agitation and anxiety) and adult failure to thrive (a syndrome weight loss, decreased appetite and poor nutrition, accompanied by dehydration and depressive symptoms). The 01/26/2024 comprehensive assessment showed Resident 112 required partial assistance of one staff member for Activities of Daily Living (ADLs - activities related to personal care such as bathing, dressing, using the toilet, and getting in and out of a chair or bed). The assessment also showed the resident had a severely impaired cognition. During an interview on 02/01/2024 at 10:25 AM, Resident 112 stated that no one offered them a snack in the evening. They stated they would like a snack, but they did not get one. <Resident 8> Review of the medical record showed Resident 8 was admitted to the facility on [DATE] with diagnoses including age-related memory disorder and type 2 diabetes (a group of diseases that result in too much sugar in the blood). The 11/07/2023 comprehensive assessment showed Resident 8 required partial to maximum assistance of one staff member for ADLs. The assessment also showed the resident had a severely impaired cognition. <Resident 9> Review of the medical record showed Resident 9 was admitted to the facility on [DATE] with diagnoses including dementia (the impaired ability to remember, think, or make decisions that interfere with doing everyday activities) and depression (a feeling of sadness and loss of interest in activities causing a significant impairment in daily life). The 11/27/2023 comprehensive assessment showed Resident 9 required maximum assistance of one staff member for ADLs. The assessment also showed the resident had a severely impaired cognition. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a Resident Council (an organized group of residents that meet regularly to discuss and address concerns about their rights, quality of care, and quality of life) meeting conducted by the survey team on 01/30/2024 at 8:30 AM, Residents 8 and 9 stated they were not offered a snack in the evening or in between meals. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including a stroke with right sided weakness, atrial fibrillation (an irregular heart rate that causes poor blood flow), and depression. The 11/21/2023 comprehensive assessment showed the resident was dependent on assistance of two staff members for ADLs. The assessment also showed the resident was cognitively intact. During an interview on 01/29/2024 at 9:34 AM, Resident 3 stated they were not offered snacks in the evening. They stated they might like a snack if they were offered one. <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility on [DATE] with diagnoses including arthritis and muscle weakness. The 11/07/2023 comprehensive assessment showed Resident 6 required maximum assistance/dependent on one staff member for ADLs. The assessment also showed the resident had an intact cognition. During an interview on 02/02/2024 at 10:53 AM, Resident 6 stated they would like a snack in the evening. Resident 6 stated they had not seen anyone with snacks lately. <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and anxiety. The 12/18/2023 comprehensive assessment showed the resident required partial to maximum assistance of one staff member for ADLs. The assessment also showed Resident 7 had a moderately impaired cognition. During an interview on 02/02/2024 at 10:58 AM, Resident 7 stated no one had asked if they wanted a snack in the evening. They stated they might want one if they had been asked. During an interview on 01/31/2024 at 10:53 AM, Staff I, Registered Nurse, stated that not all residents received snacks in the evening. They stated the kitchen brought snacks for residents that have an order for evening snacks, but they did not offer snacks to all residents. During an interview with both Staff A, Administrator, and Staff B, Acting Director of Nursing Services on 02/01/2024 at 3:36 PM, Staff B stated that snacks were readily available to residents. They stated that the residents that had physician ordered snacks received them from the kitchen. Staff B stated they did not believe the staff were going around to residents and offering snacks in the evening. Staff A stated they agreed that evening snacks needed to be offered. Reference: WAC 388-97-1120(1) (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	45117

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 45117 Based on observation and interview, the facility failed to ensure the proper disposal of trash for 1 of 1 dumpster (Dumpster 1) reviewed for outdoor refuse storage. The failure to ensure Dumpster 1 was covered, placed the facility at risk of attracting bugs, rodents, and an unsanitary environment. Findings included . A concurrent observation and interview on 01/31/2024 at 10:19 AM with Staff F, Dietary Manager (DM), showed a tan dumpster with a wire mesh cover that was operated by a hand crank. The mesh cover was in the open position with bags of trash visible above the top of the dumpster. Staff F stated the cage top was always open so staff could put trash into the dumpster. An observation on 02/01/2024 at 7:37 AM, showed the same tan dumpster with the mesh cover in the open position. There were trash bags visible above the top of the dumpster and a cardboard box on the ground in the back corner of the dumpster enclosure. During an interview on 02/02/2024 at 9:50 AM, Staff F stated they reviewed the regulation and were not aware that the facility was responsible for the dumpster/refuse area. During an interview on 02/01/2024 at 3:41 PM, Staff A, Administrator, stated the facility needed to follow the regulations regarding the dumpster/refuse area to ensure compliance. Reference: WAC 388-97-1320(4)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46722 Based on interview and record review, the facility failed to perform an annual review of the Facility Assessment (FA, an evaluation that determine what resources are required to meet each resident's care/service needs with the facility's resident population) and did not include a representative of the governing body or medical director in the development of the FA. Additionally, the FA failed to address the staffing competencies necessary to provide the level and types of care needed for the resident population. These failures placed all residents at risk of unidentified and/or unmet care and service needs. Findings included . Review of the 02/03/2023 Centers for Medicare and Medicaid Services (CMS) State Operations Manual - Appendix PP, showed, CFR 483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update the assessment, as necessary, and at least annually . Additionally, The facility assessment must address or include .the staff competencies that are necessary to provide the level and types of care needed for the resident population . Review of the facility's document titled, Facility Assessment Tool, dated 01/17/2021, showed the FA had not been completed for the 2023 to [AGE] year and did not involve the medical director nor a representative of the governing body in the FA. Additionally, the document did not include the staffing competencies that would be needed to provide the level of care need for the current resident population. During an interview on 02/01/2024 at 5:01 PM, Staff A, Administrator, stated they were aware that the FA was required to be completed annually and that a current FA had not been completed. Additionally, Staff A stated that the FA should have addressed the staffing competencies needed to care for the resident population. Reference: WAC 388-97-1620(2)(b)(i)(ii)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43280 Based on interview and record review, the facility failed to conduct a Performance Improvement Project (PIP) that focused on a high risk or problem prone areas of the resident population annually for 3 of 3 quarterly (Q, every three months) meetings (Q1, Q2 and Q3) reviewed for the Quality Assurance and Performance Improvement (QAPI) process. This failure placed residents at risk regarding quality care improvement, unidentified complications, and prompt corrective action towards high-risk/problem prone areas. Findings included . Review of the facility's policy titled, Performance Improvement Plan, dated 08/09/2022, showed that a PIP's focused on .areas of high risk, high volume or prone components of care ., and that the Administrator was to manage the QAPI program. Review of the facility's 2023 QAPI meeting minutes (Q1, Q2, Q3), showed that a PIP was not implemented in any of the quarters reviewed. During an interview on 02/02/2024 at 12:32 PM, Staff A, Administrator, stated they monitored, analyzed, and evaluated high-risk problem prone resident care areas, but don't remember the last PIP done. Reference: WAC 388-97-1760(1)(2)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 43280 Based on interview and record review the facility failed to; 1) maintain a Quality Assessment and Assurance (QAA) committee that included the medical director, or their designee, to participate in the committee's effort for 3 of 3 quarterly (Q, every three months) meetings (Q1, Q2, Q3 2023) reviewed for the QAA process, and 2) ensure that a thorough analysis of the high risk/adverse events were acted upon, and, a good faith attempt was made (once the facility had become aware of the adverse event) to correct quality deficiency and care concerns identified by the facility's infection control committee (which information was submitted to the facility's QAPI committee) for 2 of 3 quarterly meetings (Q2 and Q3 2023), reviewed for QAPI and infection control concerns identified on survey. This failure placed all residents at risk for unidentified complications and prompt corrective action in resident care/services areas. Findings included . Review of the facility's policy titled, Performance Improvement Plan, dated 08/09/2022, showed that the administrator, a representative of the governing body, medical staff and departmental managers would be involved in the performance improvement committee for managing of the Quality Assurance Performance Improvement (QAPI) program. The Policy showed the committee's responsibilities were to have a planned, continuous, systematic and organization wide approach to designing, measuring, assessing, and improving performance. Oversight of staff education and training for performance improvement .Identify organizational trends or opportunities for improvement projects from reports received throughout the organization. Sources of data and information include report from infection control studies .integrating PI (Performance Improvement) efforts with daily work activities. Additionally, each department was to submits quality assessments studies that were being conducted on an ongoing basis and could lead to a performance improvement studies or a quick fix process which was to be used for identified problems, which do not require a comprehensive approach to problem solving and solutions implementation. Review of the facility's 2023 QAPI meeting minutes (Q1, Q2 and Q3) showed the medical director, or their designee were not in attendance during the meetings. The Q2 infection control section showed that the facility had an outbreak of COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death). Additionally, the Q3 infection control section showed that a COVID-19 outbreak had occurred in the assisted living section of the facility (the nursing home and assisted living were connected by a double door) isolation precautions were initiated but 7 other residents were affected. (continued on next page)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's 2023 infection control /QAPI meeting minutes showed that in Q2 2 long-term patients contracted COVID, the source of the infection was not determined . and that all staff were to wear an N95 (a mask used to filter out and protect against harmful viruses like COVID-19) mask while preforming care with resident on the assisted living side and on the hospital side for the duration of the outbreak. The Q3 meeting noted that a COVID-19 outbreak had taken place in the assisted living side of the facility and that staff were wearing a surgical mask (a mask that does not filter out viruses like COVID-19) unless staff had become positive and then would wear and N95 mask. The Q3 meeting also noted that 14 staff were COVID-19 positive in September. During an interview on 02/02/2024 at 12:32 PM, Staff A, Administrator, stated the medical director, or their designee, did not always attend the QAPI meeting. Staff A explained if the medical director or designee had attended QAPI meeting, it would have been documented on the QAPI meeting minutes. Staff A stated that a COVID-19 outbreak would have been a high-risk/adverse event and they implemented the same outbreak measures and monitored the same quality indicators as they had been doing in previous quarters regarding infection control. Staff A stated that they were aware of the COVID-19 outbreaks and were monitoring the COVID rates in the facility but that no additional monitoring or revisions of corrective action had taken place. Refer to F880 for additional information. Reference: WAC 388-97-1760(1)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to ensure infection control interventions intended to mitigate the risk of exposure and transmission of COVID-19 (an infectious disease-causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing, that could result in severe impairment or death) were consistently implemented during a COVID-19 outbreak [two or more facility-acquired cases with epi-linkage (an overlap on the same unit or other patient location, or having the potential to have been cared for by common healthcare professionals (HCP) within a seven day time period of each other)]. The facility failed to implement infection control interventions for: personal protective equipment (PPE - protective clothing, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection) use for 8 of 9 staff (Staff K, B, Q, L, O, I, R, and P) reviewed for PPE use; COVID-19 testing for 2 of 2 residents (Residents 8 and 112) reviewed for COVID-19 testing; implementation of transmission-based precautions (TBPs) for 1 of 1 resident (Resident 7) reviewed for implementation of precautions; hand hygiene for 3 of 3 staff (Staff L, O, and I) reviewed for hand hygiene while providing personal cares for 1 of 1 resident (Resident 3) and passing medications for 3 of 3 residents (Resident 4, 6, and 3); annual review of the infection control policies and procedures. These failures in infection control practices placed all residents at risk for exposure to COVID-19 and serious medical complications. Findings included . Review of the Centers for Disease Control and Prevention (CDC) document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated 05/08/2023, showed HCP that enter the room of a resident with suspected or confirmed COVID-19 infection should adhere to Standard Precautions (minimum infection prevention practices that apply to all patient care) and use of a National Institute of Occupational Safety and Health (NIOSH) approved N95 respirator (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles), gown, gloves, and eye protection (goggles or a face shield that covers the front and sides of the face). Additionally, a resident identified as suspected or confirmed COVID-19 infection, should be placed in a single-person room. The door should be kept closed. Information regarding residents with suspected or confirmed COVID-19 infections should be communicated to appropriate personnel before transferring them to other departments in the facility (e.g., radiology). HCP that entered the room of a patient with suspected or confirmed COVID-19 infection should use Standard Precautions and use an N95 respirator, gown, gloves, and eye protection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the CDC's guidance titled How to Use Your N95 Respirator, dated 05/16/2023, showed an N95 respirator must form a seal to the face to work properly. Gaps could occur if the N95 respirator was too big, too small, or not put on correctly. The N95 respirator should be placed under the chin with the nose piece bar at the top. The top strap should be pulled over the head and placed near the crown of the head. The bottom strap should be pulled over the head and placed at the back of the neck, below the ears. The straps should not be crisscrossed or twisted. Review of the facility policy titled, Hand Hygiene - CDC Guidelines), dated 03/21/2021, showed effective hand hygiene was required to prevent the transmission of bacteria, germs, and infections. The policy showed staff were required to perform hand hygiene (HH): Before starting their shift; When hands were soiled; Before each patient encounter; After coming in contact with the resident's skin; After working on a contaminated body site and then moving to a clean body site on the same resident; After coming in contact with bodily fluids, dressings, mucous membranes; Always after removing gloves or facemasks; Leaving an isolation area. <Resident 8> Review of the medical record showed Resident 8 was admitted to the facility on [DATE] with diagnoses including age-related memory disorder and type 2 diabetes (a group of diseases that result in too much sugar in the blood). The 11/07/2023 comprehensive assessment showed Resident 8 required partial to maximum assistance of one staff member for ADLs. The assessment also showed the resident had a severely impaired cognition. <Resident 112> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including dementia with behavioral disturbances (an impairment of brain function, which causes memory loss, forgetfulness, impaired thinking abilities and can be accompanied with mood/behavior change) and chronic (long term) right hip pain. The 01/26/2024 comprehensive assessment showed the resident was cognitively impaired but was able to communicate and make their needs known to staff. Additionally, the comprehensive assessment showed the resident was taking a high-risk medication for their dementia. <Resident 7> (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Columbia Basin Hospital	200 Nat Washington Way Ephrata, WA 98823

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the medical record showed Resident 7 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks) and trigeminal neuralgia (a type of chronic pain disorder that involves sudden, severe facial pain). The 12/18/2023 comprehensive assessment showed the resident required partial to maximum assistance of one staff member for ADLs. The assessment also showed Resident 7 had a moderately impaired cognition. <Resident 3> Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including a stroke with right sided weakness, atrial fibrillation (an irregular heart rate that causes poor blood flow), obstructive uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), neurogenic bladder (a number of urinary conditions in people who lack bladder control due to a brain, spinal cord, or nerve problem) and benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland). The 11/21/2023 comprehensive assessment showed the resident was dependent on assistance of two staff members for activities of daily living (ADLs - activities related to personal care such as bathing, dressing, using the toilet, and getting in and out of a chair or bed). The assessment also showed the resident was cognitively intact. <Resident 4> Review of the medical record showed Resident 4 was admitted to the facility on [DATE]. The 11/27/2023 comprehensive assessment showed the resident required substantial/maximal assistance of one staff member for ADLs. The assessment also showed the resident had a severely impaired cognition. <Resident 6> Review of the medical record showed Resident 6 was admitted to the facility on [DATE] with diagnoses including arthritis and muscle weakness. The 11/07/2023 comprehensive assessment showed Resident 6 required maximum assistance/dependent on one staff member for ADLs. The assessment also showed the resident had an intact cognition. <PPE> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 01/29/2024 at 8:47 AM, showed signage on the door to a resident's room that showed airborne contact precautions were required when entering the room. There was a PPE cart outside of the room that contained N95 masks, surgical masks, gowns, hair covers, briefs, and wipes. There were four paper bags on the floor outside of the door. The paper bags were labeled with staff names and contained eye protection and used N95s. There was a trash can with a lid next to the left of the door, along with a food cart that contained a breakfast meal tray. Staff K, Nursing Assistant (NA), put on a gown, gloves, and hair cover. Their N95 mask had both straps around their neck. Staff K removed eye protection from a bag labeled JG (belonged to another staff member) and put them on. Staff K entered the COVID-19 isolation room. At 9:07 AM, Staff K exited the room holding their gown and gloves. They placed them in the trash can in the hallway. Staff K then placed the eye protection back into the paper bag and performed HH. They did not remove their N95 and proceeded to the nurse's station. A second observation that same day at 10:16 AM, showed Staff K putting on PPE to enter the COVID-19 isolation room. Staff K donned a clean N95 and placed both straps around their neck. Staff K stated they were trained on how to properly don PPE and were fit tested for their N95. Staff K then entered the COVID-19 room while wearing the improperly donned N95 mask. During an observation on 01/29/2024 at 11:56 AM, Staff B, Acting Director of Nursing Services, and Staff Q, Licensed Practical Nurse (LPN) were at the nurse's station. Staff B was wearing an N95 mask with the straps crossed at their ears, and Staff Q had an N95 mask dangling around their neck, leaving their nose and mouth exposed. During an interview on 01/29/2024 at 12:25 PM, Staff Q stated they were told that on the unit, they were required to wear an N95 and when at the nurse's station, they were able to wear a surgical mask. They stated that the paper bags outside of the COVID-19 isolation room contained eye protection and N95s that were reused when going into that room. They stated they were not aware of any shortage of PPE and staff were just being conservative. An observation on 01/31/2024 at 7:14 AM showed Staff L, NA, and Staff O, NA, entering a resident room wearing N95's with both straps around their neck. During an observation on 01/31/2024 at 8:11 AM, showed Staff L, NA, wearing an N95 mask with straps around their neck, don gown, gloves, and eye protection and entered the COVID-19 isolation room. At 8:23 AM, Staff L exited the room, removed their PPE in the hallway with exception of the N95 mask, cleaned their eye protection and placed them into a paper bag, performed HH, and proceeded to the nurse's station, still wearing the same N95 mask. During an interview on 01/31/2024 at 9:47 AM, both Staff L and Staff O stated they were trained to wear their N95s with one strap over the top of their head and one around the neck. Staff L stated they did not remove their N95 when exiting the COVID-19 isolation room because there were no N95 masks on the PPE cart and no trash can outside the room (that day). They stated they should report concerns such as no PPE or needing a trash can on both the inside and outside the COVID-19 isolation room to management but had not done that. An observation on 01/31/2024 at 7:14 AM, showed Staff I, Registered Nurse (RN), at the medication cart with their N95 respirator straps around the back of their neck. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation on 02/01/2024 at 8:10 AM, showed Staff R, Licensed Practical Nurse (LPN), standing at the medication cart wearing an N95 respirator. Both straps of the respirator wear at the crown of their head. An observation on 02/02/2024 at 9:12 AM, showed Staff P, NA, sitting at the nurse's station with their N95 respirator pulled down to their chin, leaving their nose and mouth exposed. During an interview on 01/30/2024 at 1:18 PM, Staff C, Infection Preventionist (IP), stated staff were to wear their N95 respirator with all patient care, not just the COVID-19 isolation resident. They stated they were permitted to wear a surgical mask at the nurse's station if there were no residents in the area. They stated staff were required to wear full PPE (N95 respirator, gown, gloves, and eye protection) when going into the COVID-19 isolation room. Staff were not to store soiled PPE in paper bags. N95 respirators needed to be replaced after leaving the COVID-19 isolation room and eye protection needed to be cleaned at that time. Staff C stated there was no shortage of PPE for staff use, the practice of reusing N95 respirators was a left over practice from when there were PPE shortages. <COVID-19 Testing> An observation on 01/31/2024 at 9:33 AM, showed Staff I at a COVID-19 testing cart outside of Resident 8's room. The cart had three shelves, the top contained a box of gloves, plastic bags that contained a test tube and swab for the specimen, resident labels, lab slips, a black pen, and hand sanitizer. The middle shelf contained a bin for the completed tests. Staff I was wearing an N95 mask with both straps around the back of their neck and eye protection. Staff I picked up a bag containing a test tube, placed a resident label on the tube and opened a swab for testing. Staff I donned clean gloves, and without wearing a gown, entered Resident 8's room. Staff I performed the nasal swab and placed the swab into the test tube, then placed the specimen into the bag. Staff I removed their gloves and exited the room with the bag and placed it into the bin on the cart. Staff I performed HH and moved the cart to Resident 112's room. Staff I, still wearing the same N95 respirator and eye protection, proceeded to complete the lab slip, remove the test tube and swab from a bag, and placed a label on the test tube. Staff I entered Resident 112's room wearing gloves, the same soiled N95 and soiled eye protection, and without putting on a gown, entered Resident 112's room and performed the nasal swab test. Staff I removed their gloves, placed the specimen into the test tube, placed the test tube into the bag, exited the resident's room and placed the bag into the bin on the cart. Staff I, wearing the same N95 and eye protection, moved to the next resident room. During a concurrent observation and interview on 01/31/2024 at 10:44 AM, Staff I stated they were trained to test for COVID-19. They stated they wore their N95 with both straps around the back of their neck because it was more comfortable that way. Staff I then placed the top strap in the correct position, at the crown of their head. Staff I stated they did not change their N95 in between resident testing because the residents were not symptomatic. They stated if a resident had coughed on them, they would have changed it. They stated they were not trained to wear a gown during testing, only if going into a COVID-19 isolation room. They stated they cleaned their eye protection after all the testing was completed because the cleaner left streaks on their glasses. During an interview on 02/01/2024 at 9:19 AM, Staff C, Infection Preventionist, stated during COVID-19 testing, they expected staff to wear full PPE, that included N95 respirator, gown, gloves, and face shield or eye protection. Staff C stated the process for testing was a failed process . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Transmission Based Precautions> During a concurrent observation and interview on 02/01/2024 at 8:10 AM, Staff R, LPN, wearing an N95 with both straps at the crown of their head, stated Resident 7 was congested that morning. They stated Resident 7 was seen by the provider that morning and had ordered a COVID-19 test to rule out infection because they were symptomatic. Observation of Resident 7's room showed the door was open and there was no signage or PPE cart that indicated isolation precautions were needed. Resident 7 was seated in their room in their wheelchair, coughing that was audible and visible from the hallway. Staff R stated a chest x-ray was also ordered. Staff R stated Resident 7 was currently not on precautions because they were keeping them isolated to their room. Staff R stated they had not done the COVID-19 rapid test yet because they did not know how to order it in the computer system. During a concurrent observation and interview on 02/01/2024 at 8:24 AM, Resident 7 stated they did not feel very well that day. They stated their nose was runny and they had a cough. Resident 7 was sitting in their wheelchair coughing and had a runny nose with watering eyes. During an interview on 02/01/2024 at 9:42 AM, Staff C, IP, stated if there were residents that were suspect for COVID-19 infection, they should be isolated to their room with the door closed until lab results proved negative. They stated the suspect resident should be placed under isolation precautions with appropriate signage on the door. Staff C stated the process for testing was a failed process . <Hand Hygiene> During an observation on 01/31/2024 at 7:14 AM, Staff L and Staff O entered the room of Resident 3, both wearing N95 respirators with the straps around the back of their necks. Both Staff L and Staff O put on clean gloves and proceeded to assist Resident 3 with their morning cares. Staff O performed personal care around the residents' genitals, then rolled Resident 3 towards Staff L. Staff O removed the residents brief that was soiled with fecal matter, while Staff L held the resident in place. Staff O placed a clean brief under the resident and Staff L rolled Resident 3 to their back. Both Staff L and Staff O positioned the resident on the brief and secured the tabs on the brief. Staff L proceeded to apply lotion Resident 3's legs and arms, still wearing the same gloves. Staff O placed the Resident 3's shirt over their head, and while still wearing the same gloves, both Staff L and Staff O assisted the resident in pulling their shirt down. Staff L and Staff O then assisted the resident by placing their legs into their pants. Staff O threaded the urinary catheter (a hollow tube placed into the bladder to drain urine) bag through the pant leg. Wearing the same gloves, Staff L and Staff O positioned the resident onto the mechanical lift sling and transferred Resident 3 to their wheelchair. Staff O, still wearing the same gloves, proceeded to make the resident's bed, while Staff L, still wearing the same gloves, obtained an electric razor from the resident's sink area, and proceeded to shave the resident. Wearing the same gloves, Staff L obtained the residents dentures from their denture cup, applied denture adhesive, and handed them to Resident 3 to place in their mouth. Staff O, wearing the same gloves, used a sanitizing wipe to clean the mechanical lift. Staff L then removed their gloves and washed their hands with soap for 11 seconds. Staff O removed their gloves and left the room without performing HH. During an interview on 01/31/2024 at 9:40 AM, Staff O stated they sanitized their hands before putting gloves on. They stated they like to change their gloves between personal cares and clean things. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/31/2024 at 9:45 AM, Staff L stated when doing personal cares, they should change gloves between the dirty and clean cares. They stated their process was to change their gloves before handling dentures but had not done it that day. During an observation on 01/31/2024 at 7:14 AM, Staff I prepared Resident 4's medications at the medication cart by placing them in a cup of applesauce. Staff I carried the medications into the resident's room, did not perform HH, and administered the medications to the resident using a spoon. Without performing HH, Staff I then removed gloves from their pocket, donned gloves, swabbed Resident 4's abdomen with an alcohol pad and administered their insulin (a medication delivered by a needle and syringe that helps the body turn food into energy and manages blood sugar levels). Staff I disposed of the needle into the sharp's container, removed their gloves, and performed HH upon exiting the room. A second observation the same day at 7:28 AM showed Staff I prepared Resident 6's medications at the medication cart by putting them into a cup of applesauce. Staff I carried the medications to the Resident 6's TBP room. Without performing HH, Staff I, wearing an N95 respirator, put on a gown and gloves. They removed eye protection from a paper bag located on the cart outside the room. Staff I then entered the resident's room and administered their medications. Staff I disposed of their gown and glove in the trash bin in the resident's room, left the room, shut the door, and performed HH. A third observation at 9:54 AM showed Staff I entered Resident 3's room, did not perform HH, administered an inhaled medication to the resident along with a cup of medications (pills), and orange juice. <Annual Policy and Procedure Review> Review of the facility's infection control standards, policies, and procedures showed they were last reviewed in their entirety on 09/30/2019. During an interview on 02/01/2024 at 9:19 AM, Staff C stated the facility infection control policies and procedures were not up to date and were not updated annually. Staff C stated they try to do them every two years and was not aware of the requirement to review them at least annually. During an interview on 02/01/2024 at 11:23 AM, Staff B, Acting Director of Nursing Services, stated they expected all staff to gel in, gel out, between the dirty and clean tasks during personal cares, and remove gloves and perform HH before moving on. Staff B stated PPE and TBP use had been communicated to staff. They were instructed to wear an N95 respirator for any patient care and should not wear their N95 from room to room. Staff B stated they should be using a paper bag for storing their N95 and could wear a surgical mask at the nurse's station. Staff B stated PPE use for the COVID-19 isolation room consisted of putting on gloves, a gown, an N95 respirator, and eye protection. They stated the N95 respirator could be reused for the isolated resident and staff should be putting in a paper bag. They needed to clean their eye protection after leaving the isolation room. Staff B then stated the use of paper bags was not a current need as there was plenty of PPE available. Staff B stated staff should be throwing away their N95 after each use. Staff B stated they did not have a lot of experience in infection control and was not aware of the requirement for policy review. During an interview on 02/02/2024 at 1:10 PM, Staff A, Administrator, stated what we are dealing with right now (continued COVID-19 outbreak), there is absolutely something wrong with our process that we need to look at with the PPE failures and continued cases of COVID-19. Reference: WAC 388-97-1320(1)(a)(c)(2)(a)(b)(5)(b) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	43280 46722

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on interview and record review, the facility failed to offer and/or provide an influenza (a common viral infection that attacks the lungs, nose, and throat) immunization (a vaccine that protects against infection by influenza viruses) for 2 of 5 residents (Resident 1 and 3) reviewed for immunizations. This failure placed the residents at risk for illness and transmission of a communicable disease. Findings included . Review of the Centers for Disease Control and Prevention (CDC) guidance titled, Influenza (flu); Flu Season, dated 09/20/2022, showed flu season usually occurs in the fall and winter. While influenza viruses spread year-round, most of the time flu activity peaks between December and February. Review of the undated Washington State Department of Health guidance titled, What's new for flu for 2023 - 2024 advised obtaining an influenza vaccination before October, although the vaccine was available through the winter months. Review of the facility provided policy titled, Flu and Pneumonia Vaccination (immunization) for Patients or Residents, dated 02/04/2020, showed the licensed healthcare professional would assess the resident for appropriateness for receiving the influenza vaccine. They would provide the resident and/or their representative with information regarding the risks and benefits of receiving the vaccine. If the resident declined, they would be educated by a licensed nurse regarding risks and benefits. The influenza vaccine would be given during the current influenza season. Administration of the influenza vaccine would be documented in the resident's medical record. <Resident 1> Review of the medical record showed Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and anxiety. The 01/23/2024 comprehensive assessment showed the resident had an upper extremity (arm) impairment on one side and was dependent one to two staff members for activities of daily living (ADLs). The assessment also showed Resident 1 had a severely impaired cognition. Record review of Resident 1's immunization record showed they did not receive an influenza immunization for the 2023 influenza season. There was no documentation that the resident had been offered the influenza immunization, had received education regarding the risks and benefits of the immunization, or that the resident had declined the immunization. <Resident 3> (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record showed Resident 3 was admitted to the facility on [DATE] with diagnoses including a stroke with right sided weakness, atrial fibrillation (an irregular heart rate that causes poor blood flow), and depression (a feeling of sadness or loss of interest that can interfere with daily living). The 11/21/2023 comprehensive assessment showed the resident was dependent on assistance of two staff members for ADLs. The assessment also showed the resident was cognitively intact. During an interview on 02/01/2024 at 1:32 PM, Resident 3 stated they thought they had received their influenza immunization at their previous facility. They stated they were not offered one when they were admitted to this facility, and no one had asked them if they already had one. Resident 3 stated they would have liked to have one (2023 influenza immunization) if they had not had it yet. Review of Resident 3's immunization record showed the resident last received an influenza immunization on 10/28/2019. There was no documentation in their medical record that showed they were offered, received education regarding risks and benefits, or that the resident had declined the immunization. During an interview on 02/01/2024 at 9:19 AM, Staff C, Infection Preventionist, stated they were responsible for tracking influenza immunizations. They stated Residents 1 and 3 had declined the immunization and there was a declination for both residents in their medical record . Staff C stated they expected all residents to be offered or given the flu shot. They stated education with risks and benefits were a pop up screen on the computer that had to be acknowledged before the nurses would be able to continue charting in the medical record During an interview on 02/01/2024 at 11:23 AM, Staff B, Acting Director of Nursing Services, stated the nurses that worked on the floor were responsible for administering the influenza immunization. Staff B stated they would locate the declinations for Residents 1 and 3. During an interview on 02/01/2024 at 1:14 PM, Staff D, Administrative Assistant, stated Staff B was unable to locate the declinations for Residents 1 and 3. Reference: WAC 388-97-1340(1)(2)