STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505086	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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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. Based on observation, interview and record review, the facility failed to ensure care and services were provided in a respectful and dignified manner for1of 3 residents (Resident 25) reviewed for dignity. This failure placed residents at risk for being treated with a lack of dignity, respect and embarrassment. Findings included . Review of the 06/2023 Activities of Daily Living (ADLs) policy showed residents will be provided with care, treatment, and services to ensure their ADLs are maintained and do not diminish. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently in accordance with the care plan including appropriate support with assistance with elimination (toileting). <Resident 25> Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood stops flowing to part of your brain) and right shoulder joint replacement. The 04/10/2025 comprehensive assessment showed Resident 2's cognition was intact and required staff assistance of one person for ADL's including toileting. During an interview on 06/09/2025 at 2:02 PM, Resident 25 stated before they came to the facility, they used the bathroom and were continent of their bowel and bladder. Resident 25 stated they had to wait such a long time for help to use the restroom, they became incontinent in their adult brief even though they were continent and it made them feel embarrassed. Record review of a document titled Admissions Bowel and Bladder Screening, dated 05/27/2025, showed Resident 25 was continent of bowel. Review of Resident 25's care plan, dated 05/27/2025, showed that the resident was continent of bowel and to toilet on awakening and as needed. Review of the June 2025 Nursing Assistant Task report showed Resident 25 was incontinent of their bowels on 06/05/2025 and 06/07/2025. During an interview on 06/13/2025 at 10:17 AM, Staff B, Director of Nursing Services, stated it was their expectation that staff followed the residents' care plan. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consents regarding the potential risks associated with the use of psychotropic medications (medications that alter thought processes) for 2 of 5 residents (Residents 33 and 64) reviewed for unnecessary medication. This failure placed the residents and/or the legal representatives at risk of not being fully informed about the medications prior to administration. Findings included . <Resident 33> Review of the electronic medical record showed Resident 33 was admitted to the facility on [DATE] with diagnoses including depression (a mental health condition where a person experiences persistent sadness, loss of interest in activities, and difficulty functioning in daily life), anxiety (a feeling of worry, nervousness, or unease, typically about an event or something with an uncertain outcome) and insomnia (when you have trouble falling asleep, stating asleep, or both, even when you have the chance to get enough rest). The comprehensive assessment dated [DATE] showed Resident 33 required moderate assistance of one to two caregivers for activities of daily living (ADLs) and was cognitively intact. Review of Resident 33's 05/13/2025 physician orders showed they were admitted to the facility on the antipsychotic medication Seroquel. Review of Resident 33's medical record showed there were no records of the resident or of their representative being informed of being placed on the medication or of a consent signed for its use. <Resident 64> Review of the electronic medical record showed Resident 64 was admitted to the facility on [DATE] with a diagnosis of chronic Post Traumatic Stress Disorder (PTSD) (an anxiety disorder that develops in some people who have experienced a shocking, scary, or dangerous event), bipolar disorder (a disorder causing extreme shifts between high and low moods), and depression. The comprehensive assessment dated [DATE] showed Resident 64 required limited assistance of one caregiver for ADLs and was cognitively intact. Review of Resident 64's physician orders showed they were admitted to the facility on two antidepressant medications, sertraline and duloxetine. Review of Resident 64's medical record showed there were no records of the resident or of their representative being informed of being placed on the medications or of consents signed for their use. During an interview on 06/11/2025 at 2:02 PM with Staff B, Director of Nursing Services (DNS), they stated the admission nurses were responsible for getting the consents signed on admission or the floor nurses if a new order came in. The DNS stated she did not know why the consents were not signed for Residents 33 and 64 ' s psychotropic medications when they were admitted to the facility, stating it must have been missed by the admitting nurses. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference (WAC) 388-97-0260(2)(d)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to report allegations of potential abuse and/or neglect in a timely manner, for 3 of 5 sample residents (Residents 19, 21, and 29), reviewed for incidents of significant falls with injury. Failure to report an allegation of significant injuries due to unwitnessed falls to the State Survey Agency, as required. This deficient practice placed residents at risk of harm related to potential unrecognized abuse/neglect and disallowed the ability to recognize patterns of repeated incidents and injuries. Findings included . Review of the Washington State Department of Social and Health Services (DSHS) Nursing Home Guidelines 'The Purple Book', dated October 2015, showed Appendix D, titled Reporting Guidelines for Nursing Homes, listing substantial injuries of unknown sources and resident-to-resident altercations with physical abuse, as incidents that required reporting to the DSHS Hotline. An annotation to Appendix D showed that .repeated injuries, even when related to condition, may become abuse or neglect if preventative measures are not taken . Further review of The Purple Book, Appendix K, titled Definitions, defined: Injuries of Unknown Source-any injury sustained by a resident where the source of the injury was not observed directly by a staff person and may be either superficial or substantial in nature. Substantial Injuries-require more than first aid, may require close assessment and monitoring by nursing or medical staff, and include any injury (superficial or substantial) occurring in areas not generally vulnerable to trauma. All injuries occurring in non-vulnerable areas of the body will be considered substantial injuries. Areas Not Generally Vulnerable to Trauma-back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital or anal areas. Review of the facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property dated 09/21/2022, showed if the allegation involves injury of unknown source will be promptly reported to the local, state, and federal agencies and thoroughly investigated by facility management. <Resident 19> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including Dementia (decline in mental ability), osteoporosis (brittle bones which increase bone fracture risk), and repeated falls. The 04/16/2025 quarterly nursing assessment showed Resident 19 was cognitively impaired with ability to respond yes or no to questions and required substantial assistance of one person to stand and transfer to and from their wheelchair. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 05/19/2025 Fall incident report showed Resident 19 had an unwitnessed fall in their room and was found on their right side on the floor at 8:40 PM. Resident 19's left eye was swollen shut and they were bleeding from the back of their head. Resident 19 was transported to the emergency room (ER), and it was determined the resident sustained a laceration (a jagged cut caused by trauma to her upper forehead and sutures were applied. Review of the Incident Report log for 05/19/2025 showed Resident 19 had an unwitnessed fall with substantial injuries to areas for the face and head not generally vulnerable to trauma. The incident was not reported to the state agency. <Resident 21> Review of the medical record showed the resident admitted to the facility 04/05/2025 with diagnoses including end stage renal disease (when your kidneys have permanently stopped working), muscle weakness and repeated falls with fractures. The 05/16/2025 comprehensive assessment showed Resident 21's cognition was moderately impaired and required assistance of one to two staff members for ADLs. Review of the 05/04/2025 incident report showed Resident 21 had an unwitnessed fall, was found on the floor lying on their left side at the end of their bed, required transfer to the hospital, and was diagnosed with a fracture of the L1 vertebra (the first top bone in the lower back) and required a back brace that supports and stabilizes the spine. Review of the Incident Report log for 05/04/2025 showed Resident 21 had an unwitnessed fall with injury. The incident was not reported to the state agency. During an interview on 06/12/2025 at 11:20 AM, Staff B, Director of Nursing Services (DNS), stated the process for unwitnessed falls with injuries was to call the state hotline. Staff B stated they recognized they have issues with investigations, and the process was not followed for Resident 21. <Resident 29> Review of the medical record showed Resident 29 was admitted to the facility on [DATE] diagnosis to include polyneuropathy (a disease affecting the peripheral nerves in the body, causing weakness, numbness and burning pain), and repeated falls. Review of the comprehensive care plan dated 04/08/2025 showed Resident 29's cognition was intact. Review of Resident 29's plan of care dated 06/07/2025 showed the resident required contact guard assist (one staff to assist) with transfers and toileting. The resident ' s care plan further showed to ensure Resident 29 had proper footwear in place due to the potential of self-transferring. Review of a facility investigation report, dated 04/23/2025 at 6:10 AM, showed Resident 29 had an unwitnessed fall where they were found on their stomach in their restroom by a nurse coming onto shift the morning of the incident. An additional review showed that the resident had reported to the nurse that they had to use their toes to pull the call light for help. Resident 29 had bruising to their left ankle and left toes. Review of an x-ray done five days after the fall showed the resident had sustained a broken left fifth toe. During an interview on 06/1/2025 at 3:08 PM, Staff B stated the incident involving Resident 29 was not reported to the state agency as they did not see it as a reportable incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference (WAC) 388-97-0640(6)(c)

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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 thorough investigations were completed for 5 of 5 residents (Residents 33, 19, 41, 21, and 29) reviewed for falls, skin impairments, and injuries of unknown source. Failure to initiate incident reports and conduct thorough investigations to identify root cause(s) and all contributing factors placed the residents at risk for unidentified abuse or neglect, unidentified corrective actions, risk for injury, and unmet care needs. Findings included . Review of the Washington State Department of Social and Health Services (DSHS) Nursing Home Guidelines 'The Purple Book', dated October 2015, showed Chapter 2, titled The Investigation Process, listed substantial injuries of unknown source as incidents that must be thoroughly investigated. Chapter 2 highlights that the key elements of any investigation were its prompt initiation and thoroughness. A comprehensive investigation aims to establish whether abuse or neglect occurred and how to prevent further occurrences. Further review of The Purple Book, Appendix K, titled Definitions, defined: Injuries of Unknown Source-any injury sustained by a resident where the source of the injury was not observed directly by a staff person and may be either superficial or substantial in nature. <Resident 33> Review of the medical record showed Resident 33 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD), diabetes, depression (a mental health condition characterized by persistant sadness, loss of interest in activities, and difficulty functioning in daily life) and heart disease. The comprehensive assessment dated [DATE] showed Resident 33 required moderate assistance of one to two caregivers for activities of daily living (ADLs) and was cognitively intact. During an observation and interview with Resident 33 on 06/10/2025 at 9:10 AM, showed two skin tears, one to the top of the right forearm that was actively bleeding and one to the top back of the right hand that had dried blood present. Resident 33 stated they did not know how they had gotten the skin tears, but the one on the top of the right hand had been there a couple of days and they had just noticed the one on the right forearm the previous evening. During an observation and interview with Resident 33 on 06/11/2025 at 8:45 AM, showed skin tears to the right forearm and left hand with dried blood on them and no dressings in place. Review of Resident 33's Treatment Administration Records (TARs) for the month of June 2025 showed there were no orders to monitor and/or treat the skin tears to right forearm or left hand. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Staff B, Director of Nursing (DNS) on 06/11/2025 at 2:02 PM, they stated they did not know Resident 33 had recent skin tears to both their hand and forearm and had not received any incident reports about the skin tears. The DNS stated the nursing s should have followed up with an incident report when the injuries were first noted and would ensure incident reports were completed for the skin tears on Resident 33's forearm and hand and investigated to rule out abuse or neglect. <Resident 19> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including Dementia (decline in mental ability), osteoporosis (brittle bones which increase bone fracture risk), and repeated falls. The 04/16/2025 quarterly nursing assessment showed Resident 19 was cognitively impaired with the ability to respond yes or no to questions and required substantial assistance of one person to stand and transfer to and from their wheelchair. Review of the 05/19/2025 Fall incident report showed Resident 19 had an unwitnessed fall in their room and was found on their right side on the floor at 8:40 PM. Resident 19's left eye was swollen shut and they were bleeding from the back of their head. Resident 19 was transported to the emergency room (ER), and it was determined the resident sustained a laceration (a jagged cut caused by trauma) to their upper forehead and sutures were applied. There was no other investigative information for the reason the resident was left alone in their room, how long the resident was in their wheelchair in their room unsupervised. There was minimal information as to what Resident 19's activities were before the fall or witness statements. During an interview on 06/11/2025 at 8:00 AM, Staff B, DNS, stated they were aware of the lack of information from the nursing staff to obtain investigation documents to determine if abuse/neglect occurred. <Resident 41> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (neurodegenerative disease with brain deterioration that affects body movements by slowing movements and causes tremors and balance issues), reduced mobility, and frequent falls. The 05/10/2025 comprehensive assessment showed the resident was cognitively impaired but able to make their needs known, required substantial assistance with transfers to and from wheelchair and toileting. Review of Resident 41's fall incident reports from 02/03/2025 through 06/03/2025 showed Resident 41 had sustained 17 falls from either the wheelchair or their bed and had sustained either head trauma, bruising and/or skin tears. Review of the incident reports showed 12 falls were unwitnessed and reoccurrences of falls were not thoroughly investigated as to determine if abuse/neglect were ruled out. During an interview on 06/11/2025 at 7:53 AM, Staff B,DNS, stated there was not sufficient informational evidence to determine if abuse/neglect was ruled out. Staff B stated the nursing staff did not determine the root cause of why the falls occurred nor thoroughly investigated the cause of the falls. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 21> Review of the medical record showed the resident admitted to the facility 04/05/2025 with diagnoses including ESRD (when your kidneys have permanently stopped working), muscle weakness and repeated falls with fractures. The 05/16/2025 comprehensive assessment showed Resident 21's cognition was moderately impaired and required assistance of one to two staff members for ADL's. Review of the 05/04/2025 incident report showed Resident 21 had an unwitnessed fall, was found on the floor lying on their left side at the end of their bed, required transfer to the hospital, and was diagnosed with a fracture of the L1 vertebra (the first top bone in the lower back/lumbar) and required a back brace that supports and stabilizes the spine. Further review showed there was no witness statements obtained, and a thorough investigation was not completed. During an interview on 06/12/2025 at 11:20 AM, Staff B stated they were aware there were not any witness statements completed for Resident 21's fall on 05/04/2025 and they recognized they had issues with investigations, and the correct process was not followed for Resident 21's fall investigation. <Resident 29> Review of the medical records for Resident 29 showed the resident was admitted to the facility on [DATE] with diagnoses including difficulty walking, muscle weakness and repeated falls. The comprehensive assessment dated [DATE] showed the resident's cognition was intact able to make their needs known. Review of Resident 29's fall incident report dated 04/23/2025 showed Resident 29 had a fall with injury in their bathroom, the resident had sustained a broken left fifth toe. Review of the incident reports showed the fall had been unwitnessed and the fall had not been thoroughly investigated as to determine if abuse/neglect were ruled out. During an interview on 06/10/2025 at 1:39 PM, Staff B, DNS, stated there were no witness statements to determine if abuse/neglect was ruled out. Staff B acknowledged that Resident 29's fall had not been thoroughly investigated. Reference: WAC 388-97-0640 (6)(a)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Pre-admission Screening and Resident Review, (PASARR) Level 1 were accurately completed upon or prior to admission and requirements for 1of 5 residents (Resident 41) reviewed for the PASARR process. This failure had the potential to place the resident at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs. Findings included . Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (neurodegenerative disease with brain deterioration that affects body movements by slowing movements and causes tremors and balance issues), depression and anxiety. The 05/10/2025 comprehensive assessment showed the resident was cognitively impaired but able to make their needs known. Review of a PASARR Level 1(Preadmission Screening and Resident Review) dated 01/29/2025 was incorrect in designation of Resident 41 diagnosis of Dementia (symptoms that affect memory, thinking and social abilities). Resident 41 was admitted to the facility on [DATE] and the facility failed to identify the error since the diagnosis of dementia was not designated at that time. During an interview on 06/12/2025 at 4:00 PM, Staff I, Social Services stated they were unaware that the resident did not have a dementia diagnosis and that the PASARR Level 1 indicated mental health issues of anxiety and depression. During an interview on 06/13/2025 at 8:50 AM, Staff I stated Resident 41 did not have a dementia diagnosis and a PASARR Level 1 with a request for a Level 2 evaluation was not requested. Reference WAC 388-97-1915(1),(2)(a-c)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 3 of 5 residents (Residents 2, 25, and 10), reviewed for activities of daily living (ADLs), received adequate grooming, transferring assistance and nail care according to the residents' care plans. This failure placed the residents at risk for unmet care needs. Findings included . <Resident 2> Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood stops flowing to part of your brain), muscle weakness and chronic kidney disease (where your kidneys are damaged and they cannot filter blood as well as they should) and diabetes (a disease where your body has trouble regulating blood sugar levels). The 04/10/2025 comprehensive assessment showed Resident 2's cognition was intact and required set- up and supervision with personal hygiene. Review of Resident 2's care plan, dated 02/16/2024, showed that the resident had an ADL self-care performance deficit and required set-up assistance with all personal hygiene. During an observation and concurrent interview on 06/10/2025 at 8:25 AM, Resident 2 had six to ten millimeter (mm) sized strands of hair, Resident 2 stated they wanted their goatee but did not want the strands of hair and would like to be shaved. The resident's fingernails were 1/4 inch long past the tip of their finger and had dark brown debris under the nail tips on both hands. During an observation on 06/12/2025 at 8:57 AM, Resident 2 was sitting up in their wheelchair. The resident continued to be unshaven and fingernails unkept. During an interview on 06/12/2025 at 11:48 AM, Staff EE, Nursing Assistant (NA), stated they offered nail care most of the time if they were doing showers. Staff E stated the shower NAs were supposed to do all nail care on shower days unless the resident was diabetic, then the nurses were responsible. Staff EE stated they would chart any refusals in the resident's nursing assistant task record. Review of the May and June 2025 nursing assistant task record showed no refusals of care for Resident 2. Review of the May and June 2025 Medication Administration Record showed the licensed nurses were doing nail checks every Friday and had no documentation of refusals. <Resident 25> Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood stops flowing to part of your brain) and right shoulder joint replacement. The 04/10/2025 comprehensive assessment showed Resident 25's cognition was intact and required staff assistance of one person for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and concurrent observation on 06/09/2025 at 2:90 PM, showed Resident 25 lying in their bed, the resident shirt had stains and food particles on the front of it. Resident 25 was unshaven with four to six mm sized facial hairs on the resident's face and neck. The resident's fingernails were ¼ long and past the fingertips with brownish debris under the tips on both hands. Resident 25 stated it really drives me crazy that they do not help me enough. Review of the May and June 2025 task record showed Resident 25 was to have a shower Mondays and Thursdays. Further review showed no documentation on 05/29/2025, 06/02/2025, 06/05/2025 that a shower was given or refused. <Resident 10> Review of Resident 10's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include diabetes (a disease in which the body does not control glucose (a type of sugar) in the blood), dementia (the loss of thinking, remembering, and reasoning- to the extent that in interferes with ADLs), muscle weakness and history of falls. The comprehensive assessment dated [DATE] showed Resident 10's cognition was severely impaired and was dependent on staff for grooming, personal hygiene, bed mobility and transfer assistance. The assessment confirmed that Resident 10 had no prior instances of rejecting care. During an interview on 06/09/2025 at 10:52 AM, Staff DD Nursing Assistant, NA, stated their tasks with showers were to do the weights and skin checks when a resident shower was done. Staff DD stated they were also to do nail care if the resident was not a diabetic. Staff DD stated once done with their tasks they give all information about what they had seen during a resident shower with the Resident Care Manger. Staff DD stated they had given Resident 10 their shower and within the last two months they had been working with the resident that they had not had Resident 10 refuse the care. An observation on 06/09/2025 at 11:01 AM, showed Resident 10 lying in bed, dressed in a purple-colored night gown. The resident's hair uncombed, both hands on their chest and the nails long, jagged with dark substance noted underneath. In an interview on 06/10/2025 at 9:39 AM, Collateral Contact, expressed their disappointment with Resident 10's care, noting that during their visit three weeks ago, the resident appeared in bed with disheveled hair and wearing the same nightgown for days. The Collateral Contact stated that they had called the facility to notify them of their disappointment with care and requested that Resident 10 get up at least three times a day, at least for their meals. The Collateral Contact stated that Resident 10 would be very upset if they were of sound mind as they used to always be up for their day and looked presentable. During an observation on 06/10/2025 at 4:18 PM, Resident 10 was lying in their bed, their hair uncombed, covered with a blanket and sleeping. During an observation on 06/11/2025 at 9:01 AM, Resident 10 was lying in their bed, and they stated they were doing good, while eating a muffin with their right hand. The resident's right hand with contractures of the middle and fourth fingers, the resident's nails were long and jagged and had food particles and a dark brown substance underneath them. (continued on next page)

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	505086	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 06/11/2025 at 1:03 PM, Resident 10 was in bed with their head of bed elevated, a bedside table over them. The resident was wearing a purple top, and their legs were covered with a blanket. The resident answered no when asked if they had got out of bed for the day. During an interview and concurrent observation on 06/11/2025 at 4:24 PM, showed the resident was lying in their bed covered with a blanket from their chest to their knees while Staff BB, Licensed Practical Nurse, assessed their feet. Staff BB stated the resident's skin was looking better and that nurses were to do the residents' skin and nails if they were diabetic every week depending on the orders. Staff BB stated that Resident 10 tended to refuse care. An observation on 06/12/2025 at 9:05 AM, showed Resident 10 sitting up in their wheelchair fully dressed. The resident's hair was uncombed, their nails long, jagged with a dark substance underneath. Resident 10 had complained that their bottom hurt sitting in the wheelchair. During an interview on 06/12/2025 at 1:22 PM, Staff CC, NA, stated today the nurse on shift explained to the resident that family had called and wanted them out of bed, so we got her up. Staff CC stated the resident did not stay up very long because they had complained about their bottom hurting, During an interview on 06/13/2025 at 10:17 AM, Staff B, Director of Nursing, stated the resident care information would be in PCC (a system in which nursing staff write out information for each resident's daily care). Staff B further stated that the expectation would be that staff followed the care plan and or orders and documented any refusals. Reference: WAC 388-97-1060(2)(c)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure staff responsible for providing cardiopulmonary resuscitation (CPR - an emergency procedure consisting of chest compressions combined with giving breaths of air) had current CPR certification for 1 of 5 licensed nursing staff (Staff S) reviewed for CPR certification status. This failure had the potential risk of the facility having a lack of staff who were properly trained in CPR readily available to respond in an emergency. Findings included . Record review of the facility's policy titled, Cardiopulmonary Resuscitation (CPR) Policy, dated 06/2023, showed personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and or basic life support (BLS), including defibrillation (the use of an electric current to stop any irregular and dangerous activity in the heart muscles), for victims of sudden cardiac arrest (when the heart stops beating suddenly). The facility policy further guided licensed staff to initiate CPR/BLS if an individual was found unresponsive unless the individual had orders that prohibited CPR. <Staff S, Medication Assistant Certified, (MA-C)> Review of Staff S's personnel file showed their CPR certification expired on 02/2025 (four months ago). During an interview on [DATE] at 11:32 AM, Staff G, Staff Development, stated they were unaware of the expired CPR certification for Staff S. Staff G stated they were told that the Nursing Assistants did not require a CPR certification, that the Director of Nursing Services (DNS) keeps track of the certifications. During an interview on [DATE] at 10:35 AM, Staff B, DNS, stated they were aware of the expired CPR certifications for Staff S and would be working on getting staff up to date with their certifications. Reference (WAC) 388-97-1060(1)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care, services and documentation that addressed skin integrity issues were provided in accordance with professional standards of practice for 2 of 3 residents (Residents 33 and 27), reviewed for quality of care. This failure placed the residents at risk for unmet care needs and negative health outcomes. Findings included . <Resident 33> Review of the electronic medical record showed Resident 33 was admitted to the facility on [DATE] with diagnoses including a fracture to the right wrist, end stage renal disease (ESRD) with dialysis three times a week, diabetes, depression and heart disease. The comprehensive assessment dated [DATE] showed Resident 33 required moderate assistance of one to two caregivers for activities of daily living (ADLs) and was cognitively intact. During an observation and interview with Resident 33 on 06/10/2025 at 9:10 AM, showed them lying on their back in bed. A skin tear was noted on the top of their right forearm measuring approximately six millimeters (mm) (a unit of measure) in length by four mm in width that was open with the skin folded back to the base of the tear and actively bleeding. A second skin tear was noted on the top back of the left hand, measuring approximately two mm by two mm that had dried blood on the top of it. Resident 33 stated they did not know how they got the skin tears, stating their skin would both tear and bleed easily and they had probably bumped their arm and hand on something on their bed, wheelchair, or bedside table. During the same interview Resident 33 stated they had the skin tear on the top of their left hand for several days and it kept opening back up and bleeding daily. They stated they had just noticed the one on their right forearm last evening and showed where their bedsheet had blood on it from bleeding through the night. Resident 33 stated that no one from nursing had come to clean up or put dressings on the skin tears since they had first noticed them, though a nursing assistant had wiped the blood off them last evening with a piece of tissue before bed. During an observation and interview with Resident 33 on 06/11/2025 at 8:45 AM, showed the skin tears to the right forearm and left hand with dried blood on them and no dressings in place. Resident 33 stated no one in the facility had yet come to look at them or dress them. They stated the skin tears were bothersome because they were on a medication that made them bleed easily, and whenever they bumped them or moved the wrong way in bed, they would start bleeding again. Review of Resident 33's Medication Administration Records (MARs) for the months of May 2025 and June 2025 showed an order for the medication Plavix (a medication used to prevent blood clots which increases the risk of serious bleeding because it reduces the blood's ability to clot) to be given every morning beginning 05/15/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 33's Treatment Administration Records (TARs) for May 2025 and June 2025, showed beginning 05/13/2025 an order was written for licensed nurses (LNs) to do a complete skin assessment with a narrative (a written assessment of the skin's condition) every day shift on Mondays for skin monitoring. There were no LN initials that showed these assessments were completed on 05/26/2025, 06/02/2025 or 06/09/2025. Further review of Resident 33's TARs for the month of June 2025 showed there were no orders to monitor and/or treat the skin tears to right forearm or left hand. During an interview with Staff B, Director of Nursing Services (DNS) on 06/11/2025 at 2:02 PM, they stated the nursing staff should follow up with an incident report anytime a skin tear was observed and should notify the resident's family and physician of any new skin impairment and obtain orders to monitor and treat the area. Staff B stated they did not know Resident 33 had recent skin tears to both their hand and forearm and had not received any incident reports about the skin tears. Review of nursing progress notes for the month of June 2025 on 06/12/2025 showed no progress notes that either Resident 33's family or physician were notified of the skin tears observed on the right forearm or left hand. Review of Resident 33's care plan showed a problem was opened on 05/21/2025 for potential impairment to skin integrity with interventions that included to follow the facility protocols for the treatment of injury and to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Further review of Resident 33's care plan showed that that a problem was opened on 05/212025 for being on an antiplatelet medication with interventions that included to monitor/document/report to MD as needed for signs/symptoms of complications, blood tinged or frank blood in urine or stool and bruising. <Resident 27> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses of contractures (a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff) of the hands and shoulders, dry skin, fibromyalgia (long-term widespread pain and fatigue), and torticollis (shortening and stiffness of the neck muscles). Review of the 04/27/2025 quarterly assessment showed Resident 27 required substantial assistance with ADL's due to bilateral (affecting both sides) impairment of upper and lower body movement. Resident 27 was able to make their needs known. During an observation and concurrent interview on 06/09/2025 at 2:37 PM, Staff Z, Nursing Assistant (NA), stated the resident could make their needs known. Resident 27 was in bed with the head of the bed at 45 degrees. The resident was positioned leaning to the left side of the bed with their head on their chest. Resident 27's right hand had blood on the top of their right hand. The resident stated they were in pain and uncomfortable. Staff Z stated Resident 27's position was always leaning to the left of the bed and required re-positioning maintained with pillows. Resident 27's top of their right hand had a four by five mm patch of skin that had been removed or injured and actively bleeding. Staff S, Medication Assistant, was notified and stated they would take care of it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/10/2025 at 10:00 AM, Resident 27 was lying in bed with fresh blood spots on their white top sheet. Resident 27 moved their contracted right hand and hit the top of the right hand under the overbed table. Staff S was notified of the incident. During an observation on 06/11/2025 at 2:00 PM, Resident 27's right top of their hand was reddened with open red spots on the top of their hand. Review of the 02/10/2021 care plan showed Resident 27 was at moderate risk for skin alteration due to resident's diagnoses and dry skin. There were no interventions related to prevent or care of skin impairments. Review of the 02/27/2025 incident report showed Resident 27 was seen by the physician for dermatitis (inflamation of the skin) of the right top of their right hand. The skin incident report showed that the physician requested that nursing staff notified them if the skin to the right hand changed. Review of the June 2025 TAR showed no treatment for Resident 27's right top of their hand. During an interview on 06/12/2025 at 8:20 AM, Staff B stated that nursing staff were to document skin issues and provide some intervention to care for bleeding of the right hand. Reference (WAC) 388-97-1060(1)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to prevent the development of pressure injuries and to implement wound treatment measures consistently to avoid worsening of pressure injuries for 1 of 3 residents, (Resident 46) reviewed for pressure injuries. Resident 46 experienced harm when they developed a pressure related fluid filled blister to the left heel and a pressure injury to their right lateral malleolus (the bony prominence on the outside of the ankle joint) that had both slough and eschar present in the wound. These failures also placed the resident at risk for pain, infection, and other medical complications. Findings included . Review of the National Pressure Injury Advisory Panel (leading expert in pressure injuries/wounds), September 2016, defined pressure injury stages as follows: Stage 2 Pressure Injury is a partial thickness skin loss with exposed dermis (the top inner layers of skin) and may be present as an open ulcer with a red or pink wound bed or as an intact or ruptured blister. Stage 3 Pressure Injury is a full thickness loss of skin, in which adipose (fat) tissue is visible in the ulcer. Slough (dead tissue) and or eschar (dried blood and tissue) may be visible, granulation tissue and epibole (rolled or curled under edges) may include with undermining (a pocket of dead space under the visible wound edges) and tunneling (a passageway under the wounds surface which may be shallow or deep and impairs wound closure). Review of an undated facility policy titled, Skin Integrity, showed the facility would provide care consistent with professional standards of practice to prevent pressure injuries, promote healing, and prevent infection. <Resident 46> Review of the medical record showed Resident 46 admitted to the facility on [DATE] with diagnoses of a right femur (thigh bone) fracture, severe dementia (an umbrella term for loss of memory and thinking skills that has various causes), severe protein calorie malnutrition (a condition where there is an insufficient intake of both protein and calories to meet the body's needs), reduced mobility (difficulty or inability to move around freely, easily, and without pain), and heart disease. The comprehensive assessment dated [DATE] showed Resident 46 required maximum assistance of one to two caregivers for bed mobility and transfers and had severe cognitive impairments. An observation of Resident 46 on 06/09/2025 at 8:24 AM, showed a small frail-appearing person lying on their back in their bed with no observable pressure relieving mattress, devices, or footwear to assist with pressure relief in place. Resident 46's eyes were open, though they did not speak or respond when spoken to. Review of Resident 46's facility admission notes dated 05/21/2025 showed the resident had no pressure injuries present on admission to the facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing note in Resident 46's electronic medical record dated 06/03/2025 at 7:53 AM, showed a licensed nurse (LN) noted a new pressure related blister to Resident 46's left heel. The note further stated the resident was placed on alert charting, to monitor the area, and to float the heels (elevate the heels off the bed surface) when in bed. An additional nursing note dated 06/03/2025 at 7:57 AM stated in part, LN spoke with the resident's representative to notify of the pressure related blister to the left heel, who asked that facility staff monitor Resident 46 closely for any open areas on their lower extremities, as they had issues in the past of not healing well. Review of a nursing note dated 06/05/2025 at 1:18 PM, an LN wrote, while providing wound care LN noted new wound on the right lateral malleolus (ankle), wound care provided, new wound care orders are in place. Review of skin and wound assessment notes showed on 06/03/2025 a blister to the left heel was measured as 5.1 centimeters (cm) (a unit of measure) in length by 4.6 cm in width and described as a fluid filled blister taking up the majority of the left heel. Further review of skin and wound assessment notes showed on 06/05/2025 a right malleolus pressure injury was measured as 1.6 cm in length by 0.7 cm in width and described as having both slough and eschar present in the wound. Review of a Braden Scale assessment (an assessment tool used to assess a patient's risk for developing pressure injuries) completed on the admission date of 05/21/2025 showed a score of 11, indicating Resident 46 was at a high risk for developing pressure injuries. Review of Resident 46's Treatment Administration Records (TARs) for May 2025 and June 2025, showed beginning 05/26/2025 an order was written for LNs to do a complete skin assessment with a narrative (a written assessment of the skin's condition) every day shift on Mondays for skin monitoring. There were no LN initials that showed these assessments were completed on 05/26/2025, 06/02/2025 or 06/09/2025. Further review of Resident 46's TARs showed beginning 06/03/2025, the LN staff were to monitor the pressure related blister to the left heel, to float the heels when in bed, and to apply a heel protector to the left foot when up in their wheelchair every shift. Observations of Resident 46 on 06/10/2025 at 8:16 AM showed them being assisted with breakfast in the dining room. There was no heel protecter in place on the left foot. Observations of Resident 46 sitting at the north nurse's station in a wheelchair on 06/11/2025 at 11:08 AM and 06/12/2025 at 8:47 AM showed there was no heel protector in place on the left foot. Observations of Resident 46 lying on their back in bed on 06/12/2025 at 11:33 AM and 2:05 PM showed the heels were not floated and both heels were pressed into the mattress. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation of dressing wound changes on 06/12/2025 at 2:26 PM with Staff Q, Registered Nurse (RN), showed the left heel blister was reddish/orange in color, had opened and drained of fluid and measured 5.0 cm by 4.8 cm. The wound to the right ankle showed a pinkish white wound bed with red tissue surrounding the wound and measured at 1.2 cm by 0.7 cm. During an observation and interview with Staff B, the Director of Nursing (DON), on 06/13/2025 at 6:11 AM showed Resident 46 lying on their back in bed with a foam wedge placed under the resident's knees to raise the heels, though both heels were pressed into the mattress. The DON stated the staff did not place the wedge correctly so the heels would float off the mattress and needed more education on how to do so. The DON also pressed on Resident 46's right heel and stated it felt mushy (a feeling of softness or sponginess indicating a potentially early sign of pressure injury development). An observation of Resident 46 on 06/13/2025 at 8:21 AM, showed them sitting in their wheelchair at a dining room table with regular shoes on their feet. Review of Resident 46's care plan on 06/13/2025 showed there was no problem opened for the development of the pressure injuries to the heel and ankle, or that any interventions were put into place to prevent new pressure injuries from occurring or to prevent the current pressure injuries from getting worse. Reference: WAC 388-97-1060(3)(b) This is a repeat citation from Statement of Deficiencies dated 03/12/2024 and 05/22/2024.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 3 of 6 sampled residents (Residents 19, 27, and 10) reviewed in a Restorative Nursing Program (RNP) for positioning, range of motion (ROM), and hand splinting, received consistent services to prevent further decrease in range of motion and hand contracture (a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff) through use of consistently following documented care plans and providing services to identified residents. This failure of not following the restorative care plans on a consistent basis increased the residents at risk of being unable to maintain their current level of functioning. Findings included . A review of the 11/15/2023 Restorative Nursing Plan policy showed residents will receive restorative nursing care as needed to promote safety and independence. Restorative nursing care consists of nursing interventions .goals and objectives are resident centered and outlined in the resident's care plan. The facility will be responsible for a monthly recap note performed by a licensed nurse. <Resident 19> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including dementia (decline in mental ability), osteoporosis (brittle bones which increase bone fracture risk), thrombocytopenia (low blood platelets which lead to increase bleeding and bruising), and history of falls. The 04/16/2025 quarterly nursing assessment showed Resident 19 was cognitively impaired with ability to respond yes or no to questions and required substantial assistance of one person to eat their meals, brush their teeth, and to stand and transfer to and from their wheelchair. Review of the 08/05/2021 RNP for Resident 19 showed they were to have transfer training from their wheelchair to bed or recliner back to wheelchair six to seven times a week for 15 minutes. Additionally, there was a grooming program for Resident 19 for brushing their teeth seven days a week for 15 minutes. Additionally, there was a nursing program for Resident 19 to ambulate 10 feet after standing in their room, corridor or similar place. During an observation on 06/09/2025 at 11:20 AM, showed the Resident 19 was quickly fed by the NA and wheeled out to a place by the nurse's station. During an observation on 06/10/2025 at 8:20 AM, Resident 19 was wheeled out of the dining room into the area by the nurse's station, at 1:00 PM and 2:00 PM the Resident 19 was lying in bed. During an observation on 06/11/2025 at 7:55 AM, Resident 19 was up in their room and wheeled to the dining room for breakfast. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2025 at 10:57 AM, Staff T, NA Restorative Aide, stated Resident 19's RNP had no real goals or instruction to residents on how to do their programs. Staff T stated they do not do the transfer RNP for Resident 19 from the wheelchair to a recliner or transfers to the bathroom. Staff T stated they brought Resident 19 either to the hallway handrail or bathroom handrail and have them stand up with assistance of the handrail to pull themselves up from the wheelchair and then they can sit down. Staff T stated that was hard to measure if the activity is working or not. Staff T stated they had so much staff turnover at the facility in the last two years with resident care managers who use to do restorative nursing programs. <Resident 27> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses of contractures (a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff) of the hands and shoulders, dry skin, fibromyalgia (long-term widespread pain and fatigue), and torticollis (shortening and stiffness of the neck muscles). Review of the 04/27/2025 quarterly assessment showed Resident 27 required substantial assistance with activities of daily living due to bilateral (both sides) impairment of upper and lower body movement. Resident 27 was able to make their needs known. Review of the RNP dated 05/14/2021 showed a goal of maintain the resident's current ROM of total body, neck, hands and bilateral lower extremities for Passive Range of Motion (PROM) and to maintain bed mobility for pressure relief. Interventions included six times weekly PROM to Resident 27's neck, hands, upper and lower body for 10 repetitions at least for 15 minutes six times a week. A RNP dining plan dated 03/21/2025 for Resident 27 showed they were to participate in set up assistance, simulate a feeding motion while wearing a half pound weigh around their wrist with a two-finger help assist with cueing and assist where needed two repetitions times 10 for 15 minutes six times a week. A 03/21/2025 Therapy restorative nursing referral form showed to optimize Active Range of Motion (AROM) for neck, hands, upper and lower body, (hold for five seconds, 10 times, and repeat) six times a week. During an observation on 06/09/2025 at 8:00 AM, Resident 27 was in bed leaning to the left side of their bed with chin bent to chest. The resident's breakfast food tray was uneaten and located on the countertop by the resident's sink. During an observation on 06/09/2025 at 11:50 AM, Resident 27 was lying in their bed their lunch tray for the resident sat on the resident's bedside table uneaten. During an observation on 06/09/2025 at 2:43 PM, Resident 27 had a small plastic cup with a handle with one third of a cup water in the cup. Resident 27 was unable to lift the plastic cup until Staff Z, poured some of the water out of the cup. Resident 27 could then lift the plastic cup to drink from a straw. There was no assessment as to functional ability for resident to maintain the daily living activities. No summation from the licensed nurse or restorative nurse to determine if the RNP was successful or needed to be revised for Resident 27. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 06/10/2025 at 8:15 AM, Resident 27 were lying in their bed, and their breakfast tray was not in their room. During an interview on 06/09/2025 Staff CC, NA, stated Resident 27 rarely ate much and that they had not seen a Restorative Aide (RA) help the resident with eating or ROM. Staff CC stated Resident 27 could only use their right hand but could not use utensils or any weighted items to eat with. Review of the 05/14/2025 through 06/10/2025 showed Resident 27 the RNP dining and range of motion programs were not completed for a period of six days and a total of 12 meals for the dining RNP. During an interview on 06/10/2025 at 11:15 AM, Staff T, Restorative Aide, stated the RNP are not very easy to do, and they had residents that need to be evaluated for a program but there had not been enough licensed nurses or a speech therapist to evaluate residents for dining programs. Staff T stated they did not always follow the RNP and would make modifications without notifying the restorative nurse. There were no identified licensed nursing monthly assessments as to result of improvement functional ability for residents or to maintain their daily living activities. During an interview on 06/12/2025 at 8:57 AM, Staff B Director of Nursing (DNS) stated they were responsible for the RNP and understood that there were concerned about the residents' programs and if they were effective or not. Staff B was unaware that residents' RNP were not being done correctly. <Resident 10> Review of Resident 10's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include dementia (the loss of thinking, remembering, and reasoning- to the extent that in interferes with ADLs), muscle weakness and history of falls. The comprehensive assessment dated [DATE] showed Resident 10's cognition was severely impaired and was dependent on staff for bed mobility and transfers. Review of Resident 10's care plan dated 12/05/2024 showed the resident had started a restorative program due to general weakness and their program scheduled at least 15 minutes six to seven times a week. Additionally, the care plan showed the resident was to have a splint/brace on in AM off in PM related to trigger fingers (a condition in which a finger bends, gets stuck and then snaps straight). During an observation on 06/11/2025 at 9:01 AM, showed Resident 10 lying in their bed, stated they were doing good. The resident's right hand was noted to have their middle and fourth fingers in a bent position, and they were unable to straighten them. The resident stated no they could not straighten their fingers. Resident 10 stated their fingers had been like that for a while, then stated that they did not wear a splint or a hand roll. During an interview on 06/11/2025 at 10:09 AM, Staff L, Director of Rehab, stated Resident 10 had worked with Occupational Therapy (OT) for their trigger fingers. Staff L stated Resident 10 was no longer in the OT program, that the resident was now participating in the restorative program that the nurses were responsible for. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations on 06/11/2025 at 1:03 PM, and at 4:24 PM, Resident 10 was lying in their bed with their head of bed elevated and their bed side table over their lap. The resident's hands were on top of the table looking at a paper, they had no splint/hand roll to their right hand. During an observation on 06/12/2025 at 9:05 AM, Resident 10 was sitting in their wheelchair and did not have a splint/hand roll to their right hand. During an interview on 06/12/2025 at 1:03 PM, Staff L, stated therapy staff had been doing finger splinting for Resident 10's trigger fingers. Staff FF, Occupational Therapist, stated staff (nurses and nursing assistants) were trained in placement of Resident 10's splint/hand roll. Staff L stated staff should be at least attempting to place the splints for the resident daily. During an interview 06/12/2025 at 1:22 PM, Staff CC, NA, stated they had received teaching on how to place the finger splints and a hand roll for Resident 10. Staff CC stated that the restorative aides were the staff that would take care of the splint. Staff CC stated they were unaware if staff had been placing the finger splint, that they had not worked with Resident 10 in over a week. Review of the June 2025 Treatment Administration Record showed Resident 10's right hand splint/hand roll had not been placed 06/01/2025 through 06/12/2025. During an interview on 06/12/2025 at 1:37 PM, Staff N, Resident Care Manager, stated the placement of the splint/hand roll should be documented whether they placed it on the resident and/or if the resident refused the placement. Staff N stated the last known was small finger splint, and the expectation was that staff at least attempted to place the fingers splint/ hand roll. During an interview on 06/12/2025 at 1:49 PM, Staff B, stated they attended the Medicaid meetings and discussed the facility's Restorative Program. Staff B stated that their expectation for the staff (both nursing staff and restorative staff) was for them to at least attempt to place splint and hand roll after Resident 10's Range of Motion exercises and document the progress and/or any refusals from the resident. WAC: 388-97-1060 (3)(d), (j)(ix)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to provide adequate supervision, assess, monitor, and revise care plan interventions for efficacy, and ensure care planned interventions were consistently followed to prevent avoidable repeated falls for 4 of 5 residents (Residents 21,19, 41, and 29) reviewed for falls. Resident 21 who had 14 falls between 04/13/2025 and 05/23/2025, experienced harm when they had an unwitnessed fall, was found on the floor lying on their left side at the end of their bed, required transfer to the hospital, and was diagnosed with a fracture of the L1 vertebra (the first top bone in the lower back) and required a back brace that supports and stabilizes the spine. Resident 19 fell while unsupervised and experienced harm when they sustained a laceration on their forehead, required transfer to the emergency room (ER) and sutures. Resident 41 fell 17 times in the facility since admission, 12 unwitnessed, from either their wheelchair or bed, and experienced harm when they sustained head trauma, bruising and/or skin tears. Resident 29 experienced harm when they fractured their left fifth toe when they were left unattended in the bathroom, staff were unavailable to provide transfer assistance, they attempted to self-transfer from the toilet and fell. Findings included . Review of the 09/21/2022 Fall Assessment and Management policy showed the facility would identify and document residents' risk factors for falls and establish individualize resident centered fall prevention plans . by identifying underlying medical conditions that may increase injuries from falls .a link between increasing episodes of falls and recent changes in medication regime pharmacy review of medications that could relate to fall risk as well as medication side effects. Care plan individualized interventions will be monitored for effectiveness and modified to increase effectiveness. Review of the Facility's Policy titled, Accident Hazards/Supervision/Device dated 06/2023 showed the facility will provide an environment that is free of accident hazards as is possible and provide supervision and assistant devices, [drop seat wheel chairs(the back seat of the wheelchair tilts back while the front of the wheelchair seat tilts up), Front wheel walkers, manual wheel chairs and nonskid foot wear] to residents to avoid preventable accidents. <Resident 21> Review of the medical record showed the resident admitted to the facility 04/05/2025 with diagnoses including end stage renal disease (when your kidneys have permanently stopped working), muscle weakness and repeated falls with fractures. The 05/16/2025 comprehensive assessment showed Resident 21's cognition was moderately impaired and required assistance of one to two staff members for ADL's. Further review showed Resident 21 had a history of falls prior to admission that resulted in fractures and had two falls resulting in minor injury and no falls with major injury after admission to the facility. Observations on 06/09/2025 at 11:53 AM, 1:40 PM, 2:19 PM, showed Resident 21 lying in bed with his door open and curtain closed. Resident 21 was not visible from the hallway. Review of the care plan dated 04/05/2025 showed that Resident 21 had no care plan in place for being a fall risk and had no interventions to prevent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Record review of the fall investigations for Resident 21 showed Resident 21 had a fall on 04/13/2025 with no care plan in place for interventions to prevent falls. Additionally Resident 21 did not have a fall care plan put into place until 04/17/2025 (four days after the first fall). Review of the care plan dated 04/17/2025 showed Resident 21 was at high risk for falls related to deconditioning, gait/balance problems and self-transferring without asking for assistance. Further review showed interventions which included the call light to be within reach and to have appropriate footwear/non skids socks on when transferring. Additionally, there was no intervention for self-transferring in Resident 21's care plan. Review of the facilities reporting log showed Resident 21 had 14 falls between 04/13/2025 and 05/23/2025, nine of which resulted in injuries to Resident 21. Record review of a facility investigation dated 05/04/2025, showed Resident 21 had an unwitnessed fall and was found on the floor lying on their left side at the end of their bed. Resident 21 was able to move all extremities without pain. Resident 21 stated they had pain in their back and neck. When turning Resident 21 to their back to assist them to a sitting position, Resident 21 yelled out in pain and stated their left hip and ankle hurt. Resident 21 agreed to go to the hospital for evaluation. Further review showed the conclusion for Resident 21 was the resident was attempting to self-transfer, care plan reviewed and updated. Review of the care plan showed no updates or interventions were made from the fall on 05/04/2025 that resulted in a major injury. Review of the hospital Discharge summary dated [DATE] showed Resident 21 sustained a fracture of the L1 vertebra (the first top bone in the lower back) and required a TLSO (a back brace that supports and stabilizes the spine) brace with specific instructions to wear when out of bed with instructions on how to apply the brace. Review of the May 2025 orders showed there was no order placed for the nurses to monitor or to place the TSLO brace for Resident 21. During an interview on 06/12/2025 at 1:51 PM Staff P, Registered Nurse, stated they had found Resident 21 on the floor on 05/04/2025 and had sent them to the ER for evaluation. Staff P further stated they should have witness statements written by the staff but were unsure if that happened. Staff P stated they received the TSLO orders from the hospital. Staff P further stated they did not write an order for the brace or collect any witness statements for the fall. During an interview on 06/12/2025 at 11:20 AM, Staff B, Director of Nursing Services (DNS), stated the process for unwitnessed falls with injuries was to call the state hotline and to update the care plan with new interventions. Staff B stated they were aware there were not any witness statements or care plan updates completed for Resident 21's fall on 05/04/2025 and they recognized they have issues with investigations. Staff B stated the process for transcribing orders from the ER was the nurse receiving them were to place them on the Medication Administration Record (MAR) and Treatment Administration Record if necessary. Staff B stated the process was not followed for Resident 21. <Resident 19> (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including Dementia (decline in mental ability), osteoporosis (brittle bones which increase bone fracture risk), thrombocytopenia (low blood platelets which lead to increase bleeding and bruising), Myeloproliferative disease (blood cancer) and history of falls. The 04/16/2025 quarterly nursing assessment showed Resident 19 was cognitively impaired with ability to respond yes or no to questions and required substantial assistance of one person to stand and transfer to and from their wheelchair. Review of the 01/31/2025 fall incident report showed Resident 19 had an unwitnessed fall at 2:45 PM in their room which showed Resident 19 sitting against the wall on their buttocks. The conclusion was that Resident 19 fell asleep and slid out of their wheelchair and should be laid down after meals or stay at the nurse's station for supervision. Review of the 05/19/2025 fall incident report showed the resident had an unwitnessed fall at 8:40 AM. Resident 19 was on their right side on the floor with their left eye closed shut and bleeding from the back of their head. The paramedics (emergency medical assistance) arrived and placed a cervical collar around Resident 19's neck to keep the neck in one position. Resident 19 sustained a laceration (jagged wound caused by trauma) on their upper forehead by their scalp which required six sutures. There was no additional information about how long the resident was on the floor. Additionally, there was no conclusion or updates to the care plan completed. Review of the June 2025 MAR showed the resident was on an anticoagulant (blood thinner). Review of the 06/23/2021 care plan showed the Resident 19 was at high risk for falls due to deconditioning, gait/balance issues and unawareness of their boundaries. The care plan interventions included laying the resident down after meals, keeping the bed in a low position, reviewing information on past falls, attempting to determine cause of falls, and keep the resident at the nurse's station. During an observation on 06/09/2025 at 8:00 AM, Resident 19 was seated in their wheelchair at a table in the assisted dining room for breakfast and was being fed by a Nursing Assistant (NA). Resident 19 was unable to move their arms up a to hold their utensils . During an observation and concurrent interview on 06/09/2025 at 9:37 AM, after breakfast the resident was seated in their wheelchair alone in their room parked by their bed. The skin on their upper forehead close to their scalp and hair line had a four-inch scar line with scattered small pinpoint black/brown scabbed areas to the scar line. Resident 19 was very soft-spoken when asked questions about their care and could not verbalize events that led up to their last fall on 05/19/2025. Resident 19 had asked to go to bed but was unable to transfer without assistance. The resident's bed was not in a low position. Resident 19 had a bruise on their lower right forearm. During an observation on 06/10/2025 at 8:45 AM, Resident 19 was seated in their wheelchair in front of nurse's station against the front wall. During an observation on 06/10/2025 at 9:10 AM, Resident 19 was still in their wheelchair against the front wall, there were no staff at the nurse's station. Resident 19 stated they were tired and started to tilt, leaning to the right of their wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an observation on 06/10/2025 at 10:30 AM, Resident 19 was still seated in their wheelchair against the wall and leaning to their right side. During an observation and a concurrent interview on 06/11/2025 at 10:57 AM, Staff T, Restorative NA, stated Resident 19 gets tired easily and cannot sit up for long. Staff T stated Resident 19's falls were due to sitting in their wheelchair in their room for too long. During an interview on 06/12/2025 at 7:53 AM, Staff B stated Resident 19's incident report was incomplete. Staff B stated staff did not follow the care plan for Resident 19 <Resident 41> Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including Parkinson's Disease (neurodegenerative disease with brain deterioration that affects body movements by slowing movements and causes tremors and balance issues), reduced mobility, and frequent falls. The 05/10/2025 comprehensive assessment showed the resident was cognitively impaired but able to make their needs known, required substantial assistance with transfers to and from wheelchair and toileting. Resident 41 used a manual wheelchair with a drop seat for mobility. The comprehensive assessment showed Resident 41 wandered around the facility in their wheelchair and had multiple falls. During an observation and concurrent interview on 06/09/2025 at 9:00 AM, Resident 41 was in their room seated in their wheelchair by their bed. The call light cord and button was under the resident's bed where they were unable to reach it. The wheelchair was stuck between their bedside table and the resident was unable to move themselves. During an interview Resident 41's stated that they wanted to go home and felt that staff did not listen to them. Resident 41's right hand had dark purple and green bruises between the thumb and index finger. The resident's right wrist on the top of the forearm to mid upper arm showed bruising brown and light green in color. Resident 41's left hand showed scattered green-yellow bruising from the top of their hand to the elbow. The resident raised their pant leg on the right leg and there was light blue green bruising from the outer lateral side of the mid-calf area to the left knee to mid-thigh. Resident 41's left leg had bruising blue green in color over their knee to mid-thigh area. When asked how they got the bruising Resident 41 stated they had fallen many times. Review of the 01/31/2025 care plan showed Resident 41 was at high risk for falls related to confusion, deconditioning, gait and balance problems, Parkinson's, psychoactive (medications that affect mood and behavior) drug use, and history of falls. Interventions included call light in place within reach, bed in low position, [NAME] wheelchair (tilt in space wheelchair) for positioning and body alignment, do not leave the resident alone in the bathroom, bed against the wall, fall mat by bed and review past falls and review root cause and effectiveness of interventions. The last update on fall interventions was 02/04/2025. During an observation on 06/09/2025 at 10:30 AM, Resident 41 was seated in front of the nurse's station by the right side of the wall. The resident was seated in their low wheelchair with the drop seat and using the woodened hand rail to pull themselves along the wall. from behind the south nurse's station Resident 41 was unable to be visualized due to their low-profile wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During an observation on 06/10/2025 at 9:45 AM, Resident 41 was in their wheelchair with drop seat leaning forward and using their feet to mobilize the wheelchair. Resident 41 was in and out of other resident's rooms and holding on to the handrail in the hallway standing up. There were no staff observed to be supervising the resident. During an observation on 06/10/2025 at 3:07 PM, Resident 41's wheelchair showed the back side of the wheelchair was loose and uneven. The left armrest was completely down and the armrest and side panel on the right was in the upright position. The resident was leaning forward and started to fall forward but caught themselves in the doorway of the south dining room. There were no staff observed to be supervising the resident. During an interview on 06/10/2025 at 1:49 PM, Staff V, Registered Nurse (RN) stated they were at the nurse's station on 06/03/2025 when Resident 41 was seated in front of the South Nurses station. Resident 41 was seated in their wheelchair for about 20 minutes and slipped out of the wheelchair onto the floor and hit their right elbow and sustained a skin tear. Staff V stated they picked Resident 41 up with assistance and put them back in the wheelchair. Staff V was unaware that Resident 41 was in a drop seat wheelchair or if the resident was positioned correctly. Staff V stated Resident 41 falls frequently and there is nothing else they can do to update the interventions of the care plan. During an observation on 06/11/2025 at 4:10 PM, Resident 41 was yelling from their room help, help in a loud tone and repeatedly asked staff to get them out of bed. Staff observed near Resident 41's room, did not respond to the residents' call for assistance. The surveyor entered Resident 41's room, and observed the resident seated close to the edge of the bed with the bottom part of their body out of the bed. During an interview on 06/11/2025 at 4:30 PM, Staff Z, NA, stated they requested a one on one (one person assigned to supervise a resident) for Resident 41 in the evening related to the resident having increased behaviors with falls and not enough staff to provide supervision. Staff Z stated if Resident 41 was assisted in bed too early they would fall out of bed. During an interview on 06/11/2025 at 4:45 PM, Staff N, RCM, RN, stated Resident 41 becomes restless and wanders around the hallway in the late afternoon. Staff N stated after they leave in the afternoon there were not enough staff to supervise Resident 41. During an interview on 06/13/2025 at 1:00 PM, Resident 41's Resident Representative (RR) stated they were very concerned about the care Resident 41 had received at the facility and the number of falls with bruises and skin tears. The RR stated they had given many interventions that would help Resident 41 such as snacks, quiet areas, conversation, music and phone call to the RR to speak to Resident 41. The RR stated they felt the facility was resistant to any suggestions they offered. Review of Resident 41 fall incident reports from 02/03/2025 through 06/03/2025 showed Resident 41 had sustained 17 falls from either the wheelchair or their bed and had sustained either head trauma, bruising and/or skin tears. Review of the incident reports showed 12 falls were unwitnessed. During an interview on 06/12/2025 at 7:53 AM, Staff B, DNS, stated Resident 19's incident reports were not complete and did not meet the requirements. Staff B stated staff did not follow the care plan for Resident 19 and did not thoroughly investigate to determine if interventions were effective. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	<Resident 29> Review of Resident 29's medical record showed the resident was admitted to the facility on [DATE] diagnoses to include polyneuropathy (a disease affecting the peripheral nerves in the body, causing weakness, numbness and burning pain), muscle weakness, unsteadiness on feet and repeated falls. The 06/07/2025 comprehensive assessment showed the residents' cognition was intact and required one staff assistance with transfers and toileting and had falls since admission. Review of the care plan dated 06/09/2025 showed Resident 29 was at risk for falls related to weakness and an unsteady balance. Further review showed interventions which included a toileting schedule, evaluate for proper attention to safety, have the call light within reach and reinforce use of the call light. Additionally, to reinforce the use of appropriate footwear for safety with transfers. An observation and concurrent interview on 06/09/2025 at 8:51 AM, Resident 29 was in their night gown, no shoes or socks on sitting in their wheelchair. Resident 29 stated the call lights will stay on forever and they needed help with getting dressed but were told they could do this themselves. The resident stated they could not stand on their own and their hands nor their knees worked. Resident 29 stated I would not be here if I didn't need the help. The resident stated the staff helped them on the toilet and never came back, so they tried to transfer themselves into their wheelchair after waiting a long time and had a fall. They stated the incident happened a month ago in their restroom and they had to yell for help. Additionally, they broke their left fifth toe in the fall. Review of the facilities incident reporting log dated 04/23/2025 showed Resident 29 was found in the bathroom lying on their stomach after a fall in their restroom that resulted in a fracture to their left fifth toe. During an interview on 06/12/2025 at 3:38 PM, Staff Z, NA, stated there were many residents who were a high risk for falls. Staff Z stated they had informed the administration and the nurses about the need for more staff supervision to decrease the falls, but they have not seen any results and the residents continue to fall. Staff Z stated they keep certain residents at the nurse's station to keep a close eye on them but sometimes that doesn't work. During an interview on 06/10/2025 at 2:54 PM, Staff N, RCM, stated when they were coming into work the morning of 04/23/2025 they were walking down the hall and heard someone yell help me. Staff N stated upon entering Resident 29's room, they found the resident lying on their stomach in the residents bathroom. Staff N stated they assisted the resident up, started an incident report, and placed resident on alert charting. Staff N stated there was bruising noted to Resident 29's left lateral ankle and left toes, and the resident had complained of pain to their left fifth toe. Staff N stated an x-ray was taken on 04/28/2025 (five days after the incident) and showed Resident 29 had a latent injury of a fractured left fifth toe. During an interview on 06/12/2025 at 10:35 AM, Staff B stated that their expectation was for staff to follow the care plan and ensure resident safety. Reference: WAC 388-97-1060 (3)(g) Cross reference F725 Sufficient Nurse Staffing; and F610 Investigate Alleged Violations (continued on next page)

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	505086	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Care and Rehabilitation	710 North 39th Avenue Yakima, WA 98902

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F 0689 Level of Harm - Actual harm Residents Affected - Some	This is a recurring citation from the Statement of Deficiencies dated May 22, 2024

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review, the facility failed to ensure that residents who were trauma survivors received trauma-informed care in accordance with professional standards of practice by not assessing or monitoring past experiences of Post Traumatic Stress Disorder [(PTSD) an anxiety disorder (develops in some people who have experienced a shocking, scary, or dangerous event) for 1of 2 residents (Resident 64) reviewed for mood and behavior. This failure placed the resident at risk for unidentified triggers, re-traumatization, and a decreased quality of life. Findings included . During an observation and interview with Resident 64 on 06/10/2025 at 9:24 AM, showed them sitting in their wheelchair at the sink in their room combing their hair. A bandage was placed on the stump of Resident 64's lower left leg, which they stated was due for a dressing change that day. Resident 46 stated they were feeling depressed due to their recent amputation and still did not understand what had happened to cause the amputation. They stated the stump wound was not healing well, and they were fearful another amputation was in the future. In addition, Resident 46 stated they had also recently lost their spouse, and it seemed as if their whole world had suddenly changed for the worst possible outcomes. Resident 46 stated they feared being in a care center for the rest of their life and was the only thing the future held for them. During the same interview, Resident 46 stated they had PTSD from being in the Vietnam war, and stated they did and saw things over there that no one should ever experience. They stated they did have flashbacks of the war frequently, had horrible dreams about it and often woke up frightened and could not get back to sleep. Resident 46 stated they had experienced some of those dreams since they had been in the facility but had not shared this or any of their PTSD symptoms with anyone else since they had been in the facility. Resident 46 stated I think someone came to my room and asked me if I had PTSD, but I do not remember who it was, and I did not go into any detail about it. During an interview on 06/11/2025 at 2:10 PM, Staff B, Director of Nursing Services (DNS) stated that Social Services were responsible for doing the PTSD screening and would call in behavioral health if needed for a resident. Staff B stated Social Services were also responsible to assure a care plan with interventions specific to the resident for the diagnosis of PTSD and/or any other mood disorder or behavior problem was completed. During an interview with Staff H, Social Services Director (SSD), on 06/12/2025 at 11:16 AM, they stated they were aware of Resident 46's diagnoses of PTSD, bipolar disorder and depression and did complete a general care plan for their mood disorder. The SSD further stated they did not go into detail about the PTSD or define any triggers Resident 46 may have that the staff should be aware of. The SSD stated they provided weekly visits with Resident 46 to discuss any issues they may have and had called and requested services from the Veteran ' s Administration as they knew Resident 46 was a Vietnam Veteran but had not yet heard back from them. Review of an assessment titled Trauma Screening Questionnaire, completed by the SSD on 05/09/2025 showed, reported PTSD from Vietnam war and a car accident in the 70's. There was no other information concerning possible triggers for the PTSD or interventions to lessen the resident's distress if behaviors were identified. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 46's care plan showed a problem was developed on 05/08/2025 showing the resident had a mood problem related to unspecified bi-polar disorder (a brain disorder that causes changes in a person ' s mood, energy, or ability to function). The goal was to maintain an even mood while in the facility and the interventions were to observe for signs and symptoms of mania or hypomania(periods of over-active and high energy behavior that can significantly impact day to day life), racing thoughts or euphoria(a feeling or state of intense excitement and happiness), increased irritability, frequent mood changes, pressured speech, flight of ideas, marked change in need for sleep, agitation or hyperactivity, and to encourage the resident to express their feelings in weekly meetings. There was no resident specific care planning addressing Resident 46's PTSD, current depression from the recent loss of their spouse and lower leg, or about their fears of being placed in a long-term care facility. WAC Reference: 388-97-0020

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, and record review, the facility failed to ensure there were sufficient numbers of competent nursing staff to provide care and services for 16 of 16 residents (Residents 2, 5, 10, 19, 21, 23, 25, 27, 29, 33, 34, 39, 41, 43, 46, and 64)reviewed for Resident Rights, Resident Mobility, Activities of Daily Living (ADLs) for dependent residents, Quality of Care, Pressure Injuries, and Accident Prevention. Additionally, reports in the facility grievance logbook, resident council meeting interviews, and staff interviews provided evidence of insufficient staffing without resolution. This failed practice placed residents at risk of not having their needs met and potential negative outcomes to their physical and mental health. Findings included . <F-550 Resident Rights> The facility failed to provide an environment that enhanced and prompted a dignified lifestyle related to maintaining a prior level of bowel and bladder continence. <Resident 25> During an interview on 06/09/2025 at 2:02 PM, Resident 25 reported that, initially they were continent of bowel and bladder while using the bathroom, they became incontinent due to a lengthy wait for help, which left them feeling embarrassed. <F-688 Prevent/Decrease in Range of Motion (ROM)/Mobility> The facility failed to ensure staff provided care and services to maintain ROM and prevent contractures. <Resident 19> During an interview on 06/11/2025 at 10:57 AM, Staff T, Restorative Aid (RA), reported that Resident 19's Restorative Nursing Programs (RNP) lacked clear goals and guidance. Staff T stated the past two years there had been such a turnover with the Resident Care Managers, and they were no longer involved in the RNP to ensure programs were accurate and followed through. <Resident 27> During an interview on 06/10/2025 at 8:15 AM, Staff CC, Nursing Assistant (NA), stated they had not seen an RA help Resident 27 with eating or perform any ROM. Staff CC stated Resident 27 could only use their right hand but could not use utensils or any weighted items to eat with. Review of the 05/14/2025 through 06/10/2025, showed Resident 27 the RNP dining and range of motion programs were not completed for a period of six days and a total of 12 meals for the dining RNP. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/10/2025 at 11:15 AM, Staff T, RA, stated they had residents that need to be evaluated for a RNP that had not been completed yet. Staff T stated they did not always follow the RNP and would make modifications without the direction of a Licensed Nurse or Therapist. <Resident 10> During an observation on 06/11/2025 at 9:01 AM, showed Resident 10's right hand was noted to have their middle and fourth fingers in a bent position, and they were unable to straighten them. Resident 10 stated their fingers had been like that for a while, then stated that they did not wear a splint or a hand roll. During an interview on 06/11/2025 at 10:09 AM, Staff L, Director of Rehab, stated Resident 10 was no longer in the Occupational Therapy program, the resident was now on an RNP that the nurses were responsible for. <F-677 ADL Care Provided for Dependent Residents> The facility failed to consistently provide assistance with transfers, grooming and nail care for dependent residents. <Resident 2> During an observation on 06/10/2025 at 8:25 AM, Resident 2 had six to ten millimeter (mm) sized strands of facial hair. The resident's fingernails were 1/4 inch long past the tip of their finger and had dark brown debris under the nail tips of both hands. <Resident 25> An observation on 06/09/2025 at 2:90 PM, showed Resident 25's shirt had stains and food particles on the front of it. Resident 25 was unshaven with four to six mm sized facial hairs on the resident's face and neck. The resident's fingernails were ¼ long and past the fingertips with brownish debris underneath the tips on both hands. Resident 25 stated it really drives me crazy that they do not help me enough. <Resident 10> During an observation on 06/11/2025 at 9:01 AM, Resident 10's right hand with contractures of the middle and fourth finger, the resident's nails were long and jagged and had food particles and a dark brown substance underneath them. During an observation and concurrent interview on 06/11/2025 at 1:03 PM, Resident 10 was in bed and answered no when asked if they had got out of bed for the day. <F-684 Quality of Care> The facility failed to ensure care, services and documentation that addressed skin integrity issues were provided in accordance with professional standards of practice. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<Resident 33> During an observation on 06/11/2025 at 8:45 AM, Resident 33 had skin tears to the right forearm and left hand with dried blood on them and no dressings in place. During an interview on 06/11/2025 at 2:02 PM, Staff B, Director of Nursing Services, (DNS), stated they did not know Resident 33 had recent skin tears to both their hand and forearm and had not received any incident reports about skin tears. <Resident 27> During an observation on 06/09/2025 at 2:37 PM, Resident 27's right hand had blood on the top of their right hand. Resident 27's top of their right hand had a four by five-mm patch of skin that had been removed or injured and actively bleeding. <F-686 Prevent/Heal Pressure Injuries> The facility failed to ensure pressure injuries did not develop or worsen in the facility. <Resident 46> Review of a nursing note in Resident 46's electronic medical record dated 06/03/2025 at 7:53 AM, showed a new pressure related blister to Resident 46's left heel. An additional nursing note dated 06/03/2025 at 7:57 AM stated in part, LN spoke with the resident's representative to notify of the pressure related blister to the left heel, who asked that facility staff monitor Resident 46 closely for any open areas on their lower extremities, as they had issues in the past of not healing well. Review of Resident 46's Treatment Administration Records (TARs) for May 2025 and June 2025, showed beginning 05/26/2025 an order was written for LNs to do a complete skin assessment with a narrative (a written assessment of the skin's condition) every day shift on Mondays for skin monitoring. There were no LN initials that showed these assessments were completed on 05/26/2025, 06/02/2025 or 06/09/2025. Resident 46 experienced harm related to the lack of monitoring. <F-689 Free of Accidents> The facility failed to provide adequate supervision to prevent accidents for four of four residents in which Residents 21, 19, 41, and 46 experienced harm. Resident 21 had 14 falls between 04/13/2025 and 05/23/2025 (nine resulted in injuries), experienced harm when they had an unwitnessed fall. Resident 19 fell while unsupervised and experienced harm when they sustained a laceration on their forehead, required transfer to the emergency room (ER) and sutures. Resident 41 fell 17 times in the facility since admission, 12 unwitnessed, from either their wheelchair or bed, and experienced harm when they sustained head trauma, bruising and/or skin tears. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 29 experienced harm when they fractured their left fifth toe when they were left unattended in the bathroom, staff were unavailable to provide transfer assistance. <Grievance Logbook> Record review of the facility grievance logbook from 02/02/2025 to 06/09/2025 showed grievances filed by residents and families related to care concerns. Additionally, there were five grievances filed by residents and families for not receiving timely assistance (including long call light wait times) to meet their basic care needs. <Staff Interviews> During an interview on 06/10/2025 at 1:23 PM, Staff AA, Staffing Coordinator, stated they completed the facility schedule for nursing staff. Staff AA stated they were unaware of the need to have 16 hours per day of RN coverage. Staff AA stated they had utilized agency nurses due to being short of licensed nurses. During an interview on 06/12/2025 at 10:35 AM Staff B, DNS, stated the facility has had staff turnover and that they have done outreach to obtain new staff, offered bonuses, and started using agency for licensed nurses and care staff coverage. Reference WAC 388-97-1080 (1), -1090 (1) This is a repeat citation from Statement of Deficiencies dated 05/22/2024.

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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 the provider responsible for performing each or any specific services/functions for 2 of 3 sampled residents (Residents 21 and 43) reviewed for hospice services. This failure placed residents at risk for not receiving necessary care and services. Findings included . Review of a policy titled Hospice, dated 03/2024, showed each resident's care plan would include both the most recent hospice car plan and the facility's care plan to attain or maintain the resident's highest practicable physical, mental, and psychosocial wellbeing. <Resident 21> Review of the medical record showed the resident admitted to the facility with diagnoses including end stage renal disease (when your kidneys have permanently stopped working). The 05/16/2025 comprehensive assessment showed Resident 21's cognition was moderately impaired and required assistance of one to two staff members for activities of daily living (ADLs). Further review showed Resident 21 was receiving hospice services. Review of Resident 21's care plan dated 05/14/2025, showed the resident was placed on hospice services on 05/14/2025 related to end stage renal disease. Resident 21's care plan was not unique to the needs of the resident's hospice care and lacked documentation of the hospice orders/input. Review of Resident 21's electronic health record (EHR) on 06/10/2025 showed Resident 21 had no hospice care plan. <Resident 43> Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (a loss of blood flow to part of the brain, which damages brain tissue) and dementia (a decline in mental ability, specifically affecting thinking, memory, and reasoning, severe enough to interfere with daily life). The 05/27/2025 comprehensive assessment showed Resident 43's cognition was intact and required assistance of two staff members for ADLs. Further review showed Resident 43 was receiving hospice services. Review of Resident 43's care plan dated 05/20/2025, showed the resident was placed on hospice services 05/20/2025 related to a terminal prognosis (less than six months to live). Resident 43's care plan was not unique to the needs of the resident's hospice care and lacked documentation of the hospice orders/input. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/13/2025 at 10:03 AM, Staff B, Director of Nursing Services, stated the process for hospice services was for the hospice care plan to be integrated into the facility's care plan. Staff B stated the hospice care plan should have been uploaded into Resident 21's EHR and it was probably still waiting to be scanned in. Staff B further stated the process was not followed for Resident 43 and 21. Reference WAC 388-97-1060(1)