STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505059	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Panorama City Conv & Rehab Ctr	1600 Sleater Kinney Road SE Lacey, WA 98503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor medical devices to prevent pressure related injuries for 2 of 4 residents (Residents 3 and 7) when reviewed for pressure injuries. Resident 3 experienced harm when they developed avoidable pressure ulcers to both heels and their left calf, related to lack of monitoring of a medical device (E-Z boot - plastic splint designed to stabilize the foot and ankle, preventing rotation and contracture with a soft, fleece-lined interior, non-skid base, and hook-and-loop velcro closure - also called a podus Boot). This failure placed residents at further risk for avoidable pressure injuries. Findings included. Review of the facility policy titled Management of Braces and Splints last reviewed 01/06/2026, showed Braces and splints shall be used only with appropriate clinical justification, proper authorization, and ongoing monitoring to prevent complications such as (including but not limited too) skin breakdown. It further showed Orders must include: Type of brace or splint, Body part affected. Purpose/medical indication, Schedule for use (e.g., wear times, removal times) and any specific precautions or care instructions.Review of the electronic health record (EHR) showed Resident 3 was admitted to the facility on [DATE] with diagnosis of left hip fracture. The resident was able to make needs known. Review of the admission minimum data set assessment (MDS) dated [DATE] showed Resident 3 was at risk for pressure injury and had no current pressure injuries. Resident was not identified as having an orthotic device/brace. Review of the care plan showed an entry for risk for pressure ulcer, dated 10/08/2025, with two interventions documented for a Braden skin assessment and to apply barrier cream to peri area.Review of the EHR showed a progress note, dated 11/07/2025, showed Was notified by staff of pressure injuries to both heels with the left heel injury larger with skin around it not blanching with a round hard area in the middle. [Resident 3] was wearing [their] own shoes at the [time] with [them] complaining that the orthotic [sole inserts] both makes them very tight and puts pressure on [their] heels. [They] also has been wearing [E-] Z boots in bed with them fitting poorly and having been found to be put on improperly at times.Review of the provider orders showed Resident 3 was prescribed an antibiotic on 11/18/2025 for a wound infection to the left lower leg.Review of the skin assessment, dated 12/18/2025, showed a new medical device related pressure injury to the left lower leg that was red and non-blanchable (did not change color when pressed) this was not related to the orthotics, what was the medical device that caused the injury to the left lower leg, the E-Z boot.Review of the wound care providers consultation, dated 01/06/2026, showed a medical device related pressure injury to the left lower leg that was covered in eschar (hard, black, dead or dying tissue).Review of the skin assessment, dated 01/22/2026, showed a medical device related pressure injury to the left calf with a start date of 12/18/2025. The document showed slough (white or yellow dead tissue) was present and drainage.Review of the care plan showed an entry for pressure injury left heel and lower leg dated 01/16/2026, with interventions for referral to wound provider, there was no care plan entry found in the EHR for E-Z boots.Review of the provider orders on 01/22/2026 showed no orders in place to monitor and manage the E-Z-boot.During an interview and observation on 01/26/2026 at 10:58 AM, Resident 3 stated they wore a boot on the left ankle when in bed and they didn't fit good. Resident 3 said they used to wear the sole inserts inside their (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	shoes but the shoes were too tight and caused the heel wound. There was a hard plastic boot device with a soft insert noted on the bedside table (E-Zboot). The resident had on the right shoe; the resident was wearing a sock with the left foot resting on a pillow. When asked if the resident had pain Resident 3 stated yes, my leg hurtsDuring an interview on 01/26/2026 at 11:07 AM, Staff H, Certified Nursing Assistant (CNA) stated Resident 3 was wearing the E-Z boot that morning when she got her out of bed and she removed it. When asked where they find out when to put the boot on or take it off Staff H stated its should be on the Kardex (care directions). Staff H reviewed the Kardex with this surveyor and stated the boot was not on the Kardex.Resident 7Review of the EHR showed Resident 7 admitted to the facility on [DATE] with a diagnosis of severe malnutrition. The resident was able to make needs known.During an interview and observation on 01/23/2026 at 9:52 AM, Resident 7 sat in their wheelchair at the bedside, a left ankle brace and right finger splint was observed, Resident 7 stated they wear the ankle brace so they can walk and the finger brace to help straighten their finger. The resident removed the finger brace and a red area was noted to the knuckle.Review of the EHR on 01/23/2026 showed no care plan / Kardex entry for the ankle brace or the finger splint and no provider orders for when to put them on, take them off or check the skin under them.During an interview on 01/26/2026 at 11:19 AM, Staff I, CNA, stated they helped Resident 7 put the ankle brace on every morning and it should be on the Kardex.During an interview on 01/26/2026 at 9:33 AM, Resident 7 stated they had been wearing the foot brace and finger splint for a couple weeks. Resident 7 stated staff did not take them off during the day.During an interview on 01/26/2026 at 9:19 AM, Staff J, Resident Care Manager, stated it was their expectation that braces and splints be included in the ADL care plan / Kardex and Resident 3's E-Z boot and Resident 7s brace and splint should have orders for when to put them on and take them off and to monitor for skin breakdown. During an interview on 01/26/2026 at 11:35 AM, Staff K, Director of Rehabilitation Services stated the therapy department provided a wear schedule and recommendations when a resident was given a brace or a splint and it should be added to the care plan and orders for staff to follow. During an interview on 01/26/2026 at 1:04 PM, Staff B, Director of Nursing Services stated it was their expectation that braces or splints have orders in place for when to put them on and take them off and to check the skin under them and if the CNAs were placing them or taking them off it should be included in the care plan or Kardex.Reference WAC 388-97-1060(3)(b)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview and record review, the facility failed to ensure the dishwasher was cleaning dishes at required temperatures for 1 of 1 kitchen dishwashers reviewed under kitchen task. This failure created the potential to expose residents to unsanitary conditions and increased risk of foodborne illness. Findings included .On 01/26/2026 at 9:55 AM, during a kitchen observation, review of the Food Services Department Daily Dish Machine Temerature Log documented, Wash Cycle must reach a temperature of 150-160 degrees Fahrenheit. Rinse Cycle must reach a temperature of no less than 180 degrees. Please report temperature outside of the required range to your Supervisor immediately. The flowing days were listed outside the required temperature ranges:01/05/2026 PM Wash 145 degrees01/10/2026 AM Rinse 179 degrees01/11/2026 AM Rinse 172 degrees01/12/2026 AM Rinse 179 degrees01/13/2026 PM Rinse 145 degrees01/14/2026 PM Rinse 145 degrees01/18/2026 AM Rinse 179 degrees01/18/2026 PM Rinse 145 degrees01/19/2026 PM Rinse 145 degrees01/20/2026 AM Wash 142 degrees01/20/2026 PM Rinse 145 degrees01/21/2026 PM Rinse 145 degrees01/22/2026 PM Rinse 145 degreesAnd were missing entries on 01/23/2026 PM, 01/24/2026 PM and 01/25/2026 AM. On 01/26/2026 at 9:59 AM, Staff D, Food Service Manager, confirmed the required temperature for the wash cycle was 150-160 degrees and the rinse cycle was greater than 180 degrees. Staff D said if it was outside the range staff should have notified the supervisor. When asked about the out of required ranges/missing temperatures, Staff D said they had not been notified of any out of range temperatures and staff should have notified them. When asked how would staff know if the dishes had been adequately cleaned, Staff D said they would not know. Reference WAC 388-97-1100 (3), -2980

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program, to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use and decrease the development of adverse side effects and antibiotic resistance for 3 of 3 residents (Residents 3, 5 and 130) when reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics. Findings included.Review of the facility policy titled Antibiotic Stewardship last reviewed 01/5/2026, showed The facility practices the core elements of antibiotic stewardship, outlined by the Centers for Disease Control and prevention. The nurse will utilize McGeer constitutional infection criteria protocol to determine if it is necessary to treat with antibiotics and notify the provider of the results of diagnostics to ensure the resident is taking the appropriate antibiotic or if the antibiotic needs to be discontinued or changed. In the event that the prescribing physician orders an antibiotic without identification of infection criteria the provider will be requested to identify rationale for ordered antibiotic.Review of the facility documentation of McGeer criteria for urinary tract infection (UTI) showed a positive urine culture would have 100 thousand Colony forming units (CFU) of no more than two organisms and reports of fever, pain with urination, hematuria (blood in urine), incontinence (unable to prevent leaking urine), urgency and/or frequency.Resident 3Review of the electronic health record (EHR) showed Resident 3 was admitted to the facility on [DATE] with diagnosis of left hip fracture. The resident was able to make needs known.Review of the EHR showed Resident 3 had reported pelvic pain and was prescribed Cipro (an antibiotic) on 01/02/2026 through 01/06/2026 for a UTI.Review of the lab results for urine collected on 12/30/2025 showed 10-25 thousand CFU of a bacteria and 25 - 50 thousand CFU of yeast.Review of the infection tracking dated 12/31/2025 showed in order to meet criteria for antibiotic use there should be at least 100 thousand CFU of no more than two microorganisms, UTI should be diagnosed when there are localizing genitourinary signs and symptoms and a positive urine culture result. Further reviews showed the resident had no genitourinary symptoms.Review of the EHR on 01/26/2026 showed no documentation of an antibiotic time out or the rationale for continued use of the antibiotic.Resident 5Review of the EHR showed Resident 5 admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with a diagnosis of pubic bone fracture. The resident was able to make needs known.Review of the urinalysis lab report dated 12/16/2025 showed 10 to 20 thousand CFU of an organism, provider had notated on the lab slip likely not a UTI on 12/19/2025.Review of the infection tracking dated 12/17/2025 was blank and not assessed for criteria.Review of the EHR showed the resident had reported pelvic pain and was having increased agitation and was prescribed an antibiotic on 12/18/2025. The resident was sent to the emergency room on [DATE] and was found to have a pelvic fracture and a UTI and returned to the facility on [DATE].Review of the provider orders showed a new order for antibiotic therapy with a start date of 12/23/2025 through 12/30/2025.Review of the EHR on 01/26/2026 showed no documentation of an antibiotic time out or the rationale for continued use of the antibiotic.Resident 130Review of the EHR showed Resident 130 admitted to the facility on [DATE] with a diagnosis of multiple sclerosis (disease that affects the central nervous system). The resident was able to make needs known.Review of the provider's orders showed an order for Bactrim (an antibiotic) for 7 days with a start date of 11/20/2025.Review of infection tracking for Resident 130 dated 12/19/2025 showed did not meet criteria for antibiotic use.Review of the EHR showed a provider order for an antibiotic dated 12/20/2025. Progress note review showed this order was phoned in by an outside provider on 12/19/2025.Review of the EHR on 01/23/2026 showed no infection tracking/assessment was completed and no urine lab tests were included in the EHR for this antibiotic.Review of the EHR on 01/26/2026 showed no documentation of an antibiotic time out or the rationale for continued use of the antibiotic.During an interview on 01/27/2026 at 1:18 PM, (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff G, Registered Nurse/Infection Preventionist (RN/IP) stated Resident 130 was having an increase in behaviors and was prescribed the antibiotic on 12/19/2025 and a urinalysis was not done. Staff G stated all new antibiotics should have been reviewed for appropriateness. Staff G stated they did not have access to review labs done outside of the facility and should so they can review for appropriateness. There should be an antibiotic time out and documented rationale for continued use of antibiotics.During an interview on 01/27/2026 at 12:24 PM, Staff B, Director of Nursing Services stated it was their expectation that the Infection Preventionist and Providers follow their antibiotic stewardship policy. Reference WAC 388-97 -1620(2)(b)(i)(ii)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medications (any drug that alters the brain affecting mood, behavior, perception and thought processes) were regularly monitored and documented on and gradual dose reduction (GRD, psychotropic medication decrease) had adequate indication for noncompletion for 2 of 5 sampled residents (Resident 40 & 85) reviewed for unnecessary medication. This failure placed residents at risk of unnecessary medication usage and a diminished quality of life. Findings included .Resident 40 Resident 40 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented Resident 40 was severely cognitively impaired. A physician's order, dated 11/22/2025, for Trazadone (antidepressant) 12.5 milligrams was prescribed for insomnia. A physician's order, dated 01/15/2026, for Trazadone (antidepressant) was increased to 25 milligrams daily for insomnia. The electronic health records (EHR) showed no documentation of side effect monitoring or target behavior monitoring for the medication. On 01/26/2026 at 9:04 AM, Staff C, Nurse Manager/Licensed Practical Nurse, reviewed January 2026's Medication Administration Record (MAR) and the Treatment Administration Record (TAR) and confirmed Resident 40 had received the medication and the increase in January 2026. Staff C was asked to find the side effect and target behavior monitoring for the medication. Staff C reviewed the EHR and confirmed there was no documentation of side effect and target behavior monitoring and said there should have been. On 01/26/2026 at 9:17 AM, Staff B, Director of Nursing Services (DNS), said to administrator a psychotropic medication, the facility must obtain a diagnosis, order, follow up and side effect and target behavior monitoring must be in place. Staff B reviewed January 2026's MAR and TAR. When asked if there should have been side effect and target behavior monitoring, Staff B would not answer the question directly but said they would have to check on that because the justification for use was insomnia, not mental health. No further answer was provided. Resident 85Resident 85 was admitted to the facility on [DATE]. Review of the Annual MDS, dated [DATE], showed the resident was cognitively intact with clear comprehension and expressed/communicated needs without difficulty. The MDS Pain Assessment Interview, showed Resident 85 received as needed (PRN) pain medication, no routine pain medication, and experienced pain/hurting rarely or not at all during the assessment period. Record review showed Resident 85 had the following orders for pain control.a) Duloxetine (an antidepressant) 60 milligrams (mg) at bedtime for pain related to polyneuropathy (disease affecting peripheral nerves in both sides of the body, causing weakness, numbness, and pain), dated 07/01/2025.b) Acetaminophen 650 mg every four hours PRN for pain from 1-10 on a scale to 10. A Consultant Report dated 10/02/2025, showed the pharmacist identified Resident 85 had received duloxetine 60 mg daily for polyneuropathy, since the previous dose increase on 07/01/2025. Due to Resident 85's creatinine clearance (lab test that measures how well ones kidneys are filtering waste from the blood) of 28 milliliters per minute ((continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ml/min, normal creatinine clearance levels for women typically range from 70 - 115 ml/min) performed on 08/14/2025, the pharmacist recommended the provider consider tapering the duloxetine to 40 mg at bedtime for one week, then 30 mg at bedtime for one week, then 20 mg at bedtime for one week and then discontinue. The rationale provided was to avoid accumulation of duloxetine and its metabolites (the substances a medication is broken down into through metabolism). The pharmacist documented that the use of duloxetine should be avoided in patients with severe kidney disease. On 10/06/2025 the provider declined the pharmacist's recommendation and cited a prior failed GDR of Resident 85's duloxetine. At the bottom of the consultant report a facility nurse documented Resident 85 had a failed GDR on 07/01/2025. A nurses note, dated 05/09/2025 at 1:59 PM, documented the provider approved a pharmacy recommendation to perform a GDR of Resident 85's duloxetine and wrote an order to decrease the duloxetine from 60 mg at bedtime to 40 mg, secondary to poor kidney function. The note documented that Resident 85 was placed on alert charting to monitor their response to the dose reduction. Review of the April and May 2025 MARs showed Resident 85's duloxetine was decreased from 60 mg to 40 mg at bedtime on 05/09/2025 as ordered. Review of Resident 85's PRN acetaminophen use showed it was administered six times during the 16 days that preceded the dose reduction (04/23/2025, 04/26/2025, 04/28/2025, 04/29/2025, 05/01/2025 and 05/07/2025) and four times in the 22 days after the 05/09/2025 GDR of the duloxetine. Review of the June 2025 MAR showed Resident 85 was administered PRN acetaminophen 12 times in 30 days. Nurses' documentation showed the acetaminophen was effective in managing Resident 85's pain. Review of the nurses' notes/provider notes from 05/09/2025 - 06/30/2025 (52 days) showed there was no documentation that Resident 85 had complained of increased or poorly controlled pain, or that the PRN acetaminophen was ineffective in managing their break-through pain A nurses' note, dated 07/01/2025 at 1:01 PM, documented Resident 85's GDR of duloxetine had failed, and their previous dose of duloxetine 60 mg at bedtime would be reinstated. On 01/27/2026 at 11:11 AM Staff B, DNS, was asked to provide the documentation /assessments that the facility's interdisciplinary team used to determine Resident 85's GDR of duloxetine had failed. On 01/27/2026 at 11:53 AM, Staff B, DNS, provided a Social Services note, dated 06/30/2025, that documented during a care conference on 06/30/2025, the resident reported increased neuropathy pain at night. The note indicated the Unit Manager would notify the provider. On 01/27/2026 at 11:53 AM, Staff B, DNS, also provided a fax communication form addressed to the provider, dated 06/30/2025, which stated the following [Resident 85] is reporting increased pain since the GDR of her duloxetine from 60 mg QD [every day] to 40 mg QD. She would like her previous dose of 60 mg reinstated after this failed attempt at dose reduction. Further review of the document showed it was signed by the provider on 07/01/2025, who hand wrote on it Agreed. On 01/27/2026 at 1:10 PM, Staff B, DNS, was asked if they could find any documentation in the EHR, given Resident 85 was placed on alert charting for staff to assess, monitor, and document their response to the GDR, that would support the facility's determination that Resident 85 had a failed GDR of their duloxetine (e.g., nurses notes, interdisciplinary notes, pain assessments/ monitors, provider notes/assessments, or provider communications etc.), or whether Resident 85's one time statement that they had increased neuropathy pain at night, provided during a care conference 52 days after the GDR of the duloxetine, was the sole determinant used to conclude and document in the record that Resident 85 had a failed GDR of their duloxetine, Staff B, DNS, said he felt Resident 85's statement that they had increased neuropathy pain at night, request that the previous duloxetine dose of 60 mg be reinstated, and the fact the provider ordered the duloxetine to be increased back to 60 mg at bedtime, was enough to show that it was a failed GDR. Reference WAC 388-97-0620 (1)(a)

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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 care and services were provided in accordance with professional standards for 1 of 6 residents (Resident 49) when reviewed for bowel management. This failure placed the residents at risk for medical complications, poor clinical outcomes and a decreased quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 49 admitted to the facility on [DATE] with diagnoses of dementia (a group of symptoms that effects memory) and adult failure to thrive. The resident was able to make needs known.During an interview on 01/23/2026 at 10:06 AM, Resident 49 stated they were given medicine to soften their stools and staff didn't tell them what they were getting. Resident 49 stated they had been having loose stools every day and did not want the medicine.Review of the EHR showed Resident 49 had been documented as having 14 soft stools and eight loose stools over the prior 24 days. Review showed the resident had two extra-large loose stools on 01/17/2026.Review of the provider's orders showed an order for Loperamide (a medicine to help with loose stools) three times daily as needed for loose stools. An order for magnesium oxide (a medication known to promote bowel movements) daily and an order for Senna (a laxative medication) twice a day for constipation and to hold (not give) for loose stools and notify the provider.Review of the January 2026's medication administration record (MAR) showed the resident had refused the evening dose 18 times and refused the morning dose twice in last 24 days.Review of the EHR showed no documentation that the provider was notified of Resident 49's loose stools or refused medications. There was no documentation that the medications were held.During an interview on 01/26/2026 at 9:39 AM, Staff L, Licensed Practical Nurse (LPN) stated they would talk with the resident and find out why they were refusing and would notify the provider. If the resident was having loose stools, they would hold the bowel medications and let the provider know.During an interview on 01/26/2026 at 9:16 AM, Staff J, Resident Care Manager stated it was their expectation that the staff should hold bowel medications and notify the provider if a resident was having loose stools or refusing medication consistently.During an interview on 01/26/2026 at 1:09 PM, Staff B, Director of Nursing Services stated it was their expectation nursing staff would have held bowel medications, notified the provider and documented in the EHR using an SBAR (SBAR, a form to communicate to providers that outlines situation, background, assessment, and request) if a resident was having loose stools and refusing their bowel medications.Reference WAC 388-97 -1060(1)-(3)