STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505085	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Health Care	505 North 40th Avenue Yakima, WA 98908

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 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** Based on interview and record review, the facility failed to provide adequate supervision, immediately assess a resident after a fall, implement and evaluate care-plan interventions for efficacy, and ensure care-planned interventions were consistently followed to prevent an avoidable fall for 1 of 5 residents (Resident 54) reviewed for hospitalizations. Resident 54 who had moderately impaired cognition with a known history of falls prior to admission and was assessed at high risk for falls, experienced harm when they had an unwitnessed fall, were found face down on the floor with multiple lacerations, required transfer to the hospital for pain, and were diagnosed with multiple complex fractures (left humerus, hip, and left tibia) which required surgical intervention.Findings included .Review of the facility's policy titled Falls Clinical Protocol, dated 01/2022, showed the facility would identify and document residents' fall-risk factors and develop individualized, resident-centered fall-prevention plans that address underlying medical conditions that may increase risk of fall-related injury. Record review showed Resident 54 admitted to the facility on [DATE] with diagnoses to include traumatic subdural hemorrhage (a serious head injury involving bleeding between the brain and its outer covering following a blow to the head), dementia (a decline in mental ability severe enough to interfere with daily life), and a history of falls prior to admission. Review of the comprehensive assessment dated [DATE] showed Resident 54 had moderately impaired cognition and required assistance of one staff members for activities of daily living. Review of the 08/08/2025 admission fall-risk assessment showed Resident 54 was assessed at high risk for falls. Review of the comprehensive care plan dated 08/08/2025 showed no specific care plan had been initiated for falls and no interventions were in place to address the resident's high fall risk. Review of the facility's investigation dated 09/11/2025, showed at 4:20 AM Resident 54 was found face down on the floor in their room by Staff Q, Nursing Assistant, (NA). Staff R, Licensed Practical Nurse, (LPN), entered the room and assisted Staff Q in lifting the resident from the floor into a wheelchair using a gait belt (a sturdy strap put around someone's waist to help safely assist them with walking, standing up, or moving from surface to surface). The investigation documented that Resident 54 had lacerations on the left hand, left forearm, left elbow, left shoulder, and left temporal (side of head near temple). The resident verbalized significant pain, stating, It hurts so much. During an interview on 12/05/2025 at 9:11 AM, Staff R, LPN, stated that during their final rounds on the morning of 09/11/2025 at approximately 4:20 AM they passed by Resident 54's room and saw the resident lying face down on the floor with Staff Q, NA, present. Staff R stated they entered the room and helped lift the resident into a wheelchair. Staff R stated they asked the resident what happened, and the resident reported they were trying to go to the bathroom. Staff R stated the resident had multiple lacerations, which they cleaned and dressed before notifying the provider. Staff R reported they had passed by the resident's room approximately 30 minutes earlier and the resident had been sleeping in bed. Staff R stated they did not perform a complete physical assessment until after the resident was transferred into the wheelchair. Staff R stated the resident did not complain of pain while lying on the floor but verbally expressed they were having significant pain to their left arm when placed in the wheelchair. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Staff R stated there were not any fall risk interventions in place for Resident 54. During an interview on 12/05/2025 at 9:37 AM, Staff Q, NA, stated they found Resident 54 lying face down on the floor and it appeared the resident had been walking toward the bathroom. Staff Q stated Staff R entered the room and helped lift the resident into the wheelchair. Staff Q stated that after Staff R left the room, another NA assisted them in helping Resident 54 to the bathroom. Staff Q stated the resident had cuts all over and was moaning in pain continuously from the time they found them on the floor. Staff Q stated they did not have any fall interventions to follow on Resident 54. During an interview on 12/04/2025 at 2:08 PM, Staff H, Clinical Case Manager, stated their responsibility was to conduct the fall risk assessment upon admission and develop appropriate, individualized care plan interventions at that time. Staff H stated the care plan developed for Resident 54 should have been more specific, given the resident was identified as high-risk for falls with a documented history of falls prior to their admission. During an interview on 12/04/2025 at 3:45 PM, Staff B, Director of Nursing Services, stated they expected the Clinical Care Manager to initiate an individualized fall risk care plan with appropriate interventions for any resident identified as a high fall risk or who possesses a history of falls. Staff B stated Resident 54's current care plan was deficient, stating it was not correct and lacked the necessary required information and interventions. Reference: WAC 388-97-1060 (3)(g)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review the facility failed to provide residents and representatives, information on how to report concerns, incidents and grievances for 4 of 6 residents (35,19, 33and 18) reviewed for grievances. The facility failed to establish a grievance policy that included prominent postings throughout the facility, right to file a grievance by written means or anonymously, the right to review the complaint in writing, and a reasonable time frame for review resolution of the concern.ˆ This failure potentially affects residents' quality of care and unresolved concerns.ˆ Findings included . Review of the 08/2025 Resident Grievances policy showed residents have a right to file a grievance and encourage them to speak with the charge nurse, and if they did not feel comfortable with the charge nurse to speak with Social Services or the Administrator.ˆ If a grievance cannot be solved by Social Services, then a formal grievance investigation can be requested, and the Director of Nursing and Administrator will be notified. A grievance can be filed by the resident, family, and/or staff. Review of the 01/01/2023 Resident Personal Property & Missing item Policy showed the inventory and documentation of personal items was the responsibility of the Social Services department. The inventory process consisted of logging items was optional, but the facility strongly encouraged listing items of value (electronics, jewelry, cash, and sentimental items).ˆˆThe facility cannot be held responsible for lost or damaged items on the personal belongings list.ˆ During the Resident Council meeting on 12/02/2025, from 10:45 AM to 11:25 AM, the residents in attendance were, Resident 35 stated the facility did not respond to their missing money (twenty dollars) complaint of six months ago there was no follow up.ˆ Resident 35 stated when there was a concern, they reported it to social services, and social services filled out the grievance but no follow up was given to the resident. Resident 19 stated they had reported missing money (nine dollars) to social services, and they had not received information about the conclusion of the investigation, but social services gave them a lock on their drawer. Resident 33 stated they had missing blankets they had reported it to social services but no follow up. During the resident council discussion with Residents 35,19 and 33 they were unaware that there were grievance forms available, and they could file grievances anonymously or have other facility staff assist them in the grievance reporting process. The resident also stated only social services could assist them with a grievance and they had social services fill out the grievance forms. Additionally, residents were unaware of the grievance policy and the policy for lost money.ˆ The resident council members were unaware when they received any money from friends or family, they had to ensure it was noted on their inventory sheet or resident trust no matter what the amount. The residents did not know about the state hotline number or Ombudsman contact information.ˆ The meeting adjourned at 11:25 AM. During an interview on 12/03/2025 at 12:03 PM, Resident 18 stated if they had missing items and told staff and there was no follow up. Resident 18 stated they were unaware of how to file concern or grievance. During an interview on 12/02/2025 at 11:30 AM, Staff O, Activities Director stated they only took notes during resident council and shared them with social services and the administrator. Staff O stated they referred residents' complaints/grievances to social services.ˆˆAdditionally, the old business discussed in the resident council was not reviewed because social services or the administrator took care of those communications with departments.ˆ During an interview on 12/03/2025 at 12:03 PM, Resident 18 stated if they had missing items and told staff but had no follow up. Resident 18 stated they were unaware of how to file a concern or grievance. During an interview on 12/03/2025 12:13 PM, Staff N Social Services Assistant, stated if a grievance for lost clothing was reported they interviewed the resident and complete a report if it was in the laundry or looked where clothes could be kept and if found, we have solved the problem and there was no need for further investigation. Staff N stated if there was missing money, they looked for it but if it is not documented on the inventory sheet, the resident would not be reimbursed. Staff N stated most residents had dementia (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and could not remember what money they had or if a family member or a visitor gave them money. During an interview on 12/03/2025 at 12:30 PM, Staff M Social Services Director, (SSD) stated they attended the resident council meetings and instructed residents on the grievance process and there were forms located on the wall file in the [NAME] Wing of the facility.ˆ Additionally, Staff M stated if they looked for missing money and could not find it, they offered a lock box for the resident to secure their money. Staff M stated that if residents received any money and had not been logged on the inventory sheet the grievance would go to the administrator for the missing item or money to be reimbursed. During an interview on 12/04/2025 at 10:52 AM, Staff K Nursing Assistant, (NA) stated if a resident had a concern, they would place the concerns like lost money clothing etc. in the SSD grievance book at the nurse's station or tell the charge nurse. During an interview and concurrent observation on 12/04/2025 at 11:48 AM, Staff J, Registered Nurse, (RN), was unable to locate the grievance forms for the residents/staff they looked in a plastic wall file holder on the [NAME] Hall and East Hall, the state inspection binder was located along with other forms and other paperwork. Staff J found the grievance forms hidden and high up on the wall ion the [NAME] Hall in a folder, behind other paperwork and unlabeled.ˆˆThe residents and staff could not locate or reach the grievance form.ˆˆStaff N stated that they were unaware that the grievance forms, grievance policy, state hotline poster and Ombudsman information were unattainable to residents. Staff N stated that the residents did not fill out the grievance forms that the SSD filled the forms out for the residents There really is no way that the residents can do the forms without SSD. During an interview on12/03/2025 at 9:35 AM, Staff A, Administrator, stated while reviewing the resident personal property and missing items policy it did not make sense. Staff A stated they would have to do some reworking on the policy.ˆˆStaff A stated that if multiple residents who might not have had their cash documented on their inventory sheet were missing money and may have received it from their family would not be reimbursed for their loss if not documented on the inventory sheet. Staff A stated they might need to change the policy due to the way it read was not correct where the policy stated, the facility strongly encouraged listing items of value.ˆ ˆ Reference WAC 377-98-0460(1)(2)(3)(4)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure investigations were completed and/or thorough for 3 of 5 residents (Resident 40, 35 and 14) reviewed for investigations. This failure to initiate and complete thorough investigations placed residents at risk for unidentified accidents, abuse/neglect and serious injuries. Findings included . Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition), all incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated. A thorough investigation was a systematic collection of a review of evidence/information that describes and explains an event or a series of events to determine what occurred and make necessary changes to a resident's plan of care and services to prevent recurrence. The investigation should include the who, what, when, why and how, of the incident and establish a reasonable cause within 24 hours of the incident. Additionally, evidence of the investigation must be readily available to state licensing and certification staff and others according to their authority. Resident 40 Review of the medical record showed Resident 40 was admitted to the facility with diagnoses including osteomyelitis (infection in a bone), respiratory failure, gastrointestinal reflux disease (GERD-a condition when stomach acid flows back up into the esophagus causing a burning sensation in the chest), and a right side below the knee amputation. The 09/01/2025 comprehensive assessment showed Resident 40 was dependent on one to two staff members for activities of daily living (ADLs) and required supervision/touching assistance of one staff member for eating. The assessment also showed Resident 40 had mild cognitive impairment. Review of Resident 40's nursing progress notes, (PN), dated 11/15/2025, showed Resident 40 choked when they ate corn chips at dinner. Resident 40 was able to produce a hard cough and clear their throat. During an interview on 12/03/2025 at 12:07 PM, Staff C, Registered Nurse/Director of Rehab, (RN/DOR), stated Resident 40's choking episode was also not investigated because we did not perform a Heimlich maneuver (procedure for dislodging and obstruction from a person's throat by a sudden strong pressure applied on the upper abdomen). During an interview on 12/04/2025 at 2:24 PM, Staff A, Administrator, stated if the facility could identify how the incident happened, they did not need to investigate. In a follow-up interview on 12/05/2025 at 10:52 AM, Staff A stated they understood the process and these incidents should have been investigated. Resident 14 Review of the medical record showed Resident 14 was admitted to the facility with diagnoses including Alzheimer's (a progressive brain disorder that slowly destroys memory, thinking skills, and eventually the ability to carry out daily tasks) disease. The 07/14/2025 comprehensive assessment showed Resident 14 had severely impaired cognition and was dependent on one to two staff members for ADLs. The assessment further showed resident 14 required substantial to maximum assistance of one staff member for eating. ^ Review of Resident 14's nursing PN, dated 09/02/2025, showed Resident 14 was provided with a cup of cocoa, removed the lid, and spilled the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contents onto their left thigh. Assessment of the area noted a small, light red area of skin discoloration. Review of the September 2025 incident reporting log showed no documentation of an incident investigation or report completed for this specific event involving Resident 14.^ During an interview on 12/04/2025 at 2:08 PM. Staff C, RN, stated there was not an incident report completed for Resident 14.^ Resident 35 Review of Resident 35's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include heart disease, diabetes (a disease in which the body does not control glucose (a type of sugar) in the blood.) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest.). The comprehensive assessment dated [DATE] showed Resident 35's cognition was moderately impaired and required supervision/touching assistance of one staff member for ADLs. Review of Resident 35's PN dated 10/09/2025 showed Resident 35 and the Activities Director entered the Social Services office and reported that they were upset and bothered that a staff member had touched them without asking permission. During an interview on 12/04/2025 at 12:50 PM, Staff G, Clinical Care Manager (CCM), stated they recalled the incident on 10/09/2025 for Resident 35. Staff G stated they had not investigated the incident, that the Social Services department had worked on it. Staff G stated Resident 35 had not been placed on alert charting (a nursing tool to monitor a resident after an incident) for the incident. Staff G stated their process for things of this nature would be to investigate and place the resident on alert for any signs of psychosocial harm. During an interview on 12/04/2025 at 1:03 PM, Staff O, Activities Director, stated, they recalled Resident 35's incident on 10/09/2025. Staff O stated they had reported it to the Social Worker and to the floor nurse that day. Staff O stated Resident 35 came in upset, not crying or anything like that upset, but pissed off upset that someone had put their hand down their shirt to look for a bra without asking the resident while they were in the hallway. Staff O stated they were not asked to write a statement about the incident. During an interview on 12/04/2025 at 1:11 PM, Staff B, Director of Nursing, stated the incident on 10/09/2025 for Resident 35 should have been thoroughly investigated to rule out abuse and neglect. Reference: WAC 388-97-0640 (6)(C)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, sanitary, comfortable environment was maintained for 2 of 3 shower rooms (East Hall and North Hall), reviewed for environment. This failure placed the residents at risk of an unpleasant, uncomfortable living environment, and safety hazards. Findings included. Review of the maintenance logbook for November 2025, and December 2025, showed no entries for repair of the East Hall shower room. East Hall Shower Room An observation on 12/02/2025 at 7:31AM, showed the East Hall shower room with three feet (ft-unit of measure) by four ft divider wall with multiple loose, cracked, chipped, and black/brown stained tiles on the shower floor that connected to the base of the divider wall. On the corner of the divider wall was a 12 inch (in-unit of measure) by 10 in corner section of the divider wall without tile that exposed a black/brown substance and yellow and white flaky wall debris that crumbled when touched. On the top of the edge of divider wall was a two in tile that was cracked in half with sharp edges. During a concurrent observation and interview on 12/05/2025 at 8:33 AM, Staff D, Maintenance Director, stated staff were to report issues with the facility that needed repairs into the maintenance logbook. Further observation of the shower room showed a resident shower chair with wheels coated in dark reddish/brown thick debris. Staff D stated they were unaware of the identified concerns with the East Hall shower room. Staff D stated the broken, missing shower tiles should be repaired and/or replaced and the shower chair wheels needed to be replaced. During a concurrent observation and interview on 12/05/2025 at 11:47 AM, Staff A, Administrator, stated they were unaware of the condition of the East Hall shower room. Staff A stated the shower tiles were uncleanable and needed to be repaired. Staff A further stated the resident shower chair should not be in use and needed to be disposed of. North Hall Shower Roomˆ Review of the maintenance logbook for November 2025 and December 2025, showed no entry for the North Hall shower room. An observation on 12/02/2025 at 11:10 AM, showed the North Hall shower room floor with pink and dark brown substance in the tile grout (a paste for filling crevices, especially the gaps between wall and floor tiles), pink and yellow soap scum on the tile floor. The shower drain had a broken drain guard, exposing an opened drain.ˆˆ During an observation and concurrent interview on 12/03/2025 at 8:36 AM, Staff T, Nursing Assistant, (NA), stated that the facility did not have a shower team, and the NAs were assigned a shower for their shift. Staff T stated they used a sanitizing spray to clean after a shower. Staff T stated they were unsure of who was responsible for the deep cleaning of the shower. Observation of the shower room showed a pink/yellow residue on the tile floor andˆdark brown substance on the tile grout.ˆ (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 12/05/2025 at 7:44 AM, Staff D, showed the North Hall shower room tile floor, had pink and dark brown substance in the tile gout, the broken drain guard exposing the open drain. Staff D stated they were not aware of the issues, and their goal was to get the facility into shape. Staff D stated staff used a maintenance log located at the South Hall nurses' station to communicate any facility issues that needed their attention and reviewed the log daily.^^ Reference WAC: 388-97-3220(1)

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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 and protect the rights of each resident, including being treated with dignity and respect, for 2 of 2 dining experiences (breakfast meal on 12/02/2025 and lunch meal on 12/05/2025), and 2 of 5 residents (Residents 35 and 51) reviewed for dignity. This failure had the potential to result in emotional distress for failed to treat residents in a dignified manner and honor their rights. Findings included . Review of the facility policy dated 12/01/2024, titled, Person Centered Care Philosophy/Resident Rights, showed the facility will ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. Federal and state laws guarantee certain basic rights to all residents of the facility and include the right to a dignified existence, be free from abuse, participate in care planning and treatment, and be supported by the facility to exercise their rights. Resident 35 Review of Resident 35's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include heart disease, diabetes (a disease in which the body does not control glucose [a type of sugar] in the blood.) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed Resident 35's cognition was moderately impaired and required assistance of one staff member with activities of daily living (ADLs). During an interview on 12/02/2025 at 11:20 AM, Resident 35 stated while they were sitting in the hallway, a staff member had placed their hand down into their shirt to feel if the resident was wearing a bra. Resident 35 stated the staff member did not ask if they could put their hand down their shirt. Resident 35 stated they do not have the right to put their hand down my shirt or pants to check to see if I'm wearing a bra or undies. Resident 35 stated it's embarrassing and that they were so upset they had gone to administration staff about it. During an interview on 12/04/2025 at 10:43 AM, Staff M, Social Services Director, (SSD), stated they recalled the 10/09/2025 incident for Resident 35. Staff M stated the resident came into their office with Staff O, Activities Director, upset and stated that a staff member had touched them to check to see if they were wearing a bra without, while sitting in the hallway, and without asking them. Staff M stated Resident 35 could not remember which staff member it was, just that it had happened in the morning. Staff M stated they had placed the incident on the grievance log and reported it to the Director of Nursing (DON) and the Administrator. During an interview on 12/04/2025 at 1:11 PM, Staff B, DON, stated, they recalled Resident 35's 10/09/2025 incident. Staff B stated they believed the Staff M went around and asked questions about the incident and spoke to Resident 35. Staff B stated that was all they knew about the incident. Staff B acknowledged that Resident 35's rights were not honored when they experienced unwanted touch in the hallway by a staff member. Dining Room (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/02/2025 at 7:41 AM, breakfast in the south dining room showed 14 residents sitting with their breakfast meals on a pale-yellow tray while they were eating. During an interview on 12/02/2025 at 7:52 AM Staff E, Nursing Assistant (NA), stated they passed out the trays and assisted residents during meals. Staff E began to assist a resident with their meal still sitting on a pale-yellow tray. During an observation and concurrent interview on 12/03/2025 at 1:33 PM, Resident 35 in the south dining room with their empty plate on a pale-yellow tray. Resident 35 stated their meal on the tray while eating was uncomfortable, making it very easy to spill/drop their food and drinks. Resident 35 stated they would prefer their plate on a table. During an observation on 12/05/2025 at 11:35 AM, lunch in the south dining room showed all residents had their lunch meals on a pale-yellow tray while eating. During an interview on 12/05/2025 at 11:40 AM, Staff F, Dietary Manager, stated resident meals should not be left on the serving trays during their mealtime. Staff F stated, when we serve in the dining area, we take the meal off the trays to keep it like their home. During an interview on 12/05/2025 at 11:52 AM, Staff E, NA, stated they should not leave a resident's meal on the serving tray. Staff E stated they had started removing serving trays from the resident meals. ^ During an interview on 12/05/2025 at 12:02 PM Staff C, Registered Nurse, stated they had completed dining room training years ago, and that serving trays should be removed from the meal when a resident is served. Staff C stated they were not sure when that practice had stopped. Staff C stated, this is the residents' home, and we should not be serving their meals on a serving tray. Resident 51^ ^ Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses of heart disease, kidney disease and arthritis.^ Review of the resident comprehensive assessment dated [DATE], showed the resident was hard of hearing but understood what was said and could make their needs known. Resident 51 was alert and oriented and required staff assistance for transfers, dressing and ambulating with their walker.^ During an interview on 12/02/2025 at 11:36 AM, the resident was eating their lunch meal in their room. Resident 51 stated that staff did not treat them with dignity by not asking them if they wanted to get up and dressed for the day.^The resident stated the staff just started moving them without explanation or permission into bed.^ During an interview on 12/03/2025 at 11: 40 AM, Resident 51's Power of Attorney (POA), stated that the resident was sad about the treatment and dignity of some of the ways staff treat them.^ The POA stated they did not want to cause problems for Resident 51. The POA stated they had spoken to the nursing staff but had no follow up.^ (continued on next page)

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	505085	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent Health Care	505 North 40th Avenue Yakima, WA 98908

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	^ Reference WAC 388-97-0180 (1-4)^

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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 residents were free of unnecessary psychotropic medications (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) when they did not monitor resident specific behaviors or consistently attempt non-pharmacological interventions (alternative treatment of a resident's symptoms that do not involve medications and directed toward understanding, preventing and relieving a resident's distress or loss of abilities) prior to psychotropic medication use for 1 of 5 residents (Resident 54) reviewed for unnecessary psychotropic medications. This failure placed residents at an increased risk for falls, experiencing medication-related adverse side effects, and unmet care needsFindings included .Review of the policy titled, Antipsychotic (a type of drug that balances chemicals in the brain to manage symptoms of psychosis [when someone loses touch with reality]) Medication use, dated 01/2021, showed antipsychotic medications were to be used only when necessary to treat a specific, documented condition and not for behavioral symptoms resulting from mild symptoms like wandering or restlessness or impaired memory. The nursing staff and physician will monitor and document in detail the individualized targeted symptoms. The nursing staff will observe, document, and report what interventions were attempted and the outcome. Record review showed Resident 54 admitted to the facility on [DATE] with diagnoses to include dementia (a decline in mental ability severe enough to interfere with daily life) without behavioral disturbance and a traumatic subdural hemorrhage (a serious head injury involving bleeding between the brain and its outer covering following a blow to the head). Review of the comprehensive assessment dated [DATE] showed Resident 54 had moderately impaired cognition and required assistance of one staff member for activities of daily living (ADLs). Further review of the assessment showed Resident 54 had no wandering or refusal of care behaviors exhibited during the assessment period. Review of Resident 54's nursing progress note dated 08/10/2025, showed Resident 54 was self-transferring and walked without the use of their front wheeled walker. Resident 54 preferred to walk the halls independently. Review of Resident 54's nursing progress notes dated 08/13/2025, 08/14/2025, and 08/15/2025, showed Resident 54 had been exit seeking but staff were able to easily redirect them. Review of Resident 54's nursing progress notes dated 08/17/2025, 08/18/2025, 08/19/2025, 08/20/2025, 08/21/2025, and 08/22/2025 showed no behaviors were documented for Resident 54 during this period. Review of Resident 54's physician orders dated 08/08/2025 showed no orders were initiated to monitor for behaviors until 08/19/2025 (three days prior to an anti-psychotic medication being started) the medical record showed no non-pharmacological interventions had been implemented or documented for Resident 54 prior to the anti-psychotic medication being ordered. Review of the physician's progress note dated 08/20/2025, showed an order was written for Seroquel (a type of anti-psychotic medication) 12.5 milligrams (mg- a unit of measure) at bedtime for a chief compliant of worsening behaviors. Review of the August 2025 Medication Administration Record (MAR) showed Seroquel 12.5 mg was started on 08/22/2025 and to be given at bedtime for diagnosis of cognitive decline and sundown (a pattern of increased confusion, anxiety, and agitation that occurs in people with dementia during the late afternoon and evening) with dementia. Review of Resident 54's progress notes from 08/22/2025 to 08/28/2025 showed no documented behaviors. Further review showed a progress note dated 08/29/2025 that Resident 54 exited the front door and was immediately redirected by a visitor and was brought inside. Review of Resident 54's progress notes from 8/30/2025 to 09/03/2025 showed one episode of exit seeking and wandering in the hallway and no other behaviors were noted. Review of the physician's visit progress note dated 09/03/2025, showed an order was written to increase Seroquel from 12.5mg to 25mg at bedtime and start Zoloft (a type of anti-depressant medication) 25 mg daily for seven days and 50 mg daily thereafter. The (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses used were unspecified dementia sundown with hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not actually there), delusions (a false belief that someone holds true, even when presented with clear proof that it isn't), and exit seeking, even though there were no documented behaviors or progress notes to show the resident had these behaviors. Review of an incident report dated 09/11/2025 showed Resident 54 had a fall that resulted in multiple fractures (eight days after the increase of the anti-psychotic and the start of the anti-depressant medication). Review of [NAME] (2025), clinical guidelines, classify both antipsychotics and antidepressants as Fall-Risk- Increasing drugs, injuries being highest in the initial weeks after starting the medications. During an interview on 12/03/2025 at 11:30 AM, Collateral Contact 2 (CC2), stated the expectation was for clear, specific charting of resident behaviors in the medical record and non-pharmacological interventions were attempted first especially before medication initiation or dosage increases. The CC2 stated the rationale for any medication change should have been thoroughly documented and they assumed the behavior monitoring was in place based on verbal reports from nursing staff. The CC2 stated they relied on the nurses for that documentation. During an interview on 12/04/2025 at 11:09 AM, Collateral Contact 3 (CC3), associated with the Pharmacy, stated behaviors should be monitored for a minimum of 30 days prior to initiating psychotropic medications. The CC3 stated if behaviors were infrequent or showed no clear pattern, the facility should have continued monitoring. The CC3 stated the interdisciplinary team should have first ruled out underlying, non-dementia related causes for behaviors before starting a psychotropic medication. During an interview on 12/05/2025 at 10:19 AM, Staff I, Licensed Practical Nurse, stated they were aware Resident 54 had exhibited increased behaviors and updated the CC2 during rounds. Staff I reviewed Resident 54's medical record and stated they clearly did not have enough documentation to support the addition of the psychotropic medications. During an interview on 12/05/2025 at 3:45 PM, Staff B, Director of Nursing Services, stated residents prescribed psychotropic medications were expected to have resident specific behavioral monitoring and resident specific non-pharmacological interventions in place. Staff B stated Resident 54's medical record lacked sufficient documentation of behaviors, monitoring, and necessary interventions to justify adding psychotropic medication. Reference: (WAC) 388-97-1060 (3)(k)(i)(4)

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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** Based on observation, interview, and record review, the facility failed to ensure allegations of abuse/neglect involving unwitnessed events with substantial injuries were reported to the State Agency (SA), as required for 1 of 4 residents (Residents 35), reviewed for accidents. The failure to report to the SA resulted in the facility's inability to recognize patterns of potential abuse and/or neglect. Findings included . Review of the Nursing Home Guidelines The Purple Book dated October 2015, sixth edition showed, Immediate reporting is required when there is reasonable cause to believe abuse, neglect, abandonment, mistreatment, personal and/or financial exploitation, or misappropriation of resident property has occurred. Substantial injuries of unknown source must be reported within 24 hours if, through the process of a thorough investigation, the injury is not considered reasonably related to a disease process or known sequence of events. Resident 35 Review of Resident 35's medical record showed the resident was admitted to the facility with diagnoses to include heart disease, diabetes (a disease in which the body does not control glucose (a type of sugar) in the blood) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The comprehensive assessment dated [DATE] showed Resident 35's cognition was moderately impaired and required supervision/touching assistance of one staff member for activities of daily living (ADLs). During an interview on 12/02/2025 at 11:20 AM, Resident 35 stated a staff member had placed their hand down their shirt while in the hallway to check for a bra. Resident 35 stated the staff member did not ask for permission Resident 35 stated they do not have the right to put their hand down my shirt or pants to check to see if I'm wearing a bra or undies. Resident 35 stated it's embarrassing and they were so upset they reported it to administration staff. Review of Resident 35's progress notes dated 10/09/2025 showed Resident 35 and Staff O, Activities Director, entered the Social Services office and reported that the resident was upset that a staff member had touched them without asking permission. During an interview on 12/04/2025at1:03 PM,Staff O,stated they had reported the incident the Social Worker and to the floor nurse the same day. Staff O stated Resident 35 came into the activity office visibly upset that someone had put their hand down their shirt to look for a bra without asking. Staff O stated they were not asked to write a statement. During an interview on 12/04/2025 at 1:11 PM, Staff B, Director of Nursing, stated they recalled the incident on 10/09/2025 that involved Resident 35. Staff B stated the incident should have been investigated and reported to the SA. Reference: WAC 388-97-0640 (6)(c)

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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. Based on interview and record review, the facility failed to ensure that resident's received appropriate care and services for dialysis (a medical therapy that removes waste products, excess fluids, and toxins from the bloodstream) that were consistent with professional standards of practice for 1 of 1 resident (Resident 7) reviewed for dialysis. The facility did not provide ongoing monitoring or assessment of Resident 7's condition, including obtaining vital signs upon return to the facility after dialysis. The facility also failed to establish an effective, coordinated process for communication with the offsite dialysis center to promote continuity of care. In addition, the facility did not develop or implement an individualized care plan addressing the resident's dialysis needs, associated risks, and required post-dialysis monitoring. This failure placed the resident's at risk for unrecognized complications and adverse outcomes following dialysis. Findings included. Review of the medical record showed the resident was admitted to the facility with diagnoses including end-stage renal disease (a condition in which the kidneys are no longer able to remove waste from the blood) requiring hemodialysis (a process in which a machine artificially filters waste from the blood when the kidneys no longer work) and diabetes (a condition that happens when your blood sugar is to high). The 11/13/2025 comprehensive assessment showed Resident 7's cognition was intact and required the assistance of one-two staff members for Activities of Daily Living (ADL)s. Further review showed Resident 7 was receiving dialysis care. Record review of Resident 7's December 2025 physician's orders showed there were no dialysis orders in place. Review of the resident's progress notes from 06/01/2025 to 12/05/2025 showed no follow-up assessmentsˆto monitor for complications after the resident returned from dialysis. Record review of the resident's vital sign documentation showed no recorded post-dialysis vital signsˆbetween 11/01/2025 and 12/01/2025. Review of Resident 7's care plan showed no dialysis information or interventions. During an interview on 12/04/2025 at 8:58 AM, Staff G, Clinical Case Manager (CCC), stated Resident 7's dialysis days were Monday/Wednesday/Friday and licensed staff were to check the resident's blood sugar, administer insulin as ordered, and provide a meal upon their return. Staff G stated that post-dialysis vital signs shouldˆbe obtained when the resident returns; however, the facility's current practice only required checking blood sugars. Staff G reported that they assumed vital signs were taken at the dialysis center and therefore did not routinely complete post-dialysis assessments upon the resident's return. Staff G reported they did not have a standardized communication form or routine communication method with the dialysis center, communication generally only occurred when there was a specific concern. Staff G further stated Resident 7 did not have a dialysis-specific care plan and should have had one in place that included monitoring for the presence of thrill and bruit, site care instructions, pre- and post-dialysis observations, and scheduling details. Staff G stated they did not have a defined process for dialysis residents and that improvements were needed. During an interview on 12/04/2025 at 10:30 AM, Collateral Contact 1 (CC1) associated with the Dialysis center, stated the communication expectations and clinical processes for nursing home residents receiving dialysis treatments were the nursing facility was responsible for initiating and sending all necessary communication forms to the dialysis center for completion. CC1 stated they did not recall Resident 7 ever arriving with a communication form from the facility and that the center typically received limited or inadequate information from the nursing home, aside from the weekly update sheet that the dialysis center itself provides. CC1 stated the nursing facility was expected to conduct post-treatment monitoring, explaining that residents returning from dialysis must be assessed for blood pressure drops, cramping, nausea, vomiting, or other signs of hypotension (low blood pressure). CC1 added that post-treatment vital signs should be obtained upon the resident's return to ensure stability. CC1 further stated dialysis access-site monitoring was required after treatment, including checking for breakthrough bleeding, ensuring pressure dressings were replaced with gauze and tape if needed, evaluating for signs of infection such as redness or swelling, and assessing for the presence of a (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bruit (the whooshing, blowing, or humming sound heard with a stethoscope over the dialysis access site). A concurrent observation and interview on 12/04/2025 at 11:16 AM, Resident 7 was in their room sitting up in their wheelchair. Resident 7 stated they went to the dialysis center on Monday/Wednesday/ Friday. Resident 7 stated they returned most evenings by 5:30 PM and did not recall staff obtaining their vital signs upon return from dialysis treatment. During an interview on 12/04/2025 at 11:20 AM, Staff B, Director of Nursing, stated they did not have a communication method that the facility was using to communicate with the dialysis center. Staff B stated they would expect physician's orders be in place and a dialysis specific care plan to reflect dialysis care and all relevant information. Staff B stated they were aware this was not being followed for Resident 7. During an interview on 12/04/2025 at 3:45 PM, Staff A, Administrator, stated they would expect any resident receiving dialysis services to be monitored pre- and post-treatment and to have a dialysis specific care plan in place. Staff A stated the correct process was not followed for Resident 7. Reference: WAC 388-97-1900 (1), (6)(a-c)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that accommodated food preferences for 2 of 4 sample residents (Resident 9 and 51), reviewed for preferences. This failure placed the resident at risk for decreased dietary intake and decreased quality of life. Findings included . Resident 9ˆ Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include Lewy bodies dementia (a brain disorder that causes problems with thinking, movement and behaviors due to a buildup of protein clumps [Lewy bodies] in the brain that leads to memory loss and confusion) and heart disease.ˆ Review of the 10/07/2025 comprehensive assessment showed the resident was able to make their needs known and required assistance with using utensils to bring food to their mouth and to monitor swallowing once a meal was served.ˆ During an observation and concurrent interview on 12/02/2025 at 12:00 PM, Resident 9 was served chicken nuggets and French fries.ˆ The resident's food card showed the resident was on a Mechanical Soft diet (a diet of foods that are easy to chew or swallow and often modified mashing or finely chopped), due to dysphagia (difficulty swallowing). The resident stated the chicken nuggets were too hard to chew and could not eat them. Resident 9 was not offered another meal selection. Review of the 10/03/2025 care plan showed the resident required setup assistance for their meals. The resident was able to feed themself. During an interview on12/03/2025 at 9:20 AM, Staff F, Dietary Manager, stated that Resident 9 was on a mechanical soft diet. ˆ Staff F was unaware the resident required a dysphagia diet.ˆ Staff F stated the resident should have been served softer mechanical soft food.ˆ Review of Resident 9's 12/02/2025 ?Crescent Health Care Diet Type Report' showed the resident was on a regular mechanical soft diet with thin liquid, Easy to chew dysphasia regular diet. Add extra butter/sauce/gravy to meals. Give super cereal (fortified with increased calories and protein) the morning for breakfast. Give a high calorie supplement three times a day. ˆResident 51ˆ Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses of heart disease, kidney disease and arthritis.ˆˆReview of the resident comprehensive assessment dated [DATE] showed the resident was hard of hearing but could understand others and made their needs known.ˆˆResident 51 was alert, oriented and required setup assistance for meals.ˆ During an observation and concurrent interview on 12/02/2025 at 11:50 AM, Resident 51 was served a lunch tray in their room which consisted of breaded chicken nuggets and French fries. The resident could not eat the chicken nuggets and stated they could not bite into them because they were tough. The residents' Power of Attorney (POA) stated they had talked to the Administrator and nursing assistants about the resident's diet stated the resident did not like chicken or pork.ˆ Review of the resident's diet card showed the resident was on a mechanical soft textured diet. There was no documented dislike of pork or chicken on Resident 51's diet card.ˆ Review of the 12/02/2025 'Crescent Health Care Diet Type Report' showed Resident 51 was on a no added salt, low fat diet with chopped meat and thin fluids.ˆ Additional directions showed no chicken or pork, no fortified juices. extra gravy/sauces soft no raw vegetables, nothing crunchy. ˆ During an interview on 12/03/2025 at 9:15 AM, Staff F stated Resident 51 who was on a mechanical soft diet did not like pork chops which was the second entre' choice on 12/02/2025 so they served them chicken nuggets instead.ˆ The resident's diet was mechanical soft with chopped meats. ˆ Reference WAC 388-97-1100(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure foods were stored in a clean, dry and sanitary manner and in accordance with professional standards of cleanliness and food safety for 1 of 1 kitchen, 1 of 1 ice machine, and 1 of 1 dry storage room reviewed for food safety. This failure placed residents at risk for ingestion of contaminated food or beverages, cross contamination, and a potential food borne illness. Findings included .Review of the Washington State Retail Food Code dated, March 01, 2022, showed Food must be protected from contamination by storing food: In a clean, dry location, where it is not exposed to splash, dust, or other contamination. At least six inches (a unit of measure) above the floor. Food in packages and working containers may be stored less than six inches above the floor on case lot handling equipment. Kitchen During an observation and concurrent interview on 12/02/2025 at 6:21 AM, initial kitchen tour showed the kitchen ceiling had black dirt buildup on the pipes and ventilation fan. Further observation of the top of the stove hood identified a vent pipe that had gray, fuzzy dust and dirt buildup. During an observation and concurrent interview on 12/03/2025 at 9:36 AM, Staff Dietary Manager, stated maintenance scheduled the cleaning of the kitchen ventilation fan and pipes. Ice machine During multiple observations on 12/02/2025 at 7:14 AM, 12/03/2025 at 8:08 AM, and 12/04/2025 at 7:45 AM, showed the ice machine located in the east hallway had a white residue on the inside of top lid and a pink slimy residue on the back and side of the walls. The ice machine contained ice, and a scoop was stored in a lidded plastic container mounted on the wall next to the ice machine. Additionally, on 12/03/2024 this surveyor placed a glove and wiped across the pink residue. The residue was slimy in texture and came off onto the glove. During an observation and concurrent interview on 12/04/2025 at 1:36 PM, Staff F, Dietary Manager stated there was only one ice machine in the facility located in the east hallway and that it was used for the residents. Staff F stated that maintenance was responsible for cleaning and maintaining the ice machine. During an observation and concurrent interview on 12/05/2025 at 7:44 AM, Staff D, Maintenance Director, showed the ice machine in the east hallway with the white and pink residue. Staff D stated they were new to the facility and were aware of the cleaning of the kitchen ceiling pipes but were unsure if they were responsible for the ice machine. Staff D stated they had a maintenance to do list in their office. Staff D reviewed the maintenance to do list that showed the ice machine was the responsibility of the maintenance department. Staff D stated they also had a note pad at the nurses' station that they checked daily. Staff D stated the staff would write down things that needed to be fixed, this way they could keep up with the daily maintenance needed for residents. Dry Storage During an observation on 12/02/2025 at 6:00 AM showed the office of Staff C, Director of Rehab, had four large boxes that contained boxes of muffin mix and seven large boxes that contained bags of decaffeinated coffee, the boxes were all sitting on the carpeted floor. ^ During an observation on 12/03/2025 at 9:59 AM, dry goods and food items were stored in Staff C's office. Observation of boxes of hashbrowns, boxes of muffin mix, and boxes of coffee sitting on the carpeted floor. During an interview on 12/04/2025 at 3:40 PM, Staff F, Dietary Manager, stated they had been storing some of the kitchen dry goods in the staffing office because they did not have enough space in their office located in the kitchen. Staff F stated they were aware of keeping the dry goods off the floor, related to the possibility of the boxes getting wet when staff were mopping in the kitchen. Staff F stated they did not think about having the boxes on a carpeted floor and the possibility of cross-contamination. Reference: WAC 388-97-1100 (3)