STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505033	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwood South Hill	East 2903 25th Avenue Spokane, WA 99223

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to date, cover and discard expired food in the dry storage areas and 1 of 3 refrigerators (refrigerator 1), dishwasher final rinse temperatures were not maintained as required for the dishwasher, and refrigerator and freezer temperatures were not maintained at the required ranges for 2 of 2 dining room refrigerators (DR refrigerator 1 and DR refrigerator 2). The facility further failed to complete hand hygiene when indicated during 2 meal services. Findings included .<Undated/expired/uncovered food> During an initial tour of the kitchen on 03/16/2026 at 9:00 AM, the dry storage area contained the following food items that were undated: 10-pound cans of beans, peaches, pineapples, and pears; cornbread mix; jalapeno peppers; box of dry gravy mix; and a box of opened powdered potatoes. The following foods were expired: marshmallow cream topping, a case of green peppercorns, scalloped potatoes, a bag of chopped peanuts, a bag of hazelnuts, and a bag of dry pasta. Observation of refrigerator 1 found two containers of lettuce that were uncovered and undated. Staff O, Food Services Director, threw away all undated and expired foods. In an interview on 03/16/2026 at 9:00 AM, Staff O stated all food needed to be dated and expired food thrown away for food safety. <Dishwasher Temperatures> During an observation of the kitchen on 03/19/2026 at 12:16 PM, Staff O ran the dishwasher with a final rinse temperature of 162 degrees. Staff O stated it was a high temperature dishwasher and no chemicals were used. Review of the dishwasher temperature logs from 02/15/2026 through 03/19/2026 showed 58 occasions the dishwasher temperature did not reach the required 180 degrees during the final rinse. In an interview on 03/19/2026 at 12:50 PM, Staff O stated the final dishwashing rinse temperature was required to reach 180 degrees to kill bacteria. In an interview on 03/23/2026 at 11:22 AM, Staff Q, Assistant Supervisor for Engineering, confirmed the dishwasher was a high temperature dishwasher and stated final rinse temperature needed to be a minimum of 180 degrees. <Dining Room Refrigerators 1 and 2> During an observation of the North and South Atrium Dining Rooms on 03/16/2026 at 10:01 AM, the (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	refrigerators and freezers did not have temperature logs displayed and were requested from maintenance. Review of the refrigerator/freezer temperature logs from 03/01/2026 through 03/17/2026 showed 56 instances that the temperature of the refrigerators were above 40 degrees as required, and 72 instances that the temperature of the freezers were above 0 degrees as required. In an interview on 03/19/2026 at 12:10 PM, Staff O stated that it was important to maintain the correct refrigerator and freezer temperatures to avoid food borne illnesses and acknowledged the temperatures were out of range. In an interview on 03/23/2026 at 11:22 AM, Staff Q stated the refrigerators needed to be between 35 degrees and 38 degrees, and freezers 0 degrees or less. Reference: WAC 388-97-1100(3) and WAC 388-97-2980(1)(2) <Hand Hygiene> During a meal observation on 03/16/2026 at 11:34 AM, Staff G, Nursing Assistant, put their hair net and apron on, did not perform hand hygiene, then put on a pair of gloves and placed soup on a meal tray. At 11:36 AM, Staff G opened the refrigerator with the same gloved hands and obtained a nutritional shake and placed it on a meal tray. Staff G then walked down the hall wearing the same gloves and knocked on Resident 30's door. Staff G entered the room and placed the meal tray down, removed their gloves, put on a new pair of gloves on without performing hand hygiene and assisted Resident 30 to scoot up in bed. While wearing the same gloves used to assist the resident, Staff G grabbed the top of the soup bowl and tried to hand it to the resident. Staff G used the same gloved hands and opened the resident's nutritional drink, moved their tray closer to them, placed a clothing protector on the resident, opened their silverware and placed their spoon in the soup. At 11:40 AM, Staff G removed their gloves and left the room without performing hand hygiene. In an interview on 03/16/2026 at 11:59 AM, Staff G stated hand hygiene was completed at the beginning of the meal service and when they were contaminated. Staff G stated they should have completed hand hygiene after they put their hair net on and after scooting the resident up in bed prior to touching their food and eating utensils. Staff G stated it was important to perform hand hygiene for infection control. In an observation on 03/19/2026 at 11:37 AM, a nursing assistant student put their hair net on and then put gloves on without hand hygiene performed. The nursing student then sat down and assisted a resident to eat. In an interview on 03/19/2026 at 12:04 PM, the nursing assistant student stated they should wash their hands after they touched their hair and prior to assisting the resident to eat. They stated it was important to wash their hands to prevent germs. In an interview on 03/20/2026 at 1:05 PM, Staff D, Resident Care Manager, stated hand hygiene was completed before entering and exiting the dining room, after putting on hair nets, prior to serving food, after touching the residents and things like door handles, cabinets, drawers, stools, and wheelchairs. Staff D stated it was important to complete hand hygiene to prevent the spread of germs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 03/20/2026 at 1:12 PM, Staff B, Director of Nursing, stated hand hygiene needed to be completed prior to touching food or other items, and it was important to prevent the transmission of diseases. Reference: WAC 388-97-1100(3) and WAC 388-97-2980(1)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement a comprehensive infection prevention program designed to reduce the risk of infections for 1 of 1 residents (Resident 40). These failures placed residents, staff and students at risk of acquiring infections and unintended health consequences.Findings included.<Annual Review of Infection Prevention and Control Policies> Infection Prevention and Control policies were not reviewed annually. During the Entrance Conference conducted on 03/16/2026 at 9:06 AM, policies regarding the Infection Prevention and Control program were requested. The following policies were provided in addition to others requested during the survey: -Infection Prevention and Control, revised 06/19/2024 -Immunizations-Influenza and Pneumococcal Vaccines, updated 11/08/2022 -Antibiotic Stewardship Policy, dated 09/01/2024 -TB Testing Policy and Procedure, revised 05/10/2023 -Powered Air Purifying Respirator Usage, approval date 11/03/2020 During an interview on 03/23/2026 at 1:21 PM, Staff B, DNS, acknowledged there had been turnover in the Infection Prevention position, and the policies had not been reviewed annually as required. < Transmission-based Precautions> The CDC 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated September 2024 and retrieved from https://www.cdc.gov/infection-control/hcp/isolation-precautions/index.html, documented standard precautions were based on the principle that all blood, body fluids and secretions may contain infectious agents, and included the use of hand hygiene, and donning (putting on) personal protective equipment (PPE) to include gowns, gloves, masks and eye protection if exposure could be anticipated, such as by splashes for example. Contact precautions prevented transmission of organisms spread by direct or indirect contact with the patient or their environment. Healthcare personnel were to don a gown and gloves when entering a room to care for a resident on contact precautions and discard the PPE before exiting the room. Droplet precautions were recommended when caring for patients infected with pathogens transmitted by respiratory droplets when they coughed, sneezed or talked. Masks were to be worn upon entry into the patient room. Appendix A-Type and Duration of Precautions Recommended for Selected Infection and Conditions of the above guideline documented Human metapneumovirus (a common virus that caused upper and lower lung infections and cold like symptoms) required Contact and Standard Precautions for the duration of the illness. Review of the record showed Resident 40 was admitted to the facility on [DATE]. The comprehensive admission assessment was in progress. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 03/14/2026 Basic Care Plan, documented Resident 40 had diagnoses that included Alzheimer's dementia and pneumonia caused by Human metapneumovirus. The care plan documented Resident 40 had a respiratory infection related to the Human metapneumovirus that required droplet precautions. Staff were instructed to maintain droplet precautions and provide all services in the resident's room with appropriate PPE worn. On 03/16/2026 at 8:30 AM, the facility was entered to begin the recertification survey. Staff B, Director of Nursing, DNS, stated there were no active outbreaks in the facility. They stated there was one resident on a separate hall on isolation for viral pneumonia. On 03/16/2026 at 9:53 AM, Resident 40 was observed in room [ROOM NUMBER]. The door was shut and two signs hung on the door. One sign documented droplet precautions were in place and instructed individuals to wear a surgical mask in addition to eye or face shields. Below was a sign that indicated Aerosol precautions (synonymous with Airborne precautions) were in place and instructed individuals to keep the door to the room closed and wear a NIOSH approved respirator (N95, PAPR, or CAPR). A large red metal cart was at the entrance to the room, and contained yellow gowns, disposable gloves, eye protection, bleach wipes, alcohol hand sanitizer wipes, individual wrapped Purell brand sanitizing wipes, signage that documented the correct steps to follow to don and doff PPE, signage that stated bleach was not to be used to clean any part of the PAPRs, and boxes of surgical masks. During an observation on 03/16/2026 at 10:28 AM, the door to Resident 40's room opened. Three nursing assistant students from a local high school vocational program were observed in Resident 40's room. They wore yellow gowns, gloves, surgical masks, instead of higher-level respirators, and did not have on eye protection. Two students pushed Resident 40, who was seated in their wheelchair, down the hall in their full PPE, and went in the shower room. Resident 40 did not have a surgical mask on but covered their mouth with a tissue. A third student was met in the hall by the red PPE cart by their instructor who reminded the student to remove their gown, gloves, and mask and to sanitize their hands, which was all done in the hallway. During an observation on 03/17/2026 at 1:50 PM, Staff R, a maintenance member, was observed pulling a small cart down the hall. The door to Resident 40's room was open. Staff R entered the room without putting on any PPE or respirator and stated the soap dispenser was to be changed. Staff R went back to their cart, retrieved items, then returned to the room. At 2:01 PM, Staff R exited the room and went to the next room with their cart. At no time did Staff R wear PPE or any type of mask or respirator while in Resident 40's room. On 03/19/2026 at 9:17AM, a copy of the facility's TBP policy was requested and at that time, one was not provided. At 12:01 PM, an email was received that documented the facility followed the CDC's guidelines for management of COVID. A Policy for TBP was not provided. During an interview on 03/23/2026 at 11:08 AM, Staff Q, Assistant Supervisor for Engineering, stated they were the supervisor for Staff R. They stated maintenance staff were educated regarding resident isolation and were expected to follow any signage for any resident that was on isolation. Staff Q stated staff needed to wear the appropriate PPE to change soap dispensers. During an interview on 03/23/2026 at 1:21 PM, Staff B, DNS, stated they were not aware students had entered an aerosol precaution room wearing only surgical masks. At this time, Staff B reviewed CDC guidance that recommended that an individual that was ill from Human metapneumovirus be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	placed on standard and contact precautions, not droplet or aerosol. Staff B stated when a resident was placed on aerosol precautions, staff were to wear the PAPRs and had been trained in their use. Staff B expected staff to follow any posted signage for any room on isolation precautions. <Respiratory Protection Program> The OSHA Respiratory Protection Standard 29 CFR 1910.134 required the employer to develop and implement a written respiratory protection program with required worksite specific procedures and elements for required respirator use that incorporated all required components of the standard. The employer shall include procedures for selecting respirators for use in the workplace, medical evaluations of employees required to use respirators at no cost to the employee, procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding and otherwise maintaining respirators. The program shall include training employees in the proper use of the respirator and the respiratory hazards to which they are potentially exposed. The employer shall identify a physician or other licensed healthcare professional to perform medical evaluations using a medical questionnaire or initial medical exam that contained the same information as the questionnaire that determined an employee's ability to use a respirator. The employer shall designate a program administrator who is qualified by appropriate training or experience that equaled the complexity of the program to oversee the respiratory protection program and conduct required evaluations of program effectiveness. The 11/03/2020 Powered Air Purifying Respirator Usage facility policy documented each staff member was trained and then received their own assigned PAPR hood (positive air pressure respirator that blew contaminated air away and prevented it from being inhaled) and this was to be stored in the COVID (a respiratory virus responsible for a deadly disease outbreak beginning in 2019) unit supply room when not in use. Staff were instructed to clean the power unit, hose and belt with Purell brand sanitizing wipes only, and clean the hood with a mild solution of soap and water and a clean cloth only. A respiratory protection program was not developed according to the Occupational Safety and Health Administration (OSHA) requirements. During an observation on 03/17/2026 at 1:50 PM, Staff R, a maintenance member, was observed entering a resident room that had signage on the door that indicated the resident was on isolation requiring aerosol and droplet precautions. The resident's door was open, and Staff R entered the room without PPE, a mask or a PAPR. Staff R completed repairs in the room, went out to a cart and retrieved supplies, returned to the room then exited a final time at 2:01 PM. On 3/18/26 at 3:13 PM, fit tests (a test completed for those required to use an N95 respirator that determined the mask fit appropriately and a tight seal was achieved around the nose and mouth that protected one from inhaling infectious particles suspended in the air) were requested for a sample of staff members (Staff F, T, X, Y and Z). On 03/18/2026 at 3:48 PM, Staff B, DNS, responded by email and documented the facility did not fit test; they used CAPRs and PAPRs. On 03/19/2026 at 9:42 AM, a copy of the facility's Respiratory Protection Program was requested. On 03/19/2026 at 9:59 AM, the respiratory protection on the red PPE cart was observed. There were two battery/filter packs with tubing and belts attached lying on the top of the PPE cart on top of other PPE supplies. Two battery chargers were in a compartment on the side of the cart; one was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	empty and the other contained a battery. The battery/filter pack was observed to be 3M brand Versa flow and was NIOSH approved. Two loose fitting white PAPR hoods were observed; one was lying on the seat of a resident's four-wheeled walker that was in the hall next to Resident 40's door, and the other was stuffed into the handrail behind the PPE cart lid. It was unable to be determined if the hoods had been disinfected after use. During an interview on 03/19/2026 at 10:21 AM, a telephone call was made to 3M customer support. The 3M agent stated PAPR battery life had to be maintained by replacing the battery on the charger when not in use. The charger had an indicator that indicated battery life. The agent stated facility policies determined the reuse of PAPR hoods as long as the hood was maintained, not damaged and properly stored. The agent also stated all components of the OSHA respiratory protection regulation were required, which would include a medical evaluation; the only thing the PAPR did not require was the fit test. On 03/19/2026 at 10:54 AM, PAPR hoods were observed in the hall outside Resident 40's room; one on the seat of a walker, and the other in the handrail behind the lid of the PPE cart. On 03/19/2026 at 12:01 PM, the facility provided the following documents: -a document that described staff responsibility when ill, - a document that stated the facility followed the CDC guidelines for management of COVID, -a document regarding COVID and Influenza staff vaccinations, -a document that detailed required TB testing for staff, -clinical guidance from the CDC regarding TB, -the facility TB Testing Policy and Procedure -an employee TB Update and Assessment Form, -a copy of the form that recorded TB skin testing results, -the [NAME] Administrative Codes regarding TB surveillance, staff screenings, and record keeping, -a COVID vaccine Consent form -the CDC COVID Vaccine Information Sheet, -a copy of facility COVID testing results form, -a document that showed a flu vaccination clinic was held on 09/26/2025 -the CDC Influenza Vaccine Information Sheet, -a picture of the facility's model of PAPR used, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-a diagram that documented how to set-up and put on a CAPR, -a document that described return to work instruction after COVID illness. A policy and procedure for a Respiratory Protection Program was not provided. On 03/20/2026 at 11:02 AM, two white PAPR hoods were on an overbed table at the entrance to Resident 40's room. An additional PAPR hood was still in the handrail behind the lid to the PPE cart. During an observation and interview on 03/20/2026 at 11:20 AM, Staff S, Speech Therapist, prepared to enter Resident 40's room. They stated they had been employed at the facility for 8 years and had education on the use of a PAPR during the COVID outbreak when the facility chose to use the PAPRs instead of N95 respirators. Staff S stated they had completed a medical screening for use of respirators once during their employment but was unable to recall when. Staff S stated they cleaned the white part of their hood with a bleach wipe and the face shield portion with an alcohol wipe. Staff S reviewed the isolation signage on Resident 40's door and stated a PAPR was required for anyone on droplet precautions. On 03/23/2026 at 9:37 AM, respiratory protection medical screenings were requested for Staff R and Staff S. On 03/23/2026 at 10:13 AM, room [ROOM NUMBER] was observed with the door open, and Resident 40 had been moved. Outside the door, the red PPE cart had been removed. A white PAPR hood remained stuffed in the handrail, and two white PAPR hoods remained on an overbed table in the hall. During an interview on 03/23/2026 at 10:58 AM, Staff T, Nursing Assistant, stated they had been employed by the facility for 3 years. They stated when they were hired when COVID was still active, they had completed a medical screen for use of the PAPR, but that was the only time. On 03/23/2026 at 11:49 AM, Staff B responded by email that for respiratory equipment testing, N95s were not used. The facility used CAPRs and PAPRs that required no fit-testing and were used for COVID residents only. During an interview on 03/23/2026 at 1:21 PM, Staff B, DNS, stated Staff W, Licensed Practical Nurse, Infection Prevention, was unavailable for interview. Staff B stated Staff W was the administrator of the facilities Respiratory Protection Program and monitoring PAPR use. Staff B acknowledged that their policies focused on COVID management but there were additional illnesses that required staff use of respirators. Staff B expected staff to follow any posted signage for aerosol and droplet precautions. Staff B acknowledged they were not aware medical screenings regarding respirator use were required. At 3:16 PM, three white PAPR hoods were observed with Staff B outside Resident 40's room, and Staff B removed them from the hall at that time. <Hand Hygiene During Medication Administration> The Centers for Disease Control and Prevention (CDC) 10/25/2002 Guideline for Hand Hygiene in Health-Care Settings updated March 18, 2024 retrieved from https://www.cdc.gov/infection-control/hcp/hand-hygiene/index.html, described hand hygiene as applying alcohol based hand rub to the hands to reduce the number of microorganisms on the skin or washing hands with plain soap and water. Hand hygiene was indicated when hands were visibly dirty (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 03/18/2026 at 12:18 PM, Staff H, Registered Nurse, stated Resident 25's wound was a pressure ulcer (localized injuries to the skin and underlying tissue caused by prolonged pressure, friction, or shear, typically over bony prominences). In an observation on 03/19/2026 at 2:34 PM, Resident 25 did not have an EBP sign on their door or outside of their room and no available PPE (personal protective equipment, gloves, gowns and masks) related to their pressure ulcer. In an interview and observation on 03/23/2026 at 10:36 AM, Staff F, Nursing Assistant, stated Resident 35 had blood in their brief from their wound. Staff F stated nursing put a band aid on it with some cream. An EBP sign was not on the door outside of Resident 35's room and no PPE was available. In an observation on 03/23/2026 at 12:15 PM of Resident 35's pressure ulcer with Staff C, Staff F removed their brief and was not wearing PPE. Resident 35 had bloody drainage in their brief. In an observation on 03/23/2026 at 12:54 PM, Staff B, Director of Nursing, observed Resident 35's pressure ulcer with assistance from Staff F and no PPE was worn. In an interview on 03/20/2026 at 1:50 PM, Staff K, Nursing Assistant, stated Resident 35 had bloody drainage in their brief from their wound. Staff K stated a resident would be placed on EBP when they had an infection or a wound. In an interview on 03/23/2026 at 12:21 PM, Staff C, Resident Care Manager, stated Resident 35 should have been on EBP related to their draining wound. In an interview on 03/23/2026 at 12:45 PM, Staff B stated EBP were put in place for residents with catheters, chemotherapy and draining wounds and this was important to prevent the spread of disease. <Water Management Plan> The CDC Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings dated September 2025 documented elements of a water management program included describing building water systems using text and diagrams, identifying areas where Legionella (a bacteria that caused lung infections by breathing in contaminated water) could grow and spread, deciding where control measures should be applied and how to monitor them, establishing ways to intervene when control limits were not met and ensuring the program was running as designed. The document recommended a review of the program at least once yearly. The facility was to establish a Water Management Program team that included staff with expertise in infection prevention. The facility Water Management Plan did not contain the recommended elements and had not been reviewed annually. On 03/23/2026, a binder that contained the facility Water Management Plan was reviewed. The plan listed 5 staff members that made up the team. There was no inclusion of the Infection Prevention Department listed in the plan. There was no documentation when the plan was last reviewed or revised if indicated. The water flow throughout the facility was demonstrated via diagrams and had symbols that indicated where bacterial growth might occur. The plan did not have written descriptions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the interventions the facility took to limit the growth of Legionella, what control measures were to be applied, timeframes the interventions would be completed such as daily, weekly or monthly, or what would be implemented if the control limits were not met. The plan also did not discuss the frequencies that the team met or a process for a yearly review at a minimum of the program. Documentation of vacant rooms where water flushes occurred was documented on a log in the back of the binder. The list of rooms did not include any of the empty resident rooms on the wing formerly used as a COVID unit. There were no water flushes documented after the first week of February 2026. Additionally, water flushes were not conducted during the weeks the staff member responsible listed they were on vacation. During an interview on 03/23/2026 at 11:08 AM, Staff Q, Assistant Supervisor for Engineering, reviewed the list of Water Management Team members. Staff Q stated one of the members had not worked at the facility for about 5 years. Staff Q stated they were not part of the team but completed monthly testing of the water for Legionella. There had been no positive test results. During an interview on 03/23/2026 at 2:38 PM, Staff AA, Maintenance Manager, acknowledged there were elements of the Water Management Plan missing. Staff AA stated they would add specific measures the facility took to mitigate the risk of Legionella. <Lift equipment> A Mechanical lift was not cleaned after use with 1 resident (Resident 42) before being used on another during 1 transfer observed. In an observation on 03/20/2026 at 12:46 PM, Staff K, Nursing Assistant and Staff M, Nursing Assistant, left Resident 34's room after assisting them to lay down and did not sanitize the hoyer lift (a machine used to lift residents to transfer them from one place to another). Staff K and Staff M then entered Resident 42's room with the same hoyer lift and used it to lay the resident down in bed. Staff M put on a pair of gloves, performed incontinence cares, and with the same gloves grabbed Resident 42's call light and placed it in the Residents hand. In an observation on 03/20/2026 at 12:52 PM, Staff K and Staff M came out of room [ROOM NUMBER] with the hoyer lift and placed it in the hall and continued to do other cares. The lift was not sanitized. In an interview on 03/20/2026 at 12:56 PM, Staff K and Staff M stated the hoyer lift needed to be sanitized between each use. Staff K stated it was important to sanitize the hoyer to prevent the spread of germs. Staff K stated they should have sanitized the hoyer lift between Resident 34 and Resident 42. In an interview on 03/20/2026 at 12:59 PM, Staff M stated they should have removed their gloves and performed hand hygiene after they did incontinence cares, prior to giving Resident 42 their call light and it was important to prevent the spread of germs. In an interview on 03/20/2026 at 1:01 PM, Staff D, Resident Care Manager, stated hoyer lifts were sanitized between each resident. Staff D stated hand hygiene should have been performed after incontinence cares, prior to Staff M assisting resident 42 with their call light and this was important to prevent the spread of germs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer to WAC 388-97-1380 Tuberculosis – Testing required.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to implement bowel protocols for 3 of 3 sampled residents (Residents 3, 4 and 13) reviewed for constipation. This failure put the residents at risk of discomfort and more serious health consequences.Findings included.The facility policy titled, Constipation Management reviewed December 2024, documented staff were to check a resident's bowel record every shift and implement the following interventions if appropriate:1) Laxloaf (a medication made at the facility to treat constipation) daily as needed,2) Milk of Magnesia (MOM-used to treat occasional constipation) to be given on the evening shift of the second day with no bowel movement (BM) with results documented,3) Dulcolax suppository (stimulant laxative) to be given on night shift of the third day with no BM with results documented, and 4) notify the provider if no BM results by the fourth day.The policy instructed staff to document a bowel assessment, provider notification, and orders initiated.<Resident 3> The 06/04/2025 care plan for Resident 3 did not address constipation, goals or interventions. The 03/03/2026 quarterly assessment documented Resident 3 had diagnoses which included chronic obstructive pulmonary disease (COPD, a group of lung diseases that make it difficult to breathe), malnutrition and heart failure. The resident had moderate cognitive impairments and required supervision to touch assistance with toileting. Review of Resident 3's provider orders showed the following: -House bowel protocol: initiate at second day if no BM unless contraindicated, provider to specify contraindications -Laxloaf as needed for constipation, may offer daily -MOM as needed for constipation, given on the second day of no bowel movement -Dulcolax suppository rectally as needed for constipation, given on night shift of the third day of no bowel movement -Miralax every 12 hours as needed for constipation Review of Resident 3's bowel record from 02/16/2026 through 03/16/2026 showed no bowel movement from 02/21/2026 to 02/24/2026 (four days), and 03/02/2026 through 03/04/2026 (three days). The February and March 2026 Medication Administration Record (MAR) showed Resident 3 received Laxloaf on 02/22/2026 and 03/01/2026, and MOM on 03/05/2026. The facility failed to follow the BM protocol on day two and day three for constipation for Resident 3. In an interview on 03/16/2026 at 10:50 AM, Resident 3 stated they had issues with constipation. In an interview on 03/20/2026 at 10:29 AM, Staff K, Nursing Assistant, stated bowel movements were monitored every shift and a small bowel movement did not necessarily count. Staff K stated if a resident only had a small bowel movement in three days the nurse would still administer a suppository. Staff K stated for residents who toileted themselves they would ask them if they had a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bowel movement. Staff K stated Resident 3 complained of constipation and got constipated often. In an interview on 03/20/2026 at 10:36 AM, Staff H, Registered Nurse, stated MOM was given on day two of no bowel movement and a suppository on day three. Staff H stated the residents were also given Laxloaf. Staff H stated a small bowel movement did not count. In an interview on 03/20/2026 at 11:02 AM, Staff D, Resident Care Manager stated Laxloaf was given after two days of no bowel movement and an abdominal assessment needed to be completed to include bowel tones, distension and tenderness. Staff D stated Resident 3 should have received their bowel medications as ordered and it was important to prevent an impaction (dry, hard stool stuck in the rectum or colon that often-required medical intervention), and bowel obstruction. <Resident 4> The 09/02/2025 care plan documented Resident 4 had an ADL self-care deficit and was dependent on staff for toileting. On 09/02/2025, the following provider orders were given: -House Bowel Protocol: Initiate at second day of no BM unless contraindicated. -Laxloaf as needed for constipation; may offer daily. -MOM as needed for constipation; give on evening shift of the second day of no BM. -Dulcolax Suppository as needed for constipation; give on night shift of the third day no BM. -Bowel assessment and documentation on day two of no BM, and at each bowel intervention. Document if bowel tones were present and normal or not present, less active, if distention was present, or if there was tenderness present. The 01/29/2026 quarterly assessment documented Resident 4 had diagnoses that included dementia and sciatica (compression of the sciatic nerve that caused pain and tingling from the lower back down one leg). Resident 4had moderate cognitive impairment, required substantial assistance with ADLs, and took opioid pain medications regularly. On 03/07/2026, the care plan was updated to show Resident 4 wished to maintain normal bowel elimination patterns. Staff were instructed to encourage dietary fiber intake at meals, allow adequate time for bowel elimination and follow the house bowel protocol as needed. A 30-day look back of the Nursing Assistant bowel movement documentation from 02/17/2026 to 03/17/2026 showed Resident 4 had no BM from 03/06/2026 through 03/14/2026 (nine days). On 03/15/2026, Resident 4 had three small BMs documented. Review of March 2026 MAR showed Resident 4 received MOM on 03/10/2026, 03/11/2026 and 03/12/2026, and all were documented that the medication was ineffective. There were no entries for administration of Laxloaf, Dulcolax Suppository, or bowel assessments for the month. When reviewed on 03/20/2026 at 2:01 PM, the Provider Communication Binder had no entries for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4 regarding lack of BMs from 03/06/2026 to 03/14/2026. During an interview on 03/16/2026 at 2:34 PM, Resident 4 stated they took pain medications regularly and had on-going issues with constipation. Resident 4 stated they were unsure what medications they were given for the constipation or when. During an interview on 03/20/2026 at 1:05 PM, Staff E, Registered Nurse, reviewed the March 2026 MAR. Staff E stated they gave Resident 4 the MOM on 03/11/2026 and 03/12/2026. They stated Resident 4 did not like the taste of it, so they also gave the resident a large glass of prune juice when they were constipated. Staff E stated a resident was to receive medication after two days with no BM. Staff E acknowledged there was no bowel assessment documented and stated Resident 4 had no complaints of bowel discomfort, bloating or other associated symptoms. During an interview on 03/23/2026 at 8:52 AM, Staff C, Resident Care Manager, stated the bowel protocol instructed staff to give bowel medications as needed and complete a bowel assessment after no BM for two days. Staff C stated they expected staff to follow the protocol and to notify the provider when indicated. <Resident 13> The 05/02/2024 care plan documented Resident 13 had an activities of daily living (ADL) self-care deficit and required assistance of one to two staff for toileting. The 01/30/2026 quarterly assessment documented Resident 13 had diagnoses that included dementia and malnutrition. Resident 13 had moderate cognitive impairment and was dependent on staff assistance for toileting. The 01/31/2026 care plan showed Resident 13 had altered bowel elimination related to reduced mobility and medication use. Staff were instructed to monitor bowel movements daily and implement the facility bowel protocol. Review of Resident 13's provider's orders showed the following: -House bowel protocol: Initiate on second day of no BM unless contraindicated. Doctor to specify contraindications. - Laxloaf as needed for constipation, may offer daily. - MOM as needed for constipation to be administered on evening shift of the second day of no BM. - Dulcolax suppository as needed for constipation to be administered on night shift of the third day with no BM. - Miralax every 24 hours as needed for constipation. - Senna every 12 hours as needed for constipation. - Bowel assessment with each use of as needed bowel medications, documenting at day two of no BM and with each bowel intervention. Documentation was to include bowel tones (gurgling, rumbling, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or clicking noises made by the intestines pushing food, fluid, and gas through the body), abdominal distention (swelling or bloating commonly caused by constipation), and abdominal tenderness. Review of BM documentation from 02/01/2026 through 03/18/2026 showed Resident 13 had no BM from 02/07/2026 through 02/10/2026 (four days), 02/15/2026 through 02/18/2026 (four days), 02/24/2026 through 02/26/2026 (three days), and 02/28/2026 through 03/04/2026 (five days). Review of the February and March 2026 MAR showed Resident 13 was administered Laxloaf on 02/14/2026 with ineffective results, and on 02/22/2026 with unknown results. They received MOM on 02/01/2026, 02/02/2026, 02/05/2026, and 02/11/2026. Resident 13 was administered a Dulcolax suppository on 02/06/2026, 02/27/2026, and 03/05/2026. The February and March 2026 MAR contained no documentation bowel assessments were completed per provider orders. Reference: WAC 388-97-1060(1)-(3)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to establish and maintain a system of records for receipt and disposal of all controlled drugs (substances or medications that have a high potential for abuse, misuse and addiction) in sufficient detail to enable an accurate reconciliation for 3 of 3 controlled medication emergency kits (e-kit) (e-kit 309, e-kit 314 & e-kit 315) reviewed for medication storage. This failure placed the residents at risk by the facility being unable to identify potential drug diversion.Findings included.Review of the policy titled Ordering and Receiving Controlled Medications dated January 2023 showed, controlled substances and medications classified as controlled substances were subject to special ordering, receipt, and record keeping requirements. Controlled medications were dispensed by the pharmacy in readily accountable quantities and containers designed for easy counting of contents. The medications were to be logged in a narcotic book with the following information: the resident's name, prescription number, medication name, medication strength, medication dosage form, date received, quantity received and name of the person who received the medication supply. The controlled substances were to be counted every shift. During observation, interview and record review on 03/19/2026 at 1:37 PM, the medication room refrigerator was observed with Staff E, Registered Nurse. The refrigerator contained one unsealed clear plastic box labeled as e-kit #309 that contained two sealed 30 milliliter (ml) bottles of Lorazepam concentrate (antianxiety medication commonly utilized during end of life to help relieve symptoms of air hunger) and two sealed vials of injectable Lorazepam. The top of the clear box contained a manifest showing the contents the box was to contain. Review of the manifest showed the emergency Lorazepam kit was to contain three 30 ml bottles of Lorazepam concentrate and two vials of injectable Lorazepam. Staff E acknowledged they accessed the Lorazepam e-kit the day prior and removed one bottle of 30 ml Lorazepam concentrate for a resident. Staff E explained the emergency kit was not counted routinely. It was only counted when an item was removed from the kit for a particular resident then was logged in the narcotic tracking book on the medication cart. A med fridge narcotic tracking book was observed on the counter. Review of the narcotic tracking book showed e-kit 309 was logged on page 41 on 03/17/2026, was full, and was sealed with tag number 05612405. No entries were found to show the kit was accessed or that one bottle of the Lorazepam concentrate was removed, as per Staff E. Additional review of the med fridge narcotic tracking book showed e-kit 315 was logged onto page 39 (date unknown) with tag numbers 05612001 and 04907885. A 03/09/2026 entry showed a remaining quantity of two, however, e-kit 315 was not observed to be in the refrigerator. E-kit 314 was logged onto page 40 on 03/11/2026 with tag number 05976576. A 03/16/2026 entry showed the kit was full, however, e-kit 314 was also not in the refrigerator. Review of the med fridge narcotic tracking book Change of Shift Count signature pages documented no shift change narcotic counts occurred since November 2025. The November 2025 Change of Shift Count signature documented narcotic counts were completed 19 out of 31 days. No documentation was found for December 2025, January, February or March 2026.During interview and record review on 03/19/2026 at 2:01 PM, Staff D, Resident Care Manager, explained the plastic e-kit containers were to be sealed with two red tags that contained numbers. If the kit was accessed, then the tags were to be replaced and the kit should always be secured with red tags. Staff D further stated there was a narcotic tracking book in the medication room where e-kits were logged and tracked, nursing staff was to verify the tag numbers were accurate twice daily. The med fridge narcotic tracking book was reviewed. Staff D acknowledged the e-kit was not counted or tracked since November 2025. Staff D explained that when the pharmacy delivered a new e-kit, they picked up a previously used e-kit. The facility typically only had one Lorazepam e-kit on hand. Staff D further stated e-kit 315 and 314 were picked up by the pharmacy and only e-kit 309 was on hand, Staff D acknowledged the narcotic tracking book did not reflect that. Pharmacy manifests to include delivery and pick up for e-kit 315, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	314 and 309 were requested at that time. Review of pharmacy e-mail correspondence provided did not show sufficient detail for an accurate reconciliation of the Lorazepam e-kits. During interview and record review on 03/19/2026 at 3:34 PM, Staff B, Director of Nursing, explained the Lorazepam e-kit was to be tracked/counted each shift by verifying the tag numbers remained the same. The med fridge narcotic tracking book was reviewed. Staff B acknowledged the Lorazepam e-kits had not been tracked or counted since November 2025 and there was no documentation to show e-kits 315 and 314 were picked up by the pharmacy. Staff B stated in February 2026, nursing staff was educated on narcotic chain of custody to include counting the controlled substances stored in the refrigerator and ensuring sufficient documentation for an accurate reconciliation. Staff B stated they expected staff to count and track controlled substances with sufficient detail to enable an accurate reconciliation, as required.Reference WAC 388-97-1300(1)(b)(ii)(c)(ii)-(iv)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure pharmacy recommendations were addressed timely for 4 of 5 sampled residents (Residents 4, 13, 17 and 27) reviewed for pharmacy monthly medication reviews. This failure placed the residents at risk for medication side effects or unintended health consequences. Findings included.Review of the facility policy titled, Medication Monitoring: Medication Regimen Review and Reporting dated January 2024 showed medical records were reviewed to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The consultant pharmacist was to review the medication regimen of each resident at least monthly to appropriately monitor the medication regimen and ensure the medications each resident received were clinically indicated. The findings were communicated to the director of nursing or designee and the medical director. The facility was to follow up on the recommendations to verify that appropriate action was taken. Recommendations were to be acted on within 30 calendar days. The attending physician either accepted and acted upon the recommendations or rejected it. The rationale of why the recommendation was rejected was to be documented in the resident's medical record.<Resident 4> The 01/29/2026 quarterly assessment documented Resident 4 had diagnoses that included Gastroesophageal Reflux Disease (GERD, when stomach acid backflows into the esophagus causing irritation) and was mildly cognitively impaired. On 11/04/2025, the provider ordered the following medications to treat Resident 4's GERD: Protonix Extended Release (treats GERD) 40 milligrams twice daily 30 minutes before meals, and sucralfate (treats ulcers) 1 gram four times daily 30 minutes before meals and at bedtime. On 11/30/2025, after a review of Resident 4's medications, the Consultant Pharmacist sent documentation that noted sucralfate and Protonix were duplicate therapies. The Pharmacist recommended discontinuing sucralfate as it was less effective and interfered with the body's ability to absorb other medications. The recommendation was unsigned by the provider. On 12/31/2025, the Consultant Pharmacist made the same recommendation to discontinue the sucralfate for the same reasons. The recommendation was unsigned by the provider. On 01/31/2026, the Consultant Pharmacist made the same recommendation to discontinue the sucralfate for the same reasons. On 02/10/2026, the order was given to trial a decrease for 14 days, then discontinue the medication and this was completed. <Resident 27> According to the 02/02/2026 quarterly assessment, Resident 27 had diagnoses that included glaucoma (an eye disease that can caused vision loss or blindness), repeat falls and depression. A 10/31/2025 pharmacy consultation report recommended changing the indication for the medication from eye health to glaucoma. The physician's response section on the report was not completed. A pharmacy consultation on 11/30/2025, 12/31/2025 and 1/31/2026 again suggested the indication for the medication be changed from eye health to glaucoma. A provider response was documented on (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/10/2026. Review of a February 2026 Medication Administration Record showed Resident 27 received Rhopressa (an eye drop to lower eye pressure for adults with glaucoma) and Timolol (an eye drop that lowered eye pressure for adults with glaucoma). In an interview on 3/23/2026 at 2:05 PM, Staff B, Director of Nursing, stated the facility had 30 days to address the pharmacy recommendations and were to be reviewed upon receipt. Staff B also stated that if the information was not in the resident's record, it most likely was not done. <Resident 17> According to the 12/18/2025 quarterly assessment, Resident 17 had diagnoses that included anxiety, depression, and transient ischemic attack (TIA, temporary blockage of blood flow to the brain that caused sudden stroke-like symptoms). The assessment further showed Resident 17 received antidepressant and antipsychotic medications. Review of provider orders showed Resident 17 was to receive Aspirin (ASA, to prevent blood clots) daily for heart health. On 06/12/2025, the provider ordered Resident 17 to receive Torsemide (reduced fluid buildup caused by heart failure) daily for swelling. Review of the consultant pharmacist recommendations to the provider showed the following: -10/31/2025 Aspirin had an indication listed as heart health and the pharmacist recommended updating the indication to history of TIA. The recommendation was unsigned by the provider. -On 11/30/2025, 12/31/2025 and 01/31/2026, the same recommendation was made regarding the ASA. The recommendation was unsigned by the provider. The pharmacist also noted Resident 17 took Torsemide, and recommended a Comprehensive Metabolic Panel (CMP, blood test that evaluated liver function, kidney function, electrolyte and fluid balance) be completed. This recommendation was also unsigned by the provider. On 02/10/2026, the recommendations included a handwritten response yes-done signed by the provider. Additional record review as of 03/17/2026 showed a 02/10/2026 order to obtain a CMP. Review of the February 2026 medication administration record showed omissions for the CMP. No documentation was found to show the CMP was obtained as ordered. Additionally, Resident 17's Aspirin order continued to show the indication of HEART HEALTH. During interview and record review on 03/23/2026 at 10:39 AM, Staff C, Resident Care Manager (RCM), stated the monthly pharmacist medication reviews were sent to medical records, the provider, and the Director of Nursing (DNS). They were not distributed to the RCMs for follow-up and recently requested they receive them. Staff C reviewed Resident 17's medical record. Staff C acknowledged Resident 17's Aspirin indication was still for heart health. Staff C further stated a CMP order was written but the blood work was not obtained as ordered. Staff C acknowledged the pharmacist monthly medication reviews with recommendations were not addressed timely and should have been. <Resident 13> (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 01/30/2026 quarterly assessment, Resident 13 had diagnoses that included heart failure (heart too weak or stiff to pump enough blood to meet the body's needs). The assessment further showed Resident 13 received blood thinners and a diuretic. Review of the consultant pharmacist recommendations to the provider showed the following: -10/31/2025 Resident 13 was taking Torsemide and a potassium supplement. The pharmacist recommended a CMP be obtained, the last CMP on file was from November 2024. The recommendation was unsigned by the provider. -12/31/2025 the recommendation from 10/31/2025 was repeated. The recommendation was unsigned by the provider. -02/28/2026 Resident 13 was taking Apixaban (blood thinner), Furosemide (diuretic), Lisinopril (medication used to lower blood pressure), and a potassium supplement. The pharmacist again recommended a CMP be obtained. The recommendation was unsigned by the provider. Additional review of the record showed no CMP had been obtained as recommended. During an interview on 03/23/2026 at 10:52 AM, Staff C, RCM, reviewed Resident 13's record. Staff C acknowledged the last CMP on file was November 2024, other labs drawn were not equivalent to a CMP. In an interview on 03/23/2026 at 2:26 PM, Staff B, DNS, explained the monthly pharmacy medication review recommendations were given to the provider for review, the provider was to document their response on the form, and then the form was scanned into the resident's record. Staff B stated they expected the pharmacist recommendations to be addressed timely. Reference WAC 388-97-1300(4)(c)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, interview, and record review the facility failed to obtain informed consent for 1 of 1 sampled residents (Resident 27) reviewed for resident rights. This failure resulted in position change alarms (a sensor pad the resident sits on that emits an audible alarm when the resident moves in certain ways) being implemented without consent from the resident and/or the resident representative.Findings included.A care plan dated 08/08/2025, showed Resident 27 was at risk for falls and instructed staff to ensure the bed was in the lowest position, a fall mat was at the bedside, appropriate non-skid footwear was worn, and position change alarms were to be used in the bed and chair.Review of Resident 27's medical record showed that prior to use, on 8/8/25, no consent that included potential risks versus benefits for the use of the position change alarms was obtained from the resident and/or their representative. According to the 02/02/2026 quarterly assessment, Resident 27 had diagnoses that included repeat falls and depression. The assessment further showed Resident 27 sustained two or more falls since admission, had moderate cognitive impairment and required the use of a walker.In an observation on 03/16/2026 at 10:37 AM, Resident 27 was sitting in their chair with a position change alarm box placed on the top of the chair and the sensor on the seat cushion. Additional observations were made on 03/17/2026 at 8:46 AM and on 03/19/2026 at 8:39 AM.In an interview on 03/16/2026 at 10:37 AM, Resident 27 stated they did not sign a consent for the alarm, it just showed up one day. Resident 27 attempted to stand up from the chair and the position change alarm sounded. The alarm stopped when Resident 27 sat back down.In an interview on 03/18/2026 at 9:24 AM Staff E, Registered Nurse (RN), stated that Resident 27 was alert, had a position change alarm and was instructed to use their call light when in need of assistance from staffIn an interview on 03/20/2026 at 11:32 AM, Staff B, Director of Nursing, stated that position change alarms could be considered a restraint and required consent from the resident or resident representative. Staff B further stated if consents were not in the resident chart, then they probably were not obtained.Reference: WAC 388-97-1020(4)(a-b)

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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 provide assistance with activities of daily living (ADL) as care planned and needed for 2 of 3 sampled residents (Residents 17 and 29), reviewed for ADLs. This failure contributed to Resident 17 not being provided with adaptive equipment and assistance at meals and Resident 29 not being provided basic hygiene. This failure placed residents at risk of hunger, lack of dignity and diminished quality of life.Findings included.<Resident 17> On 07/07/2025, the care plan documented Resident 17 required set up and clean up assistance at meals. Staff were instructed to add foam handles to the eating utensils. The 07/07/2025 nutrition care plan instructed staff to provide Resident 17 fluids in a Kennedy cup (a specialized durable plastic mug designed for people with tremors, arthritis, or limited mobility) with a straw, provide finger foods, encourage and remind the resident to eat their meal, and offer a meal supplement twice daily. On 01/05/2026 the care plan was updated for staff to provide 1:1 extensive assistance during meals. According to the 12/18/2025 quarterly assessment, Resident 17 had diagnoses that included Parkinsonism (syndrome characterized by movement issues, slowness, tremor, stiffness and balance problems), and a need for assistance with personal care. Resident 17 had moderate cognitive impairment. During continuous observation on 03/18/2026 from 11:23 AM until 11:49 AM, Resident 17 sat in the dining room with their meal, a bowl of soup with a regular spoon with no foam handles, in front of them. Resident 17 moved their hand toward the soup spoon but was unable to grab it, then they moved their hand up to their mouth while holding nothing and licked their fingers. Resident 17 was unsuccessful at eating their soup and began to attempt to eat their sandwich but had a difficult time grasping it in their hands. At 11:27 AM Staff L, Restorative Aide, assisted Resident 17 by cutting up their sandwich and placing a bite on a fork that had no foam handle. Resident 17 did not grab the fork and Staff L began to briefly place food in Resident 17's mouth. Resident 17 then attempted to drink soda from a can with a straw in it, not a Kennedy cup as care planned. Resident 17 was served a piece of cake and provided a fork without a foam handle. Resident 17 attempted to eat the cake using the fork but was unsuccessful and began to grab pieces of cake with their hands. During an observation on 03/19/2026 at 11:11 AM, Resident 17 was served fried fish, waffle fries and a small bowl of fresh fruit chunks. Resident 17 was provided with a fork without a foam handle and attempted to stab the fruit piece with the fork and the fruit bowl tipped over. Staff provided Resident 17 with a sandwich. Resident 17 grabbed the sandwich, but it fell apart as it reached their mouth. During an observation on 03/20/2026 at 7:07 AM, Resident 17 sat in the dining room with a regular red cup in front of them with a straw, not a Kennedy cup as care planned. Resident 17 was served a cut up pancake, cut up fresh fruit, scrambled eggs, cut up bacon and were provided regular utensils without foam handles. Resident 17 did not use the utensils, attempted to pick up the food items with their hands but were unable to grasp the items. They continued to repeatedly move their hands towards their mouth without food. Resident 17 attempted to use their fork to stab scrambled eggs but were unable. They grabbed the scrambled eggs with their hand, attempted to put the eggs in their mouth, but the food fell on the floor. Resident 17 then attempted to stab a piece of pancake with the fork but were unable to but moved the fork up to their mouth without food on it. Resident 17 put the fork back down and attempted to eat their food with their hands again. At 7:49 AM Resident 17 was removed from the dining room with numerous pieces of pancake, scrambled eggs and fruit noted on (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the floor where they had been sitting. During a continuous observation on 03/20/2026 from 11:14 AM until 11:43 AM, Resident 17 sat in the dining room, leaning to the right, and was provided with a set of utensils without foam handles. Staff K, Nursing Assistant, served Resident 17 a bowl of soup and told them they would be back to help them in a minute. Resident 17 attempted to reach for items on the floor and sat in front of their bowl of soup without attempting to eat it. At 11:19 AM, staff K served Resident 17 a plate with half of a sandwich cut in half and some potato chips. Resident 17 repeatedly moved their hands towards their plate of food, were unable to grasp any items, and continued to move their hands up to their mouth without food and licked their fingers. At 11:21 AM, Resident 17 picked up a single potato chip and got it to their mouth. Resident 17 continued to move their hands to their plate and grasp more food but dropped items on their lap and on the floor. At 11:28 AM, Resident 17 was able to grasp a single potato chip and place it in their mouth. Resident 17 continued to move their hands towards their meal plate and back up to their mouth without food items and licked their fingers that touched their food. At 11:31 AM, Resident 17 placed a quarter of a piece of bread from their sandwich into their mouth. At 11:33 AM, Resident 17 was able to get a quarter of a tomato slice from their sandwich into their mouth followed by another potato chip. At 11:37 AM, Resident 17 attempted to grab another quarter piece of bread from their sandwich, and it fell on the floor. At 11:43 AM, Resident 17 picked up their plate, knocked it into their drink, causing the drink, that was in a regular maroon mug (not a Kennedy cup) to spill and their uneaten bowl of soup. Staff K picked up Resident 17's dishes. Staff K was not observed during this observation providing Resident 17 assistance consuming their meal. During interview and record review on 03/20/2026 at 11:43 AM, Staff K was asked how much of the meal Resident 17 ate. Staff K stated Resident 17 ate 75%. Observations showed Resident 17 ate approximately two potato chips, a quarter of a tomato slice and a quarter of a piece of bread. Staff K stated the food falling in Resident 17's lap or on the floor was a recurring issue and Resident 17 needed help eating. Staff K was asked if Resident 17 could state they were hungry and Staff K replied, no. Staff K was asked what assistive devices Resident 17 needed during meals. Staff K reviewed Resident 17's individual service plan and stated Resident 17 required extensive 1:1 assistance with meals, utilized a Kennedy cup with a straw and required foam handles added to their utensils. Staff K further stated there were no Kennedy cups in the dining room and acknowledged we never put foam on utensils. Staff K was asked what the facility process was if a resident ate 50% or less of a meal. Staff K replied the facility had no process, residents were not offered a meal supplement, but they did have snacks like shortbread cookies available. Staff K acknowledged shortbread cookies were not equivalent to a meal. During observation and interview on 03/20/2026 at 1:21 PM, Staff H, Registered Nurse, stated they were unsure if the facility had a policy about offering a supplement or meal replacement if a resident ate 50% or less of their meal. Staff H stated Kennedy cups should be in the dining room. Staff H opened the cabinets in the dining room and found no Kennedy cups, and one built up fork (an adaptive utensil that features a widened thick handle designed for individuals with arthritis, limited grip strength, or hand tremors). Staff H stated, I have not seen foam handles in the dining room. Staff H stated they were not informed of Resident 17's intake at lunch. During interview and record review on 03/20/2026 at 1:26 PM, Staff D, Resident Care Manager, reviewed Resident 17's care plan and stated they required extensive 1:1 assistance with meals. Staff D stated they were not aware of a facility process for offering a supplement or meal replacement if a resident did not consume a certain percentage of a meal. Supplements were scheduled to be given in between meals. Staff D was informed of Resident 17's meal observation. Staff D stated Resident 17 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could not voice being hungry. Staff D acknowledged that shortbread cookies did not have the same nutritional value as a full meal. Staff D stated they expected staff to follow care planned interventions. During an interview on 03/23/2026 at 2:33 PM, Staff B, Director of Nursing, stated the standard was for staff to offer a meal replacement if a resident ate 50% or less of their meal. Staff B stated they expected staff to provide residents' assistance and their assistive devices as indicated in their care plan. <Resident 29> The 08/16/2025 ADL care plan documented Resident 29 was dependent on staff for personal hygiene and oral care. The 02/09/2026 quarterly assessment documented Resident 29 had diagnoses which included dementia, glaucoma (a group of eye diseases that damaged the optic nerve and led to vision loss or blindness), and arthritis. The resident had severe cognitive impairments and was dependent on staff for hygiene. In an observation on 03/16/2026 at 10:10 AM, Resident 29 was observed lying in bed asleep. Resident 29 had brown matter around the edges of their mouth. In an observation on 03/17/2026 at 12:27 PM, Resident 29 was observed lying in bed. Resident 29 had brown matter under the left corner of their mouth. In an observation on 03/19/2026 at 8:50 AM, Resident 29 was sitting in the common area in their wheelchair. Resident 29 spoke and had eggs in their mouth from their breakfast that morning and on the front of their clothes. At 10:19 AM Resident 29 had eggs around the edges of their mouth. In an observation on 03/20/2026 at 8:06 AM, Resident 29 was sitting in the common area and had brown matter under their fingernails. In an observation on 03/23/2026 at 9:50 AM, Resident 29 was sitting in their wheelchair in the common area and had brown matter under their fingernails. In an interview on 03/23/2026 at 9:45 AM, Staff G, Nursing Assistant, stated they knew what care the residents needed by looking at their care plan. Staff G stated personal hygiene included brushing teeth, washing face and hands, and shaving. Staff G stated oral care was completed in the mornings, evenings, and when needed. Staff G stated nails were cleaned after showers or if they were unclean. Staff G stated Resident 29 required assistance with personal hygiene. In an interview on 03/23/2026 at 9:57 AM, Staff H, Registered Nurse, stated oral care was completed in the mornings. Staff H stated nails were cleaned whenever they were unclean. Staff H stated the resident's hands and faces were cleaned every morning, in between meals and when needed. In an interview on 03/23/2026 at 1:04 PM, Staff B, Director of Nursing, stated their expectation was the resident's hands and faces be cleaned when needed, oral care completed after meals, and nails cleaned when they were dirty. Staff B stated this was important to prevent the transmission of disease and choking and for the residents' rights and their autonomy. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1060(2)(a)(i).

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement interventions, develop treatment goals and notify the appropriate parties after a resident developed a pressure ulcer for 1 of 1 sampled residents (Resident 25) reviewed for pressure ulcers. This failure placed the resident at risk for further deterioration of their skin, unintended health consequences and decreased quality of life.Findings included .Edsberg, L. E., Black, J. M., [NAME], M., [NAME], L., [NAME], L., & Sieggreen, M. (2016). Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System; Journal of Wound Ostomy Continence Nurs, 43(6), 585-597 retrieved 10/21/2024 from https://npiap.com/page/PressureInjuryStages defined a stage 2 pressure injury as a partial-thickness skin loss, the wound bed is pink or red, moist and may also present as an intact or ruptured serum-filled blister.The 02/24/2026 quarterly assessment documented Resident 25 had diagnoses that included Parkinsons disease (a progressive disease that affected the nervous system and caused tremors, difficulty with movement and impaired balance), dementia and weakness. Resident 25 had severe cognitive impairments, was partial to total assistance for most of their activities of daily living (ADLs) and was at risk for pressure ulcers. The 11/01/2024 skin at risk care plan, revised 03/11/2026 documented Resident 25 had fragile skin and moisture associated skin damage (MASD, inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage, saliva or mucus). The care plan instructed nursing to check and change frequently, gentle handling with repositioning and transfers, lay resident down after lunch until dinner, treatment orders per the wound clinic and provider, turn frequently as resident allows, wound healing referrals, and a pressure relieving wheelchair cushion.The 03/18/2026 weekly skin issue evaluation showed Resident 25 had a facility acquired pressure ulcer.In an observation on 03/18/2026 at 11:39 AM, Resident 25 was sitting in their wheelchair eating lunch and stated they needed help. The resident was asked if they were uncomfortable and they stated their buttocks hurt. Staff K, Nursing Assistant, told Resident 25 they were going to lay them down after lunch.In an observation on 03/18/2026 at 12:04 PM with Staff K, Resident 25 had an open area on their right buttock, approximately the size of a quarter and the top layers of the skin were gone. Staff K stated they were instructed to put cream on the area. Staff K stated Resident 25 was sitting up the majority of the day, laid in bed only at nighttime and did not refuse care. In an interview on 03/18/2026 at 12:18 PM, Staff H, Registered Nurse, stated the wound on Resident 25's buttock was a pressure ulcer and the area opened that day. As of 03/18/2026, review of Resident 25's medical record showed there were no progress notes, orders or interventions added to the resident's treatment plan regarding the pressure ulcer that had developed on their right buttock.In an interview on 03/20/2026 at 1:58 PM, Staff H stated when a new pressure ulcer was discovered they took a picture of it, made a progress note, placed the resident on alert charting, notified the Resident Care manager and providers, obtained treatment orders, and communicated to the nursing assistants. Staff H stated they notified the Resident Care manager and provider of the new pressure ulcer on 03/18/2026. Staff H stated when they looked at Resident 25's care plan they realized the resident needed to be in bed from lunch to dinner, that was not being done. Staff H stated the providers were notified via a communication binder. In an interview on 03/20/2026 at 2:10 PM, Staff BB, Registered Dietician, stated they were notified of pressure ulcers when they occurred. Staff BB stated for a resident with a pressure ulcer they added a wound healing supplement and Vitamins C and D to their regime. Staff BB stated they were not notified of Resident 25's pressure ulcer and should have been so they could add nutritional interventions to promote wound healing. In an interview on 03/20/2026 at 2:20 PM, Staff CC, Occupational Therapist, stated they were notified of pressure ulcers after a meeting that occurred daily. Staff CC stated they assessed wheelchair cushions and gave roho cushions (a cushion that delivered comfort and distributed pressure) to residents that had pressure ulcers. Staff CC stated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were unaware Resident 25 had a pressure ulcer. Staff CC stated they were not working with Resident 25, so Restorative assessed the wheelchair cushions.In an interview on 03/23/2026 at 9:10 AM, Staff L, Restorative Aide, stated they were notified by their supervisor whenever a resident had a pressure ulcer. Staff L stated roho cushions were available to residents with pressure ulcers if ordered by the therapy department. Staff L stated they were made aware of Resident 25's pressure ulcer the week prior but therapy needed to assess the wheelchair cushions. Staff L confirmed Resident 25 had not been assessed for a roho cushion.In an interview on 03/23/2026 at 12:21 PM, Staff C, Resident Care Manager, stated when a new pressure ulcer was found, the nurse took a picture of it, uploaded the measurements into the system and an evaluation came up on the computer. Staff C stated nursing needed to notify the providers for a treatment order, therapy, Registered Dietician, and Resident Care Managers so a referral could be made to the wound healing clinic. Staff C stated it was important to notify the different departments to get interventions in place such as wound healing supplements, vitamins, wheelchair cushions, and treatment orders.In an observation on 03/23/2026 at 12:33 PM, the provider communication binder to the provider showed no notification was made regarding Resident 25's pressure ulcer.In an interview on 03/23/2023 at 12:45 PM, Staff B, Director of Nursing, stated when a new pressure ulcer was found the family and doctor were notified along with the departments mentioned above. Staff B stated the care plan was updated for preventative and curative measures. Staff B stated they were unaware Resident 25 had a pressure ulcer. During an observation with Staff B at 12:54 PM, Staff B stated the wound was a Stage II pressure ulcer. Staff B stated they were notifying the provider for a treatment order. Staff B added Resident 25 had refused cares for an entire night and laid in a wet brief after being approached multiple times for cares and refused.Reference: WAC 388-97-1060(3)(b)

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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 (Residents13 and 30) and failed to administer oxygen per provider orders for 1 of 3 sample residents (Resident 30), reviewed for respiratory care. This failure placed residents at risk of potential medical complications, potential respiratory infections, and diminished quality of life.Findings included.The facility provided an Oxygen Concentrator instruction guide that included care instructions for cleaning. The filter door and vents were to be inspected periodically and wiped with a dry or damp cloth every seven days and as needed to remove dust. <Resident 13> Review of the 05/15/2024 heart failure care plan showed Resident 13 received oxygen therapy and instructed staff to change the oxygen tubing per facility protocol. No documentation was found to show how the oxygen equipment was to be maintained. Review of providers orders showed an active 11/14/2024 order for Resident 13 to be administered oxygen to maintain their oxygen levels above 90% related to heart failure. A 11/25/2024 order instructed staff to rinse the oxygen concentrator filter, and change, initial and date the oxygen tubing once weekly on Sundays. According to the 01/30/2026 quarterly assessment, Resident 13 had diagnoses that included heart failure (ineffective pumping of the heart that caused fluid buildup and difficulty breathing), was dependent on supplemental oxygen and received oxygen. Resident 13 had moderate cognitive impairment. During an observation on 03/16/2026 at 9:34 AM, Resident 13 wore a nasal cannula with oxygen administered from a black oxygen concentrator. A thick layer of dust debris covered the slotted area in the back of the concentrator that housed the filter and allowed air flow into the machine. Upon opening the compartment, the thick layer of dust debris covered the entire compartment adjacent to the filter. Additional observations were made on 03/18/2026 at 2:33 PM, on 03/19/2026 at 8:47 AM, 10:36 AM, 12:27 PM and 3:07 PM, and on 03/20/2026 at 1:09 PM. <Resident 30> Resident 30's 04/18/2025 provider order instructed nursing staff to rinse the concentrator filter every seven days and as needed. The 01/07/2026 quarterly assessment documented Resident 30 had diagnoses which included chronic obstructive pulmonary disease (COPD, a progressive lung disease that blocked airflow and made it hard to breathe), and respiratory failure. The resident was dependent on oxygen. The 01/04/2026 oxygen care plan instructed nursing staff to administer 4L (liters) of oxygen at night and to maintain oxygen saturation greater than 88 percent during waking hours. There were no instructions on maintaining the oxygen equipment in a clean manner. The 03/15/2026 provider order showed Resident 30 was prescribed oxygen 2-3L to keep their oxygen saturation between 88-93 percent. (continued on next page)

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	505033	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockwood South Hill	East 2903 25th Avenue Spokane, WA 99223

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The March 2026 medication administrator record (MAR) showed Resident 30 received 4L of oxygen daily except for the evening shift on 03/15/2026. In an observation on 03/16/2026 at 9:57 AM, Resident 30 was lying in bed receiving a breathing treatment. The vented area on the oxygen concentrator next to the filter was covered in dust debris. In an observation on 03/19/2026 at 8:46 AM, Resident 30 was lying in bed wearing oxygen at 4L, not 2-3L as ordered. Observations of Resident 30's oxygen concentrator on 03/17/2026 at 8:58 AM and 2:13 PM, 03/18/2026 at 9:06 AM, 03/19/2026 at 8:46 AM, and 03/20/2026 at 8:02 AM showed it had dust debris over the vented area next to the filter. Observations on 03/19/2026 at 2:33 PM and 03/20/2026 at 8:02 AM showed Resident 30 was on 4L of oxygen, not 2 to 3L as ordered. In an interview on 03/23/2026 at 9:18 AM, Staff H, Registered Nurse, stated they were unsure how often oxygen equipment was cleaned. Staff H stated it would be important to keep the vented area near the filter clean to keep the machine from getting clogged. Staff H stated it was important to administer oxygen as ordered to avoid oxygen toxicity for residents with COPD. Staff H looked at Resident 30's MAR and stated they were to receive 2-3L of oxygen. Staff H observed Resident 30's oxygen concentrator and stated it needed to be cleaned. In an interview on 03/23/2026 at 1:06 PM, Staff B, Director of Nursing, stated the night nurse was responsible for wiping the concentrators down. Staff B stated there was no area on the MAR to document the cleaning of the concentrators but there should be. Staff B stated it was important to keep the oxygen concentrators free of dust debris near the filter, so the machines worked properly, the residents got the correct flow of oxygen and to prevent disease transmission. Staff B stated it was important to administer oxygen as ordered to prevent residents from retaining carbon dioxide and it was their expectation that nursing staff contacted the provider for orders to increase the oxygen. Reference: WAC 388-97-1060 (3)(j)(vi)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to transcribe provider orders correctly and administer medications as intended by the provider for 1 of 6 sampled residents (Resident 31), reviewed for unnecessary medications. This failure placed residents at risk of adverse side effects and unnecessary medications. Findings included .According to the 01/19/2026 admission assessment, Resident 31 was admitted with diagnoses to include a mental health disorder. The resident was able to make their needs known.Review of the 01/05/2026 admission orders showed the resident took Seroquel (chemical substances that affect brain function, altering mood, thoughts, behavior, or perception to treat mental health conditions) 25 milligrams (mg) once a day.Resident 31's Medication Administration Record (MAR) for January 2026 and February 2026 showed an order was entered on 01/05/2026 for Seroquel 25 mg once a day, give .5 mg in the evening. The MAR showed the resident received a 1/2 tablet (12.5 mg) of Seroquel from 01/05/2026 through 02/09/2026 every evening.Review of a 02/09/2026 facility investigation, showed the resident admitted with an order of Seroquel 25 mg every evening and the order was transcribed incorrectly into the MAR as Seroquel 25 mg once a day, give .5 mg. The pharmacy sent 12.5 mg (1/2 tablet of 25 mg) which was administered to the resident from 01/05/2026 to 02/09/2026. The provider was notified of the medication error.In an interview on 03/19/2026 at 2:50 PM, Staff C, Resident Care Manager (RCM), stated they had investigated the medication error for Resident 31. When asked about their process for placing orders into the MAR when a resident was admitted to the facility, Staff C stated the nurse would place the orders into the computer and print them, a second nurse did not review the orders for accuracy. The process had been changed after the medication error for Resident 31 was identified, and now one nurse entered the order, a second nurse reviewed them, and both nurses would sign the orders.In an interview on 03/20/2026 at 2:00 PM, Staff B, Director of Nursing (DNS), confirmed the order for Resident 31's Seroquel was transcribed incorrectly, and the resident received the wrong dose. Reference: WAC 388-97-1060(3)(k)(iii)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the requirements to protect resident rights in an arbitration agreement for 2 of 4 sample residents (Residents 13 and 14) reviewed for arbitration. This failure placed residents at risk of losing legal protection, forfeiture (loss or giving up of something) of the right to a jury or court, lack of understanding of the legal document signed, and a diminished quality of life.Findings included.Review of the admission and Discharge report provided by the facility on 03/17/2026 included a handwritten statement across the top that documented all admissions signed arbitration agreements (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) upon campus move in. The report showed the skilled nursing facility had 147 admissions between 01/06/2025 and 03/16/2026.Review of campus residency agreement showed the facility operated as part of a continuing care community. As part of the community, residents were granted priority access over those who did not reside in the community for use of the health care facilities which included a licensed skilled nursing facility, licensed assisted living apartments and a licensed memory support center. As part of the skilled nursing care admission process, residents agreed to sign a separate skilled nursing admission agreement in its then-current form. The form stated Following your execution of the skilled nursing admission agreement, the terms of this agreement shall continue to apply; and in the event of a conflict between the terms of the two agreements, this agreement shall govern. The agreement included a section titled resolution of disputes with the arbitration procedure listed. Review of the arbitration agreement, embedded in the residency agreement, showed any dispute shall be finally settled exclusively by mandatory binding arbitration, you waive any right(s) to have any dispute decided in court by a judge or jury, and expressly agree to binding arbitration. The agreement included the following statement by signing this agreement, you agree to comply with the policies and procedures of the community, and you understand that your residency is subject to the terms and conditions in this agreement. The agreement contained no documentation to grant the resident and/or their representative the right to rescind the agreement within 30 calendar days of signing or state that neither the resident nor their representative were required to sign an agreement for binding arbitration as a condition of admission or to continue to receive care. The agreement was signed by both Resident 13 and 14 on 11/24/2017 with community residency to begin 12/01/2017.<Resident 13>According to the 01/30/2026 quarterly assessment, Resident 13 admitted to the skilled nursing facility on [DATE] with diagnoses that included dementia. The assessment further showed Resident 13 had moderate cognitive impairment with inattention and disorganized thinking.In an interview on 03/23/2026 at 11:47 AM, Resident 13 was asked what arbitration was. Resident 13 replied sell something? I don't know and referred the surveyor to their spouse, Resident 14.Review of Resident 13's record showed no documentation the arbitration agreement embedded in the community residency agreement was explained in a form and manner understood by the resident and/or their representative.<Resident 14>According to the 12/26/2025 annual assessment, Resident 14 admitted to the skilled nursing facility on [DATE] with diagnoses that included medically complex conditions. The assessment further showed Resident 14 was cognitively intact, understood, was understood, and was able to clearly verbalize their needs.In an interview on 03/23/2026 at 11:36 AM, Resident 14 stated they reviewed and signed their own paperwork as well as their spouse's (Resident 13) paperwork. Resident 14 was asked what arbitration was. Resident 14 explained arbitration was going to a mediator if a conflict arose related to care in that institution instead of going to court. Resident 14 stated they did not recall any staff reviewing arbitration paperwork with them and were not aware if arbitration paperwork was included in the initial community residency or admission paperwork. Resident 14 further stated they would not have signed or agreed to arbitration.Review of Resident (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14's record showed no documentation the arbitration agreement embedded in the community residency agreement was explained in a form and manner understood by the resident.In an interview on 03/23/2026 at 1:18 PM, Staff C, Resident Care Manager, explained the community had different residency contracts that new community residents could choose from. Staff C was unsure who was responsible for reviewing the community residency contracts with the residents, and that it was not done as part of the skilled nursing facility admission process.During interview and record review on 03/23/2026 at 1:28 PM, Staff I, Accounting Manager, explained the community had 26 different residency contracts that new community residents could choose from and each contract should have the arbitration agreement included in it. Staff I was asked who was responsible for reviewing the community residency contracts with skilled nursing facility residents. Staff I called Staff J, [NAME] President of Sales and Marketing. Staff J stated their team reviewed the residency contracts for admission into their community. Staff J explained all community residency contracts had the same arbitration agreement embedded in them under the section titled resolution of disputes, and it was part of the residency agreement. Staff I pulled up a recent admission residency agreement with the embedded arbitration agreement in it for review. Staff J was informed the arbitration agreement did not contain verbiage that explicitly granted the resident and/or their representative the right to rescind the agreement within 30 calendar days of signing or stated that neither the resident nor their representative were required to sign an agreement for binding arbitration as a condition of admission or as a requirement to continue to receive care. Staff J acknowledged the arbitration agreement was a condition of admission. Staff I further stated residents had 90 days to move out if they did not agree to the terms of the community admission.In an interview on 03/23/2026 at 2:47 PM, Staff B, Director of Nursing, stated they were unsure if the facility had a policy on the arbitration agreement process. Staff B acknowledged the community campus residency agreement was utilized by the skilled nursing facility residents and explained community residents could move between all the different care settings including independent living, assisted living, memory care and the skilled nursing facility. A new residency contract was not required when moving between the different care settings within the community. Staff B stated they expected the arbitration agreement to include and meet the requirements for arbitration. No associated WAC

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to maintain a resident's call light system in a functional manner for 1 of 3 sampled residents (Resident 25) reviewed for environmental concerns. This failure placed all facility residents at risk of potentially avoidable accidents, unmet care needs, and diminished quality of life.Findings included.The 02/04/2026 quarterly assessment documented Resident 25 had diagnoses that included Parkinsons disease (a progressive disorder that affected movement), dementia, and weakness. Resident 25 required set up assistance to total assistance from staff to perform activities of daily living (ADLs). Resident 25 had severe cognitive impairment and was able to make their needs known. The 11/19/2020 care plan documented Resident 25 was at risk for falls related to Parkinsons, poor balance, dementia, vision impairments and a history of falls. Staff were instructed to keep Resident 25's call light in reach at all times and remind the resident to use their call light to request assistance.In an observation on 03/17/2026 at 2:19 PM, Resident 25 was sitting in their room in their wheelchair. Their leg came out of their foot trough (a device to hold limbs in place) and they were unable to put their leg back in. At 2:36 PM Resident 25's call light was activated and it was noted after leaving the room the call light did not light up outside of resident's room. At 2:38 PM the call light was turned on again but did not light up outside of Resident 25's room. At 2:41 PM, Staff U, Registered Nurse, was notified the call light was not working. Staff U stated sometimes the call light did not work and they had to pull it out of the wall and plug it back in. Staff U stated if that did not work, they would notify maintenance right away. At 2:50 PM Staff U stated it did not work when they pulled the call light out of the wall and plugged it back in. Resident 25 remained sitting in their room in their wheelchair. On 03/18/2026 at 9:24 AM Resident 25's call light was activated, and it did not light up. At 12:02 PM, Staff K and Staff F, Nursing Assistant, laid Resident 25 down in bed and performed cares. At 12:12 PM, Staff F stated they knew when a resident needed help by the call lights, and by checking on them. Staff F stated when the light was not working, they notified maintenance. At 12:14 PM, Staff K pushed the call light, and it did not light up. Staff F stated there should be a secondary way to call for help like a bell. Staff K stated the facility had a problem with the call lights not working.In an observation on 03/18/2026 at 12:17 PM, Staff F reported the call light was not working to Staff V, Health Care Services Director.In an observation on 03/18/2026 at 12:22 PM, Resident 25 was lying in bed. The resident picked up their call light and pushed it and the call light did not light up. When asked, Resident 25 stated if their call light was not working, they would yell for help. On 03/18/2026 at 1:57 PM, Resident 25 was lying in bed, their call light was turned on, and it did not light up. At 2:09 PM Staff B, Director of Nursing, was notified of Resident 25's call light not working. At 2:21 PM, Staff B stated staff were doing every ten-minute checks on Resident 25. At 2:44 PM, Staff B stated the call light was fixed. On 03/19/2026 at 8:55 AM, Resident 25's call light was turned on and was working. In an interview on 03/23/2026 at 2:16 PM, Staff B stated the call lights needed to work to meet the residents' needs immediately and to prevent an adverse event from happening. Reference: WAC 388-97-2280(1)(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure wheelchairs were maintained in a clean manner for 2 of 3 sampled residents (Residents 25 and 29) reviewed for physical environment. This failure placed residents at risk of potentially avoidable accidents, lack of dignity and diminished quality of life.Findings included .<Resident 25>The 02/24/2026 quarterly assessment documented Resident 25 had diagnoses that included Parkinsons disease (a progressive disorder that affected movement), dementia and weakness. The resident had severe cognitive impairments and required partial to total assistance with activities of daily living.The revised care plan dated 01/28/2026 documented Resident 25 was wheelchair bound and was dependent on staff for locomotion.In an observation on 03/16/2026 at 1:08 PM, Resident 25 was sitting in their wheelchair in their room. The wheelchair was unclean with food debris on the back of the wheelchair, sides and side bars, and the seat cushion. The right arm of the wheelchair was torn. Similar observations of the wheelchair being unclean with food debris were made on 03/18/2026 at 1:57 PM and 03/19/2026 at 1:54 PM. During those observations, there was a strong urine odor from the wheelchair cushion and food underneath the seat cushion. On 03/20/2026 at 1:48 PM, the strong urine odor and food underneath the seat cushion remained.Similar observations of the wheelchair arm being torn were made on 03/18/2026 at 11:53 AM, 03/19/2026 at 1:54 PM, and 03/20/2026 at 10:32 AM. <Resident 29>The 02/09/2026 quarterly assessment documented Resident 29 had diagnoses that included dementia, arthritis, and glaucoma (an eye condition that led to vision loss or blindness). The resident had severe cognitive impairments and was dependent on staff for all cares except eating. The 03/01/2026 care plan documented Resident 29 was wheelchair bound and was dependent on staff for locomotion.In an observation on 03/16/2026 at 10:10 AM, Resident 29 was lying in bed asleep. Their wheelchair was unclean with food on the seat cushion, brown and white splatter on the wheels, spokes and foot pedals. Similar observations of the wheelchair being unclean were made on 03/18/2026 at 9:12 AM and 2:49 PM, 03/19/2026 at 8:50 AM and 1:58 PM, 03/20/2026 at 10:33 AM, and 03/23/2026 at 9:50 AM. In an interview on 03/20/2026 at 1:42 PM, Staff M, Nursing Assistant, stated wheelchairs were cleaned by the nursing assistants and this was completed mainly on night shift. Staff M stated it was important to maintain wheelchairs in a clear manner for dignity. In an interview on 03/23/2026 at 9:10 AM, Staff L, Restorative Aide, stated wheelchairs were consistently assessed for needed repairs and wheelchair arms were replaced when they saw they needed to be. Staff L stated it was important to maintain the wheelchairs in good repair for infection control and to prevent injury. In an interview on 03/23/2026 at 12:45 PM, Staff B, Director of Nursing, stated night shift was responsible for cleaning the wheelchairs and it was important for infection control. Staff B stated wheelchairs were assessed for needed repairs every time they were used, and it was important to prevent injury and for infection control. Reference: WAC 388-97-3220(1)