STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure annual Minimum Data Set (MDS - an assessment tool) were completed within 14 days of the ARD (Assessment Reference Date) for 3 of 26 residents (Residents 18, 100 & 2), reviewed for comprehensive assessments. This failure placed the residents at risk for delayed and/or unmet care needs, and a diminished quality of life.Findings included . Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.20.1, dated October 2025, showed that the completion date of the annual MDS assessment must be no later than 14 days after the ARD (ARD plus 14 calendar days). The MDS RAI manual further showed that the admission assessment must be completed by the end of day 14, counting the date of admission to the nursing home as day one. RESIDENT 18Review of Resident 18's annual MDS dated [DATE] showed that it was completed on 10/27/2025 (six days late). RESIDENT 100Review of Resident 100's annual MDS dated [DATE] showed that it was completed on 01/29/2026 (seven days late). In an interview and joint record review on 04/14/2026 at 12:31 PM, Staff D, MDS Coordinator, stated that the facility followed the RAI manual for MDS assessment completion. A joint record review of Resident 18's annual MDS dated [DATE] showed that it was completed on 10/27/2025. A joint record review of Resident 100's annual MDS dated [DATE] showed it was completed on 01/29/2026. Staff D stated that Resident 18's and Resident 100's annual MDS assessments were completed late, and it should have been completed within 14 days. In an interview on 04/15/2026 at 8:35 AM, Staff B, Director of Nursing, stated that the facility would follow the RAI manual as guidance for MDS completion, and stated they expected MDS assessments to be completed timely and accurately. RESIDENT 2Review of Resident 2's face sheet printed on 04/10/2026 showed that Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's admission MDS dated [DATE], showed that it was completed on 01/05/2026 (11 days late). A joint record review and interview on 04/15/2026 at 6:03 PM with Staff D, showed the RAI manual revealed that an admission MDS was to be completed on day 14 of admission. A joint record review of (continued on next page)

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2's admission MDS dated [DATE] showed that it was completed on 01/05/2026. Staff D stated that the MDS was not completed timely and that it should have been completed by 12/25/2025. In an interview on 04/16/2026 at 4:57 PM, Staff B stated that they expected MDS assessments to be completed accurately and timely. Reference: (WAC) 388-97-1000(1)(b)(3)(a) .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) for 3 of 6 residents (Residents 10, 9 & 7), reviewed for SCSA. This failure placed the residents at risk for delayed care planning, unmet care needs, and a diminished quality of life.Findings included. Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed that a SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline. It further showed that a SCSA completion date (item Z0500B) must be no later than 14 days after the determination that the criteria for a SCSA were met. Review of the facility's policy titled, MDS Completion and Submission Timeframes, revised in October 2023, showed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. RESIDENT 10Review of Resident 10's progress note dated 10/03/2025 showed that the SCSA date of determination by the IDT was 10/03/2025. Review of Resident 10's SCSA MDS dated [DATE] showed a completion date (item Z0500B) of 11/18/2025 (32 days late). In an interview and joint record review on 04/14/2026 at 12:32 PM, Staff D, MDS Coordinator, stated that they followed the RAI manual for MDS assessment completion. A joint record review of Resident 10's progress note dated 10/03/2025 showed the SCSA date of determination by the IDT was 10/03/2025 and the SCSA MDS dated [DATE] showed that it was completed on 11/18/2025 (32 days late). Staff D stated that Resident 10's SCSA MDS was not completed timely. In an interview on 04/15/2026 at 8:25 AM, Staff B, Director of Nursing, stated that they expect Resident 10's SCSA MDS to be completed timely. RESIDENT 9Review of Resident 9's nursing progress notes dated 01/19/2026 showed the resident was readmitted to the facility on [DATE], and that a SCSA MDS was scheduled for 01/21/2026. Review of Resident 9's SCSA MDS dated [DATE] showed it was completed on 02/04/2026 (three days late). A joint record review and interview on 04/15/2026 at 5:56 PM with Staff D, showed the RAI manual revealed that a SCSA MDS should be completed no later than 14 days after determination that significant change in resident's status occurred. A joint record review of the nursing progress notes dated 01/19/2026 showed the IDT determined to do a SCSA MDS on 01/21/2026, and it showed it was completed on 02/04/2026. Staff D stated that Resident 9's MDS was not completed timely and that it should have been. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/16/2026 at 4:57 PM, Staff B stated that they expected MDS assessments to be completed accurately and timely. RESIDENT 7 Review of the nursing progress note dated 10/03/2025 showed Resident 7 had developed a pressure wound (bedsore) to their right heel and that Resident 7 would benefit from a significant change in condition MDS- ARD is set for 10/06/2025. Review of Resident 7's SCSA MDS dated [DATE] showed it was completed on 10/27/2025 (10 days late). A joint record review and interview on 04/15/2026 at 3:54 PM with Staff D, showed that Resident 7's SCSA MDS dated [DATE] was completed on 10/27/2025. Staff D stated that Resident 7's SCSA MDS was not completed timely. A joint record review and interview on 04/16/2026 at 10:41 AM with Staff B, showed Resident 7's SCSA MDS dated [DATE] was completed on 10/27/2025. Staff B stated that they expected Resident 7's SCSA MDS to be completed timely per regulation. Reference: (WAC) 388-97-1000 (3)(b)(5)(a) .

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete quarterly Minimum Data Set (MDS- an assessment tool) timely within 14 days from the Assessment Reference Date (ARD) for 3 of 21 residents (Residents 14, 10 & 7), reviewed for resident assessments. This failure placed the residents at risk for delayed care planning, unmet care needs, and a diminished quality of life.Findings included. Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed a quarterly assessment was considered timely if the MDS completion date (Item Z0500B) must be no later than 14 days after the ARD (ARD + [plus] 14 days). Review of the facility's policy titled, MDS Completion and Submission Timeframes, revised in October 2023, showed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. RESIDENT 14Review of Resident 14's quarterly MDS dated [DATE], showed a completion date (item Z0500B) of 01/27/2026 (one day late). In an interview and joint record review on 04/14/2026 at 12:32 PM, Staff D, MDS Coordinator, stated that they followed the RAI manual for MDS assessment completion. A joint record review of Resident 14's quarterly MDS dated [DATE] showed that it was completed on 01/27/2026. Staff D stated that Resident 14's quarterly MDS was not completed timely. In an interview on 04/15/2026 at 8:25 AM, Staff B, Director of Nursing, stated that they expected Resident 14's quarterly MDS to have been completed timely. RESIDENT 10Review of Resident 10's quarterly MDS dated [DATE], showed a completion date of 01/27/2026 (eight days late). A joint record review and interview on 04/14/2026 at 12:32 PM with Staff D, showed that Resident 10's quarterly MDS dated [DATE] had a completion date of 01/27/2026. Staff D stated that Resident 10's quarterly MDS was not completed timely. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 10's quarterly MDS to have been completed timely. RESIDENT 7 Review of Resident 7's quarterly MDS dated [DATE] showed it was completed on 01/27/2026 (four days late). A joint record review and interview on 04/15/2026 at 3:54 PM with Staff D, showed that Resident 7's quarterly MDS dated [DATE] was completed on 01/27/2026. Staff D stated that Resident 7's quarterly MDS was not completed timely. In an interview on 04/16/2026 at 10:41 AM, Staff B stated that they expected MDS assessments to (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be completed on time per regulation. Reference: (WAC) 388-97-1000 (4)(a)(5)(a) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident assessments were completed accurately for 9 of 32 residents (Residents 49, 100, 14, 13, 66,19, 3, 10 & 71), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessment was marked on the MDS regarding weights, PASRR [Preadmission Screen and Resident Review], insulin injections (medication used to manage blood sugar levels), Serious Mental Illness (SMI), diagnosis, weight loss, medication, and Bilevel Positive Airway Pressure (BiPAP - a noninvasive ventilator that helps people breathe easier by delivering pressurized air through a mask) placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life.Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. RESIDENT 49Review of the RAI manual showed, The measurement of weight is one guide for determining nutritional status. check the medical record and enter the weight taken within 30 days of the Assessment Reference Date (ARD or assessment period) of this assessment. If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (- [dash]) and document rationale on the resident's medical record. Review of the annual MDS dated [DATE] showed that Resident 49's weight was recorded as 202.2 pounds (lbs. – a unit of measurement). Review of the Weight and Vitals Summary record printed on 04/09/2026 showed that Resident 49's last weight was taken 08/01/2024 and it was 202.2 lbs. In an interview and joint record review on 04/14/2026 at 12:37 PM, Staff D, MDS Coordinator, stated that the facility used the RAI manual for MDS assessment completion. Staff D stated that they used Resident 49's last weight record to document weights in MDS. A joint record review of the annual MDS dated [DATE] showed Resident 49's weight was recorded as 202.2 lbs. A joint record review of Resident 49's Electronic Health Record (EHR- under weights/vitals) showed their last weight was taken on 08/01/2024 and it was 202.2 lbs. Staff D stated they used the weight taken on 08/01/2024 for the annual MDS dated [DATE]. Staff D further stated that the weight recorded on the MDS was not obtained within 30 days of the ARD. RESIDENT 100The RAI manual directed, Code 1, yes: if PASRR Level II [refers to the evaluation process conducted after a Level I screening indicates a possible serious mental illness or Intellectual Disability (ID) to ensure that individuals receive appropriate care and support based on their specific needs and conditions] screening determined that the resident has a serious mental illness and/or ID/DD [Developmental Disabilities] or related condition, and continue to A1510, Level II Preadmission (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Screening and Resident Review (PASRR) Conditions. Review of the annual MDS dated [DATE] showed that Section A1500 (PASRR) showed Resident 100 was marked no for state Level II PASRR. Review of the Level II PASRR dated 02/03/2026 showed Resident 100 had a Level II PASRR determination (eligible for behavioral services). During a joint record review and interview on 04/14/2026 at 12:31 PM with Staff D showed Resident 100's annual MDS dated [DATE] was marked not considered by the state Level II PASRR. Staff D stated that the MDS was marked No for the Level II PASRR and it should have been marked, Yes. In an interview on 04/15/2026 at 8:35 AM, Staff B, Director of Nursing, stated that they expected MDS assessments to have been completed timely and accurately. RESIDENT 14Review of Resident 14's annual MDS dated [DATE], showed that Resident 14 was marked No, in Section A (A1500- PASRR). Review of Resident 14's PASRR level II dated 11/12/2020, showed that Resident 14 had a Level II PASRR determination. In a joint record review and interview on 04/14/2026 at 12:32 PM with Staff D, showed that Resident 14's annual MDS dated [DATE] was marked No, in Section A1500. A joint record review of Resident 14's PASRR level II dated 11/12/2020, showed that Resident 14 had a Level II PASRR determination. Staff D stated that Resident 14's annual MDS was not marked accurately. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 14's annual MDS to have been completed accurately. RESIDENT 13Review of the RAI Manual showed, .Count the number of days that the resident received any type of injection while a resident of the nursing home. Record the number of days that any type of injection. was received in Item N0300 [injections received during the seven [7] day look back period]. Enter in Item N0350A [insulin injections]. Review of Resident 13's quarterly MDS dated [DATE] showed it was marked for 7 injections in Section N0300 and 0 [zero] days for insulin injections in Section N0350A. Review of Resident 13's March 2026 Medication Administration Record (MAR) showed that Resident 13 was given insulin injections for 6 [six] days (03/19/2026, 03/20/2026, 03/22/2026, 03/23/2026, 03/24/2026 and 03/25/2026) during the look back period. A joint record review and interview on 04/15/2026 at 5:48 PM with Staff D, showed Resident 13's MDS dated [DATE] was marked for seven injections and zero insulin injections. A joint record review of March 2026 MAR showed that Resident 13 was given insulin injections for six days during the look back period. Staff D stated that Resident 13's MDS was not accurate and that it should have been marked for six injections and six insulin injections. In an interview on 04/16/2026 at 4:57 PM, Staff B stated that they expected MDS assessments to have been completed accurately and timely. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 66 Review of the RAI manual coding instructions showed that if the resident had been diagnosed with SMI to code it in Section A1510A. Review of the admission record printed on 04/09/2026 showed Resident 66 had a diagnosis of Major Depressive Disorder (MDD-persistent feelings of sadness, loss of interest). Review of the annual MDS dated [DATE] showed Resident 66's MDS under Section A1510A was not marked for SMI. Review of a behavioral progress note dated 01/02/2026 showed Resident 66 had a diagnosis of MDD and had been undergoing mental health visits. A joint record review interview on 04/15/2026 at 3:59 PM with Staff D, showed Resident 66's annual MDS dated [DATE] showed Section A1510A was not marked for SMI. A joint record review of Resident 66's EHR (admission record and physician's order) showed a diagnosis of MDD. When asked if SMI should have been marked, Staff D stated that they would consult with Staff O, MDS Nurse. A joint record review and phone interview on 04/15/2026 at 5:02 PM with Staff O, showed Section A1510A on Resident 66's annual MDS dated [DATE] was not marked for SMI. Staff O stated that Resident 66 had MDD and had mental health visits. When asked if SMI should have been marked, Staff O stated, Yes. RESIDENT 19 Review of the RAI Manual coding instructions showed, Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Review of the quarterly MDS dated [DATE] showed Resident 19's MDS under Section I (Active Diagnoses) was not marked for anxiety disorder (having intense, excessive and persistent worry and fear about everything). Review of the March 2026 MAR showed Resident 19 was receiving medication for anxiety during the observation period. Review of a physician progress note dated 03/23/2026 showed Resident 19 had a diagnosis of anxiety disorder. A joint record review and interview on 04/15/2026 at 4:42 PM with Staff D, showed Resident 19's quarterly MDS dated [DATE] was not marked for anxiety disorder. A joint record review of the March 2026 MAR showed Resident 19 was taking medication for anxiety. Staff D stated that Resident 19's quarterly MDS was not accurate and that anxiety disorder should have been coded. In an interview on 04/16/2026 at 1:19 PM, Staff B stated that they expected staff to follow MDS coding per regulation. Staff B further stated that Resident 66's SMI and Resident 19's anxiety disorder should have been marked in their MDS. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 3The RAI showed, 10% [percent – standardized scale of 100] weight loss in 180 days.start with the resident's weight closest to 180 days ago and multiply it by 90 [or 90%]. The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has a lost 10% or more body weight. Review of Resident 3's quarterly MDS dated [DATE], showed that Resident 3 was marked, No or unknown, under Section K (K0300 - Loss of 5% or more in the last month or loss of 10% or more in the last 6 months). Review of Resident 3's September 2025 through March 2026 weights showed 147.4 lbs on 09/02/2025 and 132 lbs. on 03/01/2026. The weights further showed a 10.45% weight loss in the last 6 months. A joint record and interview on 04/14/2026 at 12:32 PM with Staff D, showed Resident 3's quarterly MDS dated [DATE], was marked, No or unknown, under Section K0300. A joint record review of Resident 3's September 2025 through March 2026 weights showed a weight of 147.4 lbs on 09/02/2025 and a weight of 132 lbs. on 03/01/2026. Staff D stated that Resident 3's quarterly MDS was not marked accurately and that it should have been marked, Yes [Loss of 5% or more in the last month or loss of 10% or more in the last 6 months]. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 3's quarterly MDS to have been completed accurately. RESIDENT 10The RAI showed, Check if an opioid [medication to treat moderate to severe pain] medication was taken by the resident at any time during the 7-day look-back period. Check if there is an indication noted for all opioid medications taken by the resident any time during the observation period. Review of Resident 10's significant change MDS dated [DATE], showed that Resident 10 was marked Is taking and Indication noted, under Section N (N0415H- Opioid). Review of Resident 10's October 2025 MAR showed that Resident 10 did not receive an opioid during the MDS look back period. In a joint record review and interview on 04/14/2026 at 12:32 PM with Staff D, showed that Resident 10's significant change MDS dated [DATE] was marked Is taking and Indication noted, under Section N (N0415H-Opioid). Staff D stated that Resident 10's significant change MDS was not marked accurately. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 10's significant change MDS to have been completed accurately. RESIDENT 71The RAI showed, Code any type of CPAP [Continuous Positive Airway Pressure – a device that treats sleep apnea [disorder where breathing repeatedly stops and starts while sleeping] by blowing a steady stream of air into a mask worn over the nose or mouth] or BiPAP use during the first three days of admission. Review of Resident 71's admission/5day MDS dated [DATE], showed that Resident 71 was marked CPAP under Section O0110G3. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 71's March 2026 physician orders showed that Resident 71 was prescribed a BiPAP machine. Review of Resident 71's March 2026 Treatment Administration Record showed Resident 71 used a BiPAP during the look back period. In a joint record review and interview on 04/14/2026 at 12:32 PM with Staff D, showed Resident 71's admission/5day MDS dated [DATE] was marked CPAP in Section O0110G3. A joint record review of Resident 71's March 2026 physician orders showed that Resident 71 used a BiPAP. Staff D stated that Resident 71 used a BiPAP and that their admission/5day MDS was not marked accurately. In an interview on 04/15/2026 at 8:25 AM, Staff B stated that they expected Resident 71's admission/5day MDS to have been completed accurately. Reference: (WAC) 388-97-1000(1)(b) .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure smoking materials were safely stored for 8 of 10 residents (Residents 66, 54, 63, 61, 75, 13, 2 & 85), reviewed for smoking. This failure placed the residents at risk for accidents, injury and a diminished quality of life.: Findings included. Review of the facility's policy titled, Smoking, dated 08/09/2022, showed, It is the policy of this facility to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them. The policy further showed that the Interdisciplinary Team will develop an individualized plan for safe storage, use of smoking materials. RESIDENT 66 Review of the care plan for smoking printed on 04/10/2026 showed that Resident 66's smoking materials would be maintained with the smoking aide. In an interview on 04/08/2026 at 8:50 AM, Resident 66 stated that they smoked without supervision once a day and kept their cigarette and lighter in a bag inside their drawer. An observation and a follow-up interview at 11:47 AM showed Resident 66 had two lighters inside the open side pocket of their small black bag stored in their drawer. Resident 66 stated, I had everything [smoking materials] inside the bag. Another observation and interview on 04/10/2026 at 8:03 AM, showed Resident 66 had a small black bag inside their middle drawer. Further observation showed a lighter on the open side pocket of the small black bag. Resident 66 stated that they had been keeping the lighter all this time and that nobody told them that they could keep it. In an interview and joint observation on 04/14/2026 at 9:07 AM, Staff EE, Certified Nursing Assistant (CNA), stated that Resident 66 smoked independently outside the facility. Staff EE stated that Resident 66 kept their smoking materials in a small black bag. A joint observation with Staff EE showed a cigarette in the small black bag placed inside Resident 66's drawer and a lighter on top of Resident 66's bedside table. When asked about Resident 66's lighter, Staff EE stated, He is independent. They can keep it. RESIDENT 54 Review of the care plan for smoking printed on 04/14/2026 showed Resident 54's smoking materials are kept with [the] smoking aide. Observation and interview on 04/08/2026 at 11:30 AM, showed Resident 54 in their room sitting on the floor by their bedside. Resident 54's room smelled of cigarette smoke and an unlit half-smoked cigarette placed in a dark-purple cup with crumpled foil lining the inside of the cup. When asked if they had smoked in the room, Resident 54 stated, I do, sometimes, but I don't [do not] do it anymore. When asked if they kept lighter and cigarette in their room, Resident 54 mentioned they had a lockbox and that they had lost the key to their lockbox. Resident 54 showed the lighter they had placed on top of their pile and declined further questions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/14/2026 at 8:59 AM, Staff EE stated that they had smelled cigarette smoke in Resident 54's room and did not see Resident 54 smoking inside their room. Staff EE stated that Resident 54 kept their smoking materials in their pocket. Staff EE further stated that they did not see a lockbox in Resident 54's room. RESIDENT 63 Review of Resident 63's smoking care plan printed on 04/15/2026 showed that their smoking materials are securely maintained in the smoking cart. The care plan further showed, Maintain [resident's] smoking materials at nurses' station. In an interview and observation on 04/08/2026 at 11:40 AM, Resident 63 stated that they smoked independently outside in the gazebo. When asked where they would keep their smoking materials, Resident 63 stated, I keep my lighter in my pocket and then showed their lighter and an empty pack of cigarette from their jacket. Resident 63 stated that they could not use the lockbox because it does not have a key and that they were informed by a facility staff about a new lockbox and [has] been waiting for it since Christmas. In an interview on 04/14/2026 at 9:03 AM, Staff EE, stated that Resident 63 kept their smoking materials in their pocket and that sometimes [their roommate, Resident 73] keeps it for Resident 63. In an interview and joint record review on 04/15/2026 at 2:52 PM, Staff C, Assistant Director of Nursing, stated that smoking materials for supervised smoking residents were kept in the smoking cart and that smoking materials for independent smoking residents were kept in the lockbox. Staff C stated that Resident 66, Resident 54 and Resident 63 were independent smoker. A joint record review of the smoking care plan for Resident 66, Resident 54 and Resident 63, showed that their smoking materials were to be maintained with the smoking aide and/or in the smoking cart. A joint record review of the care plan did not show use of a lockbox for their smoking materials. Staff C stated that it was not safe for the residents to keep their smoking materials with them. Staff C further stated that the smoking care plan for Resident 66, Resident 54 and Resident 63 were not implemented and/or updated to reflect their status. Resident 61 Review of Resident 61's smoking care plan printed on 04/15/2026 did not show how to safely store their smoking materials. On 04/08/2026 at 1:06 PM, Resident 61 was observed with an unlit cigarette on their mouth and a lighter on their hand, and an unknown staff wheeled Resident 61 to the smoking area. In an interview on 04/16/2026 at 7:41 AM, Resident 61 stated that they smoked independently outside in the gazebo. When asked where they kept their smoking materials, Resident 61 stated that they had their smoking materials in their pocket and that nobody has told me to use it [lockbox]. I have never used it. I think it is there somewhere. In an interview on 04/16/2026 at 8:09 AM, Staff C stated that Resident 61 was an independent smoker and that they were not aware that Resident 61 had not been using their lockbox. Staff C stated that they would educate Resident 61 to use their lockbox. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/16/2026 at 10:43 AM, Staff B, Director of Nursing, stated that they expected residents' smoking materials to be kept in a safe and a secured place and that the lockbox was considered a safe place for them to keep their smoking materials. Staff B further stated that the residents' [smoking] care plans should be implemented, reviewed and/or revised. RESIDENT 75Review of the unsigned smoking evaluation dated 03/13/2026 [printed on 04/08/2026], showed Resident 75 required supervision with smoking For safety. Review of the smoking care plan printed on 04/08/2026 showed, [Resident 75] may smoke with supervision per smoking assessment. Further review of the care plan showed an intervention to Inform family and significant others that the patient [resident] needs supervision while smoking. supervise patient with smoking in accordance with assessed needs. The care plan did not indicate where Resident 75 could safely keep their smoking materials. On 04/08/2026 at 11:31 AM, Resident 75 was observed in the designated smoking area sitting on their power wheelchair and removed a cigarette and a lighter from a brown leather-like bag hanging over their shoulder. Resident 75 lit their cigarette, placed their lighter back in their brown bag, and continued to smoke their cigarette. Resident 75 was observed smoking without staff supervision. In an interview on 04/15/2026 at 2:05 PM, Staff W, CNA, stated that Resident 75 smoked in the designated smoking area and they did not know if Resident 75 kept their cigarettes with them. On 04/16/2026 at 10:27 AM, Resident 75 stated that they smoked independently and kept their cigarettes and lighter in my purse pointing at their brown leather-like bag that was sitting on a chair in their room. In an interview joint record review on 04/16/2026 at 1:03 PM, Staff C stated they expected a smoking assessment to be done to determine if a resident was able to smoke independently or with assistance. Staff C stated that independent residents who smoke would keep their lighters and cigarettes with them and that they would be provided with a lockbox to store their smoking materials. A joint record review of the smoking care plan, and smoking evaluation dated 03/13/2026, revealed that Resident 75 required supervision with smoking. Staff C stated that staff should have followed Resident 75's smoking care plan to provide supervision with smoking. In an interview on 04/16/2026 3:48 PM, Staff B stated that residents who were evaluated to smoke independently would have a lockbox to store their smoking materials. Staff B stated that Resident 75's care plan should have been followed to provide for supervision when smoking. RESIDENT 13Review of the smoking evaluation dated 12/09/2025 showed Resident 13 was allowed to smoke independently. Review of the smoking care plan printed on 04/08/2026 indicated that Resident 13 smoked independently. Further review of the care plan showed an intervention to Maintain smoking materials with the smoking aid. Monitor [Resident 13] for compliance that was last revised on 03/25/2021. On 04/08/2026 at 11:29 AM, Resident 13 was observed sitting on their power wheelchair in the designated smoking area lighting their cigarette, smoked independently, and placed their lighter back in their pocket after they were done smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/08/2026 at 12:24 PM, Resident 13 stated they smoked independently and kept their cigarettes and lighter with them in their pocket. Observations on 04/08/2026 at 1:31 PM and on 04/10/2026 at 11:59 AM, showed Resident 13 was smoking independently in the designated smoking area. In an interview on 04/15/2026 at 2:21 PM, Staff DD, CNA, stated that Resident 13 smokes independently and that they kept their cigarettes and lighter with them, usually under [Resident 13's] control]. In a joint record review and interview on 04/16/2026 at 1:22 PM with Staff C, revealed that Resident 13's smoking evaluation dated 12/09/2025, showed that Resident 13 was independent with smoking. A joint record review of Resident 13's smoking care plan showed to Maintain smoking materials with the smoking aid. Monitor [Resident 13] for compliance. Staff C stated that Resident 13 was independent with smoking and that it was okay for them to keep their smoking materials. Staff C further stated that Resident 13's smoking care plan should have been updated. In an interview on 04/16/2026 at 3:43 PM, Staff B stated that Resident 13 was independent with smoking and that they kept their smoking materials with them. Staff B further stated that Resident 13's smoking care plan should have been updated to keep their smoking materials in a lockbox. RESIDENT 2Review of the smoking evaluation dated 12/24/2025 showed Resident 2 was independent with smoking. Review of the comprehensive care plan printed on 04/08/2026 did not show Resident 2 had a care plan for smoking. On 04/08/2026 at 11:49 AM, Resident 2 stated they kept their lighter and cigarettes with them. Resident 2 was observed taking out their lighter and a pack of cigarettes from their zippered black bag. On 04/10/2026 at 12:37 PM, Resident 2 was observed smoking independently in the designated smoking area. A joint record review and interview on 04/16/2026 at 12:53 PM with Staff C, Resident 2's smoking evaluation dated 12/24/2025, showed they were independent with smoking. A joint record review of the comprehensive care plan did not show Resident 2 had a care plan for smoking. Staff C stated that Resident 2 should have had a care plan for smoking. A joint record review and interview on 04/16/2026 at 3:48 PM with Staff B, Resident 2's smoking evaluation showed they were independent with smoking. Staff B stated that Resident 2 smoked independently and kept their smoking materials with them. A joint record review of the comprehensive care plan showed that Resident 2 did not have a care plan for smoking. Staff B stated that Resident 2 did not have a care plan for smoking and should have had. RESIDENT 85Review of Resident 85's comprehensive care plan printed on 04/13/2026 showed an intervention to, Maintain patients smoking materials are securely maintained in the smoking cart. In an interview and observation on 04/08/2026 at 12:48 PM, Resident 85 stated that they smoked (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	independently and that they kept their cigarettes and lighter with them. Observed Resident 85 took out one pack of cigarettes and a lighter out of their right leather jacket pocket. Resident 85 stated, I have to keep it in a lockbox. I'm waiting for a lockbox though. In an interview on 04/15/2026 at 1:14 PM, Staff W stated that some residents would keep their smoking materials in the smoking storage cart. Staff W further stated that they were unsure where Resident 85 kept their smoking materials. In an interview on 04/16/2026 at 10:58 AM, Staff C stated that they would expect residents to store their smoking materials in the smoking cart. A joint record review of Resident 85's care plan showed an intervention to, Maintain patients smoking materials are securely maintained in the smoking cart. Staff C stated that Resident 85 should not have kept their smoking materials in their pocket when not in use. In an interview on 04/16/2026 at 1:13 PM, Staff B stated that they would expect Resident 85 to have stored their smoking materials in the smoking cart. In an interview on 04/16/2026 at 1:22 PM, Staff A, Administrator, stated that independent residents should store their smoking materials in a lockbox in their room and for residents who need assistance should store their smoking materials in the smoking cart. Staff A further stated that they would expect Resident 85 to have stored their smoking materials in a lockbox. Reference: (WAC) 388-97-1060(3)(g) .

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively assess and evaluate the need for bed rails for 3 of 6 residents (Residents 9, 74 & 103), reviewed for bed rail use. This failure placed the residents at risk for entrapment, injury, and a diminished quality of life.Findings included .Review of the facility's policy titled, Bed Rails, dated 02/21/2025, showed, It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. As part of the residence comprehensive assessment, the IDT will review and determining [determine] the resident's needs, and whether or not the use of bed rails meets those needs. Once the IDT determines that the resident may benefit from a use of side rail, the licensed nurse will complete the bed rail assessment. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. Upon receiving informed consent, the facility will obtain a physician's order for the use of a specific bed rail.RESIDENT 9Review of a bed rail evaluation dated 01/26/2026 showed Resident 9's bed rail recommendations were, No to Rail/s.Mobility bars not indicated for this resident at this time.Review of the Electronic Health Records (EHR -miscellaneous/documents tab from 05/13/2025 to 04/01/2026) did not show that Resident 9 had a consent for their right-side bed rail.Review of the comprehensive care plan printed on 04/15/2026 did not show that Resident 9 had a care plan for the bed rail.During an observation and interview on 04/07/2026 at 11:42 AM and on 04/09/2026 at 1:37 PM, Resident 9 had a bed rail on their right side in the raised position. Resident 9 stated that they used their bed rail.A joint observation and interview on 04/15/2026 at 2:35 PM with Staff BB, Certified Nursing Assistant (CNA), showed Resident 9 had a right bed rail in the raised position. Staff BB stated that Resident 9 used their bed rail.In a joint observation and interview on 04/15/2026 at 2:59 PM with Staff CC, Registered Nurse, showed Resident 9 had a right bed rail in the raised position. Staff CC stated that Resident 9 had their bed rail since they were readmitted to the facility.In an interview and joint record review on 04/16/2026 at 1:28 PM, Staff C, Assistant Director of Nursing, stated that before a bed rail gets installed on the resident's bed, the facility would complete a bed rail assessment, obtain consent, and develop a care plan. A joint record review of Resident 9's bed rail assessment dated [DATE], showed no indication for bed rail use. A joint record review of Resident 9's EHR (miscellaneous/documents tab and care plan) did not show they had a consent and/or care plan for bed rail use. Staff C stated that Resident 9 should have had an evaluation for the right-side bed rail, consent, and a care plan.In an interview on 04/16/2026 at 4:00 PM, Staff B, Director of Nursing, stated that they expected residents to have a bed rail evaluation, consent, and a care plan for bed rail use. Staff B further stated that Resident 9 should have had an evaluation for their right-side bed rail, consent, and a care plan for bed rail use.RESIDENT 74Review of a bed rail evaluation dated 02/11/2026 showed Resident 74's bed rail indications for use and recommendation revealed, Bed rail/transfer bar is not indicated. No to Rail/s.Review of the EHR (miscellaneous/documents tab from 12/20/2025 to 04/13/2026) did not show Resident 74 had a consent for bed rail use.Review of the comprehensive care plan printed on 04/15/2026 did not show Resident 74 had a care plan for bed rail use.Observations on 04/07/2026 at 11:50 AM and on 04/09/2026 at 1:39 PM showed Resident 74 had bed rails attached on both sides of their bed in the raised position. Resident 74 stated they used their bed rails.A joint observation and interview on 04/15/2026 at 2:36 PM with Staff BB, showed Resident 74 had bed rails attached on both sides of their bed in the raised position. Staff BB stated that Resident 74 used their bed rails and that they had them since admission.A joint observation and (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 04/15/2026 at 3:00 PM with Staff CC, showed Resident 74 was lying in bed, and had their bed rails in the raised position. Staff CC stated that Resident 74 used their bed rails and that they had had them for a while.A joint record review and interview on 04/16/2026 at 1:41 PM with Staff C, showed Resident 74's bed rail evaluation did not indicate use of bed rails. A joint record review of Resident 74's EHR (miscellaneous/documents tab and care plan) did not show Resident 74 had a consent and a care plan for bed rail use. Staff C stated that Resident 74 should have an evaluation, a consent, and a care plan for bed rail use.In an interview on 04/16/2026 at 4:07 PM, Staff B stated that Resident 74 should have had an evaluation, a consent, and a care plan for bed rail use.RESIDENT 103Review of a bed rail evaluation dated 02/22/2025 showed resident was evaluated for a left upper bed rail.Observation on 04/07/2026 at 8:41 AM, showed Resident 103 was in bed and had bed rails on both sides of their bed in the raised position. Resident 103 stated that they used their bed rails.A joint observation and interview on 04/15/2026 at 2:26 PM with Staff DD, CNA, showed Resident 103 had bed rails on both sides of their bed in the raised position. Staff DD stated that Resident 103 used their bed rails.A joint record review and interview on 04/16/2026 at 1:45 PM with Staff C, showed Resident 103's bed rail evaluation dated 02/22/2025 indicated that they were evaluated to use a left bed rail. Staff C stated that Resident 103 should have had a bed rail evaluation for both bed rails.In an interview on 04/16/2026 at 4:09 PM, Staff B stated that Resident 103 should have had an evaluation for both bed rails.Reference: (WAC) 388-97-1060 (3)(g).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing information included the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift for 9 of 10 days (04/01/2026 to 04/08/2026 & 04/10/2026), reviewed for posted nurse staffing information. In addition, the facility failed to post the current nurse staffing information for 1 of 8 days (04/09/2026). The failure to post a complete and current nurse staffing form daily prevented the residents, family members, and visitors from exercising their rights to know the actual nursing staff hours worked in the facility.Findings included.Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised in August 2022, showed Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The policy showed that within two hours of the beginning of each shift, the number of licensed nurses including Registered Nurses, Licensed Practical Nurses and the number of unlicensed nursing personnel including Certified Nursing Assistants directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The policy further showed that the charge nurse completes the form and posts the staffing information in the location designated by the administrator.Observation on 04/07/2026 at 8:06 AM, showed a Daily Nurse Staffing Form, dated 04/07/2026 with the number of staff and scheduled hours filled out. The form further showed the hours worked column was blank.Observations on 04/09/2026 at 8:25 AM, at 10:30 AM, at 3:00 PM, and on 04/10/2026 at 8:00 AM, showed a Daily Nurse Staffing Form dated 04/08/2026 (not the current date or current nurse staffing information, what was posted was 04/08/2026).Observation on 04/10/2026 at 1:22 PM, showed the hours worked column on the Daily Nurse Staffing Form was blank.In an interview and joint record review on 04/10/2026 at 2:34 PM, Staff G, Scheduler, stated that they were responsible for the Daily Nurse Staffing Form and that it should be filled out completely for each nursing category with scheduled and actual hours [worked]. Staff G stated that the form should be current. Staff G stated that they filled out the hours worked column at the end of the shift and would know which staff showed up at the beginning of the shift. A joint record review of the Daily Nurse Staffing Form, dated 04/01/2026 to 04/08/2026 and 04/10/2026 showed the hours worked column was blank. Staff G stated that the forms should have been completed. Staff G stated that on the weekends they would leave the forms and update the hours worked on Monday when they returned. Staff G further stated that they were out of the facility on 04/09/2026 and did not update the form.In an interview on 04/15/2026 at 2:17 PM, Staff A, Administrator, stated that they expected the Daily Nurse Staffing Form to be complete, filled out including actual hours, be current and posted at the beginning of the shift.Reference: (WAC) 388-97-1620 (2)(b)(i).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a system was in place for tracking and accounting of controlled drugs, and failed to store controlled drugs in a locked, permanently affixed compartments in 1 of 2 medication rooms (Medication room [ROOM NUMBER]'s E-Kit [emergency medication box]), reviewed for controlled drugs management. This failure placed the facility at risk for potential loss and/or drug diversion of controlled drugs.Findings included.Review of the facility's policy titled, Controlled Substances, revised in November 2022, showed, Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substance record. Controlled substances are separately locked in permanently affixed compartment, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.During a joint observation and interview on 04/10/2026 at 1:37 PM with Staff H, Director of Staff Development, and Staff I, Licensed Practical Nurse, showed the Medication room [ROOM NUMBER]'s second medication refrigerator did not have a lock. Inside the unlocked refrigerator, a clear, removable emergency medication box (E-Kit) was stored. The E-Kit's security seal (a yellow zip tie) was found taped to the side of the box and was not applied to the E-Kit to secure the contents. Observation showed the following controlled drugs were stored in the E-kit: two 2 mg (milligram- a unit measurement) vials of Lorazepam (a controlled drug used to treat severe anxiety) injectable solution and two 30 ml (milliliter - a unit measurement) bottles of Lorazepam oral solution. Further observation showed there was no controlled drug logbook in the E-Kit. Staff H stated that the E-Kit was delivered by the facility's new pharmacy provider, and they had not seen the E-Kit's controlled drug logbook. Staff I stated that the refrigerator containing the E-Kit with controlled drugs should have been locked.In an interview on 04/15/2026 at 11:14 AM, Staff B, Director of Nursing, stated that controlled drugs must be counted, logged on the controlled drug book, and stored in a locked box. Staff B stated that they were unaware the E-Kit with controlled drugs were delivered by the new pharmacy. Staff B further stated that the medication room refrigerator used for storage of controlled drugs should have been locked and a controlled drug logbook should have been in place.Reference: (WAC) 388-97-1300 (3)(a).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure adverse side effects and target behaviors were monitored for medication use and/or physician's orders were followed when administering medication for 3 of 6 residents (Residents 30, 13 & 7), reviewed for unnecessary medications. These failures placed residents at risk for adverse side effects, related complications, and a diminished quality of life.Findings included. Review of the facility's policy titled, Administering Medications, revised in April 2019, showed, Medications are administered in a safe and timely manner as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label three times to verify the right result and right medication, right dosage, right time and right method (route) of administration before giving the medication. MONITORING OF SIDE EFFECTS AND TARGET BEHAVIORSRESIDENT 30Review of Resident 30's physician orders printed on 04/07/2026 showed an order for nortriptyline (antidepressant – medication for depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) to be given at bedtime. Review of Resident 30's January 2026 through April 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not show monitoring for adverse side effects and/or target behaviors related to antidepressant use. In an interview and record review on 04/16/2026 at 2:34 PM, Staff C, Assistant Director of Nursing, stated they expected residents on antidepressants to be monitored for adverse side effects and target behaviors. A joint record review of the January 2026 through April 2026 MAR and TAR did not show that Resident 30 was being monitored for adverse side effects and/or target behaviors. Staff C stated that Resident 30 should have been monitored for adverse side effects and target behaviors related to antidepressant use. In an interview and joint record review on 04/16/2026 at 4:22 PM, Staff B, Director of Nursing, stated that they expected residents to be monitored for adverse side effects and target behaviors due to antidepressant use. A joint record review of the January 2026 through April 2026 MAR did not show Resident 30 was being monitored for adverse side effects and target behaviors related to use of antidepressant. Staff B stated that Resident 30 was not monitored for adverse side effects and/or target behaviors and should have been. MEDICATION ORDERS WITH PARAMETERSRESIDENT 30Review of the physician orders printed on 04/07/2026 showed Resident 30 had orders for metoprolol (medication for high blood pressure [force of blood flowing through the blood vessels) to be given two times a day with an instruction to hold if systolic blood pressure (the top number in a blood pressure reading, representing the pressure in the arteries [blood vessels that carry blood to the organs] when the heart beats) was less than 100 and if pulse was less than 60. Review of the January 2026, February 2026, March 2026 and April 2026 MAR, showed Resident 30 had orders for metoprolol to be given at 8:00 AM and at 4:00 PM. Further review of the January 2026 through April 2026 MAR did not show that the blood pressure and pulse were recorded in the MAR. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 04/16/2026 at 1:56 PM, Staff C stated that they expected staff to follow physician orders with parameters and to document them in the residents' MAR. A joint record review showed Resident 30's MAR from January 2026 through April 2026 had an order for metoprolol to be given at 8:00 AM and at 4:00 PM with instructions to hold the medication if systolic blood pressure was less 100 and if pulse was less than 60. Further review of the MARs showed the blood pressure and pulse were not recorded prior to giving Resident 30's metoprolol. Staff C stated that the metoprolol order did not include spaces to record Resident 30's blood pressure and pulse, and it should have been included in the MAR. In an interview on 04/16/2026 at 4:16 PM, Staff B stated they expected staff to follow doctor's orders with parameters for administration of medications. RESIDENT 13Review of the March 2026 MAR showed that Resident 13 had an order for insulin (medication/hormone that regulates blood sugar levels) Lispro (fast-acting insulin) to be given in the evening with an instruction to hold it if the blood sugar level was less than 150. Further review of the MAR showed insulin were administered when Resident 13's blood sugar was less than 150 on the following dates:- 03/07/2026: blood sugar level of 100- 03/28/2026: blood sugar level of 100- 03/31/2026: blood sugar level of 134 In an interview and joint record review on 04/16/2026 at 1:51 PM, Staff C stated that they expected staff to follow blood sugar parameters as ordered. A joint record review of the March 2026 MAR showed that insulin were given to Resident 13 when their blood sugar level were below 150. Staff C stated that insulin were given and should have been held when Resident 13's blood sugar were below 150. In an interview and joint record review on 04/16/2026 at 4:19 PM, Staff B stated they expected staff to follow physician orders. Staff B stated that a check mark in the MAR meant the medication was administered. A joint record review of the March 2026 MAR showed Resident 13 were given insulin when their blood sugar were below 150. Staff B stated that insulin should have been held. RESIDENT 7 Review of Resident 7's physician order dated 03/13/2026 showed an order for metoprolol two times a day (morning and at bedtime), with an instruction (parameter) to hold it if their systolic blood pressure was less than 110 and the diastolic pressure (the bottom number in a blood pressure reading indicating how much pressure is in the arteries when the heart is filling blood) was less than 60. Review of the March 2026 Electronic Health Record under vital signs for blood pressure and March 2026 MAR showed Resident 7's were administered metoprolol without their blood pressure monitoring at bedtime on the following dates: - 03/23/2026- 03/24/2026 - 03/25/2026 - 03/26/2026 - 03/29/2026 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the March 2026 MAR showed metoprolol were given on the following dates when Resident 7's systolic blood pressure was below 110 and/or their diastolic blood pressure were below 60: - 03/22/2026: 108/69 at bedtime - 03/27/2026: 121/50 in the morning - 03/28/2026: 120/50 in the morning. Review of the April 2026 MAR showed that on 04/05/2026 Resident 7 was administered metoprolol in the morning when their blood pressure was 105/46 and it was given at bedtime when their blood pressure was 106/65. In an interview and joint record review on 04/13/2026 at 2:36 PM, Staff V, Registered Nurse, stated that they were expected to follow physician orders regarding parameters. A joint record review of Resident 7's physician order showed they had an order to take metoprolol twice a day and to hold it if their systolic pressure was less than 110 or their diastolic pressure was less than 60. A joint record review of the March 2026 Electronic Health Record under vital signs for blood pressure and March 2026 MAR showed Resident 7's were administered metoprolol without their blood pressure monitoring and/or when Resident 7's systolic blood pressure was below 110 and their diastolic blood pressure were below 60. Review of the April 2026 MAR showed that on 04/05/2026 Resident 7 was administered metoprolol in the morning when their blood pressure was 105/46 and it was given at bedtime when their blood pressure was 106/65. Staff V stated that Resident 7's blood pressure should have been checked twice or prior to medication administration and that their metoprolol should not have been administered when their blood pressure were low. In an interview and joint record review on 04/15/2026 at 1:44 PM, Staff C stated that staff were expected to follow parameters for blood pressure medication and checked the resident's blood pressure prior to administration of medication. A joint record review of the March 2026 Electronic Health Record under vital signs for blood pressure and March 2026 MAR showed Resident 7's were administered metoprolol without their blood pressure monitoring and/or when Resident 7's systolic blood pressure was below 110 and their diastolic blood pressure were below 60. Review of the April 2026 MAR showed that on 04/05/2026 Resident 7 was administered metoprolol in the morning when their blood pressure was 105/46 and it was given at bedtime when their blood pressure was 106/65. Staff C stated that staff should have checked Resident 7's blood pressure twice a day and should have held Resident 7's medication when their blood pressure readings were below the parameters. During a joint record review and interview on 04/16/2026 at 10:16 AM with Staff B, showed Resident 7's physician order for metoprolol was to be given twice a day and to hold if parameters were less than 110 for systolic and less than 60 for the diastolic. A joint record review of Resident 7's vital signs record, March 2026 and April 2026 MAR, showed the above orders/parameters were not followed. Staff B stated, [Staff] are supposed to check the BP [blood pressure] twice a day and they need to follow physician's order. Reference: (WAC) 388-97-1060 (3)(k)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs were properly labeled and stored in accordance with current accepted professional standards for 3 of 3 medication carts (Medication Cart 3, Medication Cart 4 & Medication Cart 2), and for 1 of 2 medication rooms (Medication room [ROOM NUMBER]), reviewed for medication storage and labeling. These failures placed the residents at risk of receiving compromised and ineffective medications.Findings included .Review of the facility's policy titled, Medication Labeling and Storage, revised in February 2023, showed, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.Multi-dose vials that have been opened or accessed (e.g. [example] needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.MEDICATION CART 3 A joint observation and interview on 04/10/2026 at 1:31 PM with Staff I, Licensed Practical Nurse, showed an opened Albuterol Sulfate (used for breathing treatment) inhaler stored in Medication Cart 3. Observation showed the inhaler had a sticker attached Date Opened. Further observation showed the sticker's date opened field was blank and unlabeled. Staff I stated that the Albuterol inhaler should have been labeled when it was opened.MEDICATION CART 4 A joint observation and interview on 04/10/2026 at 3:14 PM with Staff K, Registered Nurse (RN), showed an opened Combivent Respimat (used for breathing treatment) inhaler stored in Medication Cart 4. Further observation showed the inhaler was not labeled with opened date. Staff K stated that the medication did not have an open date.MEDICATION CART 2A joint observation and interview on 04/10/2026 at 3:16 PM, with Staff J, RN, showed the following medications stored in the Medication Cart 2:- Resident 53's insulin (a hormone that helps regulate blood sugar levels) glargine (long-acting insulin) pen had a sticker that was blank/unlabeled (no pen date).- Two amantadine hydrochloride (used for movement disorders) oral solution bottles, the sticker attached to it was blank/unlabeled. - One opened Spiriva Respimat (used for breathing treatment) inhaler, the sticker attached to it was blank/unlabeled.Staff J stated that these medications should have been labeled with open date.MEDICATION room [ROOM NUMBER]A joint observation and interview on 04/10/2026 at 1:59 PM with Staff H, Director of Staff Development, showed there was an open Tuberculin (a solution used for tuberculosis [a contagious bacterial infection that primarily attacks the lungs] test) vial labeled with open date of 02/17/2026 stored in the refrigerator. Staff H stated that the vial was opened on 02/17/2026.Another joint observation and interview on 04/10/2026 at 3:28 PM with Staff J showed that there were two opened, unlabeled Tuberculin vials stored in the medication room [ROOM NUMBER]'s second refrigerator. Staff J stated that the vials were opened and had not been labeled.In an interview on 04/15/2026 at 11:14 AM, Staff B, Director of Nursing, stated that staff were expected to label medications with an open date. Staff B stated that any medication that had a sticker and required an open date must be labeled at the time of opening. Staff B further stated that Tuberculin vials should be labeled with the open date and be discarded within 30 days of opening. Reference: (WAC) 388-97-1300 (2).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Infection Prevention and Control Program (IPCP) policies and procedures were reviewed annually as required. In addition, the facility failed to ensure hand hygiene was performed after removal of Personal Protective Equipment (PPE - gloves and gown), disinfect shared medical equipment after resident use, ensure proper PPE and/or Enhanced Barrier Precautions [EBP-specialized infection control measures used to prevent the spread of specific infections) were followed for 3 of 8 staff (Staff P, Staff L & Staff M), reviewed for infection control. These failures placed residents, visitors, and staff at an increased risk for infection and related complications. Findings included. Review of the facility's policy titled, Infection Prevention and Control Program, dated 09/18/2023, showed, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy showed, The program is reviewed annually and updated as necessary. The policy further showed that infection prevention included ensuring staff adherence to proper techniques and procedures and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC). IPCP ANNUAL REVIEW Review of the IPCP policies and procedures showed that they have not been reviewed at least annually. The Infection Prevention and Control Program and Antibiotic Stewardship were dated 09/18/2023 and the Water Management Program was dated 06/24/2021 and these policies did not show that they were reviewed annually. In an interview and joint record review on 04/16/2026 at 1:20 PM, Staff B, Director of Nursing, stated that they were not sure when the policies were reviewed. Staff B stated, The corporate does the review of the policies. A joint record review of the IPCP, antibiotic stewardship and the water management program showed they were not reviewed at least annually. Staff B stated that they would follow up with the corporate office, and informed Staff A, Administrator, during the interview. HAND HYGIENE STAFF P Review of the facility's policy titled, Handwashing/ Hand Hygiene, dated 09/18/2023, showed, This facility considers hand hygiene the primary means to prevent the spread of infections. The policy further showed that hand hygiene would be performed after removing personal protective equipment. Observation on 04/15/2026 at 8:08 AM, showed Staff P, Certified Nursing Assistant (CNA), performed hand hygiene, put on a gown and a pair of clean gloves, carried a breakfast meal tray and entered room [ROOM NUMBER] (a TBP [specialized infection control measures used to prevent the spread of specific infections] room). At 8:11 AM, Staff P [already removed their gloves and gown] and exited room [ROOM NUMBER]'s room. Staff P did not perform hand hygiene after removing their PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/2026 at 8:21 AM, Staff P stated that they delivered and set up the breakfast tray to the resident in room [ROOM NUMBER]. When asked if they were expected to perform hand hygiene after removing their PPE, Staff P stated, Yes. Staff P further stated, Oh, I missed that [hand hygiene]. No, I did not sanitize my hands. In an interview on 04/15/2026 at 8:27 AM, Staff I, Licensed Practical Nurse, stated that staff were expected to perform hand hygiene after removing their PPE. Staff I further stated, Staff should hand wash or use hand sanitizer. In an interview on 04/16/2026 at 2:57 PM, Staff B stated that they expected staff to perform hand hygiene after removing their PPE. MEDICAL EQUIPMENT CLEANINGSTAFF LReview of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised in September 2022 showed, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) recommendations for disinfection and OSHA [Occupational Safety and Health Administration] Bloodborne Pathogens [germs in human blood that can cause disease in humans] Standard. Observation on 04/10/2026 at 7:40 AM, showed that Staff L, Registered Nurse, removed a digital blood pressure cuff from the medication cart and entered Resident 110's room to check the resident's blood pressure and heart rate (vital signs). After checking the resident's vital signs, Staff L left the room, performed hand hygiene, and placed the blood pressure cuff on the medication cart. Further observation showed Staff L stored the cuff in the medication cart drawer without cleaning or disinfecting it after use. In an interview on 04/10/2026 at 8:13 AM, Staff L stated that blood pressure cuffs should be cleaned between resident use. Staff L further stated that they did not clean the blood pressure cuff after using it on Resident 110 and stated that it should have been cleaned. EBPSTAFF MReview of the facility's policy titled, Enhanced Standard/Barrier Precaution, revised on 02/21/2025, showed, Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant (to at least one drug in three or more different classes of antimicrobial agents, making infections harder to treat) organisms that employs targeted gown and glove use during high contact resident care activities. The policy showed the facility would make PPE available near or outside of the resident's room. The policy further showed that residents with indwelling urinary catheters (a flexible tube inserted into the bladder to drain urine) would benefit from EBP and changing linens and briefs were considered high contact resident care activities. Review of the order summary report printed on 04/14/2026 showed that Resident 110 had an order for indwelling urinary catheters with an order start date of 04/08/2026. Observation on 04/10/2026 at 9:16 AM, showed that there was no EBP signage or PPE cart available near or outside of Resident 110's room. Observation showed Staff M, CNA, entered Resident 110's room, performed hand hygiene and applied gloves. Further observation showed Staff M provided incontinence care for Resident 110 and changed the resident's bed linens. Staff M did not wear a gown during high contact resident care activity as required. In an interview on 04/10/2026 at 9:34 AM, Staff M stated that residents with indwelling catheters (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would require EBP, including the use of gown and gloves during incontinence care. Staff M stated that Resident 110 was a new admission, and there was no EBP signage or PPE cart outside the door. Staff M further stated that they should have worn a gown before providing incontinent care. In an interview on 04/15/2026 at 8:26 AM, Staff B stated that staff were expected to clean and sanitize blood pressure cuffs after each use before storing them. Staff B stated that for residents on EBP, an EBP sign would be posted on the door, and a PPE cart would be available. Staff B further stated that gloves and gowns should be worn during high-contact care activities of residents on EBP. Reference: (WAC) 388-97-1320 (1)(a)(c) (5)(c).

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident was evaluated, and a physician order was obtained for safe administration of medication for 1 of 1 resident (Resident 25), reviewed for self-administration of medication. This failure placed the resident at risk for inaccurate and unsafe medication administration, adverse side effects, and medical complications.Findings included.Review of the facility's policy titled, Self-Administration of Medications, revised in February 2021, showed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy showed that if the resident had been determined to be not safe to self-administer medication, the nursing staff would administer the resident's medications. The policy further showed, Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.Review of a face sheet printed on 04/09/2026 showed Resident 25 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia (a long-term condition where the lungs cannot supply enough oxygen to the blood).Review of the physician order printed on 04/10/2026 showed no documentation to indicate that Resident 25 had an order for self-administration of medication.Review of the Medication Self-Administration Evaluation dated 01/29/2026 showed Resident 25 was unable to administer inhalant (through nose and/or mouth) medications with proper procedure. It further showed, Resident is dependent on staff for all [their] cares and medication administration.Review of Resident 25's electronic health records (progress notes and care plans) did not show Resident 25 could keep medication at their bedside.An observation on 04/10/2026 at 7:59 AM showed Resident 25 was receiving nebulization (a process of converting liquid medication into a fine mist or aerosol, allowing it to be inhaled directly into the lungs). Further observation showed an albuterol (brand name-used to relieve breathing difficulties) inhaler with a red chamber (a tube-like device that attaches to a metered-dose inhaler [MDI]) at Resident 25's bedside table.An observation and interview on 04/13/2026 at 7:58 AM showed Resident 25 was using an inhaler with a blue chamber. When asked if they knew how much puff they should take, Resident 25 answered, I don't [do not] know. I just do it many times. Further observation showed an inhaler with a red chamber on Resident 25's bedside table. Both blue and red inhalers label showed, albuterol-sulfate HFA [or Hydrofluoroalkane, a propellant used in inhalers to deliver medication safely to the lungs] and did not show Resident 25's name on both inhalers. When asked, Resident 25 stated, that is my inhaler [red chamber] from home. While talking with Resident 25, Staff E, Registered Nurse, went inside the room and had a concurrent observation of two inhalers on Resident 25's bedside table. Staff E stated, [Resident 25] normally has inhaler at bedside and takes it by [themselves]. When asked about the red inhaler, Staff E stated, it is empty, and proceeded to throw the red inhaler in the garbage bin.During a follow-up interview on 04/13/2026 at 8:14 AM, Staff E stated that they were aware that Resident 25 brought inhalers when they were admitted to the facility. Staff E stated that they had told Resident 25 that they could not have inhalers at their bedside, but that Resident 25 insisted to have them at their bedside. When asked if Resident 25 was allowed to self-administer the inhaler, Staff E responded, I already told [Resident 25] that [they] cannot have it [inhaler] at bedside. Staff E stated that they had called and informed the provider. When asked if they had documented about it, Staff E stated, I don't [do not] remember. Staff E stated that Resident 25's inhaler with a red chamber was their rescue inhaler [fast-acting medication that quickly open airways to relieve sudden breathing difficulties] and that they did not know where the inhaler with a blue chamber came from. Staff E stated that Resident 25 was alert and oriented and that they would ask Resident 25 about the blue inhaler. A concurrent joint observation and interview showed Resident 25 had the blue inhaler at their bedside. When asked, Resident 25 stated that the blue inhaler came from my doctor in the ER [emergency room]. Resident (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	25 stated that the staff were aware that they keep the inhaler and that staff had seen them using the inhalers. Staff E then stated that they would conduct assessments for residents who self-administer medication and that there should be a doctor's order.In an interview on 04/14/2026 at 4:26 PM, Staff B, Director of Nursing, stated that residents should be assessed for self-medication administration before they were allowed to have medications at their bedside and that there should be a doctor's order. When asked if Resident 25 should have been allowed to keep and self-administer their inhalers, Staff B stated that Resident 25 should have been assessed, have had a doctor's order, provided education, and a care plan.Reference: (WAC) 388-97-0440,1060(3)(I).

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit the resident Minimum Data Set (MDS-an assessment tool) to the Centers for Medicare & Medicaid Service (CMS) within the required timeframe for 1 of 32 residents (Resident 94), reviewed for resident assessments. This failure placed the resident at risk for unmet care needs and a diminished quality of life.Findings included .Review of the Long-Term Care Facility Resident Assessment Instrument [RAI-instructional guidelines for MDS completion] 3.0 User's Manual Version 1.20.1, revised in October 2025, showed that a discharge (non-comprehensive) MDS must be completed no later than 14 days after the Assessment Reference Date (ARD-look back period), and it must be submitted/transmitted within 14 days of the MDS completion date to the database as required.Review of the facility's policy titled, MDS Completion and Submission Timeframes, revised in October 2023, showed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.Review of Resident 94's discharge MDS dated [DATE] showed that it was completed on 11/07/2025, however, it was not submitted/transmitted to CMS.In an interview and joint record review on 04/15/2026 at 5:45 PM, Staff D, MDS Coordinator, stated that they followed the RAI manual for completion of MDS. Staff D stated that the discharge assessment was to be submitted/transmitted 14 days from completion. A joint record review of Resident 94's discharge MDS dated [DATE] showed that it was completed on 11/07/2025 and was not submitted/transmitted. Staff D stated that Resident 94's discharge MDS should have been submitted/transmitted within 14 days from completion by 11/21/2025.In an interview on 04/16/2026 at 4:57 PM, Staff B, Director of Nursing, stated that they expected MDS assessments to be submitted/transmitted timely.Reference: (WAC) 388-97-1000(5)(e)(ii)(iii).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, the facility failed to ensure the Preadmission Screen and Resident Review (PASRR or PASARR) Level II (refers to the evaluation process conducted after a Level I screening indicates a possible serious mental illness or intellectual disability to ensure that individuals receive appropriate care and support based on their specific needs and conditions) was obtained for 2 of 10 residents (Residents 6 & 30), reviewed for PASRR coordination. This failure placed the residents at risk of not receiving the necessary behavioral health services and a diminished quality of life.Findings included .Review of the facility's policy titled, PASRR Completion, revised on 09/30/2024, showed, The Center will make sure that all admissions have the appropriate Patient [Preadmission] Screen and Resident Review (PASRR) completed. The facility will [follow] state-specific guidelines for completion.RESIDENT 6Review of an admission record printed on 04/08/2026 showed Resident 6 had diagnoses that included schizophrenia (a chronic mental disorder with symptoms such as hallucinations [experience involving the apparent perception of something not present], delusions [a false belief, judgment, or perception], cognitive challenges [affects the ability to think, learn, and process information], and anxiety [excessive, persistent and uncontrollable worry and fear about everyday situations] and Post-Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event that was either experienced or witnessed).Review of a document titled, PASRR Notice of Determination, dated 05/13/2025, showed that Resident 6 had a mental health diagnosis, met the requirements for nursing facility level of care due to current mental health needs, and that Resident 6 may benefit from specialized behavioral health services. Further review of the document showed, The full PASRR [Level II] report will be sent to the nursing facility where you are staying and will become part of your medical record within 30 days.Review of the Electronic Health Record (EHR - miscellaneous/documents tab from 06/19/2024 to 03/28/2026) printed on 04/08/2026 did not show Resident 6's Level II PASRR full report.In an interview and joint record review on 04/15/2026 at 3:07 PM, Staff N, Social Services Director, stated they oversaw PASRRs and that if there were Level II PASRRs they would follow the Level II PASRR recommendations. A joint record review of the PASRR Notice of Determination dated 05/13/2025 showed Resident 6 met requirements for nursing facility level of care and may benefit from specialized services. A joint record review of the miscellaneous/documents tab did not show Resident 6's had a Level II PASRR report. Staff N stated that there was no Level II PASRR report for Resident 6 in their clinical record. Staff N further stated that they should have requested the Level II PASRR report after 30 days of receiving Resident 6's PASRR notice of determination.RESIDENT 30Review of a physicians' orders printed on 04/07/2026 showed Resident 30 had diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (having excessive/persistent worry and fear).Review of a document titled, PASRR Notice of Determination, dated 04/02/2025, showed that Resident 30 had a mental health diagnosis, met the requirements for nursing facility level of care due to current mental health needs, and that Resident 30 may benefit from specialized behavioral health services. Further review of the document showed, The full PASRR [Level II] report will be sent to the nursing facility where you are staying and will become part of your medical record within 30 days.Review of the EHR (miscellaneous/ documents tab from 04/05/2024 to 04/03/2026) printed on 04/07/2026 did not show Resident 30's Level II PASRR full report.A joint record review and interview on 04/15/2026 at 3:27 PM with Staff N, showed the PASRR Notice of Determination dated 04/02/2025 indicated that Resident 30 met requirements for nursing facility level of care and may benefit from specialized services. A joint record review of the miscellaneous/documents tab did not show Resident 30 had a Level II PASRR report. Staff N stated that there was no Level II PASRR for Resident 30 in their clinical record. Staff N further stated that they should have requested the Level II PASRR report after (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	30 days of receiving Resident 30's PASRR notice of determination.In an interview on 04/16/2026 at 11:19 AM, Staff A, Administrator, stated they expected staff to follow their PASRR policy and that they expected the facility to follow up/obtain the Level II PASRR reports for Residents 6 and 30.Reference: (WAC) 388-97-1975(8)(10).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure a new Level I Preadmission Screening and Resident Review (PASARR or PASRR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or related conditions are not inappropriately placed in nursing homes for long-term care) was completed for an exempted hospital discharge resident who remained in the facility for more than 30 days and/or a Level I PASARR was completed accurately for 2 of 10 residents (Residents 99 &19), reviewed for PASARR screening. These failures placed residents at risk of not receiving the appropriate care, limited access to necessary specialized services, and a diminished quality of life.Findings included. Review of the facility's policy titled, PASRR Completion Policy, revised on 09/30/2024, showed, The Center will make sure that all admissions have the appropriate Patient [Preadmission] Assessment and Resident Review (PASRR) completed. The policy further showed that the facility would follow state-specific guidelines for completion. Review of a Level 1 PASRR form, revised in June 2025, showed, Exempted Hospital discharge: .a person may be admitted to a NF [nursing facility] directly from a hospital after receiving acute inpatient care at the hospital; the NF admission is to treat the condition for which the person was hospitalized ; and the person's attending physician, ARNP [Advanced Registered Nurse Practitioner], or physician's assistant certifies that the person requires fewer than 30 days of nursing facility services. RESIDENT 99Review of Resident 99's Level 1 PASARR dated 08/12/2025 showed that Section IA (SMI Indicators) was marked for Post Traumatic Stress Disorder (PTSD-a mental health condition that can develop after a traumatic event), mood disorders (conditions that significantly impact a person's emotional state, leading to prolonged periods of extreme sadness, hopelessness, or irritability), and anxiety. Further review showed that Section IV (Service Needs and Assessor Data), was marked, No level 2 evaluation indicated at this time due to exempted hospital discharge: Level 2 must be completed if scheduled discharge does not occur [after 30 days from admission]. Review of the Electronic Health Records (EHR-miscellaneous/documents tab) showed Resident 99 had no new Level 1 PASRR completed after 30 days of admission and no Level 1 PASARR was sent to the PASRR Coordinator. A joint record review and interview on 04/14/2026 at 11:12 AM with Staff N, Social Services Director, showed Resident 99's Level I PASARR dated 08/12/2025 was marked as exempted hospital discharge [for residents who were expected to be in the facility for less than 30 days]. Staff N stated, I supposed to send out a new PASARR Level I before they exceeded their [residents] 30 day. When asked if Resident 99 stayed in the facility for more than 30 days, Staff N stated, Yes. Staff N further stated that they did not complete a new Level I PASARR for Resident 99. RESIDENT 19Review of the admission record printed on 04/09/2026 showed Resident 19 had a diagnosis of PTSD. Review of Resident 19's Level I PASARRs dated 10/02/2025 and 02/18/2026 did not show PTSD were marked on both forms. Review of Resident 19's trauma questionnaire dated 10/10/2025 showed diagnosis of PTSD. Review of Resident 19's physician history and physical notes dated 11/26/2025 and 02/25/2026 showed diagnosis of PTSD. In an interview and joint record review on 04/14/2026 at 10:26 AM, Staff N stated that they would review Level I PASARR for SMI and need for a Level 2 referral for residents admitted to their facility as part of their process. A joint record review of Resident 19's Level I PASARRs dated 10/02/2025 and 02/18/2026 showed PTSD were not marked. Staff N stated that they were not sure if Resident 19 had PTSD. A joint record review of Resident 19's EHR (face sheet/admission record, trauma questionnaire and progress notes) showed diagnosis of PTSD. When asked if PTSD should have been marked and a new Level I PASARR completed for Resident 19, Staff N stated, Yes. In an interview and joint record review on 04/16/2026 at 8:42 AM, Staff A, Administrator, stated that their process would be to review residents' PASARR upon admission. Staff A stated that they expected staff to complete a Level I PASARR if required. A joint record review of Resident 99's Level I PASARR dated 08/12/2025 showed SMI and exempted hospital (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge were marked. Staff A stated that Resident 99 continued to stay in the facility past 30 days. A joint record review of Resident 19's admission record showed they had PTSD and was not marked in Resident 19's Level I PASARRs dated 10/02/2025 and 02/18/2026. When asked if a new Level I PASARR should have been completed for Resident 99 and Resident 19, Staff A stated, Yes. Reference: (WAC) 388-97-1915(1)(2)(a-c) .

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on interview and record review, the facility failed to notify the State Pre-admission Screening and Resident Review (PASARR or PASRR-an assessment used to identify people [residents] referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities, or related conditions are not inappropriately placed in nursing facilities for long term care) Coordinator and complete a new Level I PASARR after a significant change in status occurred for 1 of 1 resident (Resident 7), reviewed for PASARR. This failure placed the resident at risk for unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy titled, PASRR Completion Policy, revised on 09/30/2024, showed that the facility would follow state-specific guidelines for completion. Review of the Level I PASRR form revised in June 2025 showed, In the event the resident experiences a significant change in condition.the NF [Nursing Facility] must complete a new PASRR Level 1 and make referrals to the appropriate entities. Review of the admission record printed on 04/09/2026 showed Resident 7 had a diagnosis of major depressive disorder (a mental condition characterized by persistent feelings of sadness and loss of interest). Review of the MDS (Minimum Data Set-an assessment tool) look up page showed Resident 7 had a Significant Change Assessment (SCSA) dated 10/06/2025. Review of the nursing progress note dated 10/03/2025 showed Resident 7 had developed a pressure wound (bedsore) to their right heel and that Resident 7 would benefit from a significant change in condition MDS and was scheduled for 10/06/2025. In a joint record review and interview on 04/14/2026 at 10:59 AM with Staff N, Social Services Director, showed Resident 7 had a SCSA dated 10/06/2025. Staff N stated, I thought only when [residents] have a change in [their] mental condition, that a new Level I PASARR would be completed. When asked if the PASARR Coordinator was notified of Resident 7's significant change in condition through completion of a Level I PASARR, Staff N stated, No. In an interview on 04/16/2026 at 8:48 AM, Staff A, Administrator, stated that they expected staff to complete a new Level I PASARR for residents who had a significant change in condition and notify the PASARR Coordinator. Reference: (WAC) 388-97-1975(7).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and/or implement a care plan for 2 of 26 residents (Residents 1 & 19), reviewed for comprehensive care plans. The failure to develop and/or implement care plans for psychotropic (medications that change how the brain works to affect mood, thoughts, feelings, or behavior) and Post Traumatic Stress Disorder (PTSD - a mental health condition that can develop after a traumatic event) placed the residents at risk for unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy titled, Care Plans Comprehensive, dated 08/25/2021, showed, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. RESIDENT 1Review of the admission Minimum Date Set (MDS-an assessment tool) dated 02/09/2026 showed Resident 1 was receiving an antidepressant (a psychotropic drug that relieves symptoms of depression) during the assessment period. Further review of the MDS's care area assessment showed that Resident 1's psychotropic drug use would be addressed in their care plan. Review of the February 2026, March 2026, and April 2026 Medication Administration Record showed Resident 1 was receiving Mirtazapine (an antidepressant) medication. Review of Resident 1's comprehensive care plan printed on 04/13/2026 showed that no care plan developed for Resident 1's psychotropic (Mirtazapine) use. In an interview and joint record review on 04/15/2026 at 1:43 PM, Staff C, Assistant Director of Nursing, stated that if a resident placed on an antidepressant medication, a comprehensive care plan would be developed. A joint record review of Resident 1's comprehensive care plan printed on 04/13/2026 showed there was no care plan developed for Resident 1's antidepressant medication. Staff C stated that there was no care plan initiated for Resident 1's antidepressant medication. In an interview on 04/16/2026 at 9:15 AM, Staff B, Director of Nursing, stated that they expected that care plan was initiated for psychotropic medication use. RESIDENT 19 Review of the admission record printed on 04/09/2026 showed Resident 19 was admitted to the facility on [DATE] with diagnosis that included PTSD. Review of Resident 19's quarterly MDS dated [DATE] showed PTSD was marked. Review of the progress note dated 03/23/2026 showed Resident 19 had diagnosis of PTSD. Review of Resident 19's comprehensive care plan printed on 04/10/2026 did not include plan of care for PTSD. In an interview on 04/14/2026 at 8:33 AM, Resident 19 stated that they were diagnosed with PTSD. Resident 19 stated that they got visits from doctors and taking medications related to their PTSD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 04/15/2026 at 2:36 PM with Staff C did not show Resident 19 had a care plan to address their PTSD. Staff C stated, If [Resident 19] has PTSD, it should have been included in their [comprehensive] care plan. A joint record review and interview on 04/16/2026 at 10:03 AM with Staff B did not show Resident 19 had a care plan to address their PTSD. A joint record review of Resident 19's admission record showed diagnosis of PTSD. Staff B further stated that Resident 19 should have had a PTSD care plan. Reference: (WAC) 388-97-1020(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to ensure the care plan was revised accurately to reflect changes related to use of hearing devices for 1 of 2 resident (Resident 66), reviewed for care planning. This failure placed resident at risk for unidentified and unmet care needs, and a diminished quality of life.:Findings included. Review of the facility's policy, titled, Care Plan Comprehensive, dated 08/25/2021, showed, Assessments of resident are ongoing, and care plans are reviewed and revised as information about the resident and the resident condition change. Review of the comprehensive care plan printed on 04/10/2026 showed Resident 66 had impaired communication as evidenced by hard of hearing. Further review of Resident 66's impaired communication care plan showed the following interventions that were created between 2018 to 2022 and did not show they were revised to reflect Resident 66's status:- Ensure batteries are working in pocket talker-[Resident 66] has bilateral hearing aids.-Plug in [Resident 66's] hearing aids every night-[Resident 66] also has a pocket talker available to assist with hearing verbal communication. An observation and interview on 04/08/2026 at 8:39 AM, showed Resident 66 had hearing difficulty and did not have hearing aids and/or pocket talker. Resident 66 stated that they had not used a pocket talker or worn hearing aids. In an interview and observation on 04/14/2026 at 2:29 PM, Staff S, Certified Nursing Assistant, stated that Resident 66 had hearing difficulty. Staff S stated that they did not see Resident 66 worn hearing aids and/or had a pocket talker. Staff S went and looked around Resident 66's room and stated that they did not see any hearing devices. In an interview on 04/14/2026 at 2:42 PM, Staff E, Registered Nurse, stated that Resident 66 had hearing difficulty. Staff E stated that they did not see Resident 66 used hearing aids or a pocket talker. In an interview and joint record review on 04/15/2026 at 2:52 PM, Staff C, Assistant Director of Nursing, stated that they would review residents' care plans during their Interdisciplinary Team meeting and would revise care plans if there were changes in residents' care or status. A joint record review of Resident 66's comprehensive care plan showed interventions that included use of hearing aids and a pocket talker. Staff C was informed about Resident 66 not using hearing aids or a pocket talker and when asked about it, Staff C stated that they may need to review more. In an interview on 04/16/2026 at 10:43 AM, Staff B, Director of Nursing, stated that they expected Resident 66's comprehensive care plan to have been reviewed and revised to reflect their status. Reference: (WAC) 388-97-1020 (5)(b).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide ongoing activities/programs for 1 of 1 resident (Resident 91), reviewed for activities. This failure placed the resident at risk for unmet leisure interests, poor psychosocial well-being, and a diminished quality of life.Findings included. Review of the facility's policy titled, Activity Programs, revised in June 2018, showed, Activity programs are designed to meet the interests of and support the physical, mental and psychosocial well-being of each resident. The policy showed that activities were scheduled seven days a week.The policy further showed that all activities were documented in the resident's medical record.reflected the.choices and rights of the residents.hobbies, life experiences and personal preferences of the residents. Review of Resident 91's Recreation Comprehensive assessment dated [DATE] showed, While in the facility, resident states that it is important that [they have] the opportunity to engage in daily routines that are meaningful relative to their preferences. Review of Resident 91's activity care plan printed on 04/10/2026 showed that staff would assist resident to activities at least once a week. Resident 91's activity care plan further showed their interests and activities that were important for them such as participating in building club, having reading materials, engaging in stamp collection, going outside, gardening and attending religious services/veteran events. A review of the February 2026 Participation Record showed no evidence that Resident 91 participated in or refused their preferred activities or interests during the period of 02/22/2026 through 02/28/2026. A review of the March 2026 Participation Record showed no evidence that Resident 91 participated in or refused their preferred activities or interests during the period of 03/19/2026 through 03/30/2026. On 04/09/2026 at 8:53 AM, Resident 91 was observed lying in bed while watching television (TV). Resident 91 stated that they did not go out of their room and that staff did not provide or offer them activities. Observation and interview on 04/10/2026 at 10:42 AM showed Resident 91 was lying in bed while watching TV. When asked about their leisure interests, Resident 91 stated that they used to go to bingo in the other place [previous facility]. Resident 91 stated that they don't [do not] think they have bingo here. Resident 91 stated that they want to do some model building like model cars or model planes. Resident 91 further stated, It would be nice if they could set me up. Nobody has really invited me or talked to me about activities. In an interview and joint record review on 04/10/2026 at 11:48 AM, Staff T, Activity Director, stated that they provided activities according to residents' preferences and interests. When asked about Resident 91's activities, Staff T stated that they would do room visits as they delivered Resident 91 their daily chronicle. Staff T stated, We do see [Resident 91] once a week and we offered [them] Lego sets because [they] like model building. We have a participation record where we would mark down their participation. A joint record review of the February 2026 and March 2026 participation records did not show activities were provided from 02/22/2026 to 02/28/2026 and from 03/19/2026 to 03/30/2026. When asked about the missing entries, Staff T stated that there was another staff member, Staff U, Activity Assistant, who would document residents' participation in another document. In an interview and joint record review on 04/10/2026 at 3:28 PM with Staff U and Staff T, Staff U stated that they would document residents' activity participation in the census form named lunch attendance and would transfer them in the monthly participation record and kept in the binder. A joint record review of the census forms showed no evidence that Resident 91 participated in or refused their preferred activities or interests during the period of 02/22/2026 through 02/28/2026 and from 03/19/2026 through 03/30/2026. Staff T stated that they had provided visits to Resident 91 and had written notes during the activity dates being questioned. Staff T was unable to provide documentation about Resident 91's activities. Staff T stated that they expected that activities should be provided to the residents and documented timely. In an interview on 04/13/2026 at 11:49 AM, Staff A, Administrator, stated that they expected staff to offer/provide activities preferred by the residents and that if they refused, an alternative activity should be offered and to document refusals. Reference: (WAC) 388-97-0940(1)(2).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure coordination of care and communication with medical providers were consistently followed timely in accordance with professional standards of practice and ensure neurological/neuro assessments (used to establish a baseline or identify acute changes in condition) were consistently conducted following an unwitnessed fall for 1 of 1 resident (Resident 106), reviewed for change of condition. These failures placed residents at risk for potential harm, poor clinical outcomes, unmet care needs, and a diminished quality of life.Findings included.Review of the facility's undated policy titled, Transfer or Discharge, showed that when the facility transfers or discharges a resident, the basis for the transfer or discharge, date and time, mode of transportation, and a summary of the resident's overall medical, physical, and mental condition are documented in the medical record and appropriate information is communicated to the receiving health care institution or provider.Review of the facility's policy titled, Physician Orders, dated on 03/22/2022, showed Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order.Review of the facility's policy titled, Neurological Assessment, dated on 06/01/2023, showed the purpose of the assessment was to monitor a resident for neurological compromise. The policy further showed, Neurological evaluation will be performed as indicated or ordered. When a Resident sustains an injury to the head or face and/or has an unwitnessed fall, neurological evaluation will be performed: Every 15 minutes x [times] two hours, then Every 30 minutes x two hours, then Every 60 minutes x four hours, then Every eight (8) hours until at least 72 hours.Review of Resident 106's death in facility Minimum Data Set (MDS- an assessment tool) showed, they expired on 01/28/2026.Review of Resident 106's quarterly MDS dated [DATE], showed they were cognitively intact. The MDS further showed that they had an active diagnosis of Type 2 Diabetes Mellitus with ketoacidosis without coma (a life-threatening, emergency complication of diabetes [mainly Type 1] caused by severe insulin [used to regulate BS] deficiency, leading to high blood sugar [BS -main sugar found in the bloodstream, derived from food, and serves as the body's primary energy source for cells, tissues, and the brain] and acidic ketone buildup).Review of Resident 106's fall investigation report dated 01/24/2026, showed they had an unwitnessed fall. The report showed The resident has a BIMS [Brief Interview for Mental Status- a cognition test] score of fifteen and is cognitively able to accurately describe the events leading to the fall. The report showed, The resident reported she had been attempting to pick up her bag from the floor when she became unbalanced and slid downward, making contact with the lip of the garbage can under her right arm and lightly striking the right side of her head. The resident denied head pain but reported discomfort in the right armpit. The report showed pain medication was given for discomfort and neuro checks were initiated.Review of the document titled, Neurological Evaluation Flow Sheet, initiated on 01/24/2026, showed neuro checks were completed (01/24/2026 and 01/25/2026) for Resident 106 and not on the last two days (01/26/2026 and 01/27/2026) they were blank.Review of a progress note dated 01/24/2026, showed Resident 106 had a heart rate of 124 [a normal resting heart rate for adults is typically 60 to 100 beats per minute]. The note showed Resident complained of weakness, nausea, no appetite. Noted confusion. When blood sugar was checked, glucometer [device used to measure the concentration of BS in the blood] indicated HI which meant BS was above 600. BS double checked, and [provider] on call notified. The note further showed an order for insulin and rechecking of vital signs [measurements of the body's most basic functions] and BS.Review of a progress note dated 01/25/2026, showed Resident 106 had a heart rate of 104. The note showed a lab [laboratory] blood sugar of 467, a recheck of 454, and the provider was notified. The note further showed the provider ordered intravenous (IV- administration of fluids, medication, or nutrients directly into a patient's [resident's] bloodstream via a tube or needle) hydration, and a repeat lab.Review of a Psych Evaluation [assessment conducted by a mental health professional through telemedicine (continued on next page)

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	505042	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(remote delivery of healthcare services) to understand a person's cognitive, emotional, and behavioral functioning], dated 01/26/2026, showed, Staff to assess patient, she reports a recent fall, also reports heart burn. She states she does not feel well. The evaluation further showed, Patient states she is very sick and would like to go to the hospital due to a recent fall. She reports poor appetite and good sleep .Review of the January 2026 Medication Administration Record showed the following one-time orders:-Insulin Lispro 10 units STAT (give immediately) dated 01/24/2026-Insulin Lispro 5 (five) units STAT dated 01/25/2026-Insulin Lispro 10 units STAT dated 01/25/2026Review of a follow-up documentation in the progress note dated 01/26/2026, Staff E, Registered Nurse, documented that resident was weak and dehydrated [dehydration - a condition occurring when the body loses more fluids than it takes in, resulting in an insufficient water supply for normal, healthy functioning], and on alert for a fall. The note further showed Resident 106 was in bed all shift and had decreased intake and on an IV for hydration.Review of a follow-up documentation in the progress note dated 01/26/2026, Staff E documented that Resident is alert and orientated x1 [a medical assessment term indicating a patient is awake and conscious, but only oriented to person]. On alert for a recent fall. No pain verbalized. Resident refused to eat and fluid intake is poor.Review of a follow-up documentation in the progress notes dated 01/27/2026 [Electronic Health Record (EHR) showed effective at 22:14 (10:14 PM)], Staff E documented that Resident 106 was on alert for a fall and dehydration. The note further showed, Called On call provider to get an order for hydration but could not reach the on call provider after multiple attempt. Current blood sugar is 335 following administration of 5 [five] units of insulin. No fever noted at this time. Will continue to monitor. The note did not show when the 5 units of insulin were administered.Review of a nurse progress note dated 01/28/2026 [EHR showed effective 08:30 [8:30 AM], Staff E documented, Spoke to inhouse provider about the need of hydration. Upon visiting the resident, the provider order 1000ml [1,000 milliliter- unit of measurement] 0.9 NS [normal saline] for hydration. Provider will speak to nurse manager for potential hospitalization.Review of a progress note dated 01/28/2026 [EHR showed effective 08:44 (8:44 AM)], Staff C, Assistant Director of Nursing, documented that Resident was seen by facility MD [Medical Doctor], and new order was given to send resident out to the hospital due to change of condition. Call placed to resident's [representative] and spoke to him about MD recommendations. [Representative] stated it was ok for resident to be sent out to the nearest hospital for further evaluation and treatment. Order noted.Review of a physician 30-day follow up progress note dated 01/28/2026 (9:40 AM) showed, Patient seen today at bedside laying [lying] in bed. She is unable to provide any history at this time. Per nursing staff, patient had an unwitnessed fall on Saturday [01/24/2026] and since then has had increasing lethargy [or lethargic - a state of severe, persistent lack of energy, sluggishness, and decreased mental alertness]. She has had a poor oral intake [NAME] [as well]. No reports of fever, cough or urinary [bladder] symptoms. The note showed Resident 106 was lethargic, minimally arousable, and was confused. The note further showed, Will send out to ER [Emergency Room] for urgent evaluation.Review of a physician order dated 01/28/2026 (created and confirmed by Staff C at 10:41 AM, after Resident 106 expired), showed, May send resident to the ER for further evaluation and treatment r/t [related to] change of condition.Review of a progress note dated 01/28/2026 (2:38 PM), Staff E documented that Resident passed away around 1000 [10;00] AM. Family and [Provider] were notified. [Name of] Funeral Home Picked her body at 1430 [2:30 PM]. Family was here when her body was released.Further review of the progress notes (from 01/24/2026 to 01/28/2026) did not show that emergency services were contacted to transfer Resident 106 out to the hospital as ordered by the physician.In an interview and joint record review on 04/15/2026 at 3:16 PM, Staff C stated that when a resident had a change in condition, they expected staff to document, notify the provider, call family, and follow the orders as indicated. Staff C stated that if a resident had an unwitnessed fall they expected staff to complete neuro checks for a total of 72 hours. Staff C stated that this would be important because if there were any changes in neuros then that would be a significant change, and would need to notify the provider (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right away. Staff C stated Resident 106 had an unwitnessed fall on 01/24/2026 and a major change in condition after that. A joint record review of a progress note dated 01/24/2026, showed Resident 106 had a heart rate of 124, Staff C stated it seemed to be a little elevated. Staff C stated that Resident 106 was cognitively intact at baseline and had no impairment. A joint record review of the psych evaluation dated 01/26/2026, showed that Resident 106 wanted to go to the hospital. Staff C stated that Resident 106 did not get transferred to the hospital at that time and that they did not see documentation that the provider notified the facility staff. A joint record review of a follow-up documentation note dated 01/27/2026, showed staff [Staff E] had reached out to the on-call provider for an order for hydration and was unable to reach them. Staff C stated that there was a change in condition, and staff should have kept trying and called the Director of Nursing (DON), Administrator, or the Medical Director. Staff C stated that the doctor had given an order to send Resident 106 to the hospital on [DATE]. Staff C stated that Resident 106 did not go to the hospital and that they did not see any documentation that emergency services were called. A joint record review of Resident 106's neuro checks dated 01/26/2026 and 01/27/2026 showed they were blank. Staff C stated they would have expected staff to complete them.In an interview on 04/15/2026 at 5:00 PM, Staff B, DON, stated that when a resident had a change in condition, they expected staff to assess, place them on alert monitoring, notify the doctor and family, complete a change in condition evaluation, document, and follow the doctor's recommendations. Staff B stated that if a resident had an unwitnessed fall, they expected staff to complete neuro checks. Staff B stated that Resident 106 had an unwitnessed fall. A joint record review of the psych evaluation dated 01/26/2026, showed that Resident 106 wanted to go to the hospital. Staff B stated that they were not aware and that there was no documentation on what the provider had done regarding Resident 106's statement. Staff B further stated that they expected staff to use their nursing judgment, call other providers if one was not available, call the medical director, and see if it became a safety issue for the resident to call 911. Staff B further stated that there was no excuse as to why Staff E did not follow up on 01/27/2026 when they could not reach the provider.In an interview on 04/16/2026 at 9:08 AM, Staff E stated that when a resident had a change in condition, they would notify the provider, monitor the resident, and place them on alert. Staff E stated that if a resident had an unwitnessed fall they would expect to complete neuros and that it would be important because it would show if the resident was doing better or worse. Staff E stated that they had worked with Resident 106 many times and were familiar with their baseline. Staff E stated that they worked on 01/26/2026, on 01/27/2026, and on 01/28/2026 as Resident 106's nurse. Staff E stated that they received report that Resident 106 had a fall over the weekend and had a change in condition. Staff E stated that they did not document neuro checks for Resident 106 on 01/26/2026 and on 01/27/2026 and should have. Staff E stated that Resident 106's IV hydration had been completed and that they continued to not drink fluids and based on their assessment wanted to get another order for IV hydration on 01/27/2026 and that the provider did not answer their calls. Staff E stated there was no further follow up on that day and that the following day Resident 106 was lethargic and not doing good, and that they notified Staff F, Medical Doctor on 01/28/2026 when they were in the facility. Staff E stated that Staff F gave an order for IV hydration and was going to speak with Staff C regarding possible hospitalization. Staff E stated that they were not present when Staff F gave an order to send Resident 106 to the hospital. Staff E further stated that they did not call 911 or AMR services to send the resident to the hospital on [DATE] as ordered and were not sure if Staff C had called.In a follow-up interview on 04/16/2026 at 10:46 AM, Staff C stated that Staff E was aware that Resident 106 needed to be sent out to the hospital. Staff C stated that they did not call 911 to send Resident 106 to the hospital. Staff C further stated that they wanted to help out and called Resident 106's Representative and documented what they had done in a progress note.In a follow-up interview on 04/16/2026 at 11:56 AM, Staff B stated that they did not see documentation in Resident 106's medical records that they were sent out to the hospital on [DATE]. Staff B stated that they would have expected nursing staff to follow the physician's order. Staff B further stated that the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse who received the order from Staff F should have called 911.In a phone interview on 04/16/2026 at 12:06 PM, Staff F stated that they gave an order to send Resident 106 to the hospital on [DATE] to the assigned nurse on the cart (Staff E). Staff F stated that they were not aware that facility staff did not call 911 on 01/28/2026 to send Resident 106 out. Staff F further stated that Resident 106 had an unexpected death because they were not on hospice. On 04/16/2026 at 12:48 PM, Staff A, Administrator, stated that if a resident had an emergency or change in condition that required hospitalization, they would expect staff to follow the physician's order and call emergency services and send the resident out.Reference: (WAC) 388-97-1060 (1).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory services in accordance with accepted professional standards of practice for 2 of 2 residents (Residents 71 & 25), reviewed for respiratory care. The failure to properly store the Bilevel Positive Airway Pressure (BiPAP - a noninvasive ventilator that helps people breathe easier by delivering pressurized air through a mask) mask and oxygen (O2) nasal cannula (flexible tube used to deliver O2) when not in use, ensure to label/date O2 tubing, and to change AIRVO 2 (a humidifier with an integrated flow generator that delivers warmed, humidified, high-flow air and/or oxygen) water bag, placed the residents at risk for unmet care needs, respiratory infections, and related complications.Findings included . Review of the undated facility's policy titled, CPAP [Continuous Positive Airway Pressure – a device that treats sleep apnea (disorder where breathing repeatedly stops and starts while sleeping)]/BiPAP Support and Cleaning, showed that the purpose of CPAP/BiPAP was to provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental O2 and to improve arterial oxygenation (the volume of O2 taken up across the lungs per minute or the volume). Review of the facility's policy titled, Oxygen and Nebulizer [a device that turns liquid medicine into mist allowing it to be inhaled into the lungs through a mouthpiece or mask] Tubing, revised in November 2011, showed, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. RESIDENT 71Review of the admission record printed on 04/09/2026 showed Resident 71 was admitted to the facility on [DATE] with diagnosis that included acute and chronic respiratory failure (a long-term condition where the lungs cannot supply enough oxygen to the blood) and sleep apnea. Review of the admission Minimum Data Set (an assessment tool) dated 03/30/2026 showed Resident 71 was cognitively intact. The assessment further showed Resident 71 had respiratory failure and sleep apnea. Review of Resident 71's physician orders printed on 04/09/2026 showed orders for a BiPAP machine and O2 for acute respiratory failure. The physician orders further showed, Oxygen – tubing change weekly on Sunday every night shift every Sun [Sunday]. Review of the comprehensive care plan printed on 04/09/2026 showed that Resident 71 had altered respiratory status/difficulty breathing related to shortness of breath, use of BiPAP secondary to respiratory failure and obstructive sleep apnea and an intervention, Oxygen – tubing change weekly on Sunday every night shift every Sun [Sunday]. An observation on 04/07/2026 at 10:26 AM showed Resident 71's BiPAP mask was on the floor and not stored in a bag. Observation on 04/07/2026 at 2:35 PM, showed an O2 nasal cannula tubing connected to a portable concentrator (a device that used to generate oxygen) was undated, not stored in a bag, touching Resident 71's other personal items. In an interview on 04/08/2026 at 8:37 AM, Resident 71 stated they used the O2 all the time, that they used the BiPAP at night, and that staff helped them put on and off the BiPAP. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 04/08/2026 at 8:46 AM, on 04/09/2026 at 2:45 PM, and on 04/10/2026 at 1:56 PM, showed Resident 71's BiPAP mask was not stored in a bag, sitting on top of the dresser and touching Resident 71's other personal items. Further observation showed that Resident 71's undated O2 nasal cannula was not stored in a bag, hanging on their wheelchair touching the wheelchair's backrest and other personal items. A joint observation and interview on 04/10/2026 at 2:00 PM with Staff X, Registered Nurse (RN), showed Resident 71's BiPAP mask sitting on top of the dresser not in bag and their undated O2 nasal cannula tubing hanging on their wheelchair touching the wheelchair's backrest. Staff X stated that the BiPAP mask and O2 nasal cannula tubing should be stored in a bag when not in use and that O2 nasal cannula tubing should have been labeled/dated when last changed. In an interview on 04/15/2026 at 8:25 AM, Staff B, Director of Nursing, stated that they would expect Resident 71's BiPAP mask and O2 nasal cannula tubing to have been stored in a bag when not in use and that their O2 nasal cannula tubing to have been labeled/dated when it was last changed. RESIDENT 25 Review of the admission record printed on 04/09/2026 showed that Resident 25 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure with hypoxia. Review of Resident 25's physician order summary report printed on 04/10/2026 showed an order, My AIRVO 2 gives a heated humidified airflow to the resident.The water bag can be changed every 30 days along with the tubing. with an order date of 02/11/2026. Observations on 04/09/2026 at 8:46 AM and at 2:15 PM, on 04/10/2026 at 7:59 AM and on 04/13/2026 at 7:58 AM, showed the AIRVO 2 machine on top of a table by Resident 25's bed. Further observation showed that the AIRVO 2 water bag was dated 1/29/26 [01/29/2026]. A joint observation and interview on 04/13/2026 at 9:12 AM with Staff E, RN, showed Resident 25's AIRVO 2 water bag was dated 1/29/26. Staff E stated that they refilled the water bag with distilled water. A joint record review at 10:42 AM with Staff E, showed Resident 25's April 2026 physician order revealed to change the water bag every 30 days. Staff E stated that they had the instructions on how to maintain the AIRVO 2 equipment and pointed to the document titled, My AIRVO 2 instructions pinned on the wall across Resident 25's bed. A joint record review of the AIRVO 2 instructions showed that the water bag should be replaced or changed every 60 days. Staff E stated that Resident 25's water bag had not been replaced since they were admitted on [DATE]. In an interview and joint record review on 04/15/2026 at 2:45 PM, Staff C, Assistant Director of Nursing, stated that they expected staff to follow physician's order. A joint record review of Resident 25's physician order showed that AIRVO 2 water bag to be changed every 30 days. Staff C was informed about the AIRVO 2 manufacturer's instructions pinned inside Resident 25's room, Staff C stated that Resident 25's AIRVO 2 water bag should have been changed. A joint record review and interview on 04/16/2026 at 10:09 AM with Staff B, showed Resident 25's physician order, My AIRVO 2 gives a heated humidified airflow to the resident.The water bag can be changed every 30 days along with the tubing. In addition, Staff B was informed about AIRVO 2 manufacturer's instructions pinned inside Resident 25's room. Staff B stated, The staff is expected to follow the doctor's order. The [water] bag was dated 1/29 [01/29/2026] so it was more than 30 or (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	60 days. It should have been changed. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently monitor weights before and after hemodialysis (a procedure that removes waste from the blood via a machine when the kidneys can no longer function properly) and include transportation information in the care plan per professional standards of practice for 1 of 3 residents (Resident 19), reviewed for dialysis. This failure placed the resident at risk for unmet care needs, related complications, and adverse outcomes.Findings included. Review of the facility's policy titled, Dialysis Care, dated 08/25/2021, showed, To provide dialysis care for residents in renal [kidney] failure and those residents who require ongoing dialysis treatments. The policy further showed that the facility would arrange transportation to and from the dialysis provider and that the resident's care plan will be updated as needed. Review of the admission record printed on 04/09/2026 showed Resident 19 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (a condition in which kidneys have lost their normal functions). Review of Resident 19's physician order summary printed on 04/10/2026 showed, Pre [before dialysis] and post [after]-dialysis weight is taken and documented, two times a day every Mon [Monday], Wed [Wednesday], Fri [Friday] for Dialysis. Further review of the physician order did not show Resident 19's dialysis transportation information. Review of Resident 19's January 2026, March 2026 and April 2026 Medication Administration Record (MAR), showed there were no pre-dialysis weights were taken on 01/02/2026, on 01/12/2026 and on 03/06/2026 and no post-dialysis weights were taken on 01/07/2026, 04/06/2026, on 04/08/2026 and on 04/10/2026. Review of Resident 19's February 2026 MAR showed no recorded pre-dialysis and post-dialysis weights on 02/06/2026. Review of Resident 19's comprehensive care plan printed on 04/10/2026 did not show their dialysis transportation information. In an interview on 04/09/2026 at 1:45 PM, Resident 19 stated that they would go to the dialysis center three times a week every Monday, Wednesday and Friday. Resident 19 stated that they would ride a transport service from the facility to the dialysis center. In an interview and joint record review on 04/13/2026 at 1:42 PM, Staff V, Registered Nurse, stated that Resident 19 had dialysis three times a week. When asked about Resident 19's transportation information, Staff V stated that Resident 19 rides [name of the transport service]. A joint record review of Resident 19's active physician orders and their comprehensive care plan did not show dialysis transportation information. Staff V stated, The care plan did not include information about time of pickup or the transport service. A joint record review of Resident 19's active physician order showed to document pre-dialysis and post-dialysis weight monitoring. A joint record review of Resident 19's weight records from January 2026 to current (04/13/2026) showed weights were not consistently taken before and/or after dialysis. Staff V stated that staff should have followed physician orders to monitor Resident 19's weight before and after dialysis. In an interview and joint record review on 04/16/2026 at 9:07 AM, Staff B, Director of Nursing, showed Resident 19's January 2026, March 2026 and April 2026 MAR, revealed no pre-dialysis weights were taken on 01/02/2026, on 01/12/2026 and on 03/06/2026 and no post-dialysis weights were taken on 01/07/2026, 04/06/2026, on 04/08/2026 and on 04/10/2026. Review of Resident 19's February 2026 MAR showed no recorded pre-dialysis and post-dialysis weights on 02/06/2026. Staff B stated that Resident 19's weights should be monitored and that their dialysis transportation information should be in their care plan. Reference: (WAC) 388-97-1900(1).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to perform hand hygiene before putting on new gloves for 2 of 6 staff (Staff Z and Staff AA), reviewed for food services. This failure placed the residents at risk for food-borne illnesses (caused by the ingestion of contaminated food or beverages), cross-contamination, and a diminished quality of life.Findings included.Review of the facility's policy titled, Food Preparation and Service, revised in November 2022, showed, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.Observation on 04/10/2026 at 12:29 PM showed Staff Z, Assistant Dietary Manager, cut up the baked fish with a knife while they held the baked fish in place with their other gloved hand. Staff Z proceeded to remove and discard their soiled gloves and then put on new gloves. Staff Z did not perform hand hygiene between glove change.Observation on 04/10/2026 at 12:34 PM showed Staff AA, Dietary Aid, picked up a whipped spread sealed condiment off the ground and discarded it in the trash. Staff AA proceeded to remove and discard their gloves and put on new gloves. Staff AA did not perform hand hygiene between glove change.In an interview on 04/10/2026 at 1:02 PM, Staff Z stated that if they had touched a food item or a dirty surface with their gloved hands, they would discard their gloves, wash their hands, and put on new gloves. Staff Z stated that they should have performed hand hygiene prior to donning (putting on) new gloves.In an interview on 04/10/2026 at 1:05 PM, Staff AA stated that if they touched a dirty surface with their gloved hands, they would discard the gloves, wash their hands, and change gloves. Staff AA stated that they should have performed hand hygiene prior to donning new gloves.In an interview on 04/10/2026 at 1:47 PM, Staff Y, Dietary Manager, stated that they would expect staff to perform hand hygiene and put on new gloves after they have touched a food item and/or if they picked up an item off the floor.In an interview on 04/15/2026 at 8:25 AM, Staff B, Director of Nursing, stated that they would expect staff to perform hand hygiene between glove changes.In an interview on 04/16/2026 at 9:34 AM, Staff A, Administrator, stated that they would expect staff to perform hand hygiene and wear new gloves if a staff member touched a food item and then started another task and/or if they picked up an item off the floor.Reference: (WAC) 388-97-1100(3).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505042	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ballard Center	820 Northwest 95th Street Seattle, WA 98117

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure pneumococcal vaccine (used to prevent pneumonia [a lung infection]) was administered for 1 of 5 residents (Resident 19), reviewed for pneumococcal immunization. This failure placed the resident at risk for acquiring, transmitting, and/or experiencing potential complications from pneumococcal disease.Findings included. Review of the facility's policy titled, Pneumococcal Vaccine, revised in October 2023, showed that all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy further showed, Pneumococcal vaccines are administered to residents.per our facility's physician-approved pneumococcal vaccination protocol. Review of the Vaccine Informed Consent dated 10/02/2025 showed Resident 19 had signed to receive a pneumococcal vaccine. Review of Resident 19's Electronic Health Record (EHR-immunization record, progress/clinical notes and treatment record) did not show Resident 19 was administered their pneumococcal vaccine. In an interview and joint record review on 04/14/2026 at 4:24 PM, Staff B, Director of Nursing, stated that residents who had signed consents for immunization would be administered their vaccines. A joint record review of the vaccine consent dated 10/02/2025 showed Resident 19 signed to receive a pneumococcal vaccine. Further joint record review of the EHR did not show Resident 19 received their pneumococcal vaccine. Staff B stated that they would inquire more and would provide information regarding Resident 19's pneumococcal immunization. In a follow up interview on 04/16/2026 at 10:50 AM, Staff B stated that they could not find any record to show Resident 19 received the pneumococcal vaccine. Reference: (WAC) 388-97-1340(2).