STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Park Health Care & Rehab Center	4755 South 48th Tacoma, WA 98409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the State Survey Agency within 24 hours an unwitnessed fall, and failed to log the incident in the facility's reporting log, for 2 of 3 sample residents (Resident 1 and Resident 2) reviewed for falls. This failure placed residents at risk of incidents not being reported and placed residents at risk for abuse and neglect. Findings include . <Resident 1> Resident 1 was admitted to the facility on [DATE] for nursing care and rehabilitation after a fall that required surgery to their hip and femur (thigh bone). Resident 1 was alert and oriented, was their own decision maker and able to make their needs known. On 02/20/2026 at 10:20 AM, Resident 1 said a couple of days before, they had tried to get into their chair and fallen onto the floor around 9:00 PM at night. Resident 1 said when they fell, they hit their hip and it hurt. Resident 1 said they could not reach their call light so they crawled to the door to yell for help. A 02/19/2026 8:19 AM Nurses Progress Note documented the nurse heard a voice yelling for help, went to the resident's room and found the resident laying on the floor. The nurse said Resident 1 stated they lost their balance and fell while trying to sit down on the wheelchair, when it moved away from them and the resident fell. The resident was assisted back into bed with a gait belt and two-person assist. The nurse noted that the resident's walker and wheelchair were far away from the fall position, and the resident said they had pulled themself over to the door to call for help. Review of the resident's record noted Resident 1 had an x-ray taken of their hip on 02/19/2026, the provider documented the resident's unwitnessed fall in a follow-up note dated 02/20/2026, and the resident's fall was reviewed by the facility Interdisciplinary Care Team where the resident's therapy was suspended pending evaluation of the resident's surgical site. Review of the facility's incident reporting log did not include an entry for a fall by Resident 1 on 02/18/2026. Review of the State Agency reporting site did not locate a report by the facility regarding a fall by Resident 1 on 02/18/2026. On 03/26/2026 at 04:05 PM, Staff B said Resident 1's fall had been reported on their internal system but did not realize it had not been added to the facility State reporting log. <Resident 2> Resident 2 was admitted to the facility on [DATE] with multiple diagnoses, including dementia, chronic kidney disease and pressure ulcers, for respite nursing and palliative care. Resident 2 was cognitively impaired and was able to make their needs known, and required staff assistance for activities of daily living. On 03/16/2026 at 2:15 PM, A Collateral Contact (CC-1) said Resident 2 was bedridden and they did not understand how Resident 2 could have fallen out of bed. CC-1 also said staff could not tell them how long Resident 2 had been on the floor and felt like the resident should have been checked on more often. A 02/21/2026 at 11:56 PM nursing note documented Resident 2 was found by staff laying on the floor adjacent from the bed. The resident was not able to verbalize how they had fallen. Resident 2 was moved from the floor to the bed via Hoyer with 2-person assist. The resident was assessed and no injuries were found. The provider and the resident's family were notified. Nursing documented that a facility Interdisciplinary team reviewed the resident's fall on 02/23/2026 and recommended visual cues to remind the resident to use their call light and the resident's care plan was updated. Review of the facility's incident reporting log did not include an entry for a fall by Resident 2 on 02/21/2026. (continued on next page)

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

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

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(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 - Few	Review of the State Agency reporting site did not locate a report by the facility regarding a fall by Resident 2 on 02/21/2026. On 03/26/2026 at 04:05 PM, Staff B said Resident 2's fall had been reported on their internal system but did not realize it had not been added to the facility State reporting log. Reference WAC 388-97-0640 (7)(a)(b)(i) .