STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505093	A. Building B. Wing	05/01/2026

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 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 interview and record review, the facility failed to ensure residents received necessary care and services for 1 of 3 residents (Resident 2) reviewed for quality of care when Resident 2 experienced a delay in care and developed a skin rash. This failure placed residents at risk of unmet care needs, discomfort, and decreased quality of life.Findings included Resident 2 was admitted to the facility on [DATE] with multiple diagnoses for medical management, nursing care and rehabilitative services. The resident was alert and aware and was their own decision maker. The Nursing Evaluation Documentation, dated 03/19/2026 at 9:24 PM, documented Resident 2 was continent of bowel and bladder. The skin assessment section documented the resident had swelling to the scrotum, and did not document the presence of a rash. On 03/25/2026, a provider note documented, under the physical exam section, that Resident 2 had scrotal edema and a diffuse rash. The provider wrote for zinc oxide to apply to groin and genitals topically every 12 hours as needed for rash. Review of Resident 2's Medication Administration Record for March 2026 noted the order dated 03/25/2026 at 1:30 PM for zinc oxide to be applied to groin and genitals topically every 12 hours as needed for rash. No doses were noted to be documented as given. Review of resident 2's care plan did not reference a change in the resident's skin condition or treatment of the resident's rash. On 03/26/2026, a Collateral Contact (CC-1) reported Resident 2 had a two-hour wait for a bedpan at the facility and urinated and defecated while waiting for the bedpan and then developed a rash in their peri area. On 05/01/2026 at 1:55 PM, when asked about nursing interventions for a change in a resident's skin condition, Staff C, a Registered Nurse and a Unit Manager, said there should have been an assessment, the provider should have been notified, there should be notification to the resident and/or family, an order for the treatment, and the care plan updated and it should have documented. On 05/01/2026, Staff C said they were not real familiar with Resident 2's rash. Staff C looked through Resident 2's electronic chart and noted there was an order for zinc oxide for a provider report of 'diffuse rash,' and did not see any alert charting regarding the rash. On 05/01/2026 at 3:17 PM, Staff B, a Registered Nurse and the facility Director of Nursing Services, said they believed the order for the zinc oxide may have been entered directly by the provider and Nursing had not been updated about the rash or the order for treatment. When asked, Staff B said the resident should have been assessed, and documentation of the rash completed and it should have been monitored. On 05/01/2026 at 3:55 PM, Staff A, the facility Administrator, did not have any questions and said it seemed very straightforward. Reference WAC 388-97-1060(1) .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505093	A. Building B. Wing	05/01/2026

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents (Resident 1) reviewed for a significant medication error. This failure placed Resident 1 at risk of medical complications and unintended adverse reactions, and placed other residents at risk for medication errors and unmet needs, when they were discharged with medications that were prescribed to two other residents of the facility, along with their own medications. Findings included .Resident 1 was readmitted to the facility on [DATE] with multiple diagnoses, including history of a stroke with one-sided paralysis and weakness. Resident 1 was alert and oriented and was their own decision-maker. Resident 1 was discharged to their home on [DATE]. Discharge Plan Documentation dated 12/17/2025 showed Resident 1's prescribed medications at discharge included furosemide 20 mg (a diuretic or water pill), one tablet to be taken two times a day, and Warfarin, an anticoagulant (commonly called a blood thinner, that helps to keep blood clots from forming), 4 mg at bedtime until 12/18/2025. Review of incident logs for December 2025 and January 2026 did not include an entry for Resident 1, or the residents whose medications were given to the resident at discharge. On 04/29/2026 at 10:04 AM, Resident 1 stated the facility had sent the resident home with 2 different peoples' medications. Resident 1 said that they took the medications until the resident realized they were not their medications. On 04/29/2026, when asked, Resident 1 reported the medications they received that were labeled with other persons' names were furosemide 20 mg, and Xarelto 20 mg, an anticoagulant. On 04/29/2026 Resident 1 said when facility staff called the resident to check on them after discharge, Resident 1 let them know they had been sent home with someone else's pills. Resident 1 said facility staff asked the resident to return the medications or send them a picture of the medications so that they could be refilled. On 05/01/2026 at 1:46 PM, when asked Staff C, a Registered Nurse and a Unit Manager, said they had heard Resident 1 had a complaint about going home with other residents' medications but did not know what happened with it after that. 05/01/2026 at 3:17 PM, Staff B, a Registered Nurse and the facility Director of Nursing Services, said they expected staff to follow medication safety and ensure residents received medications appropriately. On 05/01/2026 at 3:55 PM, Staff A, the facility Administrator, recalled Resident 1 reported they were sent home with other residents' medications at discharge, and said they asked if Resident 1 could return them to the facility and offered to have them picked up. When asked if there was an investigation completed when Resident 1 reported they had been sent home with medications prescribed to other residents, Staff A said they had spoken with the nurse and had provided education to staff. On 05/04/2026, Staff A provided a copy of an in-service Record on the topic of Correct Discharge Medications that was given to licensed nursing staff on 01/06/2026 presented by Staff B. Reference WAC 388-97-1060 (3)(k)(iii) .