STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505313	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Manor	32300 First Avenue South Federal Way, WA 98003

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide required liability notices for 1 of 3 residents (Resident 247) reviewed for liability notices. Failure of the facility to issue a Notification of Medicare Non-Coverage (NOMNC) before coverage for Medicare services ended for Resident 247 and discharged from the facility, placed the resident at risk for not fully understanding their Medicare benefits. Findings included . <Resident 247> Record review revealed Resident 247 admitted to the facility on [DATE] and was discharged to an adult family home on [DATE]. Resident 247's record showed no indication the facility provided a NOMNC letter to the resident. A 01/28/2025 social services note showed the discharge plan was for the resident to discharge to an adult family home when they completed their course of antibiotic medication. A 01/29/2025 social services progress note showed Resident 247 was scheduled to discharge back to an adult family home, transportation was arranged to pick up the resident on 01/30/2025, and discharge papers were prepared. In an interview on 05/07/2025 at 11:03 AM Staff C (Social Service Director) stated they did not provide a NOMNC letter to Resident 247. Staff C confirmed the discharge was a planned discharge. REFERENCE: WAC 388-97-0300(1)(e),(5),(6). .

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a safe, clean, and homelike environment was provided to the residents. Failure to ensure resident rooms were personalized for 1 (South Wing) of 2 wings reviewed and maintain resident weight scales clean and free from rust for shower rooms on 2 (North and South Wing) of 2 wings reviewed, left residents at risk for a less than homelike environment. Findings included . <Facility Policy> According to the facility's Resident Belongings and Home Like Environment policy, revised 06/12/2024, the facility would provide a safe, clean, comfortable, and homelike environment. The policy showed it was the responsibility of all facility staff to create a homelike environment and promptly address any cleaning needs. <South Wing> Observation on 05/06/2025 at 10:17 AM showed room [ROOM NUMBER] occupied one resident in the bed nearest the window. The walls were blank and did not have any décor or personal items for the resident. Observation on 05/06/2025 at 10:28 AM showed room [ROOM NUMBER] occupied one resident in the bed nearest the window. The walls were blank and the room did not contain any décor or personal items for the resident. The room smelled strongly of urine and a bedside commode was noted on the right side of the bed, containing urine in it. Observation on 05/13/2025 at 10:05 AM showed room [ROOM NUMBER] occupied two residents. The room was dark and the walls were blank. There was no décor or personal items in the room for the residents. In an observation and interview on 05/13/2025 at 12:42 PM, Staff A (Administrator) confirmed the walls were blank in the resident rooms. Staff A stated they were aware of the problem and were working with the company to try and obtain items that would add a personal touch. Staff agreed that the resident rooms could be improved and more homelike. <North Wing> Observation on 05/12/2025 at 8:44 AM of the shower room in the 300 hall had a weight scale with a ramp. The scale ramp had rust around the poles and along the bottom edges along the ramp. <North Wing - room [ROOM NUMBER]> (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 05/12/2025 at 9:21 AM, Resident 85 rolled themselves out of their room and were looking for staff members. Resident 85 stated the light bulb was out in the hallway leading into their room. The light switch was in the on position and there was no light in the hallway in the resident's room. The hallway contained two resident closets and the resident's bathroom door. Resident 85 stated the light was out for the last two days and they told staff about it, but no one fixed it. Resident 85 stated it was very dark, and they did not like it when it's dark, especially at night time. In an interview on 05/12/2025 at 9:27 AM, Resident 85 told Staff Q (Certified Nursing Assistant) their light was not working in their hallway. Staff Q observed light was not working. Staff Q stated when they become aware of a maintenance issue, they told the maintenance staff directly, or put the concern into the facility's maintenance system. Staff Q stated they did not know the light bulb was out, but it should be changed because it was not safe for the residents' lights to be out. Observation on 05/13/2025 at 8:37 AM showed the hallway light into room [ROOM NUMBER] was off, the light switch was in the on position indicating the light was not working. In an interview on 05/13/2025 at 9:58 AM, Staff B (Director of Nursing) stated staff should have notified the maintenance department when the light bulb was out. The maintenance team should be notified in person or by phone to fix the light as this was important for residents' safety and to prevent falls. REFERENCE: WAC 388-97-0880. <South Wing - 600 Hall> An observation on 05/06/2025 at 9:47 AM showed the roll-on weight scale in the shower room on 600 hall had rust on the ramp and the top edges of the three safety rails. Rust dust was on the floor surrounding the scale. In an interview on 05/12/2025 at 1:01 PM, Staff I (Resident Care Manager) stated residents could come into contact with the rust and the scale should be repaired or replaced.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 35> Review of a 10/22/2024 nursing progress note showed Resident 35 was transferred to the hospital for complaints of abdominal pain, chest pain, and shortness of breath. Review of Resident 35's records on 05/13/2025 showed no documentation staff provided Resident 35 or their representative with a written transfer notice. There was no progress note or copy of the written transfer notice available in Resident 35's record. In an interview on 05/13/2025 at 11:12 AM, Staff B and Staff F reviewed Resident 35's record and stated staff did not document the written transfer notice was provided as required. Staff B stated it was their expectation staff provided the notice within at the time of the resident being transferred, and in emergencies, the notice should be provided within 24 hours, and a copy was expected to be in the resident's record. Based on record review and interview, the facility failed to provide the bed hold policy upon transfers to the hospital for 2 of 7 residents (Residents 3 & 64), call report on resident's status to the receiving hospital for 3 of 7 residents (Resident 3, 64, & 80), provide a written transfer notification for 4 of 7 residents (Residents 3, 64, 80, & 35) , notify the Office of the State Long Term Care Ombudsman (LTCO) for 1 of 7 residents (Resident 94) reviewed for hospitalizations, and notify the medical provider for 1 supplemental resident (Resident 93) who discharged from the facility. Failure to offer bed holds placed residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized . Failure to call report to the receiving hospital placed residents at risk of a break in communication and continuity of care. Failure to notify the LTCO and ensure written notification was provided to the resident/resident representative, in a language and manner they understood, placed residents at risk for not having an opportunity to make informed decisions about their transfer/discharge rights. Failure to notify the provider of resident's discharge placed resident's at risk for a break in continuity of care. <Resident 3> According to a 02/02/2025 Discharge Return Anticipated Minimum Data Set (MDS - an assessment tool) Resident 3 transferred to an acute care hospital on [DATE] with their return to facility anticipated. Record review of Resident 3's health records showed a bed hold was not offered to the resident or their representative for the 02/02/2025 transfer to hospital. Resident 3's records showed no written transfer notification was provided to the resident or their representative for the 02/02/2025 transfer to the hospital. Record review showed staff did not document they called the resident's medical report to the hospital upon transfer on 02/02/2025. In an interview on 05/06/2025 at 6:22 PM Resident 3's representative stated they were notified of the 02/02/2025 hospital transfer after the resident was in the hospital for a day. Resident 3's representative stated they were still unsure of the reason as to why Resident 3 was transferred to the hospital and did not receive a written notification of transfer from the facility. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/12/2025 at 12:13 PM Staff B (Director of Nursing) and Staff F (Regional Director of Clinical Services) reviewed Resident 3's health records and stated a written transfer notification was not provided to the resident or their representative for the hospital transfer on 02/02/2025. Staff F stated report was not called to the receiving hospital for Resident 3's transfer to the hospital on [DATE]. Staff F stated they expected staff to call report to the receiving facility upon resident transfer out and document the name of who the staff reported off to. Staff B stated they expected staff to provide a written transfer notification to the residents or representative to ensure they understood their rights regarding the transfer out. In an interview on 05/12/2025 at 1:27 PM Staff B stated they reviewed Resident 3's paper chart and records sent to the facility's medical records department. Staff B stated staff did not document they provided a written transfer notification provided to the resident or their representative. In an interview on 05/12/2025 at 2:31 PM Staff E (Business Office Manager) stated a bed hold was not provided to Resident 3 or their representative for the hospital transfer on 02/02/2025. <Resident 64> According to a 07/03/2024 Discharge Return Anticipated MDS Resident 64 was transferred to an acute care hospital on [DATE]. Resident 64's records also showed Discharge Return Anticipated MDS's for 07/27/2024, 08/10/2024, 09/11/2024, and 09/25/2024 transfers to an acute care hospital. Record review of Resident 64's health records showed a less than 24-hour transfer to an acute care hospital on [DATE]. Record review showed staff did not document they called the resident's medical report to the receiving hospital on [DATE], 07/27/2024, 09/11/2024, 09/25/2024, or 10/18/2024. In an interview on 05/12/2025 at 9:57 AM Staff G (Social Service Assistant) stated the LTCO was not notified for Resident 64's transfer to the hospital on [DATE]. In an interview on 05/12/2025 at 12:13 PM Staff B and Staff F reviewed Resident 64's records and stated staff did not document that report was called to the receiving hospital for the 07/03/2024, 07/27/2024, 09/11/2024, 09/25/2024, or the 10/18/2024 transfers to the hospital. Staff B and Staff F reviewed Resident 64's records and stated a written transfer notification was not provided to the resident for the 07/03/2024, 07/27/2024, 08/10/2024, 09/11/2024, 09/25/2024, or 10/18/2024 transfers. Staff B stated it was important to call a report to the receiving hospital when staff transferred a resident to an acute care hospital to ensure good communication for the resident's continuity of care and provide a written transfer notification to ensure the resident understood their rights to an appeal and how to do that. Staff B stated when staff obtained verbal consent for cares/treatments from a resident or resident representative, they expected staff to have another staff member witness the verbal consent. In an interview on 05/12/2025 at 2:31 PM Staff E showed bed hold forms for 07/03/2024, 07/27/2024, 08/10/2024, 09/11/2024, and 09/25/2024 with verbal consent from resident declining the bed holds. The bed hold forms showed Staff E's signature without a witness staff signature for the bed hold declinations. <Resident 80> (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/25/2025 and 02/22/2025 Discharge Return Anticipated MDS Resident 80 was transferred to an acute care hospital on both of those dates. Record review showed staff did not document they called Resident 80's medical report to the hospital upon transfer on 01/25/2025. In an interview on 05/12/2025 at 12:13 PM Staff B and Staff F reviewed Resident 80's health records and stated a report was not called to the receiving hospital for the 01/25/2025 transfer out. Staff B and Staff F stated written transfer notification was not provided to Resident 80 or their representative for the 01/25/2025 or 02/22/2025 transfers to the hospital. In an interview on 05/12/2025 at 1:28 PM Staff B stated they reviewed Resident 80's paper chart and there was nothing supporting written transfer notifications for either of the hospital transfer on 01/25/2025 and 02/22/2025. <Resident 94> According to a 02/05/2025 Discharge Return Not Anticipated MDS Resident 94 discharged home. In an interview on 05/12/2025 at 9:57 AM Staff G stated the LTCO was not notified for Resident 94's transfer home on [DATE]. In an interview on 05/13/2025 at 9:49 AM Staff C (Social Service Director) stated they expected LTCO notification for all transfers out of facility. Staff C stated the LTCO should be notified of Resident 64's transfer to the acute care hospital on [DATE].<Resident 93> Review of Resident 93's medical record showed a progress note dated 02/11/2025 that Resident 93 was discharged home. Review of medical records did not show staff documented that Resident 93's medical provider was notified of the discharge. In an observation and interview on 05/13/2025 at 11:35 AM Staff B stated staff were to receive an order from the doctor when a resident was being discharged . Staff B reviewed Resident 93's medical record and stated they could not locate the discharge orders from the provider or that a notification to the provider was made regarding Resident 93's discharge. Staff B stated it was very important to receive the necessary orders from the provider before a resident discharged for safety and for the provider to be made aware of the discharge. REFERENCE: WAC 388-97-0120(2)(a-d)(3)(a)(4), -0140(1)(a)(b)(c)(i-iii). .

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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 Based on record review and interview, the facility failed to ensure a Significant Change in Status Assessment (SCSA) was completed within 14 days from the date of determination for 1 of 1 resident (Resident 92) reviewed for death. Failure to identify the need for a SCSA when Resident 92 had a decline in condition and started on Hospice/Palliative care services placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . According to the Resident Assessment Instrument Manual (RAI - a document directing staff when assessments of resident status is required) a .SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice) and remains in the nursing home. <Resident 92> Review of Resident 92's 03/03/2025 Minimum Data Set (MDS - and assessment tool) showed a 03/03/2025 Death in Facility MDS. Resident 92's records did not show a SCSA was completed. Review of Resident 92's health records showed a 01/26/2025 Social Services significant change progress note stating the resident was on comfort care measures for increased confusion and was bedridden due to fatigue (weakness and/or loss of energy). Resident 92's records showed a 02/04/2025 progress note reporting the residents' blood pressure was dropping below parameters and the Nurse Practitioner instructed staff to discontinue Resident 92's blood pressure medications at that time. Resident 92's records showed a 02/10/2025 progress note reporting a new pressure ulcer to sacrum. Resident 92's records showed a 02/12/2025 progress note reporting resident refusing all foods and fluids due to difficulty in swallowing and was experiencing increased pain. The 02/12/2025 progress note showed the resident representative requested comfort measures for Resident 92's goal for care. Resident 92's records showed a 02/23/2025 physician order for Hospice service for comfort care was implemented. In an interview on 05/13/2025 at 10:46 AM Staff B (Director of Nursing) reviewed Resident 92's health records and stated the progress notes showed the resident started refusing food and fluids on 02/12/2025 and the nurse practitioner ordered palliative/comfort care services per the representative's request. Staff B stated they would expect staff to complete a SCSA per the RAI manual guidelines when a resident enrolls in terminally ill services. In an interview on 05/13/2025 at 11:32 AM Staff D (MDS Nurse) reviewed Resident 92's health records and stated they had a change in mobility, food and fluid intake, level of assistance required, increased pain, and obtained a physician order for Hospice for Comfort care. Staff D stated a SCSA should be completed when two or more changes in activities of daily living occurred and without progress after a 14-day observation period per the RAI Manual. Staff D stated Resident 92 should have a SCSA completed prior to their death but did not. REFERENCE: WAC 388-97-1000(3)(b). .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) accurately reflected the status for 1 of 3 residents (Resident 94) reviewed for closed records and 1 of 7 residents (Resident 1) reviewed for falls. This failure placed residents at risk for unidentified and/or unmet needs, and a diminished quality of life. Findings included <Facility Policy> According to the facility's Resident Assessment Instrument and Care Plan Development policy revised 09/05/2024, the facility would follow procedures described in the Resident Assessment Instrument (instructions/guidelines) when completing MDS assessments. <Resident 1> According to the 03/06/2025 Quarterly MDS, Resident 1 had intact cognition, normal thinking and memory. The MDS showed Resident 1 had functional impairment to one arm and one leg, required partial/moderate assistance from staff for transfers in and out of their bed and wheelchair, and for sitting to standing position. The MDS showed Resident 1 did not have a fall during the assessment period. Observation and interview on 05/06/2025 at 9:33 AM showed Resident 1 lying in bed, their bed was in a low position. Resident 1 stated they fell a lot. Review of a 02/22/2025 nursing progress note showed staff documented Resident 1 was seen lying on the floor in their room by a staff member. The progress note showed the resident was trying to get clothes from their closet without staff assistance and fell onto the floor. In an interview on 05/13/2025 at 9:55 AM, Staff D (MDS Coordinator) reviewed the 03/06/2025 Quarterly MDS and confirmed the MDS should have captured Resident 1's 02/22/2025 fall, but the MDS was inaccurate. <Resident 94> According to a 02/05/2025 Modification of Discharge Return Not Anticipated MDS, Resident 94 discharged to an acute care hospital on [DATE]. Review of Resident 94's health records showed a 02/05/2025 progress note that the resident discharged home per doctor orders. In an interview on 05/12/2025 at 11:45 AM Staff L (MDS Coordinator) stated Resident 94 discharged home and the MDS should be coded as discharge home/community but it was coded in error as discharged to hospital. REFERENCE: WAC 388-97-1000 (1)(b). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR) Level 2 comprehensive evaluations (a process to determine what mental health services residents required after a Level 1 PASRR determined mental health services were necessary) were obtained for 5 (Residents 35, 80, 3, 5, & 71) of 9 residents whose PASRRs were reviewed. This failure placed residents at risk for not receiving necessary mental health care and services. Findings included . <Policy> According to a facility policy titled, Pre-admission Screening and Resident Review, revised 09/26/2024, a resident with a Serious Mental Illness (SMI) would indicate a positive level 1. The policy stated a positive level 1 screen necessitated an in depth evaluation of the resident by the state designated authority, known as a PASRR level 2, which would be conducted prior to admission to the facility or the referral would be made for the level 2 at time of new identified SMI's. <Resident 35> According to the 03/13/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 35 had diagnoses of a brain disorder that caused a gradual decline in thinking abilities, memory, and behavior, and anxiety and depression. The MDS showed Resident 35 had rejection of care one to three days during the assessment look back period. Review of Resident 35's 11/29/2024 PASRR Level 1 showed the resident was being reassessed for mental health conditions due to a recent change in condition. This PASRR showed Resident 35 had a SMI of mood, anxiety, and psychotic disorders. The PASRR showed Resident 35 was being referred for a PASRR Level 2 evaluation. Review of Resident 35's documents, assessments, Care Plan (CP), and progress notes on 05/13/2025 showed no indication a PASRR Level 2 determination was obtained. There were no progress notes showing the facility followed up to obtain the Level 2 determination, five months after the referral was sent. In an interview on 05/13/2025 at 10:28 AM, Staff C (Social Services Director) stated the facility sent the referral for the PASRR Level 2 evaluation but the facility did not have a process for following up on PASRRs that were referred for Level 2 evaluations to ensure they were obtained. <Resident 80> According to a 07/13/2024 admission MDS Resident 80 admitted to the facility on [DATE]. The MDS showed Resident 80 had diagnoses of, but not limited to, depression. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 80's health records showed a 07/08/2024 diagnosis of anxiety disorder. Resident 80's records showed a PASRR 1 with SMI documented as depression and anxiety disorder. Resident 80's PASRR 1 showed no level 2 evaluation indicated. <Resident 3> According to a 06/13/2024 Annual MDS, Resident 3 had diagnoses of, but not limited to, anxiety disorder, depression, and psychotic disorder. Record review of Resident 3's health records showed a 06/26/2024 updated PASRR 1 with SMI documented as Schizophrenic disorder (mental disorder affecting the way a person thinks, feels, and behaves), psychotic disorder, depression, and anxiety disorder. Resident 3's PASRR 1 showed no level 2 evaluation referral was made. <Resident 5> According to a 01/09/2025 Annual MDS, Resident 5 had diagnoses of, but not limited to, depression, anxiety disorder, and post traumatic stress disorder. Record review of Resident 5's health records showed a 03/08/2024 updated PASRR 1 with SMI documented as depression and anxiety disorder. Resident 5's PASRR 1 showed no level 2 evaluation indicated. In an interview on 05/12/2025 at 9:57 AM, Staff G (Social Service Assistant) stated Resident's 80, 3, & 5 had SMI so they should have been referred for a level 2 PASRR. Staff G stated a level 2 evaluation was important to ensure the residents were receiving appropriate mental health care services. In an interview on 05/13/2025 at 9:49 AM, Staff C stated they expected a PASRR 2 referral to be made when a resident had SMI's per regulation. Staff C stated it was important to ensure the residents were receiving the best mental health care services. <Resident 71 > According to the 02/26/2025 Quarterly MDS, Resident 71 admitted to the facility on [DATE] and had diagnoses of anxiety and depression. According to the revised 08/08/2023 PASRR Level 1 screening, Resident 71 required an updated PASRR Level 1 because of a new diagnosis of depression. The PASRR Level 1 showed no level 2 was indicated. Review of the 10/13/2023 Behavior Problem CP showed Resident 71 had a behavior problem of seeking pain medication, feelings of emptiness, and worrying. Review of a physician ordered dated 03/19/2024 showed Resident 71 had diagnoses of depressive disorder and anxiety. Record review did not show a change of condition PASRR Level 1 was completed and did not show a PASRR level 2 referral was made after the 03/19/2024 diagnoses. Review of the 05/24/2024 CP showed Resident 71 had the potential to be verbally aggressive related to ineffective coping skills and poor impulse control. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Manor	32300 First Avenue South Federal Way, WA 98003

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 05/07/2025 at 9:33 AM showed Resident 71 lying in bed, watching Television, (TV) and stated they were watching TV but did not really like anything that was on TV. Resident 71 stated they had pain all the time in their joints and was verbally upset at the facility for taking away their arthritis cream. In an interview on 05/13/2025 at 11:45 AM Staff C stated for changes of condition an updated PASRR Level 1 screening was important to keep track of residents' condition and to inform the facility of physical and mental changes. REFERENCE: WAC 388-97-1915(4). .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview the facility failed to ensure development of a Palliative care plan for 1 of 3 residents (Resident 92) reviewed for closed records. Failure to develop a Palliative care plan placed residents at risk of unmet care needs and decreased quality of life. Findings included . <Policy> According to a facility policy titled, Comprehensive Care Plans and Conferences, revised 09/05/2024, the facility would ensure timeliness of each resident's person-centered care plan, and that each resident/representative would be involved in development of their care plan. <Resident 92> According to a 03/03/2025 Death in facility Minimum Data Set (MDS - an assessment tool) Resident 92 passed away in the facility on 03/03/2025. Review of Resident 92's health records showed a 02/13/2025 physician progress note stating the resident representative agreed to Palliative care services. Resident 92's health records showed no Palliative care plan. In an interview on 05/13/2025 at 10:46 AM Staff B (Director of Nursing) reviewed Resident 92's health records and stated they did not have a Palliative care plan but should have. Staff B stated it was important to develop Palliative care plans to ensure staff were aware of interventions to keep the residents as comfortable as possible for the end of life. Reference: WAC 388-97-1020(1), (2)(a)(b). .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to facilitate quarterly care conferences for 3 of 3 residents (Resident 1, 50, & 64) reviewed for care conferences, and failed to ensure Care Plans (CP) were revised as required for 2 (Resident 71 and 88) of 2 residents reviewed for care planning. These failures placed residents at risk for unmet care needs, unnecessary care, frustration, and other negative health outcomes. Findings included . <Facility Policy> According to a facility policy titled, Comprehensive Care Plans and Conferences, revised 09/05/2024, the facility would ensure the timeliness of each resident's person-centered, comprehensive CP, and ensure the comprehensive CP was reviewed and revised by the interdisciplinary team composed of individuals who have knowledge of the resident and their needs, and each resident and/or resident representative was involved in developing the CP and making decisions about their care. The policy showed the interdisciplinary team consisted of, at a minimum, the resident's physician, a registered nurse, a nurse aide, a member of the dietary department, the resident, and the resident representative, if applicable. The policy showed care conferences would be offered/conducted within seven days of admission, quarterly, and as needed. <Care Conferences> <Resident 1> According to the 03/06/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE]. The MDS showed Resident 1 had diagnoses including inability to control blood sugar levels, anxiety, and depression. In an interview on 05/06/2025 at 9:39 AM, Resident 1 stated they were not sure about when they last had a care conference with staff. Review of Resident 1's progress notes showed an 11/26/2024 social services note stating the resident declined to have a quarterly care conference. There were no other progress notes or follow up documentation regarding scheduling further care conferences or that the next quarterly care conference was offered. These progress notes showed the last care conference documented was on 11/09/2023, over two and a half years ago. <Resident 50> According to the 03/12/2025 Quarterly MDS, Resident 50 admitted to the facility on [DATE]. The MDS showed Resident 50 was in a persistent, vegetative state and had diagnoses including a seizure disorder, anxiety, and depression. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 50's record showed a 12/12/2024 social services progress note that a voicemail was left with the resident's representative to schedule a quarterly care conference. There were no other progress notes or follow up documentation regarding scheduling further quarterly care conferences. In an interview on 05/13/2025 at 10:19 AM, Staff C (Social Services Director) stated care conferences for long-term care residents should be held quarterly. Staff C stated care conferences were documented in progress notes in the resident's record. Staff C confirmed Resident 1 and Resident 50 were not offered/provided care conferences quarterly. Staff C stated their process for providing quarterly care conferences was a work in progress.<Resident 64> According to a 03/28/2025 Quarterly MDS, Resident 64 readmitted to the facility on [DATE]. The MDS showed Resident 64 had no memory impairment. In an interview on 05/07/2025 at 8:41 AM, Resident 64 stated the facility did not offer or conduct a care conference with them since their admission to the facility. Review of Resident 64's records showed no documentation a care conference was performed. In an interview on 05/12/2025 at 9:57 AM, Staff G (Social Service Assistant) reviewed Resident 64's health records and stated there was a social service progress note on 02/05/2025 stating Resident 64 declined a quarterly care conference. Staff G stated Resident 64's records showed no other care conferences were offered or conducted. Staff G stated they were expected to offer care conferences within 72 hours of admission, quarterly, and as requested/needed. In an interview on 05/13/2025 at 9:49 AM Staff C stated they expected care conferences be conducted within the first week of admission if possible, quarterly, if they could get to them, but at least annually, and as needed. Staff C stated social services, nurse manager, business office manager, dietary, and therapy would attend new admission care conferences and skilled resident care conferences, and social services and nurse manager would attend long term care resident care conferences. When asked if dietary or activities would attend long term care resident care conferences, Staff C stated they used to but stopped showing up to resident's care conferences. <Resident 71> According to an 02/26/2025 Quarterly MDS, Resident 71 had respiratory failure. According to revised 02/27/2024 oxygen CP, Resident 71 was to have oxygen supplementation, as needed, if their oxygen saturation rate (measure of oxygen carried by the blood) was below 92%. Review of May 2025 Medication Administration Record (MAR) did not show oxygen supplementation was provided. In an interview on 05/13/2025 at 9:58 AM Staff F (Regional Director of Clinical Services) stated Resident 71's CP should have been revised to remove oxygen saturation monitoring after supplemental oxygen was discontinued, but was not. Staff F stated this could cause confusion and the CP should be revised. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1020(4)(e),(5)(b). <Care Plan Revision> <Resident 88> According to the 04/22/2025 MDS, Resident 88 had multiple medically complex diagnoses including risk for malnutrition (lack of nutrients to maintain health), heart failure, and dysphagia (difficulty speaking). Review of physician admission note dated 04/10/2025 at 3:21 PM showed the provider was aware Resident 88 had delirium during the recent hospital admission and was refusing care. Review of a 04/10/2025 physician order directed staff to obtain Resident 88's weight for the first 3 days following admission, once per week for 4 weeks and then once per month. An order dated 05/09/2025 showed staff were to reweigh Resident 88 on the same day. Review of progress note dated 05/08/2025 at 11:48 AM showed provider noted Resident 88's weight was to be monitored for the management of medications related to heart failure. Review of Resident 88's weight summary report on 05/12/2025, showed weigh entries of 211 pounds on 04/10/2025 at 2:48 PM and 96 pounds on 05/02/2025 at 1:03 PM. Review of Resident 88's April and May 2025 Medication Administration Records (MARs) showed staff attempted to obtain Resident 88's weight on 04/11/2025, 04/12/2025 and 04/13/2025, treatment was refused and no weights were recorded. An entry on 04/17/2025 showed Resident refused treatment and 211 pounds was documented. Entries on 04/24/2025 and 05/01/2025 showed Resident 88 was weighed and 211 pounds was documented. An entry on 05/08/2025 showed Resident 88 was weighed and weight was documented as N/A. An entry on 05/09/2025 at 5:01 PM showed no weight recorded and coded as drug refused. Review of a nursing progress note dated 04/11/2025 at 1:32 PM and 04/13/2025 at 5:49 PM showed Resident refused to be weighed. Review of CP, last revised on 04/29/2025, showed Resident 88 was resistive to care; brief, linen changes, meal refusals, medication refusals and showers with a goal that they would cooperate with care through the next review date. The CP goal and interventions for resistance to care were initiated on 04/11/2025 and remained unchanged. Review of Resident 88's record on 05/12/2025, showed no documentation of specific interventions performed by staff to obtain the resident's weight. In an interview on 05/12/2025 at 1:01 PM, Staff I (Resident Care Manager - RCM) stated they were aware of Resident 88's refusals to be weighed, expected staff to accept refusals of care as the resident's right, and to follow the current CP interventions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/13/2025 at 12:36 PM, Staff F (Regional Director of Clinical Services) reviewed Resident 88's CP and stated obtaining weights should have been included in Resident 88's list of care refusals. Staff F stated they expected staff to revise the CP to include specific interventions to assist staff in obtaining Resident 88's weight.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to ensure: physician orders were obtained for bed rails and blood sugar parameters, clarify physician orders, and medications were administered within ordered parameters for 3 (Residents 80, 88, & 1) of 20 sample residents. These failures placed residents at risk for medication errors, delayed treatment, and adverse outcomes. Findings included . <Blood Sugar Parameters> <Resident 80> According to a 07/13/2024 admission Minimum Data Set (MDS - an assessment tool) Resident 80 had a diagnosis of, but not limited to, Diabetes (unstable blood sugar levels). Review of Resident 80's records showed a physician order for a blood sugar lowering injectable medication. Resident 80's records did not include physician orders for parameters of when to notify the physician of dangerously out of range blood sugar levels. In an interview on 05/12/2025 at 12:13 PM, Staff B (Director of Nursing) stated Resident 80 should have physician instructions to notify when their blood sugar was less than 60 but did not. Staff B stated this was important to ensure the resident's blood sugar did not drop below 60 and end up in the hospital <Obtaining Physician Orders> <Resident 80> Observation and record review on 05/06/2025 at 9:24 AM showed bilateral bed rails to Resident 80's bed. Review of Resident 80's records showed no physician order for the bilateral bed rails. In an interview on 05/12/2025 at 12:13 PM, Staff B stated Resident 80 should have a physician order for the bilateral bed rails but did not. Staff B stated it was important to obtain physician orders for all cares/treatments for a resident. <Administering Medications Outside of Parameters> <Resident 88> According to the 04/22/2025 admission MDS, Resident 88 had multiple medically complex diagnoses including high Blood Pressure (BP - pressure against blood vessel walls when the heart pumps). Review of a 04/10/2025 physician order directed staff to administer a medication to reduce BP twice daily with instructions to hold the medication if Systolic BP (SBP - a measure of the pressure inside your arteries when the heart squeezes) was less than 110 mmHg (millimeters of mercury). Review of Resident 88's April and May 2025 Medication Administration Records (MARs) showed staff did not follow instructions and administered the medication on 04/18/2025 and 05/06/2025 at bedtime, and 05/04/2025 and 05/09/2025 in the morning when their SBP was less than 110 mmHg. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/12/2025 at 1:01 PM, Staff I (Resident Care Manager) reviewed Resident 88's record and confirmed staff failed to hold the medication per the physician's orders. Staff I stated it was their expectation staff follow physician orders and hold medications, as instructed. <Clarifying Physician Orders> <Resident 1> Review of Resident 1's physician orders tab showed a 04/29/2025 order directing staff to administer a diuretic (medication that removed excess fluid from the body) to the resident once daily. The order included instructions to staff to check Resident 1's BP prior to administering the medication. Review of Resident 1's April 2025 and May 2025 MARs showed the instructions to check the resident's BP did not transfer to the MAR, therefore staff were not checking the resident's BP prior to administering the medication. In an interview on 05/13/2025 at 10:55 AM, Staff B and Staff F (Regional Director of Clinical Services) reviewed Resident 1's order for the diuretic and the MAR. Staff B and Staff F stated the order required clarification from the physician. Refer to F700 - Bedrails. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i). .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. <Resident 61> According to the 02/22/2025 Quarterly MDS, Resident 61 was moderately impaired with their thinking/processing abilities and required cues and supervision for daily decision making. Resident 61 had impairment to both legs and required the use of a wheelchair for mobility. Resident 61 was totally dependent on staff for transfers to and from their bed to wheelchair. Observation on 05/06/2025 at 10:32 AM showed Resident 61 sitting in their wheelchair in their room, the resident was asleep. Observations on 05/07/2025 at 9:03 AM showed Resident 61 asleep, sitting in their wheelchair in their room. The room was dark, the television and radio were off. In an interview on 05/07/2025 at 10:40 AM, Resident 61's representative stated the facility would assist Resident 61 out of bed in the morning before breakfast and then leave the resident in their wheelchair until around 3:00 PM. Resident 61's representative stated the resident usually ate dinner in bed because they were too tired to get up in the wheelchair again. Resident 61's representative stated I wish [staff] would put Resident 61 back in bed after breakfast. Observation on 05/08/2025 at 8:55 AM showed Resident 61 sitting in their wheelchair in a group activity in the day room. Resident 61 was asleep. Observations on 05/08/2025 at 10:06 AM and at 12:23 PM, showed Resident 61 was back in their room in their wheelchair. Observation on 05/12/2025 at 9:48 AM showed Resident 61 at an activity, asleep in their wheelchair. Observations on 05/12/2025 at 11:36 AM and 1:22 PM showed Resident 61 sitting in their wheelchair. In an interview on 05/12/2025 at 1:41 PM, Staff P stated Resident 61 did not lie down after breakfast and that staff kept the resident in the wheelchair. In an interview on 05/13/2025 at 11:21 AM, Staff B stated they expected staff to provide assistance to residents to lie down, especially if the resident was asleep in their wheelchair. REFERENCE: WAC 388-97-1060(2)(c). <Resident 46> According to the 01/06/2025 admission MDS, Resident 46 could make their needs known, understood others, and was dependent on staff for bathing, lower body dressing, and putting on footwear. According to the 01/02/2025 ADL self-care performance deficit CP, Resident 46 had deficits related to impaired balance. Staff were to encourage Resident 46 to participate in ADLs and document any refusals. The CP showed Resident 46 was dependent on staff for bathing, hygiene/oral care, and two staff were needed for dressing. Review of Resident 46's care staff task list from 05/01/2025 through 05/13/2025 showed staff documented ADL care daily for all day and evening shifts except evenings of 05/11/2025, 05/12/2025, and 05/13/2025. There was no documentation showing Resident 46 refused showers, dressing, or personal hygiene, on day or evening shifts. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/06/2025 at 10:22 AM, Resident 46 stated staff did not clip their nails and the resident had to bite them to keep them short. Resident 46 stated the staff did not offer to clip their toenails, and stated they had diabetes (inability of the body to regulate blood sugar levels), and their feet, hands, and skin should be observed by staff. Resident 46 stated the staff did not give them a washcloth in the morning and one of the nurses told Resident 46 it was not their job to provide nail care. Resident 46 stated they did not think the nurses wanted to provide nail care to them. In an interview on 05/06/2025 at 1:37 PM, Resident 46 stated their feet became swollen and they needed diabetic socks. Resident 46 stated they told staff they would like to be shaved but staff stated they could not shave the resident because of their diabetes. Resident 46 stated the care staff did not routinely offer them a washcloth to wash their hands or their face. Observation on 05/12/2025 at 8:37 AM showed Staff H (Registered Nurse) assess Resident 46's bilateral feet and legs. Resident 46 had long toenails extending a half inch past the nail bed. Some nails were cracked and had jagged edges. Dry, flaky, and dark black skin was observed in several spots around both feet. Resident 46's left leg was more swollen in comparison to their right leg. Resident 46 was observed to tell the nurse the care staff did not remove the resident's socks in three weeks. In an interview on 05/12/2025 at 8:42 AM, Staff H stated Resident 46 often refused care including showers and nail care, and Resident 46 was not on the list to see the podiatrist due to refusals. Staff H stated staff should document refusals of care and the nurses were responsible for informing the social services team when a resident needed to be added to the podiatrist list. In an interview on 05/12/2025 at 9:03 AM, Staff G (Social Service Assistant) stated the facility had a podiatrist that came to the facility every 6 to 8 weeks. Staff G stated the social services team placed residents on the list for the podiatrist and they added diabetic residents to the podiatrist list routinely as diabetic residents were susceptible to skin and wound issues. Staff G stated Resident 46 was not on the podiatrist list for routine diabetic foot care. In an interview on 5/13/2025 at 9:43 AM Staff B (Director of Nursing) stated care staff should have alerted the nurses right away for any issues they observed. Staff B stated for diabetic foot care, the nurses should make a referral to the podiatrist and routinely check diabetic residents' skin. Staff B stated the staff should have alerted the nurse for all refusals of care and then the unit manager and social services team would be aware. Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs) for 3 (Residents 46, 61 & 62) of 7 residents who were assessed to be dependent on staff for ADLs. The failure to provide ADL assistance as required left residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes. Findings included . <Facility Policy> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's [ADLs] policy, revised 09/10/2024, residents would receive assistance with ADLs as needed. Any change in the ability to perform ADLs would be reported to the nurse. For bed and wheelchair mobility, staff would assist residents with bed/wheelchair repositioning as necessary to prevent skin breakdown. For fingernail care, staff would ensure fingernails were clean and trimmed to avoid injury and infection. <Resident 62> According to the 04/28/2025 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 62 had a significant change in their health status, resulting in their transition to hospice care (a comfort-focused approach). Resident 62's functional abilities for eating were changed from setup assistance to supervision assistance. Review of a revised 05/07/2025 Care Plan (CP), showed Resident 62 required supervision by one staff member when eating. Observations on 05/08/2025 at 12:40 PM, 05/09/2025 at 7:46 AM, 05/09/2025 at 12:52 PM, 05/10/2025 at 1:02 PM, and 05/12/2025 at 8:29 AM, showed Resident 62 with a meal tray on their bedside table and no staff supervision provided between delivery time and removal of the tray. In an observation on 05/09/2025 7:58 AM, Resident 62 was heard coughing from the hallway while feeding themselves. Staff I (Resident Care Manager) entered Resident 62's room and exited room at 8:01 AM. No eating supervision was provided. In an interview on 05/07/2025 at 12:39 PM, Resident 62 stated they lost weight since they were admitted to the facility. In an interview on 05/12/2025 at 08:32 AM, Staff P (Certified Nursing Assistant - CNA) was assigned to care for Resident 62 and stated they were setup assistance only for meals. In an interview on 05/12/2025 at 1:01 PM, Staff I reviewed Resident 62's most recent MDS and stated the resident was assessed to require staff assistance with eating. Staff I reviewed Resident 62's CP and stated a staff member should sit with them during each meal to provide support.

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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** <Resident 80> According to a 07/13/2024 admission Minimum Data Set (MDS - an assessment tool) Resident 80 admitted to the facility on [DATE] and had no memory impairment. The MDS showed Resident 80 had a diagnosis of, but not limited to, high cholesterol. Review of resident 80's health records showed 03/04/2025 physician orders for a cholesterol lowering medication and a medication for high uric acid (a waste product that can cause painful inflammation in the body when not excreted) levels in the body. Resident 80's health records showed no lab results for blood cholesterol or uric acid level. Resident 80's health records did not show a diagnosis related to high uric acid levels. In an interview on 05/12/2025 at 12:13 PM Staff B (Director of Nursing) reviewed Resident 80's health records and stated they did not have a cholesterol or uric acid level monitored but should. Staff B reviewed Resident 80's most recent hospitalization and stated they did not see the labs were not obtained at the hospital either. Staff B stated it was important to obtain these levels prior to prescribing these medications so they were not administering the medications unnecessarily. Staff B stated they expected staff to ensure they received copies of blood work for these medications to ensure the medications were not prescribed in error. <Change In Condition> <Resident 46> According to an 01/06/2025 admission MDS, Resident 46 had clear speech, was understood and able to understand others. The MDS showed Resident 46 had an active diagnoses of heart failure with pulmonary edema, morbid obesity, diabetes and was at risk for skin pressure injuries. Review of an 01/02/2025 ADL self-care performance deficit Care Plan (CP), showed Resident 46 was totally dependent on two staff for mobility, dressing and personal hygiene. Staff were to observe and report any changes in Resident 46's condition and decline in functional abilities. In an interview on 05/06/2025 at 1:37 PM Resident 46 stated they were diabetic and no one at the facility checked their feet or legs to see if they had swelling. In an interview on 05/12/2025 at 8:27 AM Resident 46 stated the staff probably could not see their legs were swollen because the staff did not take their socks off while providing care to check their legs. Observation on 05/12/2025 at 8:37 AM Staff H (Registered Nurse) assessed Resident 46's legs. Resident 46 had blue socks that were pulled up towards the middle part of their leg. Staff H removed the socks and stated Resident 46 had edema to their left leg in comparison to their right leg. Resident 46 told Staff H, the staff did not take their socks off for three weeks and no one had looked at their legs when providing care. Staff H stated no one had reported to them that Resident 46 had edema in their legs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/13/2025 at 9:43 AM Staff B (Director of Nursing) stated they expected staff to provide care as stated in the CP and to observe and report any findings or changes in condition to the nurse and the nurse would assess the resident right away. Staff B stated staff were expected to routinely monitor residents with diabetes for the condition of their skin. <Resident 44> According to an 02/27/2025 quarterly MDS Assessment, Resident 44 had diagnoses of end stage renal disease, history of a stroke, partial body weakness, communication deficit and was dependent on dialysis treatments. Review of the 03/18/2024 Dialysis CP, showed staff were to report any signs and symptoms of infection of the dialysis access site for redness, swelling, warmth or drainage. Staff were to observe and report peripheral edema and not to take a blood pressure in the right arm due to interference with the dialysis access site. Observation and interview on 05/13/2025 at 8:32 AM showed Resident 44's right hand was red in color and was swollen. Resident 44 stated they had pain and wanted to put their arm up. In an interview on 05/13/2025 at 8:35 AM Staff H (Registered Nurse) observed Resident 44's right hand was swollen, warm to the touch and was red in appearance. Staff H stated no one told them that Resident 44's hand was swollen and red. In an interview on 05/13/2025 at 9:35 AM, Staff W (CNA) stated they did not notice anything wrong with Resident 44's right hand while providing morning personal hygiene care. Staff W stated Resident 44 had a shower today and the shower aid did not report to them an issue with the resident's hand. In an interview on 05/13/2025 09:40 AM, Staff Q (CNA-Shower Aid) stated they gave Resident 44 a shower today but did not notice swelling to Resident 44's right hand and noticed Resident 44 had a pillow underneath their right arm, but did not know why and did not report this to the nurse. In an interview on 05/13/2025 at 9:43 AM, Staff B (Director of Nursing) stated staff were to observe for changes of condition when providing care, especially when issues caused discomfort or pain, or were considered unusual. <Pain Management> <Resident 65> According to an 03/12/2025 Quarterly MDS assessment, Resident 65 had a history of falling and had a history of fracture to their vertebrae. Review of the revised 12/24/2024 Vertebrae Fracture CP showed staff were to provide pain medications as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the May 2025 Medication Administration Record (MAR) showed an order dated 05/08/2025 for Resident 65 to receive their pain medication according to their pain rating, on a pain scale level of 1 out of 10 (1 meaning no pain and 10 meaning the highest pain). Resident 65 should receive one tablet of pain medication when the resident's pain level was 1 to 4 on the pain scale and should receive two tablets of pain medication when their pain level was 5 to 10 on the pain scale. According to the May 2025 MAR, staff documented Resident 65 received one tablet of pain medication instead of two tablets as ordered on the following dates: on 05/08/2025 pain level was a 5; on 05/9/2025 pain level was a 6; on 05/10/2025 pain level was a 6; on 05/12/2025 pain level was a 7 and on 05/13/2025 pain level was a 6. <Pain Patch> Review of May 2025 Medication Administration Record showed a 05/08/2025 physician's order for a pain patch and to apply it every 72 hours for chronic pain disorder and then remove the patch. The MAR showed on 05/08/2025 the staff did not give Resident 65 their pain medication because the medication was not filled by the pharmacy. Review of progress notes showed staff received the pain patch on 05/09/2025, one day after the missed dose on 5/8/2025 but did not give Resident 65 their pain patch until their next scheduled application date on 5/11/2025, three days after the order was received. In interviews on 05/08/2025 at 11:36 AM and on 05/12/2025 at 11:36 AM Resident 65 stated they did not have any pain. In an interview on 05/13/2025 at 11:40 AM Staff B stated they expected the nurses should follow physician orders as indicated as this was important for improved pain management for residents using pain medications based on the pain scale. Staff B stated staff should have restarted the pain patch when they received it on 05/9/2025 instead of waiting until 05/11/2025, but did not. REFERENCE: WAC 388-97-1060 (1). Based on observation, interview, and record review, the facility failed to ensure adequate laboratory testing for 2 (Resident 80 & 88) of 5 residents reviewed for unnecessary medications, failed to report changes of condition for 2 (Residents 44 & 46) of 2 sampled residents, and failed to administer pain medications for 1 (Resident 65) of 1 sampled residents. These failures to ensure adequate testing to prevent unnecessary medication use, identify changes of condition, and administer pain medications placed residents at risk for the administration of unnecessary medications, discomfort from skin impairments and untreated pain, and other negative health outcomes. Findings included . <Laboratory Testing> <Resident 88> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 04/22/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 88 had multiple medically complex diagnoses including hypothyroidism (HT - thyroid gland does not make enough thyroid hormones). Review of a 04/10/2025 physician order directed staff to administer a medication to increase Resident 88's thyroid hormone level. Review of Resident 88's April and May 2025 Medication Administration Records (MARs) showed staff administered the medication to Resident 88 each day, beginning on 04/11/2025. Review of Resident 88's record on 05/12/2025, showed no documentation of a Thyroid Stimulating Hormone (TSH -test to measure thyroid function) blood test having been drawn. In an interview on 05/12/2025 at 1:01 PM, Staff I (Resident Care Manager) reviewed Resident 88's record and stated the facility failed to draw a TSH blood test. Staff I stated it was possible the hospital had drawn the test prior to Resident 88's admission. No further documentation was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. <North Unit> Observations on 05/06/2025 at 10:35 AM showed the north hall shower room door propped open without staff in the shower room. Chemical cleaning agents, razors, and scissors were observed in the north shower room unlocked cabinets. In an interview on 05/06/2025 at 10:36 AM Staff Q (CNA) stated the chemicals, razors and scissors should be stored behind locked cabinets. Observation on 05/07/2025 at 10:35 AM showed the north soiled utility room door unlocked and accessible to residents. The north soiled utility room had 2 bottles of chemical cleaning agents and a mini fridge with a lab specimen in it. In an interview on 05/07/2025 at 10:36 AM Staff V (Licensed Practical Nurse) stated the north soiled utility room should always remain locked. Staff V stated it was important to keep the soiled utility room locked for resident safety. <Storage Rooms> <Soiled Laundry Room> An observation and interview on 05/08/2025 at 9:02 AM, the door to the soiled laundry room was unlocked and no staff were present. Multiple containers of laundry sanitizer, softener and detergent were observed inside unlocked cabinets and on the counter. Chemical cleaning agents were observed on the counter. Staff AA (Laundry Assistant) stated locks for the cabinets were not available. Staff AA stated they unlocked the door at the beginning of their shift, and it remained unlocked until the end of their shift. <Central Supply Room> An observation on 05/09/2025 at 12:28 PM, the door to the central supply room was propped open and no staff were present. Eye drops, nail clippers, disposable razors, glucose testing and wound care supplies, anti-bacteria ointment, and bottles of rubbing alcohol, hydrogen peroxide and iodine were observed on the shelves and within reach. In an interview on 05/12/2025 at 1:01 PM, Staff I (Resident Care Manager) stated all rooms and cabinets containing chemicals and hazardous items should remain locked to ensure residents' safety. REFERENCE: WAC 388-97-1060(3)(g). .Based on observation, record review, and interview, the facility failed to ensure sharps and chemicals were stored safely for 2 units (South and North Units) and 2 storage rooms (Soiled Laundry Room & Central Supply Room) reviewed. This failure to ensure sharps and chemicals were secured placed residents at risk for exposure to sharps and chemicals, and other negative health outcomes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings included . <Policy> According to a facility policy titled, Storage of Chemicals, revised 06/17/2024, the facility would appropriately store chemical's to ensure residents environment remained free from accident hazards. The policy showed chemicals would be stored out of reach of residents. According to a facility policy titled, Safer Sharps and Safe Injection Practices Policy, revised 06/03/2024, the facility would ensure sharps devices were never left unattended within residents reach. <South Unit> Observations on 05/06/2025 at 9:47 AM, 05/08/2025 at 9:21 AM, and 05/09/25 at 12:25 PM, the door to the shower room on the south 600 hallway was propped open and no staff were present. Anti-dandruff shampoo, conditioner, body wash, shaving cream, disposable razors and toenail clippers were on the ledge of the shower wall within reach from the door. The overhead cabinets were unlocked. When the cabinets were opened, bottles of shampoo, conditioner, ointments, barrier cream, cleansers, and disposable razors were observed on the shelves and within reach. Observation on 05/06/2025 at 10:08 AM showed the south 700 hall shower room door unlocked. Inside the shower room was an open bottle of a virus killing cleanser. The bottle was on a low, half wall and not locked out of reach. In an interview on 05/08/25 at 10:56 AM, Staff T (Certified Nursing Assistant - CNA) stated they left the south unit 600 Hall shower room open because the lock was broken.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. <Resident 3> Continuous observation on 05/08/2025 at 12:11 PM showed staff bring Resident 3 their lunch tray to their room. Staff elevated Resident 3's head of bed to a sitting position, placed their lunch tray on the over the bed table in front of them, and then exited the room. The lunch tray had ground pork in gravy, potatoes, and green beans. Observation showed Resident 3 did not feed themselves. At 1:04 PM Staff BB (CNA) entered Resident 3's room to remove the lunch tray and Resident 3 stated they could not feed themselves. Staff BB asked Resident 3 if they wanted assistance and Resident 3 stated yes but the food was probably cold now. Staff BB stated it was still warm and asked if Resident 3 wanted a bite of green beans, the resident replied yes. Staff BB assisted Resident 3 with a bite of green beans and the resident stated yuck, it's cold. Staff BB asked how about some meat and assisted Resident 3 with a bite of ground pork. Resident 3 stated yuck, it's cold. Staff BB stated they did not think they had a microwave to warm the food up and asked Resident 3 if they wanted some pudding. At 1:12 PM, two other staff entered the room and stated they were there to assist with changing Resident 3's brief. One of the staff, Staff R (CNA), asked for the resident's tray and proceeded to remove it from the room. Staff BB or Staff R did not offer a meal replacement to Resident 3. Resident 3's lunch tray had one bite of ground pork, one bite of green beans, and 75% of the pudding missing, less than 10 % of the total meal consumed. Review of Resident 3's health records showed no documentation of a meal replacement offered for the less than 10 % lunch consumed on 05/08/2025. In an interview on 05/12/2025 at 12:13 PM, Staff B stated they expected staff to offer and document in the resident health records a meal replacement when less than 50 % of the meal was consumed. Staff B stated this was important for residents' health and nutritional status. Based on observation, interview, and record review the facility failed to provide nutritional care, weight monitoring, and storage of food provided by outside sources for 3 (Resident 46, 62, and 88) of 8 residents reviewed. The failure to offer meal replacements when residents consumed less than 50% of their meals, collect timely and accurate weights as ordered and per facility policy, and proper storage of foods brought to residents by outside sources, placed residents at risk for nutrition-related complications, unplanned weight fluctuations, inaccurate assessments and delayed interventions of nutritional status, fluid overload, and other negative health outcomes. Findings included . <Facility Policy> According to the facility's revised 09/10/2024, Hydration and Nutrition Policy, each resident would receive enough food to maintain acceptable parameters of nutritional status and were to be offered a therapeutic diet when there was a nutritional problem. Each resident would be offered three meals per day and if a meal or food was refused, the resident would be offered a substitute of a similar nutritive value. The facility would document intake percentages, and the physician would be notified of any concerns. <Meal Replacements> (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 46> According to the 03/24/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 46 had diagnoses including morbid obesity, heart failure, high fat in the blood, and malnutrition (lack of nutrients to maintain health). Review of the 01/02/2025 Diabetic Care Plan (CP) showed staff were to provide a diabetic diet and Resident 46 was lactose (milk sugar) intolerant. Review of physician's orders dated 02/04/2025 showed Resident 46 was not to be provided milk or milk products. In an interview on 05/06/2025 at 1:27 PM, Resident 46 stated they were diabetic and lactose intolerant, and they told staff all the time they could not eat high fats or sugar, but staff do not listen. In an interview on 05/09/2025 at 8:32 AM, Resident 46 stated for breakfast they received three slices of bacon and one slice of toast cut in half, and stated they did not want to eat that. Observation on 05/09/2025 at 8:44 AM Staff R (Certified Nursing Assistant - CNA) stated they would offer Resident 46 snacks when they refused their meal. Staff R stated they would provide residents with crackers and cookies if they refused their meal. Interview on 05/09/2025 at 8:51 AM showed Staff R brought Resident 46 two fruit flavored grain bars, honey graham cookies, two nut candy bars, and one carton of milk. Resident 46 stated to Staff R they were lactose intolerant and could not drink milk. Staff R stated they knew Resident 46 was lactose intolerant but knew Resident 46 would refuse it. Observation on 05/09/2025 at 12:51 PM Resident 46 stated they did not want any of the lunch food and stated they would be eating the bag of chips on their nightstand. In an observation and interview on 05/12/2025 at 8:28 AM, Resident 46 stated they did not want the breakfast that was served as it was always the same thing. Resident 46 stated the facility bought them an outside vendor sandwich yesterday on 5/11/2025 and they would eat that today instead of the meals provided. Resident 46 pointed to an undated, wrapped sandwich on their nightstand. Resident 46 stated they did not think the ham sandwich would be old if they ate it today. In an interview on 05/12/2025 at 9:07 AM, Staff G (Social Services Assistant) stated Resident 46 often refused their meals but was not sure about supplements provided if Resident 46 refused to eat. Staff G stated the facility did buy Resident 46 the sandwich yesterday and the facility had a resident refrigerator that could store residents' food, but the sandwich was not stored. In an interview on 05/13/2025 at 10:39 AM, Staff N (Registered Dietician) stated if Resident 46 refused their meal, staff should offer snacks, sandwiches, or meal alternatives and never offer Resident 46 milk. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/13/2025 at 9:43 AM, Staff B (Director of Nursing) stated staff should offer meal alternatives for Resident 46 if they refused their meal and all outside food brought in should be stored in the nurse's refrigerator. <Resident 88> In an observation and interview on 05/08/2025 at 1:23 PM, Staff JJ (CNA) entered Resident 88's room and removed their meal tray. Staff JJ stated they would document 5% of the meal was consumed and offer Resident 88 ice water. The lid was removed and one bite of food was eaten from the plate. No meal replacement was offered. In an observation and interview on 05/09/2025 at 7:55 AM, Staff II (CNA) entered Resident 88's room, removed their meal tray and stated they would document 25% of the meal was consumed. The lid was removed and 25% of food had been eaten. No meal replacement was offered. In an observation and interview on 05/09/2025 at 1:21 PM, Resident 88 was observed in bed with their eyes closed. Their meal tray was on the bedside table with lid covering plate. Staff II entered the room, removed the meal tray and stated they would document 0% of the meal was consumed. The lid was removed and the food was untouched. No meal replacement was offered. In an interview on 05/12/2025 at 1:01 PM, Staff I (Resident Care Manager) stated staff should offer meal replacements to all residents who consume less than 50% of their original meal. Staff I stated they expected staff to verbally report to the nurse what meal replacement was offered and the percentage consumed. <Resident 88> <Weight Monitoring> According to the 04/22/2025 admission MDS, Resident 88 had diagnoses including risk for malnutrition, heart failure, and dysphagia (difficulty swallowing). Review of a 04/10/2025 physician order directed staff to obtain Resident 88's weight for the first 3 days following admission, once per week for 4 weeks, and then once per month. A 05/09/2025 order directed staff to reweigh Resident 88 on the same day. Review of Resident 88's weight summary report on 05/12/2025, showed weight entries of 211 pounds on 04/10/2025 at 2:48 PM and 96 pounds on 05/02/2025 at 1:03 PM. Review of Resident 88's April and May 2025 Medication Administration Records showed staff attempted to obtain Resident 88's weight on 04/11/2025, 04/12/2025 and 04/13/2025, treatment was refused and no weights were recorded. An entry on 04/17/2025 showed Resident refused treatment and 211 pounds was documented. Entries on 04/24/2025 and 05/01/2025 showed Resident 88 was weighed and 211 pounds was documented. An entry on 05/08/2025 showed Resident 88 was weighed and weight was documented as [not applicable]. An entry on 05/09/2025 at 5:01 PM showed no weight recorded and coded as refused. Review of a nursing progress note dated 04/11/2025 at 1:32 PM and 04/13/2025 at 5:49 PM showed Resident 88 refused to be weighed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/12/2025 at 1:01 PM, Staff I reviewed the weight entry on 05/02/2025 at 1:03 PM of 96 pounds and stated the facility failed to accurately document Resident 88's weight on that date. Staff I stated the facility failed to follow the physician order to obtain weights. Staff I stated expected staff to attempt alternative methods to weighing residents who frequently refuse care. REFERENCE: WAC 388-97-1060(3)(h). .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, record review, and interview, the facility failed to ensure ongoing monitoring of bed rail use for 3 of 6 residents (Residents 5, 64, & 80) reviewed for accident hazards. This failure placed residents at risk for injury, entrapment, and other negative health outcomes. Findings included . <Policy> According to a facility policy titled, Bed Rails - Safe and Effective Use of Bed Rails, revised 09/06/2024, the facility would ensure, at a minimum, evaluation for bed rail use would be completed quarterly and with a change of condition. <Resident 5> According to a 01/09/2025 admission Minimum Data Set (MDS - an assessment tool) bed rails were not used on Resident 5's bed. Observation on 05/06/2025 at 1:06 PM showed bilateral bed rails on Resident 5's bed. Review of Resident 5's records showed a 06/17/2024 physician order for bed rails to be applied to their bed. Resident 5's health records did not show ongoing bed rail use monitoring was completed. <Resident 64> According to a 03/28/2025 Quarterly MDS bed rails were not used on Resident 64's bed. Observation on 05/07/2025 at 9:04 AM showed bilateral bed rails on Resident 64's bed. Review of Resident 64's records showed a 02/14/2025 physician order for bilateral bed rails to their bed. Resident 64's health records did not show ongoing bed rail use monitoring was completed. <Resident 80> According to a 07/13/2024 admission MDS bed rails were not used on Resident 80's bed. Observation on 05/06/2025 at 9:24 AM showed bilateral bed rails on Resident 80's bed. Review of Resident 80's records showed a 07/22/2024 care plan for bilateral bed rails on their bed. Resident 80's health records did not show ongoing bed rail use monitoring was completed. In an interview on 05/12/2025 at 12:13 PM Staff B (Director of Nursing) reviewed Residents 5, 64, and 80's health records and stated quarterly bed rail use evaluations were not done as expected. Staff B stated it was important to monitor ongoing use of bed rails to ensure they were still appropriate and safe for the residents. (continued on next page)

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	505313	A. Building B. Wing	05/13/2025

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Hallmark Manor	32300 First Avenue South Federal Way, WA 98003

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to F658 - Services Provided Meet Professional Standards. Reference: WAC 388-97-1060(3)(g). .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure a licensed pharmacist's monthly Medication Regimen Reviews (MRRs) were added to the resident records and that the recommendations were reviewed and acted upon for 2 (Resident 35 & 1) of 5 residents who were reviewed for unnecessary medications. This failure placed residents at risk for delays in necessary medication changes, risk for adverse side effects, and receiving medications without required pharmacist oversight. Findings included . <Facility Policy> According to the facility's Pharmacy Services and Medication Regimen Review policy, revised 09/16/2024, the facility would maintain the resident's highest practicable level of physical, mental, and psychosocial well-being while preventing or minimizing adverse side effects of medications by ensuring oversight by a licensed pharmacist. <Resident 35> According to the 03/13/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 35 received several medications including antipsychotic (medication that affects brain function), antidepressant, anticoagulant, antiplatelet, medications to help control blood sugar levels, and antiseizure medications. Review of a MRR binder provided by the facility showed Resident 35 had a 01/08/2025 through 01/10/2025 MRR recommendation form. This form showed the reviewing pharmacist recommended staff obtain routine blood work for Resident 35 related to cancer treatment medication Resident 35 was receiving. The MRR was blank and not acknowledged by staff. The MRR was not included in Resident 35's record. Review of Resident 35's progress notes and orders on 05/13/2025 showed staff did not complete the pharmacist's recommendations or discuss the recommendations with the physician, for more than five months after the recommendation was received. Review of the MRR binder showed a 02/01/2025 through 02/06/2025 MRR that was not included in Resident 35's record. Review of Resident 35's records showed the only MRR reports included in their record were August 2024, September 2024, and December 2024. There were no other MRR reports in the resident's record. In an interview on 05/13/2025 at 11:05 AM, Staff B (Director of Nursing) and Staff F (Regional Director of Clinical Services) confirmed the January 2025 MRR was not followed up on or implemented for Resident 35. Staff B stated the MRR form should be provided to the physician for review, orders completed, and included in the resident's record, but it was not. <Resident 1> (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's 03/06/2025 Quarterly MDS showed the resident received several medications including antianxiety, antidepressant, water pills, and antiplatelet (blood thinning) medications. Review of the facility's MRR binder showed a 01/08/20025 through 01/10/2025 MRR recommendation form for Resident 1. The form gave recommendations to staff to consider reducing one of their medications related to blood test results. The form was blank and no response from staff was documented. A second MRR for dated 01/08/2025 through 01/20/2025 gave a recommendation to staff to consider decreasing a second medication related to blood test results. This form was also blank and no response from staff was documented. Review of Resident 1's progress notes showed the pharmacy recommendations were not addressed until 03/16/2025 and 03/20/2025, over two months after the pharmacist gave the recommendations. Review of Resident 1's records showed the only MRR reports included in their record were April 2025 and September 2024. There were no other MRR reports in the resident's record. In an interview on 05/13/2025 at 11:01 AM, Staff B confirmed the 01/08/2025 MRR was not included in Resident 1's record. Staff B stated it was their expectation MRRs were addressed within one month of receiving the recommendation. REFERENCE: WAC 388-97-1300(1)(c)(iii), (4)(c). .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 6 sampled residents (Resident 26) reviewed for unnecessary medications. Failure to evaluate the need for continued use of an antibiotic medication placed residents at risk for use of unnecessary medications and at risk for adverse side effects. Findings included . <Facility Policy> According to the facility's 11/28/2022 Antibiotic Stewardship guidelines, antibiotic stewardship would be accomplished by improved antibiotic prescribing, administration and management practices to reduce inappropriate use, to ensure that residents received the right antibiotic for the right indication, dose and duration. According to the 03/06/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 26 admitted to the facility on [DATE] with a history of urinary tract infections and a skin infection of the lower leg. Review of the 01/10/2025 Pain care plan,showed Resident 26 had pain in their lower leg related to a recurring bacterial skin infection. Review of a 03/15/2025 physician order directed staff to administer an antibiotic to Resident 26 twice daily to treat their chronic skin infection to their lower leg. The order directed staff to follow up with the provider regarding the infection. Review of a 04/02/2025 pharmacy medication review dated showed the pharmacist noted the antibiotic 500 mg medication was missing a stop date or duration time of use and noted this increased the risk of resistance and adverse events that Resident 26 could experience. Recommendations were provided to the facility's interim director of nursing and facility physician to document the intended duration of therapy or stop date. The pharmacy medication review showed the physician noted Resident 26 had a history of recurring lower leg skin infection and the resident was on a maintenance or suppressive therapy dosage. There was no notation on the form to show a stop date or duration was provided by the facility. Review of the March 2025, April 2025 and May 2025 Medication Administration Records (MAR) showed Resident 26 started the antibiotic medication on 03/15/2025 and received the medication daily every 12 hours through 05/13/2025. Review of Resident 26's progress notes did not show a provider was notified of the need for a stop date or to clarify the duration of the antibiotic usage. In an interview on 05/12/2025 at 12:35 PM, Staff J (Infection Preventionist-IP) stated they were only aware Resident 26 was on an antibiotic for another condition and that medication was discontinued on 3/14/2025. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/13/2025 at 9:23 AM Staff J stated they did not follow up on Resident 26's antibiotic for the skin infection and was not aware Resident 26 was receiving this medication. Staff J stated the antibiotic usage should be documented on the care plan but was not. Staff J stated both the nursing staff and the IP should have followed up with the provider as stated on the physician's order, but did not. REFERENCE: WAC 388-97-1060(3)(k)(i). .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 1 of 4 medication carts (Medication Cart 300/400) and 2 of 4 halls (600 & 300 Hall) reviewed for medication storage. This failure placed residents at risk for receiving expired medications, ineffective treatment, accidental ingestion of medication, and a diminished quality of life. Findings included <Medication Cart 300/400> Observation on 05/06/2025 at 9:56 AM showed three opened inhaler medications without the open date on the inhalers. In an interview on 05/06/2025 at 10:15 Staff V (Licensed Practical Nurse) stated all inhalers should have an open date on them, but they didn't. Staff V stated the inhalers are only good for 30 days after the open date and would need to be disposed of after 30 days.<300 Hall> Observation and interview on 05/07/2025 at 11:08 AM showed an opened bottle of vitamins with ten remaining tablets next to the sink in room [ROOM NUMBER]. Staff GG (RN) stated they did not see them there before, but residents should not have medications at the bedside. In an interview on 05/07/2025 at 11:10 AM Staff HH (Resident Care Manager) stated the resident in room [ROOM NUMBER] often ordered from an online delivery store. Staff HH stated they spoke with the resident in room [ROOM NUMBER] and educated them about medications at bedside requiring a physician order. Staff HH stated the resident denied knowledge of the medications, so they removed the bottle from the room. Staff HH stated medications at bedside should include a resident assessment, physician order, and be stored behind a locked cabinet. Staff HH stated inhalers should be dated when they are opened and discarded in 30 days. Staff HH stated all medications should be stored behind locked doors for resident safety. REFERENCE: WAC 388-97-1300(2), -2340. <600 Hall> Observation on 05/06/2025 at 9:47 AM showed the door to the shower room on the 600 hall was propped open, no staff were present. The overhead cabinet was unlocked and contained an unsecured prescription medication, labeled with a resident's name, on the shelf within reach. In an interview and observation on 05/06/2025 at 2:10 PM, the shower room door on the 600 Hall was propped open. Staff S (Registered Nurse - RN) stated the prescription medication should be secured in the medication cart. Staff S removed the medication from the cabinet and carried it out of the shower room.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review the facility failed to serve foods that were appetizing in appearance and palatable. Observations of meal trays and interviews with 5 (Residents 61, 46, 71, 145, & 29) sample residents and 4 supplemental (Residents 69, 45, 83, & 70) residents identified concerns about the taste and overall palatability of the meals served, and being offered alternate meals by the facility. Facility failure to ensure meals were palatable, appetizing in appearance, and alternate meals were offered by staff placed residents at risk for less than adequate nutritional intake and dissatisfaction with daily meals. Findings included . <Facility Policy> Review of the facility's Hydration and Nutrition policy revised 09/10/2024, showed if a resident refused a meal or particular food, staff would offer a substitute of similar nutritive value. <South Hall Day Room> Observation of breakfast on 05/09/2025 at 8:18 AM showed several residents in the South Hall day room eating breakfast. Resident 69 and Resident 45 were eating together at a table. Both breakfast trays contained eggs that were a pistachio green color. The residents were not eating the eggs. Observation on 05/09/2025 at 8:22 AM showed Resident 61 receiving assistance with eating their breakfast by Staff X (Certified Nursing Assistant - CNA). When asked what the green item on the breakfast tray was, Staff X furrowed their eyebrows and stated they are scrambled eggs. Staff X stated the residents were served green eggs before. <400 Hall Trays> In an interview on 05/09/2025 at 8:41 AM, Resident 83 and Resident 70 were in their joint room. The residents no longer had their breakfast trays in front of them. Resident 83 and Resident 70 were asked how breakfast was that day. Resident 83 stated Green eggs today! They were nasty! Resident 70 expressed dissatisfaction with breakfast stating the eggs were green and mushy. Resident 83 and Resident 70 stated they were not offered alternate breakfast meals. Both residents stated staff never offered them an alternate meal when they do not like what was served. <Resident 46> In an interview on 05/06/2025 at 10:22 AM, Resident 46 stated, they did not get enough food from the facility and they asked their family to bring in outside food. In an observation and interview on 05/09/2025 at 8:32 AM, Resident 46 had three slices of bacon and one slice of bread cut in half. Resident 46 stated the bread was stale and did not look good so they did not want their breakfast that day. <Resident 71 > (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/09/2025 at 8:16 AM, Resident 71 was observed eating breakfast in their room. Observation showed the breakfast tray had pale green colored, scrambled eggs that were mushy in appearance. Resident 71 stated they were only going to eat 1 piece of bacon and their hot cereal, and would not eat the eggs. Resident 46 stated, .look at these eggs would you want to eat them? Resident 46 stated they would like other food options but that was all they were provided. <Resident 145> In an observation and interview on 05/09/2025 at 8:17 AM, Resident 145 was in bed eating breakfast. Staff U (CNA) held a fork and placed eggs in Resident 145's mouth. Resident 145 stated yuck. The eggs were pale green. Staff U stated the eggs were green and Resident 145 did not like them. <Resident 29> In an observation and interview on 05/09/2025 at 8:37 AM, Resident 29 was in their room and their breakfast tray was on the bedside table. Resident 29 stated they had eaten everything except the scrambled eggs. Resident 29 stated the eggs did not taste right. Resident 29 stated they liked eggs, but not the facility's eggs. In an interview on 05/09/2025 at 11:02 AM, Staff Y (Cook) stated they had problems with the eggs that morning. Staff Y stated the facility did not get their regular shipment of eggs and were sent a substitute of egg whites from the facility's supplier. Staff Y stated they cooked the eggs as usual and placed them on the steam table. Staff Y stated they turned green after being on the steam table, but served the eggs anyway. Staff Y said nobody likes green eggs. In an interview on 05/12/2025 at 1:10 PM, Staff Z (Dietary Director) stated the facility had problems with supply and the steam table turned the eggs green. Staff Z stated it was their process to send out an announcement to the residents letting them know when there were food related problems. Staff Z stated all residents should be offered alternative meals and resident room should have a list of alternate meals available. REFERENCE: WAC 388-97-1100(1)(2). .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to ensure staff followed infection control practices to help prevent the transmission of communicable diseases. The facility failed to ensure staff performed Hand Hygiene (HH) when providing personal care for 1 (Resident 50) and failed to follow an Enhanced Barrier Precaution (EBP) sign for 1 (Resident 50) who required EBP. These failures placed residents at risk for the development of contagious, communicable diseases, and an unclean environment. Findings included . <Facility Policy> Review of the facility's Hand Hygiene policy, revised 06/03/2025, showed staff would perform HH (even if gloves were used) before and after resident contact and after contact with body fluids. Review of the facility's Transmission-based Precautions and Isolation Procedures policy, revised 09/24/2024, showed EBPs were an infection control intervention designed to reduce transmission of multidrug-resistant organisms and utilized gown and glove use during high contact resident care activities. <Resident 50> Review of Resident 50's tube feeding (a method of delivering nutrition directly into the stomach through a surgically placed tube) care plan, revised 10/16/2023, showed the resident required nutrition via a feeding tube related to a swallowing disorder. The care plan included an intervention directing care staff to use EBP. Observation on 05/07/2025 at 9:45 AM showed Staff O (Certified Nursing Assistant) providing personal care to Resident 50. Staff O wiped Resident 50 with incontinence wipes and removed their soiled brief. Staff O removed their soiled gloves, did not perform HH, left the resident's room to obtain a new box of gloves, returned to the resident's room, did not perform HH, and put on a clean pair of gloves. In an observation on 05/12/2025 at 11:41 AM, Staff S (Registered Nurse) was preparing to administer feeding and medications to Resident 50 through their feeding tube. Staff S opened the feeding tube and removed residual feeding from Resident 50's feeding tube. Staff S did not follow the EBP sign and put on a gown prior to working with Resident 50's feeding tube. In an interview on 05/12/2025 at 2:03 PM, Staff S confirmed they forgot to put a gown on prior to assisting Resident 50 with their feeding tube and stated they should have gowned up. Staff S stated anytime staff worked with Resident 50's feeding tube, staff were supposed to gown up. In an interview on 05/13/2025 at 11:23 AM, Staff B (Director of Nursing) stated it was their expectation staff performed HH before and after providing care to a resident. Staff B stated they expect staff to follow EBP signs and gown up when directed. REFERENCE: WAC 388-97-1320 (1)(a),(c). (continued on next page)

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