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	01/09/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote resident dignity during mealtime in the dining room for 3 of 8 residents (Resident 70. 28 and 74) reviewed for dignity. Resident 70 had their medical information discussed while eating their meal and Resident's 28 and 74 were referred to by pet names. This failure placed residents at risk for embarrassment and a poor quality of life.ˆ Findings included . Record review of an undated facility policy titled The Dining Experience; Staff Responsibilities showed, the dining experience will enhance each individual's quality of life through person centered dining. Staff will treat each individual with dignity and respect. Staff will respect the confidentiality of any individuals. Resident 70 Review of the resident's medical record showed the resident was admitted with diagnoses which included history of a stroke (blood supply is cut-off from the brain) with right hemiplegia (paralysis of one side of the body usually following a stroke) and dementia. Review of the comprehensive assessment dated [DATE] showed they had cognitive impairment and were dependent on staff for dressing grooming, transfers and mobility needs. During an observation on 01/05/2026 at 12:51 PM, in the large dining room Staff N, Nursing Assistant, (NA) stated to Staff I, Resident Care Manager (RCM), that Resident 70 was not eating very well. Staff N continued to discuss their concerns about Resident 70's nutritional status and stated they were trying to get Resident 70 to drink health shakes to replace their refused meals. Staff I questioned Staff N about Resident 70 having a possible urinary tract infection (UTI) which may be causing their poor appetite. Staff I further stated they were going to get a urine sample from Resident 70 to rule out a UTI. The confidential health conversation between Staff N and Staff I about Resident 70 occurred in front of eight other residents who were sitting in the dining room eating their meals. Resident 28 Review of the resident's medical record showed the resident admitted with diagnoses which included dementia, and chronic kidney disease. Review of the comprehensive assessment dated [DATE] showed the resident had mild cognitive impairment and required extensive assistance from staff for dressing and mobility. ˆ During an observation on 01/05/2026 at 12:56 PM, showed Staff M, NA, conversing at the dining room table with Resident 28. During the conversation Staff M referred to Resident 28 as honey several times as they were talking. Resident 74 Review of the resident's medical record showed they were admitted with diagnoses which included dementia and hypertension. Review of the comprehensive assessment dated [DATE] showed the resident had cognitive impairment and required moderate assistance from staff for dressing and mobility. ˆ During an observation on 01/07/2026 at 8:40 AM, Staff P, Director of Therapy, came into the dining room and approached Resident 74 who was sitting at their dining room table with two other residents. Staff P stated Hello Sweetheart to Resident 74 and reminded them that they were going to work with them later that day. During an interview on 01/09/2026 at 12:40 PM Staff B, Director of Nursing, stated they expected staff to not discuss medical information in the dining rooms or refer to residents by nick names such as honey or sweetie unless the resident preferences were known. Reference WAC 388-97-0180(1-4) ˆ ˆ

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview and record review, the facility failed to ensure residents were evaluated, assessed, and physician orders were obtained for safe self-administration of medication for 1 of 3 residents (Resident 10), reviewed for self-medication administration. This failure placed residents at risk for inaccurate and unsafe medication administration, adverse side effects, and medical complications. Findings included . Review of the policy titled, Storage and Expiration Dating of Medications and Biologicals, revised date 06/30/2025, showed the facility should not provide bedside medications without a physician order and approval by the Interdisciplinary Care Team and facility administration. Review of policy titled, General Dose Preparation and Medication Administration, revised date 11/15/2024, showed the facility staff would not leave mediations unattended and observe the resident's consumption of the medication. Review of the medical record showed Resident 10 was admitted to the facility with diagnoses including diabetes (a condition that causes high blood sugar in the blood), heart failure and glaucoma (a progressive vision condition that can lead to blindness). The 11/02/2025 comprehensive assessment showed Resident 10 was independent with Activities of Daily Living (ADLs), with exception of supervision with bathing. The assessment also showed Resident 10's cognition was intact. During an observation and interview on 01/05/2026 at 3:24 PM, showed Resident 10 in their room with two medications in a small unlabeled clear cup and a bottle of eye drops on top of a bedside table. Resident 10 stated they had returned from an outing and the nurses placed their medications on their beside table when they returned. Resident 10 stated one of medications was for their joints and the other was for their blood pressure. Resident 10 stated they would give the eye drops back to the nurse when they were done using the eye drops. During an observation and interview on 01/06/2026 at 8:49 AM, showed Resident 10 in their room eating breakfast. On their bedside table was an unlabeled clear cup with two large white medication tablets Resident 10 stated they had taken some of their morning medications and had left these two large white tablets to take after their breakfast and did not know what the medications were. During an observation and interview on 01/08/2026 at 9:25 AM, showed Staff E, Registered Nurse, entered Resident 10's room and obtained two bottles of eye drops used for the treatment of glaucoma, and then returned to the medication cart. Staff E stated they left the medications with Resident 10 as they had requested to take their medication by themself. Record review of Resident 10's medical record showed that there was no self-medication assessment or a physician's order in place for the safe self-administration of medications. During a concurrent interview on 01/08/2026 at 4:19 PM, Staff B, Director of Nursing, stated staff should be observing residents take their medications and not leave them at the resident's bedside. Staff B stated if a resident wanted to self-administer their medications, the process would be to perform a cognitive assessment and obtain a provider order. Staff B stated that would be done to ensure a resident was safe to be able to self-administer medications. During the same interview at 4:30 PM, Staff C, Regional Director of Clinical Operations, stated that for a resident that wanted to self-administer their medications, the facility would ensure the facility provider visited the resident and ordered a self-medications assessment to verify appropriateness for the resident to self-administer their medications. Staff C stated Resident 10 did not have that process completed and their medications should not be left at their bedside. Reference WAC: 388-97-0440

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide copies personal medical records, as required, to 1 of 2 resident (Resident 27), reviewed for resident rights. This failed practice placed residents at risk of not having access to their complete medical history, potential emotional stress affecting their ability to make informed decisions about their care, and a violation of their resident's rights. Findings included . Review of the facility's November 2025 policy titled Resident Rights showed upon request, the resident has the right to receive records, in a language he or she can understand, pertaining to his or her care within 24 hours of request. Further review did not show residents were required to give a written request for their medical records. Resident 27 Review of the medical record showed Resident 27 admitted to the facility on [DATE] with diagnoses to include diabetes (a disease in which the body does not control sugar in the blood), muscular dystrophy (genetic disorders causing progressive weakness and loss of muscle mass), heart and kidney disease. Review of the comprehensive assessment dated [DATE] showed Resident 27's cognition was intact and independent with personal cares. During the Resident Council meeting conducted by the State Agency on 01/07/2026 at 9:47 AM, Resident 27 stated they were unable to have a copy of their medical records. Resident 27 stated they were only offered to view their records on the computer. During an interview on 01/07/2026 at 3:57 PM, Resident 27 stated that they had some blood drawn in December and wanted to know their lab results. Resident 27 stated their doctor had ordered the labs and had stated they could have a copy of their results. Staff I looked them up on the computer and stated they could write down their results. Resident 27 stated they asked Staff I for a copy of their records and were told they could not have a copy. Resident 27 stated Staff I had asked if they had My chart (online system that contained Resident medical history) Resident 27 stated they said no, they did not have a computer. Resident 27 stated they had a genetic disorder and a heart condition. Resident 27 stated they were thinking the nurse had seen something wrong and did not want them to see it. During an interview on 01/08/2026 at 9:16 AM, Staff I, Resident Care Manager (RCM), stated they had explained to Resident 27 once medical records were in the chart they may need a written request for their medical records. Staff I stated they had offered to sit and view lab results from the computer with Resident 27. Staff I stated they wanted to check the facility's policy about giving out medical records once records were in the facility's system. Staff I stated they had gone over the lab results with the resident in office and offered for Resident 27 to write it down while they double checked the policy. Staff I stated that occurred on Monday 01/05/2026 and then got distracted. ^ During an interview on 01/08/2026 at 10:21 AM, Resident 27 stated their family had history of severe illness and kept close record of their results. Resident 27 stated they did not want to write results down, they just wanted a paper copy to review on their own. During an interview on 01/09/2026 at 10:53 AM, Staff A, Administrator, and Staff B, Director of Nursing, stated there had been some miscommunication between Staff I, RCM and Resident 27. Reference: WAC 388-97-0300 (2)(a)(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop comprehensive person-centered care plans to address vision impairments for 2 of 3 Residents (Resident 42 and 76) reviewed for care plan development. This failure placed the residents at risk for unmet care and/or safety needs related to inaccurate or inadequate direction to staff. Findings included.Resident 42 Review of the medical record showed the resident admitted to the facility with diagnoses including chronic congestive heart failure (heart is not pumping blood as strongly as it should), dementia (a significant decline in thinking, memory, and reasoning skills that's bad enough to interfere with daily life) and visual disturbance. The 11/27/2025 comprehensive assessment showed Resident 42s cognition was moderately impaired and required assistance of one staff member for activities of daily living (ADLs). Further review showed Resident 42's vision was severely impaired. A concurrent observation and interview on 01/06/2026 at 11:05 AM, showed Resident 42 lying in bed with their water cup located on the bedside table. The bedside table was positioned out of the resident's reach. Resident 42 stated, I cannot see well; all I see is black. It's scary when I try to get up and go somewhere. If I bump into people, they get mad; they don't understand that I am blind. Resident 42 further stated that their water cup was out of reach on the end table, stating, I don't know where my water cup is; I can't see it. I sometimes put my water on the floor so I can find it. I could reach it if they put the table right by me. During an observation on 01/06/2026 at 2:54 PM, Resident 42 was observed lying in bed; the water cup was located on an end table positioned out of the resident's reach. During an observation on 01/07/2026 at 9:17 AM, Staff O, Nursing Assistant, was observed assisting Resident 42 to bed. Afterwards, Staff O failed to position the bedside table or water cup within the resident's reach. The table was located to the left of the nightstand, inaccessible to the resident. Record review of the Electronic Health Record (EHR) on 01/09/2026, showed no care plan was in place to address Resident 42's vision impairment, nor were there documented interventions to guide staff on environmental safety or accessibility related to the resident's severely impaired vision. Resident 76Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood flow to part of the brain is suddenly cut off, either by a blockage or a burst blood vessel, causing brain cells to die from lack of oxygen, leading to sudden impairment or loss of function like weakness, numbness, or trouble speaking). The 11/18/2025 comprehensive assessment showed Resident 76's cognition was moderately impaired and required assistance of one-two staff member for ADL's. A concurrent observation and interview on 01/07/2026 at 4:06 PM, showed Resident 76's bedside table was positioned out of the resident's reach. Resident 76 was observed attempting to reach their water but was unable to do so. The resident stated they could not see the table or the water because they were positioned out of their visual field. Resident 76 further stated that they could not see anything to the side unless they turn their head significantly. When asked to use the call light to request assistance, the resident stated they could not find the button. The call light was observed clipped to the upper right-hand corner of the bed, out of the resident's visual field and reach. During an observation on 01/08/2026 at 11:45 AM, Resident 76 was observed lying in bed with their water cup out of reach. The resident attempted to obtain the water cup but tipped it over while searching for it. Resident 76 stated, I cannot see it. The water cup was located to their right on the bedside table, positioned in the middle of the table rather than being pushed to the edge for accessibility. Record review of the EHR on 01/09/2026, showed no care plan was in place to address Resident 76's vision impairment, nor were there documented interventions to guide staff on environmental safety or accessibility related to the resident's vision. During an interview on 01/08/2026 at 10:26 AM, Staff G, Resident Case Manager, stated they were aware of the vision deficits for Resident 42 and Resident 76. Staff G stated the facility's process was to have a vision care plan in place for these residents. Staff G further stated, I did not do either one of them. I just (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overlooked it. During an interview on 01/09/2026 at 9:37 AM, Staff B, Director of Nursing Services, stated they expected vision-specific care plans to be implemented for residents with visual impairments to ensure staff are provided with the necessary direction to provide care. Reference WAC 388-97-1020 (1), (2)(a)(b)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide necessary adaptive equipment for residents with highly impaired vision to maintain the highest practicable level of independence for 1 of 4 residents (Resident 42) reviewed for Activities of Daily Living (ADL's). This failure placed residents at risk for decreased nutritional intake, weight loss and a diminished quality of life. Findings included.Review of the medical record showed the resident admitted to the facility with diagnoses including chronic congestive heart failure (heart is not pumping blood as strongly as it should), dementia (a significant decline in thinking, memory, and reasoning skills that's bad enough to interfere with daily life) and visual disturbance. The 11/27/2025 comprehensive assessment showed Resident 42s cognition was moderately impaired and required assistance of one staff member for ADLs and set-up assistance for eating. Further review showed Resident 42's vision was severely impaired, and they were not receiving any specialized care with eating. During an interview on 01/06/2026 at 11:01 AM, Resident 42 stated they had a hard time eating and would like to have better forks and spoons to help them eat, it's hard to get my food onto theses ones. Resident 42 was referring to he plastic utensils they were currently using. During an observation on 01/07/2026 at 8:59 AM Resident 42 was observed using their hands to feel for their food, had plastic utensils, regular plate and no adaptive equipment. Resident 42 ate with their hands the entire meal. Food was observed on the resident's shirt and spilled from the plate onto the table. During an observation on 01/07/2026 at12:39 PM Resident 42 was served a lunch tray consisting of chopped ham, mashed potatoes, green beans and cake. Resident 42 was observed using a standard spoon to eat mashed potatoes. Food was observed falling off the spoon onto the resident's shirt. Resident 42 used their hands to scoop their food from the plate onto the spoon, food was spilling off the side of the plate. No adaptive equipment was utilized. During an interview on 01/08/2026 at 12:16 PM, Staff T, Registered Dietician, stated they had observed Resident 42 eating and was aware of their poor vision. Staff T stated the facility's process was for Occupational Therapy (OT) to assess residents to determine if they would benefit from adaptive equipment. Staff T stated they could not verify if OT had assessed Resident 42 because nursing was responsible for obtaining OT orders for adaptive equipment needs. Staff T confirmed Resident 42 did not have any active orders for adaptive equipment related to eating. During an interview on 01/08/2026 at 1:22 PM, Staff P, Director of Rehab, stated Resident 42 had not been evaluated by OT for their eating or for any adaptive equipment needs. Staff P stated they were aware of the need for Resident 42 to have an assessment. During an interview on 01/09/2026 at 9:37 AM, Staff B, Director of Nursing, stated they expected Resident 42 would have received a nursing evaluation and a referral to OT to address eating deficits related to his severely impaired vision. Reference WAC 388-97-1660 1(b)

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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 document post dialysis (a treatment to filter wastes and water from the blood) assessments for 1 of 2 resident (Resident 6 and 22) reviewed for dialysis. This failure placed the resident at risk for unmet care needs and a potential for medical complications. Findings included .Review of the facility's policy titled, Dialysis Policy revised March 2024, showed a licensed nurse to complete the pre- and post-dialysis assessments with each dialysis visit. Review of the medical record showed Resident 6 had been admitted to the facility on [DATE], with diagnosis to include kidney failure, heart disease, depression and dementia. The comprehensive assessment dated [DATE] showed Resident 6's cognition was intact, and dependent on two staff members for care and transfers. Review of Resident 6's physician orders showed the resident required dialysis every Tuesday, Thursday and Saturday. Further review showed staff were to follow dialysis flow sheet protocol for pre and post dialysis and to check pressure dressing post dialysis and remove after two to three hours. During an interview on 01/05/2026 at 3:27 PM, Resident 6 stated they were unaware of the communication between the dialysis when being sent or when coming back to the facility after the dialysis visit.ˆResident 6 stated the staff were not consistently checking on them when they returned from dialysis. Review of Resident 6's December 2025 Licensed Nurse administration record showed the resident did not have post dialysis vitals on 12/16/2025and 12/23/2025. Review of Resident 6's November 2025 Licensed Nurse administration record showed the resident did not have post dialysis vitals on 11/04/2025, 11/11/2025, and 11/22/2025. ˆDuring an interview on 01/06/2026 at 3:43 PM, Staff J, Nursing Assistant (NA), stated their process after dialysis was to get the resident in bed, get them a meal and a quick change. Staff J stated they do not always get the vitals, if the nurse is too busy then they will ask us to do the vitals. ˆ During an interview on 01/08/2026 at 8:45 AM, Staff K, Resident Care Manger, (RCM), stated a Dialysis communication form was sent with the resident with each visit and the dialysis center would fill it out when the resident session was done and send it back with the resident. The facility then checked for new orders on the form. Staff K stated the communication forms were not always completed by the dialysis center. The dialysis center would call if the resident had trouble with their treatment or if they had to send them to the local emergency to be evaluated. During the same interview Staff L, Registered Nurse, (RN), stated dialysis would send a monthly report, although the dialysis center had been inconsistent lately, nursing had been having to call them for the information. ˆ During an interview on 01/09/2026 at 9:42 AM, Staff K, RCM reviewed the licensed nurse administration record for Resident 6's post dialysis care with the missing documentation. Staff K stated their expectation of their staff were for them to follow the dialysis protocol for the residents' post dialysis care. Reference: WAC 388-97-1900 (1), (6)(a-c)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to develop and maintain a current hospice (a type of care that focuses on comfort and quality of life for people who were terminally ill or near the end of their life) care plan in collaboration with contracted hospice services, that identified what provider was responsible for performing specific services/functions for 1 of 2 sampled residents (Resident 24) reviewed for hospice services. This failure placed residents at risk for not receiving necessary care and services. Findings included . Review of the Hospice Contract, dated 01/05/2026, showed the facility and hospice provider must maintain a coordinated Care Plan that is responsive to the unique needs of the patient and their representative while remaining consistent with hospice philosophy. This unified care plan must identify specific hospice services, including interventions for pain management and symptom relief, and provide a detailed statement of the scope and frequency of these services along with measurable anticipated outcomes. Furthermore, the plan must delineate the specific provider responsible for performing each function, including the administration of drugs, treatments, medical supplies, and appliances necessary to meet the patient's needs. Review of the medical record showed the resident admitted to the facility with diagnoses including chronic congestive heart failure (heart is not pumping blood as strongly as it should) chronic kidney disease (your kidneys are not working well enough to filter waste and extra fluid from your blood). The 12/03/2025 comprehensive assessment showed Resident 24's cognition was moderately impaired and required assistance of one staff member for activities of daily living (ADLs). Further review showed Resident 24 was receiving hospice services. Review of Resident 24's electronic health record (EHR) on 01/06/2026 showed Resident 21 had no hospice care plan. During an interview on 01/08/2026 at 10:20 AM, Staff G, Resident Case Manager, stated they did not integrate the hospice care plan with theˆfacility'sˆcare plan when a resident was admitted to hospice services, ?I just use our care plan. Staff G further stated theyˆwere unsure of the process for integrating the hospice care plan with the facility'sˆcare plan. During an interview on 01/08/2025 at 11:41 AM, Collateral Contact 1 (CC1) associated with Hospice, stated the process for the hospice care plan was for it to be fully integrated with the facility's comprehensive care plan. To ensure continuity of care and professional standards, CC1 stated that all disciplines must maintain a unified approach, ensuring that patient-centered goals and clinical interventions are consistent across both providers. During an interview on 01/09/2026 at 9:25 AM, Staff B, Director of Nursing, stated that the expectation for nursing staff was that they must incorporate theˆhospiceˆcare plan into theˆfacility's comprehensiveˆcare plan. The integration ensures all interventions coincide and allˆcomponentsˆare clearly documented for continuity of care. Staff B stated this process was not followed for Resident 24. Reference WAC 388-97-1060(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 staff followed Enhanced Barrier Precautions (EBP, [a type of isolation used to prevent spread of infections]) for three of five residents (Resident 6, 31, and 76) reviewed for infection control. Ensure hand hygiene was performed and ensure proper use of Personal Protective Equipment (PPE) during daily resident cares and wound care treatment. These failures placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included .Resident 76 Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood flow to part of the brain is suddenly cut off, either by a blockage or a burst blood vessel, causing brain cells to die from lack of oxygen, leading to sudden impairment or loss of function like weakness, numbness, or trouble speaking). The 11/18/2025 comprehensive assessment showed Resident 76's cognition was moderately impaired and required assistance of one-two staff member for activities of daily living (ADLs). Wound Care During a concurrent observation and interview on 01/05/2026 at 10:28 AM, Staff U, Registered Nurse, was observed entering Resident 76's room to perform wound care without a gown or gloves. Staff U failed to place a barrier on the bedside table prior to placing wound supplies. Staff U , after leaving and re-entering the room, donned (put on) gloves without performing hand hygiene. Staff U removed the soiled dressing from the resident's left lower leg wound. After removing the contaminated dressing, Staff U continued to use the same gloves to clean the wound with saline, handle clean gauze, and apply Iodosorb (a gel that cleans and treats wet, infected wounds like ulcers) medication with a tongue depressor. Staff U further used the contaminated gloves to apply the new dressing, replace the resident's sock, and adjust the bed linens. When interviewed during the observation, Staff U stated the correct process was to remove the old dressing, perform hand hygiene, and don new gloves before cleaning the wound and placing a new dressing. Staff U stated they only use gloves for PPE; further stating I am not required to wear any other PPE; there is nothing on the wound orders. Enhanced Barrier Precautions During a concurrent observation and interview on 01/08/2026 at 3:17 PM, Staff V and Staff W, Nursing Assistants, entered Resident 76's room to assist the resident into bed. Both Staff V and Staff W applied the Hoyer sling and assisted Resident 76 to their bed, they wore only gloves and failed to don required gowns. Staff V stated, Yes, we would normally use EBP including a gown, but I just forgot; I have been here since 6:00 AM. Staff W stated, I just forgot as well. Both staff members stated they were aware of the requirement, stating the signage on the door indicates when gowns are necessary. Staff W continued to provide care without donning the proper PPE. While repositioning the resident, their clothing came into direct contact with the resident's surfaces, including the bed and the resident's own clothing. A review of the signage outside room [ROOM NUMBER] confirmed that Bed A and Bed B were on EBP's, requiring staff to wear gloves and gowns for high-contact care activities, including transferring and repositioning. Review of the facility's policy titled, Hand Hygiene Policy, dated 01/2026, showed to prevent the spread of infection by implementing appropriate precautions when a resident is identified with a (continued on next page)

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	01/09/2026

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

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communicable disease and requiring staff to use proper hand hygiene during resident cares. Enhanced Barrier Precautions Resident 31Review of the medical record showed Resident 31 admitted to the facility on [DATE] with diagnoses to include kidney disease, diabetes (a disease in which the body does not control glucose (a type of sugar) in the blood), weakness and their cognition was intact. During an observation and concurrent interview on 01/05/2026 at 11:40 AM, Staff Q, Registered Nurse, (RN), entered a room with an EBP sign and stated they would be doing a dressing change. Staff Q had placed gloves on and proceeded to remove Resident 31's sock, no other Personal Protective Equipment (PPE). Staff Q removed their gloves, sanitized their hands, and placed a barrier on the table for their wound supplies. Staff Q used a pillow from Resident 31's chair to elevate the resident's wound on the left heel. Staff Q changed their gloves and washed their hands, replaced gloves and then set a barrier underneath the resident's heel. Staff Q cleansed resident's heel with a gauze with normal saline (a sterile solution) and used a Q-Tip to remove any film from the left heel wound. Staff Q removed their soiled gloves, sanitized their hands and reapplied clean gloves. Staff Q applied Santyl (a medicated ointment) on the wound and placed a bordered gauze over the left heel. Staff Q stated they should have been wearing a gown during the wound care for Resident 31. Staff Q stated they had got nervous and forgot. Resident 6Review of the medical record showed Resident 6 had been admitted to the facility on [DATE], with diagnosis to include kidney failure, heart disease, and depression. The comprehensive assessment dated [DATE] showed Resident 6's cognition was intact, and dependent on two staff members for care and transfers. During an observation and interview on 01/05/2026 at 3:01 PM, Staff R, NA were in Resident 6's room (an EBP room) they repositioned the resident and cleaned up spilt water off the floor, Staff R was wearing gloves and had no other PPE. Staff R was unable to state what the EBP sign had directed them to do, after reviewing the EBP signage, Staff R stated they should have been wearing a gown in Resident 6's room while doing their care. During an interview on 01/09/2026 at 8:43 AM, Staff S, Infection Preventionist (IP) stated they were aware of the staff's failure to use proper PPE while delivering care to residents who were in EBP rooms. Staff S stated there is no exception, the staff need to follow the signs that are placed for the protection of everyone. Reference: WAC 388-97-1320 (1)(c), (2)(b)