

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Rock Hill Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 James Street Bellingham, WA 98225	
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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review the facility failed to ensure the designated Infection Preventionist (IP) responsible for the facility's Infection Control Program met the education qualifications for certification prior to accepting the role as the IP in a long-term care facility. This failure placed residents at risk for not having an adequate oversight of infection control issues specific to long-term care. Findings included . Review of the undated facility policy titled, Infection Preventionist documented the IP had obtained specialized infection prevention control training beyond initial professional training or education prior to assume the role. In an interview on 05/28/2026 at 10:58 AM, Staff B, Director of Nursing Services, stated they were in charge of IP until they hired someone for that role. Staff B stated they did not have a copy of their IP certification but had completed it in 2022. Staff B stated no one else in the building had an IP certification. Staff B stated they sent an email to get a copy of their IP certification but had not heard back. No confirmation of IP certification was provided. Reference WAC: 388-97-1320(1)(a)		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the facility environment was clean, sanitary and orderly for 3 of 3 halls and rooms [ROOM NUMBER]. The facility failed to identify and provide the necessary maintenance and housekeeping in resident rooms and common areas. These failures placed residents at risk for decreased quality of life and potential infection control issues. Findings included. On 05/26/2026 at 9:44 AM, a privacy curtain was observed in room [ROOM NUMBER], located between the two beds, to contain yellowish and white matter on the middle of the curtain, consistent with the height of the bed. Red debris was noted on the flooring near the window which was sticky when stepped on. In an interview on 05/26/2026 at 9:44 AM, Resident 14 stated they did not have housekeeping services everyday. On 05/27/2026 at 8:48 AM, 05/28/2026 at 11:08 AM and 05/29/2026 at 3:30 PM, the shared bathroom between 136 and 135 were observed to have a dime sized piece of fecal matter on the rim of the toilet and smelled of urine/feces. On 05/28/2026 at 2:27 PM, the flooring throughout the hallways of the facility was observed to have various cracks, dried brown liquid and visible dirt between the door and frames, round brownish marks consistent with spills, and debris stuck to the flooring (easily removed with pressure and pushing with a shoe). On 05/28/2026 at 2:27 PM, an overbed table in room [ROOM NUMBER], the bottom portion/frame of the overbed table was observed to have debris and dried brown liquid on it. On 05/28/2026 at 2:50 PM, there were three long rectangular light fixtures observed in the main nurse's station ([NAME] Lane), to contain multiple debris in the light cover to include the outline of dead bugs. The hand sanitizer dispenser tray next to the nurse's station contained a dead bug and dust in a pool of hand sanitizer. On 05/29/2026 at 12:02 PM, the visitor's bathroom, located in the dining room, had cracked linoleum with large black spots under the flooring, and knicks and gouges in the flooring, tears and rips in the drywall around the door frame, and brown matter on the wall below the light switch. In an interview on 05/29/2026 at 11:18 AM Staff I, Housekeeper stated the housekeeper schedule was typically 6am to 2pm with one housekeeper that worked in the evenings, one to two times a week. Staff I stated there were two housekeepers working together unless there was a call out. Staff I stated they split the hallways and rooms up with the other housekeeper and duties included disinfecting high touch areas, sweeping and mopping floors, disinfecting toilets and taking out the trash. Staff I, when asked about cleaning overbed tables, stated they were to be wiped down completely to include the bottom frame. Staff I stated there was a daily cleaning checklist they used. Staff I stated deep cleaning for resident rooms only occurred when a resident moved or discharged . (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the daily cleaning checklist documented housekeepers were to check and fill soap and sanitizer dispensers, sweep and mop the bathrooms and clean the toilets, and empty garbage. There was no mention of how and when to clean the overbed tables. In an interview on 05/29/2026 at 11:35 AM Staff P, Maintenance Director, stated they had just taken over the housekeeping department, had not supervised housekeeping prior and had previously only been a maintenance director. Staff P stated they expected the housekeepers to clean, stock, move and clean under beds, wipe windowsills, toilets, and everything. Staff P stated the hand sanitizer dispensers were in the process of getting replaced, when they were shown the tray with the dead bug. When asked about scheduled deep cleaning rooms and privacy curtains, Staff P stated privacy curtains were cleaned when they were visibly soiled and deep cleaning was done daily on a rotation. Reference WAC 388-97-0880(1)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to have a system in place to ensure information was readily available and posted in prominent places for residents on how to file grievances or complaints for 1 of 1 resident groups and grievances were addressed and resolved in response to residents' concerns for 2 of 2 residents (Residents 7 and 47) who voiced grievances. These failures placed residents at risk of feeling frustrated, unimportant, with diminished self-worth and decreased quality of life. Findings Included . Review of the facility policy titled Grievances/Complaints Policy, revised 07/27/2022, documented residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (State Ombudsman). The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative. <RESIDENT 47> Resident 47 admitted on [DATE]. In an observation on 05/28/2026 at 2:09 PM, at the nurse's station, Staff G, Nurse's Aide Certified (NAC) was talking to Staff L, NAC and stated a resident (no name provided) was complaining about their food being cold. Staff G said Sorry [NAME], I just took it off the cart and that is just how it is. If you want your food hot, then you need to go to the dining room. Staff C, Social Worker, quickly turned to Staff G, NAC and asked when that happened. Staff G stated it was the night the resident had admitted . Staff G said, I told (resident) we can't just keep putting your food in the microwave. Staff G was asked who the resident was and Staff L responded it was the resident in room [ROOM NUMBER], (Resident 47). Staff C stated they were in the process of completing a grievance form for this. In an interview on 06/01/2026 at 12:29 PM, Staff A, Administrator, stated the process for grievances included attempting to resolve the concern immediately and completing the grievance form. Staff A stated they would reeducate the staff on the grievance process. They stated they were unaware residents and staff did not know the grievance process. Staff A stated a grievance should have been initiated for Resident 47 at the time they complained. <RESIDENT 7> Review of the grievance log dated December 2025 documented a grievance for Resident 7 dated 12/09/2025, they had never received valium (an anti-anxiety medication) prior to their dental appointment. The grievance was reported by an employee and assigned to social services for resolution. The grievance was documented to have been resolved on 12/11/2025. In an interview on 05/28/2026 at 9:30 AM Staff C, Social Services, stated they were unable to locate (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the grievance form with the resolution as described in the log. In an interview on 05/29/2026 at 9:34 AM, Resident 7 stated they had spoken to the prior social worker about the grievance. They said they were never provided the medication and were told the facility never received the prescription from the dentist's office. The resident stated their dentist was unhappy they did not receive the medication at the facility as they required additional numbing medication at the appointment. <RESIDENT COUNCIL> During Resident Council on 05/29/2026 at 2 PM, Residents 12, 19, 23, 30, and 33 (five of the six residents who attended) stated they were unaware of who the grievance official was or where they could locate a grievance form. Resident 12 stated when they have asked for a grievance form, they are told I'll fill it out for you. Resident 23 stated they believed the grievance official was the activities director. On 06/01/2026 at 12:28 PM, grievance forms were located at the time clock area, attached to the employee board. The facility cat litter box was located below the board, making the forms out of reach of residents. In continued observation of the facility a large, framed noticeboard was in the hallway near the nurses' station, partially concealed by a wall. The notice board contained large black and white print with contacts for the state agency and ombudsman. In additional observation a wooden grievance box was in the reception area, above wheelchair height and table was below it, obstructing access. The grievance box was locked and there was one blank grievance form folded into a square in the front pocket of the box. In an interview on 06/01/2026 at 12:56 PM Staff C, stated they were the grievance official. Staff C stated when grievances were initiated, the completed form would be sent to them, and they would attempt to resolve the grievance immediately or if they were more complex, they would be forwarded to department heads to resolve. Staff C stated residents were informed of the grievance process at admission and they also let them know. Staff C stated if a resident had a complaint the staff would provide the form to the residents to fill out or assist if needed. Staff C stated they did not have the key to the grievance box located in the receptionist area and were not sure when it was last checked. Staff C stated the only other place a resident could locate a grievance form was at the time clock area. Reference: (WAC) 388-97-0460		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance with bathing for 4 of 5 residents (Residents 3, 5, 7 and 50) reviewed who were unable to carry out their ADL's (activities of daily living) independently. Failure to provide bathing assistance according to the resident's needs and preferences placed the residents and others at risk for poor hygiene, diminished dignity and diminished quality of life. Findings included .Review of the undated facility's policy titled, Shower/Tub Bath, showed the purpose of the procedure was to promote cleanliness, promote comfort and to observe the condition of the resident's skin. The procedure directed qualified nursing staff to provide a bed bath to the residents as needed. At a minimum of at least two full baths or showers a week. The documentation was to include the date and time the shower or tub bath was performed and if the resident had refused, include the reason. The licensed nurse was to be notified of refusals. <RESIDENT 3> Resident 3 admitted on [DATE] following a stroke which resulted in paralysis of the right side of the body and speech deficits. Review of the admission Minimum Data Set (MDS) (a required assessment tool) dated 02/09/2026 documented Resident 3 required extensive assistance for bathing. Review of Resident 3's care plan related to bathing documented substantial/maximum assistance was required and did not include resident bathing preferences. In an interview on 05/26/2026 at 12:08 PM, Resident 3 stated they were not receiving showers as scheduled. Resident 3 stated they were supposed to have showers on Mondays and Thursdays which was not happening. In a follow-up interview on 05/28/2026 at 11:29 AM, Resident 3 stated they had not been asked regarding their preferences for bathing. Resident 3 stated they were told the schedule was twice a week, but they were not getting showers at all for a while and now they only got one a week. Resident 3 stated the wash up was not a real bath but the staff tried to say it was. Resident 3 stated they were supposed to have a shower today (Thursday) but nobody had come yet and they would have come by now if they were going to. Review of Resident 3's bathing documentation showed Resident 3 was scheduled for eight showers on Mondays and Thursdays in the Month of May 2026 and was documented as receiving four showers and two bed baths. There were no refusals documented. Review of prior months of bathing documentation revealed Resident 3 was scheduled for eight showers in the month of April 2026 and received only one. The April 2026 documentation contained several documentations of N/A (not applicable) with no further explanations. Resident 3 was not charted as having any refusals of bathing. Review of documentation for March 2026 and February 2026 revealed no documentation. The requested reports pulled up showed no data available. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/01/2026 at 8:45 AM, Staff H, Nursing Assistant, Shower Aide, stated Resident 3 was supposed to get two showers per week and there should not be any documentation that says N/A, That is wrong. Staff H stated they were sometimes pulled from shower duties to work on the floor and the floor staff should attempt showers and should be documenting yes, no, or refused, and then offer again later that shift, or try the next day. Staff H stated Resident 3 sometimes only wanted a sponge bath or could refuse which was their right. Staff H stated this should be reflected in the documentation, though, showing attempts and refusals if they had occurred. <RESIDENT 5> Resident 5 readmitted to the facility on [DATE] with diagnoses to include cerebral infarction with hemiplegia (paralysis on one side of body) and hemiparesis (weakness on one side of body), dementia and multiple sclerosis (a disorder where the immune system is impaired and signals are misinterpreted between the brain, spinal cord and rest of the body). Review of the quarterly MDS dated [DATE] showed the resident had cognitive impairment, upper and lower extremity impairment on one side and required extensive assistance for bathing. Review of the Kardex (guide to show nurses aides how to care for resident) did not include how the staff were to provide grooming assistance or bathing. Resident 5's bathing preference was not included. Review of Resident 5's April bathing documentation on the documentation survey report showed Resident 5 wanted two showers a week on Tuesdays and Saturdays. Resident 5 received showers on six rather than eight days (04/07/2026, 04/09/2026, 04/14/2026, 04/18/2026 04/21/2026 and 04/29/2026). <RESIDENT 7> Resident 7 admitted to the facility on [DATE] with diagnoses to include depression, low back pain, muscle wasting, atrophy and muscle weakness. Review of the quarterly MDS dated [DATE] showed Resident 7 had no cognitive impairment, required moderate assistance for bathing and did not refuse care. Review of the Kardex directed staff to provide moderate assistance with bathing. Resident 7's bathing preference was not included. The Kardex did not include that Resident 7 experienced nightmares related to being stuck in a bathtub for multiple days prior to admit which resulted in PTSD. Review of Resident 7's April bathing documentation on the documentation survey report showed Resident 7 wanted three showers a week on Mondays, Wednesday and Fridays. Resident 7 received showers on six rather than eleven days (04/09/2026, 04/13/2026, 04/16/2026, 04/23/2026, 04/27/2026 and 04/30/2026). Review of Resident 7's May bathing documentation on the documentation survey report showed they (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received showers on eight rather than thirteen days (05/04/2026, 05/07/2026, 05/14/2026, 05/18/2026, 05/20/2026, 05/21/2026, 05/25/2026 and 05/28/2026). In an interview and observation on 06/01/2026 at 10:00 AM, Resident 7 was sitting on the edge of their bed with greasy and uncombed hair and body odor noted. They stated they were not getting showers as often as they liked. <RESIDENT 50> Resident 50 admitted to the facility on [DATE] with diagnoses to include depression, heart failure and muscle weakness. Review of the admission MDS dated [DATE] showed Resident 50 had cognitive impairment, required moderate assistance for bathing and did not refuse care. Review of the Kardex directed staff to provide moderate assistance with bathing. Resident 50's bathing preference was not included. Review of Resident 7's May bathing documentation on the documentation survey report showed they received one shower 13 days after admit on 05/25/2026. In an interview on 05/29/2026 at 1:24 PM, Staff L, NAC stated the shower aide had been pulled to work the floor rather than bathing duties quite a bit since the new company took over. Staff L stated they had heard residents complain about not getting their showers. In an interview on 05/29/2026 at 2:32 PM, Staff D, Registered Nurse/ Resident Care Manager reviewed shower documentation of Resident's 5, 7 and 50. Staff D stated Resident 50 refused some showers and they would document that in their progress notes. Staff D stated Resident 50 had not and would not refuse their showers. Staff D stated the expectation is the resident would be offered a shower the next day after refusals. They stated the NAC's and nurses needed to document refusals. In an interview on 06/01/2026 at 8:41 AM, Staff H, shower aide stated they are pulled from their duties to work the floor once a week. Staff H confirmed Resident 50 had one shower in May. They stated Resident 5 accepted showers. They stated when they are pulled from their duties the PM shift aides were supposed to complete one shower. Staff H stated Staff D gave them a missed shower list when they work Monday through Thursday. They stated refusals were to be reattempted three times and documented when they occur. In an interview on 06/01/2026 at 12:25 PM, Staff B, Director of Nursing was asked about missed showers for Resident's 3, 5, 7, and 50. Staff B stated the nurses were to document refusals. They stated they would be adding reviews of missed showers to their clinical meeting. Staff A, Administrator stated they would be adding a performance improvement plan for those who missed documentation. No additional information given (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1060 (2) (c)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a system to evaluate staff competencies in skills and techniques to ensure staff provided necessary care and responded to each resident's individualized needs for 3 of 5 certified nursing assistants (CNA) (Staff G, U and V) reviewed for nursing services. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, unmet care needs, and diminished quality of life. Findings included . Review of the facility assessment dated [DATE] documented Certified Nursing Assistants participated in annual skills assessments and were assessed annually for care competencies by qualified nurses in addition to training during all staff in-services. Review of the facility staff roster documented Staff V, CNA, was an agency aide that was used by the facility and was hired on 10/01/2025. Staff V's competencies checks, training and education were requested on 05/27/2026. There were no competencies, training, or education for Staff V provided by the facility. Review of the facility staff roster documented Staff U, CNA, was hired on 04/02/2024. Review of the competencies provided by the facility documented their last competency evaluation was completed on 04/30/2025. Review of the facility staff roster documented Staff G, CNA, was hired on 05/02/2024. Review of the competencies provided by the facility documented their last competency evaluation was completed on 05/06/2025. In an interview on 05/28/2026 at 10:37 AM Staff E, Business Office Manager/Human Resources, stated they were unable to provide proof of education and training for Staff G, U, and V as the facility recently went through a change of ownership and the proof of education and training were in electronic files that could no longer be accessed. Staff E stated the prior staff development coordinator had completed competencies for staff prior to them leaving. In an interview on 06/01/2026 at 10:20 AM Staff B, Director of Nursing Services, was unaware competencies were not completed and electronic access to staff education had been removed. Reference: WAC 388-97-1080(1), 1090(1)		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 6 of 7 sampled staff (Staff B, G, H, T, U and W) reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or underqualified care staff, and diminished quality of life. Findings included . Review of the facility staff list documented: Staff B, Director of Nursing Services, was hired 04/25/2025, Staff G, Certified Nursing Assistant (CNA) was hired 05/02/2025, Staff H, CNA, were hired 06/19/2024, Staff T, CNA, were hired 10/15/2018, Staff U, CNA were hired 04/02/2024, and Staff W, Physical Therapist Assistant, was hired 03/03/2016. The most recent performance evaluations for Staff B, G, H, T, U, and W were requested on 05/27/2026 and none were provided. In an interview on 05/28/2026 at 10:37 AM Staff E, Business Office Manager/Human Resources, stated they were unable to provide proof of performance evaluations for Staff B, G, H, T, U and W, as the facility recently went through a change of ownership and the proof of performance evaluations were in electronic files that could no longer be accessed. This is a repeat deficiency from SOD dated 05/01/2025. Reference: WAC 388-97-1680(1), (2)(a-c)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to dispose of expired medications in 2 of 2 medication rooms (Forest and Artist Medication Rooms), failed to properly label and discard open vials of Tuberculosis solution (TB solution - used to test for persons with possible Tuberculosis - an infectious respiratory disease), and failed to correctly monitor temperatures of vaccines in 1 of 2 medication refrigerators (Forest Medication Room). These failures placed residents at risk of receiving compromised or ineffective medications. Findings included . Review of the undated facility policy titled, Medication Storage, documented that the facility shall not use outdated drugs or biologicals. Review of the Center for Disease Control (CDC) guidelines titled, Vaccine Storage and Handling, dated 03/29/2024, documented to check and record temperatures with the minimum and maximum temperatures at the start of each workday. If the temperature monitoring device does not read minimum/maximum temperatures, then you are to check and record the current temperature a minimum of two times per workday. <ARTIST MEDICATION ROOM> In an observation on 05/27/2026, at 1:52 PM, with Staff O, Licensed Practical Nurse (LPN), the Artist Medication room contained probiotics that were in the medication refrigerator with an expiration date of 04/2026 and multiple individual packets of white petroleum in the cupboard with an expiration date of 11/2025. The medication refrigerator had no vaccines observed. In an interview on 05/27/2026 at 1:56 PM, Staff O confirmed the expiration dates on the probiotics and white petroleum. Staff O took the medications from the medication room and stated they would dispose of them. Staff O stated they only keep vaccines in the Forest Medication Room. <FOREST MEDICATION ROOM> In an observation on 05/27/2026, at 2:21 PM, with Staff D, Registered Nurse/Resident Care Manager, the Forest Medication room contained probiotics that were in the medication refrigerator with an expiration date of 04/2026 and another bottle of probiotics in the cupboard with an expiration date of 04/2026. The medication refrigerator had two bottles of TB solution with a label that documented good for 30 days after open. No open date was observed. The medication refrigerator did contain influenza vaccines. Review of the medication refrigerator temperature logs on 05/27/2026, at 2:30 PM, documented checking both refrigerator temperatures only daily. The temperature log had four missing temperatures in January 2026 for both medication refrigerators, one missing temperature for both medication refrigerators in February 2026, one missing temperature for both medication refrigerators in March 2026, four missing temperatures for both medication refrigerators in April 2026, and one (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing temperature for medication refrigerators in May 2026 as of 05/27/2026. In an interview on 05/27/2026, at 2:34 PM, Staff D stated the probiotics did not need to be in the refrigerator and confirmed the expiration dates. Staff D took the medications from the medication room and stated they would dispose of them. Staff D confirmed there was no open date on the TB solution and stated they should be dated when opened. Staff D stated night shift checked both medication room refrigerators temperature once a day. Staff D stated they were unaware of the CDC guidelines to check the temperatures twice daily for vaccines. In an interview on 05/28/2026, at 10:58 AM, Staff B, Director of Nursing Services/Infection Preventionist, stated they were unaware of the vaccine temperature guidelines for checking temperatures twice daily. Staff B stated their expectation for the medication rooms was that expired medications were to be discarded and TB solution be dated when opened. Reference WAC: 388-97-1300(2)		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to ensure there was not greater than 14 hours between the evening meal and breakfast in the main resident dining room without the approval of the resident group and with the provision of a substantial evening snack. This had the potential to affect all residents who received their meals in the main dining room and impact resident quality of life. Findings included . Review of the facility's mealtime schedule documented the main dining room was served dinner at 5:30 PM and served breakfast at 8:00 AM, which was greater than 14 hours. In an interview on 05/28/2026 at 12:54 PM, Staff K, Dietary Manager, stated they had adjusted times and thought they were within the 14 hours. Staff K stated nursing assistants offered snacks in the evening as residents requested, but there was not a specific routine snack provided in the evening. Staff K stated the facility had started a food committee and they attended resident council but confirmed that the time frames for meal service had not been discussed as they were not aware there was an issue. In an interview on 05/29/2026 at 10:45 AM, Staff A, Administrator, confirmed the posted dining room times were accurate and stated they had not recognized the mealtimes for the main dining room exceeded 14 hours. Staff A confirmed there had been no approval by the resident group or a substantial evening snack provided. In a resident group interview on 05/29/2026 at 2:00 PM, the resident council confirmed there had been no approval by the group for meal service between dinner and breakfast to exceed 14 hours. Refer to WAC 388-97-1120 (1)(3)(a)(b)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure dishwashing temperatures met the requirements in the facility kitchen. Failing to ensure proper dish sanitation placed residents at risk for food borne illness. Findings included . Review of the Washington State Retail Food code (dated March 1, 2022) stated high temperature dishwashers required wash cycle temperatures of 150 degrees Fahrenheit (f) and rinse cycle temperatures of 180 degrees f. In an observation and interview on 05/28/2026 at 11:51 AM, Staff K, Dietary Manager, stated the facility utilized a high temperature dishwasher which was being leased. A High Temperature Dish Machine Log, dated May 2026, specified a wash cycle of 150-165 degrees f and a rinse cycle greater than or equal to 180 degrees f. There were columns for temperature entries three times per day. There were observed to be 18 entries logged where the dishwasher had not met the minimum wash cycle temperature of 150 degrees f and three instances it had not met the minimum rinse cycle temperature of 180 degrees f. Staff K stated the company they leased the dishwasher from, reported the machine was functioning properly and was getting up to temperature. Staff K stated they were told their dial was reading about 5 degrees off and they had instructed the dietary staff to continue to write down exactly what the dial read. Staff K stated they had been told by the company the machine was functioning, so they were not concerned. Staff K stated they would provide the most recent maintenance notes from the company. Record review of the provided dishwasher service note on 05/28/2026 revealed the date of the most recent service was March 2026 and did not include notes regarding low temperature readings at the facility or inaccurate dial readings at the time of the service visit. In an interview on 05/29/2026 at 10:47 AM, Staff A, Administrator, stated they were not aware of the low dishwasher temperatures. They stated it was a leased machine and if the dishwasher dial was not reading correctly and if the temperatures were not reaching the minimum temperatures, the company needed to be contacted for repairs and come repair it. Refer to WAC 388-97-1100 (3)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure a system was in place in which residents' records were complete, accurate, accessible, and systematically organized for 6 of 6 residents (Resident's 4, 17, 23, 30, 44, and 50) reviewed for accurate and complete medical records. The facility failed to ensure the medical records reflected weight and sleep monitoring and alert charting after an allegation for Resident 50 and a discharge note for Resident 4. Further, Residents 4 and 23 had other resident records in their medical record. The failure to maintain complete and accurate medical records placed residents at risk for medical complications, unmet care needs, and diminished quality of life. Findings included . Review of the facility policy titled, Release of Medical Records, revised 08/05/2022 showed Medical Records are a collection of documents prepared and maintained during a resident's stay in the facility that records the clinical/medical care of the resident. These documents can be written or electronic information and include progress notes, physician orders, nursing notes, consultations, laboratory, diagnostic reports, and plans of care. <RESIDENT 50> In an observation and interview on 05/26/2026 at 12:27 PM Resident 50 was in bed with only a top sheet on them. The resident's blanket was noted to be on the floor. The resident was asked if staff treated them with dignity and respect. The resident stated that everybody was nice, but this one b**ch, she was just nasty, she works in the evenings. You do it her way or no way. I have told them (staff) about her. The resident said they had to holler for staff when they were cold and their blanket was on the floor. They also stated they had waited 3 to 4 hours for their call light to be answered. Review of a progress note on 05/27/2026 at 4:16 PM showed one entry from Staff A, Administrator that showed Resident 50 had made a statement to Surveyor that they had to wait 2 hours for their call light to be answered. The progress note did not include information about the concern with a staff member. Review of Resident 50's progress notes showed the resident was not placed on alert for monitoring every shift for 3 days to assess for any psychosocial distress after their allegation on 05/26/2026. There were no other progress notes about the allegation. Review of Resident 50's May Medication Administration Record (MAR) showed missing documentation of daily weights on 05/18/2026 and 05/23/2026. The sleep monitor was set up for a check mark as task completed rather than the number of hours. This resulted in no monitoring of sleep for nursing to evaluate the sleep pattern. <RESIDENT 44> Review of Resident 44's electronic health record (EHR) documented they discharged with their family to a facility in Michigan on 04/03/2026. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 44's progress from 04/01/2026 through 4/03/2026 provided no information regarding their discharge. In an interview on 05/27/2026 at 10:38 AM Staff D, Registered Nurse/Resident Care Manager (RCM), stated the RCM's had taken over the discharge process to include completing assessments and faxing to the pharmacy. When asked if a progress note is completed when a resident was discharged , Staff D stated there should be a note. Staff D stated they must have forgotten to complete a discharge note for Resident 44. <RESIDENT 4> Review of Resident 4's EHR under miscellaneous records, contained a hospice note which belonged to Resident 17. In an interview on 05/29/2026 at 1:02 PM Staff D, stated medical records were responsible for uploading documents into the medical records of residents. <RESIDENT 23> Review of Resident 23's EHR, under miscellaneous records, contained a pharmacy recommendation which belonged to Resident 30. In an interview on 06/01/2026 at 12:25 PM, Staff A, Administrator stated they were going to add a performance improvement plan (PIP) on charting. Staff A was asked about lack of discharge note for Resident 4 and missed daily weights, hours of sleep and alert charting for Resident 50. They were unaware that Resident 4 and Resident 23 had other resident records scanned into their record. Staff A stated they were not sure why the staff were not charting. Staff A stated they were going to review charting while they were at home before bed and follow up with staff accordingly. Staff A stated the resident care managers and Director of Nursing Services (DNS) were to audit daily. Staff A stated they would no longer give verbal warnings; there would be a written warning for failure to document. They stated they would discuss the issues with medical records and have them do an audit of charts. They stated Staff B, DNS just started using the missed documentation audit in the EHR and they should be doing standard audits. No additional information was provided. This is a repeat deficiency from SOD dated 05/01/2025 Refer to WAC 388-97- 1720 (1)(a)(i-iv)(b)		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility failed to ensure 5 of 5 nurse aides (Staff G, H, T, U, and V) had their required 12 hours of in-service training. The failure to ensure Nursing Assistants Certified (NACs) received 12 hours per year in-service training placed residents at risk of less than competent care and services from staff. Findings included .Review of the facility staff roster documented: Staff G, CNA, was hired 05/02/2025, Staff H, CNA, were hired 06/19/2024, Staff T, CNA, were hired 10/15/2018, Staff U, CNA, was hired on 04/02/2024, and Staff V, CNA, was an agency aide that was used by the facility and was hired on 10/01/2025. Staff G, H, T, U, and V's, required 12 hours of in-service training were requested on 05/27/2026, none were provided by the facility or staff. In an interview on 05/28/2026 at 10:37 AM Staff E, Business Office Manager/Human Resources, stated they were unable to provide proof of education and training for the Staff G, H, T, U, and V, as the facility recently went through a change of ownership and the proof of education and training were in electronic files that could no longer be accessed. Staff E stated the prior staff development coordinator had completed competencies for staff prior to them leaving. In an interview on 06/01/2026 at 10:20 AM Staff B, Director of Nursing Services, was unaware required education were not completed and electronic access to staff education had been removed. Reference WAC 388-97-1680(2)(a-c)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address the required documentation for advance directives (AD) for 3 of 6 residents (Residents 4, 7 and 8) reviewed for advance directives. This failure placed residents at risk for not having their preferences and decisions honored for end-of-life care. Findings included . The undated facility Advance Directives policy defined an Advance Directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under state law, relating to provision of health care when the individual is incapacitated. The policy directs staff upon admission to provide with written instruction information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if he or she chooses to do so. The policy documented that prior to admission or upon admission of a resident, the Social Services Director or designee will inquire about the resident or his/her family member and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. If the resident indicated that he or she has not established an AD, the facility staff will offer assistance in establishing one. Nursing staff will document in the medical records the offer to assist and the resident's decision to accept or decline assistance. <RESIDENT 7> Resident 7 was admitted to the facility on [DATE]. Review of the facility advance directives tab showed Resident 7 had a Physician Orders for Life-Sustaining Treatment (POLST,) a medical order from a physician, nurse practitioner or physician's assistant or other health professional with instructions that complement an advanced directive developed on 08/13/2025 in place but no AD. The residents POLST showed they did not want resuscitation attempted and chose comfort-focused treatment. The POLST does not take the place of an Advance Directive or replace the need for or the importance of a durable power of attorney for healthcare. Review of the progress notes since admission showed no discussion of AD with Resident 7 however provider progress notes on 03/21/2026 at 10:24 AM and 04/16/2026 at 4:21 PM showed the resident did not have an advanced directive and directed the facility to provide discussion and counseling on advanced directives. In an interview on 05/26/2026 at 1:03 PM, Resident 7 stated that they did not have an advanced directive and had not been offered assistance to formulate one. <RESIDENT 8> (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 8 admitted to the facility on [DATE] on Hospice (specialized care for people with terminal illnesses) with diagnoses to include cerebrovascular disease (any condition that affects the blood vessels and blood flow in the brain), dementia (loss of memory, language, problem-solving, and other thinking abilities) and chronic kidney disease. Review of Resident 8's admission MDS dated [DATE], documented that the resident had severe cognitive impairment. Review of Resident 8's quarterly Minimum Data Set assessment, dated 05/05/2026, documented that the resident is rarely/never understood and is severely impaired for cognitive skills for daily decision making. Review of Resident 8's electronic health record (EMR) documented a power of attorney (POA - a legal document that names someone to make decisions on your behalf when you are unable to) who had been making decisions for Resident 8 since their admission to the facility. Resident 8's EMR did not have a copy of the legal POA paperwork. In an interview on 06/01/2026, at 8:51 AM, Staff C, Social Services Director, stated they were unable to find Resident 8's POA paperwork in the EMR. At 11:36 AM Staff C stated the paperwork may have been lost during the transition of the new company and that they did not have Resident 8's POA paperwork on file. <RESIDENT 4> Resident 4 admitted to the facility on [DATE] with diagnoses to include left leg fracture and post-traumatic stress disorder. Review of Resident 4's EMR dated 12/05/2025 though 05/26/2026 showed no documented instances where they were notified verbally or in writing of their right to formulate an AD, types of AD's available to them, or how to formulate one. In a review of Resident 4's admission agreement signed 11/28/2025 showed no documentation that AD's were discussed or reviewed with them. In an interview on 05/28/2026 at 10:15 AM Staff R, Admissions, stated they were recently hired in March 2026, and they stated there was a process in place to provide and review AD information to residents in writing and verbally. Staff R stated when AD's options were reviewed and discussed with the residents they would place the information in their electronic health record. In an interview on 06/01/2025 at 12:25 PM, Staff A, Administrator, stated they had not located the advanced directives for resident's 2, 4, 7, or 8. Staff A stated the expectation was advanced directives would be offered to each resident and if they did not have one and that there should be documentation on this. Reference: (WAC) 388-97-0300 (3)(b-c)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to provide 2 of 3 residents (Residents 38 and 51) required notices regarding anticipated Medicare non-coverage. The facility failed to provide a Notice of Medicare Non-Coverage (NOMNC) for Resident 51. Additionally, the facility failed to provide Resident 38 a Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN), which informs the beneficiary about potential non-coverage and the option to continue services by accepting the cost of continuing the services. These failures had the potential to impact residents and their representative's ability to decide if they wish to continue receiving the skilled services that may not be paid for by Medicare, assume financial responsibility or exercise their right to an appeal. Findings Included .Review of SNF (Skilled Nursing Facility) Beneficiary Review form provided by the facility documented Resident 51 started to receive Medicare skilled services on 11/29/2025 which ended on 12/04/2025. The form documented both a NOMNC nor SNFABN were provided to Resident 51. Review of the SNF (Skilled Nursing Facility) Beneficiary Review form provided by the facility documented Resident 38 started to receive Medicare skilled services on 09/03/2025 which ended on 09/18/2025. The form documented a SNFABN form was not provided to Resident 38. In an interview on 05/26/2026 at 1:47 PM Staff C, Social Services Director, stated Resident 51 and 38 should have received an SNFABN to explain potential costs of their care. Staff C stated they were unable to locate a NOMNC for Resident 51 or documentation that one was provided to them. Reference WAC 388-97-0300(1)(e),(5),(6)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 5 sampled residents (Residents 8 and 23) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to obtain consent, monitor and document behaviors and symptoms, failed to attempt and document non-pharmacological interventions prior to administration and demonstrate adequate indication of use of medications. These failures placed the residents at risk for medication-related complications such as drowsiness, withdrawal from activities and socialization, movement disorders, falls with injury, stroke, and increased risk of death, for receiving unnecessary psychotropic medication. Findings included . As referenced in the Food and Drug Administration (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective. They commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Black Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. Review of the undated facility policy titled, Antipsychotic Medication Use, documented that antipsychotic medications are only to be used when necessary to treat specific conditions for which they are indicated. The policy documented that antipsychotic medications will not be used unless behavioral symptoms are not sufficiently relieved by non-pharmacological interventions or not due to psychological stressors (such as loneliness). <RESIDENT 8> Resident 8 admitted to the facility on [DATE] on Hospice (specialized care for people with terminal illnesses) with diagnoses to include cerebrovascular disease (any condition that affects the blood vessels and blood flow in the brain), dementia (loss of memory, language, problem-solving, and other thinking abilities) and chronic kidney disease. Review of Resident 8's quarterly Minimum Data Set (MDS) assessment dated [DATE], documented the resident had no hallucinations or delusions. Resident 8 had physical symptoms (i.e. hitting, kicking, pushing, etc.) directed towards others occurred one to three days in the seven-day lookback period. The MDS documented conflicting information about the impact and risks to the resident and others. Review of Resident 8's physician orders, dated 02/13/2026, documented Hospice ordered an as needed antipsychotic gel (CMPD ABHR (a compounded topical medication prescribed to manage severe nausea, vomiting, and sometimes anxiety or agitation) topical compounded gel, which included 1 milligram (mg) of Lorazepam (a fast acting anti-anxiety medication that slows down your nervous (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	system), 25mg Benadryl (an antihistamine with known sedative effects and contraindicated in the elderly) and 1 mg Haldol (a first generation antipsychotic medication with increased side effects vs second generation, used for schizophrenia and delirium) to start if resident was refusing oral medications and to apply topically as needed for anxiety, restlessness, or agitation. Applying a topical antipsychotic when the resident refused their oral medications removed the residents right to refuse. Review of Resident 8's electronic health record (EHR) documented consent was not obtained for the antipsychotic gel until 03/02/2026 by Resident 8's power of attorney (POA - a legal document that gives someone the authority to make decisions for you when needed). The POA documentation was not found in Resident 8's EHR. Review of Resident 8's February 2026 MAR documented that the as needed antipsychotic gel was administered on 02/27/2026 and 02/28/2026. Non-pharmacological interventions in the February 2026 MAR documented to offer coffee, sit and talk, or take for a walk as needed. Nursing staff were to document interventions prior to administration and document the effectiveness. No non-pharmacological interventions were attempted as documented in February 2026. Review of Resident 8's March and April 2026 MAR documented the as needed antipsychotic gel was administered nine times in March and four times in April. Non-pharmacological interventions in the March and April 2026 MAR documented to offer coffee, sit and talk, or take for a walk as needed. Nursing staff were to document interventions prior to administration and document the effectiveness. No non-pharmacological interventions were attempted as documented in March and April 2026. Review of Resident 8's care plan, dated 04/18/2026, documented antipsychotic use for Quetiapine (an antipsychotic medication) and an antipsychotic gel. The care plan directed use of non-pharmacological interventions before administering anti-psychotic medications and to document for behaviors related to anxiety, restlessness, and agitation. Review of Resident 8's quarterly MDS dated [DATE], documented that the resident had no hallucinations or delusions. Resident 8 had physical symptoms directed towards others that occurred one to three days in the lookback period and had no impact on the resident or on others. The MDS documented no behaviors associated with rejecting care or wandering. They had a change in behavior and their symptoms had worsened. Review of Resident 8's May 2026 MAR documented the as needed antipsychotic gel was administered 11 times. Non-pharmacological interventions directed nursing staff to reposition, massage, involve in an activity, provide a quiet setting, relaxation techniques, music, remove from area, distraction, toilet, ambulate, provide food/drink, education, one on one, or other (other was not defined) as needed before administration of the as needed medication. Nursing staff were to document interventions prior to administration and to document the effectiveness. No non-pharmacological interventions were documented in May 2026. Beginning 05/01/2026, a behavior monitor was implemented specifically for the use of the antipsychotics. The monitor directed nursing staff to document times the behavior (hallucinations, delusions and verbal aggression) occurred per shift however the behavior monitor was set up to document a check mark, and nursing staff initials rather than a number. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rock Hill Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 James Street Bellingham, WA 98225	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a progress note on 05/03/2026 at 11:02 AM showed Resident 8 was on 15-minute checks, and while checked on in the dining room at 10:45 AM, they were found leaning to the right with both arms hanging down. The resident was hard to arouse, and required a sternal rub (applying firm, grinding pressure to see if unconscious person is responsive, commonly used in drug overdoses). The resident became alert when the blood pressure cuff was being inflated. Review of a progress note on 05/04/2026 at 3:20 PM, Staff C, Social Services documented Resident 8 had severe cognitive impairment, was currently taking 6 psychoactive medications and had an increase of wandering and grabbing staff and peers. Review of a progress note on 05/21/2026 at 3:57 PM documented Resident 8 was very drowsy and had a hard time opening their eyes when calling their name. The nurse held their 2:00 PM medications as they were not safe to administer in their drowsy condition. In observation on 05/26/2026 at 2:11 PM, Resident 8 was sitting with nurse at the medication cart. In observations on 05/28/2026 at 10:31 AM Resident 8 was opening the door and attempting to enter the beauty shop. At 11:06 AM, Resident 8 was going into another resident's room (113). Staff Y, Activity Director went to get the resident and redirect them. At 11:09 AM, they were sitting and grabbing at the nurse. In an interview on 05/28/2026 at 1:14 PM, Staff Z, Registered Nurse stated Resident 8 took all their medications yesterday and this morning, and they were feisty. Staff Z stated the provider just adjusted some of their headache medications and also increased their anti-psychotic medication Quetiapine. They stated that on Sunday, it was very hard to give Resident 8 their medication and today they accepted no medications. Staff Z stated it was hard to get them to take the Carbamazepine (seizure medication) since it was increased to 300 mg and it was a large amount. Staff Z stated they applied the ABH gel today and would reapproach giving the pills after lunch. In observations on 05/28/2026 at 3:24 PM, Resident 8 was trying to get into the therapy office and another resident was helping to redirect them back to the hallway then they started to propel themselves down the hallway back to Artist lane. At 3:28 PM, Resident 8 was self-propelling and opened the door to the outside courtyard with no staff present. Minutes later Staff E was walking by and told them they could not go out there. In observations on 05/29/2026 at 9:56 AM, Resident 8 was still in bed asleep. They woke briefly at 10:17 AM then were back asleep at 10:27 AM. At 2:00 PM, they were trying to get into the utility room. In an observation on 05/29/2026 at 3:59 PM, Resident 8 self-propelled their wheelchair into a new admit in their wheelchair who had just arrived and then ran into this surveyor then used the medication cart drawer handle to propel themselves down the hall. Staff J, Staffing Coordinator tried intervening but did not prevent the unwanted touching. Review of a revised Pre-admission Screening and Resident Review (PASRR- assessment/federal requirement for Medicaid-certified nursing facilities to ensure individuals, especially those with (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental illness, seeking admission are appropriately placed and receive necessary services) for Resident 8 on 05/29/2026 showed the resident experienced mood disorder including depression and anxiety with no psychosis (delusions or hallucinations). Staff C, Social Services documented the resident was currently taking psychotropic medications Citalopram (antidepressant), ABH (Ativan (antianxiety), Benadryl and Haldol (anti-psychotic) gel, Lorazepam (anti-anxiety), Clonazepam (anti-anxiety) and Quetiapine (anti-psychotic). In an interview on 06/01/2026 at 10:10 AM, Staff B, Director of Nursing Services (DNS) stated consent for the use of psychotropic medications should be obtained before administering the medication. Staff B stated that non-pharmacological interventions should be followed before administration of an as needed antipsychotic medication and documented. In observations on 06/01/2026 at 10:40 AM Resident 8 was asleep in the hallway. At 12:47 PM they were in bed asleep and did not eat lunch. <RESIDENT 23> Resident 23 was admitted to the facility on [DATE] with diagnoses to include anxiety disorder, unspecified depression, and pseudobulbar affect (PSA-neurological condition characterized by involuntary, sudden, and frequent episodes of laughing or crying that do not match a person's actual mood or the situation). In a review of Resident 23's Annual Care Area Assessment (CAA-tool used to develop individualized care plans) dated 09/23/2025 documented they were prescribed Abilify for depression, their behaviors were such that a gradual dose reduction was not warranted, with the goal for their behaviors to improve and to have no side effects. In a review of Resident 23's medication order summary as of 05/26/2026 documented they were prescribed Abilify (an antipsychotic medication) 5 milligrams by mouth twice daily on 01/27/2026 for treatment of unspecified depression. In a review of Resident 23's care plan dated 05/27/2026 documented their target behaviors for use of the Abilify was for depression and PSA to include excessive crying, verbal aggression toward staff and refusing care and meals. In a review of Resident 23's MAR for May 2026 showed a behavior monitor, implemented as of 03/26/2026, to document excessive crying, verbal aggression toward staff and refusing care and meals. There was one instance of excessive crying documented for May 2026. There were no documented non-pharmacological interventions used in May 2026 per the MAR. Review of a progress note dated 05/29/2026 documented the provider was contacted to provide an appropriate diagnosis for Resident 23's use of Abilify. In an interview on 05/29/2026 at 1:02 PM Staff D, Registered Nurse/Resident Care Manager, stated when a resident admitted to the facility on a psychotropic medication, the order and monitor for side (continued on next page)		

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	effects were put into the MAR by nursing and social services put in the behavior monitors. Staff D stated the nurse who completed the MDS- inputted the Odiagnoses for the resident and then assigned the diagnosis for the use of psychotropic medication. Staff D stated they attended gradual dose reduction meetings monthly and could contact the provider to obtain the proper diagnosis for the use of Abilify for Resident 23. Staff D stated the unspecified depression was not an appropriate diagnosis for the use of Abilify. In an interview on 05/29/2026 at 2:03 PM Staff B, DNS, stated if a resident admitted with use of psychotropic medication, they would implement monitoring for behavior and side effects. Staff B stated social services were responsible for ensuring the care plan was completed related to psychotropic drug use and there were monthly meetings to review residents on those medications. Staff B stated Resident 23's diagnosis of unspecified depression was not an appropriate diagnosis for use of Abilify. Reference: (WAC) 388-97-0620 (1)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to thoroughly investigate and report timely an allegation of verbal/mental abuse for 3 of 4 residents (Residents 1, 7, and 38) reviewed for abuse. The lack of thorough investigation prevented the facility from ruling out abuse and failure to report immediately caused a delay in further investigation and protection of the residents. These failures placed residents at risk for harm related to potential unrecognized abuse. Findings Included. Review of the facility policy titled, Abuse dated 10/01/2021 documented each resident had the right to be free from abuse. staff would immediately review and investigate all allegations or observations of abuse. protect the resident .and ensure each mandated reporter reported immediately. Review of an incident report dated 02/20/2026 documented Resident 1 reported to Staff D, Registered Nurse/Resident Care Manager on 02/15/2026 that the social services director (currently no longer with the facility), had called Resident 7 a derogatory name using profanity in conversation with Resident 38 on 02/14/2026. Review of the timeline of events as outlined in the incident report documented Resident 1 reported that Resident 7 was upsetting Resident 38 in conversation and this was reported to the social services director on 02/14/2026. There was no specific description of what Resident 7 had said to Resident 38 to upset them. There was no documentation, interviews, or witness statements to determine what was said by Resident 7 to Resident 38. An investigation was initiated on 02/20/2026 and a report was made to the state hotline, five days after knowledge of the alleged verbal/mental abuse. The incident report contained staff education for As a mandated reporter, when a resident makes an allegation against a staff member it is an immediate call to the DNS or ED for guidance. This is abuse/neglect prevention, and there are steps that need to be followed timely. Review of the incident reporting log dated February 2026 showed no other incident reports related to Resident 1, 7, or 38. In an interview on 05/28/2026 at 2:00 PM Staff D stated they were notified by a staff member they could not recall, of the social services director calling Resident 7 a derogatory name using profanity in conversation with Resident 38. Staff D stated they could not recall the date of when they were informed. They had spoken to Resident 1 and they reiterated what the staff member had reported. Staff D stated they reported the allegation to Staff B, Director of Nursing, either that day or the following day and did not make a report to the state hotline but should have. Staff D stated they spoke with Resident 38 and they could not recall any details of their conversation with the social services director. In an interview on 05/29/2026 at 12:44 PM Resident 1 stated they did not report the allegation of the social services director calling Resident 7 a derogatory name. Resident 1 stated they were not surprised to hear of the allegation as the social services director often used derogatory language and profanity as they were one to speak their mind. Resident 1 stated they had heard the social services call Resident 7 derogatory names with use of profanity in the past. Resident 1 stated Resident 7 often visited their room they share with Resident 38, and they had been roommates with Resident 7 in the past. Resident 1 stated Resident 7 had told Resident 38 sexually inappropriate, demeaning, and (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	critical comments and they had to ask Resident 7 to leave the room. Resident 1 stated they had been looking out for Resident 38. In an interview on 05/29/2026 at 12:53 Staff C, Social Services Director, stated they had no knowledge of the allegation and had not reviewed the incident report related to the prior social services director. Staff C stated they had started with the facility in March 2026. Staff C stated Resident 7 had been roommates with both Resident 1 and Resident 38 in the past and it had not worked. Resident 7 resided in a room by themselves and were next door neighbors with Resident 1 and 38. Staff C stated they had received reports from staff about Resident 7 eavesdropping from the shared bathroom when staff were in the room with Resident 1 and 38. Staff C stated they were unaware of Resident 7 making sexually related comments to Resident 38. In an interview on 06/01/2026 at 10:20 AM, Staff B stated they were familiar with the allegation involving Resident 7, 38 and 1 and stated the social services director at the time was attempting to reassure Resident 38 in conversation about Resident 7 and Resident 38's comfort around using the toilet. Staff B stated a mandated reporter was anyone who worked with a vulnerable adult and were mandated to make a report to the state agency if there were allegations of abuse or neglect of a vulnerable person. Staff B stated the allegation was reported on 02/19/2026 and the facility called it into the hotline on 02/20/2026. Reference WAC 388-97-0640(2)(b)(5)(a)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of bed hold at the time of transfer to the hospital for 3 of 3 residents (Residents 1, 4, and 42) reviewed for hospitalization and failed to ensure notification to the Office of the State Long-Term Care Ombudsman (LTCO - resident advocates) occurred for 1 of 3 residents reviewed for hospitalization. Failure to offer bed holds placed residents and/or representatives at risk of not having the necessary information to make an informed decision regarding their ability to return to the facility. Failure to notify the LTCO and ensure written notification was provided to the resident and/or representative placed residents at risk for not having an opportunity to make informed decisions about their transfer/discharge rights. Findings included . Review of the facility policy titled, Bed Hold Notice, dated 10/01/2021, documented that prior to transfers, residents or resident representatives will be informed in writing of the bed-hold and return policy. <RESIDENT 42> Resident 42 was discharged to the hospital on [DATE] while out at a medical appointment. Review of Resident 42's electronic medical record (EMR) showed no uploaded document to show a bed hold was offered to them or their representative. The EMR showed a progress note dated 04/20/2026 documented the Resident 42's representative was offered a bed hold and a notice was signed. In an interview on 05/27/2026 at 2:20 PM Staff F, Medical Records provided a copy of the signed bed hold document. Staff F stated they had not uploaded the record into the EMR and found the record in the administration documents. Staff F stated Staff E, Business Office Manager, uploaded the document into financial documents not in the EMR. Review of the bed hold notice signed 04/20/2026 documented Resident 42's representative wanted to hold their bed. The form was incomplete and lacked signature where the bed hold policy was provided to the resident or their representative. In an interview on 05/27/2026 at 2:36 PM Staff E stated they received the signed bed holds in their box when completed and they reviewed them for signatures. Staff E stated they only reviewed the form for billing purposes. In an interview on 05/28/2026 at 2:12 PM Staff O, Licensed Practical Nurse (LPN), stated they had not completed a bed hold in a while. Staff O stated the facility process was that nursing would ask the resident or resident representative if they wanted a bed hold at the time of transfer. Staff O stated they would fill out the bed hold paperwork and forward it to social services for review. When asked if they had provided the bed hold policy at the time a bed hold was offered, Staff O stated they (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had not and only had them fill out a bed hold form. In an interview on 05/28/2026 at 2:15 PM Staff C, Social Services, stated the facility process for bed hold was for nursing to complete them with the resident and or representative at the time of transfer. Staff C stated if nursing were unable to get a signature or review the form with the resident and or representative then they would attempt to contact the family to explain the bed hold and attempt to get a signature. Staff C stated when a resident was transferred to the hospital, they would look in their clinical record to ensure a bed hold was offered and if it wasn't they would know to follow up with the resident and or representative. Staff C stated they did not review completed bed holds completed by nursing, but when they completed them, they ensure they were complete and then they uploaded them into the EMR. <RESIDENT 1> Resident 1 initially admitted to the facility on [DATE]. Resident 1 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. Review of Resident 1's progress notes on 02/05/2026 at 3:33 AM, Staff S, LPN, documented Resident 1 was sent to the hospital for their well-being. Review of Resident 1's EMR showed no documentation of written bed hold information being provided to the resident or responsible party at the time of discharge to the hospital. In an interview on 05/29/2026, at 1:00 PM, Staff D, Registered Nurse (RN)/Resident Care Manager (RCM), stated that when residents are transferred to the hospital that a bed hold should be provided at the time of transfer either to the resident if possible or the resident's responsible party. Staff D stated the bed hold should be in a progress note or uploaded to the EMR. Reference: WAC 388-97-0080		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the level one Pre-admission Screening and Resident Review (PASRR- assessment/federal requirement for Medicaid-certified nursing facilities to ensure individuals, especially those with mental illness, seeking admission are appropriately placed and receive necessary services) were referred and followed up on for 3 of 5 residents (Residents 1, 4 and 8) reviewed for PASRR. This failure placed residents at risk of unmet mental health services and a diminished quality of life. Findings included . Review of the undated facility policy titled, Long-Term Services and Supports Screening, PASRR Policy documented that when a resident has a positive level one screening, the facility will initiate the level two screening request by contacting the PASRR coordinator. <RESIDENT 1> Resident 1 admitted to the facility on [DATE] with diagnoses to include heart failure, depression, and anxiety. Review of Resident 1's level one PASRR dated 05/20/2024 documented that a level two evaluation referral was required for serious mental illness (SMI). The comments stated that Resident 1 had a history of depression and anxiety and was taking an antidepressant medication. No other updated PASRR was in Resident 1's EMR and the progress notes showed no documentation about a level two evaluation. Review of Resident 1's progress notes on 05/14/2026, at 1:04 PM, Staff C, Social Services Director (SSD), documented that they had requested an invalidation or a level two PASRR from the PASRR coordinator and were awaiting response. In an interview on 05/28/2026 at 12:22 PM, Staff C stated they had just done a PASRR audit for all residents. Staff C stated a new PASRR had not been completed for Resident 8 on his admission. They stated this was due to the hospital not completing a new one since it had not been more than 30 days. Staff C stated social services should have completed a new PASRR. <RESIDENT 8> Resident 8 admitted to the facility on [DATE] on Hospice (specialized care for people with terminal illnesses) with diagnoses to include cerebrovascular disease (any condition that affects the blood vessels and blood flow in the brain), dementia (loss of memory, language, problem-solving, and other thinking abilities) and chronic kidney disease. Review of Resident 8's level one PASRR dated 11/06/2025 documented the resident was positive for a SMI with indicators marked for mood disorders (depression) and anxiety. Section C also marked no for the individual having a diagnosis of dementia. The service needs section documented that no level (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two evaluation was indicated as person did not show indicators of SMI. The comment section documented that the resident was on Hospice, nearing end-of-life within final weeks to months of life and that their anxiety and depression were stable with current medications. PASRR level one was completed by a Hospice social worker. In an interview on 05/28/2026, at 12:27 PM, Staff C, SSD, stated that they had been auditing the PASRR's and saw that Resident 8's PASRR was incorrect and they sent in a new PASRR on 05/26/2026 to the PASRR coordinator. Review of Resident 8's updated PASRR dated 05/26/2026, completed by Staff C, stated a level two evaluation referral was required for SMI. The comments documented that the previous PASRR was positive but no level two evaluation needed was checked. Comment section also documented that Resident 8 was still on Hospice, had a diagnosis of dementia and was on antipsychotic, antianxiety, and antidepressant medications. <RESIDENT 4> Resident 4 admitted to the facility on [DATE] with diagnoses to include anxiety disorder, depression, and post-traumatic stress disorder. Review of Resident 4's PASRR dated 11/24/2025 documented they had known indicators of serious mental illness and were exempted from receiving a Level II evaluation as they were anticipated to be in the nursing facility for less than 30 days. Review of Resident 4's progress notes documented two progress notes, one dated 01/11/2026 when the Level II evaluator was notified, they remained in the facility past 30 days and another on 04/13/2026 indicating the evaluator was planning on completing the Level II evaluation. In an interview on 05/28/2026 at 11:10 AM Staff C, Social Services, stated admissions reviews the PASRR and then they review. Staff C stated if a resident has an exemption they would send electronic communication to the evaluator on day 25 and provide admission date, behaviors, medications and the discharge plan for the resident. Staff C stated Resident 4 had a hospital exemption of a Level II evaluation at admission, there was a progress note on 01/11/2026 and a follow up note on 04/30/2026. Staff C stated there was currently a backlog of Level II evaluations to be completed by the evaluator and they follow up with them from every 30 days to six weeks. Reference: WAC 388-97-1915(1)(2)(a-c)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure care plans were revised as need for 4 of 5 residents (Residents 7, 8, 38, and 44) reviewed for care planning. The failure to review and revise care plans by the interdisciplinary team placed residents at risk for unmet care needs, anxiety, fear, decreased quality of care related to outdated or inaccurate care plans, and a diminished quality of life. Findings included .<RESIDENT 8> Resident 8 admitted to the facility on [DATE] on Hospice (specialized care for people with terminal illnesses) with diagnoses to include cerebrovascular disease (any condition that affects the blood vessels and blood flow in the brain), dementia (loss of memory, language, problem-solving, and other thinking abilities) and chronic kidney disease. Review of Resident 8's physician orders, dated 02/13/2026, documented Hospice ordered an as needed antipsychotic gel (CMPD ABHR (a compounded topical medication prescribed primarily in palliative and hospice care to manage severe nausea, vomiting, and sometimes anxiety or agitation) topical gel, which included 1 milligram (mg) Lorazepam (a fast acting anti-anxiety medication that slows down your nervous system), 25mg Benadryl and 1 mg Haldol (a first generation antipsychotic medication) to start if resident was refusing oral medications and to apply topically as needed for anxiety, restlessness, or agitation. The order was active on the medication administration record (MAR) as of 02/16/2026. Review of Resident 8's care plan, dated 04/18/2026, did not include the antipsychotic gel until 04/18/2026. In an interview at 06/01/2026, at 10:10 AM, Staff B, Director of Nursing (DNS) confirmed the antipsychotic gel was ordered in February 2026 and was not updated on the care plan until April 2026. Staff B stated that their expectation of the care plan should have been updated timelier. <RESIDENT 38> Resident 38 was admitted to the facility on [DATE] with diagnoses to include dementia (loss of memory, language, problem-solving, and other thinking abilities), schizoaffective disorder (mental health condition that includes symptoms of both schizophrenia and mood disorders), post-traumatic stress disorder and homelessness. Review of Resident 38's progress notes documented an elopement from the facility on 10/02/2025 and 10/13/2025. Review of Resident 38's care plan, dated 02/26/2026, documented that Resident 38 an elopement risk with an initiation date of 10/03/2025. The care plan documented interventions to include an air-tag on Resident 38. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 38's elopement risk assessment, dated 05/26/2026, Staff B, DNS documented that the resident was no Review of Resident 38's progress notes dated 05/26/2026 at 11:31 AM, Staff B, DNS documented that Resident 38 is not at risk for elopement at this time. The electronic health record did not contain any information that the interdisciplinary team reviewed or revised the comprehensive care plan after the elopement risk assessment. In an interview on 05/29/2026 at 2:23 PM, Staff B, DNS stated that care plans should be updated for residents when assessments are updated. <RESIDENT 44> Review of Resident 44's electronic medical record (EMR) documented they discharged with their family to a facility out of state on 04/03/2026. Review of Resident 44's care plan documented an area of focus, discharge, resolved as of 06/13/2025 that they had no discharge plan. There was no discharge care plan since 06/13/2025. Review of Resident 44's care conference record dated 09/10/2025 documented there was a discussion of them moving to another state with a family member. Review of a progress note dated 03/27/2026 documented by Staff C, Social Services, showed there was a plan for Resident 44 to discharge with family to another state. Review of a hospice note dated 03/31/2026 documented there was a discharge plan for Resident 44 to discharge to another state with their family member. In an interview on 05/27/2026 at 10:50 AM Staff C, stated there was not an active discharge care plan for Resident 44, and confirmed the prior one had been resolved in June 2025, and was unaware of the reason why it was resolved, and there should have had current one. <RESIDENT 7> Resident 7 admitted on [DATE] with diagnoses to include schizoaffective disorder (mental health condition with hallucinations, delusions, mania and depression), PTSD, depression and anxiety. Review of Resident 7's psychosocial well-being care plan initiated on 04/09/2026 showed Resident 7 had a diagnosis of PTSD and had difficulty falling asleep and nightmares related to being stuck in the bathtub for multiple days when living in the community. The care plan lacked a personalized care plan that outlined the resident's physical symptoms, triggers, recovery goals and actionable coping strategies to decrease anxiety and fear. The care plan had no interventions related to bathing to mitigate this known trigger. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/01/2026 at 8:41 AM, Staff H stated they were unaware of any specific bathing approaches for Resident 7. This is a repeat deficiency from SOD dated 05/01/2025. Reference: WAC 388-97-1020(5)(b)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a safe resident environment was maintained, free of accident hazards, for 2 of 3 residents (Residents 8 and 31) reviewed for wandering. The facility failed to ensure adequate supervision to prevent Resident 8 from unsupervised access while entering other resident rooms, prevent unwanted touching, resident to resident altercations and falls. The facility failure to timely document, follow-up, evaluate, and analyze data gathered to establish a root cause after wandering, falls, resident to resident altercations placed the resident at risk for subsequent falls, elopement, avoidable serious injuries, negative health outcome, and a diminished quality of life. Findings included Review of the facility policy titled, Elopement Prevention Guideline, dated April 2023, documented that when a resident is identified at risk the resident will have a Resident Identification Form completed and placed in the elopement risk binder. The policy documented that the facility will check placement each shift and function of the elopement bracelet daily. <RESIDENT 8> Resident 8 admitted to the facility on [DATE] on Hospice (specialized care for people with terminal illnesses) with diagnoses to include cerebrovascular disease (any condition that affects the blood vessels and blood flow in the brain), dementia (loss of memory, language, problem-solving, and other thinking abilities) and chronic kidney disease. Review of Resident 8's care plan dated 02/10/2026, documented resident was a high fall risk related to weakness, dementia, and history of repeated falls. The care plan documented not to leave Resident 8 alone in their wheelchair anywhere that there was not supervision and to conduct frequent safety checks throughout each shift. Review of Resident 8's Care Area Assessment (CAA - a tool used to create individualized care plans), dated 11/16/2026, documented that the resident had two falls since admit. The CAA documented that Resident 8 was impulsive and attempted to self-transfer unsafely. Resident 8's care plan dated 04/18/2026, directed staff to conduct and document 15-minute checks. Review of Resident 8's progress notes from 11/10/2025 through 05/28/2026, documented the resident had 12 falls since admission on : -11/10/2025 -11/16/2025 -12/21/2026 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/27/2025 -04/11/2026 -04/27/2026 -05/02/2026 X 2 -05/03/2026 -05/09/2026 -05/11/2026 -05/15/2026 Review of the facility's incident reporting log on 04/22/2026, showed Resident 8 had an altercation with another resident. Resident 8 and the other affected resident were not put on alert charting. There were no progress notes about the altercation documented. Review of the May incident reporting log did not contain incidents of Resident 8 crawling on the floor on 05/09/2026 and 05/11/2026. Review of the clinical record showed Resident 8 had severe cognitive impairment and could not provide details of why they were crawling on the floor, necessitating an investigation. There was no assessment for injuries or incident investigations to find the root cause of Resident 8 being found on the floor. Review of a progress note on 05/04/2026 at 3:20 PM, Staff C, Social Services documented the Resident 8 had severe cognitive impairment, was currently taking 6 psychoactive medications and had an increase of wandering and grabbing staff and peers. In a progress note on 05/07/2026, at 1:26 PM, Staff Q, Resident Care Manager/Registered Nurse, documented that it was discussed with Hospice that Resident 8 would benefit from a companion or some sort of assistance to help prevent falls. At 5:22 PM, the resident was restless, banging and knocking on doors. Review of a provider progress note on 05/22/2026 at 5:23 PM documented Resident 8 was observed scooting in their wheelchair and approaching residents and staff. The provider documented the resident had most recently experienced multiple falls. The resident had restlessness, fidgeting, agitation, and combative behavior documented frequently, with episodes of aggression toward staff and other residents. In a progress note on 05/28/2026 at 11:07 AM, Resident 8 was restless, grabbing stuff, banging on (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doors and going into other resident rooms. In an observation on 05/28/2026, at 10:31 AM, Resident 8 was seen opening a door and attempting to enter and employees only door. In an observation on 05/28/2026, at 11:06 AM, Resident 8 was seen going into another residents room, room [ROOM NUMBER]. The activity director went to go assist Resident 8 and redirect. In an observation on 05/28/2026, at 3:24 PM, Resident 8 was seen in another hallway trying to get into the therapy office. Another resident of the facility was trying to assist Resident 8 back to the hallway. In an observation on 05/29/2026, at 2:00 PM, Resident 8 was seen trying to get into a locked utility room. At 3:59 PM, Resident 8 self-propelled their wheelchair into a new admit who had just arrived then ran into this surveyor and used the medication cart handle to propel themself down the hall. Staff J, Staffing Coordinator tried intervening but did not prevent the unwanted touching. In an interview on 05/29/2026, at 2:47 PM, Staff B, Director of Nursing Services (DNS) stated that after an incident such as a falls or altercations, residents should be put on alert charting for every shift for at least three days. Staff B stated that they are working on improving that. In an interview on 06/01/2026, at 8:53 AM, Staff H, Shower Aide, stated that Resident 8 is very confused and has tried to go into other resident rooms. Staff H stated they always had to keep their eyes on them because they always try to open doors. In an interview on 06/01/2026, at 11:16 AM, Resident 8's power of attorney (POA) stated that they have had a lot of falls at the facility and had tried adjusting medications to help with that. Resident 8's POA stated that that facility staff had to keep a close eye on them to prevent them from falling. In a joint interview on 06/01/2026 at 12:25 PM, Staff B, Director of Nursing (DNS) stated Resident 8 was busier than usual the past 2 weeks. Staff A, Administrator stated Resident 8 would be better in a memory care facility, but the family was against it. Staff A stated they might give the resident a 30-day notice to discharge as the resident needed to be in a dementia unit with specialized care and more staff supervision. They stated with the unwanted touching, falls, going into resident rooms, the resident needed increased supervision. Staff B, DNS stated Hospice sent someone once a week to sit with them for about an hour, which was not really helpful. Staff A stated the family was not involved and maybe they would have a care conference to discuss that family needed to help them out with watching them. <RESIDENT 38> Resident 38 was admitted to the facility on [DATE] with diagnoses to include dementia (loss of memory, language, problem-solving, and other thinking abilities), schizoaffective disorder (mental health condition that includes symptoms of both schizophrenia and mood disorders), post-traumatic stress disorder and homelessness. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 38's progress notes documented an elopement from the facility on 10/02/2025 and 10/13/2025. Review of Resident 38's elopement risk assessment documented on admission, 09/03/2025, that the resident was not at risk of elopement. On 10/03/2025 the elopement risk assessment documented that the resident was at risk for elopement with comments that stated the resident had left the facility once since admission and that a wander guard bracelet was put on the resident. On 02/05/2026 the elopement risk assessment documented that the resident was an elopement risk. On 05/26/2026 the elopement risk assessment was completed by Staff B, DNS and documented that the resident was no longer an elopement risk with comments that stated the resident had two elopement episodes in 2025, the most recent in October. Resident 38 wandered the halls, without exit seeking and no exit seeking behaviors in seven months. Review of the electronic health record (EHR) showed no discussion of the interdisciplinary team regarding the removal of the elopement risk. Review of Resident 38's physician orders, as of 05/27/2026, documented, wander guard in place for elopement risk, but the order did not have supplemental documentation that went onto the medication administration record MAR for the nursing staff to check and document placement as per the facility policy. Review of Resident 38's care plan, dated 02/26/2026, documented Resident 38 had an air tag (an electronic tracking device) on them. Resident 38's care plan, dated 04/18/2026, documented the resident had a wander guard. Review of the facility's elopement binder, reviewed on 06/02/2026, documented completed resident identification forms for Resident 38 and Resident 19. Resident 38 was no longer an elopement risk as of 05/26/2026 according to the elopement risk assessment. Resident 19's care plan, dated 04/08/2026 was documented as an elopement risk but did not have a wander guard bracelet in place. Resident 31's care plan, dated 04/07/2026, documented them as an elopement risk and had a wander guard in place but was not placed in of the elopement binder. In an observation on 05/26/2026, at 11:03 AM, Resident 38 stated he did not have a bracelet on and showed both wrists and ankles without a wander guard bracelet attached. In an interview on 05/29/2026, at 11:34 PM, Staff L, NAC stated that Resident 38 does wander around the building and should have a wander guard on. Staff L did not observe one on Resident 38 and started to look around for it and stated that Resident 38 sometimes takes it off. In an interview on 05/29/2026, at 2:20 PM, Staff B, DNS stated that Resident 38 does not have a wander guard any longer due to them taking it off but did have an air tag in their jacket. Staff B confirmed there was no monitor for placement of the wander guard or to check for function, but stated those should be in place for anyone with a wander guard. In an interview on 06/01/2026, at 10:10 AM, Staff B, DNS stated that the elopement binder was to be updated by the team and not designated to a specific person. Reference WAC 388-97-1060(3)(g)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free from significant medication errors when medication was not administered in accordance with provider orders for 1 of 2 sampled residents (Resident 7) reviewed for significant medication errors. This failure placed residents at risk of adverse medical conditions, a change in health conditions, anxiety and a diminished quality of life. Findings included . Review of the December 2025 grievance log documented a grievance for Resident 7 dated 12/09/2025. Resident 7 reported they had never received valium (an anti-anxiety medication) prior to their dental appointment. Review of the Medication Administration Record for December 2025 documented an order dated 12/09/2025 for Resident 7 to attend a dentist's appointment and have an escort due to them being medicated with valium prior to the appointment. Review of Resident 7's progress note dated 12/05/2026 documented the facility nurse contacted the dental office and requested the prescription for valium be faxed to the facility. There were no additional notes found regarding the prescription, whether it had been received, or processed. Review of a dental visit note for Resident 7 dated 12/09/2025 documented that they did not take the medication as prescribed for their appointment, which was for extraction of teeth. In an interview on 05/26/2026 at 9:34 AM Resident 7 stated they were supposed to take a medication (could not recall the medication but was to help with sedation) prior to their dentist's appointment for teeth extractions and never received it. Resident 7 stated they received more numbing medications as a result and the dentist was unhappy with them because they thought they just didn't take it. Resident 7 stated the facility nursing staff told them they did not get the medication from the pharmacy, stating what they order and what they get are two different things. In an interview on 05/29/2026 at 9:45 AM Staff D, Registered Nurse/Resident Care Manager, stated the facility contacted the dentist office several times to obtain the order for Valium for Resident 7. Staff D stated the dentist's office stated they faxed the prescription, but the facility never received it. Staff D stated they would expect there would be progress notes in Resident 7's clinical record with the details. In an interview on 06/01/2026 at 10:20 AM Staff B, Director of Nursing Services, stated risk management was completed for all medication errors. Staff B stated Resident 7's dentist did not provide a prescription for Valium and there was no communication between the dentist and the facility. Reference WAC 388-97-1260 (3)(k)(iii)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the provision and follow-up of dental services for 1 of 2 residents (Resident 3) reviewed for dental care. This failure had the potential to result in a decreased quality of life for Resident 3, who was experiencing dental pain. Findings included .Resident 3 admitted on [DATE] following a stroke. Review of the admission Minimum Data Set Assessment (MDS) dated [DATE], documented Resident 3 had obvious and likely cavity or broken natural teeth. The Dental Care Area Assessment (CAA, a tool used to develop the individualized care plan) documented the resident had some missing lower teeth which were in poor shape. The CAA further documented the resident had an upcoming dental appointment and was eating a dysphagia (swallow deficit) diet and directed staff to proceed to the care plan related to current dental issues. Review of Resident 3's care plan on 05/26/2026 documented the resident required assistance with dental care and personal hygiene, with generic interventions which directed staff to observe for complaints of pain or discomfort and refer to dentist as indicated. There were no interventions or additional personalized information addressing Resident 3's current dental problems or dental pain. No monitoring was found. In an interview and observation on 05/26/2026 at 12:14 PM, Resident 3 stated they had sore teeth and gums. Resident 3 opened their mouth and pointed to their right lower jaw area which was observed to have missing and broken teeth with small white fragments visible. The gum tissue was reddened and swollen. Resident 3 stated they had been eating soft food and had to be careful brushing their teeth because that side was sore. Resident 3 stated they went to a dentist who made reference to them having a stroke and they did not know anything more about the follow-up. Resident 3 stated they had not seen anyone since their admission to the facility about their dentition or dental pain in their mouth and had nothing they could take for a sore tooth. Review of Resident 3's medical record on 05/28/2026 revealed no documentation regarding a dental visit since admission or any pending dental visit. Review of Resident 3's physician's orders documented an order for a topical mouth/throat gel dated 02/05/2026, ordered every six hours as needed for tooth pain. Review of the Medication Administration Records from 02/05/2026 through 05/28/2026 documented only one instance on 02/27/2026 for the as needed oral gel being administered. In a follow-up interview on 05/28/2026 at 11:23 AM, Resident 3 stated they were not aware they had any orders for tooth gel and stated they think it would help but nobody had offered it to them. In an interview on 05/28/2026 at 11:33 AM, Staff Q, Registered Nurse, Resident Care Manager, stated Resident 3 went to a dentist with their daughter about a week after they admitted . Staff Q stated they did not have any paperwork from that dental visit and did not know about any follow-up. Staff Q (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they would have to get in touch with Resident 3's daughter or call the dental office. Staff Q stated they had been told by Resident 3's daughter that since Resident 3 had a recent stroke, they would have to wait 3-6 months to safely do dental work, but Staff Q acknowledged the facility had not received any information from the dental provider. Staff Q stated Resident 3's mouth pain had subsided after admission and was not aware it was bothering them again. Staff Q stated they should be utilizing the mouth gel and coordinate a follow-up appointment for evaluation and plan. No additional information was provided. Refer to WAC 388-97-1060 (3)(vii)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the infection prevention and control Antibiotic Stewardship Program (ASP, a system-wide implementation of measures for monitoring/tracking of antibiotics along with reducing the risk of unnecessary antibiotic use) was implemented for 3 of 3 residents (Residents 5, 23, and 27). This failure increased the resident's risk for development of multidrug-resistant organisms (a bacteria that are resistant to many antibiotics) along with potential for unidentified nursing care trends that identify risk related to infection prevention. This failure had the potential for adverse outcomes associated with unnecessary or inappropriate antibiotic use and a decrease in quality of life for all facility residents. Findings included. A review of the undated facility policy titled, Antibiotic Stewardship Guideline included a letter to the provider that detailed 11/28/2017 Centers for Medicare and Medicaid requirements of participation. Studies have shown that 40-75% of antibiotics prescribed in nursing homes may be unnecessary or inappropriate resulting in the overuse and potential harm of residents. Harm includes infections such as clostridium difficile (infection with severe diarrhea), increased adverse drug events and drug interactions, and colonization and or infection with antibiotic resistant organisms. Review of pamphlets on display at the Artist Lane nurses station were undated, labeled Antibiotics for urinary tract infections in older adults, information for patients and families from Rochester nursing home collaborative documented antibiotics should be used when a person has UTI symptoms and or a fever. Urinary tract infection (UTI) symptoms are burning with urination, increased urge to urinate and need to urinate more often. If an older person does not have symptoms of a UTI, then antibiotics will not help, even when bacteria is seen in the urine. Antibiotics should be avoided if not needed due to side effects including allergic reaction, fever, rash, nausea, vomiting, kidney damage and diarrhea. Antibiotics increase the risk for future infections as antibiotics can kill good germs natural to our body. This can lead to potentially fatal and severe diarrhea caused by clostridium difficile (C. Difficile, a bacteria resulting in inflammation and frequent episodes of diarrhea). Further antibiotics promote stronger resistant germs, making infections harder to kill with commonly used antibiotics and fewer treatment choices available. Doctors and other practitioners are not always sure what may be causing the symptoms in a patient, and sometimes the best option for the patient is observation and monitoring. <RESIDENT 5>Resident 5 admitted to the facility on [DATE] with diagnoses to include high blood pressure, and a history of UTI. Review of Resident 5's physician orders directed nurses to administer antibiotic Cephalexin 250 mg by mouth in the morning for UTI prophylaxis related to personal history of UTI since admission on [DATE]. No stop date was included in the order. Review of the clinical record revealed there was no trial discontinuation or physician documentation that prophylactic antibiotics were indicated for Resident 5. <RESIDENT 23>Resident 23 readmitted to the facility on [DATE] with diagnoses to include anxiety and depression. Review of Resident 23's physician orders directed staff to administer antibiotic Macroclantin 100 mg every evening for UTI prophylaxis beginning 09/26/2023. No stop date was included in the order. Review of the clinical record revealed there was no trial discontinuation or physician documentation that prophylactic antibiotics were indicated for Resident 23. <RESIDENT 27>Resident 27 readmitted to the facility on [DATE] with diagnoses to include kidney disease and a history of UTI. Review of Resident 27's physician orders directed staff to administer antibiotic Fosfomycin 3 grams in the morning every 10 days for UTI prophylaxis beginning 04/11/2026. No stop date was included in the order. Review of Resident 27's clinical record revealed there was no physician documentation that prophylactic (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Rock Hill Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1530 James Street Bellingham, WA 98225	
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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotics were indicated for Resident 27 until 05/29/2026 at 10:57 AM related to a history of recurrent urinary tract infections with current symptoms of dysuria (painful urination) and burning sensation reported on 05/28/2026. Staff X ordered a referral to urology for frequent UTI symptoms. In an interview on 05/29/2026 at 9:46 AM, Staff X, Medical Director stated they had just discussed antibiotic stewardship with Staff B, Director of Nursing (DNS) on three residents. Staff X stated if residents had been on the prophylaxis antibiotic and they have not had a breakthrough UTI; we can call the prophylaxis antibiotic successful. They stated that it was common and not unreasonable to have residents on prophylaxis antibiotics. They stated for residents with chronic UTI's they could attempt a trial discontinue when it was reasonable to do so. Staff X said they just reviewed Resident 5's medical record and stated they had a recent UTI so it would not be appropriate to have their prophylactic antibiotic discontinued at this time. Staff X stated they needed to dig deeper on Resident 23 and Resident 27. They were reviewing the medical records and stated Resident 23 had pyuria (elevated white cell in urine indicating inflammation of the bladder) and dysuria and grew organisms, but they did not lead to infection, so prophylaxis was successful. They stated they were ok with Resident 23 having a trial discontinuation of their antibiotic. They stated Resident 27 had a UTI hospitalization in the past 6 months so they would need to continue the antibiotic. They stated prophylaxis antibiotics are prescribed on a case-by-case situation, and they would review the antibiotics for Resident 5 and Resident 27 in six months. In an interview on 05/29/2026 at 1:02 PM, Staff D, Registered Nurse/Resident Care Manager stated residents on prolonged or prophylactic antibiotics should be monitored for side effects, symptoms present and this should be documented in the medical record. The antibiotic care plan should be developed by the infection preventionist. In an interview on 05/29/2026 at 2:03 PM, Staff B, DNS stated their expectation for prophylactic antibiotics would be to obtain a urinalysis, referral to urology and trial to discontinue the medication. In a joint interview on 06/01/2025 at 12:25 PM, Staff B, Director of Nursing Services (DNS) stated they were the infection preventionist and responsible for antibiotic stewardship program at the facility. Staff A, Administrator, acknowledged there was lack of reasoning and follow through on antibiotic use and there needed to be better documentation why the residents were on a prophylactic antibiotic. Staff A stated they would meet with Staff X and in-service them. Reference (WAC) There is no associated reference.		