

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  06/12/2025
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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .</b></p> <p>Based on observation, interview, and record review the facility failed to ensure resident choices/preferences regarding their bathing schedule were honored for 1 of 2 sampled residents (Resident 40) reviewed for choices. These failures placed the residents at risk for decreased cleanliness, increased risk of infection and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed, Resident 40 was admitted to the facility on [DATE] with diagnoses to include cerebral palsy (congenital disorder of movement, muscle tone, or posture), urinary tract infection and muscle weakness. Resident 40 was able to communicate needs.</p> <p>During an observation on 06/08/2025 at 12:28 PM, Resident 40 was sitting in their wheelchair in their room. Resident 40 stated they could not set their own shower time, per the facility schedule, it was provided only two times a week at specific times that were not followed.</p> <p>During an interview on 06/11/2025 at 9:07 AM, Staff P, Residential Care Manger / Licensed Practical Nurse (RCM/LPN), stated the shower aids had a schedule, and they offered choices to the residents.</p> <p>During an interview on 06/11/2025 at 2:04 PM, Staff H, Certified Nursing Assistant (CNA), stated the showers were assigned based on the room and bed location. Staff H stated Resident 40 was on the list for today (06/11/2025) to have a shower.</p> <p>During an interview on 06/12/2025 at 9:26 AM, Resident 40 stated there was no shower provided to them, the staff put it off and the shower aide left at 4:00 PM, Resident 40 stated they were to get a shower today.</p> <p>During an interview on 06/12/2025 at 10:44 AM, Staff B, Director of Nursing Services (DNS) stated the expectations were for staff to ask for preferences and honor the shower preferences.</p> <p>Review of the shower documentation on 06/13/2025 showed showers were not provided on 06/11/2025 and 06/12/2025 as scheduled.</p> <p>Reference WAC 388-97- 0900(1)-(4)</p>

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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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview, and record review the facility failed to assess for adverse side effects (ASE) related to the use of psychoactive (affecting the mind) medications for 1 of 5 sampled residents (Resident 107) when reviewed for unnecessary medication use. Failure to conduct/obtain an initial/baseline abnormal involuntary movement (AIM) assessment for the use of an antipsychotic medication (a psychoactive medication that affects a person's mental status) and identify potential involuntary movement placed Resident 107 at risk of unidentified presence and severity of AIM ASE, medical complications, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 107 readmitted to the facility on [DATE] with diagnoses that included dementia (a decline in mental ability that interferes with daily life) with psychotic disturbance (a mental state where individuals experience a significant disconnect from reality), and a cognitive (mental process in the brain for thinking, attention, language, learning, memory and perception), communication deficit.</p> <p>Review of the admission minimum data set assessment, dated 04/18/2025, showed Resident 107 initially admitted to the facility on [DATE], received an antidepressant medication, and antipsychotic medication on a routine basis. Resident 107 was able to make needs known.</p> <p>Observation on 06/08/2025 at 10:57 AM, showed Resident 107 laid across the bed, appeared anxious, and scratched their private area with legs spread apart. An unidentified staff member attempted to reposition Resident 107; however, the resident refused.</p> <p>Observation and interview on 06/10/2025 at 11:14 AM, showed Resident 107 laid in bed with a facility gown over their pants, moving both legs from a bending position to straight position, moving feet from side-to-side, and lifting up and pulling down the bottom of their gown multiple times. When asked if they were in pain Resident 107 stated, No. When asked if they were ok, Resident 107 stated they were, OK.</p> <p>Review of the June 2025 medication administration record (MAR) from 06/01/2025 - 06/09/2025 showed Resident 107 received an antipsychotic medication twice a day. The MAR showed to monitor extrapyramidal symptoms (a group of movement disorders) that included tardive dyskinesia (TD, involuntary, repetitive, and writhing movements, often affecting the face, torso, and limbs that can be caused by antipsychotic use) tremors, gait issues, involuntary movement of mouth/tongue related to antipsychotic medication use.</p> <p>Review of the EHR showed no AIM base line assessment documented for Resident 107's admission on [DATE] or readmission on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview, and record review, the facility failed to thoroughly and timely investigate falls and/or injuries and implement interventions to prevent repeat falls for 4 of 6 sampled residents (Resident 14, 110, 21 and 29) reviewed for abuse / neglect. These failures placed the residents at risk for repeated falls, avoidable injuries and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 14</p> <p>Review of the electronic health record (EHR) showed, Resident 14 was admitted to the facility on [DATE] with diagnoses to include dementia (impaired memory and judgment), chronic obstructive pulmonary disease (COPD, a condition which blocks airflow that makes it difficult to breathe), hypotension (low blood pressure), and anemia (a low red blood cell count). Resident 14 was not able to communicate needs.</p> <p>Review of the EHR showed Resident 14 had falls on the following dates: 02/05/2025, 02/13/2025, 03/18/2025, 03/31/2025, 04/02/2025, 04/29/2025, 05/24/2025, and 05/26/2025.</p> <p>Review of the facility incident reports showed a fall investigation from 02/13/2025 was completed on 02/24/2025 (11 days later), fall investigation on 04/02/2025 was completed on 04/10/2025 (8 days later), and investigations for falls on 05/24/2025 and 05/26/2025 were not completed.</p> <p>Review of Resident 14's care plan dated 01/21/2025 showed interventions were delayed and unclear.</p> <p>Resident 110</p> <p>Review of the EHR showed Resident 110 admitted to the facility on [DATE] with diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), difficulty walking and muscle weakness. Resident 110 was able to make needs known. Resident 110 required extensive assistance for transfers and used a wheelchair for mobility. Resident 110 was assessed as a fall risk.</p> <p>Review of Resident 110's incident report, dated 05/14/2025, showed Resident 110 had a witnessed fall resulting in a two-inch head laceration.</p> <p>Review of Resident 110's the incident report, dated 05/20/2025, showed Resident 110 had an unwitnessed fall that resulted in an elbow skin tear. Resident 110 denied pain and did not remember why they fell. Resident 110 had a skin tear on left elbow. The incident report showed the facility implemented immediate and long-term preventive interventions. The incident report was completed on 05/27/2025, seven days after the incident.</p> <p>Review of Resident 110's care plan showed no new interventions were added following the fall on 05/20/2025.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the incident report, dated 05/29/2025, showed Resident 110 had a third fall which was unwitnessed on 05/27/2025 that resulted in an occipital hematoma (blood collection at the back of the head). Resident 110 was unable to verbalize pain details or fall mechanics due to dementia. The incident report concluded, The resident's fall occurred due to an unassisted movement from or within an unlocked wheelchair, in the context of cognitive impairment, physical frailty, and brief lack of direct supervision. The resident's dementia likely led to poor safety awareness, and their medical conditions compounded the risk.</p> <p>Review of Resident 110's care plan showed it was updated with new interventions on 05/28/2025 which included continue interventions on the at-risk plan, anticipate and meet the resident's needs, supervision and not to be left unattended at all times (Do not leave up in room when in wheelchair. Keep in high visualized area when up in wheelchair), toileting schedules pre-post meals, before bedtimes, low bed while in bed to help reduce risk of injury from falls.</p> <p>During an interview on 06/10/2025 at 2:13 PM, Staff P, RCM/LPN, stated the care plan was not revised and no interventions were put in place after the 05/20/2025 fall but should have been.</p> <p>During an interview on 06/12/2025 at 2:02 PM, Staff B, DNS stated new interventions should have been implemented and care planned timely after Resident 110's, 05/20/2025 fall. Staff B stated the lack of care implementation, timeliness and care plan revision did not meet expectations.</p> <p>Resident 29</p> <p>Review of the EHR showed Resident 29 was admitted to the facility on [DATE] with diagnoses to include COPD, diabetes (high blood sugar), depression and anxiety. Resident 29 was able to make needs known.</p> <p>Observation on 06/08/2025 at 10:13 AM showed Resident 29 laid in bed and was bruised and had sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision) on the left side of their forehead near the eye. Resident 29 stated they fell from the bed and had to go to the emergency room for sutures. Resident 29 stated the fall happened during a repositioning / turning in the bed with one staff member. Resident 29 stated since the incident they were afraid to be turned in bed by staff.</p> <p>Review of Resident 29's EHR showed a fall with injury on 05/30/2025.</p> <p>Review of the facility's May and June 2025 incident logs on 06/09/2025 showed no record of Resident 29's fall.</p> <p>Review of facility incident report for Resident 29's fall on 05/30/2025 concluded staff did not follow the care plan and were educated. The investigation was completed on 06/05/2025 (7 days later).</p> <p>During an interview on 06/11/2025 at 11:44 AM, Staff B, Director of Nursing Services (DNS), stated the process for falls was to be thoroughly investigated with staff and resident interviews, and reenactments to determine and document what happened. Staff B stated the late investigations did not meet expectations.</p> <p>Resident 21</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the EHR showed Resident 21 admitted to the facility on [DATE] with diagnoses that included aftercare for joint replacement surgery, presence of left artificial hip joint and muscle weakness. Resident 21 was weight bearing as tolerated.</p> <p>During an interview on 06/12/2025 at 10:47 AM, Resident 21 stated on 05/29/2025 while staff were attempting to transfer them to their wheelchair Staff X, Certified Nursing Assistant (CNA), moved their left leg in jerking motion while on the bed which resulted in a loud pop. Resident 21 stated they asked the staff, did you hear that? The staff looked at each other and Staff X stated, yes. Resident 21 stated they immediately felt excruciating pain at a level of 110. Staff X lowered Resident 21's left leg back down on the bed and left the room. Resident 21 stated they yelled in pain for the nurse to give them something for pain. Resident 21 stated the nurse ordered an x-ray; however, stated it could take hours. Resident 21 stated their family member requested transport to the emergency department (ED) due to the possible wait time. Resident 21 stated they were crying and screaming in pain while at the ED until they were given pain medication and underwent surgery.</p> <p>Review of the EHR showed an ED Discharge summary, dated [DATE], with a final diagnosis of left hip dislocation which was surgically repaired. Resident 21 was discharged from the ED on 05/30/2025.</p> <p>Review of the facility's incident and grievance logs dated May 2025 through June 2025 showed no documentation related to Resident 21.</p> <p>During an interview on 06/12/2025 at 11:54 AM, Staff W, LPN, stated while coming back from break Staff X reported that Resident 21 was in extreme pain. Staff W stated when asked about the pain, Resident 21 stated they couldn't move their leg and was in excruciating pain because the CNA was careless and hurt my hip.</p> <p>During an interview on 06/10/2025 at 1:21 PM, Staff P, Resident Care Manager / Licensed Practical Nurse (RCM/LPN), stated the nurse did report the incident; however, no investigation was completed but should have been.</p> <p>During an interview on 06/12/2025 at 1:35 PM, Staff B, Director of Nursing Services, stated Resident 21 reported to the nurse that a staff member moved their leg and it popped. The incident should have been reported and investigated.</p> <p>Reference WAC 388-97-0640(6)(a)(b)(c)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on interview, observation and record review, the facility failed to ensure an accurate assessments for 2 of 4 sampled residents (Resident 15 and 40) reviewed for dental conditions, 1 of 4 sampled residents (Resident 67) reviewed for respiratory care and 1 of 1 sampled residents (Resident 14) reviewed for restraints. These failures placed the residents at risk of unmet care needs and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 15</p> <p>Review of the electronic health record (EHR) showed Resident 15 admitted on [DATE] with multiple diagnoses to include quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso [trunk of the body]), malnutrition, muscle weakness, and depression. Resident 15 was able to make needs known and required substantial assistance with activities of daily living (ADLs).</p> <p>During an observation and interview on 06/08/2025 at 11:31 AM, Resident 15 laid in bed, the resident's oral cavity showed multiple lower teeth missing and with their remaining teeth deeply stained dark brown in color. Resident 15 stated they had not seen a dentist since being admitted but needed to see one.</p> <p>Review of a progress note, dated 02/06/2025, showed a staff documented Resident 15 had missing teeth.</p> <p>Review of a nursing evaluation (initial admission assessment), dated 02/06/2025, showed the licensed nurse had documented in Section E: resident had missing/broken teeth.</p> <p>Review of Resident 15's initial minimum data set (MDS, a required assessment tool), dated 02/19/2025, for Section L0200 dental facility staff documented No for whether the resident had obvious or likely cavities or broken natural teeth.</p> <p>During an interview on 06/09/2025 at 1:00 PM, Staff E, Social Work (SW), stated they were unaware of Resident 15's dental issues. Staff E stated the process was a group effort for getting the resident into seeing a dentist and relied on the admission nurse after they completed their initial assessment, to inform them of the resident's dental needs.</p> <p>During an interview on 06/09/2025 at 1:06 PM, Staff O, MDS Nurse, stated they were the only one in the section and they relied on the admission nurse to conduct the initial assessment and note if the resident had missing or stained teeth. Staff O further stated their initial assessment was incorrect on 02/19/2025 related to the MDS dental / oral section.</p> <p>During an interview on 06/09/2025 at 1:18 PM, Staff B, Director of Nursing Services (DNS) stated it was their expectation the facility staff would conduct accurate dental assessments and contacted dental services as needed.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 67</p> <p>Review of the EHR showed Resident 67 readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, a long-term disease that makes it hard to breathe) with acute exacerbation (sudden and severe worsening of respiratory symptoms of COPD), dementia (loss in brain function that affects a person's ability to think, remember, and reason), and atrial fibrillation (irregular heartbeat). Resident 67 was able to make needs known.</p> <p>Observations on 06/08/2025 at 11:03 AM, 06/09/2025 at 1:13 PM, and 06/10/2025 at 8:56 AM, showed Resident 67 laid in bed with the head of the bed elevated and received oxygen (O2) via a nasal canula (NC, a flexible tube used to deliver extra O2 through the nose) connected to an O2 concentrator (medical device that provides supplemental oxygen).</p> <p>Review of the modified quarterly MDS, dated [DATE], showed Resident 67 received Hospice care (specialized care for people who are nearing the end of their life). This MDS did not show Resident 67 received oxygen therapy.</p> <p>Review of the interdisciplinary care conference progress note dated 04/30/2025 showed, Resident 67 rested in bed, was pleasantly confused, and had oxygen per NC.</p> <p>Review of the provider order, dated 01/06/2025, showed Resident 67 was prescribed supplemental O2 at 2 - 4 liters to keep saturation (oxygen levels in the blood) above 90% as needed for shortness of breath/low saturation.</p> <p>During an interview on 06/10/2025 at 12:37 PM, Staff L, Licensed Practical Nurse (LPN), stated Resident 67 received O2 therapy and had an order for it. Staff L stated Resident 67's 04/30/2025 modified MDS was not coded for O2 use and should have been coded Yes, for O2 therapy.</p> <p>During an interview on 06/10/2025 at 1:55 PM, Staff B, DNS stated Resident 67 was receiving O2 therapy and had a provider order dated 01/06/2025 for the supplemental O2. Staff B stated Resident 67's significant change in condition MDS dated [DATE] showed the resident was on O2 therapy; however, the modified quarterly MDS dated [DATE] was not coded for O2 therapy and should have been.</p> <p>Resident 14</p> <p>Review of the EHR showed, Resident 14 was admitted to the facility on [DATE] with diagnoses to include dementia, chronic obstructive pulmonary disease, hypotension (low blood pressure), and anemia (a low red cell count in the body). Resident 14 was unable to make needs known.</p> <p>Review of the quarterly MDS, dated [DATE], showed Resident 14 had a partial trunk restraint.</p> <p>During an interview on 06/10/2025 at 11:14 AM, Staff O, MDS Nurse, stated it was marked in error, Resident 14 did not use trunk restraints.</p> <p>Resident 40</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Resident 14</p> <p>Review of the EHR showed Resident 14 was admitted to the facility on [DATE] with diagnoses to include dementia (impaired memory and judgment), chronic obstructive pulmonary disease (COPD, a condition which blocks airflow that makes it difficult to breath), hypotension (low blood pressure), and depression. Resident 14 was unable to make their needs known.</p> <p>Review of a provider order, dated 01/21/2025, showed an antidepressant was prescribed.</p> <p>Review of June 2025 medication administration record showed Resident 14 was administered an antidepressant medication three times a day and a second antidepressant medication for appetite stimulation.</p> <p>Review of a Level I PASARR, dated 01/21/2025, showed Resident 14 had indications for serious mental illness. No Level II referral was completed.</p> <p>During an interview on 06/10/2025 at 1:44 PM, Staff E, SW, stated they performed audits to correct PASARR's after admission to the facility; however, Resident 14's PASARR was missed. Staff E stated the lack of Level II referral did not meet expectation.</p> <p>Reference WAC 388-97-1915(1)(2)(a-c)</p> <p>Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASARR, a mental health screening tool) assessments were accurately completed for 2 of 5 sampled residents (Residents 91 and 14) when reviewed for PASARRs and unnecessary medications. This failure placed the residents at risk for unidentified mental health care needs.</p> <p>Findings included .</p> <p>Review of a document titled, PASRR Completion Policy, dated 09/03/2024, showed the center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed. In addition, the center administrator will designate either the Admissions Director or Social Worker to make sure the PASSR and/or Level of Care (LOC) was done on all potential residents. Furthermore, the facility will follow state-specific guidelines for completion.</p> <p>Resident 91</p> <p>Review of Resident 91's admission minimum data set (MDS, a required assessment tool), dated 05/05/2025, showed the resident admitted on [DATE] with multiple health conditions including pneumonia, anxiety, depression and post-traumatic stress disorder (PTSD, a disorder that develops when a person experienced or witnessed a traumatic event). The resident was able to make their needs known.</p> <p>(continued on next page)</p>

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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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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Level I PASARR, dated 04/22/2025, showed it was completed by a local medical care facility's social work staff. The PASARR form had documentation for Section 111 marked exempted hospital discharge per section II.A: marked all three boxes which meets the requirements for an exempted hospital discharge and can be referred to a nursing facility without a PASRR Level II; however, the form showed the resident's provider also documented the attending provider certified the resident was likely to require fewer than 30 days of nursing facility care.</p> <p>During an interview on 06/09/2025 at 12:57 PM, Staff D, Social Service Director (SSD), stated if Resident 91 had a behavioral health diagnosis when admitted to the facility with a hospital exempt discharge but remained at the facility longer than 30 days then the PASRR should have been corrected and a Level II referral completed.</p> <p>During an interview on 06/12/2025 at 2:16 PM, Staff A, Administrator, stated it was their expectation if Resident 91's Level I PASARR was a hospital exempt discharge and the resident remained longer than 30 days in the facility then the PASSR should have been corrected and referred for a Level II evaluation for any potential behavior health care services that were needed.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .</b></p> <p>Based on observation, interview, and record review the facility failed to develop and/or implement individualized comprehensive care plans related to oxygen therapy and oral/dental status for 3 of 23 sampled residents (Residents 67, 40, and 90) whose care plans were reviewed. Failure to develop and implement care plans that were individualized, and accurately reflected resident care needs placed residents at risk of unmet care needs and potential negative outcomes.</p> <p>Findings included .</p> <p>Resident 67</p> <p>Review of the electronic health record (EHR) showed Resident 67 readmitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD, a long-term disease that makes it hard to breathe) with acute exacerbation (sudden and severe worsening of respiratory symptoms of COPD). Resident 67 was able to make needs known.</p> <p>Observations on 06/08/2025 at 11:03 AM, 06/09/2025 at 1:13 PM, and on 06/10/2025 at 8:56 AM, showed Resident 67 laid in bed with the head of the bed elevated and received oxygen (O2) via a nasal canula (NC, a flexible tube used to deliver extra O2 through the nose) connected to an O2 concentrator (medical device that provides supplemental oxygen).</p> <p>Review of the provider order dated 01/06/2025 showed Resident 67 was prescribed supplemental O2 at 2 - 4 liters to keep saturation (oxygen levels in the blood) above 90% as needed for shortness of breath/low saturation.</p> <p>During an interview on 06/10/2025 at 12:37 PM, Staff L, Licensed Practical Nurse (LPN), stated Resident 67 received O2 therapy and had an order dated 01/06/2025 for the O2 therapy. Staff L stated they were unable to locate a care plan for oxygen use for Resident 67 and it should have been care planned. Staff L stated this did not meet expectations.</p> <p>During an interview on 06/10/2025 at 1:55 PM, Staff B, Director of Nursing Services (DNS), stated Resident 67 received O2 therapy and had a provider order dated 01/06/2025 for the supplemental O2 use; however, Resident 67's O2 use had not been care planned. Staff B stated Resident 67's comprehensive care plan did not meet expectations related to O2 therapy.</p> <p>Resident 40</p> <p>Review of the EHR showed, Resident 40 was admitted to the facility on [DATE] with diagnoses to include cerebral palsy (congenital disorder of movement, muscle tone, or posture), urinary tract infection and muscle weakness. Resident 40 was able to communicate needs.</p> <p>During an observation on 06/08/2025 at 12:28 PM, Resident 40 sat in their wheelchair in their room. Resident 40 had many broken and discolored upper front teeth. Resident 40 stated they had many problems with the teeth.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 40's care plan initiated on 05/28/2025 showed instruction about oral care, and no information about broken teeth and potential for oral pain.</p> <p>Resident 90</p> <p>Review of the EHR showed Resident 90 admitted to the facility on [DATE] with diagnoses to include malnutrition, gastrointestinal hemorrhage (bleeding in stomach), chronic pain, and was dependent on artificial feeding.</p> <p>During an interview on 06/08/2025, Resident 90 stated they needed lower dentures, but they had upper dentures.</p> <p>Review of Resident 90's care plan initiated on 01/23/2025 showed no plan and instructions about missing lower teeth.</p> <p>During an interview on 06/12/2025 at 10:44 AM, Staff B, DNS, stated the expectation was for residents care plan to include broken and/or missing teeth.</p> <p>Reference WAC 388-97-1020(1),(2)(a)(b)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards for 3 of 23 residents (Residents 44, 14, and 90) when reviewed for quality of care. The facility failed to follow provider ordered boots (used to protect the heel and alleviate pressure) to heels every shift (Resident 44), to follow provider parameters (Resident 14), and to obtain orders to care for a central line/central venous catheter (CVC, flexible tube inserted into a large vein used to deliver fluids/nutrition (Resident 90). These failures placed residents at risk for unmet care needs, medical complications, and a diminished quality of life.</p> <p>Findings included .</p> <p>According to the Lippincott Manual of Nursing Practice, Tenth Edition ([NAME], [NAME] &amp; [NAME], 2014, page 16), The practice of professional nursing has standards of practice setting minimum levels of acceptable performance for which its practitioners are accountable.</p> <p>According to [NAME], Duell &amp; [NAME], Clinical Nursing Skills, 6th Edition, page 4, paragraph Nurse Practice Act identified skills and functions that professional nurses perform in daily practice included, in part, to administer treatments per physician's orders.</p> <p>The Washington State Nurse Practice Act, WAC 246-840-710(2)(d), states nurses violate standards of practice by, Willfully or repeatedly failing to administer medications and/or treatments in accordance with nursing standards.</p> <p>Resident 44</p> <p>Review of the electronic health record (EHR) showed Resident 44 readmitted to the facility on [DATE] with diagnoses that included diabetes (high blood sugar levels), stiff joints, muscle weakness, and heart failure. Resident 44 was able to make needs known.</p> <p>Observation and interview on 06/11/2025 at 10:52 AM showed Resident 44, sat in their wheelchair in the facility's front lobby area and did not have boots located on both heels. Resident 44 stated they preferred not to wear boots on heels while up in their wheelchair but, wore them while in bed.</p> <p>Review of Resident 44's June 2025 treatment administration record (TAR) showed an order for boots to be placed on bilateral (both) heels every shift, with a start date of 04/01/2024, and the documentation showed it was being implemented on all three shifts.</p> <p>During an interview on 06/11/2025 at 11:01 AM, Staff B, Director of Nursing Services (DNS), stated Resident 44 had orders to have boots on heels be in place every shift; however, saw that Resident 44 was in the front lobby area, in their wheelchair, with no boots in place. Staff B asked the resident about the boots and Resident 44 stated they did not wear the boots while up in the wheelchair and only wore them when in bed. Staff B looked at Resident 44's June 2025 TAR and stated there were no refusals documented for the ordered boots.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/11/2025 at 12:24 PM, Staff V, Certified Nursing Assistant (CNA), stated Resident 44 wore boots on both heels when in bed; however, preferred not to wear them when up in their wheelchair.</p> <p>During an interview on 06/11/2025 at 12:28 PM, Staff U, Licensed Practical Nurse (LPN), stated they interpret Resident 44's order dated 04/01/2024 for boots to heels to be in place all the time for every shift. Staff U stated Resident 44 preferred not to wear the boots when up in a chair; however, when they provided Resident 44's medications this morning they were still in bed with the boots in place.</p> <p>During a follow up interview on 06/11/2025 at 12:28 PM, Staff B, DNS, stated the aids should have reported Resident 44's refusals to wear boot on heels when up in their wheelchair, the nurses should have documented refusals in the TAR, informed the provider and clarified orders.</p> <p>Resident 14</p> <p>Review of the EHR showed, Resident 14 admitted to the facility on [DATE] with diagnoses to include dementia (impaired memory and judgment), chronic obstructive pulmonary disease (COPD, a condition which blocks airflow that makes it difficult to breath), hypotension (low blood pressure), and depression. Resident 14 was not able to communicate needs.</p> <p>Review of the May 2025 providers' orders showed Resident 14 had an order for midodrine (medication for low blood pressure) to be held when the systolic (top number of the blood pressure reading) blood pressure was greater than 120.</p> <p>Review of May 2025 medication administration record (MAR) showed Resident 14 had the medication administered on two occasions when their blood pressure was 127/56 on 05/01/2025 and 125/65 on 05/30/2025.</p> <p>During an interview on 06/11/2025 at 10:26 AM, Staff B, DNS stated the expectation was for nurses to follow orders, hold the medication when it is out of parameters and notify the provider.</p> <p>Resident 90</p> <p>Review of the EHR showed Resident 90 admitted to the facility on [DATE] with diagnoses to include malnutrition, gastrointestinal hemorrhage (bleeding in stomach), chronic pain, and dependent on artificial feeding.</p> <p>During an interview on 06/09/2025 at 9:10 AM, Resident 90 stated they received all their nutrition through a central line into the blood stream. Resident 90 stated they get ill when they consume food through the mouth.</p> <p>Review of Resident 90's provider orders for June 2025 showed no order for the care of the resident's central line to include monitoring for infection, dressing changes, size and length.</p> <p>During an interview on 06/12/2025 at 10:43 AM, Staff B, DNS, stated Resident 90 did not receive care for the central line and did not meet expectations.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview and record review, the facility failed to develop and implement an individualized activity plan for 1 of 1 sampled resident (Resident 97) reviewed for activities. This failure placed the resident at risk for boredom, isolation, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 97 admitted to the facility on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain), diabetes (too much sugar in the blood) and dementia (a decline in mental ability that interferes with daily life).</p> <p>Observations on 06/09/2025 at 1:09 PM, 06/10/2025 at 12:27 PM and 06/12/2025 at 11:49 AM, showed Resident 97 in their wheelchair sitting next to the nurse's station.</p> <p>Review of the EHR showed no activities assessment was completed upon admission and the care plan did not have a activities focus area.</p> <p>During an interview on 06/12/2025 at 11:46 AM, Staff J, Recreation Director (RD), stated no recreation assessment or activity care plan was completed for Resident 97 because they were on isolation precautions at admission. Staff J stated they were unaware if Resident 97 was still on isolation.</p> <p>During an interview on 06/12/2025 at 2:07 PM, Staff A, Administrator, stated the expectation was activity care plans would be completed within 72 hours of admission. Staff A stated if a resident was on isolation precautions staff should have offered one-on-one visits or in room activities for the resident.</p> <p>Reference: WAC 388-97-0940 (1)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview, and record review, the facility failed to provide the necessary care and services for the treatment of non-pressure skin injuries for 2 of 3 sampled residents (Residents 44 and 65) when reviewed for non-pressure skin conditions. Additionally, the facility failed to develop a collaborative comprehensive care plan involving Hospice (specialized care for people who are nearing the end of their life) service for 1 of 2 sampled residents (Resident 67) when reviewed for Hospice and end of life. These failures placed the residents at risk for unmet care needs, poor clinical outcomes, and diminished quality of life.</p> <p>Findings included .</p> <p>Resident 44</p> <p>Review of the electronic health record (EHR) showed Resident 44 readmitted to the facility on [DATE] with diagnoses that included diabetes (high blood sugar levels), stiff joints, muscle weakness, and heart failure. Resident 44 was able to make needs known.</p> <p>Review of Resident 44's June 2025 treatment administration record (TAR) showed Resident 44 had a provider order with a start date of 05/04/2025 to clean the left buttock wound with wound cleanser, pat dry, and apply foam dressing until healed every dayshift for wound care. Documentation showed wound care was refused twice and provided eight out of 10 times offered. This order did not indicate the type of wound.</p> <p>Review of Resident 44's focused skin care plan initiated on 02/06/2023 showed to provide wound care per provider orders and conduct weekly wound assessments to include measurements and description of wound status. Review showed Resident 44 had refusals of treatment and to provide wound related pain management interventions such as premedication. This care plan did not show that Resident 44 had a wound on their left buttock.</p> <p>Review of Resident 44's EHR on 06/11/2025 showed no documentation to describe the type of wound the resident had on their left buttock.</p> <p>During an interview on 06/12/2025 at 12:29 PM, Staff L, Licensed Practical Nurse (LPN), stated they were unable to locate documented information to show what type of wound was on Resident 44's left buttock. Staff L stated Resident 44 should have had the left buttock wound assessed to show the type of wound, weekly measurements documented, and it should have been care planned.</p> <p>During an interview on 06/12/2025 at 1:46 PM, Staff B, Director of Nursing Services (DNS) stated they had been verbally informed that Resident 44's wound to the left buttock was scattered moisture associated skin damage (MASD, damage to skin caused by moisture); however, was not able to locate that information in Resident 44's EHR. Staff B stated Resident 44's left buttock wound should have had weekly assessments of the wound documented to show type of wound and status located in the EHR, and care planned. Staff B stated this did not meet their expectations.</p> <p>Resident 65</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the EHR showed Resident 65 readmitted to the facility on [DATE] with diagnoses to include heart failure, arthritis (inflammation/swelling and stiffness of the joints), and depression. Resident 65 was able to make needs known.</p> <p>Review of Resident 65's annual minimum data set (MDS, a required assessment tool) dated 05/06/2025 showed the resident had no skin issues.</p> <p>Observation and interview on 06/08/2025 at 11:33 AM showed Resident 65 had a bandaid on their right-hand middle finger. Resident 65 stated they got a sore on their middle finger because they had bumped it, and the bandaid got changed today (06/08/2025) and was being taken care of by the staff.</p> <p>Review of Resident 65's current provider orders on 06/12/2025 showed no order for treatment to the right-hand, middle finger.</p> <p>Review of Resident 65's current focused skin care plan on 06/12/2025 did not show actual skin impairment to the right-hand middle finger documented.</p> <p>Review of the progress note, type: situation, background, assessment, recommendation (SBAR) dated 06/06/2025 showed Resident 65 had a change in skin color or condition and Skin status evaluation: skin tear, the resident had no pain. Review showed the resident had asked for a bandaid for a skin tear to the right hand third finger (middle finger) towards interdigital folds (between the fingers). It further showed the cut was cleaned with normal saline and a bandage placed. It showed there was a hematoma (blood filled blister) separately on the same finger with measurements and the DNS, Resident Care Manager (RCM), and provider was notified via SBAR.</p> <p>During an interview on 06/12/2025 at 10:43 AM, Staff L, Licensed Practical Nurse (LPN), stated they did not see treatment orders for the Resident 65's right hand middle finger skin injury and unable to locate it documented in Resident 65's current care plan. Staff L stated this did not meet expectations and needed to be followed up on.</p> <p>During an interview on 06/12/2025 at 10:59 AM, Staff B, DNS, stated there should have been a treatment order obtained at the time the provider was notified, skin issues monitored, and care plan revised to show actual skin impairment to Resident 65's right-hand middle finger. Staff B stated this did not meet their expectations and needed to be followed up on.</p> <p>Resident 67</p> <p>Review of the EHR showed Resident 67 readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, a long-term disease that makes it hard to breathe) with acute exacerbation (sudden and severe worsening of respiratory symptoms of COPD), dementia (loss in brain function that affects a person's ability to think, remember, and reason), and atrial fibrillation (irregular heartbeat). Resident 67 was able to make needs known.</p> <p>Review of the significant change MDS dated [DATE] showed Resident 67 received Hospice care.</p> <p>Review of the modification quarterly MDS dated [DATE] showed Resident 67 received Hospice care.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/10/2025, when asked if they were satisfied with the care provided by Hospice, Resident 67 nodded their head to indicate yes. When asked if they were in pain, Resident 67 mouthed the word no, and turned their head from side to side.</p> <p>Review of the provider order dated 01/29/2025 showed Resident 65 was admitted to [an outside provider] Hospice.</p> <p>Review of Resident 67's current care plan on 06/10/2025 showed no comprehensive care plan for Hospice.</p> <p>During an interview on 06/10/2025 at 12:37 PM, Staff L, Licensed Practical Nurse (LPN), stated there was nothing regarding Hospice located in Resident 67's care plan and this did not meet expectations. Staff L stated Resident 67's care plan needed to be updated to include Hospice care.</p> <p>During an interview on 06/10/2025 at 12:49 PM Staff B, DNS, stated Resident 67's current care plan did not include Hospice care and this did not meet expectations. Staff B stated Resident 67's Hospice comprehensive care plan should have been developed with their significant change in condition MDS dated [DATE].</p> <p>Reference WAC 388-97-1060 (1)</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on interview and record review, the facility failed to assist residents obtain new glasses for 1 of 2 sampled residents (Resident 63) when reviewed for communication/sensory. This failure placed the resident at risk of being unable to participate in activities, social isolation, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record showed Resident 63 admitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood), obesity, and chronic pain. Resident 63 was able to make needs known.</p> <p>During an interview on 06/08/2025 at 9:45 AM, Resident 63 stated their glasses were four years old and they needed new glasses. Resident 63 stated they were seen by an eye doctor, but there was no follow-up.</p> <p>Review of the annual minimum data set assessment, dated 06/03/2025, showed Resident 63's vision was adequate with glasses.</p> <p>During an interview on 06/11/2025 at 3:38 PM, Staff L, Licensed Practical Nurse, stated residents who had vision needs were seen yearly for an eye exam. Staff L stated the eye doctor was last in the facility in May 2025, and Resident 63 was not seen. Staff L stated Resident 63's lack of new glasses did not meet expectations.</p> <p>During an interview on 06/11/2025 at 3:55 PM, Staff B, Director of Nursing Services, stated residents with vision needs were seen yearly by the facility's provider and sent for further referral as needed. Staff B stated Resident 63 should have been seen by the eye doctor and lack of an eye exam did not meet expectations.</p> <p>Reference WAC 388-97-1060(3)(a)</p>

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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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> &amp;lt;Elopement&amp;gt;</p> <p>Review of a facility's policy titled, Elopements (when a resident identified as wandering leaves the facility without staff knowledge or authorization) - Resident Behavior and Facility Practices, dated 02/21/2025 showed when a resident who exhibited wandering behavior and/or were at risk for elopement received adequate supervision to prevent accidents, and received care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement. Review showed monitoring and managing residents at risk for elopement and unsafe wandering showed the effectiveness of interventions would be evaluated and changes made as needed. The procedure for locating missing residents would be followed to include alert personnel using facility approved protocol.</p> <p>Review of the facility's policy titled, Elopement of Resident dated 07/12/2023, showed a process for managing at risk (residents) for elopement, to include residents would be evaluated for elopement risk not only upon admission and quarterly but with any change in condition as part of the clinical assessment process. Those (residents) determined to be at risk would receive appropriate interventions to reduce risk and minimize injury, to include a person-centered care plan developed when applicable.</p> <p>Review of the facility's Inservice record / topic: Elopement, dated 01/02/2025 showed several procedures for staff to initiate to include checking with the front desk (staff) to see if the resident was checked out, announcing three times on the facility's intercom system a code pink (an alert/code use by the facility to indicate possible elopement of a facility's resident). If unable to locate the resident quickly notification of law enforcement as soon as possible (ASAP).</p> <p>Resident 56</p> <p>Review of the quarterly minimum data set (MDS, a required assessment tool), dated 05/22/2025, showed Resident 56 re-admitted on [DATE] with multiple diagnoses to include Parkinson's disease (a progressive neurodegenerative disorder that primarily affects movement), dyskinesia (impairment of voluntary movement), muscle weakness, and depression. The MDS showed the resident had a brief interview for mental status (BIMS) score of seven which indicated severe cognitive impairment and was dependent on staff for assistance with activities of daily living (ADLs) and was a high risk for falls. The MDS showed staff had documented a change in behavior in Section E1100 for the question How does the resident's current behavior status, care rejection, or wandering compared to prior assessment, a social service staff documented Resident 56 was worse for the behaviors section.</p> <p>Review of Resident 56's current care plan, initiated on 03/08/2025 had impaired / decline in cognitive function impaired thought processes related to dementia, Parkinson's disease, short/long term memory loss. Interventions included for staff to observe and evaluate types of changes in cognitive status i.e. confusion, orientation, forgetfulness, decision making ability and impulsiveness.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 56's social services progress note, dated 05/30/2025, showed facility staff documented resident continued to have poor safety awareness, needed reminders about safety, had history of falls and needed to be offered more assistance. The note showed the resident would like to be transferred to an adult living facility and angry and wanted to move to a new setting and can become irritable and angry mostly due to wanting to move to a new setting.</p> <p>Review of Resident 56's EHR, dated 06/02/2025, showed the resident ambulates (walk; move about) using a walker and required supervision one person) for ambulation.</p> <p>During an observation and interview on 06/08/2025 at 9:07 AM, showed Resident 56 sat on their bed, a staff member sat on a nearby chair and observed the resident. When asked what the staff was doing in the resident's room, Staff H, Certified Nurse Aide, (CNA) stated they were told from an earlier report Resident 56's had eloped yesterday 06/07/2025 and they were there to observe the resident to ensure they did not elope out of the facility again.</p> <p>Review of Resident 56's EHR progress note dated 06/07/2025 showed the resident was reported to be missing by the front desk. Front desk staff reported the resident walked out to the parking lot to get some sunshine at 3:15 PM; however, the resident did not return. The front desk staff informed the nurse at 3:45 PM, the resident's emergency contact was notified at 4:00 PM, who was also unaware of the resident's location. At 4:20 PM a facility staff contacted / called 911 related to the missing resident. At 4:40 PM a local nursing home several blocks away contacted the facility after Resident 56 was brought there by a woman who witnessed the resident stumbling/falling. A facility staff (manager on duty) retrieved the resident. Resident 56 stated they were looking for the highway to go home.</p> <p>During an interview 06/10/2025 at 1:10 PM, Staff B, DNS, stated their expectation was for a code pink to be called immediately by the manager on duty and if unable to initially find a resident then 911 should be called simultaneously and not delay the call during the search for the missing resident.</p> <p>During an interview on 06/10/2025 at 1:49 PM, Staff J, Recreation Director (RD), stated they were the manager on duty the day Resident 56 went missing and all the managers received a similar text regarding Resident 56 was missing. Staff J stated they walked around the facility outside for approximately 15 -20 minutes but were unable to locate the resident during that time frame. Staff J stated that another text came in to call 911. Staff J stated there was some confusion as to who was tasked with calling 911, either the manager on duty or the nurse in charge, so there was a delay in calling 911 related to the missing resident.</p> <p>During an interview on 06/10/2025 at 1:51 PM, Staff G, Social Work (SW) stated they had documented a change in Resident 56's MDS (current behavior status) on the previous MDS dated [DATE] and informed Resident 56's care manager.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/10/2025 at 12:45 AM, Staff A, Administrator (ADM) stated their expectation would be anytime a resident had a change in behavior (potential elopement risk) an assessment would need to be done to see if they were appropriate for increase monitoring and whether a placement of a wander guard was necessary. When asked about the front desk staff who observed Resident 56 leave the facility unaccompanied and whether they had elopement training / education, Staff A stated the receptionist was a recent hire (new staff) and they had recognized the receptionist had dropped the ball. The receptionist was now suspended, and education was done related to elopement risks. Staff A stated they were unable to find the front desk receptionist initial elopement training in their training documentation.</p> <p>Resident 14</p> <p>Review of the EHR showed Resident 14 was at risk for elopement and required a Wander Guard device (an alarm device that triggers when a resident attempts to leave the facility) on their wheelchair.</p> <p>Review of treatment administration record (TAR) for June 2025, showed Resident 14's Wander Guard was not in place for eight of 17 opportunities from 06/01/2025 - 06/09/2025.</p> <p>Review of Resident 14's TAR record for May 2025 showed missed documentation for the Wander Guard for 20 out of 62 opportunities.</p> <p>During an interview on 06/12/2025 at 10:32 AM, Staff Q, Resident Care Manager, stated they just replaced the Wander Guard as the Resident cuts it off. Staff Q stated the expectation was for the licensed nurses to check and ensure Resident 14 had a Wander Guard in place and documented.</p> <p>Refer to F-610 for additional information.</p> <p>Reference WAC 388-97-1060 (3)(g).</p> <p>.</p> <p>.</p> <p>Based on observation, interview and record review, the facility failed to consistently provided the assessed level of supervision to prevent avoidable injuries and falls, assess if care plan interventions were effective and provide timely revisions for 5 of 6 sampled residents (Residents 14, 15, 29, 21 and 110) reviewed for accidents and falls. Resident 29 experienced harm when a staff member provided bed mobility assistance without a second staff member as required per the plan of care resulting in a fall with a periorbital (area around the eye) laceration (cut) to the left eye that required hospital evaluation and sutures. Resident 21 experienced harm when staff failed to implement hip precautions during a transfer resulting in a hip dislocation and severe pain that required surgery and hospitalization. Resident 110 experienced harm from repeated falls, three between 05/14/2025 and 05/27/2025, with injuries to include a head laceration, skin tear to the elbow, and including an occipital hematoma (blood collection at the back of the head). The facility failed to protect residents from eloping (exiting the facility without the required supervision) or attempting to exit the facility for 2 of 2 sampled residents (Residents 56 &amp; 14) reviewed for accidents. These failures placed residents at risk of significant injury and a decreased quality of life.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Findings included .</p> <p>&amp;lt;Avoidable Injuries&amp;gt;</p> <p>Resident 29</p> <p>Review of the electronic health record (EHR) showed Resident 29 was admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, a condition which blocks airflow that makes it difficult to breath), diabetes (high blood sugar), depression and anxiety. Resident 29 was able to communicate needs.</p> <p>Observation on 06/08/2025 at 10:13 AM showed Resident 29 lying in bed with bruising and sutures (a stitch or row of stitches holding together the edges of a wound or surgical incision) on the left side of their forehead near the left eye. Resident 29 stated they fell from the bed and had to go to the emergency room for sutures. Resident 29 stated the fall happened during repositioning / turning in the bed by one staff member. Resident 29 stated since the incident they were afraid to be turned in bed by staff.</p> <p>Review of Resident 29's progress notes in the EHR showed a fall with injury on 05/30/2025. During routine care by one staff member Resident 29 fell from the unsupervised side of the bed air mattress. Resident 29 struck their head against the floor resulting in deep periorbital (area around the eye) laceration (cut) to the left eye.</p> <p>Review of the care plan self care focus area, dated 05/17/2025, showed intervention Resident is totally dependent on staff for repositioning and turning in bed, and The resident requires 2 staff participation to reposition and turn in bed.</p> <p>Review of facility incident report investigation, dated 06/06/2025 for the fall on 05/30/2025, showed one of the immediate actions was Due to the extent of the eye injury and head trauma, the provider ordered to be transferred to the hospital. Review showed, The care was performed by one staff member, despite the resident requiring two staff, the aide did not follow the care plan, and There was a lack of adherence to care plan protocols and enforcement to ensure compliance with required assistive staffing for high-risk residents.</p> <p>Observation on 06/10/2025 at 11:06 AM showed Staff R, Registered Nurse (RN) performed a skin check and turned Resident 29 in bed by themselves and stated, I am not going to drop you.</p> <p>Resident 21</p> <p>Review of the EHR showed Resident 21 admitted to the facility on [DATE] with diagnoses that included aftercare for joint replacement surgery, presence of left artificial hip joint and muscle weakness. Resident 21 was weight bearing as tolerated.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/12/2025 at 10:47 AM, Resident 21 stated on 05/29/2025 while staff were attempting to transfer them to their wheelchair Staff X, Certified Nursing Assistant (CNA), moved their left leg in jerking motion while on the bed which resulted in a loud pop. Resident 21 stated they asked the staff, did you hear that? The staff looked at each other and Staff X stated, yes. Resident 21 stated they immediately felt excruciating pain at a level of 110. Staff X lowered Resident 21's left leg back down on the bed and left the room. Resident 21 stated they yelled in pain for the nurse to give them something for pain. Resident 21 stated the nurse ordered an x-ray; however, stated it could take hours. Resident 21 stated their family member requested transport to the emergency department (ED) due to the possible wait time. Resident 21 stated they were crying and screaming in pain while at the ED until they were given pain medication and underwent surgery.</p> <p>Review of the EHR showed an ED Discharge summary, dated [DATE], with a final diagnosis of left hip dislocation which was surgically repaired. Resident 21 was discharged from the ED on 05/30/2025.</p> <p>Review of progress note from Staff W, Licensed Practical Nurse (LPN), dated 05/29/2025, showed Resident 21 complained of popping sound while being moved to the wheelchair from the bed to get weighed. Resident 21 stated, 2 gentleman tried to move me from the other side of the bed to the wheelchair when I heard a popping sound from my left hip and now, I can't move. and Resident was able to transfer from wheelchair to the bed with stand-and-pivot when they first came to the facility without complaint of pain.</p> <p>During an interview on 06/12/2025 at 11:54 AM, Staff W, LPN, stated while coming back from break Staff X reported that Resident 21 was in extreme pain. Staff W stated when asked about the pain, Resident 21 stated they couldn't move their leg and was in excruciating pain because the CNA was careless and hurt my hip. Staff W stated the admissions department was putting Resident 21's orders in the EHR at that time of the incident; however, the resident was weight bearing as tolerated.</p> <p>Review of Resident 21's EHR showed signed discharge orders from the previous facility, dated 05/29/2025, which included an order, Weight bearing as tolerated with walker, posterior hip precaution (eliminating hip flexion/bending and internal rotation / turning leg inward, and adduction / flexing inward) X 6 weeks full weightbearing.</p> <p>Review of the current providers order on 06/12/2025, showed no order for: Weight bearing as tolerated with walker, posterior hip precaution for six weeks full weight bearing.</p> <p>During an interview on 06/12/2025 at 1:35 PM, Staff B, Director of Nursing Services, stated Resident 21 reported to the nurse that a staff member moved their leg and it popped.</p> <p>&amp;lt;Falls&amp;gt;</p> <p>Resident 110</p> <p>Review of the EHR showed Resident 110 admitted to the facility on [DATE] with diagnoses that included dementia (a group of thinking and social symptoms that interferes with daily functioning), difficulty walking and muscle weakness. Resident 110 was able to make needs known. Resident 110 required extensive assistance for transfers and used a wheelchair for mobility. Resident 110 was assessed as a fall risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 110's incident report, dated 05/14/2025, showed Resident 110 had a witnessed fall resulting in a two-inch head laceration. At approximately 1:10 PM, housekeeping staff reported witnessing Resident 110 attempting to stand from their wheelchair with foley catheter (tube to drain urine) still attached resulting in a fall. Resident 110 was found lying on the floor on their right side, near the foot of the bed by the window. Review showed a nurse applied pressure to an actively bleeding head wound. Resident 110 was unable to verbalize pain but was grimacing and holding their right leg. Resident 110's wheelchair was located outside the bathroom door with a tray table and meal tray.</p> <p>Review of Resident 110's care plan, dated 05/14/2025, showed supervised feeding at nurses' station or dining room for meals were the fall prevention interventions put in place.</p> <p>Review of Resident 110's the incident report, dated 05/20/2025, showed Resident 110 had an unwitnessed fall that resulted in an elbow skin tear. At approximately 7:15 PM a nurse noticed Resident 110 was on the floor on the left side of the bed on top of the floor mat, lying on their left side. Resident 110 denied pain and did not remember why they fell. Resident 110 had a skin tear on left elbow. The fall occurred despite appropriate fall precautions (e.g., floor mat, routine checks). The incident report showed the facility implemented immediate and long-term preventive interventions. The incident report was completed on 05/27/2025, seven days after the incident.</p> <p>Review of Resident 110's care plan showed no new interventions were added following the fall on 05/20/2025.</p> <p>Review of the incident report, dated 05/29/2025, showed Resident 110 had a third fall which was unwitnessed on 05/27/2025 that resulted in an occipital hematoma (blood collection at the back of the head). At approximately 3:50 PM a facility staff heard a loud yell from the hallway. Staff responded immediately and found the Resident 110 on the floor in front of their wheelchair, lying on their left side, with the left occipital area of the head touching the wall. A hematoma was noted on the left occipital scalp (no bleeding). Resident 110 was grimacing, saying ouch. The FACES pain scale indicated pain. Resident 110 was unable to verbalize pain details or fall mechanics due to dementia. The resident was not sent to the hospital. The incident report concluded, The resident's fall occurred due to an unassisted movement from or within an unlocked wheelchair, in the context of cognitive impairment, physical frailty, and brief lack of direct supervision. The resident's dementia likely led to poor safety awareness, and their medical conditions compounded the risk.</p> <p>Review of Resident 110's care plan showed it was updated with new interventions on 05/28/2025 which included continue interventions on the at-risk plan, anticipate and meet the resident's needs, supervision and not to be left unattended at all times (Do not leave up in room when in wheelchair. Keep in high visualized area when up in wheelchair), toileting schedules pre-post meals, before bedtimes, low bed while in bed to help reduce risk of injury from falls.</p> <p>During an interview on 06/10/2025 at 2:13 PM, Staff P, RCM/LPN, stated the care plan was not revised and no interventions were put in place after the 05/20/2025 fall but should have been.</p> <p>During an interview on 06/12/2025 at 2:02 PM, Staff B, DNS stated new interventions should have been implemented and care planned timely after Resident 110's, 05/20/2025 fall. Staff B stated the lack of care implementation, timeliness and care plan revision did not meet expectations.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 15</p> <p>Review of the quarterly minimum data set assessment (MDS), dated [DATE], showed Resident 15 admitted on [DATE] with multiple diagnoses to include quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso [trunk of the body]), malnutrition, muscle weakness, and depression. The MDS showed the resident was able to make needs known and required substantial assistance with activities of daily living (ADLs) and was documented a high falls risk.</p> <p>Observation and interview on 06/08/2025 at 11:31 AM, showed Resident 15 laying in bed with fall floor mats positioned on both the left and right side of their the bed. Resident 15 stated they had fallen a few times previously when they were either reaching for something that dropped on the floor or attempted to get out of bed without assistance. The resident further stated they had been provided a reacher tool (a device known as a grabber extender, a handheld mechanical device designed to extend a person's reach and grip, allowing them to grasp objects that was otherwise out of arm's length); however, it always seemed to be stored on their wheelchair at the foot of their bed and their call light was also out of their reach.</p> <p>Review of Resident 15's care plan, dated 02/06/2025, showed Resident 15 was at risk for falls due to multiple diagnoses and had recurrent falls. Interventions included for the resident to have positioned floor mats, a reacher tool, call light within reach and to provide verbal cues for safety.</p> <p>Review of Resident 15's incident report, dated 05/07/2025, showed the resident fell next to their bed. The report showed the residents' roommate had used their own call light to alert the facility staff for assistance regarding Resident 15's fall. Prior to the fall the resident had a discussion with a facility staff member, (an unidentified registered nurse, RN) of the need to get out of bed to purchase a soda, the report showed the resident stated they were, going to anyway. The report showed the RN told the resident to wait until additional help arrived; however, the report did not indicate whether the RN waited with the resident until additional help arrived and they were reportedly found on the floor next to their bed a short while later. The report concluded Resident 15 had moderate cognitive impairment and their behavior led to poor judgment and was noted to be impulsive.</p> <p>During an interview on 6/10/2025 at 12:10 PM, Staff B, DNS, stated the licensed nurse should have waited with Resident 15 on 05/07/2025 until additional help arrived, especially after the resident had made the statement they were, going to do it anyway (get out of bed). Staff B stated Resident 15 was a two person assist with transfer and had impulsivity and poor judgement.</p> <p>Resident 14</p> <p>Review of the EHR showed, Resident 14 was admitted to the facility on [DATE] with diagnoses to include dementia, COPD, hypotension (low blood pressure), and anemia (low blood cell count). Resident 14 was unable to make needs known.</p> <p>Review of the EHR showed Resident 14 had falls on the following dates 02/05/2025, 02/13/2025, 03/18/2025, 03/31/2025, 04/02/2025, 04/29/2025, 05/24/2025, and 05/26/2025.</p> <p>Review of the facility's incident investigation showed an investigation of fall on 05/24/2025. Review showed no new interventions were put in place.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Some	Review of the EHR showed Resident 14 had a repeat fall on 05/26/2025.

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview and record review, the facility failed to provide respiratory care consistent with physician orders for oxygen (O2) therapy for 2 of 4 sampled residents (Residents 65 and 97) reviewed for respiratory care. This failure placed the residents at risk for unmet needs and potential negative outcomes.</p> <p>Findings included .</p> <p>Resident 65</p> <p>Review of the electronic health record (EHR) showed Resident 65 readmitted to the facility on [DATE] with diagnoses to include heart failure, chronic obstructive pulmonary disease (a long-term lung disease that makes it hard to breathe), and asthma (a condition where the airways in the lungs get inflamed/swollen and narrowed, making it hard to breathe). Resident 65 was able to make needs known.</p> <p>Observation on 06/08/2025 at 11:41 AM, showed Resident 65 with oxygen (O2) being administered at five liters via nasal canula (NC, a flexible tube used to deliver extra O2 through the nose) connected to an O2 concentrator (medical device that provides supplemental oxygen). Resident 65 stated they had no problems with O2 therapy.</p> <p>Observation on 06/10/2025 at 11:24 AM showed Resident 65 laid in bed with eyes closed and O2 was being administered at six liters via NC.</p> <p>Review of the EHR showed Resident 65 had a provider order dated 02/07/2025 for O2 to be provided at three liters per minute via NC, continuously.</p> <p>Review of the June 2025 treatment administration record (TAR) on 06/10/2025 showed Resident 65's order for O2 at three liters per minute was documented as provided per provider's order.</p> <p>During an interview on 06/10/2025 at 1:31 PM, Staff L, Licensed Practical Nurse (LPN), stated Resident 65 had O2 at six liters per minute via NC. Resident 65 told Staff L they had been receiving O2 at six liters after getting sick in February (2025) but, they use to get O2 at three liters. Staff L stated Resident 65's provider order dated 02/07/2025 showed the resident was to receive O2 at three liters. Staff L stated this did not meet their expectations and provider orders should have been followed. Staff L stated Resident 65's EHR showed no documentation to provide O2 at six liters or that the provider was notified related to changing O2 liter flow rate.</p> <p>During an interview on 06/10/2025 at 2:12 PM, Staff B, Director of Nursing Services (DNS), stated they were not aware that Resident 65 had been receiving O2 at six liters even though Resident 65 had orders to receive O2 at three liters continuously via NC. Staff B stated the expectation was that nurses checked the liter flow to ensure to follow provider orders. Staff B stated if O2 was not at the correct liter flow the nurse should have assessed the resident, notified the provider, and clarified orders.</p> <p>Resident 97</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the EHR showed Resident 97 admitted to the facility on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain), diabetes (too much sugar in the blood) and dementia (a decline in mental ability that interferes with daily life).</p> <p>Observations on 06/10/2025 at 8:45 AM, 06/11/2025 at 10:02 AM and 06/12/2025 at 8:11 AM showed Resident 97 received O2 set to three liters (L) per minute via a nasal canula.</p> <p>Review of Resident 97's care plan showed an intervention for oxygen settings at one L continuously.</p> <p>During an interview and observation on 06/12/2025 at 9:07 AM, Staff W, LPN, observed Resident 97's O2 and stated it was set at three liters. Staff W stated the O2 should have been set at one L.</p> <p>During an interview on 06/12/2025 at 2:00 PM, Staff B, DNS stated the expectation was that staff followed the providers order and monitor the O2 setting every shift.</p> <p>Reference WAC 388-97-1060 (3)(j)(vi)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview and record review, the facility failed to store medication requiring refrigeration in the medication refrigerator and to discard expired equipment and/or supplies in 1 of 2 medication rooms (East medication room) when reviewed for medication storage and labeling. These failures placed residents at potential risk for receiving medications contaminated by food items and/or for receiving compromised or ineffective supplies that had expired.</p> <p>Findings included .</p> <p>Observation on 06/11/2025 at 1:14 PM, with Staff L, Licensed Practical Nurse (LPN) at the East medication storage room showed the following:</p> <p>&amp;lt;Resident's food refrigerator&amp;gt;</p> <p>*Located in the bottom drawer of the refrigerator was a large plastic bag labeled with Resident 90's name that was filled with an intravenous (IV, a way of giving a drug or other substance through a needle or tube/catheter inserted into a vein) solution of liquid nutrition along with two vials of infuvite (multivitamin supplement), and an infusion kit (collection of devices used to administer fluids and medications via an IV catheter).</p> <p>&amp;lt;Expired supplies/equipment&amp;gt;</p> <p>*Located in a cabinet were two universal viral transport kits with a tube and swab (used to obtain a culture for testing) one had expired on 09/30/2023 and the other expired on 05/31/2025.</p> <p>*Located in another cabinet was a box with 38 universal viral transport kits to include a tube and swab that expired on 09/30/2023 and two other kits that expired on 11/30/2022.</p> <p>*Located in a cabinet were four containers of ECOLAB peroxide test strips (used to measure the concentration of sanitizers in cleaning and disinfecting solutions, ensuring they were at the proper strength for effective cleaning and disinfection) that expired in March 2025.</p> <p>*Located in a cabinet were two boxes of cleansing towelettes with 100 packets in each box that had expired on 06/10/2024.</p> <p>*Located in a cabinet was a canister with gel/wound vac therapy system package (a device used to remove and store fluid, exudate/fluid leakage from a wound, and infectious materials away from a wound site) that had expired on 01/31/2025.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/11/2025 at 1:14 PM, Staff L, LPN, stated that Resident 90's items should not have been stored in the resident's food refrigerator and should have been stored in the medication refrigerator. Staff L stated expired equipment, and supplies should not be stored in the medications room and needed to be thrown away so as not to be used. Staff L stated these findings did not meet expectations.</p> <p>During an interview on 06/11/2025 at 2:41 PM, Staff B, Director of Nursing Services (DNS), stated residents' medications should not be stored in the resident's food refrigerator and should be stored in the medication refrigerator. Staff B stated that expired supplies/equipment should not be stored in the medication room, and this did not meet their expectations.</p> <p>Reference WAC 388-97-1300(2)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview, and record review the facility failed to provide routine dental care for 1 of 4 sampled residents (Resident 40) reviewed for dental care. This failure placed the residents at risk for difficulty eating, dental pain, unintended weight loss and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the electronic health record (EHR) showed Resident 40 was admitted to the facility on [DATE] with diagnoses to include cerebral palsy (congenital disorder of movement, muscle tone, or posture), urinary tract infection and muscle weakness. Resident 40 was able to make needs known.</p> <p>Observation on 06/08/2025 at 12:28 PM showed Resident 40 sat in their wheelchair in their room. Resident 40 had many broken and discolored upper front teeth. Resident 40 stated they had many dental issues.</p> <p>Review of Resident 40's EHR showed no dental consultation, plan or treatment.</p> <p>During an interview on 06/11/2025 at 2:39 PM, Resident 40 stated staff told them they were unable to see the dentist in the facility as they were a temporary resident.</p> <p>During an interview on 06/12/2025 at 1:17 PM, Staff E, Social Work, stated social services scheduled the routine appointments and if emergent they were referred out of the facility. Staff E was unable to provide information about Resident 40's dental appointment status.</p> <p>Reference WAC 388-97-1060(3)(j)(vii)</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> .</p> <p>Based on observation, interview, and record review the facility failed to provide assistance and follow up on an appointment for dental care services for 2 of 4 sampled residents (Residents 15 and 90) reviewed for dental services. This failure placed the residents at potential risk for continued dental problems and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the quarterly minimum data set (MDS, a required assessment), dated 05/14/2025, showed Resident 15 admitted on [DATE] with multiple diagnoses to include quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso [trunk of the body]), malnutrition, muscle weakness, and depression. Resident 15 was able to make needs known and required substantial assistance with activities of daily living (ADLs).</p> <p>Observation and interview on 06/08/2025 at 11:31 AM showed Resident 15 laid in bed, the resident's oral cavity showed multiple lower teeth missing with their remaining teeth deeply stained dark brown color. Resident 15 stated they had not seen a dentist since admission but, needed to see one.</p> <p>Review of a provider's order, dated 02/06/2025, showed an order for Resident 15 to have a dental consult and provide treatment as needed for patient health and comfort.</p> <p>Review of a progress note, dated 02/06/2025, showed staff had documented Resident 15 had missing teeth.</p> <p>Review of Resident 15's nursing documentation evaluation (initial admission assessment), dated 02/06/2025, showed the licensed nurse had documented in section E, the resident had missing/broken teeth.</p> <p>Review of Resident 15's initial MDS, dated [DATE], for Section L0200, Dental facility staff documented No for whether the resident had obvious or likely cavity or broken natural teeth.</p> <p>During an interview on 06/09/2025 at 1:00 PM, Staff E, Social Work (SW) staff, stated they would normally make the dental appointments for the residents if the nursing staff informed them the resident had a dental issues and it appeared Resident 15 had just been re-approved for Medicaid (insurance) so there would be no reason why the resident was not seen for their dental needs.</p> <p>During an interview on 06/09/2025 at 1:22 PM, Staff F, Registered Nurse / admission Nurse (RN/AN) stated if they assessed a newly admitted resident during their initial assessment and observed a dental issue then they were to inform the social work staff to get them on the list (dental) to be seen by a provider.</p> <p>During an interview on 06/09/2025 at 1:18 PM, Staff B, Director of Nursing Services (DNS), stated their expectation was if the admission nurse or staff saw a dental issue with a resident, then social work should have placed them on the dental providers list.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 90</p> <p>Review of the EHR showed Resident 90 admitted to the facility on [DATE] with diagnoses to include malnutrition, gastrointestinal hemorrhage (bleeding in stomach), chronic pain, and dependent on artificial feeding.</p> <p>During an interview on 06/08/2025 at 9:09 AM, Resident 90 stated they had upper dentures; however, they needed lower dentures.</p> <p>Review of Resident 90's care plan initiated on 01/23/2025 showed no plan related to the residents missing lower teeth.</p> <p>Review of Resident 90's EHR showed no dental consultation or plan for lower teeth.</p> <p>During an interview on 06/12/2025 at 1:17 PM, Staff E, Social Work, stated social services scheduled routine appointments, and, if emergent, the resident should have been referred out of the facility.</p> <p>Reference WAC 388-97-1060(3)(j)(vii)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>.</p> <p>Based on observation, interview, and record review, the facility failed to provide food services which met resident preferences for 5 of 8 sampled residents (Residents 91, 21, 89, 16, and 80) when reviewed for food. This failure placed residents at risk of decreased mood, feelings of hunger, avoidable weight loss, and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 91</p> <p>During an interview on 06/08/2025 at 10:48 AM, Resident 91 stated they filled out a menu at the beginning of the week with their preferences, but it was not honored.</p> <p>During an interview on 06/10/2025 at 2:01 PM, Resident 91 stated the previous night they had not received their ordered cheeseburger. Resident 91 stated they went to the kitchen and the dietary manager prepared a cheeseburger for them.</p> <p>Resident 21</p> <p>During an interview on 06/09/2025 at 12:58 AM, Resident 21 stated they ordered a hamburger, juice, and tea for lunch, but they did not receive it. Resident 21 stated their food preferences were frequently ignored.</p> <p>Resident 89</p> <p>Review of the facility's grievance log showed Resident 89 had filed a grievance related to food on 05/06/2025 and it was resolved on 05/07/2025.</p> <p>During an interview on 06/10/2025 at 1:38 PM, Resident 89 stated they had filed a grievance related to wanting double portions of meals and the dietary manager had come to speak with them. Resident 89 stated they still frequently did not receive double portions, and they did not feel the grievance was resolved.</p> <p>Resident 16</p> <p>Review of the facility's grievance log showed Resident 16 had filed a grievance related to food on 05/06/2025 and it was resolved on 05/11/2025.</p> <p>During an interview on 06/10/2025 at 1:42 PM, Resident 16 stated they had filed a grievance related to double portions and two juices with meals. Resident 16 stated they frequently did not receive their requested meals.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation and record review on 06/11/2025 at 1:51 PM showed Resident 16 received a hamburger with no condiments, juice, or peanut butter sandwich. Review of the meal card showed to provide double portions, juice, and a peanut butter sandwich with meals.</p> <p>Resident 80</p> <p>Review of the facility's grievance log showed Resident 80 had filed a grievance related to double portions on 06/05/2025 and it was resolved on 06/07/2025.</p> <p>During an interview and record review on 06/10/2025 at 1:48 PM, Resident 80 stated they had filed a grievance related to not receiving double portions. Resident 80 stated they did not consistently receive their requested foods, and they did not feel the grievance was resolved. Review of a meal ticket showed Resident 80 received 3/4 portion of meals.</p> <p>During an interview on 06/11/2025 at 1:13 PM, Resident 80 stated they did not receive double portions for lunch.</p> <p>During an interview on 06/11/2025 at 1:52 PM, Staff M, Regional Dietary Manager, stated the facility would assess residents for food preferences on admission and would provide a weekly menu which could be marked to indicate to kitchen staff which foods the resident would like. Staff M stated if a resident had a food concern, then the dietary manager would meet with the resident to update their food preferences. Staff M stated a grievance may be filed for a food concern and it would then be resolved by the dietary manager. Staff M stated the expectation was resident would receive their preferred foods and would feel their grievances were resolved. Staff M stated the kitchen was not allowed to change resident preferences to double portions, and the facility's registered dietician would need to be contacted to make that change.</p> <p>During an interview on 06/11/2025 at 2:03 PM, Staff N, Registered Dietician, stated when residents wanted double portions the facility would let them know and they would meet with the resident. Staff N stated they were unaware of Resident 89, 16, or 80's grievance related to double portions. Staff N stated Resident 80's meal card directed staff to give small portions.</p> <p>During an interview on 06/11/2025 at 2:13 PM, Staff A, Administrator, stated food preferences were obtained when the resident was admitted to the facility and should be honored. Staff A stated residents should feel that grievances were resolved, and Residents 89, 16, and 80's lack of double portions did not meet expectations.</p> <p>Reference WAC 388-97-1120 (2)(a), -1100(1), -1140 (6)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .</b></p> <p>Based on interview and record review, the facility failed to report an infectious disease outbreak to the local health department (LHD) as required for 1 of 1 Covid-19 outbreak (Resident 377 and 20) when reviewed for infection control. The facility failed to implement infection control practices for surveillance of current infections for 2 of 3 months (03/2025 and 04/2025) when reviewed for infection control. The facility failed to complete timely ordered labs for a possible infection for Resident 378. These failures placed the residents at risk for communicable diseases, clinical complications and a decreased quality of life.</p> <p>Findings included .</p> <p>&amp;lt;Covid-19 Outbreak&amp;gt;</p> <p>Review of the facility policy titled reportable diseases revised 09/2022 showed, When a resident(s) presents with a suspected or confirmed infection, illness or condition that is reportable, the administrator (or designee) notifies the local health department (LHD) within the required timeframe.</p> <p>Resident 377</p> <p>Review of the electronic health record (EHR) showed Resident 377 admitted to the facility on [DATE] with a diagnosis of dislocated left shoulder. On 05/29/2025, Resident 377 was sent to the emergency room (ER) for low oxygen levels. While at the hospital the resident was diagnosed with a Covid-19 infection (a highly contagious respiratory infection).</p> <p>Review of the facility documentation showed testing for Covid-19 was completed for all residents and staff of the affected hall and one additional resident tested positive, (Resident 377's roommate prior to being sent to the ER.)</p> <p>Resident 20</p> <p>Review of the EHR showed Resident 20 admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (a progressive disease that destroys memory and other important mental functions). The resident shared a room with Resident 377 on 05/29/2025 and tested positive for Covid-19 on 05/31/2025.</p> <p>During an interview on 06/10/2025 at 4:03 PM, Collateral Contact (CC/LHD), infectious disease, stated they had not received a report of the spread of Covid-19 in the facility and should have.</p> <p>During an interview on 06/09/2025 at 1:14 PM, Staff C, Infection Preventionist (IP), stated they follow the facility policy and should have notified the LHD when the second resident tested positive but did not.</p> <p>During an interview on 06/09/2025 at 1:45 PM, Staff B, Director of Nursing Services stated it was their expectation that the IP notify the LHD of Covid-19 outbreaks and follow their recommendations, but this did not happen for Residents 377 and 20's Covid-19 infections.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>&amp;lt;Infection/Surveillance&amp;gt;</p> <p>Review of the infection control line listing for the months of 03/2025, 04/2025 and 05/2025 showed no data was available for review for the month of 03/2025. Review of the 04/2025-line listing showed the facility was not tracking all infections and no monthly summary was available for review.</p> <p>Resident 378</p> <p>Review of the EHR showed Resident 378 admitted to the facility on [DATE] with a diagnosis of an open abdominal (stomach) wound and chronic kidney disease. Review of the provider orders showed to obtain urine for testing on 03/07/2025, 03/10/2025, 03/12/2025 and 03/30/2025.</p> <p>Review of Resident 378s EHR showed no documentation the resident had their urine tested for infection between the dates of 03/07/2025 and 03/30/2025. Review of the urine testing results dated 04/07/2025 showed the resident had an infection and was prescribed an antibiotic medication.</p> <p>Review of the infection control line listing showed Resident 378 was not included on the line list for 04/2025 for their urinary infection and was not being tracked on the facility's infection map.</p> <p>During an interview on 06/12/2025 at 10:02 AM, Staff C, IP, stated Resident 378's urinalysis was not completed until 04/01/2025 and should have been completed sooner. Staff C also stated they should have included this infection on the 04/2025 infection control line list and tracked on the facility's infection map but had not.</p> <p>During an interview on 06/12/2025 at 10:16 AM, Staff B, DNS, stated Resident 378s urinalysis was not completed timely and should have been included on the infection control line list.</p> <p>During an interview on 06/11/2025 at 1:39 PM, Staff A, Administrator stated it was their expectation that the IP tracked and trended all infections in the facility with a line list, audited, round, tracked on the facility infection map, and completed a summary at the end of each month.</p>

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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)
<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>.</p> <p>Based on interview and record review, the facility failed to ensure each staff member received training related to resident abuse, dementia management and had continuing competencies for certified nurse aides on a yearly basis for 2 of 5 staff members (Staff S and T), reviewed for training. These failures placed residents at risk for potential abuse, lack of dementia care and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of training records on 06/12/2025 showed the training record for Staff S, Certified Nurse Assistant (CNA) was blank.</p> <p>Review of the training records on 06/12/2025 showed for the training record for Staff T, CNA, had one in-service training completed on 08/25/2023.</p> <p>During an interview on 06/12/2025 at 2:24 PM, Staff A, Administrator, stated Staff S and Staff T did not have training. Staff A stated their expectation was for staff to have their education and competencies completed before they work with residents, and the records for Staff S and Staff T did not meet their expectations.</p> <p>Reference WAC 388-97-1680(2)(a-c)</p> <p>.</p>