

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER Linden Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 802 West Third Avenue Toppenish, WA 98948	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the state agency was notified about an elopement for 1 of 1 resident (Resident 1) reviewed for elopements. This failure placed the resident at risk for potential endangerment.</p> <p>Findings included .</p> <p>&lt;Resident 1&gt;</p> <p>Review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses including high blood pressure, Parkinson's Disease (neurodegenerative disease with brain deterioration that affects body movements by slowing movements and causes tremors and balance issues), reduced mobility and homelessness. The 05/30/2025 comprehensive assessment showed Resident 1 was alert and oriented and required partial to substantial assistance with transfers, dressing and toileting.</p> <p>During an interview on 06/30/2025 at 10:30 AM, Staff B, Director of Nursing Services, stated Resident 1 left the facility without notice and staff were not aware of their location. Staff B stated Resident 1 was not assessed as an elopement risk. The facility did not call the state agency to report the missing resident who left the facility on [DATE].</p> <p>Review of the May 2025 and June 2025 (reviewed through 06/30/2025) Incident Reporting Log showed no entry for Resident 1's elopement from the facility.</p> <p>Review of the 06/23/2025 at 12:26 PM nursing progress note showed Resident 1's breakfast tray was still on their bedside table untouched and they had served the lunch meal. Resident 1's clothing and belongings were gone. They notified Staff C, Social Services.</p> <p>During an interview on 06/30/2025 at 11:00 AM, Staff C stated they had tried to call Resident 1's phone number and it was a non-working phone number. Staff C then notified law enforcement on 06/24/2025. Staff C failed to log the incident and was unaware that the state agency was to be notified.</p> <p>Reference WAC 388-97-0640 (5)(a)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a safe, comfortable environment for 3 of 6 rooms (Rooms 27, 28 and 29) for maintenance repairs. This failure placed residents at risk of injury and a diminished quality of life by not maintaining a safe and functional environment.</p> <p>Findings included .</p> <p>Review of the undated Facility Maintenance Program policy showed the facility should have .regularly scheduled inspections .building interior inspections include checking floors, ceilings and walls weekly .</p> <p>Review of the April 2025 through June 2025 maintenance log did not identify Rooms 27, 28. and 29 for maintenance inspection or repair.</p> <p>During an observation and concurrent interview on 06/30/2025 at 11:05 AM, showed room [ROOM NUMBER] with white walls and four feet long cuts into the wall located on the right side of the room by the baseboard and the lower wall. Additionally, there were multiple gouges (indentations) brown in color where the paint was removed along the wall above the base board. On the back wall near the window of room [ROOM NUMBER] there were many patched spackled (plastic paste) areas unfinished on the back wall and a patched area above the baseboard with a five by four inches with a metal plate with sharp edges partly exposed from the wall. An observation of more peeling paint above the baseboard with exposed inside of the wall was visible. The wooden closet doors to the left of room [ROOM NUMBER] upon entering the room, had sparse old varnish in some areas on the closet doors and splintered areas along the edges of the closet doors. The back right corner on the right side of room [ROOM NUMBER] between the right side of the wall and back wall was uncleanable with yellow peeling flakes from the wall above the baseboard. Staff D, Maintenance Director, stated that it was the first time they saw these areas that needed repair.</p> <p>During an observation on 06/30/2025 at 11:15 AM, room [ROOM NUMBER] had white walls and on the left side of the wall above the baseboard had peeled paint and gouges observed sporadically (intermittently) along a five foot area above the baseboard. There were three inch long scratched areas into the wall.</p> <p>During an observation on 06/30/2025 at 11:30 AM, room [ROOM NUMBER]'s wall on the left side had significant gouges and broken sheet rock from the wall behind the bed headboard. The broken sheet rock area on the wall behind the resident's bed headboard was three by four feet. The broken pieces of sheet rock was visible from the entry way to room [ROOM NUMBER].</p> <p>During an interview on 06/30/2025 at 11:45 AM, Staff D stated they made rounds in the facility daily and thorough room inspections were done monthly. Staff D was unaware that Rooms 27, 28 and 29 needed repairs.</p> <p>During an interview on 06/30/2025 at 11:50 AM, Staff A, Administrator, stated they should have repaired the rooms promptly.</p> <p>(continued on next page)</p>		

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