STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the appropriate transfer notifications for 7 of 7 residents (Residents 1, 5, 11, 8, 23, 4, & 105) reviewed for hospitalization. The failure to offer bed holds (Residents 1, 5, 11, 8, 23, & 4), provide a written transfer notice (Residents 1, 5, 11, 8, 23, 4, & 105), and notify the State Long Term Care Ombudsman (LTCO) timely of resident discharges (Residents 1, 8 & 23) placed residents at risk for a disruption in their continuity of care, an undesired room change upon readmission, and not having the opportunity to make informed decisions about their transfer/discharge rights, and inappropriate transfers.Findings included .<Policy>According to a facility policy titled Bed Hold, dated 05/2025, the facility would inform the resident or the resident's representative of a bed hold within 24 hours of being transferred.According to a facility policy titled Transfer and Discharge, dated 05/2025, the facility would provide the resident or resident representative with the name, address, and telephone number of the state health department agency designated to handle appeals of transfers and discharges. The policy states the facility would send a copy of the notice to the LTCO, document the transfer in the resident's medical record and communicate appropriate information to the receiving care institution.<Resident 1> According to the 11/12/2025 Discharge Return Anticipated Minimum Data Set (MDS- an assessment tool), Resident 1 discharged to the hospital on [DATE] related to a change in the resident's condition. The MDS showed Resident 1 had medical conditions including bladder infection and lower back pain. Record reviews showed no documentation facility staff offered bed hold to the resident and provided Resident 1 or their representative with a written notification of the reason for transfer to the hospital as required. In an interview on 12/12/2025 at 12:02 PM, Staff F (Resident Care Manager/RCM) stated they notify the resident's family about transferring residents to the hospital and send the hospital transfer form (e-INTERACT) to the hospital with residents. Staff F stated nursing staff were responsible to offer bed hold to residents/representatives during transfers/hospitalizations, nursing staff were responsible to provide written discharge notice to residents and/ or their representatives and social services were responsible to notify the LTCO during residents' hospitalizations. In an interview on 12/15/2025 at 12:47 PM, Staff B (Director of Nursing/DON) stated nursing staff were responsible to offer bed hold and to provide written discharge notice to residents/their representative during hospitalizations. Staff B reviewed Resident 1's record and stated they did not offer bed hold to the resident and did not provide discharge notice to the resident during hospitalizations. Staff B stated the facility should have offered bed hold and provided the written discharge notice to Resident 1, but they did not. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 5> According to the 10/01/2025 Discharge Return Anticipated MDS, Resident 5 was discharged to the hospital on [DATE] related to deficiency of red blood cells and change in mental status. Record reviews showed no documentation facility sent e-INTERACT to the hospital with Resident 5, no documentation showed staff offered bed hold to the resident and provided Resident 5 or their representative a written notification of the reason for transfer to the hospital as required. In an interview on 12/15/2025 at 10:12 AM, Staff E (RCM) stated their expectations from staff were to prepare all the paperwork to send with residents during transfers to the hospital including face sheet, physician orders, complete e-INTERACT. Staff E reviewed Resident 5's record and stated nursing staff should send complete e-INTERACT, offer bed hold to Resident 5/their representative, and provide written discharge notice to Resident 5/their representative, but they did not. <Resident 11> According to the 07/21/2025 Discharge Return Anticipated MDS, Resident 11 was discharged to the hospital on [DATE] related to multiple medical conditions including dialysis and leg fracture. Review of Resident 11's record showed no documentation facility sent the e-INTERACT with Resident 11 to give report to the hospital, no documentation showed staff offered bed hold to the resident and did not provide Resident 11 or their representative with written notification of the reason for transfer to the hospital as required. In an interview on 12/15/2025 at 10:12 AM, Staff E reviewed Resident 11's record and stated nursing staff should send the completed e-INTERACT, offer bed hold to Resident 11/their representative, and provide written discharge notice to Resident 11/their representative, but they did not. In an interview on 12/15/2025 at 12:53 PM, Staff B stated nursing staff were responsible to offer bed hold and to provide written discharge notice to residents/their representative during hospitalizations. Staff B stated the facility should send a completed e-INTERACT with Resident 11 to the hospital, offer bed hold and provide the written discharge notice to Resident 11, but they did not. <Resident 8> According to the 11/10/2025 Quarterly MDS, Resident 8 had no memory impairment. The MDS showed Resident 8 had urinary obstructions with bilateral nephrostomy tubes (tubes inserted into both kidneys) and a urinary catheter (tube inserted into the bladder). Review of Resident 8's health records showed transfers to an acute care hospital on [DATE] with a return to the facility on [DATE], 05/23/2025 with a return to the facility on [DATE], 06/13/2025 with a return to the facility on [DATE], 07/13/2025 with a return to the facility on [DATE], 08/14/2025 with a return to the facility on [DATE], 08/15/2025 with a return to the facility on [DATE], 09/09/2025 with a return to the facility on [DATE], and 10/08/2025 with a return to the facility on [DATE]. Review of the 01/16/2025, 05/23/2025, 06/13/2025, 07/13/2025, 08/14/2025, 08/15/2025, 09/09/2025, and 10/08/2025 hospital transfers showed no report to receiving facilities, and no written transfer notifications being provided to Resident 8. Review of the 05/23/2025, 07/13/2025, 08/14/2025, 08/15/2025, and 10/08/2025 hospital transfers showed no bed holds (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	offered to Resident 8. The facility was unable to provide documentation of Resident 8's records being provided to the receiving hospital for the 01/16/2025, 05/23/2025, 06/13/2025, 07/13/2025, 08/14/2025, 08/15/2025, 09/09/2025, and 10/08/2025 hospital transfers. In an interview and record review on 12/15/2025 at 9:46 AM Staff D (Director of Social Services) reviewed LTCO hospital transfer notifications and stated the LTCO notifications were not being done until November 2025. Staff D stated LTCO should be notified monthly but was not for Resident 8's 01/16/2025, 05/23/2025, 06/13/2025, 07/13/2025, 08/14/2025, 08/15/202, and 09/09/2025 hospital transfers until November of 2025. <Resident 23> According to 06/05/2025 Discharge Return Anticipated MDS, Resident 23 was transferred to an acute care hospital. The MDS showed Resident 23 had severe memory impairment and a diagnosis of chronic respiratory disease. According to a 03/15/2019 Advanced Directive (AD- a document showing a person's wishes regarding medical treatment) Resident 23 had a Designated Power of Attorney (DPOA). According to Resident 23's health records, they transferred to an acute care hospital on [DATE] for respiratory failure and fever. Resident 23's records showed no report was provided to the receiving hospital, no bed hold was offered or written transfer notification provided to Resident 23's DPOA, and the LTCO was not notified of Resident 23's transfer until November 2025, five months later. In an interview and record review on 12/15/2025 at 9:46 AM Staff D stated the LTCO was not notified of Resident 23's transfer to the hospital until five months after the transfer in November of 2025. Staff D stated they should have notified the LTCO within a month of transfer but did not. <Resident 4> According to 11/12/2025 Annual MDS, Resident 4 had diagnoses of anxiety and depression with no memory impairment. According to a 08/26/2022 AD Resident 4 had a DPOA in place. According to a 12/03/2025 nursing progress note, Resident 4 was unresponsive with low blood oxygen levels and transferred to an acute care hospital on [DATE]. Resident 4's records showed no written transfer notification provided to Resident 4's DPOA, no bed hold was offered, and no report provided to the receiving hospital. In an interview on 12/16/2025 at 12:38 PM Staff E stated Resident 8 was not provided with a written transfer notification and staff did not provide a report to the receiving facilities but should have. Staff E stated Resident 8 was not offered a bed hold for the 05/23/2025, 07/13/2025, 08/14/2025, 08/15/2025, and 10/08/2025 transfers. Staff E stated Resident 8's record showed no indication of Resident 8's pertinent health records being (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided to the receiving hospitals for the 01/16/2025, 05/23/2025, 06/13/2025, 07/13/2025, 08/14/2025, 08/15/2025, 09/09/2025, and 10/08/2025 hospital transfers. Staff E stated Resident 23's records did not show the facility provided the receiving hospital a report, a bed hold was offered, or that a written transfer notification was provided to Resident 23's DPOA for the 06/05/2025 transfer but should. Staff E stated Resident 4's health record did not show a written transfer notification was provided to Resident 4's DPOA, a bed hold was offered, or staff provided a report to the receiving hospital but should. Staff E stated it was important to provide a written transfer notification to residents or their representatives at the time of transfer to ensure they were aware of their right to appeal and had written instructions explaining how to do that. Staff E stated it was important to offer a bed hold to residents transferring to the hospital to give them the opportunity to return to the same bed if they wished. Staff E stated it was important to provide copies of pertinent health documents to the receiving facilities and provide reports on the residents' condition for continuity of care. <Resident 105> According to a 11/24/2025 e-INTERACT, Resident 105 was transferred to the hospital. In an interview on 12/12/2025 at 9:52 AM, Resident 105 stated they had been recently hospitalized and did not receive a written transfer notice or information to establish a DPOA. In an interview and record review on 12/16/2025 at 12:15 PM, Staff B (DON) stated there was no documentation of the required written transfer notification being provided to Resident 105. Staff B stated they expected staff to provide the document to the resident and document in a resident's medical record. Refer to F578 Advance Directives. Reference: WAC 388-97-0120(1)(2)(a-d)(3)(a)(4)(b)(5), 0080, -0140(1)(a-c)(i-iii).

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to ensure residents and/or their representatives were informed of the nature and implications of entering into a binding Arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) Agreement (AA) for 3 of 3 residents (Residents 1, 33, & 101) reviewed for arbitration. The facility failed to ensure the arbitration agreement was signed and accepted by the residents and/or their Durable Power of Attorney (DPOA) for financial affairs as required. These failures placed residents at risk of lacking understanding of the legal document signed, forfeiture (loss or giving up of something) of their right to a jury or court trial, and a diminished quality of life. Findings included . <Resident 1>According to the 11/23/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 1 had intact memory, and was able to make decisions.Review of Resident 1's AA showed the contract was signed by the resident on 05/22/2025 but Resident 1 did not check the column indicating if they accepted or declined the AA contract.In an interview on 12/12/2025 at 10:54 AM, Resident 1 did not remember signing the AA contract and stated they did not know what the AA contract was for.<Resident 33>According to the 11/06/2025 Quarterly MDS Resident 33 had no memory impairment and was able to make their own decisions.Review of Resident 33's AA showed the contract was signed by the resident on 05/20/2025 and Resident 33 did not check the column indicating if they accepted or declined the AA contract.In an interview on 12/12/2025 at 11:02 AM, Resident 33 stated they did not know what the AA contract was for. Resident 33 stated they did not remember signing the AA contract. Resident 33 stated now they knew what the AA contract was for, they would not sign the AA contract.<Resident 101>According to the 10/27/2025 Quarterly MDS Resident 101 had severe memory impairment and was not capable of decision making.Review of Resident 101's AA showed the contract was not signed by the resident and/or their representative. Resident 101's AA contract was prepared on 05/06/2025 and indicated Resident 101 was unable to sign the agreement and did not check the column to show the resident and/or their representative accepted or declined the AA contract.In an interview on 12/12/2025 at 11:43 AM, Staff A (Administrator) stated they were responsible for the AA contract process. Staff A reviewed Resident 1, 33, and 101's AA contracts and confirmed the AA contracts were not complete. Staff A stated it was important to educate residents and/or their representatives of the AA process to ensure they understood what they were entering into. Staff A stated it was their responsibility to ensure residents and/or their representatives understood all the legalities incorporated into the binding AA contract before letting them sign. REFERENCE: WAC 388-97-1620(2)(a)(b)(i), -0180(1-4).

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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 observations, interviews and record reviews, the facility failed to provide care and services in a manner that maintained residents rights for 2 of 5 sampled residents (Resident 23 and 25) and 1 supplementary resident (Resident 7) reviewed for consents and unnecessary medications. This failure placed residents at risk of diminished self-worth and overall well-being.Findings included.<Policy>According to the September 2017 Residents Rights policy, residents are informed about their federal and state rights upon admission and annually during their stay, including the resident's right to refuse any particular service so long as such refusal is documented in the resident's medical record.<Resident 23> According to 10/03/2025 Quarterly Minimum Data Set (MDS -an assessment tool) Resident 23 had severe memory impairment. The MDS showed Resident 23 had a diagnosis of dementia. Review of Resident 23's health records showed a 03/15/2019 advance directive with a healthcare Power of Attorney (POA) appointed by Resident 23. Resident 23's health records showed a 04/25/2025 vaccine consent form with Resident 23's signature declining the Influenza and Covid 19 vaccinations. Resident 23's Immunization report showed the facility administered the Influenza vaccine on 10/09/2025 and 10/10/2025, and the Covid 19 vaccine on 10/21/2025. Resident 23's records showed a 10/16/2025 psychoactive drug consent form with verbal authorization to administer an Antipsychotic medication to Resident 23 by a person that was not Resident 23's POA. In an interview on 12/16/2025 at 9:21 AM Staff B (Director of Nursing) stated they expected staff to follow the residents wishes of declining the immunizations. Staff B stated staff should have addressed consents with Resident 23's POA due to Resident 23 having severe cognitive impairment. Staff B stated it was important to have residents' POA consent prior to administration to ensure staff were implementing the residents' wishes. <Resident 25> According to the 10/23/2025 admission MDS, Resident 25 was admitted to the facility on [DATE] with diagnoses that included dementia, mood disturbance and anxiety. The MDS showed Resident 25 could be understood and was able to understand others. Review of the revised 10/27/2025 Elopement Risk Care Plan (CP) showed Resident 25 wandered and had a history of attempts to leave the facility. Interventions on the CP showed staff would attempt diversional interventions and provide frequent safety checks. The CP showed Resident 25 refused to wear a wander monitoring device. Review of the 10/24/2025 device and enabler evaluation and consent form showed Resident 25 had a wander monitoring device. The form showed Resident 25 gave verbal consent on 10/24/2025 and one staff member signature was handwritten on the form. There was no other witness signature on the form that showed Resident 25 agreed to use of the wander device. Interview and observations on 12/12/2025 at 8:21 AM and 12/15/2025 at 9:14 AM, Resident 25 stated staff would not let them leave the facility and they felt trapped. Resident 25 stated they would not wear the wander device. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/16/2025 at 12:02 PM, Staff R (LPN) stated Resident 25 often removed the wander device, because of this Staff R put the wander device in Resident 25's bag they carried when they walked around. In an interview on 12/16/2025 at 12:09 PM Staff G (LPN Care Coordinator) Staff G stated they determined Resident 25 needed a wander device and put the device on them because they frequently attempted to leave. Staff G stated Resident 25 often refused to wear their wandering device and would cut the device off. In an interview on 12/16/2025 at 1:19 PM, Staff B stated if a wander monitoring device was placed on a resident, staff should evaluate the need for the wander device and obtain correct consent to make sure the resident was fully aware of the consent for safety. <Resident 7> According to the 11/25/2025 admission MDS, Resident 7 admitted to the facility on [DATE] with diagnoses of gout (episode of swelling causing severe joint pain) and no cognitive impairment. Review of a Progress Note on 11/16/2025 showed Resident 7 arranged transportation to leave the facility and appeared confused. Staff notified Resident 7's brother, listed as the resident's emergency contact. Review of the 11/18/2025 Elopement Risk Evaluation showed Resident 7 had attempted to leave the facility without telling staff and continued to express a desire to leave the facility. Review of November 2025 MAR showed a 11/18/2025 physician order for the placement and monitoring of an elopement device (an electronic bracelet worn by residents at risk for leaving the facility without telling staff). Review of a Progress Note on 11/18/2025 at 17:00 showed staff placed the device on Resident 7. Review of the 11/18/2025 Device Consent showed the device would be implemented to alert staff if Resident 7 attempted to leave the facility. Section H showed staff indicated Resident 7 had verbally consented on 11/19/2025 for the use of the device, the day after the device was placed and no staff signatures were present. Review of the 11/19/2025 CP showed Resident 7 used the device for safety and staff were to notify the nurse if the device was missing. Observations on 12/10/2025 at 12:12 PM, 12/11/2025 at 1:46 PM, and 12/12/2025 at 10:23 AM showed the device was attached to the left handle of Resident 7's wheelchair. In an interview on 12/10/2025 at 12:12 PM, Resident 7 stated staff placed the device on their wrist without asking for their permission. Resident 7 pointed to the device hanging from their wheelchair handle and stated that staff placed it there because they refused to wear it. Resident 7 stated they told staff they did not want it on their wheelchair either. Resident 7 stated they told staff they wanted to return home and believed they were being kept at the facility against their will. In a telephone interview on 12/11/2025 at 10:35 AM, Resident 7's representative denied knowledge of (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the placement of the device and stated they believed Resident 7 was able to sign their own consents. In an interview and record review on 12/16/2025 at 9:32 AM, Staff F (Resident Care Manager) stated they created the verbal consent for Resident 7's device and had not obtained two staff signatures. Staff F stated they should have obtained the staff signatures and followed up by completing a written informed consent to be signed by Resident 7. In an interview on 12/16/2025 at 10:55 AM, Staff B stated they expected staff to obtain written consent from residents prior to implementing interventions and follow the resident's wishes of refusing care. Staff B stated they expected verbal consents to be signed by two staff members, only when written signatures were not possible. Staff B stated they expected all refusals and consents to be documented in the residents' medical record. Refer to F578 Advance Directives. Refer to F658 Services Provided Meet Professional Standards Reference WAC 388-97-0300 (3)(b).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or their representatives received written information of their right to accept or refuse treatment by formulating an Advance Directive (AD) for 2 (Resident 23 and 105) of 6 sampled residents. This failure placed residents at risk of being denied their right to make health care decisions and preventing them from exercising their right to refuse care.Findings included.<Policy>According to the August 2010 AD policy, residents would be informed of their right to make healthcare decisions including the right to refuse treatments and to prepare an AD. Staff were to obtain written acknowledgements of the receipt of such information in residents' medical record.<Resident 23> According to the 05/01/2025 admission Minimum Data Set (MDS – an assessment tool) Resident 23 had severe memory impairment. The MDS showed Resident 23 admitted to the facility on [DATE]. Record review showed 03/15/2019 AD paperwork with a designated Power of Attorney (POA) by Resident 23. Review of Resident 23's health records showed no contact information for Resident 23's POA. Resident 23's records showed the facility had not utilized their POA and showed the facility was communicating Residents care and treatment with a family member not appointed POA by Resident 23. In an interview on 12/16/2025 at 9:19 AM Staff B (Director of Nursing) stated they expected staff to communicate cares with the residents appointed POA, but they did not for Resident 23. Staff B stated it was important to follow AD to ensure the facility was implementing care and treatment according to the residents' wishes. <Resident 105> According to the 11/26/2025 admission MDS, Resident 105 was admitted to the facility on [DATE] with a brain infection, weakness, and no memory impairment. In an interview on 12/12/2025 at 9:51 AM, Resident 105 stated they did not recall being offered information to review or establish an AD. Resident 105 stated they would have assigned their brother as POA, in the event they were unable to communicate their health care preferences. Review of Resident 105's health records showed contact information for their brother as the primary emergency contact and no documentation the facility aided Resident 105 to understand and implement an AD. In an interview on 12/12/2025 at 9:55 AM, Resident 105's brother stated they had not been informed of the resident's admission by the facility but rather by another family member and when they spoke to Resident 105 via telephone, they were concerned at the significant loss of Resident 105's ability to speak and be understood verbally. Resident 105's brother stated they lived in another state but travelled to the facility to better understand Resident 105's condition. Since arrival, Resident 105's brother had not been approached by the facility regarding ADs. In an interview and record review on 12/15/2025 11:40 AM, Staff D (Social Services Director) stated (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were unable to document Resident 105's receipt of information related to AD because Resident 105 was unable to produce speech or sign the form. Staff D stated they should have verbally consented Resident 105 with the AD information and followed up with written consent when the resident was able. Staff D states they had not contacted Resident 105's brother to offer the same information. In an interview on 12/16/2025 at 10:55 AM Staff A (Administrator) stated they expected staff to obtain and document verbal and/or written consents for ADs in the resident's medical record. Refer to F550 Resident Rights. Refer to F628 Hospitalizations. Reference WAC 388-97-0260.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to ensure walls, heaters and baseboard in resident rooms were maintained in a safe, clean and homelike condition for 6 of 13 residents (Resident 113, 99, 25, 9, 61 & 23) , failed to ensure privacy curtains were maintained in a clean sanitary condition (Residents 113 & 9) and failed to ensure resident rooms were personalized (Resident 23). These failures left residents at risk for a less than homelike environment and a diminished quality of life. Findings included . <Facility Policy>According to the facility's July 2015 Homelike Environment policy, resident rooms would be personalized and organized in a manner that promotes independence through a homelike environment.<Resident 113> Observations on 12/12/2025 at 12:44 PM, 12/15/2025 at 9:46 AM and on 12/16/2025 at 12:09 PM, a privacy curtain in Resident 113's room, separating their room door and bed, was soiled with several small and large sized spots and splashes that were brown and red in color. <Resident 99> Observations on 12/12/2025 at 12:44 PM, 12/15/2025 at 9:46 AM and on 12/16/2025 at 12:09 PM, a privacy curtain in Resident 99's room was soiled with several small and large sized spots and splashes that were brown and red in color. <Resident 25> Observations on 12/11/2025 at 9:28 AM and on 12/15/2025 at 9:14 AM showed a large gouge and hole in the wall behind Resident 25's bed. Interview on 12/16/2025 at 12:20 PM, Staff C (Maintenance Director) stated they conducted monthly roomˆbyˆroom assessments and documented needs in a maintenance log notebook for future repairs. Staff C stated they expected staff to document daily repair needs in the maintenance log binder located at the nursing station in each unit. Staff C stated they toured the facility daily and addressed repair needs listed in each unit binder. After touring the facility, Staff C stated the hole in the wall in Resident 25's room and the privacy curtains in Resident 113 and Resident 99's rooms were not identified in the maintenance log sheets. Interview on 12/16/2025 at 1:39 PM Staff B (Director of Nursing) stated staff should report environmental and homelike setting concerns when they find them. <Resident 9> Observation on 12/11/2025 at 9:02 AM showed a baseboard heater underneath the window in Resident 9's room had a metal end-bracket that was not attached at the bottom edge. The metal bracket was bent and protruded out from the heater into the room. In an interview on 12/11/2025 at 9:02 AM, Resident 9 stated they often accidentally ran into the metal bracket with their wheelchair and got stuck on it. Resident 9 stated they no longer stored their walker in the corner next to the heater because they were afraid they would bump their leg on the metal bracket. Resident 9 stated they mentioned it to the nurse over a month ago, and the nurse said they would call maintenance to fix it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the unit's Maintenance Request Log on 12/11/2025 showed no entry regarding Resident 9's heater. In an observation and interview on 12/16/2025 at 11:45 AM, Staff C, stated Resident 9's heater needed to be fixed to ensure safety. <Resident 61> Observations on 12/10/2025 at 9:20 AM, 12/15/2025 at 9:19 AM, and 12/16/2025 at 12:47 PM showed a baseboard heater underneath the window in Resident 61's room was covered in dark brown spots, splashes, and debris. In an interview on 12/10/2025 at 9:20 AM, Resident 61 stated their heater was dirty. Resident 61 stated the heater should look better and tried covering the heater up. In an interview on 12/16/2025 at 12:53 PM, Staff C stated the maintenance department was responsible for cleaning the heaters, and Resident 61's heater needed to be cleaned. <Resident 23> Observation on 12/10/2026 at 9:49 AM and 12:01 PM, 12/11/2025 at 10:05 AM, 12/12/2025 at 8:38 AM and 1:12 PM, 12/15/2025 at 12:27 PM and 12/16/2025 at 11:47 AM, showed Resident 23 did not have any personal belongings in their room. Resident 23's room did not have any pictures or room decorations. In an interview on 12/16/2025 at 9:23 AM Staff B stated Resident 23 should have room decorations and personal items for a homelike environment. Staff B stated it was important to offer and provide personal items and decorate the residents room to create a homelike environment for the residents. Reference: WAC 388-97-0880.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the mental health conditions for 4 of 5 residents (Resident 5, 6, 11, & 23) reviewed for PASRR/Unnecessary Medications. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs.Findings included.<Policy>According to the facility's revised 01/01/2025 PASARR Process Policy and Procedure policy, facility would ensure all residents had a PASRR screening prior to admission and would keep a copy in the resident's record. The policy showed the facility's Social Services staff were responsible for ongoing maintenance of accurate PASRR screenings, and PASRR screening would be updated as needed to reflect changes both positive and negative to a resident's mental health status. The policy showed the facility would follow up as needed per Federal PASRR rules. <Resident 5> According to the 10/14/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 5 had moderately impaired cognition (impaired memory and problem solving) and had diagnoses of schizophrenia (mental disorder-characterized by hallucinations, delusions and disorganized thinking or behavior), depression, and anxiety. The MDS showed Resident 5 received antipsychotic and antidepressant medications during the assessment period. Review of 10/28/2025 and 11/25/2025 provider's progress notes showed Resident 5 had diagnosis of schizophrenia, anxiety, and depression disorder. The provider recommended staff continue administering antipsychotic and antidepressant medications as ordered and continue monitoring behaviors. Review of the December 2025 Medication Administration Record (MAR) showed Resident 5 received routine antipsychotic and antidepressant medications every day as ordered related to their diagnosis. Review of the 08/20/2024 Level 1 PASRR completed in the facility showed Resident 5 was identified with Serious Mental Illness (SMI) indicator for Schizophrenia, depression, and anxiety disorder diagnosis, and Level 2 PASRR evaluation was not required. In an interview on 12/15/2025 at 10:56 AM, Staff D (Social Services Director) stated Resident 5's Level 1 PASRR was updated on 08/20/2024 and Level 2 PASRR was not indicated. Staff D reviewed Resident 5's Level 1 PASRR and stated the form was inaccurate and should refer to Level 2 evaluation, but they did not. <Resident 6> According to the 10/17/2025 Quarterly MDS, Resident 6 had diagnoses of schizophrenia, depression, and anxiety. The MDS showed Resident 6 received antipsychotic and antidepressant medications during the assessment period. Review of the Resident 6's December 2025 MAR showed Resident 6 received routine antipsychotic (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and antidepressant medications every day as ordered related to their diagnosis. Review of the 06/14/2023 Level 1 PASRR showed Resident 6 was identified with SMI indicator for depression, and anxiety disorder diagnosis, and Level 2 PASRR evaluation was not indicated. In an interview on 12/15/2025 at 10:59 AM, Staff D reviewed Resident 6's Level 1 PASRR and stated Resident 6's Level 1 PASRR was not accurate. Staff D stated they should have updated Resident 6's Level 1 PASRR according to Resident 6's current mental condition and referred to Level 2 evaluation, but they did not. <Resident 11> According to the 10/21/2025 Quarterly MDS, Resident 11 had diagnoses of schizophrenia, depression, and anxiety. The MDS showed Resident 11 received antipsychotic and antidepressant medications during the assessment period. Review of the 02/27/2024 Level 1 PASRR showed Resident 11 was identified with SMI indicator for Schizophrenia, depression, and anxiety disorder diagnosis, and Level 2 PASRR evaluation was not indicated. Review of Resident 11's December 2025 MAR showed Resident 11 received antipsychotic and antidepressant medications every day as ordered related to their diagnosis. In an interview on 12/15/2025 at 11:09 AM, Staff D reviewed Resident 11's MAR and Level 1 PASRR and stated Resident 11's Level 1 PASRR was not accurate. Staff D stated they should have updated Resident 11's Level 1 PASRR according to Resident 11's current mental condition and referred to Level 2 evaluation, but they did not. <Resident 23> According to the 05/01/2025 admission MDS, Resident 23 admitted to the facility on [DATE]. The MDS showed Resident 23 was taking antipsychotic and antidepressant medications and had a diagnosis of Dementia (decline in mental ability) and a sleep disorder characterized by difficulty falling or staying asleep. Review of Resident 23's records showed a 04/25/2025 diagnosis of dementia with psychotic disturbances. Resident 23's records showed a PASRR Level 1 with no serious mental illness and no Level 2 PASRR evaluation indicated. Resident 23's PASRR Level 1 file scanned to their records also included hospital notes from 04/24/2025 which indicated Resident 23 was agitated with behaviors, refusing care, and was receiving antipsychotic and antidepressant medications at the hospital. In an interview on 12/15/2025 at 11:09 AM, Staff D reviewed Resident 23's MAR and Level 1 PASRR and stated Resident 23's Level 1 PASRR was not accurate. Staff D stated they should have updated Resident 23's Level 1 PASRR according to the Resident's current mental condition and referred for Level 2 evaluation, but they did not. REFERENCE: WAC 388-97-1915 (1). .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were updated and/or revised as needed for 4 (Residents 10, 79, 23, & 5) of 25 sample residents reviewed. Failure to ensure CPs were updated to reflect current care needs left residents at risk for unmet care needs, delay in treatments, and a diminished quality of life. Findings included . <Facility Policy>On 12/16/2025, the facility administrator did not provide Care Planning policy and stated it was Standard of Practice. <Resident 10> According to the 11/23/2025 change of condition Minimum Data Set (MDS - an assessment tool), Resident 10 was on end-of-life care services. The MDS showed Resident 10 had pressure areas on their heel and back areas. Review of the revised 11/24/2025 impairment to skin integrity CP showed interventions included hospice services for end-of-life care. The CP did not include staff interventions to address refusals of wound care treatments. Review of Resident 10's progress notes showed Resident 10 refused wound care treatments and/or wound skin assessments on 12/16/2025, 12/12/2025, 12/11/2025, 12/10/2025, 12/9/2025 and 12/8/2025. In an interview on 12/11/2025 at 10:15 AM, Resident 10 stated they had skin problems and had pain during wound care. In an interview on 12/12/2025 at 1:30 PM, Staff T (Licensed Practical Nurse - LPN, wound care nurse) stated Resident 10 often refused wound care and skin assessments. Staff T stated they would monitor Resident's 10's wound more if Resident 10 let them. Staff T stated they needed to check with Hospice services to determine if wound care treatments and measurements should continue because of Resident 10's frequent refusals. In an interview on 12/15/2025 at 1:14 PM, Staff G (LPN Care Coordinator) stated Resident 10 often refused care services and stated Hospice services were aware of refusals. Staff G stated hospice coordination and services should be incorporated into Resident 10's CP, especially for refusals. In an interview on 12/16/2025 at 1:27 PM, Staff B (Director of Nursing) stated the facility nurses should notify the provider or care providers of the refusals and obtain further directions on care needs and update the CP with staff interventions. <Resident 79> According to a 08/27/2025 admission MDS, Resident 79 was dependent on staff for turning side to side in bed. Review of a 08/28/205 impaired skin integrity CP showed staff would assist Resident 79 with frequent repositioning in bed. The 08/28/2025 ADL (Activities of Daily Living) CP showed Resident 79 was dependent on two staff to turn and reposition in bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 12/11/2025 at 10:41 AM until 1:21 PM showed Resident 79 lying in bed on their back. Resident 79 stated they needed staff to turn them on their sides because they were unable to do it on their own. Resident 79 stated they were concerned because staff do not offer help with repositioning in bed and they had a history of pressure sores to their buttocks off and on over the years. <Resident 23> According to a 10/03/2025 Quarterly MDS, Resident 23 required substantial/maximal assistance from staff for turning side to side in bed. The MDS showed Resident 23 was at risk for falls. Review of a 05/06/2025 at risk for pressure ulcer development CP showed staff would assist Resident 23 with frequent repositioning. The 04/29/2025 ADL CP showed Resident 23 was dependent on two staff to turn and reposition in bed. The 05/06/2025 communication problem related to impaired ability to make self-understood and understand others CP showed staff would ensure Resident 23's bed would remain in lowest position and avoid isolation. Observation on 12/10/2026 at 9:49 AM and 12:01 PM, 12/11/2025 at 10:05 AM, 12/12/2025 at 8:38 AM until 10:56 AM and 1:12 PM, 12/15/2025 at 12:27 PM, 12/16/2025 at 11:47 AM showed Resident 23 lying on back with their bed raised 36 inches, isolated with their door closed. In an interview on 12/16/2025 at 1:05 PM, Staff S (Registered Nurse) stated staff should reposition Resident 23 in bed every two hours and was unsure why they hadn't been repositioned. Staff S stated if Resident 23 refused repositioning the aides would inform them, the assigned nurse, and document the refusal but they were not informed of Resident 23 refusing repositioning. In an interview on 12/16/2025 at 9:26 AM, Staff B stated Resident 79 and 23 should be repositioned by staff every two hours per CP. Staff B stated they expected staff to reposition all dependent residents every two hours during their rounds and if the resident refused, staff should inform the assigned nurse and document the refusal. Staff S stated staff should keep Resident 23's bed in the lowest position and leave the door open. Staff S stated it was important to keep Resident 23's bed low because the resident is a fall risk and to leave their door open to not isolate them. Staff S stated staff should follow the CP, but they did not. <Resident 5> According to the 10/14/2025 Quarterly MDS, Resident 5 was assessed with moderate cognitive impairment, able to understand and be understood in conversation. The assessment showed Resident 5 was dependent on staff for all activities of daily living including bathing, toileting, and repositioning in bed. Review of Resident 5's Fall CP showed Resident 5 was at risk for fall or injury due to impaired balance, psychotropic medication use, and weakness. The interventions included directions for staff to keep Resident 5's bed in low position and encourage Resident 5 to call staff for assistance. Observations on 10/12/2025 at 10:07 AM, 10/13/2025 at 1:00 PM, and on 10/15/2025 at 8:33 AM showed Resident 5 was lying in their bed and had a concave mattress in bed. These observations (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed Resident 5's bed was in the high position. Review of Resident 5's 10/20/2025 nursing progress notes showed Resident 5 had a fall on 10/20/2025 from their bed with an injury on their forehead. Resident 5 was sent to the hospital for further evaluation and treatment. Review of Resident 5's record showed no physician order and no CP for concave mattress in their bed. In an interview on 12/15/2025 at 9:53 AM, Staff E (Resident Care Manager) stated updating the CPs and to follow the CP was very important to provide safe and appropriate care to all residents related to their current medical status. Staff E reviewed Resident 5's CP and stated they did not update the CPs after Resident 5's fall. Staff E stated they should update the CP to prevent further risk for injury related to fall, but they did not. In an interview on 12/15/2025 at 12:23 PM, Staff B stated their expectations from staff were to update the CP timely according to resident's current medical and mental status to provide safe care. REFERENCE: WAC 388-97-1020(2)(c)(d).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure: Physician's Orders (POs) were clarified and followed for 4 (Residents 11, 25, 120, & 23) of 25 sample residents; nurses did not document nonpharmacological interventions for pain medications for 1 (Resident 23); staff did not follow the oxygen orders, the facility Bowel Movement (BM) protocol and pain medication parameters as ordered for 1 (Resident 11); and devices in place without physician order for 1 (Resident 120) of 25 sample residents. These failures placed residents at risk for medication errors, delayed treatment, Resident Rights, adverse outcomes and diminished quality of life. Findings included .<Facility Policy> According to the facility's updated February 2025 Elopement/Wandering policy, if the facility used a monitoring system the facility would obtain a physician's order for use of the device prior to application and after consent was received.According to the facility's updated May 2025 Bowel Protocol, if a resident does not have a bowel movement for three days, the nurse administers the physician ordered bowel program. <Following Physician Orders> <Resident 11> According to the 10/21/2025 Quarterly Minimum Data Set (MDS- an assessment tool), Resident 11 had multiple medically complex diagnoses including kidney failure, chronic pain, and impaired mobility. Record review showed a 10/10/2025 physician order directing staff to provide Resident 11 oxygen at two liters per minute via nasal canula (tubing delivering oxygen directly into the resident's nostrils) continuously and to keep the resident's oxygen level above 94%. Observations on 12/11/2025 at 11:02 AM, 12/12/2025 at 1:21 PM, and 12/15/2025 at 9:00 AM showed Resident 11 received oxygen at three liters per minute via nasal canula. In an interview on 12/15/2025 at 9:08 AM, Staff P (Registered Nurse) reviewed Resident 11's physician orders and confirmed in Resident 11's room oxygen was running at three liters per minute. Staff P stated they should follow the physician orders, but they did not. Record review showed a 07/24/2025 physician order directing staff to provide Resident 11 a non-narcotic pain medication as needed for a pain level of 1-3 on a scale of 0-10, and a 10/07/2025 physician order directing staff to provide Resident 11 a narcotic pain medication as needed for a pain level of 4-10 on a scale of 0-10. Review of Resident 11's December 2025 Medication Administration Record (MAR) showed Resident 11 received their non-narcotic pain medication for a pain of 5 out of 10 on 12/01/2025, for a pain of 8 of 10 on 12/04/2025, and 7 of 10 on 12/13/2025. The December 2025 MAR showed Resident 11 received their narcotic pain medication for a pain of 0 of 10 on 12/06/2025. According to a 07/24/2025 physician order, staff should follow the ordered BM program when Resident 11 did not have a BM for 3 days. Review of Resident 11's record showed Resident 11 did not have a BM on 11/20/2025, 11/21/2025, 11/22/2025, 11/23/2025, and 11/24/2025 for a total of 5 days. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed Resident 11 did not have a BM on 11/28/2025, 11/29/2025, 11/30/2025, 12/01/2025 for a total of 4 days. Review of Resident 11's December MAR showed staff did not follow the physician orders to administer medications as ordered when Resident 11 did not have BM for more than 3 days. In an interview on 12/16/2025 at 9:47 AM, Staff E (Resident Care Manager) reviewed Resident 11's record and stated staff should follow the physician orders for oxygen administration, pain medication parameters, and BM management program, but they did not. <Medication Administration> <Resident 25> According to the 10/23/2025 admission MDS, Resident 25 admitted to the facility on [DATE] with diagnoses that included high blood pressure, anxiety and a wound on their foot. Review of the 10/28/2025 Baseline Care Plan (CP) showed Resident 25 had decreased mobility. The CP included interventions for staff to report any verbal or physical signs of pain and if the pain location was the right foot or left toe. Record review showed a 10/17/2025 Physician order showed a pain medication 325 milligrams (MG) give three tablets every eight hours as needed for pain or fever. The order did not specify the parameter for staff to know how many tablets should administer for pain and how many tablets for fever. Review of December 2025 MAR showed staff administered the pain medication on 12/2/2025, 12/4/2025 and 12/11/2025. The MAR did not have documentation to show the pain medication was used for pain or fever. In an interview on 12/16/2025 at 1:42 PM Staff B (Director of Nursing) stated the order should have an indication for what type of pain the pain medication would be used for and should include a pain range to determine how many tablets were to be used for pain or fever. Staff B stated staff should have documented the reason why the pain medication was used to better track the resident's pain or fever. <Wander Guard> <Resident 25> According to the 10/23/2025 admission MDS, Resident 25 was admitted to the facility on [DATE] with diagnoses that included dementia, mood disturbance and anxiety. The MDS showed Resident 25 could be understood and able to understand others. Review of the revised 10/27/2025 Elopement Risk CP showed Resident 25 wandered and had a history of attempts to leave the facility. Interventions on the CP showed staff should attempt diversional interventions and provide frequent safety checks. The CP showed Resident 25 refused to wear a wander guard. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 10/24/2025 nursing progress note showed staff provided Resident 25 with a wander guard to alert staff if Resident 25 attempted to leave the facility. The nursing progress note did not show Resident 25's provider was notified of the use of the wander guard and did not show a physician order was obtained prior to using on the wander guard for Resident 25. Review of Resident 25's physician orders did not show an order for a wander guard. In an interview on 12/12/2025 at 8:21 AM and 12/15/2025 at 9:14 AM, Resident 25 stated the facility staff would not let them leave the facility and they felt trapped. Resident 25 stated they did not wear a wander guard. In an interview on 12/16/2025 at 12:09 PM Staff G (Licensed Practical Nurse Care Coordinator) stated they determined Resident 25 needed a wander guard and placed the device on them because they frequently attempted to leave the facility. Staff G stated they could not find in Resident 25's medical record that a physician's order was obtained prior to use of a wander guard on the resident. Staff G stated they should follow the facility policy, but they did not. <Resident 23> According to the 10/03/2025 Quarterly MDS, Resident 23 received scheduled pain medications. The MDS showed Resident 23 was at risk for pressure ulcers and falls. Review of Resident 23's record showed Resident 23 received routine pain medications for pain management. Resident 23's records showed no nonpharmacological pain interventions implemented. In an interview on 12/16/2025 at 9:47 AM Staff B reviewed Resident 23's records and was unable to provide documentation of nonpharmacological pain interventions. Staff B stated they expected staff to obtain a physician order for the nonpharmacological pain interventions, but they did not. Refer to F550 Resident Rights REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i). .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to offer and provide assistance with Activities of Daily Living (ADL) for 2 of 7 residents (Residents 23 & 79) reviewed who were dependent on staff for daily cares/ADLs. The failure to provide assistance with ADLs placed residents at risk for poor hygiene, diminished feeling of self-worth, and a decreased quality of life.Findings included .<Policy>Facility did not provide ADL policy.<Resident 23> According to the 10/03/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 23 required staff assistance with ADLs. The MDS showed Resident 23 was frequently incontinent of urine and always incontinent of bowels. Review of Resident 23's 05/06/2025 ADL Care Plan (CP) showed they were dependent on staff for bathing, dressing, oral hygiene, and required a mechanical lift with two staff to transfer them out of bed. Review of Resident 23's health records showed an assigned bathing schedule for every Monday and Friday. September 2025 Point of Care (POC- nurse aide documentation) documentation showed Resident 23 refused bathing on 09/17/2025 and 09/20/2025. October 2025 POC documentation showed Resident 23 refused bathing on 10/01/2025, 10/17/2025, 10/24/2025, 10/27/2025, and was not offered bathing on 10/10/2025 per schedule. November 2025 POC documentation showed Resident 23 refused bathing on 11/10/2025, 11/14/2025, 11/17/2025, and 11/21/2025, 21 days without bathing. December 2025 POC documentation showed Resident 23 refused bathing on 12/05/2025. POC documentation for Resident 23 showed no bathing reoffered after documented refusals. Observation on 12/10/2026 at 9:49 AM and 12:01 PM, 12/11/2025 at 10:05 AM, 12/12/2025 at 8:38 AM until 10:56 AM and 1:12 PM, 12/15/2025 at 12:27 PM, 12/16/2025 at 11:47 AM showed Resident 23 lying in bed on their back, their hair not brushed, a sheet pulled up to their waist, and wearing no clothing. In an interview on 12/16/2025 at 1:05 PM Staff S (Registered Nurse) stated staff should offer Resident 23 assistance with morning care to include brushing hair, dressing, and getting out of bed. Staff S stated if Resident 23 refused cares they expected staff to reapproach and document continued refusals. <Resident 79> According to the 11/12/2025 Quarterly MDS Resident 79 required staff assistance with ADLs. The MDS showed Resident 79 was always incontinent of urine and bowels. Review of Resident 79's 08/28/2025 ADL CP showed they were dependent on staff for bathing, dressing, and oral hygiene. The 08/21/2025 baseline plan of care CP showed Resident 79 required a mechanical lift and two staff to transfer them out of bed. Observation and interview on 12/11/2025 at 10:41 AM, 12/15/2025 12:50 PM, and 12/16/2025 from 1:00 PM until 1:21 PM showed Resident 79 lying in bed wearing a gown with messy hair. Resident 79 stated staff did not offer to assist them with hygiene, dressing, or getting out of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/16/2025 at 9:13 AM Staff B (Director of Nursing) stated they expected staff to offer and provide morning care which included face washing, brushing hair and teeth, getting the resident dressed, brief changes if needed, providing assistance in getting the resident up and out of bed, staff introducing themself to the resident and staff to ask the resident if they need anything else. Staff B stated if a resident refused, they expected staff to reapproach the resident and if the resident continued to refuse care, staff were expected to notify the assigned nurse and document the refusal. Staff B reviewed Resident 23 and 79's bathing documentation and stated they expected staff to reapproach daily until they accepted but staff did not. Staff B stated they expected staff to obtain residents' bathing preferences and provide assistance when a resident requested a shower if it was safe for the residents to have a shower. Reference: WAC 388-97-1060(2)(c).

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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. Based on observation, interview, and record review, the facility failed to ensure the residents' environment was free of accident hazards by implementing their system for screening and storing hazardous toxic chemicals in 1 of 4 soiled utility rooms (2 [NAME] Soiled Utility Room) and 1 of 4 clean utility rooms (2 East Clean Utility Room), and 1 of 4 linen rooms (2 [NAME] Clean Linen Room) reviewed. This failure placed residents at risk of injury.Findings included.<Policy>According to the facility policy titled, Storage Areas, Environmental Services, revised February 2021, the facility would ensure housekeeping storage would be maintained in a safe manner.According to a facility policy titled, Medication Storage, dated 01/2023, medications would only be accessible to authorized staff.<2 [NAME] Soiled Utility Room>Observation, record review, and interview on 12/10/2026 at 9:03 AM showed 2 [NAME] Soiled Utility Room door not closed/locked. The soiled utility room had a bottle of shower cleaning chemical, one can of stainless-steel cleaner, and one container for Sani wipes filled with a blue liquid chemical cleaner. Staff K (Certified Nursing Assistant) stated the soiled utility room door should be pulled closed and locked so residents do not have access since there were chemicals stored in there. Staff K stated the shower cleaning chemical, stainless-steel cleaner, and Sani wipes container filled with the blue liquid chemical cleaner should be stored behind locked door for resident safety but was not.In an interview on 12/10/2026 at 9:08 AM Staff L (Infection Preventionist) stated the soiled utility room door should be pulled closed and locked for resident safety because of the chemicals stored in the soiled utility room.<2 [NAME] Clean Linen Room>Observation, interview, and record review on 12/10/2026 at 9:10 AM showed the 2 [NAME] clean linen room behind the nurse's station with no lock on the door. The clean linen room had two bottles of drug disposal chemical digestion gel and medications in them. Staff L stated the drug disposal bottles should be stored behind a locked door in the medication room for residents' safety.<2 East Clean Utility Room>Observation and interview on 12/10/2025 at 9:32 AM showed the 2 East Clean Utility Room door with a keypad lock however the door was not locking when closed. The clean utility room had 50 razors, 10 fingernail clippers, and 5 toenail clippers in it. Staff M (Registered Nurse) stated the clean utility room had sharps stored in there so the door should be locked for resident safety, but the keypad was not working so the door was not locked after it was closed.In an interview on 12/16/2025 at 9:13 AM Staff B (Director of Nursing) stated they expected all chemicals and sharps to be stored behind locked doors for resident safety.Reference: WAC 388-97-1060(3)(g).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to appropriately use Personal Protective Equipment (PPE) in accordance with Enhanced Barrier Precautions (EBP - infection control measures used to reduce the spread of multidrug-resistant organisms) for 2 supplemental residents (Residents 28 & 10) who required EBP reviewed for infection control. These failures placed residents at risk for the development and transmission of communicable diseases and an unclean environment.Findings included . <Facility Policy>According to the facility's March 2025 Transmission-Based Precautions policy, EBP required the use of gowns and gloves by care providers during high-contact resident care activities. <Resident 28> Observation on 12/12/2025 at 10:47 AM showed Resident 28's room had an EBP sign posted outside their door. The signage showed staff must clean their hands before entering the room, and wear gloves and gowns for high-contact resident care activities including dressing and transferring residents, providing hygiene and care of a urinary catheter (tubing to assist with urinary drainage). Staff I, (Certified Nursing Assistant - CNA) entered Resident 28's room and did not perform hand hygiene. Staff I and Staff J (CNA) transferred Resident 28 from their bed to a wheelchair, moved a urinary catheter bag to the wheelchair, and assisted Resident 28 with dressing and hygiene. Staff I and Staff J did not wear gowns. In an interview on 12/12/2025 at 11:00 AM, Staff J said the EBP sign showed what PPE they should wear if the resident had a disease, but Resident 28 was not sick so they did not need to wear gowns at that time. Staff J said that they were busy in another room when Resident 28 called to get up from bed, so Staff J had to rush to help and did not have time to put on a gown. <Resident 10> Observation on 12/12/2025 at 9:33 AM, Resident 10's room had an EBP sign posted outside their door. The signage showed staff must wear gloves and gowns for high contact resident care activities. Staff H (Registered Nurse - Medication Nurse) applied a medicated skin cream to Resident 10's left lower leg. Staff H did not wear a gown while applying the cream to Resident 10's leg. In an interview on 12/12/2025 at 9:36 AM Staff H stated they should wear a gown for infection control reasons when they applied the cream on Resident 10's leg but did not. In an interview on 12/12/2025 at 10:49 AM Staff L (Infection Preventionist) stated staff should follow the EBP directions on the sign and wear gloves and a gown when administering skin treatments. REFERENCE: WAC 388-97-1320 (1)(a)(c), (2)(a)(b).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to implement an Antibiotic (ABO) Stewardship program to promote appropriate use of ABO and reduce the risk of unnecessary ABO use for 2 of 3 residents (Resident 8 & 4) reviewed for unnecessary antibiotics. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate/unnecessary use of ABOs and placed residents at a greater risk of developing ABO resistance.Findings included.<Policy>According to the facility policy titled, ABO Stewardship Program, dated March 2018, the facility would ensure residents met the McGeers criteria (a tool used for infection surveillance activities and management of ABO usage) for ABO usage. The policy showed the facility would use standard evaluations and communication tools for residents with suspected infections, utilize Antibiogram reports, and implement ABO time outs. <Resident 8>Review of Resident 8's health records showed they received an ABO from 01/23/2025 until 02/02/2025 for a urinary tract infection. Resident 8's records also showed they received an ABO from 04/01/2025 until 04/04/2025 for an upper respiratory infection.<Resident 4>Review of Resident 4's health records showed they received an ABO from 07/01/2025 until 07/02/2025 for a fever only.In an interview and record review on 12/12/2025 at 10:49 AM Staff L (Infection Preventionist) stated they expected staff to track all residents with prescribed ABOs on the facility ABO Stewardship line listing. Staff L stated the facility used the McGeers criteria to assess all prescribed ABOS and would implement an ABO timeout for each prescribed ABO. Staff L stated Resident 8 and 4's ABOs were not on the ABO Stewardship line listing and did not have an ABO timeout or McGeers assessment completed for the 01/2025, 04/2025, and 07/2025 ABOs but staff should have. Staff L stated it was important to assess, monitor, and manage all prescribed ABOs to ensure no inappropriate/unnecessary ABOs were prescribed to prevent residents developing an ABO resistance.Reference: WAC 388-97-1060(3)(k)(i).