STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure, 1) proper temperatures were consistently monitored accurately and legible for 3 of 4 months reviewed for meals temperatures and 2) equipment surfaces were cleaned and sanitized for 1 of 1 kitchen. This failed practice placed residents at risk for food borne illness.Findings included.Review of the 07/2018 policy titled, Food and Nutrition Services Food Safety, showed the facility would monitor foods for bacterial growth by checking the times and temperatures of foods to ensure safety. During a concurrent interview and record review on 09/02/2025 at 9:22 AM, Staff Y, Dining Services Director, stated they expected food temperatures to be obtained when food was taken out of the oven, right before it was served out, and at the end of serve out to monitor how well the food held heat in the warmers. Staff Y stated the food logs were not completed fully or accurately. A review of the kitchen's food temperature logs showed: In June 2025, 11 out of 93 meal temperatures were not accurately completed with an additional five meals where the temperature readings were illegible. In July 2025, 10 out of 93 meal temperatures were not accurately completed with an additional six meals where the temperature readings were illegible. In August 2025, six out of 93 meal temperatures were not accurately completed with an additional three meals where the temperature readings were illegible. Kitchen Equipment An observation on 09/02/2025 at 9:00 AM, the dual ovens to the right side of the stove had built-up brown, fuzzy, strings mixed with oil on the blades of the vents. An observation on 09/02/2025 at 9:04 AM showed an ice machine to the far-left corner of the entrance to the kitchen. The lid was soiled with dried food and dirt, the vents on the outside of the ice machine had dried, splattered white and brown food particles. Inside the ice machine, there was a white plastic cover in the front of the machine that had pink and black, moist sediment to the front and the creases of the cover. There were no cleaning logs on or around the machine. An observation on 09/02/2025 at 9:24 AM, showed the plate warmer (a machine that holds and heats clean plates prior to putting food on them) had visible food crumbs on the bottom of both sides of the machine. One side of the warmer was empty, and the other side held clean plates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/08/2025 at 11:32 AM, Staff Z, Cook, stated cleaning of the kitchen and machines was supposed to be completed daily and then initialed by the person who cleaned it. Staff Z stated if the cleaning log had not been initialed then the cleaning had not been done. Staff Z stated there should have never been a time that food temperatures were not obtained or documented correctly/legibly. During an interview and concurrent observation on 09/08/2025 at 12:07 PM, Staff E, Maintenance Assistant, stated the ice machines were to be cleaned on a monthly schedule. Staff E observed the ice machine in the kitchen and the vents to the dual stove and stated they should not have that build up of dust or be soiled, they definitely could use some love. Review of a Work History Report provided by Staff E, for the past six months, March 2025 through August 2025, showed the ice machine had been cleaned twice, on 05/19/2025 and 07/28/2025. Review of the kitchen cleaning log for August 2025 showed daily cleanings of different kitchen items and equipment were to be completed by the AM/PM Cooks. The logs showed 25 different items had not been cleaned on 18 different days for the month. Review of the remaining clean logs provided showed no months, days, or dates as to when those cleanings took place. During an interview on 09/09/2025 at 9:04 AM, Staff Y stated they were aware of the missing entries and dates on the cleaning logs and that was a work in progress. Reference: WAC 388-97-1100(2)(3) This is a repeat citation from the Statement of Deficiencies dated 10/29/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a safe, clean, sanitary (the conditions that affect hygiene and health) and comfortable homelike environment regarding, A) the cleanliness of resident room Packaged Terminal Air conditioners (PTAC, a through-the-wall system that provides independent heating and cooling to a localized area) units for 3 of 7 resident rooms (301, 302 and 304), reviewed for environment cleanliness, B) soiled shower room ventilation and holes in wall tiles for 1 of 3 shower rooms (300's hallway) reviewed for environment, and C) a gouge (a hole or indentation) in a resident room flooring for 1 of 3 resident rooms (Resident 12) reviewed for a safe environment. This failure placed residents at an increased risk of injury and dissatisfaction with their living environment. Findings included. Review of the facility's policy's titled, Resident Rights Safe, Clean and Comfortable Environment, dated July 2018, showed the facility would provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior for residents. The policy showed the facility would provide residents a safe, clean and comfortable environment that delivered care and services safety and allowed residents to use their personal belongings to the extent possible. Observation in room [ROOM NUMBER] on 09/02/2025 at 3:32 PM showed dried food, crumbs and trash within the ventilation face plate of the rooms PTAC unit. During a concurrent observation and interview on 09/09/2025 at 8:50 AM the PTAC unit for room [ROOM NUMBER] showed a build-up of food crumbs and grime (dirt that is ingrained on the surface of something) within the ventilation face plate. Staff E, Maintenance Assistant, stated they had been cleaning the filters that were part of the PTAC units but not under the ventilation face plate. Staff E and surveyor observed room [ROOM NUMBER]'s PTAC unit and showed a moderate amount of dust build-up and liquid stains from something that spilled on the PTAC unit. Staff E stated the build-up and food particles needed to be cleaned up and could be a safety concern if the heater component of the PTAC unit was used. During an interview on 09/09/2025 at 1:00 PM Staff A, Administrator and Staff B stated the food particles and trash were a hazard within the PTAC units and they expected them to be cleaned out by the maintenance staff. Shower Rooms During a concurrent observation and interview of the 300's hallway shower room, on 09/09/2025 at 9:04 AM, showed two ceiling duct vents with thick dust/grime build-up. Staff E stated, we missed those ones . Observations behind the shower room door showed a black two inch (a unit of measure) one inch hole in the white tile. Staff E stated that the shower room door must have slammed into it and put a hole in the tile. When surveyor and Staff E observed closer, it was noted that the rubber doorstop (a device designed to prevent the door from swinging to far into the wall behind it) was installed incorrectly. Staff E stated the door stop needed to be reinstalled correctly and the tile needed to be fixed. During an interview on 09/09/2025 at 1:00 PM Staff A, Administrator and Staff B stated they were unaware of the shower room's doorstop being installed incorrectly and would need to be fixed. Staff B stated the ceiling ventilation ducts should have been clean and the hold in the tiled wall also needed to be fixed. Safe Environment Observation of Resident 12's room on 09/04/2025 at 4:31 PM showed a large one-foot (ft, a unit of measure) by half-foot area of the linoleum (a flexible and durable floor covering that can be glued down) flooring had a gouge scrapped out of it. The gouged section had three flapped sections of the linoleum that were draped back over the floor to cover the subfloor. During an interview on 09/09/2025 at 9:04 AM, Staff E stated they were aware of the gouged-out section of the linoleum flooring, .it is a hazard, and anyone can trip on that and needs to be replaced. During an interview on 09/09/2025 at 1:00 PM Staff A, Administrator and Staff B stated the gouge in the flooring was a hazard and would expect it to be fixed. Reference: WAC 388-97-3220(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure components of their infection prevention/control program, to prevent the development and transmission of infections with, A) the facility's water management program Legionella (a bacteria that can cause a severe respiratory disease) testing protocols, and identification of control measures (actions or steps taken) to reduce the potential growth/spread of pathogens (bacteria, virus or other microorganisms that can cause diseases) were developed/implemented for 1 of 1 water management program (WMP) reviewed for infection control, B) hand hygiene and glove change when completing resident cares for 3 of 10 staff (Staff AA, BB, K) reviewed for infection control, and C) the cleaning/disinfecting of the facility's environmental surfaces and isolation precautions room (preventative measures used to reduce the transmission of infectious bacteria and organisms in the healthcare setting) with an Environmental Protection Agency (EPA) registered disinfectant reviewed for environmental cleaning/disinfection. This failure increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included .Review of the facility's policy titled, Water Legionella Water Management Program, reviewed September 2025, showed that it applied to all the facility's water systems including, water storage tanks, water heaters, water filters, shower heads, infrequently used equipment, eye wash stations, ice machines and more. The policy showed the facility would identify areas at risk for legionella growth and ensure the necessary maintenance/monitoring was carried out. The policy showed the facility identified areas where Legionella could grow and how they would conduct visual checks of the areas at risk and temperature checks on the facility's hot water distribution. The policy did not include control measures for the facility's ice machines, shower heads, areas of water stagnation (water that stops flowing for an extended period) or infrequently used equipment and eye washing stations. Additionally, the policy did not include how the monitoring of the control measures were being completed, the frequency for monitoring the control measures, the acceptable ranges of the control measures nor the established ways to intervene when the control measures were outside the acceptable ranges. Review of the Center for Disease Control and Prevention (CDC) toolkit titled, Developing a WMP to Reduce Legionella Growth and Spread in Buildings, dated 06/24/2021, showed a facility's WMP should identify areas or devices in the building where Legionella might grow or spread to people so the risk can be reduced. The toolkit showed that parts of a building water system that were a risk for spreading contaminated water included water storage tanks, water heaters, shower heads/hoses, infrequently used equipment like eye wash stations, ice machines, and decorative fountains. Additionally, the toolkit showed that water stagnation encouraged biofilm (a community of bacteria that stick together and to a surface forming a protective layer) growth, which can protect Legionella from heat/disinfectants and was common in water devices that went unused or infrequently used. Review of the facility's policy titled, Infection Prevention and Control Program (IPCP), dated 06/08/2022, showed the facility would maintain an IPCP to help prevent the development/ transmission of communicable diseases and the staff member responsible for the IPCP was the Infection Preventionist (IP). The IP would record identified infections or residents with symptoms suspicious of an infection. The policy showed that facility staff were to perform hand hygiene, even if gloves were used, after contact with blood/body fluids/visibly contaminated surfaces, after contact with objects in a resident's room and after removing PPE. The policy showed that residents isolation precautions would have their environment disinfected routinely using an approved disinfectant. Review of Centers for Disease Control and Prevention recommendations titled, Guidelines for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Environmental infection control in Health-Care Facilities, updated July 2019, showed that cleaning and disinfecting environmental surfaces is fundamental in reducing their potential for transmission of diseases. Environmental surfaces can be medical equipment surfaces or .housekeeping surfaces (e.g., floors, walls, and tabletops), and need to go through a cleaning and disinfecting process. Additionally, the guidelines showed that environmental surface disinfectants were regulated by the EPA and labeled with an EPA registration number. During an interview on 09/09/2025 at 9:11 AM, Staff E, Maintenance Assistant, stated the facility did not have a current Maintenance Director. Staff E stated they were not familiar with the WMP but had access to what was being monitored in the facility. Staff E stated they completed water temperatures throughout the facility and presented documentation that showed the control measure was being completed. Staff E stated they had not been overseeing/completing the changing/flushing of the emergency water storage containers, the monthly water systems chlorine residual testing (a test that measures amount of chemical in the drinking water to ensure that it is safe and free from harmful microorganism), nor the weekly flushing/inspection of the eye washing stations. Additionally, Staff E stated the facility's ice machines were to be cleaned monthly, but was unsure if other monitoring/checks were performed in-between the monthly checks. Review of the control measure log documentation presented by Staff E on 09/09/2025 showed, The changing/flushing of the emergency water storage containers was every six months, last performed on 02/21/2025 (18 days late). The monthly water systems chlorine residual testing had not been completed for three of the four scheduled times in August 2025. No documentation presented for September 2025. The flushing/inspection of the eye washing stations had not been completed for 2 of the four scheduled weeks in August 2025. No documentation presented for September 2025. The ice machine, located by the main nursing station, log was last completed 08/06/2025 (three days late). During a concurrent observation/interview continued on 09/09/2025 at 9:11 AM, Staff E and surveyor observed the ice machine located by the main nursing station. Staff E opened the ice machine's storage bins lid and under the inner ice storage retainer plate (to secure or hold different items in place) was a two inch (a unit of measure) by one inch black substance that was noted. Staff E stated the black substance should not be there and the ice machine was not monitored properly. Additionally, Staff E stated the control measure logs for the emergency water storage containers should have been completed on time, along with the flushing/monitoring of the eye stations and the monthly chlorine residual testing. During a concurrent interview and observation on 09/09/2025 at 9:42 AM, Staff B, Director of Nursing Services (DNS), stated they were not familiar with the facility's WMP, control measures, the acceptable ranges for control measures or the testing protocols in place if control measures were not met. Staff B stated look like black mold when the staff member looked inside the ice machine located by the main nursing station. Staff B stated the facility's WMP needed to be fixed. Hand Hygiene, Glove Change (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 09/04/2025 at 3:37 PM showed Staff AA, Nursing Assistant (NA) and Staff BB, NA in room [ROOM NUMBER], just completed a mechanical lift transfer of a resident form the chair to the bed for an incontinent brief change. Both staff, after donning (putting on) gloves, assisted in rolling the resident and Staff AA performed a glove change but did not complete hand hygiene. Staff AA then proceeded to perform perineal care (cleaning of the private parts of a resident) then along with Staff BB assisted in rolling the resident again to the other side. Staff BB performed a glove change but did not complete hand hygiene and then proceeded to finish perineal care for the resident. Both staff were conversing/waiting for the nurse to come and assist with the resident rear end wound dressing change that had gotten soiled (dirty or contaminated). Staff AA noticed the resident was unaware of what was happening so, using the same soiled gloves, proceeded to communicate with the resident who was hard of hearing by writing down information on a piece of paper from the resident's bedside table. After finishing the brief change both staff doffed (taking off) their gloves and proceeded to touch/rearranged items on the resident's bedside table, closed the resident's privacy curtain and moved the resident's wheelchair without preforming hand hygiene. During an interview on 09/05/2025 at 4:25 PM, Staff BB stated that when performing incontinent brief changes and moving from a soiled area to a clean area they were required to change gloves and complete hand hygiene. Staff BB stated they had forgotten to bring their bottle of hand sanitizer into the room with them during the brief change in room [ROOM NUMBER]. Staff BB stated they should have completed hand hygiene in between each glove change but did not. On 09/08/2025 at 1:05 PM, Resident 34 received an incontinent brief change from Staff J, Nursing Assistant (NA), and Staff K, NA. While wearing gloves, Staff K removed Resident 34's soiled brief and cleansed the area with disposable wipes. Continuing to wear the same soiled gloves, Staff K redressed the resident, changed bed height with bed remote and put cleansing wipe container away. After tying off the soiled linen bag and waste bag, Staff K removed their gloves and disposed of them in waste container. Staff K then disposed of the bags in the soiled utility room across the hall. Next, without washing their hands with soap and water they entered another resident's room to assist transfer from their wheelchair to bed. Staff K applied clean gloves and proceeded to assist the resident. On 09/09/2025 at 11:13 AM, Staff B, Director of Nursing Services/ Infection Preventionist, stated that gloves should be changed between soiled tasks to clean tasks and hands should also be washed after removing gloves during incontinent care prior to starting new tasks. Environmental Surfaces During an interview on 09/09/2025 at 7:45 AM, Staff B stated that two residents, in the back 400's hallway, were placed on isolation precautions. During an interview on 09/09/2025 at 10:03 AM, Staff EE, Housekeeper, stated they utilized Medline Neutral Floor Cleaner when cleaning the resident rooms and all areas of the facility. During an interview on 09/09/2025 at 10:21 AM, Staff DD, Laundry/Housekeeping Director, stated all the housekeeping staff used the Medline Neutral Floor Cleaner, for the cleaning/disinfecting of all the residents' rooms within the facility. During an interview on 09/09/2025 at 10:50 AM, Staff FF, Housekeeper, stated that on that day they were charged with cleaning/disinfecting in the back 400's hallway. Staff FF stated that they were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	using the Medline Neutral Floor Cleaner on the two isolation precautions rooms in the 400's hallway and everywhere else in the facility. During a concurrent observation and interview on 09/09/2025 at 10:57 AM, Staff DD along with surveyor observed the Medline Neutral Floor Cleaner and were unable to find an EPA registration number on the chemical. Staff DD stated they were not aware that the chemical was not a registered disinfectant, .we should be using a disinfectant on all the floors of the facility. During an interview on 09/09/2025 at 1:00 PM, Staff A, Administrator and Staff B stated they were not aware the Medline Neutral Floor Cleaner utilized by housekeeping staff within the facility was not a disinfectant. Staff B stated the facility should be using an EPA registered disinfectant when cleaning/disinfection isolation precaution rooms within the facility. Reference: WAC 388-97-1320(1)(a)(2)(b)(5)(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from interference/coercion (the use of expressed or implied pressure to compel someone to act against their will) in a manner that promoted and/or supported the resident's individual choice in respect to their quality of life, without fear of reprisal, regarding the residents choice to smoke a cigarette for 1 of 3 residents (Resident 4) reviewed for the resident rights. This failed practice placed the resident at risk of increased confusion and/or frustration with facility staff regarding their individual choice to smoke and unmet care needs.Findings included .Review of the facility's policy titled, Physical Environment Smoke Free Facility, revised February 2025, showed the facility was designated as a smoke-free building and a smoke-free campus that would extend to the perimeters of the facility's property. The policy showed that residents smoking paraphernalia (items like cigarettes, electronic cigarette, vaping [inhaling a mist of nicotine from a handheld device] devices, lighters and matches) would need to be surrendered to facility staff to keep in a locked box until signed out. Residents were to be informed of violations of the facility's smoking policy that could place the resident at risk for discharge due to a safety threat and possible danger to other residents/individuals in the facility. Additionally, the policy showed, The non-smoking policy will be included in the admission packet and explained to new residents as part of the admission process. The smoking policy showed no information on smoking assessments or a process for facility residents that chose to continue to smoke cigarettes or new residents who chose to smoke, and how to safely dispose of them. Resident 4Review of the resident's medical records showed they were admitted on [DATE] with diagnoses including a fracture of their left arm, depression and anxiety. The 08/05/2025 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. Review of Resident 4's hospital documentation showed the resident was brought in 03/12/2025 after they had a fall and was found to have a shoulder injury and was admitted . The records showed Resident 4 smoked cigarettes every day and last attempted to quit 13.2 months ago. Review of Resident 4's signed admission documentation, dated 05/01/2025, 05/06/2025, and 05/09/2025 showed no documents regarding the facility's smoking policy and/or rules had been signed or given to the resident or their representative. Review of Resident 4's provider note dated 05/09/2025, showed the resident had been smoking for over 30 years, since they were [AGE] years old and had quit smoking cigarettes two to four months prior (between January 2025 to March 2025). During a concurrent observation and interview on 09/02/2025 at 12:01 PM, Resident 4 was observed in the dining room with their motorized wheelchair. Resident 4 stated that on an unknown date they had made the choice to smoke a cigarette, off of the facility's property, and the facility staff saw the resident smoking and stated they were in violation of the facility's smoking policy and would be discharged or transferred out to another facility if the resident did not switch to vaping. Resident 4 showed the surveyor their vaping device and observed the resident's ability to hold/maneuver the device, which weighed more than a cigarette, without complications. The resident stated they were currently using the vape device instead of smoking a cigarette, I don't want to leave. Resident 4 stated they were always smoking off the facility's property and still got my butt in trouble. Review of Resident 4's smoking evaluation, dated 08/25/2025, showed that Resident 4 smoked one to two times a day, liked to smoke in the afternoons/evenings, was cognitively intact, could communicate with others effectively, was able to demonstrate the ability to physically hold a cigarette, could call for help in the event of an emergency, and was able to light their cigarette safely. The evaluation also showed that Resident 4 was unable to retrieve their cigarette if it was dropped, and unable to demonstrate a safe technique for extinguishing their matches/lighter nor disposing of their cigarette ashes safely. The smoking evaluation determined that Resident 4 was unsafe to smoke independently, and that .we are a smoke (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	free facility . The smoking evaluation did not include information on how the resident could dispose of the cigarette ashes safely or if the resident was able to demonstrate safe technique after education from staff on proper disposal of their cigarette ashes. During an interview on 09/05/2025 at 12:24 PM, Resident 4's representative (RR), stated facility staff had caught Resident 4 smoking about a week ago, off the facility's property and because of that, was going to send the resident somewhere else (as in transferring and/or discharging Resident 4 for smoking a cigarette). The RR stated the facility staff did not want Resident 4 to smoke at all, even off of the facility's property (Resident 4) wanted to try cigarettes again. Review of Resident 4's progress notes for August and Sep 2025 showed: 08/25/2025 at 3:27 PM, Staff Q, Social Services Director, stated on 08/22/2025 Resident 4 was observed taking a pack of cigarettes out of their pocket and was informed of the facility being a .100 percent non smoking facility . Resident 4 mentioned they had been unaware of this rule, so Staff Q educated them about having cigarettes in the building and provided the resident with a locked box to store the cigarettes. 08/25/2025 at 10:40 AM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), discussed events on 08/22/2025, the smoking policy and that by having possession of smoking paraphernalia, the resident was breaking the facility policy. Resident 4 stated they were holding onto the cigarettes for someone else and that they did not smoke. Staff D asked Resident 4 to hand over the cigarettes to the staff member or the RR, and the resident handed over two packs of cigarettes. Staff D stated, .however; I could visibly see more in (Resident 4's) purse. I told (Resident 4) I saw another pack, and (Resident 4) reluctantly (without really wanting to) handed me one more . 08/25/2025 at 1:00 PM, Staff B, Director of Nursing Services (DNS), stated the resident was noted to make their way out the front entrance of the facility, utilized their motorized wheelchair to go off the facility's property, and pulled out a cigarette and lighter from their phone pouch. Staff B stated, .Resident was asked if nursing staff could assess for smoking assessment to which resident allowed . and the resident stated they disposed of the cigarette butts (the end of the cigarette which is usually discarded after use) onto a rocky area down the road. Staff B stated they observed Resident 4 .improperly dispose of ashes and was immediately educated on proper disposal, strict adherence on safety measures, and sign in/out procedures. (Resident 4) was receptive to feedback, discussed tentative plan-as (Resident 4) failed to meet safe smoking practices. 08/25/2025 at 4:21 PM, Staff A, Administrator, and Staff B, informed the resident that based on the smoking assessment completed by Staff B, the resident was not safe to smoke. Resident 4 informed both staff that they would not smoke anymore and did not want to vape but would request a nicotine patch if the resident needed it. Staff A informed the resident that if they .were discovered to be smoking unsafely, we would potentially be discussing a discharge notice . 08/29/2025 at 12:28 PM, Staff A had observed Resident 4 smoking on the sidewalk .upon resident's return to facility, resident initially denied smoking until informed that (Resident 4) was witnessed . Resident 4 informed the Administrator they were smoking off of the facility's property .so there is nothing wrong with that , and Staff A stated they were aware that Resident 4 was non-compliant with the facility's smoking policy, had been informed of the facility smoking policy, and the resident had failed the smoking safety assessment. Staff A informed the resident that they would be looking for alternative placement. During an interview on 09/05/2025 at 3:20 PM, Staff A showed documentation that the facility became a smoke-free facility and implemented the smoking policy on 05/05/2025. Staff A was unsure when the facility residents were informed of the change in policy. Review of the facility's records showed that a meeting was held with the facility's known smoking residents on 07/02/2025 to discuss the transition of the facility to a smoke-free facility. No documentation showed that Resident 4 attended the meeting. During an interview on 09/05/2025 at 3:54 PM, the RR stated the resident was smoking prior to their hospital stay in March 2025 and that Resident 4 felt the facility staff were getting pretty upset with the resident for smoking cigarettes, even though they were off the facility's property. During an interview on 09/08/2025 at 10:26 AM, Staff R, Medical Records, stated they did not have any record of Resident 4 signing the facility's non-smoking policy nor was it (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	given in the resident's admission paperwork. During an interview on 09/08/2025 at 10:52 AM, Staff G, Activities Director, stated the facility moved to a smoke-free facility in May 2025 and started reviewing the smoking policy for residents that previously smoked on 05/08/2025. Staff G stated that previous, current, or new facility residents were no longer allowed to smoke cigarettes at all while they were a resident at the facility. During a concurrent interview on 09/08/2025 at 10:53 AM, Staff A and Staff B stated some residents were still smoking off of the facility property. Staff A stated that residents who smoked had a smoking evaluation completed and the evaluation would explain why a resident was able to smoke independently. Staff A stated that residents had a right to smoke, but the facility wanted them to be safe when smoking. Staff A stated that a smoking receptacle for disposing of cigarette butts had been placed outside last week, before the survey team arrived. Both staff were aware of Resident 4 smoking cigarettes off of the facility's property, had observed Resident 4 smoking cigarettes, and documented progress notes on the resident. Staff B stated that Resident 4 was not safe to smoke independently, due to the resident improperly disposing of their cigarette ashes during the smoking evaluation and was unable to pick up the cigarette butt if the resident had dropped it on the ground. Staff B stated that Resident 4 was able to dispose of the cigarette butts on their own but the resident .should not be discarding it a couple of blocks away . The progress note made by Staff B on 08/25/2025 at 1:00PM was reviewed and Staff B stated they immediately completed education on the proper disposal/safety measures and yes the resident was receptive to the feedback/able to understand. Staff A stated based on the completed smoking evaluation by Staff B, Resident 4 posed a safety risk with smoking independently, so discussed with the resident/RR if the facility's smoking policy was not followed then the resident could potentially be discharged . Staff B stated they did not discuss with the resident how they could safely/properly dispose of their cigarette to smoke independently. Staff B stated that even though Resident 4 was admitted prior to the 05/05/2025 implementation of the facility's non-smoking policy they never indicated they wanted to smoke. During an interview on 09/08/2025 at 11:52 AM, Staff D, LPN/RCM, stated the resident had been utilizing their motorized wheelchair to travel outside since June 2025. Staff D stated they assessed the residents smoking evaluation along with the DNS on 08/25/2025. Staff D stated the resident was outside, off of the facility's property and the staff asked the resident to demonstrate how they would dispose of the cigarette ashes, so the resident demonstrated, right where everyone was at (off of the property, not by rocks), but would normally dispose of them in a rocky area. Staff D stated Resident 4 was cognitively intact and knew the rocky area was correct which showed they were aware of the potential for fire hazard, even so, it was improperly disposed of at that time. Staff D stated the resident would not be able to pick up a cigarette if it were dropped, but the resident did have a grabber (a device used to pick up items that are out of a person's reach), that even though the resident did not have on them at the time that would assist the resident in independently smoking. Staff D stated they remembered talking with Resident 4 about getting a little receptacle for (Resident 4's) wheelchair to put cigarette butts in. Staff D stated the resident was safe as long as they disposed of the ashes in the proper place. During an interview on 09/08/2025 at 2:35 PM, Staff C, Regional Clinical Director, stated the facility did not have documentation that all the facility residents or their RRs were informed about the non-smoking policy implementation nor was the smoking policy included in the admission paperwork given to residents. Staff C stated that Resident 4 should have been reassessed for safe smoking independently after they were receptive to the feedback/education provided by staff. Staff C stated the resident could have utilized their grabber to assist in independently smoking as safely as possible. Reference: WAC 388-97-0180(4)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to protect the personal privacy for 2 of 4 residents (Residents 34, 72) observed for incontinent brief change and blood glucose checksˆ(a blood test that measures the level of glucose (sugar) in the blood, the test can involve a finger prick, a nurse collects a drop of blood, the test involves a test strip and glucometer (glucose meter) with results in seconds).ˆˆThis failure placed the residents at risk for loss of the right to personal privacy.ˆ ˆ Findings included . Record review of the facility policy, Resident Rights Privacy and Confidentiality, dated 07/2018 showed each resident had the right to privacy during personal care and medical treatments.ˆ Resident 34 Review of a comprehensive assessment, dated 05/22/2025, showed Resident 34 had severe cognitive impairment, dementia (a loss of mental ability severe enough to interfere with normal activities of daily living) and an anxiety disorder (the mind and body's reaction to stressful, dangerous, or unfamiliar situations). Resident 34 was dependent on staff for their activities of daily living (ADL) that included personal hygiene and dressing. On 09/02/2025 at 11:03 AM, Resident 34 received an incontinent brief change from Staff F, Nursing Assistant (NA), in their bedroom. Staff F undressed, cleaned and dressed the lower half of the resident's body without pulling the privacy curtain around the bed. Resident 34's bed was positioned closest to the door, and their roommate was in bed by the window. The room door was closed. There were privacy curtains that hung from ceiling tracks for both beds, neither curtain was drawn to protect the view of the resident's body from Resident 34's roommate to the room entrance, in the event that someone entered the room. On 09/08/2025 at 1:05 PM, Resident 34 received an incontinent brief change from Staff J, NA and Staff K, NA. The resident's privacy curtains were not drawn to provide the resident privacy from anyone entering the room or from their roommate. On 09/09/2025 at 10:45 AM, Staff P, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated they expected staff to provide privacy during incontinent care. Staff P stated, The door should be closed. The privacy curtain dawn around the bed and if there were a roommate, the curtain should be closed to prevent view from the roommate. Resident 72 Review of a comprehensive assessment dated [DATE], showed Resident 72 had severe cognitive impairment, dementia and diabetes mellitus (a metabolic disorder in which the body has high sugar levels for prolonged periods of time). Record review of an 08/01/2025 physician's order showed an order to check Resident 72's capillary blood glucose (CBG) with a glucometer before meals and at bedtime. On 09/02/2025 at 12:15 PM, Resident 72 was eating their lunch in the dining room with other residents and Staff L, Licensed Practical Nurse (LPN), came in and knelt next to Resident 72 with a glucometer. Staff L stated I need to check your blood sugar to Resident 72 and the resident held out (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their right index finger. The nurse pricked the resident's finger and placed a drop of blood on the glucometer test strip and read the result. Resident 72 then returned to eating lunch. On 09/04/2025 at 8:44 AM, Staff N, LPN, stated Resident 72 was the only resident on the unit that required CBG checks, and when asked where they would perform the task, Staff N stated, out here in lobby or their room.^ On 09/04/2025 at 11:56 AM, Resident 72 was asleep in a chair in the lobby across from the nurse's station. Staff N pulled up a chair next to the resident and asked Resident 72 if they could check their blood sugar. Resident 72 gave a verbal ok and Staff N performed the CBG check in the common area without providing the resident privacy. On 09/08/2025 at 1:22 PM, Staff O, LPN stated Resident 72 refused their CBG check when approached in the dining room at lunch. Staff O stated [Resident 72] let me do it this morning when they were still in bed. On 09/09/2025 at 10:45 AM, Staff P, stated resident BCG checks should be done in the resident's rooms for privacy. On 09/09/2025 at 11:13 AM, Staff B, Director of Nursing Services, stated the resident's privacy should be protected during incontinent care by completely closing the privacy curtain around the resident's bed. Staff B stated treatments and procedures should not be done by staff in common areas but within the resident's room. Reference: WAC 388-97-0360(b)(d) This is a repeat citation from the Statement of Deficiencies dated 10/29/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to monitor person-centered behaviors and obtain informed consent when they received psychotropic medications (medications capable of affecting the mind, emotions, and behavior) for 2 of 5 residents (Residents 9 and 27) reviewed for unnecessary medications. This failed practice placed residents at an increased risk of receiving medications they did not want or they no longer needed and inadequate dosing of medications. Finding included . Resident 9 Review of Resident 9's medical records showed they admitted on [DATE] with multiple mental health diagnoses to include violent behaviors, hallucinations (false perception of objects or events involving your senses that seem real, but they are not), depression (a persistent feeling of sadness and loss of interest in activities that were once enjoyable), and anxiety (a feeling of worry, nervousness, or unease, typically about an imminent event or something with an uncertain outcome). The 06/10/2025 comprehensive assessment showed Resident 9's cognition was moderately impaired and received psychotropic medications. Review of Resident 9's 07/03/2025 Care Plan (CP), showed a mood and behavior CP with interventions on 11/18/2024 to monitor episodes of behaviors, determine the underlying cause, and then document in the resident's record. The CP showed target behaviors would be monitored every shift. The CP additionally showed a 03/29/2023 Behavior Monitor focus that contained interventions initiated 09/06/2022 for system listed behavior monitoring and on 11/18/2024 Resident specific [person-centered] behavior monitoring dated 11/18/2024. Review of Resident 9's July through August 2025 Medication Administration Record (MAR), showed they received an order dated 01/02/2025 for Sertraline (a brand of medication used to treat depression) and an order on 03/07/2025 for Olanzapine (a brand of medication used to treat hallucinations). The July, August, and September 2025 MAR showed no person-centered behaviors were being monitored. Review of Resident 9's consents for psychotropic medications (education that provides the risks and the benefits of the medication, giving the resident an opportunity to consent or decline receiving the medication based off of that information) showed no consent was obtained for the Sertraline medication. During an interview on 09/08/2025 at 3:54 PM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM) stated they participated in monthly psychotropic meetings to discuss whether medications were appropriate for a resident to continue taking or whether they were appropriate for a reduction/discontinuation of the medication. Staff D stated they would review the resident's behaviors and talk with staff to determine what was appropriate. Staff D stated they did not see person-centered behavior monitoring for Resident 9 and did not know why. During an interview on 09/08/2025 at 1:05 PM, Staff B, Director of Nursing Services (DNS), stated they could not find that a consent had been obtained for Resident 9's Sertraline medication and would have expected one to be done prior to the start of the medication. Resident 27 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 27's medical records showed the resident was originally admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a complex mental health disorder that includes symptoms of hallucinations and delusions [false beliefs, not based in reality] along with mood disorders, such as depression and abnormally elevated/extreme changes your mood or emotions), anxiety, depression and drug induced tremors (a specific symptom that can occur from taking antipsychotic medications [a drug used to treat hallucinations and/or delusions] and is characterized by involuntary shaking of the hands, arms, head or eyelids). The medical record showed the resident was receiving behavior health services (a program that provides intensive behavioral and medical support). The 07/17/2025 comprehensive assessment showed the resident had moderate cognitive impairments but was able to make their needs known. Review of Resident 27's physician's orders showed monitoring for adverse side effects (undesirable or harmful response to a medication) of their psychotropic medications but did not include monitoring of the resident's behaviors for the effectiveness of the medications. Review of Resident 27's September 2025 MAR, showed Resident 27 was being administered Risperidone, Perphenazine and Fluoxetine (all specific types of psychotropic medication) for their schizoaffective disorder/ depression and all were started on 08/01/2025. The September 2025 MAR did not include monitoring for individualized resident-centered behaviors related to their schizoaffective disorder and/or depression diagnoses, to see if the medication was effective or not. Review of Resident 27's CP, July 2025 to September 2025, showed they had a mood and behavior CP related to the resident's schizoaffective disorder, depression and anxiety. The CP showed/listed targeted behaviors (also known as specific individualized, resident-centered behaviors) and they were to be monitored every shift. During an interview on 09/09/2025 at 11:15 AM, Staff D, LPN/RCM, stated that residents on psychotropic medications had individualized resident-centered behaviors that were monitored. Staff D stated that monitoring of behaviors was completed on a resident's MAR and some residents had general system selected and other resident's had resident-centered behaviors. Staff D stated they did not see that Resident 27's had orders in place for behavior monitoring nor were they noted on the resident's MAR. Staff D stated that Resident 27s general system selected behavior monitoring dropped off the resident's orders/MAR during their last hospitalization and that it was not restarted when the resident readmitted on [DATE]. During a continued interview on 09/09/2025 at 11:37 AM, Staff D confirmed that Resident 27's individualized resident-centered behaviors were not being monitored. During an interview on 09/09/2025 at 1:00 PM, Staff B, DNS, stated the facility had, in general, system selected behavior monitoring for all residents. Staff B stated that residents, like Resident 27, which had behavioral health services and were on psychotropic medications were to have monitoring and documentation on the resident-centered individualized behaviors. Staff B stated the correct process was not being followed regarding the monitoring of Resident 27's individualized resident-centered behaviors. Reference: WAC 388-97-1060(3)(k)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review, the facility failed to follow up on written notices of bed holds, (holding or reserving a resident's bed while the resident was absent from the facility) with resident and/or resident representatives (RR), given at the time of hospital transfers for 2 of 2 residents (Residents 27 and 82) reviewed for the discharge process. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed, any monetary charges associated with the bed hold while in the hospital and disallowed the resident and/or their representative an opportunity to fully understand the rationale/resident rights associated with the discharge. Finding included .Review of the facility's policy titled, Notice of Bed Hold Policy Before/Upon Transfer, revised November 2018, showed the facility would provide written information to the resident or RR on the bed hold policy, the reserve bed payment policy, policies regarding bed hold duration periods and information related to the resident's ability to return to the facility. The policy showed the information would be provided before a transfer or at the time of transfer of the resident to the hospital or within 24 hours if the transfer was an emergency. Review of the undated facility's guidelines titled, Hospital Transfer Packet, showed that copies of the bed hold policy, authorization to reserve a room/bed, and the notification of transfer were in a packet that was to be sent with the resident to the hospital. The guidelines stated that if the resident was unable to comprehend the information, then the RR should be notified. Facility staff were to make a progress note about the bed hold policy being reviewed with the resident or the RR and if unable to review, the progress note would show that the bed hold policy form was sent with the resident to the hospital and staff would be following up with resident/RR with 24 hours. Resident 27 Review of the medical record showed the resident was re-admitted to the facility on [DATE] with diagnoses including diabetes (a disease that affects how the body uses blood sugar), anxiety, depression and other mental/behavioral health disorders. The 07/17/2025 comprehensive assessment showed the resident had moderate cognitive impairments but was able to make their needs known. Review of the resident's progress note showed that on 07/17/2025 at 11:44 AM, nursing staff had received abnormal laboratory results, communicated with the facility's provider/resident and the resident was transported via ambulance to the hospital where they were admitted . The progress note showed the .hospital paperwork . was given to the paramedics. The documentation showed no written bed hold information was provided to the resident or their RR before/at the time of the resident's transfer to the hospital. During an interview on 09/08/2025 at 9:34 AM, Staff D, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated that the bed hold policy, included in a hospital packet, was provided to the resident/RR when transferring out to the hospital and the documentation would be in a progress note. Staff D reviewed Resident 27's progress notes and stated they did not see the resident or the RR were informed of the bed hold policy when the resident was transported to the hospital on [DATE]. Resident 82 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a comprehensive assessment dated [DATE] showed Resident 82 had severe cognitive impairment, stroke (when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients) and dementia (a loss of mental ability severe enough to interfere with normal activities of daily living). Resident 82 was dependent on staff to meet their physical and cognitive needs. Review of a 07/19/2025 at 12:56 PM nursing progress note showed Resident 82 had a significant change in their condition and was transported to the hospital by ambulance and admitted . Review of the documentation in the resident's medical record showed no written notification that the resident or their representative received a bed hold notice. On 09/08/2025 at 2:43 PM, Staff Q, Social Services Director, stated their department was no longer part of the bed hold process and believed that now medical records handled the process. On 09/08/2025 at 2:56 PM, Staff R, Medical Records, stated they were aware residents were given a packet with the bed hold policy by the nurse sending them to the hospital. The nurse was to write a progress note that the bed hold policy was provided. On 09/09/2025 at 11:13 AM, Staff B, Director of Nursing Services, stated there was a break in system we will be improving the process. Reference: WAC 388-97-0120(3)(c)(4)(a)(b)(c) This is a repeat citation from the Statement of Deficiencies dated 10/29/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the safety and supervision of 1 of 3 residents (Resident 61) reviewed for accident risks. The facility's failure to implement their missing resident protocol when Resident 61 did not return from an outing with family at their indicated time put the resident's health and safety at risk. Findings included.Review of an undated facility policy titled, Actions for Suspected Resident Elopement/Missing Resident, showed when a resident had signed out and not returned to the facility at the indicated time, they were considered a missing resident. The protocol required the charge nurse to immediately make several telephone calls to locate the missing resident as follows: 1) Call the resident's contact phone number provided by the responsible person at sign out, 2) Call the Administrator and Director of Nursing Services (DNS) if unable to make direct verbal contact with the resident, 3) Call 911 (emergency services) and request a well-check at the resident's last known location, and 4) Call hospitals to identify if the resident was present. Resident 61 Review of a comprehensive assessment dated [DATE] showed that Resident 61 had impaired memory, depression, a chronic inflammatory lung disease that causes obstructed airflow from the lungs, and they required substantial assistance from staff for most activities of daily living and transfers. Record review of Resident 61's sign in/sign out sheet showed the following information at the top of the form for the person signing the resident out of the facility: 1) I acknowledge and accept responsibility for the safety and care of the Resident while away from the facility. 2) All residents on an outing must return to the facility by the expected time of return. If the resident had not returned by the expected time and cannot be reached by phone, the facility staff will notify police and implement the missing resident protocol. The last line on the sign out sheet showed the resident left with family on 09/03/2025 at 9:45 AM with an expected time of return at 8:00 PM. On 09/04/2025 at 2:00 PM during the facility annual recertification state survey, Staff A, Administrator, was asked about a missing resident incident that had been reported to the state hotline. Staff A stated that there was a missing resident who was signed out by family the previous morning. They stated Resident 61's failure to return to the facility was noted by staff at change of shift (evenings to nights). Staff A stated they were made aware of the missing resident last night shortly after 2:00 AM. The resident had not yet been contacted; however, Resident 61 had a history of leaving Against Medical Advice (AMA) on a previous admission. The police and their staff were currently working on locating Resident 61. Review of the facility investigation dated 09/04/2025 showed the following events: -On 09/03/2025 at 6:16 PM, Staff S, Registered Nurse (RN), was informed by the day shift nurse that Resident 61 was out with family. -On 09/03/2025 at 10:30 PM, Staff T, LPN, was informed by Staff S that Resident 61 had not returned from their outing with family. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 09/03/2025 at 11:29 PM, Staff T texted Staff B, DNS, that Resident 61 had not returned to the facility (3.5 hours after their return time). -On 09/04/2025 at 2:08 AM, Staff B read the text from Staff T, called the facility and learned Resident 61 was still out. Staff B implemented the missing resident protocol and called 911 at 2:34 AM (6.5 hours past their return time). During an interview on 09/04/2025 at 4:55 PM, Staff B, stated that Resident 61 was located at the residence of a friend. Staff B stated they found Resident 61 at 3:45 PM in their wheelchair, watching television with a friend and stated they were fine and would not be returning to the facility. Staff B stated they had emergency services come to the house to assess the resident, the resident signed AMA paperwork. Supports were put in place such as medication, follow up physician appointment and a referral for home health. Staff B stated the facility staff failed to follow the missing resident protocol that delayed ensuring the safety of Resident 61. On 09/09/2025 at 11:24 AM, Staff B stated they completed the investigation on Resident 61. Staff B stated, our system did not work, the staff did not follow the policy for a missing resident, there were delays in reporting to administration and the staff should have telephone called me and Staff A, not leave a text. Reference: WAC 388-97-1060(3)(g) This is a repeat citation from the Statement of Deficiencies dated 10/29/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to consistently implement interventions for 1 of 2 residents (Resident 9) reviewed for nutrition. This failure placed the resident at risk for continued significant weight loss and the loss of nutritional satisfaction. Findings included.Resident 9 Review of Resident 9's medical records showed they admitted with diagnoses to include dementia (a loss of thinking, remembering, and reasoning skills), malnutrition (inadequate intake of protein and/or energy over prolonged periods of time resulting in loss of fat stores and/or muscle wasting) and most recently, neck and tonsil cancer (06/06/2025, a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body). The 06/10/2025 comprehensive assessment showed Resident 9's cognition was moderately impaired, was independent for eating, complained of difficulty or pain with swallowing, and had no issues with weight loss. Additional review of Resident 9's medical records showed the resident had received weekly chemotherapy (a drug treatment used to kill cancer cells or stop them from growing) and daily radiation (a method using high powered energy beams to kill cancer cells) treatment for their neck and tonsil cancer at a local cancer center. During an interview and concurrent observation on 09/03/2025 at 8:32 AM, Resident 9 was observed sitting in their wheelchair (w/c) at their bedside table with their breakfast tray in front of them, their neck and lower part of their face was bright red. Resident 9 had scrambled eggs, crumbled sausage, dry cereal, canned pears in a bowl, a container of yogurt, and to drink they had a glass of milk, orange juice, and a cup of coffee. Resident 9 stated they tried to eat but it was painful to swallow. Resident 9 stated it was easy to get down the water and the coffee, but it was difficult to drink the milk. During an interview on 09/04/2025 at 9:21 AM, Resident 9 was lying in their bed and stated they were unable to eat any of their breakfast again today. The resident stated they were able to drink the milk today but nothing else. Resident 9 stated the staff did not offer them an alternative to not eating breakfast and stated their swallowing was a little better today but not good enough to eat. During an interview and concurrent observation on 09/04/2025 at 11:58 AM, Resident 9 was sitting in their w/c in front of their bedside table. Resident 9 had a five out of a ten pain level to their throat (on a numerical scale with zero being no pain at all and 10 being the most excruciating pain ever felt) and was able to drink the milk but nothing else. Resident 9 had soft noodles with some grounded up brown meat and soft vegetables on their tray, untouched. Resident 9 stated the staff had not offered them an alternative nor did they ask them what they would be able to eat or if they wanted something else to eat. During an interview and concurrent observation on 09/05/2025 at 12:18 PM, Resident 9 was sitting in their w/c at the bedside table with their meal tray placed on the nightstand beside their television. Resident 9 stated they could not eat because it was too painful to swallow, but that they were hungry. Resident 9 stated they received a medication that they would swallow, and it would offer them pain relief for a short time but then their throat would go back to being painful. Resident 9 stated no staff had discussed their weight loss, diet, or meal refusals with them to determine a different plan. Review of Resident 9's weight tasks from 08/05/2025 through 09/05/2025 showed on 08/05/2025 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident weighed 212.5 pounds (lb., a unit of measurement) and on 09/05/2025 they weighed 185.5 lbs. The weight tasks showed Resident 9 had a 12.71 percent weight loss (27 lbs.) in the past 30 days which was a significant weight loss. During an interview on 09/05/2025 at 12:29 PM, Staff V, Nursing Assistant, stated that when a resident did not eat the meal served, they should be offered the alternative meal. Staff V stated if the resident did not want the alternative meal either, they had other options they could offer for example a sandwich, or yogurt. Staff V stated they were unaware Resident 9 had not been eating. During an interview on 09/05/2025 at 12:40 PM, Staff W, Registered Dietician (RD), stated they would obtain a generated report, once a month, that showed which residents had weight loss/gain. Staff W stated they attended nutritional meetings once a week and notes were completed by the Unit Managers during those meetings. Staff W stated they had not reviewed Resident 9 themselves in the past two weeks but had discussed Resident 9 at the nutrition meeting earlier that day (09/05/2025). Staff W stated the resident had experienced some increased pain and did not alert the staff to that, so they only received their pain medication as needed, and it had been changed to more of a routine schedule. Staff W stated they had discussed a plan with the RD outside cancer provider, and they had given some recommendations to help with Resident 9's weight loss that they had implemented. Staff W stated one of the interventions was a high calorie supplement that was being supplied by the cancer center and nutritionally enhanced meals. Review of the RD from the cancer provider notes on 08/11/2025 showed the resident was a potential risk for significant weight loss but had not yet met the criteria. The note showed the resident should avoid spicy/acidic foods, eat small amounts at a time, eat lukewarm or room temperature foods rather than very hot or very cold foods, and suggested adding gravy or sauce to their foods for extra moisture. The note showed the resident was educated on good oral hygiene with frequent brushing and rinsing as they could tolerate it and their weight was 209 lb. Additionally, review of a note on 08/25/2025 showed the resident's weight had dropped to 192 lb. (a loss of 17 lbs since prior weight) and had severe calorie malnutrition. The note showed the same interventions that were listed on the 08/11/2025 visit. The note also showed a call was made to Staff W and it was discussed that Staff W would ensure Resident 9 would be started on nutritionally enhanced meals, snacks offered between meals, and Staff W would review downgrading the resident from a mechanical soft diet to a pureed diet as needed. During an interview on 09/09/2025 at 8:50 AM, Staff Y, Dining Services Director, stated nutritionally enhanced meals (NEM) meant a resident required extra protein and calories so staff would add extra protein portions, mighty shakes, magic cups, or super cereal (all NEM supplements) to the resident's diet. Staff Y stated if a resident required extra protein or calories, it would be reflected on the bottom of their diet slip. Review of Resident 9's 09/08/2025 diet slip showed the resident would receive orange juice (an acidic juice) and at the bottom of the diet slip the resident would receive salt and pepper and citrus fruit. The diet slip showed no NEM, extra snacks, no acidic or spicy foods, to add gravy/sauces as needed, or to offer lukewarm or room temperature foods as needed (11 days after the call with the outside RD). Review of Resident 9's 07/03/2025 Nutritional care plan showed no nutritional interventions had been added to the care plan or updated since 07/03/2025 nor had the texture of the diet been assessed or changed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 9's meal monitoring from 08/10/2025 through lunch on 09/08/2025, a total of 89 meal opportunities, showed Resident 9 ate less than 25 percent of their meals 28 times, less than 50 percent of their meals 9 times, 75-100 percent of their meals 33 times, 5 meals not documented, and 14 meals the resident refused or was not available. Review of nutrition meeting notes showed on 08/06/2025, resident was stable, and weight was 212.5 lbs. A note on 08/25/2025 (19 days from previous assessment) showed there was a conversation with the dietician at the cancer center and Resident 9's intake had decreased due to their swallowing difficulties and that a nutritional supplement would be offered in between meals. A note on 09/05/2025 (11 days after previous note) showed Resident 9 was on a very high calorie boost drink from the cancer center, was eating more over the past week and to obtain a re-weigh. The notes showed no other interventions. During an interview on 09/08/2025 at 3:54 PM, Staff D, Licensed Practical Nurse/Resident Care Manager, stated they reviewed residents with weight loss/gain weekly and they would document in the nutrition notes. Staff D stated they were currently offering Resident 9 high calorie boost shakes supplied by the cancer center and ensured a snack went with them on their treatment days. Staff D stated they had not discussed intake alternatives with Resident 9, if they should continue to lose weight. Staff D stated they had not requested, nor had they seen the dietician notes from the previous cancer treatment appointments. During an interview on 09/09/2025 at 2:44 PM, Staff B, Director of Nursing Services, stated when a resident would go out of the facility for an appointment, they were sent with a post visit order slip that they should return with for any new orders. The RCM would then process the orders, and then medical records should have requested the visit notes from the providers for the RCMs to review. Reference: WAC 388-97-1060(3)(h) This is a repeat citation from the Statement of Deficiencies dated 10/29/2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 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. Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents (Resident 9) were free of unnecessary drugs due to lack of monitoring and care planning of high-risk cancer (a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body) medication. This failed practice placed the resident at risk of adverse side effects and unmet care/personal needs.Findings included.Review of Lippincott Nursing Procedures 8th edition, dated 2019, titled Chemotherapeutic [a drug that kills cancer cells] Drug Administration, Special considerations, showed for 48 hours after receiving a chemotherapy drug, the resident's feces and urine would be contaminated and required special handling for washing clothes and linens and feces and urine, and hand washing would be completed often. The guidelines showed healthcare workers who were pregnant, were trying to become pregnant, or breast-feeding should not be exposed to chemotherapy drugs. The guidelines showed adverse side effects (ASE) were unique to the medication being administered so monitoring needed to be specific. Resident 9 Review of Resident 9's medical records showed they admitted with diagnoses to include dementia (a loss of thinking, remembering, and reasoning skills) and cancer of the neck and tonsil (06/06/2025). The 06/10/2025 comprehensive assessment showed Resident 9's cognition was moderately impaired and had pain or difficulty with swallowing. During an interview and observation on 09/04/2025 at 9:21 AM, Resident 9 was lying in bed, their lower part of their face/skin from below the eyes down to the beginning of the chest was bright red. Resident 9 stated they had pain to the areas that were red and difficulty eating due to their chemotherapy and radiation (a method using high powered energy beams to kill cancer cells) treatments. On the entrance of Resident 9's door was a sign for Neutropenic [decreased white blood cells that help to fight off infections] precautions, which directions were to wear a mask if sick, if you are visiting, check with the nurse first, and no plants or flowers. The sign showed no precautions for the chemotherapy treatment. Review of Resident 9's cancer treatment notes on 07/08/2025 showed Resident 9 would start weekly treatment of Cisplatin (a brand of chemotherapy medication) plus XRT (radiation treatment) was to begin on or around 07/21/2025. During an interview on 09/04/2025 at 9:27 AM, Staff GG, Certified Medication Assistant, stated they were responsible for monitoring Resident 9. Staff GG stated they monitored Resident 9 for pain and if they had pain, they would notify the nurse. Staff GG stated there was no other monitoring being completed that was specific to the chemotherapy and/or the radiation treatment they received. Staff GG stated there was a commode in Resident 9's room and the precautions they were monitored for were posted on the door. An observation on 09/04/2025 at 11:58 AM, showed Resident 9 used the commode in the corner of their room, to the left of the big picture window. Resident 9 did not use toilet paper or complete hand hygiene after using the commode and sat back at their table to continue their lunch. Review of Resident 9's September 2025 Medication Administration Record showed no monitoring for ASEs for the chemotherapy medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/09/2025 at 1:49 PM, Staff HH, Licensed Practical Nurse, stated they monitored Resident 9 for infection and neutropenia. Staff HH stated they did not know what chemotherapy medication Resident 9 received nor the specific precautions for the chemotherapy medication. Review of Resident 9's 07/03/2025 care plan (CP) showed no resident specific CP had been created for the use or monitoring of cisplatin. The CP showed no handling of linens/urine/feces/clothing after treatment, or the use of the bedside commode. The CP showed no special staff restrictions for pregnancy, possible pregnancy, or breast feeding. The CP showed no contact information for staff to contact if issues from the chemotherapy should arise. During an interview on 09/08/2025 at 4:25 PM, Staff D, Licensed Practical Nurse/Resident Care Manager, stated Resident 9 had chemotherapy treatment weekly and radiation treatment daily. Staff D stated they had developed a cancer treatment care plan but was not specific to the resident, the medication they received, nor did the care plan show who to contact in case there were issues or an emergency related to their cancer treatment. Reference: WAC 388-97-1060 (3)(k)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective pest control program ensuring that flies (an insect that can develop/breed in various environments, rapidly reproduce and known for spreading diseases) were not entering/gathering in hallways and resident rooms for 1 of 4 Hallways (Hall 3 [H3, 300's rooms]) reviewed for environment. This failure placed the resident at risk of infection, infestation (the state of being overrun by pests) and unmet care needs. Findings included .Review of the facility's policy titled, Physical Environment Safe, Functional, Sanitary Environment, dated July 2018, showed the facility would maintain an effective pest control program (measures to eliminate and contain common household pest like roaches, ants and flies) to control pests and rodents.Resident 12 Review of the medical record showed the resident was admitted on [DATE] with diagnoses including kidney complications, history of a stroke with dysarthria (speech disorder that occurs when the muscles used for speech are weak or difficult to control, leads to slurred or slow speech that can be hard to understand), and multiple wounds that required daily dressing changes. The 08/11/2025 comprehensive assessment showed the resident had some cognitive impairment but was able to make their needs known. During a concurrent observation and interview on 09/04/2025 at 8:09 AM, showed on H3, Resident 12 was lying in their bed. Multiple flies were observed buzzing around the resident's face and bed. The flies would land on the resident's beard/mustache, lips, head, arms, bedsheets near the resident's legs and on the bedside table. The resident communicated with the surveyor in writing and stated the flies had been in their room since they were admitted on [DATE].During a concurrent observation and interview on 09/04/2025 at 4:01 PM, showed on H3, Staff L, Licensed Practical Nurse (LPN), Resident 12's room for a wound care dressing change. Two flies were observed buzzing around the resident's face and mouth, and Staff L was waving their hand to get the flies away from the resident. During the dressing change Staff L stated, ah fly! (swatting at the fly in the air). Staff L stated they had been seeing more of the flies in the past month.During an interview on 09/09/2025 at 8:42 AM, Staff E, Maintenance Assistant, stated the facility had flies that started coming into the facility around the middle of June 2025 like every year. Staff E stated the flies would come into the facility when staff would leave open the outer door to the parking lot, where the garbage cans were at, because that was where all the supplies brought into the facility would come through and was located across from H3. Staff E stated they had placed two fly control devices up in the facility two weeks ago, because the one by the main entrance was broken. Staff E stated that three more of the fly control devices went up after the surveyors had entered the facility on H1/H2/H3, and then Staff E added two more outside the two main outer doors that went to the facility's parking lot. Staff E stated they should have started putting up more fly control devices up in the facility in June 2025 and it would have been more effective in controlling the number of flies in the facility.During an interview on 09/09/2025 at 1:00 PM, Staff A, Administrator, stated they had noticed the increased number of flies in the facility and had been looking into the facility pest control company, but they were unable to do anything. Staff A stated they started putting up fly control devices within the last week, due to the increase of the flies in the building.Reference: WAC 388-97-3360(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the nursing staff posting was posted daily and/or reflected the actual nursing staff hours worked during 3 of 3 days of the survey period. This failed practice prevented residents, family members, and visitors from knowing the facility's actual number of available nursing staff. Findings included .During an observation on 09/05/2025 at 10:30 AM, there were no nursing staff postings within the facility available for the residents/resident representatives, staff or visitors to view the actual staff available to provide resident care. During an observation on 09/08/2025 at 1:36 PM, the facility had no nursing staff postings viewable for residents, family or visitors to show actual available staff to provide resident care. The nursing staff posting was found within a binder along with the nursing staff assignments for the day. The nursing staff posting did not reflect any staffing changes. During an observation on 09/09/2025 at 2:38 PM, a nursing staff posting was hanging up in the nursing station, not viewable to residents and visitors. The nursing staff posting did not reflect any staffing changes. In an interview on 09/09/2025 at 2:41 PM, Staff H, Staffing Coordinator, stated they had a binder for the nursing staff postings, and the binder also contained nursing staff assignments for the current day. Staff H stated they were new to their position and were not aware that the nursing staff posting needed to be available for residents, family, and visitors to view current staffing available for resident care. In an interview on 09/09/2025 at 3:01 PM, Staff B, Director of Nursing Services, and Staff A, Administrator, acknowledged that the nursing staff posting had not been readily available for residents, family, or visitors to view the current nursing staff available for resident care. Reference: WAC 388-97-0020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505010	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden Village	206 South Tenth Avenue Yakima, WA 98902

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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to ensure the facility assessment (a required document describing resident population, acuity, and needs to determine staff and other resources necessary to completely care for residents) was updated to include and consider specific staffing needs for each resident unit/each shift and plans to maximize direct care staff recruitment and retention. This failure placed the residents at risk for unmet care needs.ˆ Findings included . A review of the Facility Assessment, dated August 2025 did not show documentation of residents' acuity or specific staffing needs (resources) for each resident unit in the facility and staffing needs for each shift. It showed they did not have documentation on how the facility would develop and maintain plan to maximize recruitment and retention of direct care staff. In an interview and record review on 09/04/2025 at 1:40 PM, Staff A, Administrator, stated they reviewed the Facility Assessment annually and as needed, and that they expected it to be completed as required. Staff A stated the facility assessment had not specifically included the correct staffing needs based on the overall resident acuity, and population needs of the facility. Reference: WAC 388-97-1620(2)(b)(i)(ii)