STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505024	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	6021 North Lidgerwood Spokane, WA 99207

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 maintain a urinary catheter (flexible tube inserted into the bladder) in a dignified manner for 1 of 7 sampled residents (Resident 95), reviewed for resident rights. Additionally, the facility obtained psychotropic (medications that affected the brain, mood, thoughts, behaviors, and perception) medication consent from a severely cognitively impaired resident for 1 of 5 sampled residents (Resident 11), reviewed for unnecessary medications. This failure placed residents at risk of not being fully informed of the potential risks versus benefits associated with treatment, embarrassment and a diminished quality of life.Findings included. <Resident 95> According to the 03/29/2026 admission assessment, Resident 95 had diagnoses that included encephalopathy (disease, damage, or malfunction that altered brain function). The assessment showed Resident 95 had an indwelling urinary catheter and was dependent on staff assistance for toileting. Review of the 03/23/2026 care plan showed Resident 95 had an indwelling urinary catheter and instructed staff to change the catheter per provider orders, empty the urine collection bag every shift, keep the catheter anchored to prevent tension or trauma, ensure catheter tubing and collection bag were below bladder level, and report changes in urine to the nurse. No documentation was found to show how Resident 95's dignity was to be maintained. During observations on 04/01/2026 at 11:09 AM and 11:41 AM, Resident 95 laid in bed with a urine collection bag hanging on the bedframe, without a dignity privacy cover, and yellow urine was observed in the collection bag from the hallway. Similar observations were made on 04/02/2026 at 8:29 AM, 11:30 AM, 12:10 PM and 3:47 PM, on 04/03/2026 at 8:31 AM, 10:26 AM and 2:33 PM, on 04/06/2026 at 1:10 PM and 2:24 PM, on 04/07/2026 at 8:43 AM, 10:49 AM, 11:41 AM, 1:04 PM, on 04/08/2026 at 1:32 PM, and on 04/09/2026 at 10:34 AM. In an interview on 04/09/2026 at 1:29 PM, Resident 95 was observed laying in bed with the urine collection bag, not in a dignity privacy cover with yellow urine visible from the hallway. Resident 95 was asked if it bothered them to have their urine collection bag exposed and visible for others to see. Resident 95 just stared at the surveyor and did not provide a response. During observation and interview on 04/09/2026 at 1:32 PM, Staff G, Nursing Assistant, observed Resident 95's urine collection bag, not in a privacy cover, visible from the hallway. Staff G explained that staff typically placed urine collection bags in a dignity privacy cover when residents were out of (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their room. Staff G further stated Resident 95 only spoke when they wanted to. During observation and interview on 04/09/2029 at 1:35 PM, Staff E, Licensed Practical Nurse, stated that when a resident had an indwelling urinary catheter the urine collection bag was placed in a dignity privacy cover. Staff E observed Resident 95's urine collection bag, not in a privacy cover, visible from the hallway. Staff E explained the dignity cover was only utilized when a resident was out of their room, not when in their room. Staff E further stated Resident 95 had good days and bad days and could not verbalize if it bothered them to have the urine collection bag visible to others so it should be placed in a privacy cover for their dignity. In an interview on 04/09/2026 at 1:40 PM, Staff C, Resident Care Manager, stated the facility typically utilized urine collection bags that came with an attached dignity privacy cover. Staff C acknowledged Resident 95's urine collection bag should be in a dignity privacy cover to maintain their dignity. In an interview on 04/09/2026 at 3:20 PM, Staff B, Director of Nursing, explained the facility typically utilized a urine collection bag that came with an attached dignity cover and staff were to place urine collection bags in a dignity privacy cover so it was not visible and maintain the resident's dignity. Staff B stated the facility ran out of dignity covers and acknowledged Resident 95's urine collection bag should have been placed in a dignity privacy cover. In an interview on 04/13/2026 at 11:39 AM, Staff A, Administrator, stated they expected staff to maintain a resident's catheter in a dignified manner. <Resident 11> The 12/09/2025 admission assessment documented Resident 11 admitted to the facility on [DATE] with diagnoses that included alcoholic cirrhosis of liver (advanced irreversible scarring of the liver caused by long-term, heavy alcohol use), borderline personality disorder (a mental health condition characterized by intense, unstable emotions, moods, and relationships, alongside a self-distorted image) and diabetes. The Brief Interview for Mental Status (BIMS, a screening tool used in long-term care that assessed cognitive impairment and identified potential dementia) showed Resident 11 had severe cognitive impairment. Review of the medical record showed Resident 11 admitted with orders for the following psychotropic medications: Cymbalta (antidepressant), Trazodone (antidepressant) and Seroquel (antipsychotic). The Seroquel had possible adverse effects that included increased mortality rate in the elderly. The 12/03/2025 psychotropic medication consents showed Resident 11 consented to the use of the medications. The record also showed Resident 11 signed the admission paperwork on 12/08/2025 which included monetary charges, financial obligations, and denial of Medicare and Medicaid. The 01/20/2026 care plan did not address Resident 11's impaired cognition, goals or interventions. In an interview on 04/09/2026 at 1:51 PM, Staff I, Therapy Director, stated Resident 11's St. Louis University Mental Status test (a screening tool used to detect early signs of dementia and mild cognitive impairment) was 1 out of 30, which indicated severe cognitive impairments. In an interview on 04/09/2026 at 1:55 PM, Staff J, Licensed Practical Nurse, stated they were responsible for the admission paperwork. Staff J stated they looked at the resident's face sheet to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	see if they were their own responsible party and if so, they had them sign the paperwork. Staff J stated Resident 11 was probably unable to understand the admission paperwork. Staff J stated it was important the residents understood what they were signing. In an interview on 04/09/2026 at 3:39 PM, Staff B, Director of Nursing, stated residents were able to sign admission paperwork and medication consents if they were able to answer questions appropriately and by their BIMS score. Staff B stated it was important the residents were cognizant to sign so they understood the side effects of the medication and what they were signing. Reference: WAC 388-97-0180(1)-(4)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe, clean, and homelike environment for 3 of 7 sampled residents (Resident 7, 35, and 69), reviewed for environment. Additionally, the toilet seats in 2 of 4 shower rooms (Shower room [ROOM NUMBER] - Southeast and Shower room [ROOM NUMBER] - Southwest) were broken and the South unit therapy room tile floor had significant large black and rust stains. These failures placed residents at risk of potentially avoidable accidents and diminished quality of life.Findings included.<Resident 7> The 02/23/2026 annual assessment documented Resident 7 had diagnoses that included heart failure, kidney failure and diabetes. Resident 7 was cognitively intact. In an observation on 04/01/2026 at 10:19 AM, Resident 7's closet had 2 large areas where part of the wood was missing. The first area was approximately 1 foot long by 3 inches (in) wide and the second area was approximately 6 in long by 5 in wide. The shelf above the sink was a piece of wood that was not a cleanable surface. The caulking around the sink had come loose and there was missing paint above the caulking. Resident 7's wall near the bathroom had multiple dents and pieces of missing drywall. The transition strip between the room and bathroom was missing and there was dirt built up. Observations of Resident 7's room on 04/02/2026 at 9:08 AM and 3:54 PM, 04/03/2026 at 8:28 AM, 04/07/2026 at 8:18 AM and 3:09 PM, 04/08/2026 at 1:17 PM and 04/09/2026 at 8:42 AM, showed the room was unchanged from the initial observation and required repairs. In an interview on 04/02/2026 at 8:43 AM, Resident 7 stated if this was their home the walls and holes would not look that way. Resident 7 stated it sort of bothered them. In an interview on 04/09/2026 at 8:55 AM, Staff M, Nursing Assistant, stated when something needed repaired, they placed it into the electronic notification system for maintenance. In an interview on 04/10/2026 at 2:00 PM, Staff V, Maintenance Director, stated the staff put needed repairs into the electronic notification system for maintenance. Staff V observed Resident 7's room and stated the shelf was not a cleanable surface and the room was not a homelike environment. Staff V stated the missing transition strip in the bathroom was a safety hazard and they were unaware of it. Staff V stated it was important to have Resident 7's room in good, safe repair so the resident felt like they were at home. <Resident 35> According to the 03/16/2026 admission assessment, Resident 35 had diagnoses that included fractures. Resident 35 was cognitively intact and clearly able to verbalize their needs. Review of the 03/10/2026 care plan showed Resident 35 was at risk for infection related to recent hip surgery with a healing surgical incision. During an interview on 04/02/2026 at 12:11 PM, Resident 35 stated the toilet seat in the shower room was broken and voiced concern that a resident could get injured using it. Resident 35 stated the shower room toilet seat had been broken for at least one week. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation on 04/02/2026 at 12:38 PM and 3:43 PM, the Shower room [ROOM NUMBER] - Southeast room toilet seat had approximately six in broken completely off the left front edge. Similar observations were made on 04/03/2026 at 8:29 AM, 10:21 AM, and 2:31 PM, on 04/06/2026 at 9:08 AM, 11:39 AM, and 2:23 PM, on 04/07/2026 at 8:31 AM and 1:03 PM. During observation on 04/02/2026 at 12:40 PM and 3:41 PM, the Shower room [ROOM NUMBER] - Southwest room toilet seat had approximately six inches broken completely off of the right front edge. Similar observations were made on 04/03/2026 at 8:26 AM, 10:18 AM, and 2:29 PM, on 04/06/2026 at 8:51 AM, 11:37 AM, and 2:18 PM, on 04/07/2026 at 8:27 AM and 1:01 PM. On 04/07/2026 at 1:14 PM during observation and interview in Shower room [ROOM NUMBER] - Southeast, Staff FF, Housekeeping, stated staff utilized the shower rooms daily. TStaff FF stated they were unsure of the facility process when something was broken. Staff FF acknowledged the toilet seat had been broken for approximately one month. During observation and interview on 04/07/2026 at 1:28 PM, Staff F, Nursing Assistant, stated staff utilized the shower rooms twice daily, on day shift and evening shift. Staff F stated if something was broken it needed to be reported to maintenance via an electronic notification system. Staff F observed the broken toilet seat in Shower room [ROOM NUMBER] - Southeast room. Staff F stated they were unsure how long the toilet seat had been broken but it should have been reported to maintenance for repair or replacement. In an interview on 04/07/2026 at 1:52 PM, Staff V, stated the shower rooms were utilized daily and if staff observed something broken or in disrepair it had to be entered into the electronic maintenance system so it could be followed up on. Staff V acknowledged they just received a notification about the broken toilet seats in the shower rooms. <South Unit Therapy Room Tile Floor> During interview on 04/02/2026 at 12:11 PM, Resident 35 stated they were at risk for infection and had a serious concern about the facility cleanliness. Resident 35 explained the South unit therapy gym appeared as if it had not been cleaned in ten years, it was unsanitary and needed to be cleaned and shined professionally. During observation on 04/02/2026 at 12:37 PM and 3:42 PM, the therapy room tile floor had a linear rust stain the length of a file cabinet and significantly large areas of dark black stains in numerous areas. Similar observations were made on 04/03/2026 at 8:27 AM, 10:19 AM, and 2:30 PM, on 04/06/2026 at 8:51 AM, 11:42 AM, and 2:18 PM, on 04/07/2026 at 8:29 AM, 11:38 AM, and 1:01 PM. During observation and interview on 04/08/2026 at 2:13 PM, Staff D, Physical Therapist, observed the South unit therapy room tile floor. Staff D acknowledged the therapy room tile floor had black and rust stains for over a year. Staff D explained when the facility recently remodeled the facility, the therapy room was supposed to be redone as well but it was put on hold. During observation and interview on 04/10/2026 at 12:12 PM, Staff V, observed the South unit therapy room tile floor. Staff V stated the facility had a staff member who was trained on floor maintenance and that was a task that could be addressed right away. In an interview on 04/13/2026 at 11:39 AM, Staff A, Administrator, stated they expected staff to (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintain equipment and resident care areas in a safe and sanitary manner. <Resident 69> According to a recent quarterly assessment dated [DATE], Resident 69 had moderately impaired cognition, disorganized thinking and inattention. The resident had diagnoses which included dementia and frequent falls. Resident 69 required staff assistance with bed mobility, transferring, toileting and using their wheelchair. A 01/23/2026 provider order documented to have the resident's bed against the wall for safety. On 04/01/2026 at 11:32 AM, Resident 69 was observed resting in their bed, which was against the wall. The dark brown paint on the wall had deep gouges/scrapes, which exposed the white drywall plaster next to the resident's bed. The wall was observed on 04/03/2026 at 8:57 AM, 04/06/2026 at 9:11 AM, 04/07/2026 at 9:40 AM, 04/09/2026 at 12:06 PM and 04/13/2026 at 10:36 AM in the same condition. During an interview on 04/13/2026 at 10:35 AM, Staff V, stated they were trying to create a system that they would go through each room regularly, to determine if there were any maintenance issues. They were also considering making panels to put up against the beds to protect the walls. They stated they already had Resident 69's room on their list to repair the drywall because housekeeping had told them the exposed drywall made it a non-cleanable surface, but they had not gotten around to it yet. Staff V was unsure when the housekeeper had informed them, but it was a while ago. Reference WAC 388-97-0880, WAC 388-97-2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to identify multiple incidents of resident-to-resident verbal and physical altercations as potential abuse and ensure the allegations and investigation results were reported to the state agency, as required for 13 of 20 sampled residents (Resident 4, 15, 34, 72, 90, 99, 100, 102, 103, 104, 105, 106, and 107), reviewed for abuse. Additionally, the facility failed to report a resident accident/injury and the investigation results for 1 of 20 sampled residents (Resident 8). These failures placed residents at risk for potential continued abuse, possible safety concerns due to inadequate follow-up, and diminished quality of life. Findings included. Review of the facility policy titled, Abuse Prevention and Reporting revised August 2025 showed, when allegations that met the definition of abuse were received the facility would 1) report the allegations to the State Survey Agency no later than two hours if the event caused or resulted in serious bodily injury or not later than 24 hours if the event did not result in serious bodily injury, 2) complete a thorough investigation and retain documents to show the allegation was thoroughly investigated, 3) prevent further abuse, neglect or mistreatment while the investigation was in process, 4) report investigation results to the State Survey Agency within five working days, and 5) take all necessary corrective action if the alleged violation was verified. The policy defined verbal and mental abuse as oral, written, or gestured language that included disparaging and derogatory terms to the resident, their families or within their hearing distance regardless of age, ability to comprehend, that would demean or humiliate. Mental abuse could be verbal or non-verbal and could include humiliation, harassment, or threats of punishment or deprivation. Neglect was defined as indifference or disregard for resident care, comfort or safety that resulted in or could have resulted in physical harm, pain, mental anguish, or emotional distress. <Resident 8> According to the 03/08/2026 annual assessment, Resident 8 had diagnoses that included arthritis and paraplegia (complete paralysis of the lower half of the body). The assessment further showed Resident 8 utilized a motorized wheelchair (WC) independently. Resident 8 was cognitively intact and able to clearly verbalize their needs. Review of the 06/06/2025 mobility care plan showed Resident 8 utilized a wheelchair for mobility. No documentation was found that identified Resident 8 utilized a motorized WC or to show goals and interventions for safe motorized WC mobility were developed or implemented. Review of the facility incident and accident log from 10/01/2025 through 04/01/2026 showed an entry on 01/25/2026 Resident 8 was stuck by a vehicle when out of the facility. There was no documentation of the alleged incidents or investigation findings were reported to the state agency, as required. Review of the 01/25/2026 facility incident report showed Resident 8 returned to the facility from a community outing at approximately 10 PM and reported their motorized WC had been struck by a car and it caused them to fall out of their WC. Resident 8 had abrasions to their right leg. Resident 8's motorized WC was assessed by a WC technician due to it not functioning properly after the accident and required a wheel adjustment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/08/2026 at 1:20 PM, Resident 8 sat in their room in their motorized WC. Resident 8 stated they were hit by a car when they were returning to the facility from a community outing at night. Resident 8 explained the impact caused their motorized WC to tip over, they flew out of it, sustained road rash and the impact dented their WC wheel. In an interview on 04/08/2026 at 2:07 PM, Staff D, Physical Therapist, stated if staff observed safety concerns with motorized WC use then it would be brought up to the team for follow-up. Staff D stated Resident 8 was involved in an accident recently where there was damage to the motorized WC. Staff D acknowledged Resident 8 tends to drive on the road. In an interview on 04/08/2026 at 2:40 PM, Staff C, Resident Care Manger, stated Resident 8 was involved in a car accident while they drove their motorized WC in the community. <Resident 4 and Resident 72> Review of the facility incident log from 10/01/2025 through 04/01/2026, showed that Resident 4 was involved in a physical altercation with Resident 72 on 10/24/2025 and another altercation with Resident 15 on 12/07/2025. There was no documentation that the alleged incident or investigation findings were reported to the state agency, as required. According to a comprehensive assessment dated [DATE], Resident 4 was fully alert, oriented and made their needs known. They had diagnoses that included anxiety, depression and arthritis of their hip. Resident 4 used a wheelchair independently to get around in the facility. Review of the 11/20/2025 care plan, showed Resident 4 had a impulsive behaviors and made accusations against staff. Staff were to approach in a calm manner, provide opportunities for positive interactions by stopping and talking with them, and document behaviors and resident response to interventions attempted. According to the 01/07/2026 quarterly assessment, Resident 72 had diagnoses that included anxiety. Resident 72 was cognitively intact and able to verbalize their needs. Review of the facility investigation regarding the incident on 10/23/2025 between Resident 4 and Resident 72, included Resident 4's face sheet, care plan and two reports. One report, written by the former Director of Nursing (DNS), documented that Resident 4 and Resident 72 got into a disagreement in the smoking area. The report summarized the interview with Resident 4, who reported that Resident 72 raised their fist (as if to punch), so they grabbed Resident 72 and they hit each other. The former DNS told Resident 4 that the altercation could be considered abuse. Resident 4 told the former DNS they would not threaten or hit anyone again. The document concluded that abuse was not suspected in this incident. The note from Staff DD, Social Services Director, showed the same conclusion. The investigation contained no documentation the allegation was reported to the state agency, as required. <Resident 4 and Resident 15> Review of the facility investigation dated 12/07/2025, showed a nursing assistant (NA) had reported that Resident 4 told Resident 15 to get the f**k out of my way and then backhanded Resident 15 on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shoulder as they passed. The two residents were separated and assessed. The investigation folder included a physical aggression-initiated form about Resident 4, which showed that the resident denied the situation and did not remember the interaction. A physical aggression received report about Resident 15 showed that they were unable to give a description of the incident. Both reports documented the resident was observed as they smacked Resident 15 on the shoulder while passing. The investigation contained no documentation the alleged incident or investigation results were reported to the state agency, as required. During an interview on 04/13/2026 at 11:38 AM, Staff L, NA, stated that if one resident hit another resident, that would be considered abuse, and the facility would need to report it to the state and investigate it. During an interview on 04/13/2026 at 11:53 AM, Staff H, NA, stated that if a resident was observed or admitted to hitting another resident, that needed to be reported to the state by calling the hotline. They further stated if in doubt, report it. During an interview on 04/13/2026 at 12:05 PM, Staff GG, Licensed Practical Nurse (LPN), stated that physical abuse could be hitting or pushing. If a resident hit another resident, that would definitely be abuse and should be reported to the DNS and administration immediately because there is a certain amount of time that it must be reported to the state. <Resident 34 and Resident 107> Review of the facility 10/01/2025 through 04/01/2026 incident log showed Resident 34 and 107 were involved in a resident-to-resident altercation on 11/09/2025. There was no documentation that the alleged incident or investigation findings were reported to the state agency, as required. According to the 12/04/2025 discharge assessment, Resident 107 had diagnoses that included depression. Resident 107 was cognitively intact and could clearly verbalize their needs. Review of the 02/08/2025 care plan, showed Resident 107 demonstrated verbally aggressive behaviors related to ineffective coping skills. Staff were to assess and anticipate the residents' needs and understanding of the situation, provide time to express self, intervene before agitation escalated, and guide away from the source of the distress. According to the 01/21/2026 annual assessment, Resident 34 had diagnoses that included dementia with behavioral disturbance. The assessment further showed Resident 34 was able to ambulate independently without an assistive device, had moderate cognitive impairment and could clearly verbalize their needs. Review of the 02/12/2025 care plan, showed Resident 34 received mood stabilizing medication related to exhibiting verbally aggressive outbursts. Staff were to approach in a calm manner, provide the resident opportunities for a positive interactions by stopping and talking with them, and monitor effectiveness of interventions attempted. Review of the 11/09/2025 facility investigation showed Resident 107 received verbal aggression from Resident 34. Resident 107 explained they were sitting at the nurses' station, with residents and staff present, visiting with a peer when Resident 34 approached them, grabbed an item from them and threw it in the trash. When Resident 107 stated they did not request the item be thrown out Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	34 became very upset and replied, I should just beat the s**t out of you. The investigation contained no documentation the alleged incident or investigation results were reported to the state agency, as required. <Resident 105 and Resident 106> Review of the facility 10/01/2025 through 04/01/2026 incident log showed Resident 105 and 106 were involved in a resident-to-resident altercation on 12/05/2025. There was no documentation that the alleged incident or investigation findings were reported to the state agency, as required. According to the 12/13/2025 discharge assessment, Resident 105 had diagnoses that included bipolar disorder (chronic mental health disorder characterized by intense, extreme mood swings that interfere with daily life). Resident 105 was cognitively intact. Review of the care plan initiated on 12/09/2025, showed Resident 105 had a history of making accusations towards care givers and roommates frequently. Staff were to approach in a calm manner, provide the resident opportunities for positive interactions by stopping and talking with them, monitor effectiveness of interventions attempted, and provide cares in pairs (with two staff). According to the 03/05/2026 discharge assessment, Resident 106 had diagnoses that included anxiety. Resident 106 was cognitively intact. Review of the 02/24/2026 care plan showed Resident 106 had depression. Review of the 12/05/2025 facility investigation showed Resident 105 initiated verbal aggression towards their roommate, Resident 106, regarding cleanliness of the room but contained no incident details. The investigation contained no documentation of resident or staff witness statements or interviews. A summary showed staff completed a room move, both residents remained at baseline with no psychosocial harm observed so abuse/neglect was ruled out. There was no documentation that the alleged incident or investigation results were reported to the state agency, as required. <Resident 103 and Resident 104> Review of the facility 10/01/2025 through 04/01/2026 incident log showed Resident 103 and 104 were involved in a resident-to-resident altercation on 12/09/2025. There was no documentation that the alleged incident or investigation results were reported to the state agency, as required. According to the 01/02/2026 discharge assessment, Resident 103 had diagnoses that included stroke with paralysis on one side of the body. Resident 103 was cognitively intact. Review of the 12/05/2025 self-care deficit care plan showed Resident 103 required extensive assistance from staff to perform most activities of daily living. According to the 12/14/2025 discharge assessment, Resident 104 had diagnoses that included intracranial abscess (pus-filled pocket of infection in the brain) and granuloma (solid tumor-like lump). Resident 104 was cognitively intact and able to ambulate independently. Review of the 12/09/2025 facility investigation showed Resident 103 received verbal aggression from their roommate, Resident 104. Resident 103 explained that their roommate made threatening (continued on next page)

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	505024	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	6021 North Lidgerwood Spokane, WA 99207

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	statements about putting their hands on them and they were concerned for their safety. The investigation contained no documentation of resident or staff witness statements or interviews. A summary showed staff completed a room move, both residents remained at baseline with no psychosocial harm observed so abuse/neglect was ruled out. There was no documentation that the alleged incident or investigation results were reported to the state agency, as required. <Resident 90 and Resident 102> Review of the facility 10/01/2025 through 04/01/2026 incident log showed Resident 90 and 102 were involved in a resident-to-resident altercation on 12/11/2025. There was no documentation that the alleged incident or investigation results were reported to the state agency, as required. According to the 02/11/2026 annual assessment, Resident 90 had diagnoses that included non-traumatic brain dysfunction (brain damage caused by internal forces such as illness or infection). Resident 90 had moderate cognitive impairment. Review of the care plan initiated on 12/07/2022 showed Resident 90 had the potential to demonstrate verbally aggressive behaviors towards staff and peers. Staff were to assess the residents' needs and understanding of situation, document behaviors observed, and to intervene before agitation escalated. According to the 01/23/2026 discharge assessment, Resident 102 had diagnoses that included surgical site infection. Resident 102 was cognitively intact. Review of the 10/28/2025 baseline care plan showed Resident 102's goal was to maintain quality of life. Review of the 12/11/2025 facility investigation showed Resident 90 initiated verbal aggression towards Resident 102 regarding telephone use and volume but contained no incident details. Resident 90 could not recall the incident events. The investigation contained no documentation of resident or staff witness statements or interviews. A summary showed both residents remained at baseline with no psychosocial harm observed so abuse/neglect was ruled out. There was no documentation that the alleged incident or investigation results were reported to the state agency, as required. <Resident 99 and Resident 100> Review of the facility 10/01/2025 through 04/01/2026 incident log showed Resident 99 and 100 were involved in a resident-to-resident altercation on 02/05/2026. There was no documentation that the alleged incident or investigation results were reported to the state agency, as required. According to the 02/20/2026 discharge assessment, Resident 99 had diagnoses that included dementia. Review of the 01/23/2026 care plan showed Resident 99 was resistive to cares and instructed staff to educate the resident/family of the possible outcomes of non-compliance, allow choices, and reapproach if care was refused. According to the 02/10/2026 discharge assessment, Resident 100 had diagnoses that included arm and leg skin infection. Resident 100 was cognitively intact. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 01/29/2026 care plan showed Resident 100 had anxiety and instructed staff to educate the resident/family on the potential risks versus benefits of medication use and monitor for medication effectiveness and side effects. Review of the 02/05/2026 facility investigation showed Resident 99 initiated physical aggression towards their roommate, Resident 100, after a verbal altercation became physical. Resident 99 hit Resident 100 in the forehead. The investigation contained no documentation of resident or staff witness statements or interviews. A summary showed staff completed a room move, both residents remained at baseline with no psychosocial harm observed so abuse/neglect was ruled out. There was no documentation that the alleged incident or investigation results were reported to the state agency, as required. In an interview on 04/08/2026 at 1:39 PM, Staff F, Nursing Assistant, stated when an allegation of abuse or neglect was received it was immediately reported to the nurse, social services, Director of Nursing (DNS), administrator and the State Survey Agency. Staff F explained that residents involved in verbal or physical resident-to-resident altercations were also potential allegations of abuse that needed to be reported and thoroughly investigated because it placed residents at risk for continued abuse if not. Staff F acknowledged staff should definitely take allegations of abuse seriously. In an interview on 04/08/2026 at 1:47 PM, Staff E, Licensed Practical Nurse, stated when there was an allegation of abuse to include verbal and physical resident-to-resident altercations, it was reported to the supervisor on duty and the administrator and if needed the administrator would report to the State Survey Agency. In an interview on 04/08/2026 at 2:46 PM, Staff C, Resident Care Manager, stated when there was an allegation of abuse the DNS, administrator, and State Survey Agency was notified. Staff C stated resident-to-resident altercations could be allegations of abuse. Staff C further stated residents were at risk for continued abuse and harm if abuse was not properly identified and reported. Staff C acknowledged staff were mandatory reporters. In an interview on 04/08/2026 at 2:51 PM, Staff CC, Social Service Director, stated resident to resident altercations could be potential allegations of abuse that needed to be reported to the State Survey Agency. Staff CC acknowledged staff were expected to appropriately identify and report allegations of abuse to keep residents out of harms way. In an interview on 04/08/2026 at 3:46 PM, Staff B, DNS, allegations of abuse varied and depended on what and how something was reported. Staff B further stated staff were expected to identify and report allegations of abuse to ensure resident safety. In an interview on 04/08/2026 at 4:07 PM, Staff O, Regional Director, acknowledged the resident to resident altercations mentioned above were not reported to the state agency, as required. In an interview on 04/13/2026 at 11:39 AM, Staff A, Administrator, stated they expected staff to appropriately identify and report allegations of abuse, as required. Reference WAC 388-97-0640(5)(a)

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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 observation, interview and record review, the facility failed to coordinate with the State designated authority to ensure residents with a mental disorder received integrated care based on their needs for 1 of 5 sampled residents (Resident 11), reviewed for Pre-admission Screening and Resident Review (PASRR, a mental disorder and intellectual disabilities screening). Specifically, Resident 11's Level I screening was not completed correctly prior to admission. This failure placed the resident at risk of decline in their psycho-social needs or inability to benefit from all services they were entitled to.Findings included.The 02/06/2026 significant change assessment documented Resident 11 was admitted to the facility on [DATE] and had diagnoses that included depression, anxiety and post-traumatic stress disorder (PTSD, a mental health condition triggered by experienced or witnessed terrifying, life threatening or abusive events).The history and physical from the emergency room on [DATE] documented Resident 11 had a diagnosis of anxiety.On 12/03/2025, a Level I PASRR screening (which determined the presence of a severe mental illness or developmental disability) was completed. It was documented Resident 11 had no serious mental illness and that a Level II PASRR screening (an evaluation to determine if nursing home placement was the appropriate level of care and what behavioral health or other community services were recommended once a resident is admitted to the facility) was not indicated.In an interview on 04/09/2026 at 3:19 PM, Staff DD, Social Service Director, stated PASRRs were completed in the hospital prior to admission. Staff DD stated they reviewed PASRRs for accuracy, and if they were incorrect, they were not supposed to admit the residents. Staff DD stated if a resident had a diagnosis of anxiety from the hospital and were staying in the facility greater than 30 days a Level II was required. Staff DD stated it was important the [NAME] II be completed in the hospital prior to admission to ensure the facility had the resources needed to care for the resident. Staff DD stated Resident 11's PASRR was incorrect because they had diagnoses including depression, PTSD, and substance use disorder and a Level II should have been completed. In an interview on 04/09/2026 at 3:39 PM, Staff B, Director of Nursing, stated PASRRs were completed at the hospital and evaluated by Social Services. Staff B stated most PASRRs were not completed prior to admission. Reference: WAC 388-97-1915(1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review the facility failed to implement care planned interventions for 2 of 4 sampled residents (Resident 28 and 62), reviewed for quality of care. Specifically, Resident 28 did not have bed rails in place and Resident 62 was not provided large print reading material as care planned. This failure placed residents at risk of unmet care needs and diminished quality of life.Findings included.Review of the facility policy titled, Care Planning revised May 2023 showed, the care plan was an interdisciplinary communication tool that must contain measurable objectives with time frames and describe services to be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. <Resident 28>According to the 02/18/2026 quarterly assessment, Resident 28 had diagnoses that included a left leg above the knee amputation. The assessment showed Resident 28 required substantial assistance from staff for bed mobility. Resident 28 was cognitively intact and able to clearly verbalize their needs.Review of the 08/12/2025 care plan showed Resident 28 had a self-care deficit and required extensive staff assistance of two staff for bed mobility. The 08/15/2025 care plan showed Resident 28 was to utilize bed rails to assist with bed mobility related to their left leg amputation.Review of 03/30/2026 and 04/03/2026 therapy to nursing communication notes indicated Resident 28 could benefit from bed rails to participate better with cares, repositioning, and bed mobility with reduced assistance.During observation and interview on 04/02/2026 at 9:42 AM, Resident 28 was observed laying in bed and the bed did not have bed rails or mobility bars attached. They stated their bed used to have bed rails/mobility assist bars on it, but they were removed when they changed rooms. Resident 28 explained they had significant trouble with bed mobility and was practically dependent on staff assistance. They stated if there were bed rails in place, it allowed for them to but with the bed rails in place it allowed for them to help a little with their bed mobility. Resident 28 stated I need them. I want them back. Similar observations of the resident laying in bed were made on 04/02/2026 at 3:53 PM, on 04/03/2026 at 8:28 AM, 10:22 AM, and 2:31 PM, on 04/06/2026 at 9:13 AM, 11:40 AM, 1:08 PM, and 2:23 PM, on 04/07/2026 at 8:36 AM, 10:48 AM, and 1:03 PM, on 04/08/2026 at 1:31 PM, and on 04/09/2026 at 10:27 AM.During observation and interview on 04/09/2026 at 10:46 AM, Staff G, Nursing Assistant (NA), stated they could find how much assistance and what assistive devices a resident needed by reviewing the Kardex (quick reference guide with information from the care plan). Staff G stated staff were expected to implement interventions because each resident's needs were different and the Kardex was tailored to their specific needs and could potentially have adverse effects if not followed. Staff G observed Resident 28's bed without bed rails. Staff G acknowledged Resident 28 used to have rails on their bed to assist with bed mobility.During observation and interview on 04/09/2026 at 10:59 AM, Staff E, Licensed Practical Nurse (LPN), stated a resident's care plan would identify a resident's needs. Staff E observed Resident 28's bed without bed rails. Staff E stated Resident 28 used to have bed rails on their bed. Staff E reviewed Resident 28's medical record. Staff E acknowledged Resident 28 should have bed rails on their bed to assist with bed mobility related to their left leg amputation.During observation and interview on 04/09/2026 at 11:08 AM, Staff C, Resident Care Manager (RCM), stated staff could find a resident needs in the care plan and were expected to follow it. Staff C observed Resident 28's bed without bed rails. Staff C acknowledged Resident 28's bed should have bed rails on it.In an interview on 04/09/2026 at 11:55 PM, Staff B, Director of Nursing (DNS), stated staff were expected to implement care planned interventions, the resident's ability to function could be negatively impacted if not followed. Staff B reviewed Resident 28's medical record. Staff B acknowledged Resident 28 could benefit from bed rails, they were care planned and should be on their bed.<Resident 62>According to the 03/12/2026 admission assessment, Resident 62 had diagnoses that included fractures. The assessment further showed Resident 62 had impaired vision and could see large print but not regular print in newspapers(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or books with glasses but did not use glasses. Resident 62 was cognitively intact.Review of the 03/10/2026 life enrichment evaluation showed Resident 62 read on occasion and did not wear glasses or use special reading devices such as magnifying equipment.Review of the 03/18/2026 care plan showed Resident 62 had impaired vision and instructed staff to approach from the front, keep walkways free of clutter, provide adequate lighting and large print books or books on tape as desired.During observation on 04/02/2026 at 3:42 PM, Resident 62 had an activities calendar with extremely small print on regular sized paper posted across the room from their bed, on the wall under the television. Similar observations were made on 04/03/2026 at 10:30 AM, 11:37 AM, and 2:30 PM, on 04/06/2026 at 8:52 AM, 11:38 AM, and 1:07 PM.During observation and interview on 04/06/2026 at 2:20 PM, Resident 62 laid in bed and was asked if they could read the activity calendar (which was located across the room from their bed on the wall under the television), Resident 62 stated they could not read it if they put it up close to their face and moved their hand within four inches of their eyes.During observation and interview on 04/09/2029 at 10:49 AM, Staff G, NA, stated the facility cared for residents with visual impairments and the Kardex would show what a resident's needs were. Staff G looked at the activities calendar and acknowledged the print was extremely small and a person with visual impairment could not read it. Staff G further stated, I need glasses to read it myself.During observation and interview on 04/09/2026 at 10:56 AM, Staff E, LPN, stated the facility cared for residents with visual impairments and staff could find their particular needs in the care plan. Staff E observed the activity calendar with extremely small print. Staff E acknowledged a person with visual impairment could not read the activity calendar.During observation and interview on 04/09/2026 at 11:11 AM, Staff C, RCM, stated the facility cared for residents with visual impairments and the care plan would show a resident's needs that staff were expected to implement. Staff C observed the activity calendar with extremely small print. Staff C acknowledged the print was really tiny and someone with visual impairment might not be able to read it.During observation and interview on 04/09/2026 at 11:19 AM, Staff EE, Activities Director, stated the facility cared for residents with visual impairments and the care plan would show a resident's needs that staff were expected to implement. Staff EE observed the activity calendar with extremely small print. Staff EE acknowledged the activities calendar print was tiny. Staff EE reviewed Resident 62's medical record. Staff EE acknowledged Resident 62 had visual impairment, required large print books and most likely also needed larger print for other reading materials.During observation and interview on 04/09/2026 at 11:51 AM, Staff B, DNS, stated the facility cared for residents with visual impairments and staff were expected to implement care planned interventions. Staff B observed the activity calendar and acknowledged the activities calendar font was small and was even difficult for them to read with glasses.In an interview on 04/13/2026 at 11:39 AM, Staff A, Administrator, stated they expected staff to implement care planned interventions.Reference WAC 388-97-1020 (1)(2)(a)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent and monitor residents after accidents occurred for 4 of 9 sampled residents (Resident 7, 8, 44, and 69), reviewed for accidents. These failures resulted in Resident 7 sustained an injury and placed residents at risk of potentially avoidable accidents, increased falls and defective devices. Findings included. Record review of the facility policy titled, Accidents and Incidents revised February 2023 showed, the facility was to provide an environment that was free from hazards over which the facility had control over and provided supervision and assistance devices to each resident to prevent avoidable accidents. The policy defined an avoidable accident as an incident that occurred when the center failed to: identify environmental hazards, evaluate hazards and risks, implement interventions, monitor and modify interventions as necessary. An incident report was to be completed to investigate unusual incidents. The administrator was to be notified if a medical device caused or contributed to an injury. Residents were to be monitored for a minimum of 72 hours after an incident occurred. Record review of a 2024 Neurological Assessment Flowsheet (neuro sheet) showed the form should be completed after a fall if the head was struck or if the fall was not witnessed. The form further documented that neurological checks (neuro checks, pupil reaction and hand grasps) and vital signs (VS, temperature, pulse, respiratory rate and blood pressure) should be done every hour- 4 times, then every 4 hours- 6 times. <Resident 8> According to the 03/08/2026 annual assessment, Resident 8 had diagnoses that included arthritis and paraplegia (complete paralysis of the lower half of the body). The assessment further showed Resident 8 utilized a motorized wheelchair (WC) independently. Resident 8 was cognitively intact and able to clearly verbalize their needs. Review of the 06/06/2025 mobility care plan showed Resident 8 utilized a wheelchair for mobility. The care plan did not address any identified risk, assessed hazards or ability to safely operate, safety interventions or monitoring for safety and risk regarding the WC for Resident 8. Review of the facility incident and accident log from 10/01/2025 through 04/01/2026 showed an entry that Resident 8 was struck by a vehicle when out of the facility on 01/25/2026. Review of the 01/25/2026 facility incident report which was received on 04/02/2026, showed Resident 8 returned to the facility from a community outing at approximately 10:00 PM and reported their motorized WC had been struck by a car and it caused them to fall out of their WC. Resident 8 had abrasions to their right leg. The provider was notified of the event and ordered a left shoulder x-ray. Resident 8's motorized WC was assessed by a WC technician due to it not functioning properly after the accident and required a wheel adjustment. The motorized WC was noted to have several reflectors in place for safety, staff offered additional reflectors, a safety jacket, and a light. Review of physical therapy progress notes from 01/26/2026 through 04/03/2026 showed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-01/26/2026 Resident 8's motorized WC was inspected and found to have a right bent wheel. Resident 8 was educated on avoiding long community trips and uneven terrain until the WC could be further assessed by a motorized WC technician. -1/28/2026 a motorized WC mechanic assessed Resident 8's chair and uncovered further damage and repairs would be needed. -02/03/2026 a motorized WC assessment and evaluation was completed to determine all parts required for the needed repairs. As of 04/02/2026 there was no motorized WC driving assessment or updated mobility care plan to include interventions or preventative measures. -04/03/2026 (the day after the car accident incident report was requested and 68 days after Resident 8 was hit by a car) Resident 8 was given a motorized WC driving assessment indoors with various standard tasks such as reversing, doorways, maneuvering in congested areas, out in the courtyard, and out in the community over sidewalks and crosswalks. Resident 8 was identified as independent with motorized WC use. In an interview on 04/08/2026 at 1:20 PM, Resident 8 sat in their room in their motorized WC. Resident 8 stated they were hit by a car when they were returning to the facility from a community outing at night. Resident 8 stated they were crossing the street, was halfway through the intersection, when a car failed to stop at a stop sign and hit them. Resident 8 explained the impact caused their motorized WC to tip over, they flew out of it, sustained road rash and the impact dented their WC wheel. In an interview on 04/08/2026 at 1:38 PM, Staff F, Nursing Assistant, stated residents who utilized a motorized WC needed to be evaluated by therapy for safety prior to allowing use. Staff F further stated motorized WC use should be care planned. In an interview on 04/08/2026 at 1:45 PM, Staff E, Licensed Practical Nurse, stated therapy needed to evaluate residents for motorized WC safety prior to use and motorized WC use would be care planned. In an interview on 04/08/2026 at 2:07 PM, Staff D, Physical Therapist, stated if a resident wanted to utilize a motorized WC, therapy would do an assessment. Staff D explained that the therapist would review the resident's motorized WC use history, if a resident was questionable then they would only be allowed to utilize the motorized WC during therapy sessions and required three consecutive days of error-free driving prior to clearing them for independent use and requesting the care plan be updated accordingly. Staff D further stated if staff observed safety concerns with motorized WC use then it would be brought up to the team for follow-up. Staff D stated Resident 8 was involved in an accident recently where there was damage to the motorized WC but it remained drivable while needed parts were on order. Staff D acknowledged Resident 8 tends to drive on the road. In an interview on 04/08/2026 at 2:40 PM, Staff C, Resident Care Manager, stated Resident 8 was involved in a car accident while they drove their motorized WC in the community. Staff C acknowledged Resident 8 should have been reassessed by therapy for motorized WC safety after the accident to make sure it was not an error on Resident 8's part. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/08/2026 at 3:42 PM, Staff B, Director of Nursing, acknowledged Resident 8 should have been reevaluated by therapy for motorized WC safety after they were hit by a car during a community outing. <Resident 7> The 02/23/2026 annual assessment, documented Resident 7 had diagnosis that included amputations (removal below the knee) of both lower legs. Resident 7 was cognitively intact, required set up assistance to moderate assistance with activities of daily living. The 03/10/2025 fall care plan, documented Resident 7 was at risk for falls related to poor balance and deconditioning. The fall care plan instructed nursing staff to monitor the resident for 72 hours post falls for pain, bruises, and changes in mental status and to complete neurological assessments per protocol. The facility incident log showed Resident 7 had a fall on 03/29/2026 in the bathroom. A 03/29/2026 progress note at 8:56 PM, documented Resident 7 fell off of the shower room bench due to the bench tipping forward. The bench was missing the rubber caps on the bottom of the legs which caused it to move. A 03/29/2026 progress note at 9:10 PM, documented Resident 7 fell when they attempted to get dressed in the shower room while sitting on the shower bench. Resident 7 stated the shower bench was moving and not seated correctly on the floor. Resident 7 stated they pulled up on their brief and the bench tilted forward and caused them to fall. Resident 7 received a skin tear to their right stump. A 04/02/2026 progress note by the provider stated Resident 7 reported they had a fall during the weekend due to faulty equipment in the shower. The post fall packet that was included in the facility investigation completed on 03/29/2026 documented the shower chair was missing the rubber caps that went on the bottom of the legs of the shower bench. The neurological checks were not completed on 03/29/2026 at 8:15 PM, 03/30/2026 at 2:15 AM, 2:15 PM, and 6:15 PM. In an observation on 04/07/2026 at 3:35 PM, the shower bench in the Southeast Hall was missing two of the four rubber stoppers on the bottom of the chair. In an observation on 04/08/2026 at 1:09 PM, the shower bench in the Northwest Hall was missing one of the rubber stoppers on the bottom of the chair. In an interview on 04/09/2026 at 8:55 AM, Staff M, Nursing Assistant, stated when equipment had missing parts or needed repair, they put it in the electronic maintenance system and informed the nurse. In an interview on 04/09/2026 at 9:34 AM, Staff N, Resident Care Manager, stated it was important to have the rubber stoppers on the shower benches to prevent the shower chair from slipping and falls. Staff N stated neurological assessments were required to be completed for unwitnessed falls and when someone hit their head. Staff N stated it was important to monitor neurological assessments to rule out trauma. (continued on next page)

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	505024	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spokane Falls Care	6021 North Lidgerwood Spokane, WA 99207

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/10/2026 at 2:00 PM, Staff V, Maintenance Director, stated they were notified when things were missing parts or needed repaired through the electronic maintenance system. Staff V stated they replaced the rubber stoppers on the shower bench but did not check the other benches in the rest of shower rooms. Staff V stated it was their expectation staff notified them when things were broken or missing parts. In an interview on 04/13/2026 at 11:24 AM, Staff B, Director of Nursing, stated it was their expectation that the shower benches had all their rubber stoppers on them for stability. <Resident 44> According to the 02/08/2026 admission assessment, Resident 44 admitted to the facility on [DATE] with diagnoses that included stroke and absence of right upper limb. The assessment further showed Resident 44 did not sustain any falls in the last six months prior to facility admission but sustained falls since facility admission. Resident 44 was severely cognitively impaired and required use of a wheelchair. Review of the 02/03/2026 care plan, showed Resident 44 had limited physical mobility, was at risk for falls, and was dependent on staff for cares. Staff were instructed to remind Resident 44 to use call light when needing assistance, wear proper footwear, and involve Resident 44 in activities that minimize the potential for falls while providing diversion and distraction. Review of the facility incident and accident log from 02/01/2026 through 04/01/2026 showed Resident 44 sustained 7 falls in two months: on 02/05/2026, 02/15/2026, 02/20/2026, 02/24/2026, 03/17/2026, 03/20/2026, and 03/22/2026. Review of the Resident 44's facility fall investigations showed the following: There was no documentation of vital signs and neuro checks being completed as required, per the flowsheet timeline for falls on 02/05/2026, 02/20/2026, 03/17/2026, and 03/22/2026. There was no documentation that the resident was monitored after incidents that occurred on 02/05/2026, 02/20/2026, 03/17/2026, and 03/22/2026. In an interview on 04/08/2026 at 1:14 PM Staff U, Registered Nurse, stated when a resident fell, they were to make sure the environment was safe and obtain vital signs. Staff U stated there was a paper fall packet that needed to be completed. The packet included nursing actions to be taken, such as a complete body assessment, obtain vital signs, and complete neuro checks every hour for four hours then every four hours after. Staff U also stated the fall packets should be completely filled out without omissions. In an interview on 04/09/2024 at 10:47 AM Staff C, Resident Care Manager, stated a fall packet was to be completed after a resident fell, the resident placed on alert charting to assess and monitor for latent injuries, and complete neuro checks for 72 hours. Staff C stated it was important to complete the fall packet to appropriately assess for any signs or symptoms of potential latent injury. In an interview on 04/09/2026 at 02:24 PM Staff B, Director of Nursing, acknowledged Resident 44 was not consistently monitored for injury as required after their falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 69> According to a recent quarterly assessment dated [DATE], Resident 69 had moderately impaired cognition with hallucinations, disorganized thinking and inattention. The resident had diagnoses which included dementia, history of a stroke that affected one side of the body and weakness. Resident 69 required staff assistance with bed mobility, transferring, toileting and using their wheelchair. Review of the facility incident log showed that Resident 69 had 12 falls in six months, from 10/01/2025 through 03/30/2026. Review of the fall investigations referenced in the incident log and Resident 69's medical record showed the following: There was no documentation of vital and neuro checks being completed as required, per the flowsheet timeline for falls on 10/12/2025, 02/05/2026 and 03/30/2026. There was no documentation that Resident 69 was monitored for 72 hours after the incidents, for the falls that occurred on 12/19/2025, 12/23/2025, 01/01/2026 and 02/05/2026. During an interview on 04/08/2026 at 1:21 PM, Staff M, Nursing Assistant (NA), stated that when a resident fell, they would be assessed by a nurse and then vital and neuro checks would be done. They were not sure of the frequency but did them according to the schedule on the paper neuro flowsheet. During an interview on 04/09/2026 at 12:33 PM, Staff N, Residential Care Manager (RCM), stated that after a fall where a resident may have hit their head, staff completed vital and neuro checks, according to the timeline on the neuro flowsheet. They further stated that the resident should be put on alert charting, and charted on every shift for at least 72 hours, to monitor for injury. During an interview on 04/13/2026 at 1:39 PM, Staff B, Director of Nursing, acknowledged that Resident 69 had not been monitored completely for injury, following some of their falls. Reference: WAC 388-97-1060 (3)(g)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation and interview, the facility failed to maintain oxygen equipment in a clean and sanitary manner for 2 of 3 sampled residents (Residents 62 and 74) and failed to administer oxygen per provider orders for 1 of 3 sampled residents (Resident 74), reviewed for respiratory care. This failure placed residents at risk of potential medical complications, potential respiratory infections, and diminished quality of life.Findings included. <Resident 74> The 12/04/2025 quarterly assessment documented Resident 74 had diagnoses that included chronic obstructive pulmonary disease (COPD, a progressive lung disease that blocked airflow and made it difficult to breathe), and respiratory failure. Resident 74 was cognitively intact and dependent on oxygen. The 08/28/2025 oxygen care plan instructed nursing staff to administer medications as ordered by the physician. An 08/28/2025 provider order instructed nursing staff to wash the concentrator filter weekly. A 03/21/2026 provider order instructed nursing staff to administer oxygen at 2L continuously for COPD. The March 2026 Medication Administrator Record (MAR) showed Resident 74 received 3L (liters) of oxygen on 16 occasions. The April 2026 MAR showed Resident 74 received 3L of oxygen on six occasions. In an observation on 04/01/2026 at 10:51 AM, Resident 74 was lying in bed wearing oxygen at 3L via a nasal cannula, not 2L as ordered. The oxygen filter was covered in thick dust debris. Observations of Resident 74's oxygen concentrator on 04/02/2026 at 3:41 PM, 04/03/2026 at 2:29 PM, 04/06/2026 at 8:44 AM and 1:35 PM, 04/07/2026 at 3:17 PM, 04/08/2026 at 1:21 PM and 04/09/2026 at 8:37 AM showed they received 3L of oxygen. Observations of Resident 74's oxygen filter on 04/02/2026 at 11:50 AM, 04/02/2026 at 3:41 PM, 04/03/2026 at 8:37 AM and 2:29 PM, 04/06/2026 at 8:44 AM, 12:14 PM and 1:35 PM, 04/07/2026 at 8:21 AM and 3:17 PM, 04/08/2026 at 1:21 PM, and 04/09/2026 at 8:37 AM showed it was covered in thick dust debris. In an interview on 04/10/2026 at 2:34 PM, Staff R, Licensed Practical Nurse, stated oxygen filters were cleaned weekly on Sundays by the nurses. Staff R stated it was important to maintain the filters in a clean manner, so the flow of oxygen was not blocked, and the residents received the proper amount of oxygen. Staff R stated it was important to administer oxygen as ordered to prevent residents with COPD from retaining carbon dioxide. Staff R stated Resident 74 was prescribed 2L of oxygen. At 2:39 PM, Staff R observed Resident 74's oxygen and turned it down from 3L to 2L and removed the oxygen filter. When Staff R touched the filter dust fell off, and they stated it was very dusty. In an interview on 04/10/2026 at 2:52 PM, Staff B, Director of Nursing, stated it was important to administer oxygen as ordered to maintain the resident's oxygen saturations and to avoid the residents from retaining carbon dioxide. Staff B stated it was important to keep the filters clean, so the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents did not breathe dust into their lungs. <Resident 62> According to the 03/12/2026 admission assessment, Resident 8 had diagnoses that included COPD, interstitial pulmonary disease (group of conditions that caused inflammation and scar tissue to lungs which made the lungs stiff and caused difficulty breathing), and chronic respiratory failure. The assessment further showed Resident 8 utilized a non-invasive mechanical ventilator (machine that helped a person breathe by pushing air into the lungs through a tight-fitting mask). Resident 8 was cognitively intact and able to clearly verbalize their needs. Review of the 03/17/2026 care plan showed Resident 62 had obstructive sleep apnea (common sleep disorder where the airway collapsed or becomes blocked during sleep that caused breathing to repeatedly stop and start) and utilized a Bilevel Positive Airway Pressure (BiPAP, non-invasive ventilator that delivered pressurized air through a mask). An intervention instructed staff to monitor the resident for signs and/or symptoms of respiratory distress and report to the provider. No documentation was found to show how the BiPAP was to be maintained. Review of provider orders showed a 03/10/2026 order that Resident 62 was to utilize a BiPAP nightly. No documentation was found to show how the BiPAP equipment was to be maintained. In an interview on 04/01/2026 at 2:30 PM, Resident 62 laid in bed with a BiPAP machine sitting on the nightstand. Resident 62 stated they brought their BiPAP machine in from home and wore it nightly. Resident 62 further stated staff did not clean their BiPAP mask or tubing. In an interview on 04/09/2026 at 10:51 AM, Staff G, Nursing Assistant, stated BiPAP equipment needed to be cleaned after each use to prevent bacteria build up which could cause a respiratory infection. In an interview on 04/09/2026 at 10:55 AM, Staff E, Licensed Practical Nurse, stated the nurse was responsible for cleaning the BiPAP mask and tubing daily, it would be documented in the resident's treatment administration record. Staff E further stated residents were at risk for infections if this was not completed. In an interview on 04/09/2026 at 11:13 AM, Staff C, Resident Care Manager, stated if a resident utilized a BiPAP machine, provider orders would be entered for daily cleaning of the mask and tubing with soap and water. Staff C reviewed Resident 62's medical record. Staff C acknowledged they were unable to find provider orders for routine cleaning of Resident 62's BiPAP equipment. Staff C stated residents were at risk for respiratory infections if their BiPAP equipment was not cleaned routinely. In an interview on 04/09/2026 at 11:52 AM, Staff B, Director of Nursing, stated that when a resident utilized a BiPAP orders were implemented to clean the mask and tubing daily to prevent potential infection. Staff B further stated they expected staff to maintain BiPAP equipment in a clean and sanitary manner. In an interview on 04/13/2026 at 11:39 AM, Staff A, Administrator, stated they expected staff to maintain BiPAP and oxygen equipment in a sanitary manner. Reference WAC 388-97-1060 (3)(j)(iv)-(vi)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. Specifically, two medication errors were identified during 26 medication administration opportunities. This resulted in an error rate of 7.69 %. This failure placed residents at risk of receiving subtherapeutic (a dosage or concentration that is too low to produce the intended medical effect or treat a disease) effects of their medications, possible adverse side effects, and diminished quality of life.Findings included.During observation on 04/10/2026 at 9:20 AM, Staff Q, Registered Nurse, prepared and administered ten medications for Resident 76.Included in the medications given were the following:Calcium (a supplement) 500 milligrams (mg, a unit of measurement) with Vitamin D 10 micrograms (mcg, a unit of measurement), one tablet by mouth.Colestipol (a cholesterol medication) 1 Gram (Gm, a unit of measurement), one tablet by mouth.A review of Resident 76's orders and April 2026 Medication Administration Record (MAR) showed the following morning medication orders:Calcium 500 mg daily by mouthColestipol 1 Gm, one hour before or three hours after other medications.During an interview with Staff Q on 04/10/2026 at 10:31 AM, Resident 76s morning medication orders were reviewed. Staff Q reviewed the orders on the computer and the stock medication for Calcium, and stated that they should have noticed they gave Calcium with Vitamin D, rather than just calcium. Additionally, when Staff Q looked at the screen for the Colestipol, the directions to give the medication one hour before or three hours after other meds was not fully visible, until the staff clicked on more to see the full directions. Staff Q stated they should have looked closer, and both were medication errors.During an interview on 04/13/2026 at 1:39 PM, Staff B, Director of Nursing, acknowledged both the medication errors. Reference: WAC 388-97-1060(3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure refrigerator temperatures were maintained in an acceptable range and expired medications were removed from inventory in 1 of 2 medication rooms (Medication room [ROOM NUMBER] - South Unit) observed. This failure placed residents at risk of receiving potentially compromised or expired medications. Findings included.<Glucometer Quality Control Testing Solutions>On 04/10/2026 at 9:15 AM the Southeast Medication Cart was observed with Staff E, Licensed Practical Nurse. The cart had two small bottles of control testing solutions in the box of Assure Dose Quality Controls (solutions placed on a test strip that verified the accuracy of glucometer blood sugar test results). The solutions had a manufacturer expiration date of 08/17/2025. Staff E stated the glucometer checks were completed on the nightshift. Staff E stated they did not work nights, so they were unaware of the process. The solutions were removed from the cart's inventory. During an interview on 04/10/2026 at 10:10 AM, Staff B, Director of Nursing (DNS), stated the staff on nightshift performed the glucometer quality control checks each night and documented their results in a logbook kept at the nurse's station. Results in the logbook were reviewed, and it was confirmed that the quality control checks were not completed with the expired control solutions. <Medication room [ROOM NUMBER] - South Unit Medication Room>On 04/10/2026 at 9:35 AM, Medication room [ROOM NUMBER] - South Unit was observed with Staff E and the following findings:Three bottles of Gericare brand Aspirin 325 milligram tablets were expired. One bottle had a manufacturer's expiration date of June 2025, and two bottles had expiration dates of August 2025. Staff E removed the bottles from inventory. The refrigerator was observed. The temperature was 34 degrees Fahrenheit (F), and the freezer compartment contained large quantities of frost. Contents of the refrigerator included the following:Lantus Solostar insulin pensTwo vials of Retacrit (used to treat anemia caused by kidney disease)Humalog 50/50 insulin pensTwo Lorazepam vials (used to treat anxiety)Lispro insulin pensSemglee insulin pensNovolog insulin pensOne Basaglar insulin penTubersol protein derivative (used to test for the presence of Tuberculosis, a bacterial infection found mainly in the lungs)All were reviewed by manufacturer brands and appropriate temperature range for storage was 36 to 46 degrees F.On 04/10/2026 at 10:15 AM, the April 2026 Medication Room and Refrigerator Temperature Log Sheet was reviewed with Staff B, DNS. The log instructed staff to check the temperature both inside and outside of the refrigerator and report out of range temperatures immediately to the Director of Nursing for alternate storage. The log documented refrigerator temperature parameters were 36 to 46 degrees F. The last column on the log asked, if temp is outside of specification, what was done about it? The column had no entries. The following dates had readings outside the documented parameters:04/01/2026 AM 35 degrees F04/02/2026 PM 35 degrees F04/03/2026 AM 35 degrees F04/04/2026 AM 35 degrees F04/05/2026 AM and PM, both 34 degrees F04/06/2026 AM 33 degrees F, PM 35 degrees F,04/08/2026 AM 35 degrees F, PM 34 degrees F04/09/2026 AM 35 degrees [NAME] 04/10/2026 at 10:19 AM, Staff B stated when refrigerator temperatures were too cold, maintenance checked the refrigerators. Staff B notified maintenance at this time. During an interview on 04/13/2026 at 9:52 AM, Staff P, Stock Room Nursing Assistant, stated they checked the medication rooms on Thursdays and Fridays and refilled or replaced expired medications. Staff P stated they missed removing the expired Aspirin found in Medication room [ROOM NUMBER] - South Unit. At this time, the North Medication Room was observed, and there were no additional bottles of expired Aspirin in the inventory. During an interview on 04/13/2026 at 10:31 AM, Staff A, Administrator, stated expired medications were to be removed from the medication rooms. Staff A stated they would check with the Pharmacy regarding the medications stored in the Medication room [ROOM NUMBER] - South Unit to ensure they were acceptable to use. Reference: WAC 388-97-1300(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 store food in accordance with professional standards for food service safety. Specifically, the facility failed to ensure received and opened dates were placed on food items in the refrigerator and freezer, and in 1 of 1 dry storage areas. Additionally, the tile floor in the kitchen was broken, dirty, and not a cleanable surface and there was an active water leak that had not been addressed. The facility failed to wear facial hair coverings appropriately and maintain a clean cooking environment. These failures placed residents at risk for food-borne illnesses.Findings included .<Undated food>During an initial tour of the kitchen on 04/01/2026 at 8:49 AM, the dry storage area revealed three bags of chicken and herb stuffing, a bag of opened vanilla wafers, a bag of 10 opened miniature graham cracker pie crusts, 11 large graham cracker pie crusts and a muffin in a bag that had no received or expiration dates. The main refrigerator in the kitchen had a pan that contained cheese slices, tomatoes, and lettuce that had no date. There was zucchini in a box, some were cut in half and wilted. The freezer contained a chocolate cream pie and a bag of opened waffles with no received or expiration dates. <Sanitary Environment>During an observation on 04/01/2026 at 9:41 AM, the small freezer had food debris on the bottom shelf. The juice machine was unclean with dirt debris covering the filter, the ovens were unclean with food debris on the bottom rack, the convection ovens had thick dirt debris on the outside with brown splatter down the front, the plate warmer was unclean with brown splatter on all sides and the shelf that held the mixer was unclean with food debris. There was a stool in the back near the dishwasher that had dirty rags sitting on it, the toaster had crumbs and brown splatter on the front and all sides, the counters were unclean with food on them. In the back of the kitchen near the toaster, the floors were unclean with food debris, gloves and garbage, a sheet pan that held their vegetable oils and vinegars under the steamer was unclean with spilled oils and dirt debris. As you entered the kitchen there was an area approximately 3 feet long where the tiles were broken along the wall and on the floor with thick dirt debris. There was a bucket on the floor that was catching water from a leak. On 04/07/2026 at 12:18 PM, the cook opened the oven, and it had crusted food debris on the bottom and on the oven door. The convection oven was covered with a brown/black substance on the bottom rack and food debris on the outside. The March and April 2026 cleaning schedules had multiple omissions. In an observation on 04/07/2026 at 1:49 PM, the ice machine had dust debris on the left filter slats and there was dirt built up on the right side of the machine. In an interview on 04/07/2026 at 1:54 PM, Staff T, Dietary Manager, stated it was important to keep the ice machine free of dust debris because it could get into the machine. Staff T stated it was important to keep the ovens clean to prevent bacteria and it could be a fire hazard. Staff T stated it was important to keep the juice machine, freezer, plate warmer, toaster, and shelving clean to prevent bacteria. Staff T stated the broken tiles needed repaired to maintain a clean and safe environment. In an interview on 04/10/2026 at 2:00 PM, Staff V, Maintenance Director, stated they had water damage in the kitchen, and the broken tiles were not a cleanable surface.<Beard coverings>In an observation on 04/10/2026 at 11:29 AM, Staff II, Cook, was wearing a beard cover that did not cover their long, thick mustache or all their beard. Staff II was pulling different shelves out of a cart that had food on them. In an observation on 04/10/2026 at 11:44 AM, Staff T was plating food, and their beard covering did not cover their mustache and part of their beard. Staff T had a thick mustache and beard. In an observation on 04/10/2026 at 11:45 AM, Staff II, stood over the food and read the meal tickets to the dietary manager. Their long, thick mustache and part of their beard was uncovered. In an interview on 04/10/2026 at 1:02 PM, Resident 79 stated they had hair in their food last evening. <Timeliness of meals>In an observation on 04/07/2026 at 12:00 PM, the meal trays went out to the dining room an hour after the meal service was to begin. In an observation on 04/10/2026 at 11:33 AM, the plating of the food had not begun. Staff JJ, Registered Dietician, stated the meals were normally served within (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	about five minutes of their listed times but over the last couple of weeks it had been late. On 04/10/2026 the meal cart went out to the dining room at 12:02 PM, one hour and two minutes after the meal was to be served. In an interview on 04/10/2026 at 12:44 PM, Resident 112 stated with a raised voice they discussed new timelines of when the food would be served in resident council, and the meal was over an hour late. Resident 112 stated they would probably have 10 minutes to finish their meal before their activity and that was unacceptable. In an interview on 04/10/2026 at 2:01 PM, Resident 96 stated lunch was late and they were upset. Resident 96 stated it happened frequently for lunch and dinner. In an interview on 04/13/2026 at 10:04 AM, Staff JJ and Staff T, stated it was important to label food, so they knew when it expired and to prevent bacteria. Staff T stated it was important to start the meal service on time for diabetics who received insulin and for residents who had outings. Staff T and JJ stated beard coverings were worn anytime someone had facial hair and they needed to cover all facial hair for sanitary reasons as it was a physical contaminant. In an interview on 04/13/2026 at 1:34 PM, Staff JJ stated it was important to keep the kitchen clean to prevent the spread of dirt or anything in the environment that may contaminate the food and cause foodborne illness. Reference: WAC 388-97-1100 (3), 2980