| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505093 | A. Building<br>B. Wing | 06/01/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Orchard Park Health Care & Rehab Center | 4755 South 48th<br>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.

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent abuse of 1 of 6 residents (Resident 7) reviewed for resident to resident altercations. Resident 7 experienced psychological harm, evidenced by change in social behaviors, isolating to their room and expressed changes in a trauma assessment, when the facility failed to provide adequate supervision, effective interventions to assure safety, and evaluate the effectiveness of current interventions to prevent further abuse. In addition, staff failed to adequately monitor and prevent Resident 151 from expressing aggressive behavior towards residents. These failures placed residents at risk for sexual and physical abuse, psychological harm, feeling uncomfortable and unsafe.Findings included .Review of facility provided policy titled SNF Clinic Abuse Prohibition, dated 10/25/2024, showed staff would take action to prevent abuse by identifying, correcting and intervening in situations in which abuse is more likely to occur. If the suspected abuse is resident to resident, the resident who has in anyway threatened or attacked another will be removed from the setting or situation and an investigation will be completed. The facility will provide adequate supervision when the risk of resident to resident altercation is suspected. The facility is responsible for identifying residents who have a history of disruptive or intrusive interactions or who exhibit other behaviors that make them more likely to be involved in an altercation. The facility will protect residents from further harm during an investigation by providing a safe environment.Review of Resident 7's electronic health record (EHR) showed they admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a lung disease that effects ability to breathe) and post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it). Resident 7 was able to make needs known. Review of Resident 7's answers on a trauma questionnaire, dated 12/26/2025, showed:Have you felt numb or detached from people, activities, or your surroundings: NoHave you had a nightmare about event(s) or thought about the event(s) when you did not want to: NoHave you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s): YesHave you been constantly on guard, watchful, or easily startled: NoIs there anything we should be aware of that makes you feel worse: Does not indicate-states she has dealt with it.Additional Comments: Resident reports history of being abused from childhood through adulthood. She was physically and sexually abused as a child. She had domestic violence assaults and reports she was traded and trafficked for drug and money.Review of Resident 151's EHR showed they admitted to the facility on [DATE] with diagnoses that included above the knee amputation and psychoactive substance dependance. Resident 151 was able to make his needs known.Review of Resident 151's EHR showed an acute care note, dated 05/21/2026, documenting Resident 151 was an active user of methamphetamine and marijuana three times per week.<First Incident>Review of Resident 7's progress note, dated 03/08/2026, read, Patient said to this writer that they're afraid of going to sleep because they worry about a resident who lives in room [identified as Resident 151] comes to shake them awake. When this writer came along with another nurse to [Resident 151] to make sure that it will not happen, the resident admitted they went to the<br>(continued on next page) |

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

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

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | room and woke the resident up. Resident [151] was educated about patient safety and respect and encouraged to meet other resident at a nursing station or lobby area. Continue to monitor.Review of the March 2026 incident log and March 2026 grievance log did not show an entry related to the concern documented in the progress note.During an interview on 05/22/2026 at 11:02 AM, Resident 7 stated Resident 151 would come to their room late at night and shake them awake. Resident 7 stated they reported it to the nurse because they were scared. Resident 7 stated, I've been sexually assaulted, was in an abusive marriage and I don't like being touched. Resident 7 stated facility management came and talked to them about it the next day.During an interview on 05/22/2026 at 10:14 AM, Staff H, Social Service Director (SSD), stated they were unaware of the situation. Staff H stated based on the allegation and Resident 7's past trauma, the social service department should have conducted a trauma assessment and put Resident 7 on alert to monitor any negative psychological social outcomes.During an interview on 05/22/2026 at 10:43 AM, Staff A, Administrator, stated Resident 7 was interviewed the day after the concern was documented. Staff A stated the nurse who documented Resident 7's concern should have reported it to the state if they confirmed that Resident 7 was scared. Staff A stated a trauma assessment should have been completed.Review of Resident 7's EHR did not show an investigation was conducted, no monitoring for negative psychological social outcomes related to the incident, no trauma assessment was completed and no care plan interventions to promote sense of security.<Second Incident>During an interview on 05/22/2026 at 11:02 AM, Resident 7 reported they were not friends with Resident 151 anymore because they were a former addict and when they were out in the smoking shed, Resident 151 blew methamphetamine smoke in their face. Resident 7 said when they got mad about it, Resident 151 blocked them from leaving with their wheelchair, trapping them in the smoking shed. Resident 7 said Resident 151 also pulled out his penis and started pleasuring himself in front of them. Resident 7 said they tried to stay away from him; the meth makes [Resident 151] that way. Resident 7 said she reported the incident to the receptionist but the did not work there anymore. On 05/22/2026 at 1:27 PM, the above information was reported to the facility Administrator by The Department staff.Review of Resident 7's answers on the trauma questionnaire, dated 05/22/2026, related to the allegation reported to the surveyor showed the following:Have you felt numb or detached from people, activities, or your surroundings: Yes (change from previous)Have you had a nightmare about event(s) or thought about the event(s) when you did not want to: Yes (change from previous)Have you tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s): YesHave you been constantly on guard, watchful, or easily startled: Yes (change from previous)Is there anything we should be aware of that makes you feel worse: Feeling trapped.Additional Comments: Resident says this situation with Resident 151 had triggered past childhood trauma about being molested, Resident 7 was trying to avoid further contact [with Resident 151] so the situation did not escalate. Review of Resident 7's telehealth visit, dated 05/22/2026, showed the chief complaint as inappropriate sexual abuse and diagnosis as adult sexual abuse, suspected.Review of the facility investigation, dated 05/22/2026, showed interventions included a separation plan that was implemented to avoid contact between the residents to include alternate smoking area or times and Resident 7 was to have one-to-one supervision for safety (although industry standard is to place one-to-one supervision on the perpetrator instead of the victim). Resident 151 was placed on alert status with increased monitoring and behavior risk.Review of Resident 151's nurse progress notes showed a late entry on 05/22/2026 to describe the allegations in the smoke shed. The notes did not include any documentation of implementation of a behavior based monitoring regarding the incident.Review of Resident 7's nurse progress note, dated 05/23/2026 at 09:39 PM, showed Resident 7 was on alert for psychosocial harm and had a one-to-one with staff. Review of Resident 7's EHR showed this was the second and last nurse progress note regarding alert monitoring and implementation of an intervention.Observations on 05/26/2026 at 9:00 AM and 11:40 AM and 06/01/2026 at 2:49 PM showed Resident 7 without staff supervision.During an interview on<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 06/01/2026 at 2:49 PM, Resident 7 stated they were not receiving one-to-one supervision. Resident 7 stated they felt depressed due to losing friends who asked why they told on Resident 151. Resident 7 stated they had been leaving the smoking area when Resident 151 attempted to make eye contact with them in the past few days. Resident 7 was teary-eyed and stated they are considering discharge to avoid any further problems.During an interview on 06/01/2026 at 4:13 PM, Resident 151 said, The allegation is total bulls**t. Resident 151 stated the facility hadn't restricted him from having contact with Resident 7 or told him he had to smoke elsewhere or at a different time and if they did, he would not listen. Resident 151 stated they had been in the smoke shed with Resident 7 recently and Resident 7 just leaves because they're chicken s**t, every time they see me, they leave. Resident 151 said if the facility told him he had to smoke at a different time or in a different place he would tell them bullshit, he knows his rights, plus [Administrator] won't say anything to him because he doesn't have the balls to and doesn't have a clue what's going on in the facility. Resident 151 said he's never wanted to hit a female but after the allegation he was this close.Observation on 06/01/2025 at 4:20 PM, showed Resident 7 walking in from the smoking area. Resident 7 stated they had to cut their smoke break short due to Resident 151's presence in the smoking area. Resident 7 stated I don't want any problems; I'm just going back to my room. During an interview on 06/01/2026 at 4:23 PM, Saff B, Director of Nursing, stated due to lack of staff, the one-on-one supervision for safety of Resident 7 had not been consistent. Staff B stated it did not meet their expectations that Resident 7 was still subjected to Resident 151 during smoke breaks and that the interventions had not been implemented. Staff B was asked why the one-to-one was not on Resident 151 and how the facility planned to keep other residents safe, Staff B said they were not. Staff B stated the facility had a hard time dealing with Resident 151 and their aggressive behaviors towards staff. Staff B stated the facility had not implemented the intervention to monitor/document Resident 151's behaviors and that did not meet expectations.Review of Resident 151's progress note, dated 06/02/2026, showed during a scheduled smoke break, Resident 151 was observed engaging in inappropriate interactions with another resident. Staff intervened and redirected the resident; however, the resident became verbally agitated, yelling and using abusive language toward staff. Reference WAC 388-97-0640(1) |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observation and interview, the facility failed to post the location of the survey results and place the binder in identifiable location. This failure prevented residents, family members, and visitors from exercising their right to review past survey results and the facility's plans of correction to evaluate the quality of care provided by the facility. Findings included . During an interview with Resident Council on 05/21/2026 at 1:32 PM, Residents sated they were unaware they were able to review previous survey results and did not know where the survey binder was located. Observations on 05/18/2026 at 9:00 AM, 05/19/2026 at 2:00 PM, 05/22/2026 at 10:30 AM and 05/26/2026 at 9:00 AM showed a sign at the reception desk that read Reports of surveys, certifications and complaint investigations for the preceding three years available for any individual to review upon request. Please see Center Executive Director. During an interview on 05/26/2026 at 9:34 AM, Staff G, Receptionist, stated they were not familiar with the survey binder and did not know where it was located. During an interview on 05/26/2026 at 9:40 AM, Staff A, Administrator (ADM), stated the survey binder should have included the past three years' surveys and complaint investigations. Staff A stated they were unaware of the signage referring residents/visitors to the Administrator to review the survey binder and it did not meet expectations that it was not readily available. Reference WAC 388-97-0480 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were informed of their right to establish an advanced directive (AD, a document specifying who should make medical decisions for you when you an incapacitated) for 3 of 3 sampled residents (Residents 6, 11 and 141) reviewed for AD. This failure placed residents at risk of not having someone to make medical decisions when incapacitated, inability to direct medical care, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 6 admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, lung condition that restricts airflow and makes breathing difficult) and diabetes (too much sugar in the blood). Resident 6 was able to make needs known. Review showed Resident 6 was their own responsible party but did not show the facility had reviewed their AD decisions. Review of the EHR showed Resident 11 admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (brain dysfunction caused by chemical imbalances or underlying systemic diseases in the body) and diabetes. Resident 11 was able to make needs known. Review showed Resident 11 was their own responsible party but did not show the facility had reviewed their AD decisions. Review of the EHR showed Resident 141 admitted to the facility on [DATE] with diagnoses to include acute kidney failure and diabetes. Resident 141 was able to make needs known. Review showed Resident 141 was their own responsible party but did not show the facility had reviewed their AD decisions. During an interview on 05/21/2026 at 10:50 AM, Staff H, Social Services Director, stated residents' AD decisions should be reviewed on admission, with quarterly care conferences, and at residents' request. During a follow-up interview on 05/21/2026 at 2:09 PM, Staff H stated Resident 6 had a care conference most recently on 02/24/2026 and their AD decision was not reviewed. Staff H stated Resident 11 had an initial care conference on 04/07/2026 and their AD decision was not reviewed. Staff H stated Resident 141 had a care conference most recently on 11/17/2025 and their AD decision was not reviewed. Staff H stated Residents 6, 11, and 141's lack of AD review did not meet expectations. During an interview on 05/26/2026 at 9:27 AM, Staff A, Administrator, stated social services would review AD decisions with residents on admission and with quarterly care conferences. Staff A stated Residents 6, 11, and 141's lack of AD review did not meet expectations. Reference WAC 388-97-0280(3)(c)(i)(ii), -0300(1)(b)(3)(a)-(c) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures regarding identifying, reporting and investigating incidents of resident-to-resident abuse for 2 of 6 sampled residents (Residents 114 and 150) reviewed for abuse. These failures placed residents at risk for further abuse, psychological harm and a diminished quality of life.Findings included.Resident 114Review of the electronic health record (EHR) showed Resident 114 admitted to the facility on [DATE] with diagnosis of kidney failure and bladder infection. The resident was able to make needs known. During an interview on 05/19/2026 at 9:00 AM, Resident 114 stated about two weeks ago a staff member yelled at them and was rough with their roommate. Resident 114 stated they had told another staff member about the incident but had not heard anything more about it. Review of the EHR on 05/20/2026 showed no documentation of the incident in the medical record. Review of the May 2026 facility incident log showed no documented incident of this nature on the log. During an interview on 05/19/2026 at 1:22 PM, Staff A administrator stated they were not aware of the incident and would start an investigation. Review of the facility incident investigation dated 05/20/2026 showed staff D, Licensed Practical Nurse, was aware of the allegation and did not report it as they did not believe the resident as the resident makes things up During an interview on 05/21/2026 at 9:57 AM, Staff E, Licensed Practical Nurse (LPN) stated if a resident reported an allegation of abuse to them they would go talk to that person and ask them what happened and fill out a grievance form. During an interview on 05/21/2026 at 10:02 AM, Staff F Certified Nursing Assistant, stated they would report any abuse to the charge nurse or administrator. During an interview on 05/20/2026 at 11:01 AM, Staff B, Director of Nursing Services (DNS), stated their expectation was that if a resident reports to a staff member an allegation of abuse they report it right away to management and report to the state hotline. During an interview on 05/21/2026 at 9:39 AM, Staff A, Administrator stated it was their expectation that staff D would have reported the abuse allegation immediately but did not. Resident 150Review of the EHR showed Resident 150 re-admitted to the facility on [DATE] with diagnoses that included depression, anxiety and heart failure. Resident 150 was able to make needs known. During an interview on 05/19/2026 at 9:17 AM, Resident 150 stated Resident 102 touched them inappropriately three different times twice on my shoulders and once on my head. Resident 150 stated Resident 102 came into their room at 3 AM and touched my shoulders from behind. Resident 150 stated staff were aware and they don't feel as safe as they used to but said they have a fork on their bedside table and will use it if they must. Resident 150 stated Resident 102 was supposed to have one-to-one supervision but has still came to their hall unaccompanied. Staff 150 stated when they reported Resident 102 unaccompanied on their hall to Staff M, Licensed Practical Nurse/Unit Manager (LPN/UM, they were told this is Resident 102's home also. Resident 150 stated they don't feel Resident 102 is appropriate for this type of care. Review of Resident 102's EHR showed an order dated 04/14/2026 for staff to Monitor and document inappropriate sexual behaviors towards other residents or staff, Document specific behaviors.Review of the facility investigation dated 04/27/2026 showed no witness statements nor statement from Resident 102.Review of the interventions for the facility investigation dated 04/27/2026 interventions showed Resident 102 was to have one-to-one supervision.Observations on 05/19/2026 at 10:01 AM, 05/22/2026 at 11:05 AM, 05/26/2026 at 9:11 AM, 06/01/2026 at 2:40 PM showed Resident 102 either in the East Hall or in their room without staff supervision.Review of the April 2026 Treatment Administration Record (TAR) showed documentation Resident 102 had inappropriate sexual behavior towards residents or staff on 04/23/2026, 04/24/2026, 04/29/2026 and 04/30/2026.Review of the May 2026 TAR showed documentation Resident 102 had inappropriate sexual behavior towards residents or staff on 05/01/2026, 05/02/2026, 05/06/2026, 05/08/2026, 05/13/2026, 05/16/2026, 05/19/2026, 05/22/2026, and 05/29/2026. During an interview on 05/26/2026 at 9:52 AM, Staff CC, Licensed Practical Nurse/Unit<br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Manager (LPN/UM), stated one-to-one supervision was defined as a member of staff with a resident at all times. When asked if the intervention was put in place to keep Resident 150 and other residents safe due to the allegation, Staff CC said, yes. Staff CC stated the facility did not always have staff to provide the one-to-one supervision and the expectation was for frequent checks to be completed when staff were not available.During an interview on 05/26/2026 at 9:58 AM, Staff FF, Staffing Coordinator stated facility did not have sufficient staff to provide one-to-one supervision each day.Review of the staff schedule for 05/26/2026, 05/27/2026, 05/28/2026, 05/29/2026, 05/30/2026 and 05/31/2026 showed no scheduled one to one supervision for Resident 102.During an interview on 05/26/2026 at 11:51 AM Saff B, Director of Nursing, stated the facility has not been able to implement the care planned one to one supervision due to lack of staffing. Reference WAC 388-97-0640(2) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the resident/resident's representative and Ombudsman in writing of the reason for the transfer/discharge to the hospital and provide written bed hold notice at the time of transfer to the hospital for 4 of 5 sampled residents (Residents 7, 157, 155, and 8 ) reviewed for discharge/hospitalization. These failures placed the residents at risk for lacking knowledge regarding their transfer, discharge rights, the right to hold their bed while in the hospital, and diminished quality of life. Findings included .Resident 7<br><br>Review of the electronic health record (EHR) showed Resident 7 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a lung disease that affects ability to breathe), heart failure and muscle weakness. Resident 7 was able to make needs known.<br><br>Review of Resident 7's EHR showed hospitalization on 02/07/2026 and readmission to the facility on [DATE]. There was no documentation showing a bed hold was offered or the required transfer discharge form was completed and provided to the resident, or the Ombudsman notified.<br><br>Resident 157<br><br>Review of the EHR showed Resident 157 admitted to the facility on [DATE] with respiratory failure, heart failure, and pneumonia. Resident 157 was able to make needs known.<br><br>Review of Resident 157's EHR showed a resident-initiated against medical advice discharge on [DATE]. There was no documentation the required transfer discharge form was completed and provided to the resident or the Ombudsman notified.<br><br>Resident 155<br><br>Review of the electronic health record (EHR) showed Resident 155 was admitted to the facility on [DATE] and was transferred to the hospital on [DATE]. Review of the EHR showed Resident 155 was not offered a bed hold, and there was no notice for the transfer to the hospital. In addition, the Office of the State Long-Term Care Ombudsman was not notified.<br><br>Resident 8<br><br>Review of the EHR showed Resident 8 was admitted to the facility on [DATE].<br><br>During an interview on 05/18/2026 at 1:59 PM, Resident 8 stated they were hospitalized for about five days on 03/11/2026. Resident 8 stated they did not return to the same room and were not given a bed hold and transfer notice.<br><br>Review of the EHR showed Resident 8 did not have bed hold or transfer form and the Office of the State Long-Term Care Ombudsman was not notified.<br><br>During an interview on 05/20/2026 at 12:46 PM, Staff P, Licensed Practical Nurse (LPN), stated the process for transferring residents to the hospital included a paper form of bed hold located at the nurse's station. Nurses were to fill it out and send it with the resident to the hospital or inform next of<br>(continued on next page) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | kin.<br><br>During an interview on 05/21/2026 at 10:07 AM, Staff O, Licensed Practical Nurse/Resident Care Manager, stated they completed the bed hold and transfer form when residents were transferred to the hospital.<br><br>During an interview on 05/22/2026 at 9:32 AM, Staff B, Director of Nursing Services, stated lack of bed hold, transfer to hospital form and Ombudsman notifications did not meet expectations.<br><br>Reference WAC 388-97- 0120(1)(2)(a)-(d)(3)(a)(4)(b)(5), -0080, -0140(1)(a)-(c)(i)-(iii) |

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| | 505093 | A. Building<br>B. Wing | 06/01/2026 |

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| Orchard Park Health Care & Rehab Center | 4755 South 48th<br>Tacoma, WA 98409 |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Assure that each resident?s assessment is updated at least once every 3 months.<br><br>Based on interview and record review, the facility failed to ensure resident quarterly, admission, and discharge Minimum Data Sets assessments (MDS) were completed within 14 days of the assessment reference date (ARD) as required for 11 of 11sampled Residents (Residents 46, 55, 70, 73, 99, 5, 118, 121, 128, 142 and 153) reviewed for resident assessments. Failure to timely complete MDS assessments placed residents at risk for a delay in identification of care needs and diminished quality of life. Findings included .Review of the Resident Assessment Instrument (RAI, a manual that directs staff on requirements for completion of MDS) showed quarterly assessments and discharge assessments must be completed no later than the ARD plus 14 calendar days. Resident 46Review of the electronic health record (EHR) showed Resident 46's annual MDS had an ARD of 04/09/2026 and completion date of 05/18/2026 (39 days after ARD). Resident 55Review of the EHR showed Resident 55's quarterly MDS had an ARD of 04/06/2026 and completion date of 05/15/2026 (39 days after ARD). Resident 70Review of EHR showed Resident 70's quarterly MDS had an ARD of 04/07/2026 and completion date of 05/15/2026 (38 days after ARD). Resident 73Review of EHR showed Resident 73's discharge MDS had an ARD of 04/06/2026 and completion date of 05/13/2026 (37 days after ARD). Resident 99Review of EHR showed Resident 99's quarterly MDS had an ARD of 04/06/2026 and completion date of 05/15/2026 (37 days after ARD). Resident 5Review of EHR showed Resident 5's quarterly MDS had an ARD of 04/13/2026 and completion date of 05/19/2026 (36 days after ARD). Resident 118Review of EHR showed Resident 118's quarterly MDS had an ARD of 04/03/2026 and completion date of 05/13/2026 (40 days after ARD). Resident 121Review of EHR showed Resident 121's quarterly MDS had an ARD of 04/08/2026 and completion date of 05/13/2026 (35 days after ARD). Resident 128Review of EHR showed Resident 128's quarterly MDS had an ARD of 04/14/2026 and completion date of 05/19/2026 (35 days after ARD). Resident 142Review of EHR showed Resident 142's quarterly MDS had an ARD of 04/07/2026 and completion date of 05/15/2026 (38 days after ARD). Resident 153Review of EHR showed Resident 153's quarterly MDS had an ARD of 04/15/2026 and completion date of 05/19/2026 (34 days after ARD). During an interview on 05/22/2026 at 10:53 AM, Staff Q, Registered Nurse/MDS Coordinator, stated remote corporate staff were doing the MDS and had control over the schedule. During an interview on 05/26/2026 at 11:56 AM, Staff A, Administrator, stated the expectation was for MDS to be completed timely and accurately. Reference WAC 388-97 -1000(4)(a)(5)(d) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were timely revised and/or care conferences held timely for 6 of 23 sampled residents (Residents 123, 12, 11, 7, 128, and 141) reviewed for revision of care plan. This failure placed residents at risk of having inaccurate plans of care, inability to have input in plan of care, and a diminished quality of life. Findings included.<Revision of Care Plan><br><br>Resident 123<br><br>Review of the EHR showed Resident 123 was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (a brain malfunction caused by an underlying chemical imbalance or disease in the body) and dysphagia (difficulty swallowing). Resident 123 was able to make needs known and sometimes able to understand others.<br><br>Review of the provider order dated 01/02/2026 showed Resident 123 was admitted to Hospice services on 12/26/2025 related to a terminal diagnosis of cerebrovascular accident (a stroke, blood flow to an area of the brain is interrupted which causes brain cells to die).<br><br>Review of Resident 123's care plan for Hospice showed that it was initiated/created on 01/02/2026, six days after being admitted to hospice.<br><br>During an interview on 05/22/2026 at 11:58 AM, Staff CC, Licensed Practical Nurse/Unit Manager (LPN/UM), stated once confirmation was received that a resident was admitted to Hospice services a Hospice care plan should be initiated/created. Staff CC stated Resident 123 was admitted to Hospice services on 12/26/2025 and their Hospice care plan was initiated late on 01/02/2026, and this did not meet expectations.<br><br>During an interview on 05/22/2026 at 12:31 PM, Staff B, Director of Nursing Services (DNS), stated after a provider order/intake of a resident being admitted to Hospice was obtained/received, a Hospice care plan should be initiated/created. Staff<br><br>B stated Resident 123's Hospice care plan was created on 01/02/2026 and should have been created/initiated sooner, within 48 hours for new admittance to Hospice services.<br><br><Care Plan Conference><br><br>Resident 12<br><br>Review of the EHR showed Resident 12 was admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), asthma (a respiratory condition making breathing difficult), and muscle weakness. Resident 12 was able to make needs known.<br><br>During an interview on 05/18/2026 at 1:51 PM, Resident 12 stated they did not remember going to a care conference.<br><br>Review of Resident 12's Interdisciplinary Care Conference, form dated 04/22/2026 showed the<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident was in attendance; however, it was to review discharge planning, and the form was incomplete/left opened and was not locked/not signed.<br><br>Review of Resident 12's Interdisciplinary Care Conference, form dated 05/08/2026 did not show who attended the conference.<br><br>During an interview on 05/22/2026 at 1:19 PM, Staff H, Social Services Director (SSD), stated care conferences were to be conducted initially within 48 hours of admission; however, if admitted on a Friday it may be done on Monday, on a quarterly basis, and as needed. Staff H stated the Interdisciplinary team (IDT) care conference should include the resident, social services, nursing, therapy if receiving services, and the business office manager or case manager as needed. Staff H stated Resident 12 attended a care conference on 04/22/2026; however, nursing was not in attendance, the care conference form was incomplete and not signed and this did not meet expectations.<br><br>During an interview on 05/22/2026 at 1:50 PM, Staff A, Administrator, stated Resident 12's care conference held on 04/22/2026 should have involved nursing, all areas on the care conference form should have been reviewed, and it should have been signed and locked. Staff A stated Resident 12 needed to have a care conference held to review all areas as required.<br><br>Resident 11<br><br>Review of the EHR showed Resident 11 was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy, diabetes, and dysphagia. Resident 11 was able to make needs known.<br><br>During an interview on 05/18/2026 at 10:05 AM, Resident 11 stated they did not recall going to a care conference.<br><br>Review of Resident 11's Interdisciplinary Care Conference, form dated 05/15/2026 showed attendees were Resident 11 and the social service assistant; however, Resident 11 admitted to the facility on [DATE] (wrong date entered and no other IDT staff in attendance). It showed not all areas on the form were reviewed and was incompletely filled out.<br><br>Review of Resident 11's Interdisciplinary Care Conference, form dated 05/19/2026 showed Resident 11 attended the care conference. It showed not all areas on the form were reviewed and was incompletely filled out.<br><br>During an interview on 05/22/2026 at 1:35 PM, Staff H, SSD, stated Resident 11's 05/15/2026 IDT care conference showed a wrong date was entered and it was conducted on 05/16/2026 upon admission; however, it did not show nursing or therapy involvement, and should have. Staff H stated not all areas on the form were reviewed and should have been.<br><br>During an interview on 05/22/2026 at 1:58 PM, Staff A, Administrator, stated Resident 11's 5/15/2026 and 5/19/2026 IDT care conference forms did not meet their expectations. Staff A stated Resident 11 needed to have a care conference conducted with the IDT to include reviewing all areas on the form as required.<br><br>Resident 7<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the EHR showed Resident 7 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a lung disease that effects ability to breathe), heart failure and muscle weakness. Resident 7 was able to make needs known.<br><br>During an interview on 05/18/2026 at 10:17 AM, Resident 7 stated they could not remember when they last participated in a care conference.<br><br>Review of Resident 7's EHR showed the last care conference conducted was on 01/13/2026.<br><br>During an interview on 05/22/2026 at 10:20 AM, Staff H, SSD, stated Resident 7 should have had a care conference in April 2026.<br><br>Resident 128<br><br>Review of the EHR showed Resident 128 admitted to the facility on [DATE] with diagnoses that included tremors and heart failure. Resident 128 was able to make needs known.<br><br>During an interview on 05/19/2026 at 10:01 AM, Resident 128 stated they could not remember when they last participated in a care conference.<br><br>Review of Resident 128's EHR showed the last care conference conducted was on 10/15/2025.<br><br>During an interview on 05/22/2026 at 10:20 AM, Staff H, SSD, stated the social service department was behind on care conferences. Staff H stated care conferences should have been offered quarterly, and the residents and/or resident representative should have been included.<br><br>During an interview on 05/26/2026 at 12:14 PM, Staff A, Administrator, stated the expectation was that care conferences were offered at least quarterly. The lack of timeliness did not meet expectations.<br><br>Resident 141<br><br>Review of the EHR showed Resident 141 admitted to the facility on [DATE] with diagnoses to include acute kidney failure and diabetes. Resident 141 was able to make needs known.<br><br>During an interview on 05/21/2026 at 2:09 PM, Staff H, Social Services Director, stated care conferences should be offered to residents quarterly. Staff H stated Resident 141 had last had a care conference on 11/17/2025 and this did not meet expectations for timely care conferences.<br><br>During an interview on 05/26/2026 at 9:27 AM, Staff A, Administrator, stated residents were able to give input into their plan of care through the care conference process. Staff A stated care conferences should be offered on admission, quarterly, and at resident request. Staff A stated Resident 141's lack of care conference after 11/17/2025 did not meet expectations.<br><br>Reference WAC 388-97-1020(2)(c)(d), (e)(f)(4)(b)(d)-(f), (5)(b) |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Based on observation, interview and record reviews, the facility failed to have sufficient staff to ensure residents received care according to their individualized care plans for 2 of 2 sampled residents (Resident 7 and 102) reviewed for abuse. This failure placed residents at risk for accidents, abuse and diminished quality of life.Findings included .Review of a resident-to-resident allegation facility investigation dated 04/27/2026 showed an intervention for Resident 102 to have one to one supervision related to the incident.Observations on 05/19/2026 at 10:01 AM, 05/22/2026 at 11:05 AM, 05/26/2026 at 9:11 AM, 06/01/2026 at 2:40 PM showed Resident 102 either in the East Hall or in their room without staff supervision.Review of a resident-to-resident allegation facility investigation dated 05/22/2026 showed an intervention for Resident 7 to have one to one supervision related to the incident.Observation on 05/26/2026 at 9:00 AM and 11:40 AM and 06/01/2026 at 2:49 PM showed Resident 7 without staff supervision.During an interview on 06/01/2026 at 2:49 PM, Resident 7 stated they were not receiving one to one supervision as discussed.During an interview on 06/01/2026 at 2:50 PM, Resident 124 in the same room stated they had not seen any members of staff providing one-to-one supervision to Resident 7.During an interview on 05/26/2026 at 9:58 AM, Staff FF, Staffing Coordinator stated there were three residents who required one to one supervision. Due to a recent fire and need for smoking aid the facility did not have sufficient staff to provide one-to-one supervision each day. Staff FF stated if a resident who required a one to one appeared to be stable the facility would rotate a staff member between smoking supervision and one of the residents who were care planned for supervision. Review of the staff schedule for 05/26/2026, 05/27/2026, 05/28/2026, 05/29/2026, 05/30/2026 and 05/31/2026 showed no scheduled one to one supervision for Residents 102 and 7.During an interview on 05/26/2026 at 11:51 AM Saff B, Director of Nursing, stated the facility has not been able to implement the care planned one to one supervision due to lack of staffing.See F600 and F607.Reference WAC 388-97-1060(3)(d) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Medication Regimen Review (MRR) recommendations were implemented in a timely manner for 3 of 5 sampled residents (Residents 150, 1, and 122) reviewed for unnecessary medications. This failure placed the residents at risk for possible adverse complications due to the delay in follow-up/implementation of pharmacy recommendations and a diminished quality of life.Findings included .Resident 150<br><br>Review of the electronic health record (EHR) showed Resident 150 re-admitted to the facility on [DATE] with diagnoses that included depression (mood disorder), anxiety (a feeling of worry, nervousness, or unease about something with an uncertain outcome) and heart failure. Resident 150 was able to make needs known.<br><br>Review of a document titled Consultation Report dated 03/01/2026 through 03/31/2026 showed residents whose names were on the list did not have new medication recommendations from the consulting Pharmacist. Resident 150 was not on the list.<br><br>Review of a document titled Consultation Report dated 04/01/2026, through 04/23/2026 showed residents whose names were on the list did not have new medication recommendations from the consulting Pharmacist. Resident 150 was not on the list.<br><br>During an interview on 05/26/2026 at 11:49 AM, Staff B, Director of Nursing Services (DNS), stated they had knowledge of Resident 150's MMRs for the months of March and April 2026. Staff B stated they were unable to locate any documentation.<br><br>Resident 1<br><br>Review of the EHR showed Resident 1 admitted to the facility on [DATE] with diagnoses of encephalopathy (inflammation of the brain), myocardial infarction (heart attack), and respiratory failure. The resident was able to make needs known.<br><br>Review of the facility provided MRR, completed by the pharmacy on 04/23/2026, showed a recommendation to review the use of psychotropic (effecting the brain) medication for the possibility to discontinue or decrease the dose of the medication. The recommendation had not been addressed by the provider when reviewed on 05/20/2026.<br><br>During an interview on 05/22/2026 at 9:08 AM, Staff B, DNS, stated Resident 1's MRR should have been reviewed and addressed by the provider timely but was not.<br><br>Resident 122<br><br>Review of the EHR showed Resident 122 admitted to the facility on [DATE] with diagnoses of liver failure and depression. The resident was able to make needs known.<br><br>Review of the EHR showed an MRR was completed on 05/20/2026. No other monthly reviews were found in the EHR.<br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/20/2026 at 11:01 AM, Staff B, DNS, stated they recently changed pharmacies and were unable to locate the MRR for March and April 2026 and this did not meet expectations.<br><br>Reference WAC 388-97-1300(4)(c) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>Based on interview and record review, the facility failed to maintain an infection prevention and control program to prevent the transmission of communicable diseases and infections by completing the analyzation of infection control data, identifying trends, and completing follow-up activities in response to those trends for 3 of 3 months (February, March and April 2026) reviewed for Infection Control. These failures placed residents and staff at risk for communicable diseases and infections, unidentified outbreaks, and a decreased quality of life. Findings included. Review of the facility document titled Infection Prevention and Control Program dated 01/21/2025 showed they followed accepted infection prevention and control standards set by the Centers for Disease Control. <February>Review of the facility provided infection control surveillance log for February 2026 showed 15 total infections listed which included two urinary tract infections (UTI). Review of the facility provided infection control map labeled as February showed seven UTI. Review of the facility document titled Infection Control Monthly/Quarterly Summary Report for the month of February 2026 showed number of healthcare acquired infections (HAI) [in house acquired] was 18 with seven UTIs. The form did not include identification of trends or interventions to address the trends. <March>Review of the facility provided infection control surveillance log for March 2026 showed 19 total in-house acquired infections with four UTIs. Review of the facility document titled Infection Control Monthly/Quarterly Summary Report for the month of March 2026 showed a total of 14 in-house acquired infections and did not include identification of trends or interventions to address the trends. <April>Review of the facility provided infection control surveillance log for April 2026 showed no identification of infectious organisms and included 29 in-house acquired infections. Review of the facility provided infection control map labeled as April showed 13 total infections. Review of the facility document titled Infection Control Monthly/Quarterly Summary Report for the month of April 2026 showed number of healthcare acquired infections (HAI) was 14 and did not include identification of trends or interventions to address the trends. During an interview on 05/21/2026 at 12:43 PM, Staff W, Licensed Practical Nurse/Infection Preventionist (LPN/IP), stated they had recently started as the IP and were aware of the inaccurate infection surveillance. During an interview on 05/22/2026 at 9:14 AM, Staff B, Director of Nursing Services, stated it was their expectation the infection surveillance be accurate and monthly summary should be completed to include tracking, trending, and interventions implemented. Reference WAC 388-97-1320(2)(a) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed implement policies and procedures to ensure each staff member and resident was offered and received education for the Covid-19 vaccine. This failure placed the residents and staff at risk for lack of knowledge of the risks and benefits of the vaccine and increased risk for Covid-19 infection/complications. Findings included.Resident 75Review of the electronic health record (EHR) showed Resident 75 admitted to the facility on [DATE] with a diagnosis of a stroke (when blood/oxygen is cut off to a part of the brain). The resident was not able to make needs known. Review of the EHR showed no documentation that Resident 75 or their representative were educated on the risks and benefits of the Covid-19 vaccine and offered or administered the vaccine. During an interview on 05/21/2026 at 12:43 PM, Staff W, Licensed Practical Nurse/Infection Preventionist (LPN/IP), stated the facility should have offered and educated the resident or their representative on the Covid-19 vaccine but did not see any records that it was done for Resident 75. During an interview on 05/22/2026 at 9:11 AM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that Resident 75 or their representative received education on the risks and benefits and been offered the Covid-19 vaccine. <Staff Vaccines> During an interview on 05/22/2026 at 9:47 AM, Staff X, Human Resources Director, stated they request staff Covid-19 vaccine status on hire but did not educate them on the risks and benefits, offer or direct them where to obtain the Covid-19 vaccine. During an interview on 05/22/2026 at 12:23 PM, Staff A, Administrator, stated it was their expectation that residents received education on the risks and benefits of the Covid-19 vaccine and offered as needed. Staff A stated it was also their expectation that staff be provided education on the risks and benefits of the Covid-19 vaccine and offered or directed on where to obtain the vaccine on hire and this should be documented/tracked. Reference WAC 388-97-1620(2)(b)(i)(ii) |

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| F 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to issue Notification of Medicare (federal health insurance program for people age [AGE] or older) Non-Coverage (NOMNC- a required form notifying the resident that their skilled services coverage was ending and would no longer be covered by their Medicare A benefits) at least two calendar days before the Medicare coverage ended for 2 of 3 sampled residents (Residents 27 and161) reviewed for beneficiary notices. This failure placed the residents and/or their representatives at risk of not being fully informed and losing their right to an appeals process. Findings included . Resident 27Review of the electronic health record (EHR) showed Resident 27 was admitted to the facility on [DATE] and discharged on 04/27/2026 to an adult family home. Review of records showed Resident 27 was not provided with a NOMNC form prior to discharge. Resident 161Review of the EHR showed Resident 161 was admitted to the facility on [DATE] and was discharged on 12/02/2025 to home. Review of records showed Resident 161 was not provided with a NOMNC form prior to discharge. During an interview on 05/22/2026 at 10:18 AM, Staff N, Business Office Manager, stated they were responsible for issuing the MOMNC notices and there was none to be found for Resident 27 and 161. During an interview on 05/26/2026 at 11:54 AM, Staff A, Administrator, stated the process was for Medicare insured residents to have NOMNC notice given in advance and the lack of notices for Residents 27 and 161 did not meet expectations. Reference WAC 388-97-0300(1)(e),(5),(6) |

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|---|---|---|---|
| | 505093 | A. Building<br>B. Wing | 06/01/2026 |

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

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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe environment to ensure reasonable care and protection of resident's personal property from loss or theft for 1 of 3 sampled residents (Resident 2) reviewed for environment. Failure to ensure a cell phone was protected and/or replaced when reported missing placed a resident at risk for lack of ability to easily communicate with others outside of the facility, loneliness, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed that Resident 2 was admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar) and high blood pressure and was able to make needs known. During an interview on 05/18/2026 at 10:26 AM, Resident 2 stated their cell phone went missing and staff were aware; however, it had not been found or replaced. Review of Resident 2's Inventory of Personal Effects, form dated 04/17/2026 showed Resident 2 had a cell phone with charger and black bag listed among their personal items. Review of the facility's grievance/concern log dated April 2026 showed a grievance logged on 04/27/2026 that Resident 2's family reported missing items and showed it was resolved on 05/08. Review of Resident 2's Complaint/Grievance Report, dated 05/08/2026 showed Resident 2's family member reported on 04/26/2026 that Resident 2 had missing clothing items and a phone. It showed the clothing items were found and the issue was resolved on 05/08/2026; however, it did not address the missing phone. During an interview on 05/20/2026 at 12:42 PM, Staff O, Licensed Practical Nurse/Resident Care Manager, stated Resident 2's inventory list showed the resident had a cell phone and charger. Staff O stated Resident 2's Complaint/Grievance Report, dated 05/08/2026 should have addressed the missing phone and this did not meet their expectations. During an interview on 05/20/2026 at 12:53 PM, Staff A, Administrator, stated they were not aware that Resident 2 was still without a cell phone and had thought it had been found along with their missing clothing items and this did not meet their expectations. Staff A stated Resident 2's phone needed to be replaced, or the resident compensated for the missing phone. Reference WAC 388-97-0880, -2040 |

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|---|---|
| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from chemical restraints for 1 of 6 sampled residents (Resident 65) reviewed for behavioral-emotional and unnecessary medications. The failure to evaluate and document a clinical rational for use of a psychotropic medication and ensure adequate indications for the use of the medications placed residents at risk for decline in activities of daily living, potential adverse consequences, and diminished quality of life. Findings included. Review of the electronic health record (EHR) showed Resident 65 was admitted to the facility on [DATE] with diagnoses to include urinary tract infection, diabetes (high blood sugar), dementia (decline in mental ability, memory and reasoning) and acute pyelonephritis (bacterial infection of kidneys). Resident 65 was not able to communicate their needs. Observation on 05/20/2026 at 10:03 AM and 1:25 PM to 2:20 PM showed Resident 65 sitting in wheelchair by the nurse's station with head down to shoulder and eyes closed. Observation on 05/21/2026 at 2:33 PM showed Resident 65 in their wheelchair with head down and eyes closed. Review of EHR showed Resident 65 was prescribed and administered Seroquel (antipsychotic medication) dated 05/15/2026 for agitation. Review of progress notes from 04/30/2026 to 05/15/2026 showed Resident 65 did not have behaviors or agitation documented. Review of admission minimum data set (MDS, a required assessment) dated 03/26/2026 showed Resident 65 did not experience any behaviors or indications for use of antipsychotic medication. During an interview on 05/21/2026 at 10:27 AM, Staff O, Licensed Practical Nurse/Resident Care Manager, stated the process for initiating antipsychotic medications at the facility was to first rule out any infection, environmental factors, pain and then refer to mental health. Staff O stated the order for Seroquel for Resident 65 did not meet expectations. During an interview on 05/22/2026 at 9:41 AM, Staff B, Director of Nursing Services, stated Resident 65 should have indications for use of antipsychotic medication and that did not meet expectation. Reference WAC 388-97 -1060(3)(k)(i) -0620(1)(a) |

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|---|---|
| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely complete the admission minimum data set assessment (MDS) within 14 days of admission for 1 of 24 sampled residents (Resident 114) reviewed for MDS. This failure placed the residents at risk for unmet care needs, inaccurate medical record data, and poor clinical outcomes. Findings included.Resident 114Review of the electronic health record (EHR) showed Resident 114 admitted to the facility on [DATE] with diagnosis of kidney failure and bladder infection. The resident was able to make needs known. Review of the EHR on 05/19/2026 at 10:20 AM showed the admission comprehensive MDS assessment was still in process 29 days after admission with multiple sections unanswered. During an interview on 05/20/2026 at 10:42 AM, Staff J, Minimum Data Set/Registered Nurse (MDS/RN), stated Resident 114 should have had the admission MDS assessment completed within 14 days of admission but did not. During an interview on 05/20/2026 at 11:01 AM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that the MDS was completed per the schedule and Resident 114 should have had their admission MDS assessment completed within 14 days of admission. Reference WAC 388-97 -1000(3)(a) |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an assessment for a significant change in condition for 1 of 23 sampled residents (Resident 123) whose assessments were reviewed. Failure to identify Resident 123's need for a significant change assessment related to decline in health and who received hospice services (supportive care for people in the final phase of a terminal illness, focusing on comfort and quality of life) placed the resident at risk for unidentified and/or unmet needs. Findings included.Review of the electronic health record (EHR) showed Resident 123 was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (a brain malfunction caused by an underlying chemical imbalance or disease in the body) and dysphagia (difficulty swallowing). Resident 123 was able to make needs known and sometimes able to understand others. Review of the provider order dated 01/02/2026 showed Resident 123 was admitted to Hospice on 12/26/2025 related to a terminal diagnosis of cerebrovascular accident (a stroke, blood flow to an area of the brain is interrupted which causes brain cells to die). Review of the EHR showed Resident 123 received Hospice services; however, a significant change in condition minimum data set assessment (MDS) was not completed within 14 days of being admitted to Hospice services. During an interview on 05/22/2026 at 10:14 AM, Staff J, Minimum Data Set/Registered Nurse (MDS/RN), stated Resident 123 did not have a significant change in condition MDS done timely after being admitted to Hospice services. During an interview on 05/22/2026 at 10:29 AM, Staff B, Director of Nursing Services, stated Resident 123 should have had a significant change in condition MDS when the resident admitted to Hospice services and that this did not meet expectations. Reference WAC 388-97-1000(3)(b) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure minimum data set assessments (MDS) were completed accurately for 2 of 23 sampled residents (Residents 8 and 85) reviewed for resident assessments. Failure to accurately complete MDS assessments placed residents at risk for a delay in identification of care needs and diminished quality of life. Findings included .Resident 8<br><br>Review of the electronic health record (EHR) showed Resident 8 was admitted to the facility on [DATE] with diagnoses to include cancer of breast and bone, anemia (too few healthy red blood cells) and diabetes (high blood sugar). Resident 8 was able to communicate needs.<br><br>During an interview on 05/18/2026 at 1:55 PM, Resident 8 stated they needed new glasses, they were nearsighted and were unable to read what was on TV. Resident 8 stated they had a pair of glasses at home.<br><br>Review of the admission MDS, dated [DATE], showed Resident 8 had adequate vision and did not use corrective lenses.<br><br>During an interview on 05/21/2026 at 10:31 AM, Staff R, Licensed Practical Nurse/MDS, stated the vision assessment was done by remote staff and they were unsure if it was accurate. Staff R stated they usually would assess the vison during the pain assessment.<br><br>During an interview on 05/22/2026 at 9:36 AM, Staff B, Director of Nursing Services (DNS), stated coding for Resident 8's vision did not meet expectations.<br><br>Resident 85<br><br>Review of the EHR showed Resident 85 admitted to the facility on [DATE] with diagnoses to include respiratory failure, generalized muscle weakness, and dysphagia (difficulty swallowing). Resident 85 was able to make needs known.<br><br>During an interview on 05/18/2026 at 1:32 PM, Resident 85 stated they smoke supervised in the courtyard and staff kept their kept their smoking materials.<br><br>Review of Resident 85's diagnosis list showed a diagnosis of nicotine dependence, created on 04/22/2026.<br><br>Review of the provider's progress note dated 04/24/2026, showed Resident 85 was a current smoker of a half a pack per day and there was no tobacco cessation counseling documented.<br><br>Review of the admission MDS, dated [DATE], showed Resident 85 was coded No for tobacco use.<br><br>During an interview on 05/21/2026 at 1:50 PM, Staff J, Minimum Data Set/Registered Nurse (MDS/RN), stated Resident 85's admission MDS dated [DATE] was coded No for tobacco use and should have been coded Yes. Staff J stated Resident 85's MDS needed to be modified.<br><br>During an interview on 05/21/2026 at 2:08 PM, Staff B, DNS, stated Resident 85's admission MDS dated [DATE] was not accurately coded for tobacco use and needed to be modified.<br>(continued on next page) |

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|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reference WAC 388-97-1000(1)(a)(b)(4)(a) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR, a mental health screening tool) assessments were accurately completed for 3 of 8 sampled residents (Residents 13, 14, and 150) reviewed for PASRR and unnecessary medications. This failure placed the residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet mental health care needs. Findings included .Resident 13Review of the electronic health record (EHR) showed Resident 13 admitted to the facility on [DATE] with diagnoses that included paranoid personality disorder (mental health condition characterized by a long-term pattern of distrust and suspicion of others without sufficient reason), delusional disorders (having one or more false beliefs based on an incorrect interpretation of reality), dementia, and heart failure. Resident 13 was able to make needs known. Review of Resident 13's EHR showed a Level I PASRR was completed on 11/29/2022 indicating a Level II evaluation referral was required due to serious functional limitations during the past 6 months related to mental illness. Further review showed the facility did not refer the resident to the appropriate state-designated authority for Level II PASARR evaluation and determination. During an interview on 05/22/2026 at 10:20 AM, Staff H, Social Service Director (SSD), stated the expectation was for all residents with a mental health diagnosis to be referred for a Level II evaluation and determination. Resident 14Review of the EHR showed Resident 14 admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder (mental health condition that's caused by an extremely stressful or terrifying event - either being part of it or witnessing it), chronic obstructive pulmonary disease (difficulty breathing) and chronic kidney failure. Resident 14 was able to make needs known. Review of Resident 14's EHR showed a Level I PASRR was completed on 03/17/2026 indicating The individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services (exempted hospital discharge). The PASRR showed No Level II evaluation indicated at this time due to exempt hospital discharge: Level II must be completed if scheduled discharge does not occur. Review of the EHR showed no documentation the facility referred the resident to the appropriate state-designated authority for Level II PASARR evaluation and determination. During an interview on 05/22/2026 at 10:20 AM, Staff H, SSD, stated since Resident 14 did not discharge as planned, a new PASRR and referral for a Level II evaluation should have been completed. Resident 150Review of the EHR showed Resident 150 re-admitted to the facility on [DATE] with diagnoses that included depression, anxiety and heart failure. Resident 150 was able to make needs known. Review of Resident 150's EHR showed a Level I PASRR completed by the discharging hospital on [DATE]. Section I. Serious Mental Illness Indicators showed no boxes checked. Section IV. Service Needs and Assessor Data showed No Level II indicated: Person does not show indicators of Serious Mental Illness. During an interview on 05/26/2026 at 11:16 PM, Staff H, SSD, stated Resident 150's PASRR should have been corrected to reflect their diagnoses of depression and anxiety. Staff H stated a referral for a Level II evaluation should have been completed. During an interview on 05/26/2026 at 11:45 AM, Staff A, Administrator (ADM), stated that it was their expectation that the PASRR form obtained from the hospital prior to admission was accurate and that the Social Service staff were to assess for accuracy to ensure that the process was followed and refer for Level II evaluations if indicated. Reference WAC 388-97-1975 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to formulate baseline care plans within 48 hours of admitting to the facility for 1 of 23 sampled residents (Resident 159) reviewed for position and mobility. This failure placed residents at risk of delays in services, avoidable pain, and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 159 was admitted to the facility on [DATE] with diagnoses to include traumatic subdural hemorrhage (brain injury), fractures of T5-6 vertebra (broken bones in mid back), and respiratory failure. Resident 159 was not able to communicate needs. Observation on 05/18/2026 at 1:48 PM showed Resident 159 in bed with head of the bed (HOB) elevated and their body slouching down. Observation on 05/20/2026 at 9:57 AM showed Resident 159 in bed with HOB elevated and their feet touching the lower bed frame. Review of care plan dated 05/10/2026 showed Resident 159 had no instructions or directions on how to be positioned in bed, how to transfer or bed mobility. Review of the Visual/bedside Kardex report (specific instructions for nursing assistants on how to provide care) showed no instructions on bed mobility and transfers. During an interview on 05/21/2026 at 10:11 AM, Staff O, Licensed Practical Nurse/Resident Care Manager, stated the baseline care plan should have included directions and instructions on bed mobility and transferring for Resident 159. During an interview on 05/22/2026 at 9:38 AM, Staff B, Director of Nursing Services, stated the care plan for Resident 159 did not meet expectations. Reference WAC 388-97-1020(3) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were accurate and reflected resident care needs for 2 of 23 sampled residents (Residents 103 and 2) reviewed for care plans. Failure to ensure Resident 103's fluid restriction and Resident 2's hard of hearing status were included in their plans of care placed residents at risk of fluid overload, avoidable discomfort, unmet needs, and a diminished quality of life. Findings included.Resident 103<br><br>Review of the electronic health record (EHR) showed Resident 103 was admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), amputation of leg, and end stage renal disease (last stages of kidney failure). Resident 103 was able to communicate needs.<br><br>During an interview on 05/18/2026 at 10:34 AM, Resident 103 stated they were on fluid restrictions.<br><br>Review of the providers orders showed Resident 103 had an order for Fluid restriction, 1500 mL (milliliters) Dietary=900ml and nursing=600ml/day dated 05/05/2026.<br><br>Review of the care plan dated 04/30/2026 showed Resident 103 was not on a fluid restriction.<br><br>During an interview on 05/20/2026 at 12:48 PM, Staff S, Certified Nursing Assistant, stated the care plan and Kardex had instructions for nursing assistants if someone was on fluid restriction. When asked if anyone on the same hallway where Resident 103 lived was on fluid restriction, Staff S stated no.<br><br>During an interview on 05/21/2026 at 9:53 AM, Staff T, Licensed Practical Nurse, stated the fluid restriction was documented in the care plan for the nursing assistants to know and follow.<br><br>During an interview on 05/22/2026 at 9:50 AM, Staff B, Director of Nursing Services (DNS), stated Resident 103's care plan did not meet expectations.<br><br>Resident 2<br><br>Review of the EHR showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include diabetes, dysphagia (difficulty swallowing), high blood pressure, and was able to make needs known.<br><br>Review of the modification of admission minimum data set assessment (MDS) dated [DATE] showed Resident 2 had minimal difficulty hearing with no hearing aid.<br><br>Review of Resident 2's current care plan initiated on 04/17/2026 showed no care plan for communication deficit related to being hard of hearing.<br><br>During an interview on 05/22/2026 at 10:33 AM, Staff R, Licensed Practical Nurse (LPN)/MDS, stated they were unable to locate a care plan related to Resident 2's difficulty in hearing and there should have been. Staff R stated this did not meet expectations.<br><br>During an interview on 05/22/2026 at 10:48 AM, Staff B, DNS, stated Resident 2 should have had a<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | communication deficit related to hard of hearing care plan initiated and implemented and this did not meet their expectations.<br><br>Reference WAC 388-97-1020(1)(2)(a)(b) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to monitor actual pressure injuries or prevent new pressure injuries for 1 of 3 sampled residents (Resident 1) reviewed for pressure injuries. This failure placed the residents at risk for new or worsening pressure injuries and a decreased quality of life. Findings included.Review of the facility policy and procedure titled Skin Integrity Management dated 05/26/2021 showed the facility would identify residents' skin integrity status and need for prevention intervention and the facility would perform wound observations and measurements upon initial identification of altered skin integrity, weekly and as needed. The facility would develop a comprehensive plan of care to include pressure ulcer prevention and determine the need for offloading and repositioning. Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses of encephalopathy (inflammation of the brain), myocardial infarction (heart attack), and respiratory failure. The resident was able to make needs known. During an interview on 05/18/2026 at 3:12 PM, Resident 1 stated that their sitting bones were sore. Review of the EHR showed Resident 1 was sent to the hospital on [DATE] through 04/17/2026 and returned to the facility. Review on 05/20/2026 of the admission nursing assessment dated [DATE] showed Resident 1 had a 6 centimeter (CM) by 10 cm stage 2 pressure ulcer to their tail bone and a 3 cm by 2 cm stage 2 pressure ulcer to their left heel. No further monitoring was found in the EHR of Resident 1's pressure injuries. Review of the body check assessment completed 04/24/2026 did not list the pressure injuries but showed pressure ulcer prevention measures included pillow, offloading and turning and positioning. Review of the active plan of care on 05/21/2026 showed Resident 1 had declined a low air loss mattress, no other interventions such as offloading and repositioning for pressure reduction were listed in the care plan. Observations on 05/19/2026 at 11:49 AM, 05/20/2026 at 11:30 AM and 1:48 PM, 05/21/2026 at 9:31 AM, and 05/26/2026 at 8:55 AM showed Resident 1 laid in bed on their back with no offloading devices (pillows) and their heels were pressed on the bed. During an interview on 05/20/2026 at 11:30 AM, Resident 1 stated staff never put pillows under [their] feet or turn them on [their] side and stated that would probably help me be more comfortable. There were no extra pillows or offloading/positioning devices observed near Resident 1's bed. During an interview on 05/26/2026 at 10:12 AM, Staff C, Licensed Practical Nurse, stated residents with pressure injuries should have positioning devices to offload pressure and be assisted/encouraged to reposition frequently. During an interview on 05/22/2026 at 8:42 AM, Staff B, Director of Nursing Services, stated it was their expectation that residents with pressure injuries had interventions in place for pressure reduction such as offloading and repositioning and had their pressure injuries monitored weekly, but this did not happen for Resident 1. During an interview on 05/22/2026 at 12:23 PM, Staff A, Administrator, stated it was their expectation that residents with pressure injuries had weekly assessments completed and the care plans should have appropriate interventions. Reference WAC 388-97-1060(3)(b) |

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|---|---|---|---|
| | 505093 | A. Building<br>B. Wing | 06/01/2026 |

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| Orchard Park Health Care & Rehab Center | 4755 South 48th<br>Tacoma, WA 98409 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure falls were investigated and future falls prevented and smoking assessments and interventions were in place for 1 of 6 sampled residents (Residents 85) and failed to protect residents from eloping (exiting the facility without the required supervision) and anti-elopement devices were in place for 1 of 6 sampled residents (Resident 14) reviewed for accidents. These failures placed residents at risk of significant injury and a decreased quality of life. Findings included.Resident 85<br><br>Review of the electronic health record (EHR) showed that Resident 85 admitted to the facility on [DATE] with diagnoses to include respiratory failure, generalized muscle weakness, and dysphagia (difficulty swallowing). Resident 85 was able to make needs known.<br><br><Fall><br><br>During an interview on 05/18/2026 at 1:27 PM, Resident 85 stated they had rolled over and fell out of their bed last night because they were too close to the edge of their bed but did not get hurt.<br><br>During an observation and follow up interview on 05/19/2026 at 11:32 AM, Resident 85 showed a yellow, green, purple/pinkish bruise/bump to the left side of their forehead. Resident 85 stated they were not aware they had a bruise on their forehead. Resident 85 stated a couple of nights ago a man, and a woman helped them back into bed after they fell/rolled out of the left side of their bed and yelled for help.<br><br>Review of the facility's incident log from 05/01/2026 – 05/19/2026 showed no incident logged for Resident 85 regarding a fall.<br><br>Review of Resident 85's EHR on 05/20/2026 showed no documentation of a fall.<br><br>During an interview on 05/21/2026 at 9:25 AM, Staff Z, Nursing Assistant Certified (CNA), stated Resident 85 had a bruise on their forehead and it was there yesterday (05/20/2026). Staff Z stated Resident 85 did not tell them they fell; however, on Tuesday (05/19/2026), Staff BB, Registered Nurse/Staff Development Coordinator (RN/SDC), asked them if they had heard of Resident 85 having a fall and was trying to get to the bottom of it.<br><br>During a joint interview and observation on 05/21/2026 at 9:34 AM, Staff AA, Licensed Practical Nurse (LPN), stated they were not aware Resident 85 had a fall; however, this was the first time they had noticed a six or seven centimeter purple grayish color bruise on Resident 85's forehead. Resident 85 told Staff AA that they rolled off their bed and fell around 2:00 or 3:00 AM in the morning and yelled for help and their roommate went to get help and a man and a woman helped them get up from the floor.<br><br>During an interview on 05/21/2026 at 10:08 AM, Staff BB, RN/SDC, stated if a resident was found on the floor, they should be assessed for injuries and pain, the provider and responsible party/family notified, Director of Nursing Services (DNS) and on call manager notified, process any new provider orders, place the resident on alert charting and monitor for latent injuries, initiate an incident report/risk management, obtain any witness statements, and document a change of condition/SBAR.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Staff BB stated a staff member had asked them two days ago (05/19/2026) if they had known anything about Resident 85 having a fall. Staff BB stated they made phone calls to the night shift nursing staff about it; however, they did not interview Resident 85 or document any of the interviews.<br><br>During an interview on 05/21/2026 at 11:02 AM, Staff B, DNS, stated they were not aware Resident 85 fell until they were informed about it this morning. Staff B stated Resident 85 should have been interviewed and fall verified, notifications made, reported, risk management/incident report investigation initiated, and interventions initiated prior to today. Staff B stated this did not meet their expectations.<br><br><Smoking><br><br>During an interview on 05/18/2026 at 1:32 PM, Resident 85 stated they smoke supervised in the courtyard and staff kept their kept their smoking materials.<br><br>Review of Resident 85's diagnosis list showed a diagnosis of nicotine dependence, created on 04/22/2026.<br><br>Review of the provider's progress note dated 04/24/2026, showed Resident 85 was a current smoker of half a pack per day and there was no tobacco cessation counseling documented.<br><br>Review of Resident 85's smoking evaluation dated 05/17/2026 showed supervised smoking was required and no other smoking evaluation was found in the resident's EHR.<br><br>Review of Resident 85's focused care plan for Patient may smoke with supervision per smoking assessment showed it was initiated on 05/17/2026.<br><br>During an interview on 05/21/2026 at 1:59 PM, Staff CC, LPN/Unit Manager (UM), stated Resident 85 had a diagnosis of nicotine dependence created on 04/22/2026 and had a progress note dated 04/24/2026 that showed Resident 85 was a current smoker. Staff CC stated Resident 85's smoking evaluation and care plan was initiated on 05/17/2026 and should have been initiated on 04/22/2026 when identified as nicotine dependent and this did not meet their expectations.<br><br>During an interview on 05/21/2026 at 2:13 PM, Staff B, DNS, stated smoking evaluations and smoking care plans were to be initiated upon knowing a resident smoked. Staff B stated Resident 85's smoking evaluation and care plan did not meet expectations and should have been conducted/completed on 04/22/2026.<br><br><Wanderguard><br><br>Resident 14<br><br>Review of the EHR showed Resident 14 admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing a terrifying, shocking, or dangerous event), chronic obstructive pulmonary disease (a progressive lung disease that restricts airflow, making it difficult to breathe) and chronic kidney failure. Resident 14 was able to make needs known.<br><br>Review of the EHR showed a device evaluation for Resident 14 who was at risk for elopement and<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | required a Wander Guard device (an alarm device that triggers when a resident attempts to leave the facility) on their left arm.<br><br>Observation on 05/19/2026 at 9:36 AM showed Resident 14 smoking a cigarette outside in the designated area. No Wander Guard device was observed on their arm.<br><br>During an interview on 05/19/2026 at 1:10 PM, Resident 14 stated they had a Wander Guard on their left wrist when they first admitted to the facility, but they cut it off and threw it in the woods after a week or two. Resident 14 stated If they try to put another on me, I'll do the same thing.<br><br>Observations on 05/20/2026 at 11:09 AM and 05/21/2026 at 10:30 AM showed Resident 14 did not have a Wander Guard device on their arm.<br><br>During an interview on 05/21/2026 at 10:32 AM, Staff K, Licensed Practical Nurse (LPN), who was assigned to Resident 14's hall stated they were unaware of any residents who were an elopement risk or had a Wander Guard. Staff K stated nursing staff would document that the device was working properly each shift on the treatment administration record (TAR) if a resident had a Wander Guard.<br><br>Review of Resident 14's TAR showed no area to document information related to a Wander Guard device.<br><br>Review of binders titled Elopement at nurse's stations on the [NAME] and South Hall showed a list that included Resident 14's name and a picture as an elopement risk. The binder also listed residents who were no longer in the facility.<br><br>During an interview on 05/21/2026 at 10:59 AM, Staff M, Unit Manager, stated they were unaware Resident 14 no longer had the Wander Guard in place. Staff M stated the expectation was for the licensed nurses to document the functionality and skin (to prevent breakdown) surrounding the device every shift on Resident 14's TAR. After review of the EHR, Staff M stated the order was entered incorrectly and did not show up on the TAR.<br><br>During an interview on 05/26/2026 at 12:02 PM, Staff B, Director of Nursing Services, stated the expectation for staff to ensure the Wander Guard device was in place, working properly and checking Resident 14 did not have skin breakdown due to the device each shift was not met.<br><br>Reference WAC 388-97-1060 (3)(g) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure fluid restrictions were implemented for 2 of 4 sampled residents (Residents 103 and 2) reviewed for nutrition. This failure placed residents at risk of fluid overload, avoidable discomfort, and a diminished quality of life. Findings included.Resident 103<br><br>Review of the electronic health record (EHR) showed Resident 103 was admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), amputation of leg, and end stage renal disease (last stage of kidney failure). Resident 103 was able to communicate needs.<br><br>During an interview on 05/18/2026 at 10:34 AM, Resident 103 stated they were on fluid restrictions.<br><br>Review of the providers orders showed Resident 103 had an order for Fluid restriction, 1500 mL (milliliters) Dietary=900ml and nursing=600ml/day dated 05/05/2026.<br><br>Review of May 2026 medication administration record (MAR) showed Resident 103 had order Water restriction 1500ml for Nursing only. AM- 600 ml PM- 600 ml Night - 300ml every shift-Start Date 05/01/2026. Documentation from the nurses showed no total amount and had conflicting amounts of what was given from dietary and what was from nursing.<br><br>During an interview on 05/21/2026 at 10:16 AM, Staff O, Licensed Practical Nurse/Resident Care Manager, stated the fluid restriction documentation should be clearer on what department was providing fluids and should have a total amount.<br><br>During an interview on 05/22/2026 at 9:50 AM, Staff B, Director of Nursing Services (DNS), stated the documentation of fluid restriction for Resident 103 did not meet expectations.<br><br>Resident 2<br><br>Review of the EHR showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include diabetes, dysphagia (difficulty swallowing), high blood pressure, and was able to make needs known.<br><br>During an interview on 05/18/2026 at 10:32 AM, Resident 2 stated they may be on some type of fluid restriction but was not sure how much fluid they could have.<br><br>Review of Resident 2's EHR showed a diet order dated 04/28/2026 for Resident 2 to have a liberal renal/kidney diet, easy to chew texture, and thin consistency liquids. Review did not show an order for fluid restrictions.<br><br>Review of Resident 2's at nutritional risk, focused care plan initiated on 04/17/2026 showed no intervention that included fluid restriction. It showed, offer/encourage fluids of choice, initiated on 04/17/2026.<br><br>Review of the Post Acute & Transition of Care Orders, (hospital discharge orders) dated 04/17/2026 showed Resident 2 was prescribed a fluid restriction of 1.6 liter per day.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 2's nutritional assessment dated [DATE] completed by the Registered Dietician (RD) showed, . noticed that hospital had resident in fluid restriction. RD will f/u [follow up] on review from provider.<br><br>Review of Resident 2's provider's Cardiology [branch of medicine focused on the heart and blood vessels] Follow up Note, progress note dated 05/18/2026 showed, to reinforce sodium restriction less than 2 grams per day (< 2g/day) and fluid restriction per nephrology [branch of medicine focused on kidney health] guidance.<br><br>During an interview on 05/20/2026 at 1:23 PM, Staff Y, RD, stated they had asked nursing to follow up to see if the provider wanted Resident 2 to be on a fluid restriction on 04/21/2026 via recommendation tool in the computer system. Staff Y stated Resident 2 was not currently on a fluid restriction and they had not been informed by nursing that a provider recommended/ordered Resident 2 be placed on fluid restriction.<br><br>During an interview on 05/20/2026 at 1:45 PM, Staff M, Unit Manager (UM), stated Resident 2's fluid restriction discharge orders on 04/17/2026 from the hospital should have been put in place and/or clarified with the provider. Staff M stated after Resident 2 saw cardiology on 05/18/2026 the diet order should have been updated for sodium restriction and fluid restriction. Staff M stated Resident 2's fluid restriction should have been addressed earlier, and this did not meet expectations.<br><br>During an interview on 05/21/2026 at 11:34 AM, Staff B, DNS, stated Resident 2's liberal renal diet included less that 2 gram per day sodium restriction; however, fluid restriction of 1.6 liters should have been implemented upon admit.<br><br>Reference WAC 388-97-1060 (3)(h)(i) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was administered/documented in accordance with provider's orders for 2 of 3 sampled residents (Residents 9 and 4) reviewed for tube feeding. These failures placed the residents at risk for inadequate nutrition and diminished quality of life. Findings included .<br><br>Resident 9<br><br>Review of the electronic health record (EHR) showed Resident 9 admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (weakness/paralysis) affecting right dominant side, dysphagia (difficulty swallowing) and aphasia (a neurological disorder that impairs a person's ability to speak, write, and understand both spoken and written language). Resident 9 was assessed to require nutrition through a feeding tube (device that is inserted into the stomach through the abdomen to supply nutrition).<br><br>Review of Resident 9's dietary care plan, dated 10/01/2025, showed focus area Resident is at nutritional risk. Interventions included Monitor for changes in nutritional status (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and report to food and nutrition/physician as indicated.<br><br>Review of Resident 9's EHR showed a 03/05/2026 provider's order for Enteral Feed Order at bedtime for dysphagia, Jevity 1.5 calories administered continuous via pump 97 milliliters per hour x 15 hours/day total=1455ml on at 8:00pm and off at 1100AM.<br><br>Review of Resident 9's May 2026 Medication Administration Record (MAR) showed staff documented the time the pump was turned on and turned off but failed to document the total amount of enteral feeding infused.<br><br>During an interview on 05/26/2026 at 10:31 AM, Staff M, Licensed Practical Nurse/Unit Manager (LPN/UM), stated nursing staff were not documenting the total received on the MAR or in a progress note but should have been.<br><br>During an interview on 05/26/2026 at 12:04 PM, Staff B, Director of Nursing (DNS), stated staff were expected to set up the MAR with an area for supplemental documentation where nursing staff would have documented the amount of nutrition Resident 9 received daily.<br><br>Resident 4<br><br>Review of the EHR showed Resident 4 was admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), dysphagia and artificial tube feeding. Resident 4 was able to communicate needs.<br><br>During an interview on 05/20/2026 at 12:15 AM, Resident 4 stated the tube feeding was turned off at 7:00 AM and restarted at 9:00 AM.<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the May 2026 MAR showed Resident 4 had orders for tube feeding osmolyte to run at 70 milliliters(ml) per hour for 22 hours, and to be off at 5:00 AM, and restart at 7:00 AM. Water flushes to be given at 120 ml every four hours.<br><br>Review of May 2026 MAR showed license nurses were documenting by initialing under day shift and night shift, and there was no actual time or fluid amount documented to know what Resident 4 was given.<br><br>During an interview on 05/21/2026 at 10:22 AM, Staff O, Licensed Practical Nurse/Resident Care Manager, stated the tube feeding should be documented with the specific start and stop times and should have amount given.<br><br>During an interview on 05/22/2026 at 9:47 AM, Staff B, Director of Nursing Services, stated the documentation record for Resident 4's tube feeding did not meet expectations.<br><br>Reference WAC 388-97 -1060(3)(f) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a contract with the dialysis (a process of filtering the toxins out of the blood) facility regarding dialysis care and services for 2 of 3 sampled residents (Residents 103 and 2) reviewed for dialysis. This failure placed residents at risk of avoidable complications, unmet care needs, and diminished quality of life. Findings included.Resident 103Review of the electronic health record (EHR) showed Resident 103 was admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), amputation of leg, end stage renal disease (final stage of kidney disease) and was dependent on dialysis. Resident 103 was able to communicate needs. Resident 2Review of the EHR showed that Resident 2 was admitted to the facility on [DATE] with diagnoses to include diabetes and was dependent on renal dialysis. Resident 2 and was able to make needs known. Review of facility contracts showed no active agreement and contract with the dialysis center where Residents 103 and 2 were being dialyzed. During an interview on 05/26/2026 at 12:26 PM, Staff A, Administrator, stated they do not have an agreement or contract with the dialysis center for Residents 103 and 2 and were waiting to receive one. Reference WAC 388-97-1900(1)(6)(a-c) |

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| F 0745<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide medically-related social services to help each resident achieve the highest possible quality of life.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to address the psychosocial needs for 1 of 6 sampled residents (Residents 128) reviewed for abuse. This failure placed the residents at risk of unmet psychosocial needs and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 128 admitted to the facility on [DATE] with diagnoses that included tremors (neurological condition that includes shaking or trembling movements in one or more parts of the body) and heart failure. Resident 128 was able to make needs known. Review of Resident 128's Care Plan dated 07/24/2025 showed a focus area that included: Resident is at risk for or is experiencing adjustment issues related to loss of social support network as a result of moving into the center. Interventions showed, Review for impact on social involvement and provide assistance, as needed, to increase social involvement, monitor medical conditions that may contribute to social isolation, and evaluate mood state or behavioral symptoms impacting social isolation. During an interview on 05/19/2026 at 8:49 AM Resident 128 stated they were told by a facility staff member that they were talking to reception staff for too long and interfering with their ability to get their work done. Resident 128 stated they were also informed they were no longer able to speak to facility staff unless it was related to their care and excessive social interaction should only be with activity staff members. Resident 128 stated they felt very depressed and confused by the situation and isolated to their room for several days before writing a grievance and submitting it to the facility. Review of a handwritten grievance dated 03/16/2026 showed Resident 128 reported they were told by Business office staff, nursing staff and social service staff that they were not to socialize with reception staff or others in the reception area. The last part of the grievance showed I have been isolated for 15 days (8 due to COVID). It has not been made clear to me why I am being punished, could you please end this punishment. Review of a 04/13/2026 progress note showed, Resident 128 went to social services to discuss the situation of feeling like they could not talk to staff, social services reiterated our previous discussion that they were welcome to talk to anyone in the building, but if they feel the need for long periods of one on one time they should check in with the activities department. Review of a 04/01/2026 general progress note showed, a late entry note from the director of Admissions that stated, spoke with resident several weeks ago with My Receptionist that She is very busy with many things to please not spend long periods of time at the front desk. I assured him that he was allowed to greet and talk to anyone in the building and could always take his walks. Review of a 04/01/2026 social service progress note showed, Note: Late entry for about 2 weeks ago. Resident came to social services concerned that they were not allowed to talk to the front desk anymore, I assured them that they were allowed to greet and talk to anyone in the building and then told them if they were seeking longer one on one conversations they should talk to our activities department. During an interview on 05/22/2026 at 9:59 AM, Staff H, Social Service Director (SSD), stated they were not the SSD at the time of the incident but based on Resident 128's statement of self-isolation and feeling punished social services should have assessed for any psychological social outcomes. Staff H stated they would have discussed if the situation was an allegation of mental abuse with the Administrator to determine next steps. During an interview on 05/22/2026 at 10:30 AM, Staff A, Administrator, stated they did not feel the grievance rose to the level of mental abuse. Staff A stated social services should have been involved to determine if there was any psychosocial social outcome from the misunderstanding. Reference WAC 388-97-1060(1) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505093 | A. Building<br>B. Wing | 06/01/2026 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nonpharmacological interventions (NPI, nonmedicated methods to reduce pain, e.g. massage, heat, repositioning) prior to providing as needed (PRN) pain medications for 1 of 5 sampled residents (Resident 16) reviewed for unnecessary medications. This failure placed residents at risk of avoidable side effects and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 16 admitted to the facility on [DATE] with diagnoses to include bipolar disorder (a mental health condition that causes extreme shifts between depression and mania) and dementia (a decline in mental ability that interferes with daily life). Resident 16 was able to make needs known. Review of provider's orders showed Resident 16 had an order for oxycodone (a narcotic pain medication) PRN. Review showed an order for Document Non-Pharmacological Interventions(s) A. Heat B. Repositioning C. Relaxation breathing D. Food/Fluid E. Massage F. Exercise G. Immobilization of joint H. Other: write in progress note. Review of the medication administration record for May 2026 showed Resident 16 received their PRN oxycodone on nine occasions. Review of progress notes for May 2026 did not show documentation of NPI used prior to providing PRN oxycodone. During an interview on 05/26/2026 at 10:01 AM, Staff M, Unit Manager, stated the facility ensured PRN pain medications were necessary by providing NPI to determine whether the pain could be reduced without medication. Staff M stated Resident 16 used PRN pain medications and had an order for NPI to be used. During an interview on 05/26/2026 at 10:41 AM, Staff B, Director of Nursing Services, stated NPI should be attempted prior to providing PRN pain medications to ensure the medication was necessary. Staff B stated Resident 16's lack of NPI prior to receiving PRN pain medications did not meet expectations. Reference WAC 388-97-1060(3)(k)(i) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505093 | A. Building<br>B. Wing | 06/01/2026 |

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

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide prompt dental care services and ensure a care plan reflected current dental status for 1 of 3 sampled residents (Residents 85) reviewed for dental. This failure placed the residents at risk for continued dental problems, unmet needs, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed that Resident 85 admitted to the facility on [DATE] with diagnoses to include respiratory failure, generalized muscle weakness, and dysphagia (difficulty swallowing). Resident 85 was able to make needs known. During an interview on 05/18/2026 at 12:53 PM, Resident 85 stated they had no dentures and would not mind getting dentures. Resident 85 stated they did not remember staff ever asking them if they wanted dentures, but, if they had, they would have told them Yes. Review of the admission minimum data set assessment (MDS) dated [DATE] showed Resident 85 had no natural teeth or tooth fragments. Review of the focused care plan for oral health or dental care problems created on 05/18/2026 showed Resident 85 had Broken/missing teeth, and interventions to include, Brush/clean dentures and Encourage resident to brush teeth and gums. Review of Resident 85's provider progress note dated 05/13/2026 showed Resident 85 was edentulous (no natural teeth) with chewing/swallowing difficulties. During an interview on 05/26/2026 at 11:13 AM, after looking at Resident 85's EHR, Staff J,Minimum Data Set/Registered Nurse, stated on 05/18/2026 they had sent an internal referral via email for dental services to social services for Resident 85; however, it should have been made sooner. Staff J stated Resident 85's care plan for oral health/dental problems did not meet expectations because it was inaccurate for Resident 85 having broken or loose teeth and dentures. During an interview on 05/26/2026 at 11:47 AM, staff DD, Central Supply/Transportation, stated they received messages in the internal communication board to set up appointments, and they had not received communication for them to set up a dental appointment for Resident 85. Staff DD stated there were no scheduled appointments for Resident 85 to see a dentist at this time. During an interview on 05/26/2026 at 11:47 AM, Staff EE, Social Services Assistant, stated there was an email received on 05/18/2026 to make a dental appointment for Resident 85; however, it was forwarded to the Social Services Director (SSD) on 05/19/2026. During an interview on 05/26/2026 at 11:57 AM, Staff H, SSD, stated they received an email from the SSA about setting up an appointment for Resident 85 on 05/19/2026; however, the dentist was in the facility on 05/19/2026 and Resident 85 was not seen. Staff H stated the dentist came to the facility every 60 days or so. Staff H stated Resident 85 should have been seen by the dentist on 05/19/2026. During an interview on 05/26/2026 at 12:33 PM, Staff B, Director of Nursing Services, stated Resident 85, needed to be seen by a dentist for dentures and this should have been addressed sooner. Staff B stated Resident 85's care plan needed to be revised to reflect current oral/dental status, and this did not meet their expectations. Reference WAC 388-97-1060 (2)(3)(j)(vii) |