

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/21/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff followed infection control standards of practice regarding implementation of personal protective equipment (PPE, protective equipment designed to safeguard individuals and reduce the risk of contracting or spreading infectious diseases) with residents on Transmission Base Precautions (TBP, safeguards within a room or facility that are put in place to help prevent the spread of diseases) to mitigate the spread of COVID-19 for 5 of 5 staff (Staff I, P, Q, J and K), reviewed for infection control practices. This failure placed residents, staff, and visitors at an increased risk of exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases during a COVID-19 outbreak. Findings included . Review of the Center for Disease Control and Prevention (CDC) COVID-19 guidelines titled, Infection Control Guidance: SARS-COV-2, updated 06/24/2024, showed that facilities with confirmed or suspected COVID-19 should consider implementing source control measures (a respirator/mask that covers an individual's face to prevent the spread of respiratory infections) which included the option of a NIOSH (National Institute for Occupational Safety and Health)-approved N95 (a specific fitted type of mask used against COVID-19) respirator to be worn throughout the whole facility. For staff entering a COVID-19 positive resident room, they should put on a N95 fitted respirator, a gown, gloves and eye protection (like goggles or a face shield). Review of CDC NIOSH PPE respirators guidance titled, Fit Testing, dated 02/03/2025 showed that a fit test (a testing protocol conducted to verify that a respirator provides the user with the expected protection from infectious contaminants) confirmed that a respirator formed a tight seal to an individual's face before being utilized in a workplace environment. The guidance showed that fit testing was important to ensure the expected level of protection was provided by minimizing the amount of contaminated air (like how COVID-19 can be spread) leaked into the respirator facepiece through the face seal and the specific size/model of respirator was an acceptable fit for the individual tested. Additionally, the CDC's guidance showed that facial hair could impact the N95 respirator tight facepiece seal since a proper respirator fit required an individual's face to be clean shaven at the edges of the facepiece where the seal contacted the skin. Review of the facility's policy titled, COVID-19 Using PPE, dated 01/30/2025, showed that all staff were to follow TBP when care for a resident with suspected or confirmed COVID-19 infection. The policy stated that all staff entering a COVID-19 positive room were to use an approved N95 respirator, gown, gloves and eye protection. Additionally, the policy stated that when staff were entering a COVID positive room, .a clean isolation gown is donned (to put on) upon entry into the resident room or area . During an interview on 11/17/2025 at 9:30 AM, Staff B, Director of Nursing (DON), stated the facility had multiple staff and residents that had tested positive for COVID-19 earlier on 11/17/2025. Staff B stated they had implemented facility wide N95 respirators with staff throughout the facility. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505096	Facility ID: 505096 If continuation sheet Page 1 of 16

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's documented infection reporting communication, dated 11/17/2025 showed that six facility staff and eight residents were COVID-19 positive, the facility was implementing testing, and all staff were wearing N95 respirators for exposure control (a process to minimize the risk employee/resident exposure to potential infectious diseases). During an observation and interview on 11/17/2025 at 12:38 PM, showed Staff I, Nursing Assistant (NA), wearing an N95 respirator with the head straps cut and tied into a knot behind their ears. Staff I stated they had cut the straps and tied behind their ears because it made them feel better. Staff I proceeded to enter a COVID-19 resident room with signage posted for entering for staff to wear an N95 respirator, eye protection, gown and gloves. Upon entering the COVID-19 resident room, Staff I placed a second N95 respirator that was hanging on the resident's closet door, donned a yellow gown and face shield that was hanging on a used disposable biohazard container. Staff I stated they preferred to wear two N95 respirators and kept these items in the resident COVID-19 rooms. During an observation on 11/17/2025 at 12:50 PM showed Staff P, NA, was wearing a purple mask that was not an N95 respirator while working on the East/West side resident hallways and Staff Q, Licensed Practical Nurse (LPN) wearing a BYD DE2322 (a specific brand/type of N95 respirator) respirator while caring for residents on the East hallway. Review of the facility's annual staff N95 fit-testing records showed that Staff P was fit-tested on [DATE] for a 3M 1860 (a specific brand/type of N95 respirator) and the BYD DE2322 respirator. The records showed that Staff Q was fit-tested on [DATE] for the 3M 9205 (a specific brand/type of N95 respirator) respirator. During an observation on 11/19/2025 at 8:32 AM, showed Staff J, Attending Provider, enter a COVID-19 resident room while wearing an N95 respirator. Staff J had a beard that protruded two inches from the mask, not creating a seal to the face. At 9:00 AM, Staff J stated they would never shave their beard and the N95 did not form a seal around their face as it should. Staff J stated this was not the correct process for wearing an N95 respirator. During a concurrent observation and interview on 11/19/2025 at 9:03 AM, Staff F, Registered Nurse, was performing COVID-19 testing on facility residents. Staff F was observed with an N95 respirator in place over a full faced beard that was crossing under the edges of the respirators seal prior to entering a resident room, then donned a gown and gloves. Staff F stated they were going to wear an N95 respirator and full PPE (gown, gloves, mask and eye protection) because they were testing a resident who could be COVID-19 positive but would keep the same N95 respirator throughout testing. Staff F was observed entering and exiting four different resident rooms with their N95 respirator, gown, gloves but did not wear eye protection while the testing was performed. At 9:54 AM Staff F stated that one out of the four residents were positive for COVID-19. During a follow-up interview on 11/19/2025 at 10:00 AM, Staff F stated they did not have their full beard when they were originally fit-tested for the N95 respirator and that they currently did not have a tight facepiece seal with the current full faced beard they had. During an observation on 11/19/2025 at 11:47 AM, showed Staff K, LPN, obtain a face shield hanging on the back of a medication cart, put on their head and cover their face and enter a COVID-19 resident room. Staff K, then exited the room after removing their gloves and gown, carried the face shield from the room and used a sanitizer wipe and rehang on the back of the medication cart. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview on 11/20/2025 at 12:32 PM, showed Staff K exit a COVID-19 resident room, removed gown and gloves and carried the used face shield down the hall and wiped with a sanitizer cloth and hung on the back of the medication cart. Staff K stated they had no reason why they reused the face shields. During an interview on 11/20/2025 at 3:37 PM, Staff L, Infection Control Nurse, stated when staff entered a COVID-19 resident room, staff were to be donning N95 respirator, gowns, gloves and face shields. Staff L stated staff were to place a new N95 respirator on and face shields with foam and fabric were single use and were to be disposed after use. During an interview on 10/21/2025 at 10:45 AM, Staff A, Administrator, stated the facility had enough PPE and staff were not to reuse any disposable PPE. During an interview on 11/19/2025 at 10:17 AM, Staff B, DON and Staff A, Administrator, stated the process for COVID-19 testing was the same with entering a COVID-19 positive room and staff were required to wear full PPE with a fit-tested N95 respirator, gown, gloves and eye protection. Both staff stated that Staff F had not shaved their full faced beard for religious reasons and should not have been tasked with testing residents for COVID-19 when they were unable to be correctly fit-tested for the N95 respirator. Staff B stated that they would have expected the staff member to wear eye protection when testing residents for COVID-19. Additionally, Staff B stated that facility wide implementation of N95 respirator was implemented for Staff who were entering a COVID positive room but also as exposure control, due to the number of Staff members that were becoming positive and to reduce the risk of cross contamination of the COVID-19 virus. Both staff stated the correct process for staff implementation of PPE was not followed. Reference: WAC 388-97-1320(1)(a)(2)(b)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the notification to the resident's representative (RR) of changes in the resident's mental/psychosocial status (the impact on an individual's emotional, social and environmental factors affecting their mental health and well-being) and/or the need to alter treatment for 1 of 2 residents (Resident 61) reviewed for notification of changes. This failure placed the resident at risk of not having their RR involved in the health care decision making process and increased the risk of the RR from making an informed decision regarding the resident's care. Findings included .Resident 61Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnosis including a stroke (when blood supply to the brain is blocked or reduced), dysphagia (difficulty swallowing) following the stroke, apraxia (the inability to perform purposeful movement or gestures leading to difficulties with things such as dressing and grooming), dementia (a loss of thinking, remembering, and reasoning skills) with behavioral disturbances (a pattern of disruptive behaviors that can significantly impact an individual's daily life and social interactions), mixed receptive (difficulty understanding spoken or written language)/expressive language disorder (affects the ability to express thoughts, ideas and feeling through speech and writing) and depression. The 10/24/2025 and 10/27/2025 comprehensive assessments showed the resident had a severely impaired cognition along with being administered a psychotropic medication (medications capable of affecting the mind, emotions, and behavior). Review Resident 61's legal guardianship (a legal process that allows a designated person to make decisions for an adult that has lost the capacity to make decisions independently) document, dated 10/17/2024, showed the RR was appointed as Resident 61's guardian and would make decisions on consenting to or refusing medical treatment on the resident's behalf. Record review of Resident 61's elopement (an instance where a resident leaves a safe environment without the facility's awareness, authorization and/or necessary supervision to do so) risk assessment, dated 12/23/2024, showed the resident was a high risk for elopement from the facility due to the resident being cognitively impaired with poor decision-making skills, the risk of getting to an unsafe place, changes in behaviors/new medications, and medical diagnoses of dementia/cognitive impairments. Review of Resident 61's October 2024 through December 2024 physicians orders showed: On 10/19/2024 Seroquel (a specific type of psychotropic medication) 25 milligrams (mg, a unit of measure), administered two times a day, was started for the resident's dementia with behavioral disturbances (no documentation showing education to the RR on the risks/benefits of the medication, nor the opportunity to accept or decline the medication based off that information). On 11/27/2024 Trazadone (a specific type of psychotropic medication) 50 mg, one-time a day at bedtime, was started for .agitation/behavior/unable to sleep. On 12/20/2024 a one-time dose of Seroquel was administered to Resident 61 for behaviors, exit seeking (attempts by a confused individual to leave a safe environment or facility) and agitation. On 12/20/2024 the resident's Trazadone medication dose increased to 100 mg, one-time a day at bedtime for an altered mental state (various changes in an individual's mental functioning, including confusion, disorientation and/or changes in awareness), agitation, behaviors and unable to sleep. On 12/21/2024 Seroquel 25 mg, as needed, every 12 hours started. Review of Resident 61's progress notes showed: On 12/19/2024 at 12:05 PM, nursing staff received orders from the provider to discontinue the resident's Seroquel medication (No documentation of the RR being notified of the need to alter the resident's medication treatment). On 12/19/2024 at 9:04 PM, nursing staff reported to the provider the resident's continued behaviors of agitation, aggression and received orders to increase Trazadone medications (no documentation of the RR being notified of the need to alter the resident's medication treatment). On 12/20/2024 at 6:40 PM, Resident 61 was noted to be .very agitated, angry, exit seeking , was getting more aggressive and shaking of their body with anger. The nursing staff (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eloped/contacted the RR, Resident 61 was no longer allowed to leave the facility unsupervised. Staff A and Staff B stated the correct process was not followed and the RR should have been notified of the changes in the resident's mental/psychosocial status and the need to alter Resident 61's treatment/commence a new form of treatment. Reference: WAC 388-97-0320(1)(a)(c)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review the facility failed to have a system in place to ensure Residents were aware of how to file a grievance (a formal complaint by a resident or resident representative [RR]) and who the facility's Grievance officer was, these concerns were voiced in Resident Council (a formal meeting for facility residents to communicate preferences and concerns) for 3 of 5 residents (Resident 26, 39, and 75) who expressed they were unaware of how to file a grievance or who the facility Grievance Officer was. These failures placed residents at risk for overall dissatisfaction with their lives and unresolved concerns. Findings included .Record review of a facility policy titled Resident Grievance updated 08/01/2024 showed the facility supports each resident's right to voice concerns/ grievances verbally or in writing. Additionally, Social Services Director was responsible for overseeing the grievance process. On 11/19/2025 at 1:30 PM, Resident's 26, 39, 41, 54, and 75 attended Resident Council meeting. Resident 26 stated they had been in the facility for a while, and the Resident Council had a president and that the council met monthly. Resident 26 stated they did not know how to file a grievance or who the Grievance Officer was. Residents 39, and 75 stated they were also not sure how to file a grievance or who the facility Grievance Officer was. During an interview on 11/19/2025 at 2:23 PM, Staff N, Activities Director, stated they assisted the residents to organize monthly Resident Council meetings, reviewed the residents' rights and took minutes. Staff N further stated that if any concerns from the Resident Council meeting, they would document concern on the minutes, fill out a grievance form. Staff N stated they gave a copy to the Grievance officer, to the department heads to review and provide any follow-up as indicated. Staff N stated they were unaware that residents were unaware of how to file a grievance or who the grievance officer was. During an interview on 11/19/2025 at 2:35 PM, Staff M, Social Service Director, and Staff A, Administrator, stated they shared the grievances officer responsibilities. Staff A stated the resident grievance forms were located on a clip board next to the front door. An observation, accompanied by Staff A and Staff M, showed an empty clip board hanging five feet up on the wall where the Grievance forms were to be located. Staff A and Staff M stated the signs could be lowered so that residents could see and grab a Grievance form. During an interview on 11/21/2025 at 10:12 AM, Staff B, Director of Nursing, stated that she understood about Grievance forms and the process. Staff B stated they had educated staff about the Grievances process but had not educated the residents. Staff B stated education would be provided for residents to help residents understand the Grievance process and where to obtain the Grievance form. Reference WAC 388-97-0460		

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop comprehensive resident centered care plans for 2 of 6 residents (Residents 30 and 42) reviewed for care planning. This failure placed residents at risk for unmet care needs. Findings included .Resident 30 Review of the medical record showed the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of a stroke (when blood supply to the brain is blocked or reduced) and obstructive sleep apnea (OSA, a condition in which an individual has repeated interruptions in breathing while sleep). The 06/07/2025 comprehensive assessment showed the resident had intact cognition, able to make their needs known and had a non-invasive mechanical ventilator (a device, like a CPAP machine, that utilizes pressure to force air/oxygen into an individual's lungs, through a mask to assist with breathing) device. A concurrent observation and interview on 11/17/2025 at 12:31 PM showed Resident 30's CPAP device on their bedside table. Resident 30 stated they were supposed to be using the CPAP device every night, but the facility staff were not filling up the canister anymore, and the resident could not remember the last time the device was cleaned. Review of Resident 30's current physician's orders showed that on 07/09/2025 an order had been started to Encourage resident to place CPAP mask every night for bedtime. No other orders were current regarding Resident 30's CPAP device. Review of Resident 30's care plan, last completed 09/09/2025, showed no resident focused goals or interventions related to their CPAP use. During an interview on 11/19/2025 at 4:09 PM, Staff L, Infection Control Nurse, stated they were also the case manager for Resident 30 and when reviewing the resident's care plan, did not see goals nor interventions that pertained to resident CPAP device use. Staff L stated that Resident 30's CPAP device should have been care planned and the correct process was not followed. During an interview on 11/21/2025 at 11:31 AM, Staff B, Director of Nursing (DON), stated the resident's care plan needed to include CPAP goals and interventions that pertained to resident specific care. Staff B stated the correct process was not followed and the care plan should have included the resident's CPAP device. Resident 42 Review of the medical record showed Resident 42 was admitted to the facility on [DATE] with diagnoses including morbid obesity (being 100 pounds or more overweight), OSA and anxiety. The 09/26/2025 comprehensive assessment showed Resident 42 required the assistance of one to two staff members for activities of daily living and had an intact cognition. Review of Resident 42's September 2025 Treatment Administration record (TAR) showed Resident 42 used a bilevel positive airway pressure [BiPAP] a device that aids breathing by delivering pressurized air through a mask or nasal plugs on the face). (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 42's care plan showed no resident focus areas, goals or interventions related to Resident 42's OSA and BiPAP use. During an observation and concurrent interview on 11/19/2025 at 4:24 PM, showed Resident 42 lying in their bed with a BiPAP on the nightstand. Resident 42 stated the BiPAP was brought from their home when they admitted to the facility. Resident 42 stated he did not know when it had last been serviced or if the settings were still correct for their use. During an interview on 11/21/2025 at 10:45 AM, Staff B, DON, stated resident care plans needed to include focus areas with goals and interventions that pertained to resident specific care. Staff B stated Resident 42's OSA and BiPAP should have been on their care plan. Reference: WAC 388-97-1020(1)(2)(a)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to ensure residents dependent on staff received consistent oral care and nail care for 3 of 3 residents (Residents 1, 3, and 42) reviewed for activities of daily living (ADLs) care provided for dependent residents. This failure to receive adequate, consistent grooming and oral care according to the residents' care plan placed the residents at risk for unmet care needs, impaired skin integrity, and embarrassment. Findings included .Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting revised, 03/2018, showed, residents who were unable to carry out ADLs independently would receive the services necessary to maintain grooming and personal and oral hygiene. Resident 1 Review of Resident 1's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include right leg fracture, chronic obstructive pulmonary disease (chronic lung disease that causes air to become trapped in the lungs, making it hard to breath), chronic pain, abnormal weight loss, dysphagia (difficulty swallowing), and repeated falls. Review of the comprehensive assessment showed Resident 1's cognition was moderately impaired and required substantial assistance with all care. Review of Resident 1's physician order dated 09/29/2025 showed Licensed Nurse to check fingernails and toenails once a week on bath day. Trim as needed, in the morning every Monday. During an interview and concurrent observation on 11/17/2025 at 3:03 PM, Resident 1 stated they had not had nail care done since their admission. Resident 1's fingernails were long, jagged with a yellow and dark brown substance underneath. The resident's toenails were long, jagged and curled inward towards their toes. During an interview on 11/18/2025 at 2:58 PM, Resident 1 stated their nails were long and dirty. Resident 1 stated staff had not cleaned them, nor washed their hands or face. Resident 1 stated they did not want to have long, dirty nails because they might get sick and it made them feel dirty. During an interview and concurrent observation on 11/19/2025 at 9:40 AM, Resident 1 was clean, in a blue gown leaning to their left side. Resident 1 stated they had a shower that morning. Resident 1's fingernails were long and jagged. Resident 1's toenails were long and curled inwards towards their toes. Resident 1 stated, nobody has offered to trim my nails, they are so dirty. During an interview on 11/19/2025 at 11:15 AM, Staff C, Nursing Assistant (NA), stated when they gave a shower to a resident, they were responsible to do the resident's fingernails, toenails and shave if the resident did not have a diagnosis of diabetes. Staff C stated that Resident 1 was dependent on staff for showering and did not have a diabetes diagnosis. Staff C stated Resident 1 had never refused a shower for them and received a shower that shift. Staff C stated Resident 1's nails were not done after their shower; they were busy and had not done Resident 1's nails yet. Resident 3 Review of Resident 3's medical record showed, Resident 3 was admitted to the facility on [DATE] (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Linden Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 802 West Third Avenue Toppenish, WA 98948	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with diagnoses to include Parkinson's disease (a progressive brain disorder that affects movement and balance), anxiety (a mental health condition characterized by persistent and excessive worry, fear or panic difficult to control and interferes with daily life), muscle weakness, dysphagia (difficulty swallowing) and falls. The comprehensive assessment dated [DATE] showed Resident 3's cognition was moderately impaired and required substantial assistance with all care. During an observation and concurrent interview on 11/18/2025 at 8:51 AM, Resident 3 was up in their wheelchair, their arms and legs twitching (involuntary jerking movements) as they were attempting to brush their hair and beard. The resident's toothbrush was lying on the ground under their bed. Resident 3 stated they were attempting to brush their teeth but could not hold on to the toothbrush. During an interview on 11/18/2025 at 1:13 PM, Resident 3 stated they had not received oral care nor had they been offered oral care. Resident 3 stated they had retrieved an old toothbrush head to their electric toothbrush from their top drawer, the used toothbrush head was sitting on the resident's bedside table. Resident 3 stated they had not tried to use the used toothbrush head, they wanted to sanitize it first. During an interview and concurrent observation on 11/19/2025 at 1:38 PM, Resident 3 was sitting up in their electric wheelchair and stated they had not received oral care for the day, the resident had white matter in between their teeth. Resident 3 stated staff do not consistently set up their oral care supplies or offer to assist them. Resident 3 stated they attempted to use their electric brush and that it fell on the ground. The resident's black electric toothbrush was under their bed. Resident 3 stated they would need a new toothbrush head for their toothbrush. Resident 3 stated they used Listerine (a type of mouthwash) to try to keep my mouth clean and sterilized. Resident 3 had a used toothbrush head sitting in a cup of Listerine. The resident stated they had found an old toothbrush head in their drawer and were sterilizing the brush to use. During an interview on 11/20/2025 at 3:04 PM, Resident 3 stated they had not received oral care for the day. Resident 3 stated they had an appointment with the doctor and was embarrassed not having their teeth brushed before their appointment. Resident 3 had white matter buildup to the bottom gums and in between their teeth. During an interview on 11/20/2025 at 1:59 PM, Staff D, NA, stated they were assigned to Resident 3 and that they had assisted them out of bed for the day. Staff D stated they had assisted the resident with their breakfast meal, incontinent care, hair combing and grooming, turned on their phone, and assisted them into their wheelchair. Staff D stated that Resident 3 did not receive oral care during cares. Staff D stated Resident 3 went to therapy, they got busy and forgot. Resident 42 Review of the medical record showed Resident 42 was admitted to the facility on [DATE] with diagnoses including morbid obesity (being 100 pounds or more overweight), diabetes (chronic condition of excess sugar in the blood) and anxiety. The 09/26/2025 comprehensive assessment showed Resident 42 required the assistance of one to two staff members for ADLs and had an intact cognition. During an observation and concurrent interview on 11/17/2025, showed Resident 42 lying in their bed and their teeth were yellow. On the nightstand was a basin with an unopened toothbrush. Resident 42 stated they had not been offered the chance to brush their teeth more than once since they arrived at (continued on next page)		

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility. Resident 42 stated they did need assistance with set-up (obtaining the basin, toothbrush, toothpaste and water) for oral care. Resident 42 stated they would like to be able brush their teeth every day. An interview on 11/19/2025 at 4:28 PM, Resident 42 stated they still had not been offered assistance to brush their teeth. During an interview on 11/20/2025 at 1:20 PM, Staff H, NA, stated Resident 42 required assistance for oral care by sitting them up in their bed, obtain a basin, toothbrush and toothpaste and then Resident 42 could brush their teeth. Staff H stated they had not offered assistance for oral care for quite some time and were unsure how long it had been. Staff H stated work had been busy and they did not have time to provide the oral care as they should have. During an interview on 11/21/2025 at 10:45 AM, Staff B, Director of Nursing stated NA's were required to offer and perform oral care, including brushing teeth every day for Residents. Reference: WAC 388-97-1060(2)(c)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide respiratory care in accordance with accepted standards of practice, regarding a resident's continuous positive airway pressure (CPAP, a device that uses mild pressure to keep the airway open when asleep) machine for 1 of 2 residents (Resident 30) reviewed for respiratory care and treatment. This failure placed the resident at risk of respiratory status complications and unmet care needs. Findings included .Review of the facility's policy titled, CPAP/Bilevel Positive Airway Pressure (BiPAP, a device that is similar to CPAP to assist with breathing while sleeping), revised March 2015, showed that resident CPAP devices need to be cleaned along with the humidifier canister at least weekly, replacing of disposable filters monthly and daily cleaning of mask/tubing. The policy showed that CPAP documentation should be complete in the resident medical record including, the time/duration of CPAP when used, the mode for the resident's CPAP and how the resident tolerated the procedure. Resident 30Review of the medical record showed the resident was admitted to the facility originally on 03/01/2023 and readmitted on [DATE] with diagnoses of a stroke (when blood supply to the brain is blocked or reduced) and obstructive sleep apnea (a condition in which an individual has repeated interruptions in breathing stops and restarts while sleep). The 06/07/2025 comprehensive assessment showed the resident had intact cognition, able to make their needs known and had a non-invasive mechanical ventilator (a device, like a CPAP machine, that utilizes pressure to force air/oxygen into an individual's lungs, through a mask to assist with breathing) device. A concurrent observation and interview on 11/17/2025 at 12:31 PM showed Resident 30's CPAP device on their bedside table. The device's canister that holds distilled water (a specific type of water for the device that adds moisture to the air, to prevent dryness /irritation when being utilized) was empty. Resident 30 stated they were supposed to be using the CPAP device every night, but the facility staff were not filling up the canister anymore, and the resident could not use the CPAP device without moisture to the air because it irritated their mouth and nose. Resident stated they have not been able to use the CPAP device for months.Review of Resident 30's active physician's orders showed that on 07/09/2025 an order was placed to Encourage resident to place CPAP mask every night for bedtime. No other orders were active regarding Resident 30's CPAP device.During an interview on 11/19/2025 at 2:02 PM, Staff F, Registered Nurse (RN), stated the process for a resident's CPAP was for the night shift nurse to set up the device, make sure it had the distilled water and the correct setting for the resident. Staff F stated that the morning shift nurse would assist the resident with getting the CPAP mask off and cleaning the device/mask. Staff F stated that order would be in place to implement a resident CPAP, and they would follow what was in the orders. During an interview on 11/19/2025 at 3:27 PM, Staff O, RN stated they were the nurse taking care of Resident 30 that day. Staff O stated that Resident 30 should have their CPAP orders in the medical records but was unable to find them. Staff O stated Resident 30's CPAP orders were discontinued, .it was because (Resident 30) might have been refusing. Staff O stated they were unable to find documentation of Resident 30 refusing their CPAP machine. During an interview on 11/19/2025 at 4:09 PM, Staff L, Infection Control Nurse, stated they were also the case manager for Resident 30 and when reviewing the resident's medical record did not see the required orders for a resident that was on a CPAP device. Staff L stated they did not find any documentation of the resident's refusal to wear their CPAP device nor that nursing staff were cleaning or refilling the resident CPAP device. Staff L stated that Resident 30 should have orders for cleaning of the CPAP device/tubing/mask, refilling the distilled water, on/off times for the CPAP and the CPAP settings, but they were not in place. Staff L stated the correct process for Resident 30 respiratory care with the CPAP device was not followed.During an interview on 11/21/2025 at 11:31 AM, Staff B, Director of Nursing, stated that Resident 30 should have had the CPAP orders in place for specific CPAP settings, monitoring the resident while on CPAP, nursing staff change out of the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distilled water, cleaning of the CPAP device, and documentation of refusal, if the resident was refusing. Staff B stated the correct process for Resident 30's respiratory care with their CPAP was not followed.Reference: WAC 388-97-1060(3)(j)(vi)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a cognitively impaired resident representative (RR) was offered the pneumococcal immunizations (a vaccine that protects against pneumococcal infections that can lead to serious lung infections), given the opportunity with refusal or acceptance of the vaccine on behalf of the resident, nor receive education on the risk/benefits of the vaccine for 1 of 5 residents (Resident 61) reviewed for immunizations. This failure placed the resident at an increased risk for a contagious disease without the RR having the opportunity to make an informed decision in the refusal or acceptance of the pneumococcal vaccine. Findings included .Review of the facility's policy titled, Vaccination of Residents, adopted 01/30/2025, showed the facility would offer the pneumococcal vaccine to all residents within the facility, unless it was medically contraindicated or had already been vaccinated. The policy showed that residents or their legal representatives would be provided education regarding the benefits/potential side effect of the vaccinations and documented in the resident's medical record.Resident 61Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnosis including a stroke (when blood supply to the brain is blocked or reduced), dysphagia (difficulty swallowing) following the stroke, apraxia (the inability to perform purposeful movement or gestures leading to difficulties with things such as dressing and grooming), dementia (a loss of thinking, remembering, and reasoning skills) and mixed receptive (difficulty understanding spoken or written language)/expressive language disorder (affects the ability to express thoughts, ideas and feeling through speech and writing). The 10/27/2025 comprehensive assessment showed the resident had a severely impaired cognition, was not up to date on the pneumococcal vaccine and did not have a medical contraindication regarding the pneumococcal vaccine. Review Resident 61's legal guardianship (a legal process that allows a designated person to make decision for an adult that has lost the capacity to make the decisions independently) document, dated 10/17/2024, showed the RR was appointed as Resident 61's and would make decision on consenting to or refusing medical treatment on the resident's behalf. Review of Resident 61's immunization records showed no documented assessment or nursing progress note of the RR being offered the opportunity to decline or accept the pneumococcal vaccine nor that education regarding the benefits/potential side effect of the vaccination was provided to the RR. During an interview on 11/20/2025 at 11:52 AM, Staff B, Director of Nursing, stated they did not contact Resident 61's RR to offer the pneumococcal vaccine or educate the RR regarding the benefits/potential side effect of the vaccination. Staff B stated the correct process was not followed and since Resident 61 was unable to make care decisions they should have contacted the RR to offer the pneumococcal vaccine and documented their refusal or acceptance. Reference: WAC 388-97-1340(2)		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or their representative were offered/educated on the COVID-19 (an infectious disease causing respiratory illness with symptoms including cough, fever, new or worsening malaise, headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death) immunization (the action of taking a vaccine for a particular infectious disease) for 1 of 5 sampled residents (Resident 61) reviewed for immunization status. This failure placed the resident and/or their representative at risk of making an uninformed decision and resident contracting the COVID-19 virus. Findings included .Review of the facility's policy titled, Coronavirus Disease (COVID-19) - Vaccination of residents, adopted 01/30/2025, showed the facility would offer the COVID-19 vaccine to all residents within the facility, unless it was medically contraindicated or had already been fully vaccinated. The policy showed that residents or their legal representatives would be provided education regarding the benefits/potential side effect of the vaccinations and documented in the resident's medical record. Resident 61Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnosis including a stroke (when blood supply to the brain is blocked or reduced), dysphagia (difficulty swallowing) following the stroke, apraxia (the inability to perform purposeful movement or gestures leading to difficulties with things such as dressing and grooming), dementia (a loss of thinking, remembering, and reasoning skills) and mixed receptive (difficulty understanding spoken or written language)/expressive language disorder (affects the ability to express thoughts, ideas and feeling through speech and writing). The 10/27/2025 comprehensive assessment showed the resident had a severely impaired cognition and was not up to date on the COVID-19 vaccine. Review of Resident 61's immunization records showed no documented assessment or nursing progress note of the RR being offered the opportunity to decline or accept the COVID-19 vaccine nor that education regarding the benefits/potential side effect of the vaccination was provided to the RR.During an interview on 11/20/2025 at 11:52 AM, Staff B, Director of Nursing, stated they did not contact Resident 61's RR to offer the COVID-19 vaccine or educate the RR regarding the benefits/potential side effect of the vaccination. Staff B stated the correct process was not followed and since Resident 61 was unable to make care decisions they should have contacted the RR to offer the COVID-19 vaccine. Reference: WAC 388-97-1620(2)(b)(i)(ii)		