STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505075	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at the Park	1440 SE Garrison Village Way College Place, WA 99324

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview and record review the facility failed to allow 6 of 6 residents (Residents 20, 12, 8, 56, 35, and 40) reviewed for resident rights, the right to self-determination to hold resident council meetings at the times of their choice and to discuss topics that were important to them such as dining and food choice issues. The failure to accommodate and address their right to make choices about important issues in their lives, placed the residents at risk for a diminished quality of life. Findings included . During a resident council meeting on 02/25/2025 from 10:00 AM to 11:15 AM, six residents (Residents 20, 12, 8, 56, 35, and 40) voiced the following concerns about how they felt they were not given either the time or the choice to share issues that were important to them in the monthly resident council meetings. All resident interviews were completed during the resident council meeting. <Resident 20> Review of the medical record showed the resident was admitted to the facility on [DATE] with a primary diagnosis of Multiple Sclerosis (a long-term neurological disorder where the body attacks itself and can lead to muscle stiffness and involuntary muscle spasms). Resident 20's most recent comprehensive assessment dated [DATE] showed the resident was cognitively intact and required assistance of one to two caregivers for all activities of daily living (ADLs). In the 02/25/2025 interview between 10:00 AM and 11:15 AM, Resident 20 stated this was their first month as President of the Resident Council Committee and they had attended most of the monthly resident council meetings for the past three years. Their main concern was not having enough time in the council meetings to express concerns that were important to the residents living in the facility. In the same interview, Resident 20 stated the meetings were scheduled once a month by the activities department at 11:30 AM and then were over at 12:00 PM so the residents in attendance could go to lunch. Resident 20 stated the Resident Council meetings were 30 minutes long and was not enough time to discuss their concerns. Review of the previous Resident Council meeting from January 2025 showed notes/minutes where the same questions were asked every month for issues in each department. Due to lack of time most residents said there were no problems and then the meeting ended. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same 02/25/2025 interview, Resident 20 stated committee members have repeatedly reported the quality of the food was poor in taste, presentation and service. They stated the residents rarely received what was on the menu or what it listed on their tray carts they were supposed to get. During the same interview, Resident 20 stated call light response times was another issue that was always brought up in the council meetings. They stated they knew it was a constant common problem and wished administration would explain to them what the problem was and offered choices on a reasonable way to fix the issue. <Resident 12> Review of the medical record showed the resident was readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) (a group of lung diseases that cause airflow obstruction and breathing difficulties) and Congestive Heart Failure (CHF, a weakened heart condition that causes fluid buildup in the feet, arms, lungs, and other organs). In the interview on 02/25/2025 between 10:00 AM and 11:15 AM, Resident 12 stated they had been in the facility for over two years and usually attended the resident council meetings for something to do. Resident 12 stated their call lights were not being answered timely and was a big concern they had repeatedly shared. In the same 02/25/2025 interview between 10:00 AM and 11:15 AM, Resident 12 stated their constant concern was with the food. They stated it was of poor quality and the residents were rarely served what the menu listed. <Resident 8> Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including diabetes (a chronic, metabolic disease characterized by elevated levels of blood sugar, which leads over time to serious damage to the heart, kidneys, blood vessels and other organs) and CHF. During an interview on 02/25/2025 between 10:00 AM and 11:15 AM, Resident 8 stated they had been in the facility for six months and had the most concern about getting the call lights answered timely. Resident 8 stated they had waited for more than an hour on more than one occasion. Resident 8 stated their concern, was that no one checked to see why the light was even on and staff did not attempt to check the status of the resident. In the same interview, Resident 8 also stated the food was not appealing and they did not look forward to eating it. They stated the food was often served cold and the posted weekly menus and the individual tray cards were not followed. <Resident 56> Review of the medical record showed the resident was admitted on [DATE] with diagnoses including diabetes and kidney disease. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/2025 between 10:00 AM and 11:15 AM, Resident 56 stated they had been in the facility over one year and had attended several of the Resident Council meetings and felt they were useless as far as being listened to about their concerns. Resident 56 stated they shared the concern of not getting their call light answered in a timely manner, waiting over an hour at times. Resident 56 also stated they had a diagnosis of diabetes and received the same diet as everyone else. Resident 56 stated the meals were often not what was listed on the posted menus. <Resident 35> Review of the medical record showed the resident admitted to the facility on [DATE] with a diagnosis of kidney disease. During an interview on 02/25/2025 between 10:00 AM and 11:15 AM, Resident 35 stated the slow call light response time was their main concern. In the same interview, Resident 35 stated they agreed if someone from the facility administration would talk with the members of the resident council about the problem and together come up with possible solutions, they would at least feel heard and possibly come up with a solution on how to make a better system. <Resident 40> Review of the medical record showed the resident was admitted to the facility on [DATE] with a diagnosis of diabetes. During an interview on 02/25/2025 between 10:00 AM and 11:15 AM, Resident 40 stated it was their first resident council meeting they attended and hoped that something could be done about the quality of the food and the food service. During an interview with Staff T, Activities Director, on 02/26/2025 at 2:35 PM, they stated the Resident Council meeting times could be changed to which ever date and times the residents felt would be the most beneficial to them and would discuss the issue with them and decide. During an interview with Staff A, Administrator, on 03/03/2025, at 11:05 AM, they stated they would follow up with the activities and dietary departments to work out the best times to have monthly meetings where the Resident Council could share their concerns. Reference: WAC 388-97-0900(1)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45642 Based on observation, interview and record review, the facility failed to provide a comfortable and homelike environment when residents were served and ate off the plate still on the delivery tray in 2 of 2 dining rooms (900-unit and subacute dining rooms), reviewed for dining services. This failure placed the residents at risk for a non-homelike environment. Findings included . Observation on 02/24/2025 at 12:15 PM, in the subacute dining room, showed Resident 2, Resident 7, Resident 18, Resident 22, and Resident 36 were eating their lunch meals with the plates still on the delivery trays. Staff N, Nursing Assistant (NA), assisted Resident 36 with their lunch meal, from the plate which was still on the delivery tray. Observation on 02/24/2025 at 12:27 PM, in the 900-unit dining room, showed Staff J, Nursing Assistant (NA) had served Resident 58 their lunch meal and left the resident's meal on their tray. Staff J then served Resident 63's lunch meal and left the resident's meal on their tray. Staff J then removed a tray from the meal cart, placed a clothing protector on Resident 62, performed set up for the resident, and left the lunch meal on the delivery tray and began to assist the resident. Observation and concurrent interview on 02/25/2025 at 8:36 AM, Staff M, NA, delivered the resident's meal on a tray and sat it down on their table. Staff M stated Resident 6 enjoyed fruit with their meal and required assistance during mealtime. Resident 6's breakfast meal was sitting on a tray while being assisted by Staff M. During an interview on 02/28/2025 at 8:32 AM, Staff M, NA, recalled assisting Resident 6 with their breakfast while the plate remained on the delivery tray. Staff M stated they were feeling anxious, moving too quickly, and forgetting the sequence of actions they were supposed to take at that moment. During an interview on 03/04/2025 at 8:16 AM, Staff J, NA, stated their process involved taking the plate off the tray and arranging it as if they were in their own home. Staff J stated they were feeling nervous being observed, which led to forgetting to take away the trays, to take the plate off of the tray and set it up like if they were at home. Staff J stated they were nervous being watched and forgot to remove the trays. During an interview on 03/04/2025 at 8:38 AM, Staff K, Registered Nurse, stated expectation was for staff to provide the residents a clean, comfortable and homelike environment. Reference: WAC 388-97-0880(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on interview and record review the facility failed to ensure allegations of potential abuse and/or neglect of a fall with significant injury for 1 of 1 resident (Resident 30), was reported to the State Survey Agency. The failure to report as required resulted in the inability to recognize patterns of potential abuse and/or neglect with incidents of significant injury. Findings included . Review of the Washington State Department of Social and Health Services (DSHS) October 2015 Nursing Home Guidelines: The Purple Book, showed any incident investigated for potential abuse/neglect or mistreatment causing a significant injury must be reported to the DSHS Hotline within 24 hours of the incident. <Resident 30> Review of the medical record showed Resident 30 was admitted to the facility on [DATE] with a diagnosis of a below the knee amputation (BKA) of the right leg. Review of Resident 30's care plan dated 12/27/2024 and revised on 01/15/2025 showed the resident required assistance of two caregivers and a manual mechanical lift for transfers. Review of the 01/31/2025 facility incident report showed Resident 30 had a fall with significant injury on 01/31/2025 when the surgical incision of the recent BKA caused a deep dehiscence (when the surgical incision reopens exposing the underlying tissue and requiring immediate surgical intervention). The incident report further showed the facility investigated the fall as a potential abuse and/or neglect as a nursing assistant helping the resident transfer did so without following Resident 30's care plan for a two person assist with transfers. Review of the October 2024 through March 2025 facility incident and reporting logbook showed Resident 30's fall with significant injury was not reported to the State Agency as required per the Nursing Home Guidelines. During an interview with Staff B, Director of Nursing Services (DNS) on 02/28/2025 at 12:39 PM, they stated the incident was not reported to the State Agency because they thought since the cause of the injury was known, the incident only needed to be logged into the incident and reporting logbook within five days of their investigation. Reference: WAC 388-97-0640(6)(c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 45117 Based on interview and record review, the facility failed to ensure the accuracy of the residents' comprehensive assessment [(MDS) minimum data set, a standardized assessment tool that measures health status in nursing home residents)] regarding injectable anti-diabetic medications for 2 of 5 residents (Resident 32 and 49) reviewed for injectable medication. This failure placed the residents at risk for ineffective, inaccurate care plan interventions, and unmet care needs. Findings included . Review of the Centers for Medicare and Medicaid Services guidance titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User 's Manual, dated 10/2024, showed: review the resident ' s medication administration record for the seven days prior to the assessment date for use of insulin (an injectable hormone that helps your body use blood sugar for energy and manage blood sugar levels) injections. Count the number of days insulin injections were received; enter that number of injections onto the MDS. <Resident 32> Review of the medical record showed Resident 32 was admitted to the facility with diagnoses including diabetes (a group of diseases that result in too much sugar in the blood), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and depression. The 12/20/2024 comprehensive assessment showed Resident 32 was cognitively intact and received insulin injections. During an interview on 02/24/2025 at 3:48 PM, Resident 32 stated they did not use insulin. During an interview on 03/03/2025 at 12:32 PM, Staff C, Registered Nurse/MDS Coordinator, stated they had entered the code for insulin use on the MDS for the resident's use of Trulicity (a non-insulin medication used to treat diabetes) based on guidelines that showed it was being used to manage the resident's insulin levels. During a follow up interview at 1:05 PM, Staff C stated Trulicity was not insulin, and they had coded it wrong on the MDS. <Resident 49> Review of the medical record showed Resident 49 was admitted to the facility with diagnoses including diabetes, current use of injectable non-insulin drugs, and depression. The 12/31/2024 comprehensive assessment showed Resident 49 was cognitively intact and received insulin injections. During an interview on 03/04/2025 at 9:15 AM, Staff C stated Resident 49 had been incorrectly coded on their MDS as using insulin. They stated Resident 49 received Trulicity and they would make the corrections to the MDS. During an interview on 03/03/2025 at 2:44 PM, Staff D, Regional Director of Clinical Services, stated there was a process in place to ensure accuracy of the MDS for skilled nursing (treatments for complex medical care, not day-to-day needs) only. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1000(1)(b)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45117 Based on observation, interview, and record review, the facility failed to provide treatment and services to maintain and/or prevent a further decrease in range of motion [(ROM) - how far and in what direction you can move a joint or muscle] for a hand contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to rigidity of joints) for 1 of 3 residents (Resident 7) reviewed for restorative services. This failure placed the residents at increased risk for a worsening contracture, potential decrease in range of motion, and skin integrity issues. Findings included . Review of a document titled, Restorative Program, revised 04/2018, showed the facility would promote resident independence and quality of life by maintaining functional ROM. All residents would be assessed for functional limitations in ROM during their admission assessment period and quarterly. <Resident 7> Review of the medical record showed Resident 7 was readmitted to the facility on [DATE] with diagnoses including a stroke with hemiplegia/hemiparesis (a medical condition that causes weakness or paralysis on one side of the body) affecting the left side, heart failure, and anxiety. The record showed Resident 7 was discharged to the hospital on 01/27/2025 and returned to the facility on [DATE]. The 01/27/2025 comprehensive assessment showed Resident 7 had an impairment on their upper left extremity and required substantial/maximum assistance of one staff member for upper body dressing. The assessment also showed Resident 7 had a moderately impaired cognition. Review of the quarterly comprehensive assessment dated [DATE], showed Resident 7 received six days of active ROM from a restorative nursing program in the previous seven days. A concurrent observation and interview on 02/24/2025 at 3:12 PM, showed Resident 7 lying in bed with the fingers of their left-hand curled inwards toward the palm of their left hand. Resident 7 stated they were unable to move their left hand. They stated they used to have something for their hand (splint or brace) and they try to stretch it. During an interview on 02/26/2025 at 3:26 PM, Staff E, Registered Nurse, stated Resident 7 was not currently on a restorative program. Staff E stated Resident 7 used to do finger and elbow extensions with the restorative aide. During an interview on 02/27/2025 at 2:49 PM, Staff F, Director of Rehab, stated when a resident discharged to the hospital, the facility discontinued all therapy/restorative programs. They stated the process when a resident was readmitted to the facility included receiving physical therapy (PT)/occupational therapy (OT)/speech therapy (ST) to evaluate and treat. OT did not enroll Resident 7 into an OT program. Staff F stated when a resident was not enrolled into an OT program, there was a form that should have been completed and given to the restorative aide to restart their previous restorative services. Staff F stated that step was missed due to the transition of the therapy department from contracted services to facility staff. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1060(3)(d)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35676 Based on observation, interview, and record review, the facility failed to implement care plan interventions and provide adequate supervision to prevent avoidable accidents during mechanical lift transfers for 2 of 2 residents (Residents 30 and 7) reviewed for falls. Resident 30 experienced harm when they fell from a mechanical lift while being transferred without the two-caregiver assistance as care planned onto their surgical incision site from their recent right below the knee amputation (BKA) requiring a transfer to the emergency room , surgical repair, and a five-day hospital stay. Resident 7 experienced an avoidable fall when left alone in their wheelchair after staff applied a mechanical lift sling under the resident and attached the sling to the mechanical lift. This failure placed the residents at risk for injury, pain, and recurrent falls. Findings included . <Resident 30> Review of the medical record showed Resident 30 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD), diabetes and a complete BKA of the right lower leg. Review of the most recent comprehensive assessment dated [DATE] showed Resident 30 was cognitively intact and required assistance of one to two caregivers for bed mobility, transfers, toileting and dressing. Review of Resident 30's care plan dated 12/27/2024 and revised on 01/15/2025 showed the resident required assistance of two caregivers with a Sara Steady lift (a manual lift that helps patients stand up from a seated position) for transfers. During an observation and interview with Resident 30 on 02/24/2025 at 12:56 PM showed them sitting in an electric wheelchair eating lunch independently. Resident 30 stated they had an amputation of their right lower leg on 12/26/2024 that was healing well until they had a fall from a Sara Steady lift on 01/31/2025, landing on the stump of their right leg causing the surgical incision to open again. Resident 30 stated they had been doing well working with the facility therapists and was hoping to get a lower leg prosthesis (an artificial device that replaces a missing body part) soon and get back home as soon as possible. Resident 30 stated they felt the fall had set them back considerably from all the progress they had made towards their goal of being discharged home soon. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a follow up interview with Resident 30 on 02/28/2025 at 12:18 PM, they explained how the fall on 01/31/2025 happened. They stated they wanted to move from one chair in their room to their electric wheelchair and asked for assistance from Staff P, Nursing Assistant (NA). Staff P came into the room with a Sara Steady lift (where a resident is able to stand on the lift to transfer from one place to another). Resident 30 stated they told Staff P they needed to get another person to help with the transfer because they could not stand safely on just one leg, but Staff P told them it was okay and they could do it by themselves. The resident let Staff P do the transfer alone. Resident 30 stated as soon as they grabbed the bar on the lift and was assisted to a standing position by Staff P, they could not hold on tightly enough and their one leg gave out and they fell directly down to the floor with their stump taking the full weight of their body. Resident 30 stated the pain was excruciating and the leg wound began bleeding heavily immediately. Resident 30 stated other staff immediately came into their room and got them back onto their bed and attempted to stop the bleeding. Resident 30 stated 911 was called and they were transferred back to the hospital where they had to have surgery again to repair the damage to their stump the fall caused. During the same interview, Resident 30 stated multiple staff members came in and asked questions about how the fall occurred and was told that Staff P should not have been transferring them by themselves and would be reprimanded for not getting assistance. Resident 30 stated after they returned from the hospital on 02/05/2025, their transfer status had been changed to using a Hoyer lift (an electric mechanical lift completely transfers a dependent resident) only with a two person assist. Review of a nursing progress note dated 01/31/2025 at 1:35 PM stated This RN (Registered Nurse) called to residents' room by CNA (Certified Nursing Assistant). When arrived therapy was assisting resident in wheelchair. It was reported to me that the resident was being transferred from wheelchair to a Sara Steady. Resident fell during transfer onto right stump of BKA. Stump was bleeding from site through dressing onto floor. Resident denied hitting head or feeling any other injuries. Resident was assisted by therapy team and CNA from wheelchair using a gait belt for adjustment and then transferred to bed with Hoyer lift (a mechanical lift). During transfer, this RN applied pressure to wound. Once resident was in bed, stump was elevated and dressing removed to assess surgical site. Noted that surgical site had opened and abd (a thick absorbent pad) was saturated with blood. Resident bled through second abd pad. Pressure applied. New abd pad and ace wrap applied. Resident transferred to hospital via EMS (an ambulance service). Review of the facility incident report and an interview Staff B, Director of Nursing Services (DNS) on 02/28/2025 at 12:39 PM, they stated Staff P was a newer NA that worked for the facility on a as needed basis. Staff B stated they investigated the cause of Resident 30's fall immediately on 01/31/2025 and had interviewed Resident 30, Staff P and any witnesses of the event that day. Staff B stated in the interview with Staff P they stated they knew mechanical lifts always required assistance of two caregivers and that Resident 30 should have had two persons assisting with the transfer. Staff P stated the resident was in a hurry to get transferred so they just attempted to do it themselves. Staff P stated Resident 30 did not hold on correctly when they lifted them to standing and their good leg buckled causing them to fall onto their right stump. Review of Staff P's personnel file showed they had transfer training on mechanical lifts during NA training orientation on 10/28/2024 and individual training on 01/31/2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with Staff A, Administrator, on 02/28/2025 at 1:45 PM, they stated they were aware of the fall with injury to Resident 30 and knew trainings had been completed as the plan of care was not followed for two person transfers for Resident 30, nor was the facility policy followed to have two person transfers with all mechanical lifts. 45117 Review of a document titled, Mechanical Lift Competency - Bed to Wheelchair, dated 12/2023, showed always use two person assists for all lifts, and ensure bed/wheelchair brakes are locked and secure. <Resident 7> Review of the medical record showed Resident 7 was readmitted to the facility on [DATE] with diagnoses including a stroke with hemiplegia/hemiparesis (a medical condition that causes weakness or paralysis on one side of the body) affecting the left side, heart failure, and anxiety. The record showed. The 01/25/2025 comprehensive assessment showed Resident 7 had an impairment on their upper left extremity and both lower extremities and was dependent on two staff members for assistance with transfers. The assessment also showed Resident 7 had a moderately impaired cognition. Review of a facility investigation dated 02/26/2025 at 7:11 PM, showed Resident 7 was in their room behind a closed door, yelling out for help. The resident was observed sitting on the floor with the back of their shoulders leaning against the wheelchair legs and the mechanical lift sling partially in the wheelchair. The mechanical lift was positioned in front of the resident with the legs of the lift open and the brakes not engaged. Resident 7 appeared to have slid out of their wheelchair to the floor. The wheelchair brakes were not engaged. During an interview on 02/27/2025 at 12:20 PM, Staff L, Nursing Assistant (NA), stated they were walking past Resident 7's room and saw them trying to hook their sling to the mechanical lift. Staff L stated they attached the sling to the mechanical lift and left the room to get a second NA to help with the transfer. Staff L stated the second NA needed assistance with their resident and they went to help that NA. Staff L stated they went to lunch after helping the NA with their resident and had forgotten they had left Resident 7 attached to the mechanical lift. During a follow-up interview at 12:52 PM, Staff L stated they had been trained on the safe use of mechanical lifts and had not been trained to hook up a resident to a mechanical lift and leave them alone while still attached to the mechanical lift. Staff L stated, I just forgot, it was a mistake. During an interview on 03/03/2025 at 2:26 PM, Staff D, Regional Director of Clinical Services, stated the process for safe transfers was not followed for Resident 7. Reference: WAC 388-97-1060(3)(g)

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	505075	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency at the Park	1440 SE Garrison Village Way College Place, WA 99324

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 45117 Based on observation, interview, and record review, the facility failed to coordinate a referral for denture services for 1 of 2 residents (Resident 7) reviewed for dental services. This failure placed the residents at risk for altered self-image, difficulty eating, and weight loss. Findings included . <Resident 7> Review of the medical record showed Resident 7 was admitted to the facility with diagnoses including heart failure, gastro-esophageal reflux disease without esophagitis [a disease where the stomach contents flow back into the esophagus (the tube that connects the mouth to the stomach) but do not cause inflammation or damage to the esophageal lining], and Barrett's Esophagus (damage to the lower portion of the esophagus). The 01/25/2025 comprehensive assessment showed Resident 7 required assistance of one to two staff members for activities of daily living. The assessment also showed Resident 7 had a moderately impaired cognition and was able to make their needs known. Record review of Resident 7's care plan dated 02/26/2025, showed Resident 7 had full upper dentures and partial lower dentures. An observation and interview on 02/24/2025 at 3:02 PM, showed Resident 7 resting in bed. They were not wearing dentures. Resident 7 stated they were supposed to get new dentures maybe in March (2025). Record review of a dental visit document titled, Preventative Report, dated 10/03/2024, showed Resident 7 was interested in new dentures and a referral to a denturist was ordered. There was no documentation in the medical record that the referral had been completed. During an interview on 02/27/2025 at 8:51 AM, Staff G, Patient Care Coordinator/RN, stated the process for dental referrals included forwarding those referrals to Staff H, Social Services Director, to schedule the denture care appointments. Staff G stated they did not see the referral form from Resident 7's dental appointment. During an interview on 02/28/2025 at 10:21 AM, Staff H stated their process for scheduling a denturist appointment included completing a scheduling form and giving it to Staff I, Activities Driver, to schedule the appointment and transport the resident to the appointment. During an interview on 02/28/2025 at 10:29 AM, Staff I stated they scheduled outside appointments. They stated they received the referral scheduling form from the nursing staff. Staff I stated they did not recall receiving a referral form for Resident 7. During an interview on 02/28/2025 at 12:05 PM, Staff D, Regional Director of Clinical Services, stated they were aware of the concerns and there was not a good system in place related to the process for completing dental referrals. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1060(1)(3)(vii)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45117 Based on interview and record review, the facility failed to ensure the medical record related to dental services was accurate for 1 of 2 residents (Resident 18) reviewed for complete medical records. This failure had the potential risk for healthcare providers to rely on inadequate information when making treatment decisions for residents and a potential risk for not receiving quality care. Findings included . Review of the policy titled, Record Review, revised 07/2018, showed the facility shall maintain complete clinical records for each resident. <Resident 18> Review of the medical record showed Resident 18 was admitted to facility with diagnoses including a stroke, vascular dementia with psychotic disturbance (a brain disorder caused by poor blood flow that includes delusions and hallucinations) and agitation, and depression. Record review of a nursing progress note (PN) dated 12/06/2024, showed Resident 18 did not like to wear their dentures because they had a sore spot in their mouth along the upper left gumline. The PN showed the resident had been assessed for pain with no lesion noted but had requested to see their denturist. Record review of the medical record showed Resident 18 had last seen the dentist on 10/03/2024. During an interview on 02/28/2025 at 9:32 AM, Staff G, Patient Care Coordinator/RN, stated they had informed Staff H, Social Services Director, on 12/06/2024 that Resident 18 was having pain and needed a dental appointment. Staff G stated once that information was given to Staff H, if they did not receive any follow up from Staff H, that would mean Staff H had done their piece of either scheduling the appointment or moving it on to the scheduler to schedule the appointment. Staff G stated they did not follow up on scheduling concerns related to dental issues after they had reported them to Staff H. During an interview on 02/28/2025 at 10:21 AM, Staff H stated when they received a request for dental services, especially if the resident was having pain, they completed the appointment request form and forwarded that form to Staff I, Activities Driver, to schedule an urgent appointment. During a concurrent observation and interview on 02/28/2025 at 10:29 AM, Staff I stated they recalled taking Resident 18 to dental appointments for denture adjustments. Staff I removed a file folder from their file cabinet that contained scheduling forms. They reviewed a completed form that showed Resident 18 had been taken to a dental appointment on 12/12/2024. There was no documentation in the resident's medical record that they had attended the 12/12/2024 appointment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/28/2025 at 12:11 PM, Staff D, Regional Director of Clinical Services, stated they would have expected to find a nursing progress note in the resident's record if they had been seen by the denturist. During an interview on 02/28/2025 at 2:25 PM, Staff B, Director of Nursing Services, stated they had placed a call to Resident 18's son to confirm that they had accompanied Resident 18 to their denturist appointment on 12/12/2024. Staff B stated the process should have been for the nurse to call the provider, receive a verbal report of the visit, and document that information in the resident's medical record. Reference: WAC 388-97-1720(1)(a)(i-iii)(2)(d-f)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43280 Based on interview and record review, the facility failed to ensure residents and/or their representative were offered/educated on the COVID-19 (an infectious disease causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death) immunization (the action of taking a vaccine for a particular infectious disease) for 2 of 5 sampled residents (Residents 26 and 42) reviewed for immunization status. This failure placed the residents at risk of making an uninformed decision and contracting the COVID-19 virus. Findings included . Review of the Department of Social and Health Services, Dear Nursing Home Administrator Letter, guidance titled, COVID-19 Vaccine Immunization Requirements for Residents and Staff, dated 05/20/2021, showed for COVID-19 resident vaccinations the facility was required to: Educate residents or their representatives on the benefits and potential side effects associated with the COVID-19 vaccine in a manner they can understand, Offer residents the COVID-19 vaccine, Document that a resident was educated, their decision to accept or decline the vaccine, contraindications to the resident receiving the vaccine, and administration of the vaccine, if applicable. Review of the facility's policy titled, Resident Immunizations Policy, revised November 2024, showed the facility would offer residents the COVID-19 vaccine and .will have a consent completed, including education . on the risk/benefits of the immunization. <Resident 26> Review of the resident's medical record showed they were admitted to the facility on [DATE], with diagnosis including fracture left leg, dementia (a progressive disease that destroys the memory and other important mental functions), and anxiety. The comprehensive assessment dated [DATE] showed the resident had a severely impaired cognition. Review of Resident 26's immunization notes, dated 02/06/2025 showed the resident themselves refused the COVID-19 vaccination and was educated on the risk/benefits. There was no documentation of a COVID-19 immunization assessment, education or a signed consent/declination form completed for the resident. During a concurrent observation and interview on 02/27/2025 at 8:34 AM, Resident 26 was unable to have a conversation with the surveyor and was confused when asked about their immunization status/education. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 8:53 AM, Staff O, Registered Nurse for Resident 26, stated the resident was unable to understand or make medical decisions and that all medical decisions had to go through the resident's representative. During an interview on 02/27/2025 at 9:16 AM, Resident 26's Representative stated the facility staff had never offered nor educated them on the risk versus benefits and potential side effects associated with the COVID-19 vaccine. <Resident 42> Review of the resident's medical record showed they were admitted to the facility on [DATE], with diagnosis including heart failure, dementia), and lung complications. The comprehensive assessment dated [DATE] showed the resident had a moderately impaired cognition and was able to make their needs known. Review of Resident 42's immunization notes, showed the resident had received the COVID-19 vaccine in 2023, but refused the COVID-19 vaccination on 01/02/2025 and was educated on the risk/benefits. No documentation of a COVID-19 immunization assessment, education or a signed consent/declination form was completed for the resident. During an interview on 02/27/2025 at 8:44 AM, Resident 42 stated that staff had never offered nor educated them on the risk versus benefits of the COVID-19 vaccine, but they would have wanted the current COVID-19 vaccine. Resident 42 stated their Resident Representative had usually taken care of making the medical decision like accepting or refusing vaccines. During an interview on 02/27/2025 at 9:10 AM, Resident 42's Representative stated that no staff member from the facility had offered or educated them on the risk versus benefits and potential side effects associated with the COVID-19 vaccine. They stated that Resident 42 had received the previous COVID-19 vaccination and would have wanted the current COVID-19 vaccine. During an interview on 02/27/2025 at 9:29 AM, Staff Q, Infection Preventionist, stated when a resident was admitted they offered residents all the required immunizations and obtained consent for them, including the COVID-19 vaccine. Staff Q stated when a resident was unable to make their own medical decisions due to impaired cognition, the Resident Representative (RR) would be offered/educated on the risk versus benefits and potential side effects associated with the COVID-19 vaccine. When conveyed information on Resident 26, Resident 42 and their RR interviews regarding the COVID-19 vaccine, Staff Q stated that the correct process was not followed. During an interview on 02/27/2025 at 3:38 PM, Staff B, Director of Nursing Services, stated that residents with impaired cognition who were unable to make health care decision or have a legal RR that make health care decisions for them, should have been offering/educated on the risk versus benefits and potential side effects associated with the COVID-19 vaccine. Staff B stated Resident 26, Resident 42 and their representatives were not given the chance to make an informed decision, and the correct process was not followed. Reference: WAC 388-97-1320(2)(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 43280 Based on observation and interview the facility failed to provide a safe, functional, and sanitary (the conditions that affect hygiene and health) environment for residents and staff for 1 of 1 Laundry room (LR 1), reviewed for a comfortable environment. This failure placed residents and staff at risk for not feeling safe/secure with their environment and an increased risk of the cross contamination of diseases. Findings included . During a concurrent observation and interview on 02/27/2025 at 9:55 AM, showed the LR 1's washing machine number five had an area of previous water damage (an accidental leakage or discharge of water that caused possible losses or value of materials) to the linoleum (a common floor covering) floor beneath it and an area that was currently leaking water out from the washing machine. The water had seeped (a slow flow of a liquid through a material's small holes) under the linoleum and had spread through a four foot (ft, a unit of measure) by three ft section under washing machine number five. Staff R, Housekeeping/Laundry Director, stated they knew that washing machine number five had been leaking and was in the process of ordering a new washing machine. When surveyor walked over between washing machines number four and five, the linoleum floor squished down, and a grayish sludge (a thick, soft, wet mixture of liquid) oozed out from in-between the laminate flooring. Observations of puddle of water under washing machine number four noted, which was separated from the other washing machine leak that covered a three ft by three ft section and had also seeped under the flooring. During an interview on 02/27/2025 at 10:10 AM, Staff R stated the leak from washing machine number four/five had seeped underneath the linoleum and the grayish sludge, that had oozed out underneath the linoleum flooring, had the potential to grow bacteria. Staff R stated the floor could not be disinfected because the water had already seeped underneath the flooring. During a concurrent interview and observation on 02/27/2025 at 12:06 PM, Staff Q, Infection Preventionist, stated they were informed that two washing machines in the laundry room, had a water leak, that had seeped underneath the linoleum flooring. Staff Q, with the surveyor, observed the water leak and sludge that was oozing through the linoleum flooring. Staff Q stated, could be growing something, which was not sanitary. Staff Q was joined by Staff S, Maintenance Director, and both staff members stated the floor under the washing machines was not a safe/cleanable surface and needed to be fixed. Reference: WAC 388-97-3220(1)