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	05/14/2026

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 0806 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide food that accommodated a documented food allergy for 1 of 3 residents (Resident 1) reviewed for dietary services. Resident 1 experienced harm when the resident was served food which contained an ingredient to which they were allergic, and the resident required medical intervention and monitoring. This failure placed other residents at risk for allergic reaction and medical complications. Findings included. Resident 1 was admitted to the facility on [DATE], was alert and oriented, and was their own responsible party.Review of Resident 1's Electronic Medical Record (EHR) showed that Resident 1 was admitted to the facility on [DATE], was alert and oriented, and was their own responsible party. The EHR further showed Resident 1 had allergies to multiple medications, as well as to onions and latex. Review of Resident 1's record showed that the allergies were listed throughout the resident's chart, including the Resident Profile created on admission, Medication Administration Record and Treatment Administration Records for April 2026 and May 2026.Review of Resident 1's admission diet order, dated 04/20/2026, documented Resident 1 was to receive a cardiac diet (diet to manage heart health) with regular texture and thin liquids, and at the top of the form stated the resident's allergies as onion and latex.Review of the Order Summary noted Resident 1's allergy to onions was documented on 04/20/2026, the date of admission to the facility.Review of a Nutritional Assessment by the facility's Registered Dietitian, dated 04/23/2026, documented Resident 1's allergy to onions and recommended large protein portions.Review of Resident 1's Care Plan created 04/20/2026 and revised 04/23/2026, showed to include large portions of protein to promote wound healing, noted that Resident 1 was at nutrition risk due to multiple diagnoses, but did not include interventions regarding the resident's documented allergy to onions.Record Review on 04/23/2026 at 12:05 PM, a Dietary Profile showed that Staff C, the Dietary Manager, documented they had met with Resident 1 and along with the allergy to onions, noted an allergy/food intolerance to dairy.Review of a Progress Note, dated 05/03/2026 at 7:05 PM, documented Resident 1 had an allergic reaction from onions served them from the kitchen. The nurse noted Resident 1 complained of swelling of their tongue and throat and had a hard time speaking. Nursing documented that on 05/30/2026 at 6:08 PM, Resident 1 was given an injection of epinephrine [the first-line treatment for life-threatening allergic reactions (anaphylaxis], which was effective, and that the resident's vital signs were stable. The nurse noted the resident was crying in bed, scared.On 05/03/2026, Nursing reported to a telehealth provider via SBAR Summary for Providers (communication tool between nursing and providers), dated 5/3/2026 at 7:11 PM, that Resident 1 had a severe allergic reaction to onions, epipen (injectable epinephrine) given and effective, and the resident was evaluated by a telehealth provider. At 6:30 PM, when paramedics arrived onsite to assess the resident, Nursing documented the resident had started to feel better and speak normally. The resident's provider was notified and ordered continued monitoring of the resident.During an interview on 05/06/2026 at 1:06 PM, Collateral Contact 1 relayed a concern that the facility did not listen to the resident's concerns about their diet, as they were allergic to certain foods and the facility continued to serve them the same food.During an interview on 05/11/2026 at 1:19 PM, (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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F 0806 Level of Harm - Actual harm Residents Affected - Few	Resident 1 said they were allergic to onions and facility staff frequently brought them food with onions in it. Resident 1 said when they could see the onions or smell them, they would notify staff and return the food. Resident 1 said they had had a severe allergic reaction to onions in potato salad about a week before and had to have a shot because of it. Resident 1 said the paramedics came to the facility afterward, and by then the resident was doing better. Resident 1 said they were very scared when that happened and was worried it would happen again.During an interview on 05/14/26 at 4:15 PM, Staff C, the Dietary Manager said they had recently made changes as to how allergies and preferences were coded and flagged on the tray tickets and that they were to be verified by multiple staff before the food reached the resident.During an interview on 05/14/2026 at 4:56 PM, Staff B, a Registered Nurse and the facility Director of Nurses, recalled that Resident 1 was served onions in their food, had an allergic reaction and was treated with epinephrine. When asked how the incident occurred, Staff B said they had new staff and that it was missed by the other staff. Reference WAC 388-97-1100