

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure 5 of 5 residents (Residents 1, 2, 3, 4 & 10) reviewed for insurance disenrollment were informed of the risks/benefits, options, and alternative changes in their insurance, in ways that were easy for the residents and/or the residents' representative to understand. The facility failed to develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage, including the need to obtain a document signed by the beneficiary or representative that acknowledges that the specific information regarding the impact of a change in coverage was provided to them orally and in writing, and that they understood the information. Failure of the facility placed residents at risk of non-coverage, increased cost out of pocket, and caused undue stress to residents and/or resident representatives and placed 24 Managed Medicare residents at risk of the facility disenrolling them without their request, consent knowledge or complete understanding. Findings included. Review of the undated notice of Long-Term Care Resident Rights in the facility admission Agreement Packet showed the facility must inform each resident in writing in a language the resident or his or her representative understands changes in the availability or the charges for services, items, or activities. In addition, the resident has the right to manage his or her financial affairs. <RESIDENT 1> Review of the Census List showed Resident 1 admitted to the facility 05/11/2026 on Managed Medicare and transitioned to Traditional Medicare effective 06/01/2026. Review of a Facility Attestation, (to be used if Resident's Authorized Representative requests assistance with healthcare insurance coverage changes), dated 05/26/2026, showed Staff DD, Corporate Social Worker, assisted Resident 1's spouse with the change in enrollment from Wellcare Medicare to Medicare. Staff DD signed attesting that the Resident's Authorized Representative received and understood the information contained in the Information Sheet for Residents. The form did not contain a signature of acknowledgement from the Resident's Authorized Representative. During an interview on 07/13/2026 at 11:10 AM, Resident 1 was not aware of any changes made to their insurance and asked the investigator to speak with their Representative. During an interview on 07/13/2026 at 12:56 PM, Resident 1's Representative (R1R) stated they were not aware of or remember any discussions regarding changing Resident 1's insurance. R1R did not recall receiving any information in writing and stated they were not aware of what those changes entailed. <RESIDENT 2> Review of the Census List showed Resident 2 admitted to the facility 04/21/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026. During an interview on 07/13/2026 at 11:19 AM, Resident 2 stated they were not aware their insurance was changed and asked, what does that mean? Resident 2 stated with their Medicare Advantage plan everything was covered, but now that they were put on Traditional Medicare they will end up owing money. Resident 2 stated they got something in the mail informing them that they dropped their insurance. Under Managed Medicare they had coverage for their specialists and doctors and now they are getting letters that they need to do this and do that, (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	etc.<RESIDENT 3>Review of the Census List showed Resident 3 admitted to the facility 04/20/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026.During an interview on 07/13/2026 at 11:32 AM, Resident 3 stated they did not receive anything in writing prior to their insurance being changed. Resident 3 did not recall being informed of the benefit or potential consequences of the change, other than they would be able to stay in the facility longer.Review of Resident 3's record showed no Notice of Medicare Non-Coverage (NOMNC), no progress notes regarding the change and no consent form.<RESIDENT 4>Review of the Census List showed Resident 4 admitted to the facility 04/29/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026.During an interview on 07/13/2026 at 1:21 PM, Resident 4 stated they were not aware their insurance was changed.Review of Resident 4's record showed no NOMNC, no progress note regarding the change and no consent form.<RESIDENT 10>Review of the Census List showed Resident 10 admitted to the facility 04/21/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026.During an interview on 07/15/2026 at 2:36 PM, Resident 10's Representative (R10R), stated they had no idea how Resident 10's insurance was changed. R10R stated no one talked to them before changing Resident 10's insurance, and Resident 10 did not understand it. R10R explained they went to a pharmacy to pick up medications, and they were told that Resident 10's Managed Medicare was cancelled and transitioned to Medicare A on 05/01/2026. They also lost their Case Manager and representative with the changes. They started getting a bunch of stuff in the mail, people were charging Resident 10 money. They received a bill for \$1,894.00, but it doesn't say from where, but the insurance paid zero.During an interview on 07/13/2026 at 2:29 PM, Staff N, Internal Case Manager, stated they follow the residents on Managed insurances for the duration of their stay with that insurance. Staff N sends the insurance company weekly reports as requested. When the insurance company says the resident no longer meets the criteria for coverage and they issue a NOMNC, they communicate that to the resident or resident's responsible party. Staff N stated they advise them they have three options; 1) discharge, 2) stay in the facility with coverage by a different payor (Medicaid, Private.), 3) appeal the insurance decision. Staff N stated that if the resident requested an alternate payor, the business office assisted them. Staff N stated the facility currently had 24 residents under managed care.During an interview on 07/15/2026 at 4:18 PM, Staff A, Administrator, stated the procedure was if a resident was issued a NOMNC, the staff were to educate the residents on their options. If the residents had more questions they could call the insurance company. Staff A stated, It is ultimately the resident's decision on what they want to do. When asked if they provided anything to the residents in writing, Staff A stated the notice from their insurance company, the NOMNC explained why it was being issued. When asked if the staff explained the pros and cons of changing their insurance, Staff A stated, no as they were no insurance agents. When asked who would assist the residents back on their Managed Medicare plan prior to discharge, Staff A stated they did not know.REFERENCE WAC: 388-97-0260, -0300(3)(a).		

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. Based on interviews and record reviews, the facility failed to protect 5 of 5 residents' rights to Medicare benefits. The facility disenrolled five (Residents 1, 2, 3, 4 & 10) beneficiaries from Medicare Managed Health Plans without their request, consent, knowledge and/or complete understanding. The facility failed to develop written policies and procedures regarding the process of assisting beneficiaries with changing their health care coverage, including the circumstances under which the facility could assist a beneficiary with a plan change, and the need to obtain an attestation signed by the facility staff member that assisted with the change in enrollment, attesting that the beneficiary or representative requested the change. Failure of the facility placed residents at risk of non-coverage, increased cost out of pocket, and caused undue stress to residents and/or resident representatives and placed 24 Managed Medicare residents at risk of the facility disenrolling them without their request, consent knowledge or complete understanding. Findings included. A facility policy and procedure regarding how staff assist beneficiaries with insurance coverage changes was requested on 07/13/2026 at 10:41 AM and none was provided. During an interview on 07/13/2026 at 11:56 AM, Staff C, Nurse Consultant stated that based on their conversation with the Administrator, the facility did not have such a policy. <RESIDENT 1> Review of the Census List showed Resident 1 admitted to the facility 05/11/2026 on Managed Medicare and transitioned to Traditional Medicare effective 06/01/2026. Review of a Facility Attestation, (to be used if Resident's Authorized Representative requests assistance with healthcare insurance coverage changes) dated 05/26/2026 showed Staff DD, Regional Social Worker, assisted Resident 1's spouse with the change in enrollment from Wellcare Medicare to Medicare. Staff DD signed attesting that the Resident's Authorized Representative requested the change and that the Resident's Authorized Representative received and understood the information contained in the Information Sheet for Residents. Any and all assistance provided assisting the Resident's Authorized Representative to review or make healthcare insurance coverage decisions, including disenrollment and enrollment in a Medicare health plan or Original Medicare, was in compliance with Policy on Resident Insurance Coverage and Changes. The form did not contain a signature of acknowledgement from the Resident's Authorized Representative. A Facility Attestation (to be used if Resident requests assistance with healthcare insurance coverage changes) was completed by Staff E, Social Services Director, attesting they assisted Resident 1 with the change in enrollment from WellCare to Medicare on 05/26/2026. The form did not contain a signature of acknowledgement from the Resident. During an interview on 07/13/2026 at 11:10 AM, Resident 1 was not aware of any changes made to their insurance and asked the investigator to speak with their Representative. During an interview on 07/13/2026 at 12:56 PM, Resident 1's Representative (R1R) stated they were not aware of or remember any discussions regarding changing Resident 1's insurance. <RESIDENT 2> Review of the Census List showed Resident 2 admitted to the facility 04/21/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026. During an interview on 07/13/2026 at 11:19 AM, Resident 2 stated a guy came in and talked to them about changing over their insurance, saying it would be better for them. Resident 2 said they were told nothing would change, and Resident 2 told them if they did, they could not afford it. When asked if they had provided anything in writing, Resident 2 stated they got something in the mail informing them that they dropped their insurance. <RESIDENT 3> Review of the Census List showed Resident 2 admitted to the facility 04/20/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026. Review of Resident 3's record showed no Notice of (continued on next page)		

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F 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medicare Non-Coverage (NOMNC), no progress notes regarding the change request and no consent.During an interview on 07/13/2026 at 11:32 AM, Resident 3 stated that they previously lived in their van and the facility changed their insurance so they could stay in the facility longer. Resident 3 stated a while ago; some lady talked to them because they wanted to change their insurance. Resident 3 stated the facility staff initiated the conversation.<RESIDENT 4>Review of the Census List showed Resident 4 admitted to the facility 04/29/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026.During an interview on 07/13/2026 at 1:21 PM, when asked if they requested their insurance to be changed, Resident 4 responded, No, why would I? Resident 4 denied signing any documents consenting to having their insurance changed.<RESIDENT 10>Review of the Census List showed Resident 10 admitted to the facility 04/21/2026 on Managed Medicare and transitioned to Traditional Medicare effective 05/01/2026.During an interview on 07/15/2026 at 2:36 PM, Resident 10's Representative (R10R), stated, I have no idea how that happened, I've already changed it back. Resident 10 will be back on their Managed Medicare plan effective 08/01/2026. R10R stated they asked around and nobody knows who did it. I was shocked!During an interview on 07/14/2026 at 11:32 AM, Staff E stated that Staff DD told the facility staff that if a resident got a NOMNC (Notice of Medicare Non Coverage) and was concerned about going home, didn't feel stable, they could appeal the NOMNC, apply for Medicaid, or switch to Medicare A and get therapy longer. Staff E there was a paper the resident would sign that Medical Records was uploading and an associated progress note. Staff E stated they did the first few in May 2026 (with the change effective June 1st) with Staff DD who were providing the training. Staff E stated they had not done any in subsequent months, and did not know who, if anyone, was doing them.During an interview on 07/14/2026 at 12:02 PM, Staff F, Social Services Designee, stated that Staff DD provided them with training that if residents needed to be skilled longer to transfer their insurance over to Traditional Medicare. Staff F stated they had not done so or been involved in that practice.During an interview on 07/15/2026 at 4:18 PM, Staff A, Administrator, stated the procedure was if a resident was issued a NOMNC, the staff were to educate the residents on their options. They have three options; 1) apply for Medicaid, 2) appeal the insurance decision, 3) Transition to traditional Medicare. Staff A stated their understanding was that the residents and families signed consent forms when they switched (their insurance). Staff A stated, I tell them not to influence or push the residents. We are not insurance agents.Review of Resident 2, Resident 3, Resident 4 and Resident 10's record showed no consent forms, or other documentation to support the beneficiary or representative requested the change.During an interview on 07/14/2026 at 12:57 PM, Staff M, Health Information, stated they previously uploaded all the documentation of residents' insurance changes they received.REFERENCE WAC: 388-97-0040(2), -1780(1)(2), -0180(4)(c).		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to develop and implement an effective discharge planning process that focused on residents' discharge goals and preparation of residents for discharge and failed to develop and implement comprehensive discharge care plans for 4 of 5 residents (Residents 2, 4, 3 & 5) reviewed for discharge planning. These failures placed residents at risk of a diminished quality of life, depleting valuable Medicare coverage days, unnecessarily extended length of stay and/or feeling they were being held against their will. Findings included.<RESIDENT 2> Review of the 04/27/2026 admission Minimum Data Set (MDS - an assessment tool) showed Resident 2 admitted to the facility on [DATE], was assessed to have moderate cognitive impairment, and required substantial assistance with bed mobility and transfers. Resident 2 received Occupational Therapy (OT), Physical Therapy (PT), and Resident 2's plan was to discharge to the community. According to this MDS, active discharge planning had been initiated for Resident 2 to return to the community. Review of the 04/24/2026 Comprehensive Care Plan (CP), last revised on 07/08/2026, did not provide documentation to show a discharge plan had been initiated. Review of the 04/24/2026 Activities of Daily Living (ADL) CP showed Resident 2 was non-ambulatory, required substantial/max assist with bed mobility and personal hygiene, was dependent on staff for dressing, and required a 2-person mechanical lift transfer. An intervention with the same date gave directives for PT/OT to evaluate and treat according to the physician orders. Review of the 04/21/2026 CP showed Resident 2 had a chronic indwelling urinary catheter. Review of Case Management Note dated 04/22/2026 showed that Resident 2 desired to return home to their apartment where they previously lived independently with a paid caregiver's assistance. A 04/28/2026 note showed Resident 2 was taking steps with therapy and their goal remained to be able to climb up three steps to enter their home. Review of Resident 2's PT Encounter Notes showed therapy began stair-step training on 05/13/2026. On 05/31/2026 Resident 2 ambulated with a walker 100 feet, 70 feet, 120 feet, and 100 feet with staff following behind with wheelchair and with emphasis on stride length, ambulation posture, and negotiating obstacles. Resident 2 practiced four steps up and down with handrail assist, modified independence (Mod I-ability to safely complete a physical task or mobility maneuver independently but requires the use of an assistive device, adaptive equipment, or additional time to complete the task). Review of a PT Encounter Note dated 06/01/2026 showed Resident 2's functional status with skilled interventions were Mod-I with bed mobility, transfers, ambulation with a walker, stairs, and wheelchair mobility. Resident 2's safety awareness was intact. Review of an OT-ADL Training Functional Status as a Result of Skilled Interventions note dated 06/17/2026 showed Resident 2 was assessed as Mod-I with personal hygiene, toileting, and dressing. Review of a PT Encounter Note dated 06/30/2026 showed they discussed with Resident 2 the plan of care and new goals to optimize independence and safety to return home. Review of a Medicare Recertification dated 07/12/2026, showed it was signed by the provider on 07/10/2026 and certified the need for continued daily skilled therapy and nursing care including wound care for redness and Indwelling catheter although Resident 2 had met their discharge goals with therapy for returning home independently and did not have nursing care needs that required seven days per week of skilled nursing services. During an interview on 07/13/2026 at 11:19 AM, Resident 2 stated they wanted to discharge from the facility as soon as possible, but the facility staff said they were not ready yet. Resident 2 stated they planned to discharge home to their apartment (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and only had to climb three steps. Resident 2 stated prior to admission they used a walker and/or cane and walked one-mile round trip to the grocery store three times a week. Resident 2 stated they were doing steps and walking in 150 feet therapy, and up to 410 feet outside. Resident 2 stated the therapist said they wanted [them] to be better with walking before discharge. When asked what their barriers to discharge were to discharge, Resident 2 stated they felt they were ready for discharge, they just needed the facility to say when they could discharge so they could get their caregiver scheduled. Resident 2 stated they had been asking to discharge for the past two or three weeks. During an interview on 07/13/2026 at 1:28 PM, Staff O, Director of Rehabilitation, stated they believed Resident 2 was discharging real soon, last week they were able to walk 90 feet. Initially they needed to do stairs, then they wanted to walk to grocery store with a four wheeled walker. Staff O stated they held a progress meeting on 06/13/2026 to recommend discharge, but Resident 2 still had stairs and a further distance to walk. During an interview on 07/14/2026 at 12:02 PM, Staff F, Social Services Designee, stated they had a care conference with Resident 2, three to four weeks ago and therapy reported they needed one more week to work on stairs, and that was the last had heard. <RESIDENT 4>Review of the 05/26/2026 Significant Change in Status / 5-day MDS showed Resident 4 readmitted to the facility on [DATE]. Resident 4 was alert, oriented, and required set-up assistance with oral hygiene, partial/moderate assistance with toileting hygiene, dressing and transfers, and required supervision for bed mobility. According to this MDS there was no information regarding Resident 4's overall goal for discharge, but active discharge planning was already occurring for the resident to return to the community. During an interview on 07/13/2026 at 1:21 PM, Resident 4 stated they wanted to go home. When asked what their barriers to discharge were, Resident 4 stated they did not know and they had been asking the staff the same questions. Resident 4 stated they had 3 steps to climb to enter their home, which they achieved, and they could dress themselves and use the bathroom independently. Resident 4 stated their adult child lived with them and they also had a caregiver. Resident 4 stated PT told social services they were ready to discharge a couple of weeks ago. During an interview on 07/13/2026 at 1:28 PM, Staff O stated Resident 4 had difficulty maintaining their oxygen saturation at the beginning of their stay and they were currently working on increasing activity tolerance and lower body dressing, and PT was working on functional transfers. Resident 4 currently ambulated 75 feet with contact guard assistance (CGA-a safety measure where the therapist keeps one or two hands on the patient-often a gait belt-to help with balance, the patient performs 100% of the physical effort, and the therapist provides zero assistance only steadying support in case the resident lost their balance) required for the last 15 feet. Resident 4's goal was to ambulate 150 feet. <RESIDENT 3>Review of the 04/26/2026 admission MDS showed Resident 3 admitted to the facility on [DATE], had no cognitive impairment, required supervision with bed mobility, partial/moderate assistance with oral hygiene, lower body dressing, and transfers, set up with upper body dressing, substantial/maximal assistance with toileting hygiene, showering, and personal hygiene. Resident 3 received PT, OT, and Speech-Language Pathology (SLP) at least 15 minutes a day on one or more days in the last 7 days. According to this MDS, Resident 3's overall goal for discharge was to remain in the facility and no active discharge planning had been initiated to return to the community. Review of the resident's 04/23/2026 Comprehensive CP did not provide documentation to show a CP had been initiated for discharge planning. According to the CP, Resident 3 required PT related to impaired bed mobility, impaired gait, and impaired transfers. Listed goals included the resident will would perform bed mobility with Modified Independence, would increase gait ability on flat surfaces, ambulate 150 feet with a two-wheeled walker and supervision, and increase only require supervision with transfers. Review of an Interdisciplinary Care Conference dated (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	04/21/2026 showed Resident 3's original discharge goal was to return to the community, but during the conversation, Resident 3 decided they would remain in the facility long-term as Resident 3 felt they were too sick to return to living in their van. Review of a 04/28/2026 Case Management Assessment note showed the Resident 3 intended to stay at the facility as a long-term care resident once skilled services ended. Review of PT Treatment Encounter Notes showed on Resident 3 performed transfers from bed to wheelchair with Mod-I on 05/19/2026. On 06/09/2026 Resident 3 ambulated 150 feet using four-wheeled walker (4WW) with Stand By Assist (SBA- a safety level where the caregiver stands close to supervise the task, ready to step in instantly if the resident lost their balance). On 06/10/2026 Resident 3 participated in bed mobility training and was assessed as Mod-I. On 07/13/2026 Resident 3 performed bed mobility and transfers with Mod-I, ambulated using 4WW with SBA, and was independent with WC mobility. During an observation and interview on 07/13/2026 at 11:32 AM, Resident 3 was dressed, wearing tennis shoes. Resident 3 stated they planned to stay at the facility for awhile and noted the facility changed their insurance so they could stay longer. Resident 3 stated prior to admission they lived in their van. Resident 3 stated they were currently receiving therapy for walking and stuff. During an interview on 07/13/2026 at 1:28 PM, Staff O stated Resident 3 was on PT caseload for ambulation and safe transfers and OT for upper and lower body dressing, toileting, and safely gathering items for ADL tasks. During an interview on 07/14/2026 at 12:02 PM, Staff F stated Resident 3 had no current discharge plan and they were still receiving skilled therapy services. <RESIDENT 5> Review of the 05/27/2026 admission MDS showed Resident 5 admitted to the facility on [DATE], had no cognitive impairment, and was able to communicate clearly. Resident 5 was assessed during the first three days of their stay to require set-up assistance with oral hygiene, toileting hygiene, dressing upper body, and personal hygiene, supervision with showers, dressing lower body, and walking 10 feet, and was independent with bed mobility and transfers. Resident 5 received PT and OT for at least 15 minutes a day on one or more day in the prior 7 days of the observation period. According to this MDS, Resident 5's overall goal was to discharge the community, and active discharge planning was already initiated for the residents to return to the community. Review of the 06/01/2026 CP showed Resident 5's discharge plan was to an Assisted Living Facility. The CP did not show status updates documented. The OT CP revised 06/11/2026 showed Resident 5 required OT related to decreased balance and coordination, decreased strength and endurance, impaired functional mobility and impaired ADL skills. The goals listed were that Resident 5 would perform lower body dressing independently, toilet self with modified independence, and increase functional transfers to modified independence. Review of OT ADL Training Note dated 06/24/2026 showed Resident 5 was intermittently refusing participation and was mostly independent. Resident 5 ambulated with a FWW or walking stick, and no assistive device required when ambulating in their room. OT did not discharge Resident 5 from skilled OT services until 07/07/2026. Review of the PT Evaluation dated 06/12/2026, showed Resident 5 was assessed as independent with bed mobility, transfers, modified independent with ambulation, and SBA to pick up an object. According to the evaluation, Skilled PT services were warranted to address mobility deficits, improve balance and strength, enhance safety with functional activities, and maximize independence while reducing risk of rehospitalization. A 06/23/2026 PT note showed Resident 5 ambulated the facility hallway with and without assistive devices for community distances. Review of a 06/25/2026 PT note showed Resident 5 actively participated in skilled interventions but refused group therapy and did not like therapy because they could do the exercises on their own. Skilled PT was discontinued on 07/07/2026 and Resident 5 would remain in the facility long term care. On 07/14/2026 at 9:54 AM, Resident 5 was observed ambulating independently with a walker. Resident 5 was fully dressed, (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	groomed, and wearing tennis shoes. Resident 5's left foot was in a boot. Resident 5 stated they were at the facility for their leg, that they had a titanium plate in their leg, and their leg gave out. Resident 5 stated they were receiving PT and OT. During an interview on 07/15/2026 at 9:51 AM, Resident 5 stated they did not have a place to live, and they wanted to keep the single private room they had in the facility. Resident 5 stated they were able to dress themselves, Of course, went to the bathroom, All alone, and ambulated independently. When asked about the use of a walker, Resident 5 stated it was not permanent and they were trying not to use it. Resident 5 stated they were receiving therapy, covered by their insurance. During an interview on 07/15/2026 at 5:24 PM, Staff B, Director of Nursing, stated they discussed in their clinical meeting that Resident 5 needed to discharge, but they were Medicaid Pending, homeless, with no place to go. During an interview on 07/15/2026 at 5:24 PM, Staff A, Administrator, stated that Resident 5 was on the list for a DSHS (Department of Social & Health Services) Assessment for placement. During an interview on 07/13/2026 at 2:29 PM, Staff N, Internal Case Manager, stated they managed the residents that received care and services under the Managed Medicaid and HMOs (Health Maintenance Organization, a type of Medicare Advantage Plan). Staff N stated they did not manage the residents under Traditional/Medicare A insurance. Staff N stated social services were responsible for the coordination of discharges. During an interview on 07/14/2026 at 11:32 AM, Staff E, Social Services Director, stated they did not attend the facility's Utilization Review or Interdisciplinary Team Meetings, and stated Staff F was the discharge planner. During an interview on 07/14/2026 at 12:02 PM, Staff F, stated they attended Utilization Review meetings and held discharge care conferences. Staff F stated when they heard about someone being ready for discharge, they coordinated the set-up of home health services, appointments, and initiated a discharge packet they provided to the nurse manager. When asked how they knew what factors and disciplines (nursing and/or therapy) were [NAME] a resident's stay, Staff F stated they did not know. Staff F stated residents under the traditional Medicare A were reviewed by the business office, but since the Business Office Manager quit three weeks prior no one was doing them. REFERENCE WAC: 388-97-0080		

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NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4755 South 48th Tacoma, WA 98409	
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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record reviews the facility failed to ensure^7^ of 8^ Residents (Residents 8, 12, 18, 1, 15, 22 & 9) who were unable to perform Activities of Daily Living (ADLs-including oral care, grooming, personal hygiene, toileting, and good nutrition) received the care and services they required.^ This failure placed residents at risk for unmet care needs, skin breakdown, infections, and undignified quality of life.^ Findings included . ^ <POLICY> Review of the facility's Activities of Daily Living (ADLs), Supporting policy, revised 2018, showed the staff would ensure residents who were unable to independently perform ADLs would be provided the necessary services and care they were assessed to require (and according to their care plan (CP)), including assistance with: hygiene (bathing, dressing, grooming, and oral care), mobility (transfer, ambulation, and walking), toileting (staff would do round prior to all meals to ensure that ADL care needs were met), dining, and communication (speech, language and any functional communication systems). The resident's response to care interventions would be monitored, evaluated, and revised appropriately.^ ^Review of the facility's CNA Shower Sheet, undated, showed the form was to be completed for all baths/showers provided. The sheet showed the date, resident, and room number, a body graph for accurate description of abnormal skin findings, and staff were to circle the tasks they provided during that bathing event. The choices included: shower, hair washed (unless they went to the salon regularly-then no hair wash), shave, nails trimmed (toes and fingernails-Not if Diabetic!), their weight, and any observed skin abnormalities. The tasked options did not include tub bath or bed bath performed. The form also showed that if the residents refused their scheduled bath the CNA must get the nurse to speak with the resident and any bed baths provided must be approved by the nurse.^ <RESIDENT 8>^Review of the 06/25/2026 Significant Change in Status Minimum Data Set (MDS-assessment tool) showed Resident 8 re-admitted to the facility on [DATE], had no cognition problems, and no behaviors or rejection of care. Resident 8 required maximum bathing assistance, moderate assistance with bathing transfers, and was incontinent of bowel and bladder. Resident 8 diagnoses included heart failure, diabetes, arthritis, seizure disorder, and kidney failure that required hemodialysis (an outpatient procedure where the blood is removed from the body so that the toxins can be filtered from the blood, then the blood is replaced) three times a week. Review of the 06/25/2026 ADL Care Plan (CP) showed Resident 8 was dependent on staff to provide bathing. The CP did not provide documentation to show their resident-centered preferences for bathing including weekly schedule, type of bathing they preferred, or time of day.^ ^Review of the East Shower Schedule showed Resident 8 was scheduled to receive showers on Wednesdays and Saturdays on the day shift. Review of Resident 8's Documentation Survey Report from 06/19/2026 through 07/13/2026 showed a bed bath documented on 06/27/2026 and showers documented 06/30/2026, 07/04/2026, 07/06/2026, and 07/13/2026.^ The documentation showed Resident 8 had areas of their skin that were reddened on 07/06/2026 and 07/13/2026.^ ^Review of a Shower Sheet dated 06/17/2026 showed Resident 8 received a shower and hair wash, but their nails were not trimmed, and was signed by Staff CC, Certified Nursing Assistant (CNA)/Bath Aid.^ ^Review of the June and July 2026 Treatment Administration Record (TAR) did not show licensed staff provided diabetic nail care and monitoring.^ ^Review of Resident 8s clinical record did not provide documentation to show the CNA Shower Sheets were completed with each shower provided.^ ^During an observation and interview 07/13/2026 at 11:15 AM, Resident 8 was observed to have long nails with dark debris under the nails, and their hair appeared to be oily with dry, flaky scalp.^ Resident 8 stated they did not recall how (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	many baths they had since admission to the facility but stated, Not as many as were planned. ^ Resident 8 stated they planned to have two showers per week but that did not occur during their stay because they went to dialysis during the day on Tuesdays, Thursdays, and Saturdays and their second scheduled shower day for the week was scheduled during their dialysis treatment. ^ Resident 8 stated they had asked nursing staff to have their nails trimmed, but no one ever trimmed them. Resident 8 stated I finally got a shower today, for the week, but I am discharging home today. <RESIDENT 12> Review of the 06/29/2026 5-Day MDS showed Resident 12 re-admitted to the facility on [DATE]. Resident 12 was unable to speak but was able to express themselves in a manner that others could usually understand and they usually were able to understand others. Resident 12 had severely impaired vision and severely impaired cognition. Resident 12 was assessed to have no behavior or rejections of care. Resident 12 was dependent on staff for bathing, transfers, hygiene, toileting, and was incontinent of bowel and bladder. Resident 12s diagnoses included a stroke with inability to speak or safely swallow and hemiplegia (loss of movement of one side of the body), kidney failure that required hemodialysis three times per week, a major infection, and diabetes. Resident 12 admitted to the facility with a surgical wound and Moisture Associated Skin Damage (MASD-skin impairment caused by excessive exposure to moisture from incontinence, perspiration, or other drainage). ^ Review of Resident 12s ADL CP, dated 04/08/2025, showed Resident 12 was dependent on staff to provide a bath but did not indicate their resident-centered preferences for bathing or who was responsible for providing nail care. ^ Review of the [NAME] Shower Book on 07/15/2026 11:30 AM showed a [NAME] Daily Shower Schedule, dated Monday 06/29/2026 that showed Resident 12 was scheduled to receive a shower on the day shift and it was not documented as provided. The [NAME] Shower Schedule process appeared to be different than the East Shower Schedule process. Review of Resident 12s bathing record from 06/23/2026 through 07/15/2026 showed they received a shower on 06/24/2026, 07/02/2026 (eight days later), and a bed bath on 07/03/2026. ^ The documentation showed Resident 12 had not received a bath in 12 days. 12 days as of 07/15/2026. ^ Review of Resident 12s clinical record did not provide documentation to show the CNA Shower Sheets were completed with each shower provided. ^ During an observation and interview on 07/14/2026 at 3:20 PM, Resident 12 was observed with dark matter under their nails and had long facial hair. Resident 12 indicated they would like their beard trimmed. ^ During an interview on 07/14/2026 at 3:25 PM, Staff BB, CNA, stated they did not know who was responsible to trim Resident 12's beard. Staff BB stated the nurses were responsible for trimming Resident 12's nails. Staff BB stated they had shower aids some days, but if they did not and it was Resident 12's shower day then they gave them a bed bath. ^ Review of Resident 12s June and July 2026 TAR did not provide documentation to show that licensed nurses performed/offered and monitored weekly diabetic nail care. ^ In an interview on 07/14/2026 at 3:27 PM, Staff W, Registered Nurse (RN), stated the restorative CNA or licensed nurses were responsible for providing and cleaning nails but Resident 12 had a history of refusing care. ^ <RESIDENT 18> ^ Review of the 05/11/2026 Quarterly MDS showed Resident 18 admitted to the facility on [DATE]. Resident 18 had no problems with their cognition, no behaviors, and no rejection of care. Resident 18 required a wheelchair for mobility, moderate staff assistance for bathing and set-up/supervision for transfers. Resident 18s ability to transfer in the shower was not assessed. Resident 18 was incontinent of bowel and bladder and diagnoses included: surgical aftercare for osteoarthritis of the right knee, diabetes, anxiety, depression, generalized weakness, and need for assistance with personal care. ^ Review of Resident 18s ADL CP, dated 02/03/2026, showed they required one person for staff assistance with bathing. ^ The CP did not indicate Resident 18s resident-centered shower preferences. Review of the East Shower Schedule, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	undated, showed Resident 18 was scheduled for a shower on Wednesdays and Saturdays in the evening. ^Review of Resident 18s bathing record from 06/19/2026 through 07/15/2026 showed a bed bath documented on 06/23/2026 and 06/26/2026. Showers were documented on 06/30/2026, 07/01/2026, 07/04/2026, 07/05/2026, and 07/06/2026. The documentation showed Resident 18 was not available on Saturday 07/11/2026, a shower was documented on 07/13/2026, and bed bath was documented 07/14/2026. ^Review of Resident 18s clinical record did not provide documentation of the CNA Shower Sheets from showers documented as provided. ^Review of Resident 18s June and July 2026 TARs did not provide documentation to show that weekly diabetic nail care was provided or monitored by licensed nursing staff. ^Review of the Shower Book at the nurse station showed two CNA Shower Sheets: One dated 07/01/2026 and signed by Staff CC that indicated a shower and hair wash were provided and one dated 07/08/2026, signed by Staff CC, that a shower and hair wash were provided. ^During an observation of an interaction between Staff CC and Resident 18 on 07/14/2026 at 11:15 AM, Resident 18 asked Staff CC if they could receive a shower that morning because they did not receive their scheduled shower on Saturday (07/11/2026) or their requested shower on Monday (07/13/2026-to make-up for the missed Saturday shower). Staff CC replied to Resident 18 saying they were not on the bath schedule for that day. Resident 18 was observed to have very long hair that appeared slightly matted, oily, and not combed through. ^In an interview on 07/15/2026 at 9:45 AM, Resident 18 stated they still had not received the shower they requested on 07/14/2026 at 11:15 AM. Resident 18 stated they were scheduled to receive a shower twice weekly on Wednesdays and Saturdays. Resident 18 stated they did not receive their scheduled shower on Saturday 07/11/2026. Resident 18 stated when they asked about their shower on Saturday, they were told by their CNA that the facility did not provide showers on the weekends. They requested a shower on Monday, 07/13/2026, to make up for their missed Saturday shower but did not receive one. On 07/14/2026 they again requested a shower and was told it was not their scheduled shower day. Resident 18 stated they requested to receive their shower at 11:00 AM on 07/15/2026 but was not optimistic that they would get their shower. Resident 18 stated they had skin problems that worsened when they didn't get to adequately bathe. Resident 18 showed their skin problem that appeared red and irritated. Resident 18 stated the facility provided treatment for the skin problem, but routine bathing helped prevent it from worsening. Resident 18 stated they had never received showers or bed baths on consecutive days while at the facility, as the documentation on the bathing record reflected, and confirmed they did not receive showers on 07/13/2026 or 07/14/2026. ^<RESIDENT 1>^Review of the 05/22/2026 admission Assessment MDS showed Resident 1 was assessed with moderate cognitive impairment, no behaviors, and no rejections of care. Resident 1 was always incontinent of bowel and bladder and required substantial, maximal assistance with shower/bathing, dressing, and personal hygiene.^Review of Resident 1's ADL CP, dated 05/11/2026, showed a bathing intervention dated 05/19/2026 that Resident 1 was totally dependent on staff to provide a bath and as necessary and to provide a sponge bath when a full bath or shower could not be tolerated. The CP did not indicate their resident-centered bathing preferences or who was responsible to provide nail care. Review of the undated East Shower Schedule showed that Resident 1 was scheduled for bathing on Tuesdays and Fridays. ^Review of Resident 1s bathing record from 06/19/2026 through 07/15/2026 showed a shower documented on 06/22/2026, 06/23/2026, 06/28/2026, 06/29/2026, and a bed bath on 07/05/2026. There were no documented refusals. ^Review of the shower book at the nurse station on 07/14/2026 at 11:22 AM showed CNA Shower Sheets for Resident 1 on: 06/02/2026 -shower and hair wash, no nail care or shave; 06/05/2026-shower, hair wash, no nail care or shave; 06/09/2026-Refused bathing; 06/12/2026-shower and hair wash, no nail care or shave; (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/16/2026-bed bath, no hair wash, nail care or shave; and 07/08/2026-shower, hair wash, no nail care or shave. No other shower sheets were in the binder for Resident 1. Review of Resident 1s clinical record did not provide documentation to show the shower sheets were completed, that refusals of care were addressed, or that additional showers and nail care were provided. In an observation and interview on 07/13/2026 at 11:12 AM, Resident 1 was observed to have long nails with dark matter under the nails and a noticeable odor of urine. ^ ^<RESIDENT 15> Review of the 06/30/2026 admission MDS showed Resident 15 admitted to the facility on [DATE]. Resident 15 had no problems with their cognition, no behaviors, and no rejection of care. Resident 15's daily preferences interview showed it was very important to them to choose how they took baths (whether it was a shower, tub bath, bed bath, or sponge bath). ^ Resident 15 required a wheelchair for mobility, was dependent on staff for bathing and transfers, was incontinent of bowel, and had a urinary catheter. Resident 15's diagnoses included: new traumatic spinal cord injury with paraplegia (inability to move parts of the body below the spinal cord injury site), traumatic brain injury, catheter associated urinary tract infection in the previous 30 days, other multiple fractures, and awaiting admission to inpatient rehabilitation. ^ Review of Resident 15's ADL CP, dated 06/24/2026, showed they required one person staff assistance for bathing/showering. The CP did not indicate Resident 15s resident-centered bathing preferences or weekly schedule. Review of the undated East Shower Schedule showed Resident 15 was scheduled for showers on Monday and Thursday evenings. Review of Resident 15's bathing record from 06/24/2026-07/15/2026 showed: a tub bath documented on 06/27/2026; a shower documented on 06/30/2026; a bed bath on 07/01/2026; showers on 07/04/2026, 07/05/2026, 07/06/2026, and 07/13/2026. During an observation and interview on 07/15/2026 at 11:06 AM, Resident 15 stated they did had not received a shower since admission to the facility on [DATE]. Resident 15 stated they were scheduled for showers on Mondays and Thursdays but had never been in the shower room. Resident 15 stated they received several bed baths, but they don't feel clean after bed baths. Resident 15 stated Staff CC told [them] that bed baths were easier and quicker, so they only provided bed baths and not always on their scheduled bathing day. Resident 15 stated they were able to keep up on their own fingernail care, but they had requested toenail care several times, but the care had not yet been provided. Resident 15's toenails were observed to be long and in need of care. ^ <RESIDENT 22> Review of the 06/06/2026 Comprehensive Assessment MDS showed Resident 22 admitted [DATE], severe cognitive impairment, no behaviors, and no rejections of care. Resident 22 was dependent on staff for shower/bathing/transfers and required moderate/partial assistance with personal hygiene. Resident 22 was incontinent of bowel/bladder and diagnoses included respiratory failure, diabetes, dementia, and vision problems. Review of Resident 22's ADL CP, revised 11/07/2023, showed: an intervention revised 08/06/2021 that Resident 22 required extensive assistance for personal hygiene/grooming and an intervention revised 08/06/2021 that Resident 22 required extensive assistance of one person for bathing. The CP showed it was not updated/revised to reflect the most recent 06/06/2026 Comprehensive Assessment and did not indicate their assigned shower schedule/preferences or who was responsible for nail care/trimming. Review of Resident 22's Diabetic CP, revised 10/16/2020, showed an intervention dated 11/15/2018 directing licensed nurses to perform a daily diabetic foot check, observe feet/toes for impairments and observe toenails for shape, length, and color. The CP did not address toenail care/trimming. Review of the [NAME] Shower Book showed a [NAME] Daily Shower Schedule, dated Monday 06/29/2026, showed Resident 22's room/bed was scheduled for a shower during the day. The documentation showed no shower was provided. Review of Resident 22's bathing record from 06/19/2026-07/15/2026 showed the following: a bed bath documented (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/19/2026 and 06/20/2026; showers on 06/22/2026, 06/24/2026, and 07/02/2026; a bed bath on 07/09/2026, the last documented shower/bath. During an observation on 07/13/2026 at 10:40 AM, Resident 22 was observed seated in their wheelchair in the front entrance hallway, outside the day room. Resident 22 wore a purple top that was soiled and had a large amount of loose white hair on both the front and back of the top and small visible stains/debris on their pants. They were wearing socks with no shoes. Their hair was not combed, and they had a clump of hair that was matted together tightly (about the size of a silver dollar) on the back of their head. Resident 22 had what appeared to be residual food in the creases around their mouth and they had long white chin hairs on their chin and upper lip that were approximately half an inch long. During a three-minute observation on 07/13/2026 at 1:05 PM, Resident 22 was observed to be in the same physical condition as they were observed to be at 10:40 AM. Four staff walked by them and not a single one acknowledged them or recognized their unkempt condition. <RESIDENT 9> Review of the 06/28/2026 admission MDS showed Resident 9 admitted to the facility on [DATE] with severe cognitive impairment, rarely understood others, did not talk, and was not able to make daily decisions. Resident 9 had no behaviors or rejections of care. They were assessed to be dependent on staff for showering, lower body dressing, hygiene. Review of the ADL CP, dated 06/22/2026, showed Resident 9 required two staff to assist with bathing/showering and as necessary and preferred baths but did not indicate their assigned shower schedule. Review of the undated East Shower Scheule showed Resident 9 was scheduled for bathing on Tuesdays and Fridays during the day. Review of Bathing point of care documentation for 06/22/2026-07/14/2026 showed Tuesday 06/23/2026 was Not Applicable, Friday 06/26/2026 was Not Applicable, a bed bath was documented on 06/27/2026, a shower on 06/30/2026, a bed bath 07/01/2026, 07/02/2026, Friday 07/03/2026 was Not Applicable, a shower 07/04/2026, 07/05/2026, a bed bath 07/06/2026, Tuesday 07/07/2026 was Not Applicable, Friday 07/10/2026 was Not Applicable, and a bed bath was documented on 07/13/2026, six days after the last documented bathing event. On 07/14/2026 at 9:30 AM, Resident 9 was observed with long nails with black debris underneath. The resident had long hair and a long beard. Resident 9 was unable to answer questions asked as they made vocalizations which were heard but not understood. On Tuesday 07/14/2026 at 11:01 AM, Staff V, CNA, stated they did not have a shower aid that day, so they gave Resident 9 a bed bath. Staff V stated, He's clean, see. When asked about Resident 9's nails, Staff V stated they would check to see if the resident was diabetic and if not, they sat with residents, put their nails in a water soak, and cut them, if they're not too busy. At 11:06 AM, Staff V stated they did not take Resident 9 to the shower, they gave them a bed bath instead and did not check to see if they were diabetic. In an interview on 07/15/2026 at 8:25 AM, Staff CC, CNA/ shower aid, stated when they performed showers, they only provided the shower and shave but not nail care. Nail care was the responsibility of their assigned CNA (or the nurse if the resident was a diabetic). ^ Staff CC stated the showers were scheduled by room assignment not by specified preferences. Staff CC provided the shower assignment schedule that showed each resident was scheduled two showers per week, based on the bed they occupied. Staff CC stated after the shower was provided, they completed the Shower Sheet and placed it in the shower book for the nurse to review at the end of their shift. ^ In an interview on 07/15/2026 at 3:15 PM, Staff B, Director of Nursing, stated the facility provided showers seven days a week by the designated bath aid if there was one for that day and if they did not have a designated bath aid, the CNAs were still responsible to provide the residents bathing according to their preferences and/or as scheduled, including shaving and nail care if needed, and should be documented in the clinical record. Staff B confirmed that if the resident had diabetes, the licensed nurses were responsible to monitor and trim their fingernails due to risk for infection. Licensed (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurses were responsible for toenail monitoring, care, and trimming (if their condition allowed and did not require the podiatrist to trim), the CNAs were responsible to trim nails for the residents who were not diabetics, and the resident's CP should specify responsibilities correctly but did not. Refer to F725. Refer to F745. REFERENCE WAC: 388-97-1060 (2)(c).		

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F 0689 Level of Harm - Minimal harm or potential for 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 interview and record review, the facility failed to provide the required care planned supervision to prevent accidents for 4 of 5 sample residents (Resident 1, 14, 13 & 20) reviewed for accidents/hazards. The facility failed to assess safety risks, provide adequate resident supervision, develop/implement/revise fall and elopement care plans (CP), and conduct thorough accident investigations to determine the circumstances of resident accidents and revise CPs to prevent reoccurrence for 2 of 2 residents (Resident 1 & 14) reviewed for falls and 2 of 3 residents (Resident 13 & 20) reviewed for elopement. These failures placed the residents at a potential risk of harm related to avoidable incidents. Findings included .<ELOPEMENT>POLICY Review of the facility's Leave of Absence without Notice (LAWN) policy, dated 01/16/2026, showed Elopement occurred when a resident left the facility premises or a safe area without notice/authorization (such as a physician's order for discharge or leave of absence). The Interdisciplinary Team (IDT) would evaluate residents on admission, quarterly, and with a significant change in condition to determine level of risk for LAWN and initiate a resident-centered care plan with interventions to provide a least restrictive environment. <RESIDENT 13><BEFORE admission TO THE FACILITY>Review of a hospital Trauma note dated 06/12/2026 showed Resident 13 was confused and was trying to leave against medical advice during the night but was redirectable. Review of a hospital Psychiatric Progress Note dated 06/17/2026 showed Resident 13 continued to have altered mental status and confusion and was referred to psychiatry by the neurologist due to mood, memory deficits and medication management. The psychiatrist noted that Resident 13 was confused, irritable, restless, impulsive, pulled out IV lines, refused assessments, insisted on leaving, was unsteady with ambulation, was poorly redirectable, had a Code Gray (an emergency alert that signals a combative, aggressive, or violent person) called, and was placed in restraints. Resident 13 was assessed to have poor insight into their condition and poor safety awareness. Resident 13's Responsible Party (RP) reported that since Resident 13's spouse was admitted into a memory care unit, Resident 13 showed an accelerated decline in memory, mood/personality, and behavior; making unsafe safety and financial decisions, taking their spouse home from the memory unit, multiple car accidents, and had their driver's license revoked. Resident 13 reported difficulty sleeping and awakening frequently in the night. The documentation showed their plan included the standard geriatric interventions to manage cognitive impairment with behavioral disturbance including relaxation techniques, orientation cues, correction of sensory deficits, normalization of the sleep/wake cycle, creating a behavioral care plan with known triggers and soothers, and consideration for placement near the nurse station for regular checks and staff interaction to help minimize boredom induced behavioral problems and anxiety.<AFTER admission TO THE FACILITY >Review of the 06/24/2026 admission Minimum Data Set (MDS-assessment tool) showed Resident 13 admitted to the facility 06/18/2026, with slightly impaired cognition and no wandering behaviors. Resident 13 required the use of a walker and wheelchair for mobility and partial/moderate staff assistance to transfers. Resident 13's diagnoses included a spine fracture and Traumatic Brain Injury (TBI). Review of Resident 13's Comprehensive CP, printed 07/15/2026, did not provide CP problems, goals, or interventions to support impaired cognition with behavioral disturbances or risk for elopement. Review of the Nursing admission assessment dated [DATE] under the section LAWN (Leave of Absence Without Notice) showed the resident could not ambulate or demonstrate mobility (locomotion) independently, with or without the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4755 South 48th Tacoma, WA 98409	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature was 80 degrees Fahrenheit. There was a message on Resident 13's cell phone from a Taxicab on 06/28/2026 at 2:00 AM, asking where Resident 13 was. Resident 13's RP stated they called the facility and asked where Resident 13 was and was told the facility did not know. Resident 13's RP stated Resident 13 could barely walk or use a walker and somehow, they got out of the facility without anyone knowing during the middle of the night. During an interview on 07/15/2026 at 1:56 PM, Staff B, Director of Nursing, stated Resident 13 was alert, oriented, and knew what they were doing, as they were not cognitively impaired. In an interview on 07/15/2026 at 3:12 PM, Staff B was unable to locate an evaluation of Resident 13's elopement risk in the clinical record and stated an evaluation should have been completed during admission and after Resident 13 demonstrated exit seeking behaviors but was not. <RESIDENT 20> Review of Resident 20's 04/24/2026 Quarterly Assessment MDS showed Resident 20 had difficulty making themselves understood and understanding others, had severe cognitive impairment, and going outside to get fresh air when the weather permitted was very important to them. Resident 20 was independent with dressing, transfers, and ambulation without mobility devices. Resident 20's diagnoses included a stroke with alteration in ability to speak, depression, and history of alcohol dependence. Review of Resident 20's Activity CP, revised 12/11/2025, showed it was very important for Resident 20 to go outside when the weather was good but required supervision because they were at risk for elopement. Review of Resident 20's Elopement risk CP, revised 06/30/2026, showed Resident 20 was at risk of LAWN due to aimlessly wandering, cognitive impairment, trying to exit the facility through windows, and exiting the facility through the south dining room side door to stand on the sidewalk or parking lot, then return inside the facility without leaving the premises. A revision dated 06/29/2026 showed Resident 20 will walk up the hill on the side of the parking lot to get some fresh air, attempts were made to redirect them to a safer residential common area on the premises, but [they] preferred to go out in the parking lot. The CP goal revised 06/22/2026 showed they would not attempt to exit the facility without an escort. Interventions dated 10/12/2025 included: observing for exit seeking behavior, placement in the Elopement Book, monitoring their location with visual checks during routine care, encouraging participation in activities, personalization of their room with familiar items, and providing diversional activities/objects. Review of Resident 20's physician orders did not show the physician authorized Resident 20 to exit the facility/premises independently, without an escort. Review of a Nurse Progress Note dated 02/17/2026 at 6:17 PM showed Resident 20 was under one-to-one supervision due to an elopement incident and was located safely. The clinical record did not show a LAWN re-evaluation was completed or revisions were made to the CP. Review of a Nurse Progress Note dated 03/18/2026 showed Resident 20 was on one-to-one supervision due to an elopement event where they were found out on the main street. Review of a LAWN Evaluation dated 03/18/2026 showed Resident 20 was at risk for elopement due to: cognitive impairment, poor safety awareness, ambulated independently, was unable to consent for themselves, had history of exit-seeking, substance abuse, expressed desire to go home, and wandering in and out of the facility. The IDT determined Resident 20's elopement risk was high due to actively exit seeking behaviors and wandering, agitation with redirection, and refusal to wear the facility wander alert system. The evaluation did not indicate a recent elopement event. Resident 20 was placed on one-to-one supervision and re-evaluate in 72 hours. Review of Resident 20's CP did not provide documentation to show the CP was revised/updated. Review of the clinical record did not show a re-evaluation after 72 hours. Review of a LAWN Evaluation dated 06/22/2026 showed Resident 20 had severe cognitive impairment, safety awareness was a concern, the resident had a history of exit-seeking behaviors and wandering in or out of the facility, out the South Hall dining room French doors and out to the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	parking lot, but did not wander outside the parking lot. The evaluation did not show the physician provided an order approving Resident 20 to exit the facility independently. The determination was that Resident 20 was at risk for LAWN. IDT interventions included CP review and revision, resident education on out on pass policy, and assistance with discharge planning. Review of a Tele-Health Psychiatric Follow up note dated 06/23/2026 at 9:30 AM by a Nurse Practitioner located in [NAME], Texas showed Resident 20 had multiple chronic illnesses with severe exacerbation and progression, including severe expressive aphasia, severe cognitive impairment, vascular dementia with severe behavioral disturbances (yelling, agitation, breaking windows, and elopement risk), restlessness, disorganized speech, and disorientation. Resident 20 was awake, alert, but significantly confused and communicated in a disorganized manner, pacing in their room during the telehealth visit. The provider documented instructions for behavioral interventions that included continuing close observation of wandering, restlessness, yelling, anger, agitation, and maintain elopement precautions due to wandering and cognitive impairment. The provider documented on physical exam Resident 20 appeared disheveled, would not make eye contact, showed impulsivity, was anxious, irritable, had impaired judgement, and oriented to person only. Review of a Nurse Progress Note dated 06/27/2026 at 8:00 PM showed when the nurse arrived at the facility, they were notified that the south hall dining room French doors were locked and Resident 20 was very upset because they were approved to use those doors to go in and out of the facility as they desired. Despite redirection, Resident 20 unlocked the doors and went outside. Resident 20 returned to their room without incident and then the nurse placed Resident 20 on 15-minute checks to monitor. Review of a Nurse Progress Note dated 06/29/2026 at 1:47 PM showed Resident 20 was upset that they were unable to exit the facility through the south hall dining room French doors, so they exited the facility through the alarmed egress door and was unable to get back into the facility. Resident 20 was redirected to the front door exit but was still upset and broke their knife in half during lunch. Review of a Nurse Progress Note dated 07/01/2026 at 3:51 AM showed Resident 20 was allowed to walk out the front entrance without an escort to get fresh air. Resident 20 appropriately notified the nurse when wanting to go outside and returned to the facility without incident. The documentation did not show the facility followed Resident 20's elopement CP to ensure they had an escort. Review of a Nurse Progress Note dated 07/02/2026 at 5:49 AM showed Resident 20 was compliant with using the main entrance when leaving the facility and upon returning and appropriately notified staff when leaving the facility without an escort. During an interview on 07/15/2026 at 11:20 AM, Staff J, Maintenance Director, showed an exit door on the South Hall with exit lights which was considered an egress door, triggered with an alarm, used for emergency exit and entrance only. Nearby were two sets of double doors that led onto a cement patio and the front parking lot. Staff J stated the sets of double doors were not considered fire exits and were the doors Resident 13 and Resident 20 exited the building from. Staff J stated Resident 20 was very determined to get out. Staff J stated they put wood across the double doors to the patio to secure them shut and Resident 20 busted them out. Since then, Staff J screwed metal angles across the double doors so they are no longer able to open/close. During an interview on 07/15/2026 at 3:15 PM, Staff B (a newly hired Director of Nursing) stated they were aware Resident 20 went out the South Hall French doors independently but was not yet familiar with Resident 20's complete history or care needs. Staff B stated they expected the staff to follow the Residents CP but did not. <FALLS><Policy> Review of the facility's Fall Management policy, dated 05/26/2021 showed residents would be assessed for fall risk upon admission to the facility. Residents determined to be at risk for falls would receive appropriate interventions to reduce the risk and minimize injury. The facility would communicate residents fall risk status to caregivers, develop/revise a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident-centered CP. If a resident fell, the facility would assess the resident, document the incident in the clinical record and update/revise the CP to reflect new interventions, notify the appropriate parties, and the IDT would review the resident after the fall.<RESIDENT 14> Review of the 06/11/2026 admission MDS showed Resident 14 admitted to the facility on [DATE] and had severe cognitive impairment. Resident 14 was assessed to require substantial/maximal assistance with bed mobility, transfers, and supervision with wheelchair mobility. Resident 14's diagnoses included dementia with behavioral disturbances, falls, arthritis, and neuropathy (painful nerve damage that disrupts the communication lines between your brain, spinal cord, and rest of the body). Resident 14 had falls prior to admission and after admission to the facility. Review of the Fall Risk CP, revised 07/10/2026, showed Resident 14 was at risk for falls/injury due to exit-seeking behavior, unsafe attempts to self-transfer, unsafe wheelchair positioning due to poor trunk control, impaired safety awareness, and cognitive impairment. Multiple fall interventions dated 06/07/2026 included: adjustment of bed height accordingly; assessment for mental status changes, pain and report to physician; assist with getting out of bed with the use of using standard, walker, rolling walker, quad cane, straight cane, no device, standard pivot transfer, slide board; assist with ambulation, clutter free environment. Interventions dated 07/10/2026 included directions to staff to ensure Resident 14 was safely positioned in their wheelchair with appropriate support and to monitor/provide redirection for unsafe leaning, attempts to self-transfer, or exit-seeking behaviors. Review of a facility fall investigation dated 06/06/2026 showed Resident 14 had a witnessed fall where they fell forward out of their wheelchair and hit their head. Resident 14 was transferred to the emergency department and cleared of any significant injury, then returned to the facility the same day. The updated fall interventions included the interventions initiated on admission, as the witnessed fall occurred on the same day as their admission to the facility. Review of Resident 14's Fall CP showed an intervention created 06/11/2026 that showed 1:1 supervision was initiated on 06/08/2026. Review of a Nurse Progress Note dated 06/20/2026 at 11:50 PM showed Resident 14 had an unwitnessed fall. Resident 14's 1:1 CNA monitor was in the hallway on their phone. When the CNA returned to the resident's room, they found Resident 14 on the floor. The nurse assessed Resident 14 for injury and initiated neurological monitoring. The documentation showed that Resident 14's Fall CP was not followed for 1:1 supervision. Review of the facility's fall investigation report dated 06/20/2026 at 8:00 PM showed Resident 14 had a non-injury fall because they rolled out of bed. A staff interview on 06/20/2026 showed Resident 14 had a 1:1 caregiver who was out in the hallway on their cell phone when Resident 14 fell out of bed. The Incident Summary showed Resident 14 was observed on the floor next to their bed after rolling out of bed. Despite continuous observation, the event occurred suddenly, and staff were unable to intervene before Resident 14 rolled from the bed to the floor. The root cause analysis/conclusion showed the investigation did not show neglect, abuse, staff misconduct, equipment malfunction or failure to follow the CP occurred. Based on their available evidence, the event was consistent with an accidental, non-injury fall related to cognitive impairment and unpredictable movement during sleep. Abuse and neglect were unsubstantiated. The post-fall interventions included continuing 1:1 supervision, evaluating bed safety, maintaining close distance to the resident when sleeping, and monitoring sleep patterns. During an interview on 07/14/2026 at 3:15 PM, Staff D, Assistant Director of Nursing-ADON, stated the staff member that was providing 1:1 supervision was just outside Resident 14's door, on their phone, but was about three feet from the resident, according to the CNA statement. Staff D stated the caregiver should not have been on their phone-distracted and should have been observing the resident according to the CP but did not. Review of Resident 14's Fall CP did not show any CP revisions or additional interventions dated 06/20/2026. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The documentation did not show interventions to evaluate bed safety, maintaining close distance to Resident 14 during sleep, or monitoring of sleep patterns. Review of the Nurse Progress Notes did not provide documentation to show that post-fall monitoring occurred by the licensed nurses. During an interview on 07/14/2026 at 3:15 PM, Staff D stated after an incident, residents were placed on Alert Charting that appears on the PCC (Point Click Care electronic documentation system) and after the required time, the resident is removed from alert charting. Staff D confirmed there was no way to print a report to show residents were placed on alert charting, but licensed staff were required to monitor residents after falls for 72 hours, each shift, for potential injuries or other effects after the fall as well as updating the CP. Staff D was not aware that post-fall monitoring did not occur after the fall but stated it was part of their investigation process when reviewing/conducting a fall investigation. After reviewing Resident 14s clinical record, Staff D stated that post-fall monitoring and CP updating should have occurred but did not. Review of a Nurse Progress Note dated 06/27/2026 at 6:48 PM showed Resident 14 experienced another unwitnessed fall and was found lying on the floor between the bed and their wheelchair, trying to self-transfer. The nurse assessed Resident 14 and initiated neurological monitoring. The documentation showed that appropriate notifications were made and Resident 14 remained on 1:1 monitoring. Review of the facility's witnessed fall investigation dated 06/27/2026 at 1:30 PM showed Resident 14 was under the supervision of a 1:1 caregiver when Resident 14 attempted to self-transfer. Re-directional intervention from the caregiver was implemented to intercept the unsafe transfer and additional support was called. Resident 14 became increasingly agitated, cursing at the staff members and pushing them away. Despite the redirection and additional assistance to intervene, Resident 14 fell to the floor. They ruled out abuse/neglect or staff misconduct. The investigation did not include staff/witness statements or post-fall monitoring by licensed nursing staff. Review of Resident 14's Fall CP did not provide documentation to show the CP had been reviewed, revised, or updated after the 06/27/2026 fall. Review of an Alert Note dated 06/29/2026 at 2:33 PM showed Resident 14 moved to a room closer to the nurse station. The documentation did not show why the room change was made. In an interview on 07/14/2026 at 3:15 PM, Staff D, Assistant Director of Nursing, stated Resident 14 admitted from the hospital after a stay at a previous long-term care facility where they were on 1:1 supervision, so Resident 14 was on 1:1 supervision upon admission. <RESIDENT 1> Review of the 05/22/2026 admission Assessment MDS showed Resident 1 admitted to the facility on [DATE], was assessed with moderate cognitive impairment, no behaviors, and no rejections of care. Resident 1 was always incontinent of bowel and bladder and required substantial, maximal assistance with toileting and transfers, and dependent with ambulation. Resident 1s diagnoses included a stroke, arthritis, multiple rib fractures, anxiety, abnormal walking pattern, and need for assistance with personal care. Resident 1 had no falls prior to admission and sustained two or more non-injury falls since admission to the facility. This MDS did not indicate Resident 1 had dementia. Review of Resident 1's Fall CP revised 06/01/2026 showed they were at risk for falls due to a traumatic brain injury, abdominal distention, itching, agitation/impulsivity, and low iron in the blood. The interventions dated 05/11/2026 included: to assess for mental status changes or pain; two person assist to get out of bed using standard walker, rolling walker, quad cane, straight cane, no device, standard pivot transfer, slide board; monitor and assist with toileting needs; medication evaluation as needed; therapy evaluation and treatment. The CP interventions showed they were not person-centered and did not provide interventions to address their identified fall risk factors. Review of Resident 1's Fall CP and progress notes showed the following: >FALL #1: Review of a Nurse Progress Note dated 05/12/2026 at 3:15 PM showed Resident 1 fell on the floor and was found next to their bed yelling HELP! HELP!. Review of the Fall CP showed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an intervention update dated 05/12/2026: Toileting frequently as needed.>FALL #2: Review of a Nurse Progress Note-SBAR dated 05/13/2026 at 6:29 PM showed Resident 1 fell from bed while trying to reach for their phone. Review of the Fall CP did not provide documentation to show a CP intervention was added on the day of the fall. The fall CP showed a delayed update dated 05/19/2026 (six days after the first fall, initiated 05/13/2026): Provide grabber for hard-to-reach objects to prevent bending over. The documentation showed Resident 1 fell twice (Fall # 3 and Fall # 4) between Fall #2 and the day the CP was updated on 05/19/2026 with a new intervention to prevent further falls.>FALL #3: Review of a Nurse Progress Note dated 05/17/2026 at 6:29 AM showed Resident 1 was found on the floor on the right side of their bed and their call light cord pulled out from the wall. Resident 1 stated they were looking for their phone when they slid from the bed. Their phone was located on their nightstand on their left side of the bed. Review of the Fall CP showed no CP updates on the day of the fall. The documentation showed this was Resident 1's second fall trying to reach for their phone and an appropriate intervention to prevent recurrence was not added to the CP until 05/19/2026.>FALL #4: Review of a Nurse Progress Note-SBAR dated 05/19/2026 at 10:45 PM showed Resident 1 was found on the floor next to their bed. Resident 1 reported they slid off the bed after trying to self-transfer because they were trying to get to 7-11 to get their bowling card. Review of the Fall CP showed two CP interventions: Fall mat(s), if indicated and when Resident 1 was in bed, place all personal items within reach. The documentation did not provide directions to staff on which side of the bed to place the fall mat or when it was supposed to be in place.>FALL #5: Review of the Fall CP showed Resident 1 fell on [DATE] but the CP showed no updated interventions on the day of the fall. Review of the Progress Notes did not show a progress note that detailed the events of a fall on 05/22/2026.>FALL #6: A Nurse Progress Note dated 05/23/2026 at 1:39 AM showed Resident 1 was found on the floor next to their bed. Review of the Fall CP did not show a CP intervention was added on 05/23/2026.>FALL #7: A Nurse Progress Note dated 05/25/2026 at 4:10 PM showed Resident 1 was found sitting on the floor next to their bed at 3:55 AM and stated they were trying to get up for the day. Review of the Fall CP did not provide documentation to show a CP intervention was implemented after the fall. >Review of the Fall CP showed a delayed CP intervention update dated 05/25/2026 (initiated 05/23/2026): urinalysis asap to rule out urinary tract infection due to multiple falls- Resident 1 was refusing and had increased agitation during straight catheterization (a method of urine collection to ensure a sterile sample is obtained).>FALL #8: A Nurse Progress Note dated 05/29/2026 at 2:08 PM showed Resident 1 was found sitting on the floor next to their bed. Resident 1 stated they were trying to reach their vaping device which was later found near the sink and confiscated. Review of the CP showed two new interventions dated 05/29/2026: orthostatic blood pressures for three days and concave/perimeter mattress.>FALL #9: A Nurse Progress Note dated 05/30/2026 at 9:58 AM showed Resident 1 was found sitting on the floor next to their bed yelling for help. The nurse noted Resident 1 experienced recurrent falls and their last fall was on 05/29/2026. Resident 1 said they were attempting to put their pants on and fell off the bed. Review of the Fall CP did not show a CP intervention update was added on 05/30/2026.>Review of the Fall CP showed a delayed CP intervention update dated 06/01/2026 that showed it was initiated 05/19/2026. The CP showed the CP update was 12 days after their fall on 05/19/2026. The intervention showed: Lab work to rule out infection or change of condition related to falls.>Review of the Fall CP showed a delayed CP intervention update dated 06/08/2026 (with an initiation date 10 days prior on 05/29/2026): Medication review by pharmacy due to multiple falls.>Review of the Fall CP showed a new CP intervention added on 06/01/2026: Room move to a room across from the nurse station for closer monitoring.>FALL #10: Review of a Nurse Progress Note dated 06/18/2026 at 5:44 PM showed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 1 had a witnessed fall outside. A new CP intervention was added on 06/18/2026 (initiated the same day): Educate spouse/family to not leave Resident 1 unattended when they left after visits. Enforce education about safety.>FALL #11: Review of a Nurse Progress Note dated 06/25/2026 at 12:11 PM showed Resident 1 was found on the floor next to their bed after an attempt to self-transfer. Review of the facility's fall investigation dated 06/25/2026 at 12:00 showed new interventions would include anticipate resident needs and safety, Post Fall Rehab Screen, ensure the wheelchair was properly positioned and brakes engaged when not in use, and reinforce education with the resident on using the call light and requesting staff assistance before all transfers. Review of the Fall CP did not show that any of the interventions described in the investigation were updated to the CP. Review of the Fall CP showed a delayed CP intervention update dated 06/29/2026: Anticipate care needs and safety. During an observation and interview on 07/13/2026 at 11:12 AM, Resident 1 was observed lying in bed with regular socks on (not non-skid) and a fall mat on the floor on their right side of the bed. There was strong urine odor noted in their room. Resident 1 stated they had not had any falls since admission. During an observation on 07/15/2026 at 8:30 AM, Resident 1 was observed seated in their wheelchair in the doorway of their room. Resident 1 wore regular black socks, no shoes or non-skid footwear. Their reacher/grabber was not observed to be in their room. At 8:45 AM, Resident 1 was observed at the East nurse station, hanging on to the counter while standing, with no non-skid footwear, and unlocked wheelchair brakes. Staff in the area did not recognize or respond to Resident 1's unsafe attempts to stand without assistance. In an interview on 07/15/2026 at 2:30 PM, Staff B, Director of Nursing, stated it was their expectation that when a resident fell, licensed staff were expected to update the clinical record and CP with an appropriate intervention as soon as safely possible, document the event and findings, place the resident on alert charting every shift for 72 hours at a minimum to m[TRUNCATED]		

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NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4755 South 48th Tacoma, WA 98409	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to have sufficient staff to provide necessary care and services for 7 of 8 Residents (8, 12, 18, 1, 15, 22, & 9) reviewed for Activities of Daily Living (ADL). The facility had insufficient staff to ensure residents received assistance with showers and nail care in accordance with established clinical standards, care plans, and preferences. These failures placed residents at risk for unmet care needs and negative outcomes. Findings included. <Resident 8>Review of the East Shower Schedule showed Resident 8 was scheduled to receive showers on Wednesdays and Saturdays on the day shift. Review of Resident 8's Documentation Survey Report from 06/19/2026 through 07/13/2026 they bathed on five days when they should have had seven. ^During an observation and interview 07/13/2026 at 11:15 AM, Resident 8 was observed to have long nails with dark debris under the nails, and their hair appeared to be oily with dry, flaky scalp. ^ Resident 8 stated they did not recall how many baths they had since admission to the facility but stated, Not as many as were planned. ^ Resident 8 stated they planned to have two showers per week but that did not occur during their stay because they went to dialysis during the day on Tuesdays, Thursdays, and Saturdays and their second scheduled shower day for the week was scheduled during their dialysis treatment. ^ Resident 8 stated they had asked nursing staff to have their nails trimmed, but no one ever trimmed them. Resident 8 stated I finally got a shower today, for the week, but I am discharging home today. <Resident 12>Review of Resident 12's bathing record from 06/23/2026 through 07/15/2026 showed they received three baths in 22 days. As of 07/15/2026, they had not received a bath in 12 days. During an observation and interview on 07/14/2026 at 3:20 PM, Resident 12 was observed with dark matter under their nails and had long facial hair. Resident 12 indicated they would like their beard trimmed. ^<Resident 18>Review of the East Shower Schedule, undated, showed Resident 18 was scheduled for a shower on Wednesdays and Saturdays in the evening. Review of Resident 18's bathing record from 06/19/2026 through 07/15/2026 showed bathing events documented on nine days (out of 26 days), some were documented on consecutive days. ^^During an observation of an interaction between Staff CC, Certified Nursing Assistant (CNA), shower aid, and Resident 18 on 07/14/2026 at 11:15 AM, Resident 18 asked Staff CC if they could receive a shower that morning because they did not receive their scheduled shower on Saturday (07/11/2026) or their requested shower on Monday (07/13/2026-to make-up for the missed Saturday shower). Staff CC replied to Resident 18 saying they were not on the bath schedule for that day. Resident 18 was observed to have very long hair that appeared slightly matted, oily, and not combed through. ^In an interview on 07/15/2026 at 9:45 AM, Resident 18 stated they were scheduled to receive a shower twice weekly on Wednesdays and Saturdays. Resident 18 stated they did not receive their scheduled shower on Saturday 07/11/2026. Resident 18 stated when they asked about their shower on Saturday, they were told by their CNA that the facility did not provide showers on the weekends. Resident 18 stated they had never received showers on consecutive days and confirmed they did not receive a shower on three of the days that were documented in their clinical record. <Resident 1>Review of the undated East Shower Schedule showed that Resident 1 was scheduled for bathing on Tuesdays and Fridays. Review of Resident 1's bathing record from 06/19/2026 through 07/15/2026 (26 days) showed five showers/bed baths documented as provided. ^In an observation and interview on 07/13/2026 at 11:12 AM, Resident 1 was observed to have long nails with dark matter under the nails and a noticeable odor of urine. ^<Resident 15>Review (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the undated East Shower Schedule showed Resident 15 was scheduled for showers on Monday and Thursday evenings. Review of Resident 15's bathing record from 06/24/2026-07/15/2026 (21 days) showed seven bathing events documented as provided; one tub bath, four showers, and two bed baths. During an interview on 07/15/2026 at 11:05 AM, when asked if there was sufficient staff to meet their care needs, Resident 15 stated no and that they did not receive their bathing as planned. During an observation and interview on 07/15/2026 at 11:06 AM, Resident 15 stated they had not received a shower since admission to the facility on [DATE]. Resident 15 stated they were scheduled for showers on Mondays and Thursdays but had never been in the shower room. Resident 15 stated they received several bed baths, but they didn't feel clean after bed baths. Resident 15 stated Staff CC told [them] that bed baths were easier and quicker, so they only provided bed baths and not always on their scheduled bathing day.<Resident 22>Review of Resident 22's bathing record from 06/19/2026-07/15/2026 (22 days) showed bathing events documented as provided on six days, the last day was 07/09/2026.During an observation on 07/13/2026 at 10:40 AM, Resident 22 was observed to be disheveled in appearance, with uncombed hair, and very long facial hair.Review of Resident 22s bathing record from 06/22/2026-07/14/2026 (24 days) showed bathing events documented as provided on eight days. <Resident 9>Review of the undated East Shower Scheule showed Resident 9 was scheduled for bathing on Tuesdays and Fridays during the day.On 07/14/2026 at 9:30 AM, Resident 9 was observed with long nails with black debris underneath. The resident had long hair and a long beard.On Tuesday 07/14/2026 at 11:01 AM, Staff V, CNA, stated they did not have a shower aid that day, so they gave Resident 9 a bed bath. Staff V stated, He's clean, see. When asked about Resident 9's nails, Staff V stated they would check to see if the resident was diabetic and if not, they sat with residents, put their nails in a water soak, and cut them, if they're not too busy. At 11:06 AM, Staff V stated they did not take Resident 9 to the shower, they gave them a bed bath instead and did not check to see if they were diabetic. <STAFFING>Review of the Facility Assessment Tool, updated 06/25/2026, showed the average daily census was 127 residents and the total number of Certified Nursing Assistants (CNAs) needed ranged from 35-40.Review of facility's Daily Posted Staffing records showed the following: on 06/22/2026 the census was 124 and there were 26 CNAs scheduled, on 06/29/2026 the census was 133 and there were 26 CNAs scheduled, on 07/06/2026 the census was 132 and 25 CNAs were scheduled, and 07/10/2026 the census was 131 and 30 CNAs were scheduled.Review of the [NAME] Daily Shower Schedules showed:On 06/23/2026, 23 showers were scheduled and two were documented as done, on 06/24/2026, 20 showers were scheduled and five were documented as done, on 06/26/2026, 23 showers were scheduled and none were documented as done, on 06/27/2026, 21 showers were scheduled and none were documented as done, on 06/29/2026, 21 showers were scheduled and four were documented as done, on 06/30/2026, 23 showers were scheduled and none were documented as done, and on 07/15/2026, 21 showers were scheduled and none were documented as done.Review of facility's Daily Staffing Assignment sheets showed the following:>06/19/2026- Shower aid scheduled for East Wing Day shift, but none on [NAME] Wing or South Wing. >06/20/2026- Saturday, no shower aids scheduled for the facility.>06/21/2026-Sunday, no shower aids scheduled for the facility.>06/23/2026-Shower aid scheduled for East Wing Day shift, but none on [NAME] Wing or South Wing. >06/24/2026- Shower aid scheduled for East Wing Day shift, but none on [NAME] Wing or South Wing. >06/25/2026 - Shower aid scheduled for East Hall Day Shift, [NAME] Hall Days shift, and [NAME] Hall evening shift. No shower aid scheduled for South (Day/Eve) or East and [NAME] Evening shifts.>06/26/2026- Shower aid scheduled for [NAME] Hall Day shift but none for East and South days, and no shower aids for any hall on evening shift.>06/27/2026 -Saturday, no shower aids (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scheduled for the facility.>06/28/2026 -Sunday, no shower aids scheduled for the facility.>06/29/2026- Shower aid scheduled for East Hall Day Shift, [NAME] Hall Days shift, and [NAME] Hall evening shift. No shower aid scheduled for South (Day/Eve) or East and [NAME] Evening shifts.>06/30/2026- Shower aid scheduled for East Hall Day Shift, [NAME] Hall Days shift, and [NAME] Hall evening shift. No shower aid scheduled for South (Day/Eve) or East and [NAME] Evening shifts.>07/01/2026- Shower aid scheduled for the East Wing Day shift, one for [NAME] Wing Day shift, and one for [NAME] Wing Evening Shift.On 07/14/2026 at 11:08 AM the [NAME] Shower book was reviewed and showed there were no skin sheets for 07/05/2026, 07/06/2026, 07/09/2026, 07/10/2026, 07/13/2026 and none for 07/14/2026. In an interview on 07/14/2026 at that time, Staff V, CNA, stated there was no shower aid on 07/13/2026 and 07/14/2026, and the shower aid fills those sheets out. When asked if the CNAs fill them out when they give showers, Staff V stated no, just the assigned shower aid.During an interview on 07/14/2026 at 11:04 AM, Staff CC, CNA, stated there was no shower aid scheduled so the CNAs were doing their own showers.In an interview on 07/15/2026 at 8:25 AM, Staff CC stated they were the shower aid on most days, but they were pulled to the floor yesterday (07/14/2026) and had to work a run (a section of designated residents the CNA was assigned to be responsible for all their care). Staff CC stated when that occurred, which was quite often, then the showers were the responsibility of the CNA assigned to that resident. Staff CC stated they were the designated shower aid that day (07/15/2026) and they would not be able to provide all the showers that were scheduled during their shift and that the evening shift CNA would have to give the showers that were left over.In an interview on 07/15/2026 at 3:15 PM, Staff B, Director of Nursing, stated they were just getting familiar with the facility but recognized that their facility system for providing showers was not functioning the way it should and they were in the process of analyzing their data to correct the situation. Staff BB stated it was their expectation that the facility had enough staff scheduled to meet the care needs of the residents and the residents should have had the bathing they required but did not.Refer to F677.REFERENCE WAC: 388-97-1080(1).		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure appropriate dementia related care and services were provided to 4 of 4 residents (Residents 14, 7, 16, & 13) reviewed for dementia related behaviors. The failure to develop and/or implement resident-centered dementia care plans (CP) with purposeful diversional activities and behavioral interventions to address resident's care needs who had dementia with behavioral disturbances, exit-seeking behaviors, and/or required 1:1 supervision. These failures placed the residents at risk for a diminished quality of life/quality of care, decline in mood, increased social isolation, boredom induced restlessness/anxiety/behaviors, and accidents/hazards (falls, elopement, and resident-to-resident altercations). Findings included .<POLICY>Review of the facility's Dementia-Clinical Protocol policy, undated, showed that the facility and the physician would evaluate the resident for dementia, the neurological cause of the dementia, and determine/differentiate other potential diagnoses such as delirium (confusion or altered mental status caused by other medical causes/medications side effects). For residents who were confirmed to have dementia, the Interdisciplinary team (IDT) would develop a resident-centered CP. Certified Nursing Assistants (CNAs) would receive initial training in the care of residents with dementia and related behaviors and ongoing education at least annually. The facility would strive to optimize familiarity through consistent staff-resident assignments. Direct care staff would assist the resident in completing supervised activities and tasks of daily living (bathing, mealtime assistance, therapeutic and recreational activities). The IDT would identify and document the residents' condition and level of support needed during CP development and revisions would be made as changes arose. Progressive or persistent worsening of symptoms and increase need for staff support would be reported to the IDT. The physician would order appropriate interventions to address significant behavioral and psychiatric symptoms; medications would be targeted to specific symptoms, would be used at the lowest effective doses for the shortest time possible unless clinical rationale determined otherwise. If a psychiatric consultant was called to help manage behavioral symptoms, the IDT would retain an active role by reviewing and implementing the consultant's recommendations, addressing issues that could affect mood, cognition or function, monitoring complications related to treatment, and evaluation the resident's response.<RESIDENT 14>Review of the 06/11/2026 admission Minimum Data Set (MDS - an assessment tool), showed Resident 14 had severe cognitive impairment and diagnoses included Non-Alzheimer's Dementia, arthritis, and neuropathy (severe nerve pain). Resident 14 had difficulty understanding others, impaired vision, exhibited verbal behavioral symptoms directed at others (threatening, screaming at, cursing at) daily, which significantly interfered with the resident's care and their participation in activities or social interactions. Resident 14's behaviors significantly intruded on the privacy or activities of others and significantly disrupted their care and/or living environments. Resident 14's interview for activity preferences showed it was very important to [them] to listen to music they liked, go outside for fresh air, participate in religious practices, and do their favorite activities, and did not include family (or close friend) to assist in providing insight on past-time activities/preferences they would enjoy.Review of the 06/08/2026 Activity Care Plan (CP), showed Resident 14 had little or no activity involvement related to behavioral issues: self-isolation, socially inappropriate disruptive behaviors, poor adjustment to the facility, and desire not to participate in activities. Interventions listed included providing Resident 14 with activity materials and showing their resident-centered activity preferences including watching TV, particularly (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Hallmark channel, cooking channel, animal planet, and nature shows. The CP did not include interventions to address Resident 14's activities that were important to them during as assessed during their MDS activities interview: provision of music, religious based activities, or getting some fresh air. Further review of the CP showed interventions which would not be effective for a resident with severe cognitive impairment including: Explain to the resident the importance of social interaction, provide activity calendar monthly, leisure activity time, advise resident to request pain medication before pain becomes severe, educate resident regarding other meds/food that could affect anticoagulation (blood thinning) action. Review of a Psychiatry Follow Up note, dated 06/23/2026, showed staff reported Resident 14 exhibited frequent medication seeking behavior, particularly requesting unscheduled pain medication, and demonstrated agitation with verbal outbursts including screaming, help me. Resident 14 showed decreased appetite and was easily distracted during meals. Resident 14 occasionally exhibited rare episodes of possible visual hallucinations and demonstrated aggressive behavior approximately 60 percent of the time, primarily verbal rather than physical. The plan included medication changes and directives to staff to document behaviors for proper medication adjustments. Review of a Cardiology Follow up Note, dated 06/29/2026, showed Resident 14 continued to require 1:1 supervision due to severe behavioral disturbances (agitation, verbal/physical aggression, disorientation), and was dependent with all activities of daily living (ADLs). Review of a Psychotropic Medication Management (PMM) Interdisciplinary Care Conference Note dated 07/07/2026 showed Resident 14's targeted behaviors were yelling and cussing out staff. Causative diagnoses listed included Dementia with behavioral disturbance, Bipolar II disorder, Depressive Disorder and Anxiety. Interventions listed included psychotropic medications and non-pharmacological intervention of 1:1 supervision 24/7. Review of the June 2026 and July 2026 Behavior Monitoring showed staff monitored for episodes of agitation behavior manifestation, episodes of anxiousness, restlessness, and episodes of being combative, agitation. During an observation on 07/13/2026 at 11:10 AM, Resident 14's door was observed shut. After request to enter, Resident 14 was observed lying in bed, sleeping. Resident 14's 1:1 staff member was observed seated next to the bed in a chair watching TV. Observation of their room showed no personal effects and no in-room activity items. During observations on 07/13/2026 at 12:30 PM, 1:15 PM, 2:10 PM, and 4:06 PM Resident 14's room door remained closed. During an observation on 07/14/2026 at 9:45 AM and 11:06 AM, Resident 14 was observed in their room with the door shut, in the dark, with the shades closed, asleep in their bed, and their 1:1 not engaging them with normal morning activities. During an observation on 07/14/2026 at 2:06 PM, Resident 14 was observed in a large wheelchair leaning to their right side, trying to self-propel down the hallway. Resident 14's 1:1 staff monitor, walking behind them, looking at their personal phone as they walked. The staff member was not engaging with Resident 14. During an observation on 07/14/2026 at 3:35 PM, Resident 14 was observed yelling Get Away! at a male staff member, Staff EE, Certified Nursing Assistant (CNA). When Staff EE did not allow Resident 14 space, Resident 14 attempted to self-propel in their wheelchair, out of their room, and away from Staff EE. During an interview on 07/14/2026 at 3:51 PM, Staff EE stated they had worked with Resident 14 before, but the resident slept the whole time. During an interview on 07/14/2026 at 3:38 PM, Collateral Contact 2 (CC2) stated Resident 14 was not comfortable with male staff in the past. CC2 stated that Resident 14 would yell out when they were in pain but did not believe the staff understood that as their pain indicator. CC2 stated they felt Resident 14 needed more diversional engagement and stimulation with activities they enjoyed including Christian based TV programs/music. On 07/15/2026 at 1:10 PM, Resident 14 was observed asleep in bed. The TV was playing sports. A doll was observed on the bedside cabinet, not within the resident's reach. During an (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 07/15/2026 at 1:10 PM, Staff T, CNA, stated they had seen Resident 14 slap peoples' butts, call people the 'B word', call them 'Hos' and other names. Staff T said the behaviors were exhibited towards both staff and other residents. Staff T stated Resident 14 liked dolls, candy, and coffee. When asked why the resident's room door was always shut, Staff T stated they were not too sure, but Resident 14 was asleep, and it was loud in the hallway.<RESIDENT 7>Review of the 04/27/2026 Annual MDS showed Resident 7 met a serious mental illness, was assessed with moderately impaired cognition, had no behaviors, and no rejection of care. Resident 7's activity interview showed their favorite activities and religious based activities were very important to them. Resident 7's diagnoses included Wernicke's encephalopathy (a serious brain disorder caused by lack of vitamin B1-often due to prolonged long-term heavy drinking and poor nutrition that causes cognitive decline and balance problems like dementia), repeated falls, and depression. Resident 7 required set-up/supervision of ADLs and ambulated independently.Review of Resident 7's Cognitive Decline CP dated 06/03/2025 showed their cognitive function was impaired due to dementia, memory loss, and impaired decision making. The listed interventions included monitoring for cognitive changes, medication side effects, pain, and decline in ADL abilities. Additional interventions included evaluating behavioral symptoms for underlying causes (unmet care needs), breakdown tasks, providing consistent, trusted caregiver, structured daily routine, calm/soothing environment.Review of Resident 7's Activity CP revised on 10/30/2026 showed they kept engaged with activities independently and would need visits from activity staff for social support. Interventions included: Activities would conduct weekly visits, allow choices for daily decision making, they would like pet visits (especially dogs), liked socializing, going outside for walks, people watching, and fishing.Review of Resident 7's Fall CP, revised 07/10/2026, showed Resident 7 had severe cognitive impairment, decreased safety awareness, and impaired judgement. Interventions included providing frequent safety checks to monitor resident's location, positioning, comfort, and need for assistance due to impaired cognition and inability to consistently call for help, reinforce use of call light, and educate resident on requesting assistance before attempting mobility, provide reminders as tolerated due to cognitive impairment.Review of Resident 7's Skin CP dated 12/11/2025 showed they were at risk for skin breakdown related to refusal to take a shower and non-compliance with weekly body checks. Listed interventions did not show approaches staff could take in the event of resident refusals, other than continue to encourage.Review of Resident 7's ADL CP dated 05/08/2026 showed they had self-care performance problems related to dementia and limited mobility. The personal hygiene/oral care intervention revised 06/08/2025 showed they required partial-moderate assistance standing at the sink and was dependent on staff for bathing.Review of Resident 7's Psycho-Social well-being CP revised 10/30/2025 showed they were at risk due to resident-to-resident altercations.Review of a Provider note dated 06/22/2026 showed Resident 7 had advanced dementia with multiple chronic comorbidities (simultaneous presence of two or more distinct medical or psychological conditions).Review of the July 2026 Behavior Monitoring showed for an antidepressant staff were directed to monitor episodes of blank (the 06/04/2026 order failed to specify a behavior manifestation). An additional monitor was for inappropriate sexual behaviors towards other residents or staff which was implemented 04/14/2026.An observation on 07/13/2026 at 10:30 AM showed Resident 7 standing in the doorway of their room, leaning against the left door frame. Their hair was long, uncombed, and unkempt. They had long, shaggy facial hair. Their nails were long. They had no shoes on and no non-skid footwear.During an observation on 07/13/2026 at 10:50 AM, Resident 7 was in the East nurse station area walking, yelling curse words at staff after they intervened to stop a resident-to-resident physical altercation from escalating with another resident. Resident 7 was (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	trembling with anger and yelling profanities. In the same area were four direct care nursing staff plus Staff C, Nurse Consultant. Staff C was providing directions for one of the staff members to provide redirection for Resident 7. The other three nursing staff were observed smiling/giggling and talking to each other while they watched the episode unfold. This reaction from the staff increased Resident 7's anger and paranoia. The staff member that received direction from Staff C was eventually able to redirect Resident 7 to their room without further incident. Review of a 07/13/2026 Nurses Note showed Resident 7 was involved in a physical and verbal altercation with another resident. Resident 7 called the other resident names, threatened to beat them up, and hit them on their head. During an observation on 07/13/2026 at 12:55 PM, Resident 7 was observed lying on top of a bottom sheet on their mattress and appeared to be asleep. Resident 7 had no pillow, top sheet, blanket on their bed, and no bedding in their closet or on the other bed in the room. Resident 7's pant legs exposed both their shins which had lots of scattered scabbed areas. There were no personal items in their room except for their care products. No activity items were observed in their room. On Resident 7's bedside table was their lunch tray, covered with a lid, and their meal was untouched. An observation on 07/14/2026 at 12:48 PM showed Resident 7 lying on their bed, with only a bottom sheet on the mattress, and appeared to be asleep. Resident 7 did not have a pillow or top sheet/blanket on them, on the bed, or observed anywhere in the room. During an observation on 07/15/2026 at 8:39 AM, Resident 7 was observed lying on a bottom sheet on their mattress and appeared to be sleeping. Resident 7 had no bedding on them or in their room. During an observation and interview on 07/15/2026 at 10:30 AM, Resident 7 was observed standing in the doorway of their room, leaning up against the door frame. Resident 7's hair was uncombed, long, and unkempt. They were wearing the same clothing were observed to wear the day before, on 07/14/2026. They did not have shoes on or non-skid footwear on their feet. When asked if staff assisted them with combing their hair Resident 7 shook their head no. When asked if they would let staff comb their hair and shave them, Resident 7 shook their head yes. When asked if they preferred to sleep in bed without a pillow or bedding, Resident 7 shook their head no. When asked if they would like a pillow and blankets for their bed, Resident 7 shook their head yes. During an observation on 07/15/2026 at 11:01 AM, showed Resident 7 standing outside their room, with socks on, leaning against the med cart. No staff were observed to intervene until 11:08 AM when Staff P, Registered Nurse (RN), offered Resident 7 medications, which they refused. In an interview on 07/15/2026 at 11:09 AM, Staff P stated Resident 7 asked Staff P if they wanted to fool around. Staff P stated Resident 7 often exhibited behaviors such as sticking out their tongue, making crude noises, and sexually inappropriate comments. Staff P was not aware Resident 7 did not have bedding. On 07/15/2026 at 11:14 AM, Resident 7 was observed to walk over to the nurses' station, rummage through the nourishment bin and took three boxes of cookies and other items before returning to their room. At 11:17 AM, Resident 7 walked back out of their room, eating cookies and was standing in the hallway in front of the nurses' station. During an observation on 07/15/2026 at 1:45 PM, Resident 7 was observed in the front entrance sitting area, lying on the couch with their eyes closed, one leg on the couch and the other leg hanging off the couch. Resident 7 did not have shoes on and wore socks without non-skid. Resident 7's hair was uncombed and appeared unkempt. There were two other people sitting in sitting area. <RESIDENT 16> Similar findings for Resident 16. Review of the 06/17/2026 admission MDS showed Resident 16 admitted to the facility on [DATE]. Resident 16 had moderate difficulty hearing, wore corrective lenses, had no cognitive decline, no behaviors, and no rejection of care, but showed their current behavior status, care rejection, and/or wandering was worse than from their prior assessment. Resident 16's activity/preference interview showed choice of their bedtime, family involvement, doing their favorite (continued on next page)		

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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4755 South 48th Tacoma, WA 98409	
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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities, and going outside for fresh air when the weather was good were very important to them. Resident 16 required assistance for all ADLS. Resident 16's diagnoses included severe liver damage and non-Alzheimer's dementia, and a traumatic brain injury. Resident 16 had a history of falls before admission and after admission to the facility. Review of Resident 16's Wandering/Elopement Risk CP dated 06/21/2026 showed Resident 16 was at risk for elopement and interventions included: a WanderGaurd device (alarm device that goes off if the WanderGaurd comes to close to designated exits) placed on the back of their wheelchair, identify triggers/patterns to exit seeking, and engage Resident 16 in purposeful activities. Review of Resident 16's Leave of Absence without Notice (LAWN) CP revised 06/22/2026 showed they had history of one or more attempts to LAWN since admission to the facility or previous stays at other facilities. An intervention dated 06/18/2026 showed Resident 16 was on 1:1 supervision and an intervention dated 06/18/2026 showed staff were to encourage participation in activities of preference and as diversional techniques. Review of Resident 16's Behavior CP showed Resident 16 exhibited physical behaviors that included scooting around in their wheelchair in a fast, reckless manner. Review of Resident 16's Activity CP showed interventions that included: encouraging and facilitate activity preferences, enjoyed reading materials (educational and mysteries), music (soft music, country music), keeping up with the news, crossword puzzles/games, looking out the window, naps, praying, TV, and religious activities. Review of a Nurse Progress note dated 07/01/2026 at 7:13 AM showed Resident 16 was restless, getting out of bed and resistant to redirection. Resident 16 was assisted to their wheelchair and at 1:30 AM was found entering another resident's room. At 3:00 AM, Resident 16 was back in bed, and their roommate complained that Resident 16 was touching their personal belongings. The nurse continued safety checks but did not indicate Resident was monitored 1:1 as the CP indicated. Review of the facility's Daily Staffing Assignment dated 07/01/2026 did not show Resident 16 had a 1:1 assigned to them on the schedule. Review of a Nurse Progress Note dated 07/07/2026 at 6:37 PM, Resident 16 had behaviors that were difficult to redirect, was exit seeking and after redirection became angry at staff and was wanting to fall out of the wheelchair but was intercepted by three staff members. Resident 16 was yelling profanity and was taken back to their room. The documentation did not indicate what happened after that event, what interventions were attempted and which interventions were effective at redirection. Review of a Nurse Progress Note dated 07/09/2026 at 5:03 PM showed Resident 16 engaged in self-harming behaviors when they became agitated that included hitting the bedside table despite verbal redirection and advising them to stop. The provider was notified. The documentation did not indicate what precipitated the behavior or what interventions were attempted, or the resident's response to the interventions. The documentation also did not show the responsible party was notified or if a skin evaluation was done to determine if injury occurred. Review of an initial psychiatric provider progress note dated 07/14/2026 at 1:45 PM showed Resident 16 was restless during their evaluation and diagnoses included major depressive disorder, chronic Post Traumatic Stress Disorder (PTSD), Dementia with behavioral disturbance, alcoholic cirrhosis of the liver. The provider ordered to increase their antipsychotic medication and provide BEHAVIORAL INTERVENTIONS: maintain 1:1 supervision for safety and redirection given persistent restlessness and exit-seeking behaviors, frequent verbal redirection and reassurance using simple, clear communication; avoid confrontation, address unmet needs including sleep disruption, establish structured daily routine to reduce confusion and anxiety, including a consistent sleep/wake schedule, reduce daytime oversleeping, encourage safe opportunities to go outside with 1:1 supervision to reduce exit-seeking behaviors, and provide individualized, simple activities appropriate to cognitive level, and provide ongoing staff education on dementia-related behaviors and de-escalation (continued on next page)		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	techniques.During intermittent observations on 07/13/2026 at 11:45 AM and 3:05 PM, 07/14/2026 at 9:01 AM and 2:10 PM, and 07/15/2026 at 9:12 AM and 1:10 PM Resident 16's door was observed to be shut, Resident 16 was in their room asleep, and the 1:1 monitoring staff were not engaging in activities that Resident 16 preferred and/or ADLS. The monitoring staff sat in the chair watching the resident. <RESIDENT 13>Review of the 06/24/2026 admission Minimum Data Set (MDS-assessment tool) showed Resident 13 admitted to the facility 06/18/2026, with slightly impaired cognition and no wandering behaviors. Resident 13 required the use of a walker and wheelchair for mobility and partial/moderate staff assistance to transfers. Resident 13s diagnoses included a spine fracture and Traumatic Brain Injury (TBI). Review of Resident 13s Comprehensive CP, printed 07/15/2026, did not provide CP problems, goals, or interventions to support impaired cognition with behavioral disturbances or risk for elopement.Review of Resident 13s clinical record did not provide documentation to show the facility assessed their risk for elopement.Review of a Progress Note on 06/20/2026 at 12:47 PM, showed Resident 13 was noted to be impulsive with poor safety awareness. Seen putting on their pants, when asked where they were going, Resident 13 said, ?that's none of your business.' When the nurse told them there were no doctor's order for discharge, Resident 13 said, ?he is not my doctor anymore. When asked who was going to pick them up, Resident 13 said My [RP]. The nurse called the RP and notified them of the resident's behavior. The nurse notified the physician and was given an order for medication for anxiety to be administered.Review of a 06/25/2026 Physician Progress Note showed that Resident 13 had been refusing medications, was agitated, and demanding to leave and go home. Resident 13 contacted their Responsible Party and other acquaintances to get a ride home. Resident 13 said they just wanted to go home and have their spouse by their side. Resident 13's wife was admitted to a memory care unit and Resident 13's Responsible Party was trying to find appropriate memory care placement for Resident 13.Review of a Nurse Progress Note dated 06/27/2026 at 1:45 AM showed at approximately 12:45 AM, Resident 13 was unable to be located in the facility or on the facility premises; they eloped.During an interview on 07/14/2026 at 11:32 AM, Staff E, Social Services Director, stated behaviors were discussed in clinicals, and audits of psychotropic medications were done to ensure behaviors were identified and nursing had orders for behavior monitoring. For residents who exhibit behaviors without medications, and/or diagnoses, they are referred to Behavioral Health Services (BHS).Refer to F600.Refer to F677.Refer to F689.Refer to F745.REFERENCE WAC: 388-97-1060 (1), -1040 (1) (a, b).		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medically related social service interventions that addressed refusal of care for 4 of 4 residents (Resident 12, 3, 15, 7) reviewed for care and services. Failure to have a process for resident refusals, identify, and find ways to support residents' needs related to refusals placed residents at risk for unmet care needs, and a decreased quality of life. Findings included .Review of the facility Activities of Daily Living (ADLs) Policy, revised March 2018, showed that residents would be provided with care and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition demonstrated that diminishing ADLs were unavoidable. Unavoidable decline could occur if the residents refused care and treatment. The residents and/or representatives were informed of the risk and benefits of the proposed care or treatment; and they were offered alternative interventions to minimize further decline; and the refusal and information are documented in the resident's clinical record. If a resident resisted or refused care, staff would attempt to identify the underlying cause of the behavior and consider approaching the resident in a different way or at a different time or having another staff member speak with the resident. During an interview on 07/15/2026 at 12:10 PM, Staff G, Social Services Designee, stated they were notified of refusals from their supervisor after the daily clinical meeting. They then interviewed the residents, asked what the reasons for the refusals were, wrote a progress note, and communicated back to their supervisor (Staff E, Social Services Director). <RESIDENT 12> Review of the 06/29/2026 5-day Minimum Data Set (MDS - an assessment tool) showed Resident 12 had highly impaired vision, did not talk, was cognitively impaired, usually understood others, and did not reject care. Review of the 07/02/2026 Care Plan (CP) showed interventions to provide medically related social services as ordered/indicated. Refusals were not addressed on the CP. Review of the Medication Administration Record (MAR) for July 2026 showed Resident 12 refused medications offered 07/10/2026 at 1:00 PM, and 07/12/2026 at 9:00 PM. Review of the Treatment Administration Record (TAR) for July 2026 showed Resident 12 refused treatments offered on 07/11/2026 at 8:00 AM, and 07/12/2026 at 8:00 PM. Review of a progress note dated 07/09/2026 at 1:18 PM, showed Resident 12 refused medications on 07/09/2026 and provider was notified. Review of a Nurse Progress Note, dated 07/01/2026 at 5:04 AM, showed the resident was on alert for signs of hypoglycemia (low blood sugar) due to refusing eating or eating low percentage of food offered. Further review of progress notes showed the resident was seen by the Registered Dietician on 07/01/2026 but did not document an attempt to identify the underlying cause of the refusals. On 07/14/2026 at 3:20 PM, Resident 12 was observed with soiled nails with black debris underneath. Resident 12 was observed with a long beard and indicated they would like it trimmed. Although Resident 12 was non-verbal, they were able to nod, shake head no, and used hand gestures to communicate and make needs known. During an interview on 07/14/2026 at 3:25 PM, Staff BB, Certified Nursing Assistant (CNA), said they had seen nurses try to care for Resident 12's nails, but the resident didn't like it. During an interview on 07/14/2026 at 3:27 PM, when asked who maintained Resident 12's nails, Staff W, Registered Nurse (RN), stated mostly restorative staff or nurses, but Resident 12 did not want them to touch anything. Staff W stated earlier that day the lab technician couldn't draw blood. Staff W stated Resident 12 had refused more in the last month, but they did not know why. When asked if they reported the refusals to social services, Staff W stated, I think everybody knows and added that they did report to the doctor the (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication refusals. During an interview on 07/15/2026 at 12:10 PM, Staff G said they thought they spoke to Resident 12 once that they could remember. Staff G was unable to find an associated progress note and added that if they did talk to them, they didn't document it. <RESIDENT 3> Review of the 04/16/2026 CP showed Resident 3 required one-staff assistance with bathing/showering. The documentation showed Resident 3 did not have a CP or interventions to address refusal of bathing. Review of the East Shower Book showed Shower Sheets for Resident 3 with refusal to bathe on 06/02/2026, 06/05/2026, 06/08/2026, 06/09/2026, and 06/12/2026. Review of the progress notes showed a Nurses Progress Note dated 06/02/2026 at 3:08 PM where Resident 3 was offered a shower twice during the shift but refused both attempts and an Alert Note dated 06/08/2026 at 3:26 PM, that showed Resident 3 refused their shower despite encouragement and assistance offered by the shower aide. The Licensed Nurse (LN) educated Resident 3 on the importance of personal hygiene; however, the resident continued to refuse the shower. During an interview on 07/14/2026 at 11:33 AM, Staff E stated resident refusals were brought to social services in the daily clinical meeting. The social services designee would then follow up with the resident to see why they refused and documented their findings in the progress notes. During an interview on 07/15/2026 at 12:10 PM, Staff G stated they did not recall speaking to Resident 3 about refusals, and they were not aware of Resident 3 refusing care. <RESIDENT 15> Review of the 06/30/2026 admission MDS showed Resident 15 had no cognitive impairment, behaviors, or rejection of cares. Resident 15 required substantial/maximum assistance for toileting hygiene and was dependent on staff for toilet transfers. Resident 15 was frequently incontinent of bowel and did not have a toileting program. Review of Resident 15's Comprehensive CP on 07/15/2026 did not provide documentation to show the facility developed a CP for bowel incontinence/management or medically related social services with interventions to address refusals of care. Review of Resident 15's July 2026 MAR showed a physician order, dated 07/01/2026, for the rectal bowel stimulant medication daily and scheduled for administration at 8:00 AM. The documentation showed the medication was refused on 07/01/2026, 07/02/2026, 07/03/2026, 07/08/2026, 07/14/2026, and 07/15/2026. Review of Resident 15's progress notes, from 06/24/2026-07/15/2026, did not provide documentation to show the facility assessed Resident 15 related to bowel medication refusals or required bowel program/ regime. The documentation did not show that the physician was notified of medication refusals or that nursing monitored their bowel status. In an interview on 07/15/2026 at 11:05 AM, Resident 15 stated they were aware that their clinical record showed they refused their rectal stimulant medication on multiple occasions, but they did not refuse. Resident 15 stated staff brought the medication during breakfast while they were trying to eat and asked the nurses to return after [they] were finished. Resident 15 said it was very important to them to get that medication to decrease their frustrations regarding bowel incontinence and hygiene concerns. <RESIDENT 7> Review of the Annual MDS assessment dated [DATE] showed Resident 7 was assessed to have severe cognitive impairment, exhibited no behaviors, and had no rejection of care. According to the MDS, Resident 7 required set-up assistance with bathing, dressing, and personal hygiene. Review of the 09/09/2025 CP showed Resident 7 refused skin checks at times. The documentation did not show a CP or interventions to address refusals. Review of a Psychiatric Follow-up progress note, dated 06/30/2026, showed Resident 7 consistently refused medications and care. On 07/15/2026 at 11:01 AM, Resident 7 was observed standing outside their room, leaning against the medication cart. At 11:08 AM, Staff P, RN, offered Resident 7 medications which they refused. During an interview at that time, when asked how they knew Resident 7 refused, Staff P stated that Resident 7 had asked them to fool around. Staff P stated the previous day, they offered Resident 7 a snack, and Resident 7 stated You are the snack I (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	want. During an interview on 07/15/2026 at 12:10 PM, Staff G stated they had not addressed Resident 7's refusals. Staff E stated they did have Behavioral Health Services that followed Resident 7 for all their behaviors. During an interview on 07/15/2026 at 12:10 PM, Staff E stated the facility had a clinical tool they filled out daily with everything they needed to follow up on. Staff E reviewed the form and identified there was not a specific place on the tool for refusals but there was a note of a resident refusal under the nursing section, however it was not about the four sampled residents. REFERENCE WAC: 388-97-0960(1)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure [it] was administered in a manner that used resources effectively and efficiently to attain or maintain the residents highest practical physical, mental, and psychosocial well-being, and maintain substantial compliance with state and federal regulations. Findings included. AVAILABILITY OF STAFF TO OUTSIDE FAMILIES AND OTHER ENTITIES During review of a concern reported to the State Agency by Collateral Contact 3 (CC3) the facility was not answering/returning phone calls as they were trying to get information about discharge paperwork for a resident who discharged . During an interview on 07/14/2026 at 3:38 PM, Collateral Contact 2 (CC2) stated that they called to check on Resident 14 and no one answered the phone at the nurse station, so they asked to be transferred to Resident 14's room. The phone rang and rang and was not answered, so they hung up. CC2 said they called back and told the front receptionist that staff supervising Resident 14 (who was on a 1:1) was not answering the phone and the staff at the nursing station weren't answering the phone. CC2 stated when they came into the facility on [DATE] they asked again why no one answers the phone and a staff member picked up the phone in Resident 14's room and discovered it was not plugged into the phone jack. During an observation on 07/15/2026 at 8:30 AM of the phones at the East Hall nurse station showed one phone had 153 missed calls and the other phone had 3 missed calls. The volume on both phones was down so low they were barely audible (1 button push up from off). During an observation on 07/15/2026 at 1:30 PM, Staff I , Receptionist, patched a phone call back to the East Hall nurse station. At 1:32 PM, Staff I received a phone call from the same person they had just patched back to the East nurse station. They sounded upset and the Receptionist attempted to handle their situation and offered to take a message back to the person they were trying to reach but the caller hung up on them before they could finish their sentence. When asked how often that happened, Staff I stated, All the time. Staff I stated they patched the call to the person they were requesting, but when no one answered, the caller had to call the facility back and start all over. Staff I stated they try to take messages back to the staff they were trying to reach but that was not always a timely process because they would have to have someone watch the front desk to do that. When Staff I was asked roughly how many times since 8:30 AM that day a family member, physician, or clinic had to call back because no one answered the phones on the previous transfer, Staff I stated, too many to count, a lot. During a phone test conducted on 07/15/2026 at 1:45 PM, the facility's main phone number was dialed (without Staff I knowing) and a request was made to be transferred to the East Hall nurse station, while observing three staff (Staff D, Assistant Director of Nursing, Staff AA, Certified Nursing Assistant (CNA), and Staff X, Licensed Practical Nurse (LPN)) seated/standing at the East Nurse Station. The phone was barely audible, rang eight times but none of the three staff answered the phone. One staff member was on their personal phone, one staff member was looking at some documents, and one staff member was working at the computer. All three staff were within arm's length of the phone. After eight rings an automated voice said, the party I was looking for could not be reached and then the phone hung up and did not revert to reception. There was no option for the caller to leave a voice message. In an interview on 07/15/2026 at 1:48 PM, Staff AA stated the front receptionist was responsible for answering the phones initially but if the phone rang at the nurse station, they would answer it if no one else was about to. Staff AA stated they did not hear the phone ring three minutes prior. In an interview on 07/15/2026 at 1:53 PM, Staff X stated any of the staff can answer the phones. Staff X did not hear the phone ring for a while. When Staff X was asked what the volume should be on the (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	phone, they replied that the nurse station can get loud sometimes with activity and the phone volume should be at a volume that is audible at a comfortable level. Staff X looked at the phone at the East Nurse Station and validated that the volume of the phones was on 1-nearly inaudible. Staff X stated they try to ensure the volume is appropriate at the beginning of their shift but would correct it now. During a similar phone test conducted on 07/15/2026 at 2:06 PM, and without Staff I knowing, a request was made to be transferred to the [NAME] Hall nurse station while observing one CNA who was charting on the computer, seated within reach of the [NAME] Hall phone. The phone rang 6 times but the phone at the nurse station was not audible, so the CNA had no idea someone was trying to get through. The same automated prompt came on that the party was not available and then hung up. Observation of the phone on the [NAME] Hall showed the volume was completely off and the phone screen showed 167 missed calls. During an interview on 07/15/2026 at 2:30 PM, Staff B, Director of Nursing, stated all staff can and will answer the phones when they ring. Staff B was not aware the volumes of the phones were turned down/off and would correct it immediately. UNETHICAL BILLING PRACTICES Review of the facility's Compliance and Ethics Program policy, dated January 2025, showed the facility was committed to integrity, transparency, accountability, and promoting a culture of ethical and lawful practices. The facility failed to safeguard residents' right for self-determination by prioritizing corporate revenue and changing residents' payor source without their knowledge, understanding, and required documentation. Refer to F552 and F620. FAILURE TO MAINTAIN SUBSTANTIAL COMPLIANCE Review of the facility's historical surveys showed the facility continued out of compliance after they received citations on 05/01/2026 for F684 Quality of Care and F760 Significant Medication Errors. Before the facility achieved compliance, a Complaint Investigation (CI) initiated on 05/11/2026 resulted in citations on 05/14/2026 for F806 Resident Allergies at a Harm level, and WAC L0040 for failure to maintain an admission inquiry list. Before the facility achieved substantial compliance, a Long-Term Care Survey with complaints was conducted, resulting in 29 citations on 06/01/2026. Failed practice at a Harm level was identified at F600 for failure to prevent abuse related to resident-to-resident altercations. Additional areas of failed practice included insufficient staff and failure to provide staff supervision to prevent falls and elopements. The facility achieved substantial compliance on 06/19/2026. Another abbreviated CI initiated on 07/13/2026 resulted in failed practice identified in the areas of Abuse, Staff supervision, Falls, Elopement, and Quality of Care on 07/15/2026 (including repeated citations in F600 Abuse, F689 Accidents, and F725 Staffing.) REFERENCE WAC: 388-97-1620		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to protect the resident's right to be free from abuse for 2 of 3 residents (Resident 6, 24) reviewed for resident-to-resident abuse. Resident 6 and 24 experienced physical abuse when they were hit by Resident 7. Resident 6 experienced verbal abuse when they were called disparaging remarks by Resident 7. Resident 6 experienced psychological harm, evidenced by verbalizations of fear, when the facility failed to provide adequate supervision, effective interventions to assure safety, and evaluate the effectiveness of current interventions to prevent further abuse. These failure placed the residents at risk of abuse, experiencing fear, intimidation, mental anguish, and emotional distress. Findings included. Review of the facility Abuse Prohibition Policy, dated 10/25/2024, showed verbal abuse was use of oral language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. Physical abuse includes hitting, slapping, pinching, and kicking. <RESIDENT 7> Review of the 04/27/2026 Annual Minimum Data Set (MDS - an assessment tool) showed Resident 7 was assessed with cognitive impairment, no adverse behaviors, and was independent with walking. Review of the Care Plan (CP) showed Resident 7 had a psychosocial well-being problem related to resident-to-resident altercation which was initiated on 09/30/2025 and revised on 10/30/2025. A 10/13/2025 intervention directed staff to remove residents to a calm safe environment when conflict arises. On 07/13/2026 the CP was revised to keep the resident separated from Resident 6 whenever possible, especially in common areas and during activities. Further review showed on 07/13/2026 the CP was updated with the resident was at risk for or demonstrated resident-to-resident aggression, placing self and others at risk for injury. Review of progress notes showed a 07/13/2026 Nurses Note that a nurse observed Resident 7 grab Resident 6 and verbally yell profanities at them. The nurse heard Resident 6 stated, Stop it right now. Staff intervened immediately and separated both residents. Resident 6 reported, He hit me on the back of my head and said, ?Come here fatty, I will fight you. Resident 6 further stated, I told him, ?One of these days someone will beat you if you keep doing this to other people.' Resident 6 also reported this was not the first incident. Resident 6 stated on Saturday, Resident 7 approached them and said, Come here fatty, I will fight you, but did not make physical contact at that time. On 07/14/2026 at 12:48 AM, Resident 7 was observed asleep on their bed, with only a bottom sheet. On 07/15/2026 at 11:01 AM, Resident 7 was observed standing outside their room, leaning against the medication cart. Resident 7 did not answer questions asked. During an interview on 07/14/2026 at 11:51 AM, Staff E, Social Services Director, stated Resident 7 was on psychosocial watch following the incident. When asked if the altercation was physical, Staff E stated they heard maybe poking was involved. During an interview on 07/15/2026 at 11:08 AM, Staff P, Registered Nurse (RN), stated Resident 7 was on alert monitoring for being inappropriate with residents, specifically touching some of the residents yesterday. <RESIDENT 6> Review of the 05/04/2026 Quarterly MDS, showed Resident 6 was a long-term resident, was alert and oriented, exhibited no behaviors and was mobile in a wheelchair. Review of the CP, dated 07/13/2026, showed Resident 6 was at risk for physical and emotional harm related to resident-to-resident aggression. Interventions included keep the resident separated from Resident 7 whenever possible, especially in common areas and during activities and monitoring Resident 6 for signs of physical injury, pain, or changes in condition. Review of a 07/13/2026 Assessment note showed Resident 6 stated it hurt when they got hit but the pain was no longer there. During an interview on 07/15/2026 at 10:46 AM, Resident 6 stated Resident 7 called me (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/15/2026
NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4755 South 48th Tacoma, WA 98409	
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fatso, and I told him to get out of my face. Resident 6 stated Resident 7 followed them toward their room, and that made me nervous. Resident 7 told the workers F**k you, don't come down here. Resident 6 stated Resident 7 poked, jabbed the back of their chair, He attacked me. When asked if they were hit, Resident 6 replied, he did and removed their hat and pointed to an area on the top of their head. Resident 6 stated, Everyday he wants to fight me. Resident 6 recalled the past Saturday, Resident 7 wouldn't be quiet and let them eat their meal in peace, It was scary - that guy scares me. Resident 6 stated they ate fast and got out of there as fast as they could, that scared me, I get nervous. Resident 6 recalled the night before (07/14/2026), Resident 7 yelled at staff to go back to their own country, and calls staff the N word, you have to do something! During an interview 07/15/2026 at 10:42 AM, Collateral Contact (CC)1 stated they witnessed the altercation during a visitation. Resident 6 was minding their own business, propelling their wheelchair away from the dining room entrance and Resident 7 followed them. Resident 6 spun around and said, I told you to leave me alone! Resident 7 was touching Resident 7's back and Resident 6 told Resident 7 to stop touching him. CCI stated they did not see Resident 6 get hit on the head as they were still moving and they were behind a wall at that point. CC1 stated that the Resident Care Manager pulled Resident 7 back, and they got in between both residents. Resident 7 raised their foot up trying to kick Resident 6 but they missed. CC1 stated Resident 7 also poked Resident 24. <RESIDENT 24> Review of the 05/14/2026 Quarterly MDS, showed Resident 24 had diagnoses to include dementia and was assessed with severe cognitive impairment, without behaviors and was able to self-propel their wheelchair with supervision or touching assistance. Review of the 07/14/2026 Care Plan showed Resident 24 was at risk for bruising/skin tears due to frail, fragile skin and poor safety awareness. Uses handrail to propel in hallway while in wheelchair. The resident had impaired communication and difficulty making self understood. Review of Resident 24's electronic medical record showed no documentation of the altercation with Resident 7 which CC1 witnessed. On 07/15/2026 at 10:58 AM, Resident 24 was observed in bed asleep. During an interview on 07/15/2026 at 10:58 AM, Staff Q, Licensed Practical Nurse (LPN), stated Resident 24 gets up out of bed, and can speak, but does not understand questions asked, cannot remember things and would not recall the incident. Staff Q stated they were not working the day of the incident. During an interview on 07/15/2026 at 1:31 PM, Staff B, Director of Nursing, stated Resident 6 and Resident 7 were immediately separated, notifications made, the care plans updated, and both were being monitored on alert charting. Staff B stated it was an isolated incident and the investigation was ongoing. Review of the facility incident investigation dated 07/17/2026 showed the root cause of the incident was resident-to-resident aggression precipitated by the aggressor's (Resident 7) history of mental and behavioral disorder, impaired social interactions, poor impulse control, and prior documented behaviors involving inappropriate interactions with other residents. The prior verbal threats made toward the resident were not reported to facility staff at the time of occurrence, limiting the facility's opportunity to intervene before the physical altercation occurred. Review of the conclusion showed the investigation confirmed that a resident-to-resident altercation occurred involving verbal aggression and physical contact. However, the allegation of abuse was determined to be unsubstantiated as the available evidence did not establish intent to harm. REFERENCE WAC: 388-97-0640(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 3 of 6 sample residents (Residents 9, 14 & 15) received wheelchair positioning and bowel care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. The facility failed to ensure two residents (Residents 9 & 14) received services related to positioning and one resident (Resident 15) reviewed for bowel management, had an appropriate bowel care plan (CP) and received the medications for bowel management they were ordered to receive. These failures placed Residents 9 & 14 at risk for skin breakdown, accidents/hazards, uncomfortable positioning, and placed Resident 15 at risk for skin breakdown, infections, constipation, other significant negative outcomes related to untreated constipation, and diminished quality of care/quality of life. Findings included. WHEELCHAIR POSITIONING - Review of the 06/28/2026 admission Minimum Data Set (MDS - an assessment tool), showed Resident 9 had a Cerebrovascular Accident (CVA - stroke), with Aphasia (impaired ability to speak), severe cognitive impairment, used a wheelchair, and was dependent on staff for transferring, and bed mobility. Review of Resident 9's Care Plan (CP), dated 06/22/2026, showed Resident 9 was at risk for alteration in comfort related to chronic pain and listed an intervention to assist resident to a position of comfort, utilizing pillows and appropriate positioning devices. On 07/14/2026 at 9:30 AM, Resident 9 was observed in the common area, outside the [NAME] Hall nurses' station in a Tilt in Space (TNS) wheelchair, tilted back approximately 30 degrees. The brakes were on. Although there were footrests, without a sling, Resident 9's feet dangled from the seat without support. The right footrest was stationary and could not be adjusted. The left footrest was off to the left side of the wheelchair. The wheelchair head rest was too high and did not support Resident 9's head. On 07/14/2026 at 10:41 AM, Resident 9 was leaning forward in the wheelchair, trying to adjust the footrests. The left footrest was out 90 degrees from the wheelchair, the right footrest was folded closed. Both lower extremities were dangling. On 07/15/2026 at 8:45 AM, Resident 9 was observed in the TNS, tilted back approximately 45 degrees. Resident 9's left lower extremity was elevated. There was pressure applied from the footrest to the resident's toes. The heel sling was going into the left frontal aspect of the resident's heel. Resident 9's knee was bent as the footrest was not long enough. The right leg was bent down, and the resident's foot was falling off the footrest because the footrest was not long enough and was not adjustable. During an interview on 07/15/2026 at 10:28 AM, Staff S, Physical Therapy Assistant, stated Resident 9 required a TNS for positioning. Staff S stated they did not have another one available and were waiting for delivery of a chair. Staff S stated they would get a pillow to put behind Resident 9's head to provide support. On 07/15/2026 at 11:03 AM, Resident 9 was observed in the TNS, in front of the [NAME] nurse station. The TNS was tilted back approximately 45 degrees. The left footrest was elevated, and the resident's left foot was dangling over the left side. The residents' right leg was observed with their knee higher than the wheelchair cushion, and their ankle turned inward as the footrest was too short. During an interview on 07/15/2026 at 1:21 PM, Staff U, Occupational Therapist, stated they were limited the number and types of wheelchairs they had and Resident 9 was assessed to require a TNS wheelchair. Staff U stated they would see if they could find better footrests. Staff U stated the residents did not use the head rest much, but they were required on a TNS. Staff U stated a need for a wheelchair was determined during the initial therapy evaluations, or nursing would grab a wheelchair, and if the residents' needs change, they could switch out the wheelchair based on what they had available. RESIDENT 14 - Review of the 06/11/2026 (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission MDS showed Resident 14 had severe cognitive impairment, used a wheelchair, and was assessed to require substantial/maximal assistance with bed mobility, transfers, and supervision with wheelchair mobility. Resident 14's diagnoses included dementia with behavioral disturbances, falls, arthritis, and neuropathy (painful nerve damage that disrupts the communication lines between your brain, spinal cord, and rest of the body). Resident 14 had falls prior to admission and since admission. Review of the risk for falls CP, revised 07/10/2026, showed Resident 14 required one-to-one supervision due to fall risk, cognitive impairment, and had unsafe wheelchair positioning due to forward leaning. Interventions included directions to ensure the resident was positioned safely in a wheelchair with appropriate support, monitor for unsafe leaning or attempts to self-transfer and provide redirection. During an observation on 07/14/2026 at 2:06 PM, Resident 14 was observed seated in their wheelchair in the hallway attempting to self-propel down the hall. Resident 14 was under one-to-one supervision, and the staff member supervising Resident 14 was walking behind the wheelchair, not assisting or engaging the resident. Resident 14 was leaning to their right and slightly forward, and had a pillow wedged between their right leg and the right wheelchair arm rest to help position them more upright. The wheelchair did not support safe trunk control for the resident and appeared to be too wide for their smaller stature. On 07/15/2026 at 1:10 PM, Resident 14's wheelchair was observed to be a wide chair and the name on the chair was facility rehab. In an interview at that time, Staff T, Certified Nursing Assistant (CNA), stated Resident 14 had not been able to hold themselves up for the last couple of days. BOWEL PROGRAM<RESIDENT 15> Review of the 06/30/2026 admission Assessment MDS showed Resident 15 admitted to the facility on [DATE]. Resident 15 had no cognitive impairment, behaviors, or rejection of cares. Resident 15 required substantial/maximum assistance for toileting hygiene and was dependent on staff for toilet transfers. Resident 15 had a urinary catheter, was frequently incontinent of bowel, did not have a toileting program to manage incontinence, and did not experience constipation during the observation period assessed. Resident 15's diagnoses included: new traumatic spinal cord injury with paraplegia (inability to move parts of the body below the spinal cord injury site), traumatic brain injury, catheter associated urinary tract infection in the previous 30 days, and other multiple fractures. Resident 15 admitted with a Pressure Ulcer/Pressure Injury. Review of Resident 15's Comprehensive CP on 07/15/2026 did not provide documentation to show the facility developed a CP related to bowel incontinence or risk for constipation due to their new spinal cord injury. Review of the hospital History & Physical, dated 06/07/2026, showed Resident 15 worked with therapy to develop an effective bowel program that included a specific time of day for bowel stimulant medication administration to promote a normal daily schedule and prevent constipation and incontinence. Review of Resident 15's hospital discharge physician orders, dated 06/24/2026, showed physician orders/instructions to administer the routine rectal bowel stimulant medication every day and to continue working on their established bowel program and regime. Review of Resident 15's June 2026 Medication Administration Record (MAR) showed a physician order, dated 06/24/2026, for the rectal bowel stimulant medication to be administered daily as needed. The bowel medication was not scheduled routinely at the time Resident 15 required the medication for their daily bowel program/ regime. Review of Resident 15's July 2026 MAR showed a physician order, dated 07/01/2026, for the rectal bowel stimulant medication daily and scheduled for administration at 8:00 AM. The documentation showed the medication was refused on 07/01/2026, 07/02/2026, 07/03/2026, 07/08/2026, 07/14/2026, and 07/15/2026. Review of Resident 15's progress notes from 06/24/2026-07/15/2026 did not provide documentation to show the facility assessed Resident 15 related to bowel medication refusals, required bowel program/ regime, or documented refusals. The documentation did not show the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician was notified of medication refusals or that nursing monitored their bowel status. Review of June and July 2026 Documentation Survey Reports did not provide documentation to show staff monitored Resident 15's bowel movements daily. In an interview on 07/15/2026 at 11:05 AM, Resident 15 stated prior to admission to the facility they had worked with hospital therapy and nursing staff to develop and establish an effective bowel protocol, but the facility refused to follow their ordered bowel program. Resident 15 stated they had discussed their concern with multiple nurses since admission to the facility and recalled one nurse told them It is not going to happen when they told them they needed the bowel medication every day. Resident 15 stated they just recently started receiving the medication daily but not always at the correct time of day. Resident 15 stated they were aware that their clinical record showed they refused the rectal medication on multiple occasions. Resident 15 stated they never refused the medication, they refused the time it was administered because it was brought to them while they were trying to finish their breakfast and when [they] told the nurses they would take the suppository after they were done eating, they never came back to administer the medication. Resident 15 stated they were taught how to administer the medication at the hospital and all the facility staff needed to do is assist with the toilet transfer and provide the medication. They then had effective results within 30-45 minutes and had no problems with bowel incontinence or constipation. Resident 15 stated they felt constipated and had not had a bowel movement in two days. In an interview on 07/15/2026 at 3:15 pm, Staff B, Director of Nursing, stated the facility should have assessed Resident 15's bowel incontinence and continued their ordered bowel program upon admission but did not. Refer to F745. REFERENCE WAC: 388-97-1060(1)		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information was posted daily and updated at the beginning of each shift to reflect any staff absences, total number of staff each shift, and total number of actual hours worked for 3 of 3 months (July 2026, June 2026, May 2026) reviewed. In addition, the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months. These failures caused the facility's staffing information to be unavailable to review for residents, visitors, staff, and the State Agency. Findings included .Review of the posted staffing information on 07/13/2026 at 10:00 AM, located by reception in the front entrance of the facility showed only staffing sheets for 05/18/2026 - 05/22/2026, 05/26/2026 - 05/28/2026, 06/01/2026, 06/03/2026, 06/08/2026, 06/16/2026, 06/22/2026, 06/29/2026, 07/06/2026, and 07/10/2026.Review of the posted nurse staffing for 06/22/2026 showed information for three shifts, Day Shift, Evening Shift, and Night Shift. According to the posting day shift had 3 Registered Nurses (RNs) working 8-hour shifts and 5 Licensed Practical Nurses (LPNs) working 8 hours shifts, evening shift had 3 RNs working 8-hour shifts and 5 LPNs working 8 hours shifts, and night shift had 2 RNs working 8 hours shifts and 3 LPNs working 8 hours shifts for a total of 64 hours of RN coverage and 104 hours of LPN coverage.Review of the facility's Daily Staffing Assignment sheet for 06/22/2026 showed the day shifts RNs and LPNs worked 6:30 AM - 6:30 PM (12 hours shifts), and Night shift RNs and LPNs worked 6:30 PM - 6:30 AM (12 hours shifts). Over 24 hours 5 RNs and 8 LPNs worked for a total of 60 hours of RN coverage and 96 hours of LPN coverage.In an interview on 07/13/2026 at 2:20 PM, Staff H, Staffing Coordinator, stated they posted the daily staffing the day before and on Fridays, they placed the weekend projected staffing daily sheets behind the others so the weekend staff could change them with the new day. Staff H stated there were times when the nurses did not update the daily staff posting at the beginning of their shift. When asked to provide the previous three months of daily staff postings, the only ones they could locate were the ones found at the reception desk (the same ones reviewed on 07/13/2026 at 10:00 AM). Staff H could not locate any other daily staff postings. Staff H stated after three months they sent the daily staff posting sheets to the shredding company. Staff H agreed they did not have a system to ensure daily staff postings were timely, accurate with the information that was required, or a system to maintain them for the required 18 months.In an interview on 07/13/2026 at 4:45 PM, Staff B, Director of Nursing, stated the daily staff postings should have been readily available, accurate, updated at the beginning of each shift, and maintained for three years (they believed) but were not.NO ASSOCIATED WAC.		