STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505510	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center - Federal Way	135 South 336th Street Federal Way, WA 98003

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on interview and record review, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR - a mental health screening required prior to nursing home admission) evaluation was incorporated into the Care Plan (CP) for 1 of 5 residents (Resident 13) reviewed for PASRR. This failure placed residents at risk of not receiving the necessary mental health services and a diminished quality of life. Findings included .<Resident 13>According to a 08/29/2025 Significant Change Minimum Data Set (an assessment tool), Resident 13 had multiple medically complex diagnoses and was currently considered by the state Level II PASRR process to have a Serious Mental Illness (SMI). This MDS showed Resident 13 received antipsychotic and antidepressant medications during the assessment period.Review of an updated 06/05/2025 Level 1 PASRR showed staff identified Resident 13 had an SMI and required a Level II evaluation. On 07/21/2025 the Level II evaluation was completed with recommendations provided to the facility for Resident 13's plan of care.Review of Resident 13's comprehensive CP on 11/17/2025, four months after the evaluation was completed, showed staff did not have the Level II recommendations incorporated into the resident's CP as required.In an interview on 11/21/2025 at 10:10 AM, Staff I (Social Services Director) stated it was their expectation staff incorporate Level II recommendations into resident CPs once obtained. Staff I stated it was important to incorporate the recommendations provided to ensure the goals, interventions and mental health needs of the residents were being addressed and they could be successful. Staff I reviewed Resident 13's records and stated the 07/21/2025 Level II recommendations should be but were not incorporated into the resident's plan of care.REFERENCE: WAC 388-97-1915 (4).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 observation, interview, and record review, the facility failed to update and/or revise Care Plans (CP) as needed for 3 of 25 sample residents (Residents 91, 2 & 69) whose CPs were reviewed. These failures placed residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings included . <Resident 91> According to the 11/01/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 91 admitted to the facility on [DATE] with medically complex conditions including recent abdominal surgery. The MDS showed Resident 91 was able to transfer and walk 10 feet with supervision or touching assistance, did not use a wheelchair, did not use bed rails, and required a pressure-reducing device for their chair. Review of a 10/29/2025 physical mobility Care Plan (CP) showed Resident 91 required supervision or touching assistance by staff to walk and bilateral mobility bars (bed rails on both sides of bed) to increase mobility were initiated on 11/09/2025. Review of a revised 10/29/2025 risk for falls CP showed staff were to encourage Resident 91 to use mobility aids, such as a walker or cane, when ambulating or transferring. Review of a revised 11/03/2025 potential for pressure ulcer development CP showed Resident 91 required a pressure-reducing device on their chair. Record review on 11/18/2025 showed Resident 91's CP had no documentation regarding the use of a wheelchair. Observation on 11/17/2025 at 10:17 AM showed Resident 91 sat in a wheelchair and self-propelled out of their room into the hallway. Resident 91 said they needed to get outside to get some fresh air, asked staff if it was raining outside, then self-propelled to exit the building. Observation and interview on 11/18/2025 at 10:08 AM showed Resident 91 sat in a wheelchair in their bedroom. Resident 91 grimaced and stated they needed to get up from the wheelchair because their bottom was sore. Resident 91 transferred independently to their bed. Observation showed no cushion or pressure-reducing device in the wheelchair. Resident 91 stated the facility had some wheelchair cushions, but not enough or not the right size for their wheelchair. Resident 91 stated they used to have a wheelchair cushion, but it did not fit correctly and was uncomfortable. Observation and interview on 11/18/2025 at 10:08 AM showed a padded mobility bar partially raised on the right side of Resident 91's bed, with a small fan clamped to the center of the rail. A padded mobility bar was in the down position below the left side of the bed. Resident 91 said they only used one of the mobility bars to hold their fan, they never used them for mobility, and they did not need them to turn in bed or to transfer. Observation on 11/19/2025 at 10:38 AM and 11/20/2025 at 8:17 AM showed Resident 91 lying in their bed with the right-side mobility bar partially up with a fan clamped in the center, and the left-side mobility bar in the down position. (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 11/21/2025 at 10:41 AM, Staff J (Unit Manager) stated Resident 91 requested and needed mobility bars when they were first admitted , their mobility improved not long after they admitted , and they no longer needed the mobility bars for mobility. Staff J confirmed the CP should have been updated at the time the mobility bars were no longer needed. Staff J stated the therapy department gave Resident 91 a wheelchair when they were admitted and Resident 91 preferred to use the wheelchair for long distances. Staff J confirmed Resident 91's use of a wheelchair should be included in their CP, but it was not. Staff J stated Resident 91 was no longer at risk for pressure ulcer development due to improved mobility and did not require a pressure-relieving device in their wheelchair. Staff J confirmed the CP should have been updated to show the potential for pressure ulcer development was resolved, but it was not. <Resident 2> According to a 10/03/2025 admission MDS, Resident 2 had a history of falls and had a fall since admission to the facility. This MDS showed Resident 2 had a functional limitation in range of motion to both lower legs, required substantial assistance from staff for transferring from the bed to chair, and used a walker and wheelchair. In an interview on 11/18/2025 at 9:30 AM, Resident 2 stated they had a fall since admission in their room. Observations at this time showed Resident 2 lying in bed with their wheelchair nearby. Review of a 10/02/2025 facility incident report showed Resident 2 was found on the floor between their bed and their chair and the resident reported they fell trying to get back into bed. This report showed staff revised the CP to include an intervention for a Call Don't Fall sign to be in Resident 2's room as a visual reminder to request staff assistance. Review of a revised 11/02/2025 risk for falls CP showed Resident 2 was at risk for falls due to confusion, deconditioning, and gait/balance problems. The goal established was for Resident 2 to be free of falls through the next review date. This CP was not updated or revised to include the new fall intervention identified by staff to help prevent further falls. Observations on 11/21/2025 at 7:45 AM showed no fall interventions signs in Resident 2's room. In an interview on 11/21/2025 at 1:22 PM, Staff J stated the Call Don't Fall sign was previously in Resident 2's room, but their room had been packed up, and staff forgot to put the sign back up upon the resident's return. Staff J stated the fall intervention sign should be in place and the CP needed to be updated and revised. According to a 10/03/2025 admission MDS, Resident 2 had obvious or likely tooth decay or broken teeth. Review of a 10/06/2025 Dental Care Area Assessment showed staff documented Resident 2 had broken teeth and staff would proceed to CP. Review of Resident 2's comprehensive CP showed staff only identified the resident was at risk for oral/dental problems but did not indicate Resident 2 had actual broken teeth. (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 11/21/2025 at 1:22 PM, Staff J stated it was their expectation CPs be updated and revised to reflect the current conditions of the resident. <Resident 69> According to a 10/14/2025 admission MDS, Resident 69 had multiple medically complex diagnoses including a chronic digestive disorder. Review of a revised 10/09/2025 digestive disorder CP showed interventions to staff to provide small frequent meals rather than three large ones to avoid overeating. Observations on 11/19/2025 at 8:23 AM, 11/19/2025 at 12:35 PM, and 11/20/2025 at 7:33 AM showed Resident 69 was provided the regular portion meals, rather than the small frequent meals as identified on the resident's CP. In an interview on 11/21/2025 at 1:30 PM, Staff O (Dining Services Manager) stated Resident 69 did not receive small frequent meals but instead received three regular meals a day. In an interview on 11/21/2025 at 1:22 PM, Staff J stated it was their expectation CPs be updated and revised to reflect the current conditions of the resident. REFERENCE: WAC 388-97-1020(2)(c)(d).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to ensure services provided met professional standards of practice for 5 (Residents 11, 82, 69, 13, & 7) of 25 residents reviewed. The nursing staff's failure to clarify and/or follow Physician Orders (PO) and follow medication parameters placed residents at risk for unmet care needs, risk for medication errors, delayed treatment, and potential negative outcomes. Findings included .<Facility Policy>Review of the facility's 12/01/2007 General Dose Preparation and Medication Administration policy, showed prior to administration of medication the facility staff would take all measures required each time a medication was administered; the correct medication, correct dose and correct rate was provided. The policy showed staff would verify the medication name and dose were correct when compared to the medication order on the Medication Administration Record (MAR). <Clarifying physician orders> <Resident 11> According to the 09/11/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 11 had diagnoses including brain dysfunction, anxiety and memory impairment. The assessment showed Resident 11 received hospice (end of life care) services. Review of the 06/11/2025 impaired thought processes Care Plan (CP), showed staff were to monitor side effects and effectiveness of medications used to treat their condition. Review of a 08/19/2025 Hospice physician order, showed an antianxiety medication order for 0.25 milligrams/milliliters (mg/ml) by mouth every two hours as needed or to take 0.5 mg with an end date of six months for end-of-life symptom management. Review of a 10/31/2025 physician order showed Resident 11 was discharged from hospice services on 11/03/2025. Review of the November 2025 Medication Administration Record (MAR) showed Resident 11 received an antianxiety medication on 11/04/2025, 11/13/2025, 11/15/2025 and 11/16/2025 after hospice services were discontinued. In an interview on 11/21/2025 at 12:49 PM, Staff B (Director of Nursing) stated the antianxiety medication order should have been discontinued when Resident 11 was discharged from hospice services. Staff B stated staff should have clarified the anxiety medication order, but they did not. <Resident 82> According to a 10/31/2025 Quarterly MDS, Resident 82 had multiple medically complex diagnoses including heart failure, depression, and chronic pain and required pain medication during the assessment period. Review of Resident 82's November 2025 MAR showed a 07/14/2025 physician order for staff to check Resident 82's blood pressure every six hours and to notify the provider of abnormal blood pressure. There were no parameters for staff to know when to notify the provider of abnormal blood pressure. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 82's November 2025 MAR showed a physician order directing staff to monitor Resident 82's behaviors, provide interventions and record behavior code, number of episodes, interventions, and outcome. The MAR showed staff documented Resident 82 had behaviors but did not indicate which behaviors the resident demonstrated or what interventions were provided. In an interview on 11/19/2025 at 9:29 AM, Staff K (Licensed Practical Nurse) stated there were no directions in the order to notify the provider of abnormal blood pressure. Staff K stated behavior monitor order was not clear where to document the behavior and interventions. In an interview on 11/21/2025 at 10:51 AM, Staff B stated it was their expectation of nursing staff to follow the physician orders. Staff B stated if the physician orders were not clear, staff should clarify the order with a provider. Staff B reviewed Resident 82's physician orders and stated orders needed to be clarified with the provider. <Resident 69> According to a 10/14/2025 admission MDS, Resident 69 had multiple medically complex diagnoses including fractures and required the use of narcotic pain medications during the assessment period. Review of Resident 69's November 2025 MAR showed a 10/28/2025 order directing staff to administer a narcotic pain medication to Resident 69 every eight hours as needed for a pain level of six to 10 on a pain scale. A second 10/28/2025 order showed staff were to administer a non-narcotic pain medication every eight hours as needed for a pain level of one to six on the pain scale. Both medications gave directions to staff to administer the medication for a pain level of 6. In an interview on 11/21/2025 at 1:22 PM, Staff J (Unit Manager) stated the orders needed to be clarified. <Following Orders> <Resident 13> Observations on 11/19/2025 at 9:54 AM of Staff G (Registered Nurse) providing care to Resident 13 which included applying pain patches. Staff G applied one pain patch to each of Resident 13's shoulders. According to Resident 13's November 2025 MAR, staff should apply one pain patch to Resident 13's chest area only. There was no order to apply pain patch on Resident 13's shoulders. In an interview on 11/21/2025 at 12:23 PM, Staff F (Unit Manager) stated it was their expectation nursing staff follow physician orders as directed, but they did not. <Medications Given Outside of Parameters> <Resident 11> According to the 09/11/2025 Quarterly MDS, Resident 11 received pain medications during the assessment period. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 11/13/2025 physician order, showed a five mg pain medication to be given to Resident 11 every eight hours as needed for pain. Review of the November 2025 MAR showed Resident 11 received pain medication on 11/15/2025. The MAR showed the nurse provided the pain medication after documenting Resident 11's pain level was at zero on a pain scale of zero to 10 (zero meaning no pain and 10 meaning the highest level of pain). In an interview on 11/21/2025 at 12:49 PM, Staff B stated the pain medication should not have been given to Resident 11 if the resident's pain level was at a zero before giving the medication. Staff B stated staff should follow the physician orders. <Resident 7> According to a 10/24/2025 admission MDS, Resident 7 had multiple medically complex diagnoses including high Blood Pressure (BP) and pain and required the use of narcotic pain medications during the assessment period. Review of Resident 7's November 2025 MAR showed a 10/24/2025 order for narcotic pain medication with directions to staff to administer every four hours as needed for a pain level of six to 10 on the pain scale. This order was administered outside of parameters on 11/08/2025 and 11/10/2025. A second 10/28/2025 order showed staff were to administer a non-narcotic pain medication every six hours as needed for a pain level of one to five on the scale. Staff administered this order outside of parameters on 11/06/2025 and 11/07/2025. Review of Resident 7's November 2025 MAR showed the resident was receiving a medication for high BP with directions to staff to hold the dose for SBP [Systolic BP - a measure of the pressure in your arteries when your heart beats] or pulse less than 55. This MAR showed staff did not hold the medication as directed when it was outside of the parameters on 11/07/2025. In an interview on 11/212025 at 12:23 PM, Staff F (Unit Manager) stated parameters were in place for a reason and it was their expectation the ordered parameters be followed by staff when administering medications. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure residents' ability to communicate was maintained for 2 of 3 sampled residents (Resident 13 & 69) when reviewed for communication. This failure placed the residents at risk of inability to communicate needs, social isolation, feelings of worthlessness, and diminished quality of life.Findings included .<Facility Policy>Review of an 11/2017 facility, Resident Rights policy showed health information and services would be provided in ways that were easy for the resident and/or representative to understand. The facility would offer language assistance services to residents who had limited English proficiency, provide qualified sign language interpreters, or auxiliary (additional support) aids if hearing was impaired.<Resident 13>According to an 08/29/2025 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 13's preferred language was Spanish and the resident needed or wanted an interpreter to communicate with a doctor or health care staff.Review of a revised 09/11/2025 communication Care Plan (CP) showed Resident 13 had a communication problem which included a language barrier. Interventions identified showed Resident 13 preferred to communicate in Spanish.In an interview on 11/18/2025 at 10:20 AM, Resident 13 indicated they were having a hard time understanding and preferred to communicate in Spanish. Observations at this time showed Resident 13 making hand gestures and no signage or directions for interpreter services available in the resident's room.In an interview with an interpreter on 11/18/2025 at 10:34 AM, Resident 13 stated they did not have any concerns with their hearing ability and indicated they like and do better with understanding and communicating in Spanish.In an interview on 11/21/2025 at 11:02 AM, Staff V (Certified Nursing Assistant - CNA) stated it was hard to communicate with Resident 13, they tried their best, and were usually able to figure out what the resident needed. Staff V stated Resident 13 would point to things and staff were eventually able to figure out what they wanted. When asked if an interpreter was used to communicate with Resident 13, Staff V stated the resident was able to understand English, the only problem was the resident could not let staff know exactly what they were saying. Staff V stated, we have to connect the sentences in order to figure it out.In an interview on 11/21/2025 at 12:23 PM, Staff F (Unit Manager) stated a sign was usually posted in the resident's room with directions to staff on how to reach interpreter services. Staff F stated it was their expectation staff communicate with residents in the residents' preferred language and utilize an interpreter as needed.<Resident 69>According to an 10/14/2025 admission MDS, Resident 69 had clear speech, no memory impairment, and had minimal difficulty with hearing with the use of a hearing aid or other hearing appliance.Review of a 10/10/2025 Inventory of Resident Personal Items form showed Resident 69 had one hearing aid on admission.Review of a revised 10/17/2025 communication CP showed Resident 69 had a potential communication problem related to minimal difficulty hearing. This CP did not identify Resident 69 had a hearing aid or a need for other hearing devices.In an interview on 11/17/2025 at 10:46 AM, Resident 69 said they were having difficulty hearing and kept asking for sentences to be repeated during the interview. When asked if Resident 69 had hearing aids, Resident 69 stated they did, but they were broken. Observations at this time showed no hearing aids on or hearing device headphones in Resident 69's room.In an interview on 11/20/2025 at 10:36 AM, Resident 69 indicated they did not hear good at all and stated, hopefully I will get my hearing fixed, then I will be happy. Resident 69 stated their right hearing aid was broken before they were admitted to the facility, and the left hearing aid broke a couple weeks ago. Resident 69 stated staff used a hearing device headphone once when they first got to the facility and it was never offered again by staff. Resident 69 stated they were unsure why they did not have a hearing device headphone to use but felt one would help. Resident 69 stated, it's a real nuisance for me and for them [staff] when I cannot hear them [staff] and have to keep asking them what? over and over.In an interview on 11/21/2025 at 12:35 PM, Staff X (CNA) stated Resident 69 was hard of hearing and did not have hearing aids or hearing devices. Staff X stated they would stay close to the resident and talk louder so they could hear them.In an interview on 11/21/2025 at 1:22 PM, Staff J (Unit Manager) stated they were unaware of any residents on their unit with hearing aids or currently using hearing device headphones. Staff J stated they had several devices available in their office. Staff J stated they would expect staff to assist Resident 69 to use a hearing device, if they were having difficulty with hearing.REFERENCE: WAC 388-97-1060(2)(a)(v)(3)(a).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADL), related to cleanliness and grooming for 3 (Residents 70, 17 & 52) of 5 sample residents and 1 supplemental (Resident 69) resident reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with bathing, nail care, and shaving, placed the residents at risk for poor hygiene, long facial hair, embarrassment and diminished quality of life.Findings included .<Facility Policy>According to the facility's 11/2017 Quality of Life- Activities of Daily Living policy, if a resident was unable to carry out ADL's they would receive the necessary services to maintain grooming and personal hygiene.<Resident 70> According to the 10/17/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 70 had diabetes, muscular dysfunction and weakness. The assessment showed Resident 70 had no behavior of refusing care during the assessment period and had no memory impairment. The 07/22/2025 ADL self-care performance deficit Care Plan (CP) showed Resident 70 needed substantial assistance with bathing and staff to provide nail trim and clipping on shower days. Review of the November 2025 Kardex (caregiver task sheet), showed Resident 70 shower days scheduled every Wednesday and Saturdays and as needed. Observations on 11/18/2025 at 9:40 AM, 11/19/2025 at 1:20 PM and 11/21/2025 at 10:58 AM showed Resident 70 had nails that extended half an inch past their nail bed with brown debris and dry skin underneath their nails. In an interview on 11/21/2025 at 10:58 AM, Resident 70 stated they usually trim their own nails. Resident 70 stated they wanted the nurses to follow up after they clip their own nails as they were diabetic and this had only occurred a few days ago. <Bathing> Review of the November 2025 bathing task record for Resident 70, showed staff documented a bed bath was provided on 11/1/2025, 11/8/2025, 11/12/2025, 11/14/2025 and 11/21/2025. No documentation was found in the record to show Resident 70 refused a bath. In an interview on 11/21/2025 at 10:58 AM Resident 70 stated they did not receive a bed bath. Resident 70 stated a few days ago a bed bath was offered and they refused it because their room was too cold at the time. Resident 70 stated staff did not come back since then to offer them another one. In an interview on 01/21/2025 at 12:41 PM, Staff B (Director of Nursing) stated they expected ADL's to be completed and for staff to document refusals, especially for diabetic residents. Staff B stated if a resident refused an ADL service, staff should reapproach the resident and document that they made another attempt. <Resident 69> (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 an admission MDS, Resident 69 had clear speech, was understood, able to understand others, and had no memory impairment. This MDS showed Resident 69 was dependent on staff for personal hygiene and had no rejection of care during the assessment period. Observations on 11/17/2025 at 10:46 AM showed Resident 69 with long, uneven fingernails to both hands. In an interview at this time, Resident 69 stated, they are a little long. Resident 69 stated they were unable to clip them currently, and stated staff had not trimmed them since admission. Review of Resident 69's November 2025 Medication Administration Records showed an order for staff to complete nail care weekly. This order was signed as completed by staff on 11/17/2025. Observations on 11/21/2025 at 9:44 AM showed Resident 69's fingernails remained long, uneven, and untrimmed. In an interview at this time, Resident 69 stated, I keep waiting for them to be done. In an interview and observation on 11/28/2025 at 12:28 PM, Staff L (Licensed Practical Nurse) assessed Resident 69's fingernails and stated they were long and needed to be trimmed. Staff L stated nail care should be done on shower days and as needed. <Resident 17> According to the 08/21/2025 Annual MDS, Resident 17 admitted to the facility on [DATE] with a compression fracture to lower back and right shoulder pain. The MDS showed Resident 17 required moderate one person assistance from staff with personal hygiene, showers and toileting during the assessment period. Review of a 12/22/2023 revised ADL Self Care Performance Deficit Care Plan (CP) showed Resident 17 had a history of right shoulder pain and lower back pain. The CP showed Resident 17 needed one person assistance with personal hygiene and oral care. Observation on 11/17/2025 at 12:19 PM and on 11/18/2025 at 11:02 AM, and on 11/19/2025 at 9:03 AM showed Resident 17 lying in their bed, in a hospital gown, with long facial hair and long fingernails with black debris under their fingernails. <Resident 52> According to the 10/24/2025 admission MDS, Resident 52 admitted to the facility on [DATE] with a wound infection and weakness. The MDS showed Resident 52 required one person assistance from staff with personal hygiene, toileting and showers and Resident 52 had no rejection of care during the assessment period. Review of a 10/20/2025 ADL Self Care Performance Deficit related to wound infection CP, showed Resident 52 required one person assistance with personal hygiene and toileting. The CP directed staff to provide nail care to Resident 52 on Wednesdays/Saturdays. Review of Resident 52's November 2025 Physician Orders directed staff to provide nail care weekly to Resident 52. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 11/17/2025 at 11:32 AM, on 11/18/2025 at 10:24 AM, and on 11/20/2025 at 7:37 AM showed Resident 52 in their room, nicely dressed up, and had long fingernails with black debris underneath fingernails. Resident 52 stated they needed assistance from staff to clip their fingernails. In an interview on 11/20/2025 at 1:09 PM, Staff F (Unit Manager) stated staff should provide ADLs to all dependent residents including personal hygiene, shaving and clip resident's nails weekly and as needed. In an interview on 11/21/2025 at 10:47 AM, Staff B (Director of Nursing) stated they expected staff to provide ADLs to all residents including oral care, shaving, dressing, and nail care as residents allowed, but did not. Staff B stated if residents refuse care, staff should document refusals in resident's record and notify social services. REFERENCE: WAC 388-97-1060(2)(c).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review the facility failed to ensure activity programs met the needs of each resident for 2 of 3 residents (Resident 15 & 69) reviewed for activities. The failure to provide meaningful activities left residents at risk of boredom and a diminished quality of life.Findings included . <Facility Policy>According to the facility's 11/2017 Quality of Life Activities policy, the facility would implement an ongoing activities program to support resident in their choice of activities. The programs would be based on the comprehensive assessment, care plan and the preferences of each resident to support their physical, mental, psychosocial well-being and independence. <Resident 15> According to the 10/08/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 15 had a mood disorder, respiratory failure and weakness. The MDS showed it was very important for Resident 15 to do their favorite activities that included books, newspapers and participation in religious services. The MDS showed it was important to keep up with the news, to listen to music and to go outside weather permitting. Review of the 10/07/2025 Adjustment to Placement Care Plan (CP) showed Resident 15 expressed no interest in scheduled activities, staff were to provide leisure material, and assist with setting the channel on the television. Review of Resident 15's November 2025 activity participation record showed documentation once on 11/15/2025 with no further documentation for the month of November. In an interview on 11/17/2025 at 9:22 AM, Resident 15 stated they needed someone to push them around so they could go to activities. Observations on 11/19/2025 at 8:51 AM, 11/20/25 at 8:04 AM, and 11/20/2025 at 1:53 PM showed Resident 15 lying down in bed, the room was dark with no lights on, and the television was off. In an interview on 11/20/2025 at 2:07 PM, Staff H (Recreation Director) stated they provided a survey to residents on what they like to do, and their team helped residents with their interests. Staff H stated Resident 15 did not like to do activities and preferred to stay in their room. Staff H stated they were not aware if the television was put on for the resident and the recreation staff provided one-on-one activities ongoing and brought Resident 15 writing pads. Staff H stated they did not document activities but should. In an interview on 11/21/2025 at 1:13 PM, Staff B (Director of Nursing) stated their expectation was facility staff would follow the care plan for activities and document when the care was provided. Staff B stated it was important for staff to assist residents to get up out of bed to attend an activity or to escort residents to activities to increase participation. <Resident 69> According to a 10/14/2025 admission MDS, Resident 69 had no memory impairment, was understood, and understood others. This MDS showed Resident 69 had no rejection of care and that it was very important to the resident to have books, newspapers, and magazines to read, do their favorite activities, and participate in religious services or practices. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a revised 10/13/2025 adjustment to facility CP showed Resident 69 was adjusting to the facility, would like to know what activities were scheduled, and liked to observe. This CP showed directions to staff to post the activity calendar in the room, invite them to activities and encourage participation, and provide leisure materials as the resident enjoyed magazines. In an interview on 11/17/2025 at 10:46 AM, Resident 69 stated they would get up more if there was something to do. Resident 69 stated staff got them up and then left them sitting there with nothing to do. Resident 69 stated, I just stare at this black television, I spend all morning looking for something to do. Observations at this time showed Resident 69 lying in bed, with no reading materials nearby, no music, and the television was off. Observations on 11/20/2025 at 2:50 PM showed no activity schedule nearby, no reading materials, no magazines, no music, and the television was off. There was an activity schedule posted near the door entrance of the room which Resident 69 was unable to view. In an interview at this time, Resident 69 stated they were lonely. In an interview on 11/20/2025 at 3:00 PM, Staff H (Recreation Director) stated they interview residents when they are admitted , to find out what they like to do and how staff could help them with their activity interests. Staff H stated they used the information to individualize the resident CPs, and staff should document when activities are provided or offered. Staff H stated it was their expectation that refusals be documented so they can re-evaluate a resident's current interests. Review of October 2025 activity documentation showed staff documented only three of 23 days where one to one activity participation occurred; only one of 23 days when group activity participation was offered; and only four of 23 days independent activities occurred. Review of November 2025 activity documentation showed staff documented only two of 18 days where one to one activity participation occurred and only five of 18 days when independent activities occurred. In an interview on 11/21/2025 at 2:19 PM, Staff H stated the activity participation, offers, and/or refusals were not always documented by staff when provided for Resident 69 and stated they needed to be documented, otherwise, it did not happen. REFERENCE: WAC 388-97-0940 (1).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review the facility failed to provide restorative/functional maintenance services for 2 of 4 residents (Residents 5 & 70) reviewed for limited Range of Motion (ROM) and mobility to ensure the residents maintained and/or improved their highest level of functioning. This failure placed residents at risk of further decline in ROM, loss of function, and/or permanent immobility.Findings included .<Facility Policy>According to a revised June 2018 facility Quality of Care Restorative Nursing Programs policy, the facility would assist residents to obtain and maintain their highest practicable functional levels to prevent unnecessary declines and to provide an active and healthy living environment.<Resident 5>According to a10/9/2025 Quarterly Minimum Data Set (MDS- an assessment tool), Resident 5 had slight memory impairment, muscle weakness, and functional limitation in ROM to both legs.Review of a revised 10/09/2023 limited physical mobility Care Plan (CP) showed staff were to provide gentle range of motion daily as tolerated. Review of the November 2025 caregiver task records showed no documentation staff provided range of motion activities with Resident 5.In an interview on 11/18/2025 at 8:53 AM, Resident 5 stated they needed assistance with mobility because of recent falls and thought someone would provide exercises to them in their room. Resident 5 stated staff did not discuss ROM exercises with them in over a month and they did not hear anything further since.Observations on 11/19/2025 at 8:53 AM, showed Resident 5 lying in bed attempting to sit up to talk but was unable to. Resident 5 then rested on their right elbow and stated they should go to an exercise class to help them get stronger. Resident 5 stated they could not recall a time when someone helped them with ROM exercises in their room. <Resident 70>According to a 10/17/2025 Quarterly MDS, Resident 70 had no memory impairment. The MDS showed Resident 70 had multiple diagnoses including generalized muscle weakness, paralysis and was dependent on staff for mobility. Review of the revised 07/28/2025 Activities of Daily Living self-performance deficit CP, showed Resident 70 required assistance from staff daily with active ROM while providing dressing and grooming assistance of upper arms. Review of the November 2025 caregiver task sheets showed staff were to provide Resident 70 with active ROM daily while providing personal hygiene care. There was no documentation provided by the facility to show staff completed ROM with Resident 70.In an interview on 11/18/2025 at 9:20 AM, Resident 70 stated they wanted therapy to help them get stronger and wondered if it was a cost issue for why they were not receiving help with exercises. In an interview on 11/21/2025 at 10:19 AM, Resident 70 stated their legs and arms were weak, and they would like help with exercises. Resident 70 stated because of their limited mobility it was difficult to get to the activity room for exercises and staff did not offer them exercises in their room.In an interview on 01/21/2025 at 12:41 PM, Staff B (Director of Nursing) stated the facility did not have designated staff to provide restorative and ROM exercises with residents. Staff B stated the facility was setting up a functional maintenance program to track residents' functional abilities, and this was not in place yet. Staff B stated they expected the Certified Nursing Assistants (CNA) to provide ROM with residents as stated in the CP and to document the assistance provided. Staff B stated they were not aware the CNAs did not currently provide active ROM for residents but stated they should be. REFERENCE: WAC 388-97-1060 (3)(d).

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to assess the gastrostomy tube (surgically placed tube through the abdominal wall into the stomach to provide nutrition) placement prior to initiating an enteral feeding (feeding through a tube), provide formula timely as scheduled, and failed to follow the physician orders for 1 of 1 residents (Resident 13) reviewed for tube feeding management. This failure placed residents at risk for alteration in nutrition, dehydration, and decreased quality of life.Findings included .<Facility Policy>Review of a 06/2018 facility, Tube Feeding Management/Restore Eating Skills policy showed staff were instructed to collaborate with the dietician for the appropriate method of formula (liquid nutrition) infusion using gravity flow or an infusion pump (device to deliver formula). The policy instructed collaboration of the dietician and nursing staff to validate the administration of formula and water and ensure the rate and volume of infusion followed the physician orders. This policy instructed staff to verify the potency and function of the feeding tube by checking the stomach residual volume (food, liquid, or material from a previous feeding left in the stomach at the start of the next feeding) or asking alert residents about symptoms that indicate a feeding is not well tolerated.<Resident 13>According to a 08/29/2025 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 13 had multiple medically complex diagnoses including difficulty with swallowing and required the use of a feeding tube for greater than 50 percent of their total calories received.Review of Resident 13's November 2025 Medication Administration Record (MAR) showed a 05/10/2025 order for 150 milliliters (ml) of water to be administered via feeding tube every four hours. Review of Resident 13's November 2025 Treatment Administration Record (TAR) showed a 05/11/2025 order to check the enteral tube placement and residual volume before feeding and water flushes and an 11/05/2025 order for enteral nutrition formula to be administered five times a day at 12:00 AM, 7:00 AM, 11:00 AM, 5:00 PM, and 9:00 PMObservations on 11/19/2025 at 9:54 AM showed Staff G (Registered Nurse) prepared and administered 160 ml of water into the feeding tube, rather than the 150 ml as directed on the orders from the November 2025 MAR. Staff G did not check tube placement or residual prior to administering Resident 13's water flush or formula as directed in the orders on the November 2025 TAR. Staff G did not ask Resident 13 if they were having any symptoms of not tolerating the feedings. Staff G then administered 237 ml of the enteral nutrition formula at 10:15 AM, three hours after the 7:00 AM scheduled dose. When asked if Staff G had provided any previous enteral nutrition formula during the shift, Staff G stated, no, this was their first time administering the formula for the day.In an interview on 11/19/2025 at 10:44 AM, Staff G stated it was very important to follow the tube feeding orders and stated they accidently overcounted the water flush amount. Staff G stated they should have, but did not, follow the orders and check the placement and residual prior to starting the water flush and formula. Staff G stated the formula was scheduled for 7:00 AM, but they did not have enough time to administer it until three hours later at 10:15 AM. In an interview on 11/21/2025 at 12:23 PM, Staff F (Unit Manager) stated it was their expectation staff follow the physician orders as directed and administer the tube feeding water flushes amount as ordered, check placement and residual prior to administering, and provide the tube feedings as scheduled to prevent complications.REFERENCE: WAC 388-97-1060(3)(f).

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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 observation, interview, and record review, the facility failed to implement pharmacy recommendations for 2 of 6 residents (Residents 8 & 69) reviewed for pharmacy recommendations. These failures placed residents at risk of medication errors and adverse health outcomes.Findings included . <Facility Policy>Record review of the facility's November 2017 Pharmacy Services Medication Regimen Review policy showed a pharmacist conducted medication regimen reviews at least monthly to prevent, identify, report and resolve medication-related problems, medication errors, or other irregularities. The facility was to act upon reported irregularities in order to minimize adverse consequences that might be associated with medications.<Resident 8> According to a 09/26/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 8 had recent major orthopedic surgery and required active care during their admission to the facility related to the surgery. Observations during medication pass on 11/19/2025 at 8:26 AM showed Staff G (Registered Nurse) administered one 5,000-unit capsule of Vitamin D3 (a supplement that helps the body absorb calcium to build and maintain strong bones) to Resident 8. Review of Resident 8's physician's orders showed a 09/24/2025 order for Vitamin D3 one 50,000-unit capsule every morning. Review of a 10/17/2025 pharmacy Consultation Report showed Resident 8's current order for Vitamin D3 50,000-units daily was above the recommended dose of 1,000-units to 5,000-units daily, depending on Vitamin D levels in their blood. The pharmacy recommendation included obtaining a blood test to determine Resident 8's vitamin D level. If the results showed a level of less than 30, the facility was to start Vitamin D3 50,000-units weekly or if results showed a level greater than 30, start Vitamin D3 2,000-units daily. Resident 8's physician accepted the recommendations, ordered they be implemented as written, and signed the order on 10/20/2025. Review of a 10/24/2025 Lab Results Report showed Resident 8's Vitamin D level was 47. Review of Resident 8's September 2025, October 2025 and November 2025 Medication Administration Records (MAR) showed Resident 8 continued to receive Vitamin D3 50,000-units daily from 09/24/2025 through 11/19/2025. In an interview on 11/20/2025 at 10:23 AM, Staff B (Director of Nursing) stated the facility obtained a blood test for Resident 8 but did not implement the signed physician's order to change the Vitamin D3 dose based on the blood test results. Staff B stated the Vitamin D3 dose should have been changed to 2,000-units daily when blood test results were received. <Resident 69> According to a 10/14/2025 admission MDS, Resident 69 had multiple medically complex diagnoses including fractures and a disease that causes bones to become weak and brittle. (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 69's records showed a 10/10/2025 Consultant Pharmacist Medication review with documentation to, See report for any noted irregularities and/or recommendations. This report was not found in Resident 69's records. In an interview on 11/21/2025 at 1:38 PM, Staff B stated they were previously unaware they needed to obtain the completed reports from the pharmacy website instead of automatically receiving the reports. Staff B logged in to the website and printed the report with recommendations for Resident 69 from 10/10/2025, over one month previously. The report showed recommendations to administer Resident 69's calcium and iron supplements separately from many medications for proper absorption. Review of Resident 69's November 2025 MAR showed the calcium and iron supplements were still scheduled to be administered at the same time as the resident's other medications. In an interview on 11/21/2025 at 1:38 PM, Staff B stated it was their expectation the pharmacy recommendations be obtained timely, acted on, and be available in the resident records. Staff B stated Resident 69's 10/10/2025 pharmacy recommendations needed to be addressed. REFERENCE: WAC 388-97-1300(4)(c).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 Percent (%). Failure to properly administer 6 of 32 medications for 3 of 4 residents (Resident 8, 119, & 120) observed during medication pass resulted in a medication error rate of 18.75%. This failure placed residents at risk for not receiving the correct dose or receiving less than the intended therapeutic effects of physician ordered medication.Findings included .<Facility Policy>Review of the facility's General Dose Preparation and Medication Administration policy revised on 11/15/2024 showed staff would verify the medication name and dose for accuracy on the Medication Administration Record (MAR) prior to administering medications. <Resident 8> <Vitamin D3 (a supplement)> Observation of medication pass on 11/19/2025 at 8:26 AM showed Staff G (Registered Nurse) administer one 5,000-unit capsule of Vitamin D3 to Resident 8. Record review of Resident 8's physician's orders showed a 09/24/2025 order for Vitamin D3 with directions to administer one 50,000-unit capsule every morning, not the 5,000 units as administered by Staff G. <Pain-relieving patch> Observation of medication pass on 11/19/2025 at 8:26 AM showed Staff G prepare medications for Resident 8, including a pain-relieving patch. Staff G went to Resident 8's room and administered the medications, except for the pain-relieving patch. Staff G did not offer or administer the pain-relieving patch. In an interview on 11/19/2025 at 9:28 AM, Resident 8 stated Staff G did not offer or administer the pain-relieving patch. In an interview on 11/19/2025 at 9:29 AM, Staff G confirmed they forgot to give Resident 8 their pain-relieving patch and stated they would bring it to Resident 8 at that time. In an interview on 11/20/2025 at 10:23 AM, Staff B (Director of Nursing) stated there were several mistakes that resulted in medication errors. Staff B confirmed that Staff G did not follow the physician's order during medication administration. <Resident 119> Observation of medication pass on 11/19/2025 at 8:27 AM showed Staff N (Registered Nurse) prepare and administer multiple medications to Resident 119, including two pain patches. Staff N applied one to the right knee and a second one to just below the right knee. Staff N was holding a third pain patch and stated to Resident 119, Do you want this patch too? Resident 119 stated, it's ok. Staff N did not apply the third patch. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 119's November 2025 Medication Administration Record showed the pain patch order gave directions for staff to apply three patches, not two as administered, and apply to the left lower leg, not the right knee as administered. Staff N signed this order as administered as directed on 11/19/2025 with no documentation to support why the ordered dose was not provided or indicate why the location was changed. In an interview on 11/21/2025 at 1:22 PM, Staff J (Unit Manager) stated it was their expectation physician orders be followed as directed. <Resident 120> Observation of medication pass on 11/19/2025 at 8:35 AM, showed Staff K (Licensed Practical Nurse) prepared to administer Resident 120's morning medications. Staff K administered: 1. Eye drops Ophthalmic solution one drop in both eyes. 2. Supplement- 200 milligram (mg) tablet. 3. 4% pain patch to Resident 120's right hip area. Review of Resident 120's November 2025 Physician Orders on 11/19/2025 at 9:28 AM showed a physician order for: 1. Eye drops- one drop to the left eye four times a day related to an incision. 2. A supplement- 220 mg daily. 3. Pain External Patch Apply to right hip topically one time daily for pain. There was no dosage for the pain patch in the orders. In an interview on 11/19/2025 at 10:00 AM, Staff K reviewed Resident 120's physician orders and stated the eye drops should be administered only in left eye for the incision. Staff K stated the facility did not have Supplement in the 220 mg dose available so they administered 200 mg only. Staff K stated they should clarify the pain patch order with the provider for the dosage, but they did not. Staff K stated they should have checked the orders prior to administering the medications and/or consult the provider for clarification. In an interview on 11/21/2025 at 10:47 AM, Staff B stated they expected staff to verify the correct resident's name, medication name, dosage amount, and the correct time the medication should be given. Staff B stated staff should read the order before administering medication to ensure they were administering the correct medications. REFERENCE: WAC 388-97-1060(3)(k)(ii).

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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. Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in 1 of 2 medication storage rooms (West Station Medication Room) and 1 of 3 medication carts (West Two Medication Cart) reviewed for medication storage. This failure placed residents at risk for medication errors or receiving expired medications.Findings included .<Facility Policy>According to the facility's November 2017 Pharmacy Services Labeling and Storage of Drugs and Biologicals policy, all medications would be labeled with an expiration date. The policy showed multi-dose vials would be dated with an open date and discarded within 28 days after opening, unless the manufacturer specified a shorter or longer date for that opened vial. <West Station Medication Room>Observation on 11/18/2025 at 9:17 AM of the [NAME] Station medication storage room showed a bottle of medication used to treat itching with an expiration date of 10/25/2025, and nine bags of IV (intravenous - injected directly into a patient's bloodstream) medications with an expiration date of 10/13/2025.In an interview on 11/18/2025 at 9:17 AM, Staff D (Unit Manager) confirmed the medication used to treat itching was expired and should have been discarded. Staff D stated the IV medications were discontinued on 10/03/2025 and should have been discarded or returned to the pharmacy at that time.<West 2 Medication Cart>Observation on 11/18/2025 at 12:25 PM of the [NAME] 2 medication cart showed three opened multi-dose injectable medications used to treat a blood sugar disorder with no open dates, and one that had an open date that was smeared and illegible.In an interview on 11/18/2025 at 12:25 PM, Staff E (Licensed Practical Nurse) stated the multi-dose injectable medications were to be discarded 28 days after opening. Staff E stated they would need to know the open date in order to know when to discard the medications.In an interview on 11/20/2025 at 10:23 AM, Staff B (Director of Nursing) stated if multi-dose injectable medications were not labeled with the open date, they would discard them. Staff B confirmed that expired medications should be discarded.REFERENCE: WAC 388-97-1300(2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505510	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Care Center - Federal Way	135 South 336th Street Federal Way, WA 98003

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment to help prevent the transmission of communicable diseases. The facility failed to follow precautions signs for 3 of 4 residents (Residents 52, 78, & 7) for Transmission-Based Precautions (TBP) and 2 of 2 residents (Residents 67 & 12) for Enhanced Barrier Precautions (EBP) as posted outside resident's rooms and failed to follow hand hygiene (HH) practice for 2 of 3 residents (Residents 8 & 12) during medication administration. These failures to wear PPE (Personal Protective Equipment - gown, gloves and goggles) as instructed on the signs outside resident's rooms and poor hand hygiene practice placed residents at risk for facility acquired or healthcare-associated infections and related complications. Findings included . <Facility Policy>According to a facility policy titled, Infection Prevention and Control Program (IPCP), revised 06/08/2022, the IPCP would maintain a safe, sanitary and comfortable environment to prevent the development and transmission of communicable diseases and infections. The policy showed the program would provide guidance to staff on EBP and TBP to be followed, PPE use, and HH practices. The policy showed resident room assignments would be made while taking into consideration resident diagnoses and risk factors such as not placing residents with active contagious infections in a room with residents who are at greater risk of contracting an infection. This policy showed when a resident had an infection or was potentially infectious, the infection would be tracked, and interventions would be implemented to minimize the additional risks to the residents. The policy showed the facility would monitor for proper HH, use of PPE and TBP, and proper infection prevention techniques were used during direct care including medication administration. <TBP> <Resident 52> According to the 10/24/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 52 admitted to the facility with wound infection. The MDS showed Resident received Antibiotic medications every day during the assessment period. The MDS showed Resident 52 had an indwelling catheter (a flexible tube inserted into the bladder to drain urine) in the bladder and was assessed to require one person assistance from staff for their toileting hygiene during the assessment period. Observations on 11/17/2025 at 9:12 AM and on 11/18/2025 at 1:00 PM showed a Contact Precaution sign was posted outside Resident 52's room and instructed all staff to perform Hand Hygiene and to wear PPE before entering the room. The observations showed an isolation cart filled with PPEs and placed outside Resident 52's room. In an interview on 11/17/2025 at 10:09 AM, Staff S (Licensed Practical Nurse) stated Resident 52 was on contact precautions because the resident had a wound on their back and staff had to wear PPEs before they entered the room and remove PPEs inside the room before they leave the resident's room. Staff S stated staff had to sanitize their hands before they entered the room and before they left the resident's room. Observation on 11/17/2025 at 11:10 AM showed Staff R (Certified Nursing Assistant) entered Resident 52's room without any PPEs. Resident 52 was sitting in a chair. Staff R talked to the resident, came outside the room to fill ice water pitcher and talked to the floor nurse in the hallway, filled the water pitcher and went inside the room again without any PPEs. (continued on next page)

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	505510	A. Building B. Wing	11/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/17/2025 at 12:45 PM showed Staff R went inside Resident 52's room to deliver lunch tray without any PPE. In an interview on 11/17/2025 at 1:00 PM, Staff R stated they did not have to wear gowns or gloves unless they provide direct care to residents. Staff R stated they had to follow the instructions on the sign posted outside Resident 52's room for Contact Precautions. Staff R read the directions on the posted sign and stated they should wear PPEs before they entered the room, but they did not. In an interview on 11/20/2025 at 10:12 AM, Staff Q (Infection Preventionist) stated all staff should follow the directions on the sign posted outside residents' rooms to prevent spreading infections. Staff Q stated staff should wear PPEs before they enter the rooms on Contact Precautions, but they did not. <Resident 78> Observations on 11/17/2025 at 10:15 AM showed a sign on Resident 78's door indicating the resident was on contact precautions. The sign gave directions to staff to wear a gown and gloves prior to entering the resident's room. Staff J (Unit Manager) and Staff P (Registered Nurse) were in the room at the resident's bedside assisting with resident equipment, without a gown or gloves on. At 10:21 AM Staff J and Staff P exited the room, Staff P went to their medication cart, and returned to the resident's bedside, again without wearing a gown or gloves. Record review showed Resident 78 was on contact precautions for a contagious infection that was resistant to many antibiotics and difficult to treat. <Resident 7> Observations on 11/17/2025 at 10:37 AM showed a sign on Resident 7's door indicating the resident was on contact precautions. The sign gave directions to staff to put on a gown and gloves prior to entering Resident 7's room. Staff were observed entering Resident 7's room without putting on a gown or gloves. Record review showed Resident 7 was on contact precautions for a contagious infection that was resistant to many antibiotics and difficult to treat. In an interview on 11/20/2025 at 2:19 PM, Staff Q stated it was their expectation staff follow the directions indicated on the signs posted at the resident doors. Staff Q stated to help reduce the spread of infections, staff should put on a gown and gloves prior to entering the room when a resident was on contact precautions. <EBP> <Resident 67> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/0/2025 at 8:14 AM showed an EBP sign posted on the outside of Resident 67's room door. The EBP sign directed staff to wear a gown and gloves for high contact resident care activities that included providing device care for intravenous (IV - medication provided through a needle inserted into a vein) therapy. Observed Staff M provide IV treatment for Resident 67 and did not wear a gown. <Resident 12> Observation on 11/20/2025 at 9:05 AM showed an EBP sign posted on the outside of Resident 12's room. The EBP sign directed staff to wear a gown and gloves for high contact resident care activities that included providing device care for a feeding tube. Observation on 11/20/2025 at 9:05 AM, Staff M (Registered Nurse) administered medications through a feeding tube for Resident 12. Staff M set up the resident's medications on a tray in Resident 12's room and stated they forgot a cleansing wipe from their medication cart outside of the room in the hallway. Staff M was observed to leave the room with their gown on and did not perform hand hygiene when leaving the room. Staff M came back into the resident's room wearing the same gown and did not perform hand hygiene before putting on new gloves. During an interview on 11/20/2025 at 8:14 AM Staff M read the directions on the EBP sign on Resident 67 and 12's doors and stated they did not know they had to wear a gown while providing direct care to residents. Staff M stated it was important to follow the directions on the sign outside of the room to prevent transmission of diseases and for infection control. .<Hand Hygiene> <Resident 8> Observation on 11/19/2025 at 8:29 AM showed Staff G (Registered Nurse) prepared medications to administer to Resident 8 without performing hand hygiene. Observation on 11/19/2025 at 8:44 AM showed Staff G paused medication preparation for Resident 8, put on gloves, and provided a topical treatment and dressing to Resident 8's roommate. Staff G removed their gloves and resumed medication preparation for Resident 8 without performing hand hygiene. Observation on 11/19/2025 at 8:56 AM showed Staff G performed hand hygiene, obtained additional supplies from the medication cart, then entered Resident 8's room. Staff G returned to the hallway four times to retrieve additional medications and supplies from the medication cart and returned to Resident 8's room each time without performing hand hygiene. Staff G put on gloves prior to administering injections without performing hand hygiene and did not perform hand hygiene after removing gloves. In an interview on 11/20/2025 at 10:23 AM, Staff B (Director of Nursing) stated they expected nurses to perform hand hygiene before going into a resident room, after leaving the room, and after each medication pass. REFERENCE: WAC 388-97-1320 (1)(a), (2)(b). .