STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505114	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Valley Care	414 S University Rd Spokane, WA 99206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, interview, and record review, the facility failed to provide an adequate supply of bed linens, gowns, towels and washcloths to ensure residents were maintained in a clean, comfortable, dignified manner for 15 of 15 sampled residents (Residents 4, 12, 63, 72, 77, 29, 48, 21, 31, 34, 38, 46, 19, 27, and 43) reviewed for safe, clean, homelike environment. In addition, the facility failure to ensure room temperatures for rooms 29 through 39 on the Southeast unit were at safe and comfortable levels. In addition, Resident 19 and 43's wheelchairs were not maintained in a clean manner. Those failures placed residents for potential decreased quality of life and care. <Resident Council> During a Resident Council meeting on 09/05/2025 at 10:58 AM to 12:08 PM when informed the previous three months of Resident Council minutes had been reviewed, attendees were asked if shortage of linen and/or missing clothing continued to be an issue, all residents (Resident 38, 21, 31, 34, and 46) replied in unison, “yes”. Resident 21 stated clothes don't come back from the laundry and Resident 46 stated there were afraid to sent a pillow and blanket to laundry for fear it would not be returned. Resident 38 stated it usually took a couple days for laundry to return, and they asked for linen when it first came back in order to have clean sheets. In an interview on 09/10/2025 at 9:20 AM, Staff AA, Nursing Assistant, stated there had been issues with linen running out and they did their best with what they had available. Staff AA stated the facility had changed to a new laundry service provider on 09/02/2025 and they were hoping it fixed the issues. When asked about missing personal clothing, Staff AA stated they were aware of this being an issue in the past, it was part of the problem with the other facility doing the laundry, but was not aware of any recent issues. In an observation and interview on 09/10/2025 at 3:59 PM, Staff J, Nursing Assistant, was observed at the linen supply cabinet on the Northwest Unit. Staff J stated there was no linen, nothing, and walked down the hall. <Resident 4> During an interview on 09/10/2025 at 9:29 AM, Resident 4 stated that the facility did not have enough bed linens. They reported at times they did not have a bottom sheet, or they had to use ones that were “slightly soiled”. Resident 4 stated that one time staff couldn't find a top sheet, so ended up using three pillowcases instead, one covering each leg and another across their front. They stated the facility started using a new laundry service, but they had not seen any improvement. <Resident 12> (continued on next page)

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 - Many	On 09/10/2025 at 9:28 AM, Resident 12 was observed lying in their bed, watching TV. Resident 12 stated they were still in bed because staff couldn't find a sling (fabric sling used with a mechanical lift) to get them up. Resident 12 further stated they liked being up in their wheelchair and were not happy about still being in bed. During an interview on 09/10/2025 at 10:33 AM, Staff Z, Nursing Assistant (NA) confirmed that the reason Resident 12 was still in bed was because they couldn't find a sling to get them up. Staff Z further reported that only few draw sheets and blankets were delivered, and low linen supply was an ongoing issue. Resident 12 was not observed out of their room on 09/10/2025 while the survey team was in the facility. <Resident 72> During a resident representative telephone interview on 09/09/2025 at 2:53 PM, Resident 72's representative stated that there were not enough linens. They stated that several days after the Resident's admission, Resident 72 went to the shower room to bathe. They requested towels so they could dry off and was given two hand towels. Resident 72's representative stated after that, they had to bring in bath-sized towels from their home for Resident 72 to use while they resided at the facility. <Resident 77> During an observation and interview on 09/03/2025 at 3:32 PM, Resident 77 was observed resting in their bed. They stated that for whatever reason, the facility frequently ran out of linens and gowns. Resident 77 stated the previous night at around midnight they accidentally spilled water on their bed and all there was to replace the fitted sheet was a flat sheet. The resident's mattress was observed to be uncovered from the waist up, and the flat sheet was loose, wrinkled and bunched up underneath them. Resident 77 stated that all the staff were able to find during the night and there were no sheets yet to replace the flat sheet. On 09/08/2025 at 11:37 AM, two men were observed distributing clean linens from a large rolling cart. The linen was wrapped in cellophane clear wrap in small bundles and included towels, washcloths, and bath blankets and sheets. They stated the facility just started laundry service with their company about one week prior and laundry was delivered to the facility twice weekly. They stated on their first delivery the par levels were too low and had to be increased for the next delivery. They noted that the supplier had been in discussions with the facility as it is estimated the facility needed three times the number of linens than they were currently allocated, which was part of why the facility ran out. They were unsure what services their company would be providing going forward. In an interview and observation on 09/08/2025 at 3:43 PM, Resident 77 was lying in bed. The resident stated they had no clothes and were told they were sent out to be washed. The resident stated they were kept in briefs because they had no gowns, no sheets and did not have a pillowcase for the pillow that was between their knees. In an observation and interview on 09/09/2025 at 11:44 AM, Resident 77 was lying in bed. Resident 77 stated they still did not have any clothes and were wearing a brief. In an interview and observation on 09/10/2025 at 9:35 AM, Resident 77 stated they still did not have (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	any clothes and were wearing a brief. The resident stated they spoke to the nursing supervisor, and they were going to check on it, but they never heard back from them. In an interview on 09/11/2025 at 3:17 PM, Staff A, Administrator, stated they were aware there was a shortage of linens, and it had been a consistent issue. Staff A stated their sister facility had been doing their laundry for the past 25 years. Staff A stated they had complaint investigations due to lack of linen, and it had been subpar service. Staff A stated they have worked with corporate over the past two months to outsource their linen to alleviate concerns and stated it was a work in progress. Staff A stated the only way they would be sustainable was to bring laundry in house. When Staff A was asked how the lack of linens impacted the residents, they stated it posed a barrier for showers, a homelike environment and it was a dignity issue. On 09/04/2025, a review of the Resident Council minutes showed the following concerns were expressed: - on 07/28/2025, towels were dirty and other laundry that returned from being washed did not smell clean. Resident 34 reported missing her personal big towel, 3 washcloths and a white bandana. -on 08/25/2025, bedsheets were not changed for two weeks due to low linen supply and there were a lot of missing clothes. <Resident 38> In an interview on 09/04/2025 at 9:30 AM, when asked if they had any concerns about their cares, Resident 38 stated the facility run out of linen, you need to time your bathing, so you get clean sheets. Resident 38 further the laundry was done at their sister facility and that was why they often ran out of linen. In an observation of the activity room on 09/04/2025 at 2:01 PM, a bingo activity had just ended and Staff QQ, Life Enrichment Assistant, stated there was urine on the floor and they were trying to locate towels, they didn't have any. <Resident 29> On 09/05/2025 at 8:56 AM, Resident 29 was observed lying in bed eating breakfast. The top sheet covering the resident was observed to have several large brown stains surrounded by brown circles. Similar observations of the top sheet being soiled were made that same day at 9:59 AM and 10:53 AM. On 09/08/2025 at 9:05 AM and 11:15 AM, Resident 29 was observed sleeping in bed covered by a grey and white blanket, no top sheet was in place. <Resident 48> On 09/05/2025 at 8:54 AM, Resident 48 was observed lying in bed talking on the phone. The top sheet covering the resident was observed to have several brown stains. At 1:52 AM that same day, Resident 48 was observed sleeping in bed, the top sheet continued to have brown stains. On 09/08/2025 at 8:59 AM, Resident 48 was observed lying in bed covered only with a black and white blanket, no top sheet or facility blanket was present. When complimented on the blanket, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 48 stated, it isn't mine, they brought it because I was cold. When asked if there were sheets or blankets available, Resident 48 stated they didn't know, the staff just brought the blanket belonging to another resident after telling them it was cold. <Resident 63> During a resident representative telephone interview on 09/11/2025 at 9:58 AM, Resident 63's representative stated they informed the Administrator that staff had not been putting a sheet on their family member's bed and were informed they had a shortage of sheets. The resident representative stated the aides told them the linen was not sent out and all they had was pillowcases. They are putting something under my family member now but still do not have sheets all the time for their bed. <Safe and comfortable temperatures> During an observation of the Southeast unit on 09/03/2025 at 11:29, rooms [ROOM NUMBER] were observed to have the doors closed and the entryway blocked off with caution tape across the doors. In an interview on 09/03/2025 at 11:33 AM, Resident 48 stated the room was too hot at times and it made it difficult to sleep. A fan was present on the floor across from the bed. On 09/03/2025 at 11:57 AM, an outside pest control provider was observed standing by room [ROOM NUMBER]. When asked why the rooms were taped off, the pest control provider stated room [ROOM NUMBER] was found to have bed bugs and the adjacent rooms [ROOM NUMBERS] would be heat treated as preventive measures. When asked what the process was, the provider stated the rooms would be heated to 150 degrees from 9:45 AM until 2:45 PM and then a chemical treatment would be applied, and afterwards, residents could return to their rooms. Observation showed there were 13 residents residing on the unit from rooms 29 through 39 that would potentially be affected by the increased in room temperatures caused by the heat treatment. In a follow-up interaction with Resident 48 on 09/03/2025 at 2:18 PM, the room temperature was observed to be very warm and uncomfortable. Observation of the Southeast unit on 09/03/2025 at 2:19 PM showed multiple fans placed in the hallways, the hallway was very hot and uncomfortable. Review of the resident census roster on 09/03/2025 showed there were 19 empty rooms on the Northeast unit. On 09/03/2025 at 2:21 PM, Staff O, Maintenance Director, was informed the temperature in the hallway and resident rooms on the Southeast unit felt very hot. Staff O confirmed the rooms [ROOM NUMBER] were being heat treated due to bed bugs. Staff O walked down the hallway, acknowledged that temperature was hot, and at request of surveyor, temperatures were taken. Temperatures in Fahrenheit were as follows: - room [ROOM NUMBER] entry was 86.6 degrees - room [ROOM NUMBER] entry was 86.4 degrees - hallway by room [ROOM NUMBER] was 96 degrees, inside room [ROOM NUMBER] it was 94.2 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees - hallway by room [ROOM NUMBER] was 85.7 degrees - room [ROOM NUMBER] entry was 85.6 degrees - hallway by room [ROOM NUMBER] was 89.4 degrees The temperature outside on 09/03/2025 was recorded at 103 degrees per the local weather station. In a follow-up interview at 2:56 PM, Staff O informed the survey team that the last heat treatment was completed, and the chemical treatment would start. Staff O stated the temperatures should start to decrease to more normal levels. In an observation of the Southeast unit hallway on 09/03/2025 at 3:44 PM, the temperature felt cooler and was more comfortable. In an interview on 09/12/2025 at 1:41 PM, Staff A, Administrator, was informed of the concern with the high temperatures on the Southeast unit during the heat treatment for the bed bugs and was asked if there were any discussions about moving residents to the Northeast unit. Staff A stated there was room on the Northeast unit to accommodate the residents, but there were no discussions about moving them since the treatment was short in duration and hydration rounds and fans were implemented. <Wheelchairs> <Resident 19> In an observation on 09/03/2025 at 10:22 AM, Resident 19 was sitting in their wheelchair, and it was unclean with food debris on the legs, foot pedals, and cushion. In an observation on 09/04/2024 at 11:27 AM, Resident 19 was sitting in their wheelchair across from the nurse's station. The wheelchair was unclean with food debris and there was blue foam affixed to the left wheelchair leg with cloth tape, not a cleanable surface. Similar observations of Resident 19's wheelchair being unclean with the blue foam padding were made on 09/05/2025 at 11:09 AM and 12:58 AM, 09/08/2025 at 8:43 AM, 10:21 AM and 3:39 PM, 09/09/2025 at 11:51 AM and 1:48 PM, and 09/10/2025 at 9:24 AM. <Resident 43> In an observation on 09/03/2025 at 12:05 PM, Resident 43 was sitting in their wheelchair, and it was unclean with debris on the legs and wheels. Similar observations of Resident 43's wheelchair with debris on the legs and wheels were made on 09/04/2025 at 11:21 AM, and on this day the cushion was unclean with white splatter, 09/11/2025 at 9:02 AM, 09/12/2025 at 9:00 AM and on this day there was brown matter on the cushion, and 09/15/2025 at 9:27 AM and the cushion remained with brown matter. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 09/11/2025 at 11:32 AM, Staff I, Nursing Assistant, stated the Nursing Assistants were in charge of cleaning the wheelchairs and thought they were cleaned after showers or on night shift. Staff I stated it was important to clean the wheelchairs for dignity. Staff I entered the room and observed Resident 19's wheelchair and stated it needed to be put in the shower and cleaned. In an interview on 09/11/2025 at 11:36 AM, Staff D, Registered Nurse, stated the Nursing Assistants were responsible for cleaning the wheelchairs. In an interview on 09/11/2025 at 11:56 AM, Staff A, Administrator, stated night shift cleaned the wheelchairs nightly and it was important to keep the wheelchairs clean for dignity and infection control. <Drywall> In an observation on 09/03/2025 at 10:52 AM, Resident 27 was lying in bed. There were multiple gauges out of the wall to the left of the resident's bed when you entered the room. Similar observations of Resident 27's drywall in disrepair were made on 09/03/2025 at 2:57 PM, 09/04/2025 at 11:18 AM, 09/08/2025 at 12:15 PM, 09/09/2025 at 1:44 PM, and 09/10/2025 at 9:26 AM. In an interview on 09/10/2025 at 3:08 PM, Staff O, Maintenance Director, stated they noticed when they came to the facility there were no bumpers on the walls to stop the beds from being pushed up against the walls and rubbing the paint. At 3:24 PM that same day, Staff O stated they were notified through the computer or verbally for the needed repairs and were not notified the room needed repaired. Staff O stated the room needed to be painted and it was important to maintain the rooms because this was the resident's home. In an interview on 09/11/2025 at 3:17 PM, Staff A stated a room that had peeling paint was not a homelike environment. Staff A stated their expectation was for the paint to remain intact on the walls and patch work completed in a timely manner. Staff A stated it was a potential dignity issue for the residents. <Malodorous Smell> On 08/28/2025 at 8:21 AM, the State Reporting Agency received an intake from a public complainant that the upkeep of the facility was not maintained as it smelled of urine. On 09/03/2025 at 8:30 AM, the facility was entered for the recertification survey. When going down the hall by resident room [ROOM NUMBER], 43, and 45, there was a faint smell of urine and a sour musty smell noted. During a telephone interview on 09/09/25 at 2:53 PM, a family representative for Resident 72 stated they smelled urine when they entered the facility to visit. The smells in the hall by rooms [ROOM NUMBER] were present during the entire recertification survey, more pronounced in the mornings. In an observation on 09/03/2025 at 10:52 AM, Resident 27 was lying in bed and their hair was greasy. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation on 09/08/2025 at 8:48 AM, Resident 27 was lying in bed and there was a strong body odor smell in the room. At 3:41 PM, the odor was notable from the hallway. Similar observations of the strong odor were made on 09/09/2025 at 1:44 PM, 09/10/2025 at 9:26 AM, and 09/11/2025 at 9:10 AM. In an interview on 09/10/2025 at 3:27 PM, Staff N, Housekeeping Director, stated the rooms were cleaned daily and if they noticed a foul odor in a room, they would inspect the room for feces or urine and would have the Nursing Assistants clean it. When asked how often the mattresses were changed out, Staff N stated maintenance oversaw that. Staff N stated they had not had any reports of Resident 27's room having a foul smell but sometimes the hall smelled, and they sprayed a deodorizer. In an interview on 09/10/2025 at 3:42 PM, Staff LL, Housekeeper, stated Resident 27's room had a smell and thought it was urine and the bedding. Staff LL stated they wiped the bed down when the resident was not in bed. In an interview on 09/10/2025 at 3:44 PM, Staff MM, Nursing Assistant, stated if they noticed a strong odor in a resident's room they would check to see if the resident needed care and if they could not figure out the odor, they notified housekeeping and maintenance. In an interview on 09/10/2025 at 3:48 PM, Staff B, Director of Nursing, stated mattresses could be changed out anytime and were not sure how often they were wiped down. Staff B stated they had not noticed an odor in Resident 27's room. Staff B added Resident 27 occasionally refused to be changed and showered. At 4:06 PM, Staff B stated anyone that saw the mattress unclean was responsible for wiping it down. Staff B stated the Resident Care Manager went into the room and sanitized the mattress and they were going to get the resident a new mattress. Reference: WAC 388-97-3220 (1)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure sufficient staff were available to meet the care needs for 7 of 9 sampled residents (Residents 17, 19, 29, 5, 43, 48, and 7) reviewed for activities of daily living (ADLS), and 3 of 3 sampled residents (Residents 44, 43, and 19) reviewed for restorative nursing (a personalized program that combined therapeutic techniques, exercises, and intervention to promote a resident's ability to maintain or improve their ADLS). These failures placed the residents at risk for unmet care needs, and diminished quality of life. Findings included.<Resident Observations and Interviews>In an interview on 09/03/2025 at 2:36 PM, Resident 27 stated they needed assistance with incontinence care and had to wait 30 minutes to be assisted.In an interview on 09/03/2025 at 10:42 AM, Resident 42 stated there was not enough staff and the facility was short staffed a lot. In an observation and interview on 09/03/2025 at 11:39 AM, Resident 48 stated there was not enough staff sometimes to assist with getting them out of bed. Resident 48's fingernails of both hands were observed to be long with brown matter underneath them. Subsequent observations of Resident 48 with long, dirty fingernails were made on 09/04/2025 at 10:36 AM, and 1:30 PM, 09/05/2025 at 8:54 AM and 10:51 AM, and 09/08/2025 at 8:59 AM.In an interview on 09/03/2025 at 11:45 AM, Resident 5 stated they needed assistance with incontinence care and had to wait an hour sometimes to be assisted. In an interview on 09/03/2025 at 2:27 PM, Resident 72 stated staff would come into their room, turn the call light off, and then leave without providing the care or return later. In an observation and interview on 09/03/2025 at 3:49 PM, Resident 29 stated there was not enough staff, and it sometime took awhile to be able to get assisted back to bed. Resident 29's fingernails of both hands were observed to be long with black debris underneath them. Additional observations of Resident 29 with long, dirty fingernails were made on 09/05/2025 at 8:56 AM, 10:53 AM, and 1:55 PM, 09/08/2025 at 9:05 AM and 11:15 AM, and 09/10/2025 at 9:25 AM. In an interview on 09/04/2025 at 8:58 AM, Resident 7 stated the facility had a problem with staff quitting and they had to wait to be assisted with cares. During a Resident Council meeting on 09/052025 at 10:58 AM to 12:08 PM, when attendees, (Residents 38, 21, 31, 34, and 46) were asked if there was enough staff to provide cares and assistance timely, Resident 46 replied there was not enough staff, and they had to wait 45 minutes to get their call light answered. All residents present nodded their heads in agreement. <Staffing Observations and Interviews> In an observation and interview on 09/05/2025 at 9:51 AM, the call light monitor at the South nurse's station showed the call light for room [ROOM NUMBER]-1 was on for 20 minutes. Resident 49 stated they were waiting for assistance to the bathroom, but it took too long, and they had to go in their incontinent brief. Continuous observations of the call light monitor and South hallways showed the following: - on 09/05/2025 at 10:26 AM, the call light for room [ROOM NUMBER]-2 was on for 15 minutes and 30 seconds prior to being answered.- on 09/09/2025 at 9:44 AM, the call light for room [ROOM NUMBER]-2 was on for 40 minutes, room [ROOM NUMBER]-2 was on for 39 minutes, and room [ROOM NUMBER]-1 was on for 19 minutes before being answered. At 1:42 PM, room [ROOM NUMBER]-2's call light was on for 30 minutes and the call light for room [ROOM NUMBER]-2 was on for 27 minutes before being answered.In an interview on 09/11/2025 at 10:41, Staff I, Nursing Assistant, stated there was not enough staff to provide care timely. Staff I stated there were usually two nursing assistants on each side and a float nursing assistant, but today, there were only three nursing assistants and that made it difficult to get cares done. In an interview on 09/11/2025 at 10:49 AM, Staff R, Licensed Practical Nurse, stated it was sometimes a challenge to get all tasks done when staffing was short.In an interview on 09/12/2025 at 11:32 AM, Staff B, Director of Nursing, stated there was a minimum staffing requirement, and the facility determined staffing based on the acuity of the residents and the care needed. Staff B stated staffing changed daily and every day was different, but the staffing should not (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be so bad that cares weren't provided. Please see F677 and F688 for additional informationReference (WAC): 388-97-1080 (1), 1090 (1)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview and record review, the facility administration failed to effectively use its resources to maintain facility compliance with federal regulatory requirements, to provide clean bed and bath linens that were in good repair. Specifically, bed linens were often returned from the laundry provider soiled, stained, wet and malodorous. Additionally, there was an insufficient supply of linens for the resident needs, which resulted in the residents using slightly soiled linens or going without them. These failures caused residents to have a potential decreased quality of life and care.Findings included.During interviews on 09/03/2025, 09/04/2025, 09/08/2025, 09/09/2025, 09/10/2025, 09/12/2025 and 09/15/2025, as well as in the resident council meeting on 09/05/2025, multiple residents and staff members stated that not having enough bed linens and towels was a frequent issue at the facility.During an interview on 09/11/2025 at 3:17 PM, Staff A stated that their laundry had been done by a sister facility for the last 25 years, and they were aware of the poor service and lack of linen. It had been a consistent issue for the facility. Staff a further stated they had worked with the corporation for the last two months to change laundry vendors, and it was a work in progress. Staff A stated that their temporary fix was to triple their linen supply with the new vendor, which was delivered yesterday.During an interview on 09/12/2025 at 12:16 PM, Staff A stated they were not aware that the sister facility had a room with donated, unmarked clothes and items. During an interview on 09/15/2025 at 8:51 AM, Staff A stated that they had just gone to the sister facility and found an excess of linen. Staff A then stated they possibly were not getting their linens back, after they were laundered.During an interview on 09/15/2025 at 9:48 AM, Staff A stated that even before they became the administrator in 2023, the laundry had been done at another skilled nursing facility across town, and the poor quality of service had been an ongoing issue. Staff A further stated that the Quality Assurance and Performance Improvement (QAPI) committee did a performance improvement plan (PIP) about the laundry/linen issue in December of 2024, approximately nine months ago. Staff A reported that the problem was a pattern and not just a one-time event. Since December, Staff A stated they had been trying to improve and move control of as many aspects of the laundry service back to the facility. When asked what steps or interventions were taken when they ran out of linens, Staff A stated they reached out to administration of the sister facility last for additional linens and did receive some. Staff A did provide a copy of the email sent to them on 09/10/2025 to request more linens.Review of correspondence communication on 09/14/2024 (the first report of poor laundry service provided to the survey team) and 04/13/2025 through 09/03/2025, showed Staff A had notified the corporate office of issues with their current laundry service (clothing, tablecloths returned stained; resident clothing returned bagged, instead of hung up on provided hangers and rack; linens returned wet and clean towels smelled of feces.) The correspondence did not show any short-term interventions taken by the facility to address the immediate problem of lack of clean linens, before the survey started. No further documentation was provided.See F584 and F837 for further informationReference: WAC 388-97-1620(1)

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Aurora Valley Care	414 S University Rd Spokane, WA 99206

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on interview and record review the facility failed to have a written transfer agreement with one or more local hospitals as required. This failure placed all residents at risk of delay in emergency medical treatment, medical complications, and diminished quality of life. Findings included.Hospital transfer agreements were requested from Staff A, Administrator, on 09/15/2025 at 8:53 AM and 12:11 PM. No documentation was provided. In an interview on 09/15/2025 at 1:51 PM, Staff A, stated they expected the facility to have a transfer agreement with the local hospitals as required. Reference WAC 388-97-1620 (6)(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to provide laundry services that included handling, storing, processing, and transporting linens in a manner to prevent the spread of infection. In addition, staff failed to perform hand hygiene when indicated during 2 of 3 medication administration observations. This failure placed residents at risk of potentially avoidable infections and diminished quality of life. Findings included. Review of the facility assessment updated August 2025 showed the facility's average daily census was 75 and provided complex medical care to residents with a variety of diagnoses and infectious diseases. No documentation was found to show how the facility provided laundry services. Review of an undated facility policy titled, Laundry and Linen Handling Policy showed staff were to wear tear-resistant reusable rubber gloves when handling and laundering soiled linens. Linens were to be washed using hot water ranging from 158-176 degrees Fahrenheit (F) for 10 minutes and dried completely in a commercial dryer. If hot water laundry services were not available staff were to reprocess soiled linens manually by immersion in detergent solution, use mechanical action to scrub and remove soil, disinfect by either 1) immersing the linen in boiling water or 2) immersing linen in disinfectant solution for the required contact time and rinsing, then fully drying, ideally in the sun. Each unit was to have a designated room for sorting clean linens and staff were to sort, package, transport, and store clean linens in a manner that prevented the risk of contamination by dust, debris, soiled linens or other soiled items. <LAUNDRY SERVICES> During observation and interview on 09/09/2025 at 11:53 AM, Staff L, Occupational Therapist, and Staff M, Physical Therapist Assistant, stated the facility implemented a new laundry process at the beginning of the month. Both Staff L and M stated they were unsure of the new process but were informed the facility would now be sharing the washer and dryer that was located in the therapy gym. Staff L and M explained occupational therapy (OT) utilized a washer and dryer to simulate a home environment and would ask residents who were working with OT to launder a load of their clothing in preparations for discharges back home. Observation of the therapy gym showed an alcove that contained a simulated home environment. A household top loading washer was observed in the left corner, to the right of the washer was a household front loading dryer that was heard to be running, to the right of the dryer was a kitchen environment that contained a counter, kitchen sink, stove, and refrigerator. There was no separation between clean and dirty, and protective gowns were not observed to be readily available for use when handling soiled linens. To the left of the alcove was a bathroom that contained a closet hanging rack to the left, upon entering. The closet had two handfuls of clean hanging clothing, with five walkers stored beneath the clean clothing. To the right of the walkers, within the same closet space, was a white rolling hamper that contained wet and soiled towels. There was no separation between clean and dirty, and protective gowns were not observed to be readily available for use when handling soiled linens. The dryer was heard stopping at the end of this observation. During observation and interview on 09/09/2025 at 1:11 PM, Staff N, Housekeeping Manager, stated the facility implemented a new laundry process at the beginning of the month. Staff N physically walked the surveyor through the new process while Staff N explained soiled linen was stored in large, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	covered barrels on each unit and nursing staff would transport the soiled barrels to the dirty linen room for sorting when full. Observation of the small dirty linen room showed a large, covered hanging rack surrounded by numerous larger sorting bins. Staff N stated the hanging rack was utilized to transport clean laundry to resident rooms. Staff N acknowledged the clean clothes transporting rack should not be stored in the same room as soiled linens. Staff N continued to explain staff were to wear gloves, a face shield, and a sleeveless plastic apron when sorting soiled linens. Once sorted, soiled linens were transported in a covered sorting bin to the therapy gym, located at the other end of the facility. Staff N stated they were unsure what temperature the washer reached. Staff N further explained clean linen was placed in a clean bag and transported to their office for sorting and folding. Observation of the office showed no designated sorting or folding area, the office contained a desk, chair, and shelving with stored chemicals. Stored under the desk, on the floor, was a pile of white blankets wrapped in plastic and a big black bag that contained soft pressure relieving boots was observed on the floor in the corner of the office. On the back of the office door was a hook with folded curtains and a few hangers with clothing. Staff N explained once clothes were sorted, it was folded and delivered to the resident or placed on the hanging rack, that was stored in the dirty room, to deliver. In an interview on 09/10/2025 at 1:02 PM, Staff O, Maintenance Director, stated they were unaware the facility began utilizing the household washer/dryer located in the therapy gym to wash all resident clothing and had not assessed or inspected the washer/dryer or water temperature prior to implementation of the new laundry process.The new laundry process was explained to Staff O. Staff O acknowledged the clean clothing rack should not be stored in the dirty area. In an interview on 09/12/2025 at 11:47 AM, Staff P, Infection Preventionist, stated they were not informed of the facility's newly implemented laundry process and was unsure if the facility utilized hot washing at 160 degrees F for 25 minutes or cold wash with the appropriately added chemicals. Staff P further stated dirty and clean areas should be kept separated, staff should wear gloves and sleeved gowns when handling and sorting soiled linen, including when loading the washer. Staff P stated they expect staff to store, handle, transport, and process laundry in a manner to prevent cross contamination and prevent the spread of germs. In an interview on 09/12/2025 at 12:43 PM, Staff A, Administrator, explained the facility implemented a new laundry system at the beginning of the month which included use of the household washer/dryer in the therapy gym area but recently realized the machines did not reach the required temperatures. Staff A stated they expected staff to store, handle, and process laundry in a manner to prevent cross contamination. <HAND HYGIENE> During observation on 09/11/2025 at 8:53 AM, Staff K, Licensed Practical Nurse (LPN), was observed dispensing medications for Resident 25. Staff K placed the pills in a medication cup, crushed them and mixed them with a small amount of pudding. Resident 25 was in their wheelchair near the nurses' station. Staff K gave them one spoonful of the medicine/pudding mixture, but for the next spoonful, Resident 25 turned their face away. Staff K then labeled the medication cup with the resident name using a marker, filled out a paper form at the medication cart, held a door open for another resident, in between attempts to get Resident 25 to take the rest of their medication. Staff K did not use alcohol-based hand sanitizer (ABHS) or perform hand hygiene, when changing from one task to another. A bottle of ABHS was not observed to be readily available for use, on the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observation on 09/11/2025 at 10:03 AM, Staff K dispensed medications for Resident 34 at the medication cart. Staff K then brought the medications to Resident 34's room and put on a pair of gloves. Staff K did not use ABHS or perform hand hygiene before putting on the gloves. After they finished administering all of the medications, Staff K removed and discarded their gloves and used the wall mounted ABHS. During an interview on 09/11/2025 at 12:07 PM, the surveyor described the observations during the medication administration to Staff K. Staff K acknowledged they should have used ABHS after doing other tasks and before going back to Resident 25 to attempt to give them their medicine. Staff K stated they did not usually have bottles of ABHS on the medication carts, but hand hygiene was to be done between different residents' care, and before putting on and after taking off gloves. During an interview on 09/12/2025 at 2:28 PM, Staff B, Director of Nursing, acknowledged Staff K should have performed hand hygiene between different residents' care, and with glove changes. References: WAC 388-97-1320(1)(c)(3)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on interview and record review, the facility failed to periodically review resident rights with residents during their stay at the facility for 4 of 5 sampled residents (Residents 21, 34, 38, and 46) interviewed during the Resident Council meeting. This failure placed residents at risk of not understanding their rights, a reduced ability to self-advocate, and a diminished quality of life. Findings included.During a Resident Council meeting on 09/05/2025 at 11:47 PM, attendees were asked if the facility discussed their rights as residents and if they felt they were able to exercise their rights. Resident 38 stated residents were only given a copy of their rights if they asked for them. Residents 21 and 46 stated they did not remember ever being offered information on resident rights or having discussions about their rights. Resident 34 stated they were unable to exercise their rights if they did not know what their rights were. The residents confirmed they had not seen posted information related to resident rights. Review of the Resident Council minutes documented the following: - on 06/23/2025, nine residents attended the meeting. Copies of the Resident [NAME] of Rights were given to new residents, but the minutes did not document who those residents were. The minutes did not include documentation that the Resident [NAME] of Rights was discussed with all of the residents. - on 07/28/2025, five residents attended, and no documentation was found that showed resident rights were discussed or copies were provided.- on 08/25/2025, six residents attended. Three residents received a copy of the Resident [NAME] of Rights. There was no documentation that showed the Resident [NAME] of Rights was discussed or reviewed with all the residents.On 09/05/2025 at 12:10 PM, a poster titled, Know Your Rights and an attached binder and laminated sheets that contained information on the resident's rights was observed posted on the wall next to the dining room. The poster and binder were placed high on the wall and not at a level that was readable or accessible for a resident who utilized a wheelchair for mobility. Residents 21, 38, and 46 all utilized wheelchairs. During an interview on 09/09/2025 at 10:12 AM, Staff DD, Life Enrichment Director, stated residents were notified of their right when they were admitted to the facility, and usually only new residents received a copy of the resident rights, because most of the residents had lived at the facility a long time. During an interview on 09/12/2025 at 11:41, Staff A, Administrator, acknowledged the Know Your Rights poster and binder were not at eye level for residents who used wheelchairs, and stated resident rights should be reviewed/discussed periodically with all residents. Reference: WAC 388-97-0300(1)(a), (7)(b)

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, interview and record review, the facility failed to ensure contact information of all pertinent State regulatory and advocacy groups were provided and/or posted for 4 out of 5 residents interviewed (Residents 38, 21, 34, and 46) during Resident Council. Failure to ensure contact information was posted at levels that were readable and accessible to residents in wheelchairs, placed the residents at risk of not being fully informed of their rights, potential abuse and/or neglect, and a diminished quality of life.Findings included.During a Resident Council meeting on 09/05/2025 at 12:05 PM, attendees were asked if the facility informed them how to contact the State Agency if they had concerns regarding their care. Residents 21, 34, 38, and 46 all stated they had not been informed or remember being informed on how to report to the State Agency. On 09/05/2025 at 12:10 PM, a large green and white poster was observed on the wall next to the main dining room. The poster was titled, We Care about Your Concerns and included the contact information for the State regulatory agency and advocacy groups. The poster was situated high on the wall and not at a level that was readable or accessible for a resident who utilized a wheelchair for mobility. Residents 21, 38, and 46 all utilized wheelchairs. During an interview on 09/05/2025 at 2:17 PM, Residents 21 and 46 were informed of the poster on the wall next to the dining room and were given an information sheet that contained the contact information for the State regulatory agency and advocacy groups. Residents 38 and 34 were asleep in their respective rooms and the information sheet was left on their bedside tables. During an interview on 09/12/2025 at 11:41 AM, Staff A, Administrator, acknowledged the We Care about Your Concerns poster was not at eye level for residents who used wheelchairs and stated it would be moved. Reference: WAC 388-97-0300(7)(a-d)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review, the facility failed to ensure residents and/or visitors were informed of the location of the State Recertification Survey results documents/binder, and that the binder location was known for 4 of 5 sampled residents (Residents 21, 34, 38, and 46). This failure placed residents and visitors at the risk of not being able to access the Survey results. Findings included .During a Resident Council meeting on 09/05/2025 at 11:55 AM, attendees were asked if they had access to the State Recertification Survey binder that contained the results from inspections completed by the State Agency. Residents 21, 34, 38, and 46 all stated they had never seen the binder and did not know where it was located. On 09/09/2025 at 8:05 AM, a binder that contained the State Recertification Survey results was observed in a plastic holder on the wall just underneath framed documents of the facility license at the area that previously was the lobby and main entrance into the facility. During an interview on 09/09/2025 at 10:12 AM, when informed that residents were not aware of the location of State Recertification Survey binder, Staff DD, Life Enrichment Director, stated the binder was discussed sometimes during Resident Council meetings, but they would follow up with the residents. During an interview on 09/12/2025 at 11:41, Staff A, Administrator, was informed that residents reported not knowing where the State Recertification Survey binder was located. Staff A stated there was a notice at the facility entrance that stated the survey binder was in the administrative lobby and they would follow up with the residents. No notice was seen during an observation of the lobby area after the interview. Reference (WAC): 388-97-0480

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents and/or their representatives a written notice that included the reason for transfer or discharge and failed to send a copy of the notice to the Office of the State Long-Term Care (LTC) Ombudsman (an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations), as required for 2 of 3 sampled residents (Residents 86 and 2) reviewed for discharges. This failure placed residents at risk of inappropriate transfers or discharges.Findings included.<Resident 2>The 09/05/2025 discharge assessment documented Resident 2 was discharged from the facility to the community on 09/01/2025 with a return not anticipated. Review of September 2025 nursing progress notes documented Resident 2 left the faciity on [DATE] against medical advice. There was no documentation the Ombudsman was notified of the discharge, as required. Ombudsman discharge notifications for the previous four months were requested from Staff A, Administrator, on 09/08/2025 at 2:11 PM. Review of the documentation received showed no documentation the Ombudsman was notified of Resident 2's discharge, as required. During an interview on 09/08/2025 at 2:48 PM, Staff C, Social Service Director, stated they notified the Ombudsman of each resident discharge by e-mail.During a follow-up interview on 09/09/2025 at 10:19 AM, Staff C acknowledged they were unable to find documentation the Ombudsman was notified of Resident 2's discharge. During an interview on 09/09/2025 at 10:22 AM, Staff A acknowledged they were unable to find documentation the Ombudsman was notified of Resident 2's discharge. Staff A further stated the Ombudsman should have been notified of the discharge, as required. <Resident 86>The 07/07/2025 admission assessment documented Resident 86 admitted to the facility on [DATE] and had diagnoses that included failure to thrive and end-stage kidney disease dependent on dialysis (medical treatment to remove fluid and waste from the blood when the kidneys no longer functioned). Resident 86 was cognitively intact. Review of July 2025 nursing progress notes documented Resident 86 was sent to the hospital emergency room on [DATE] from the dialysis provider related to low blood pressure. There was no documentation the Ombudsman was notified of the hospital transfer, as required. A list of hospitalizations and the corresponding Ombudsman notifications for the previous four months was requested from Staff A, Administrator, on 09/08/2025 at 2:11 PM and again on 09/09/2025 at 10:17 AM. Review of hospitalizations from 05/07/2025 through 09/09/2025 showed 43 resident transfers to the hospital occurred. No documentation was provided to show the Ombudsman was notified of the hospital transfers, as required. During an interview on 09/08/2025 at 2:48 PM, Staff C stated the floor nurse or the Resident Care Manager (RCM) notified the Ombudsman when a resident was transferred to the hospital. During an interview on 09/08/2025 at 2:59 PM, the LTC Ombudsman stated they were not notified of hospital transfers. The Ombudsman stated they typically learned of a resident transfer to the hospital when they visited the facility. During an interview on 09/09/2025 at 10:39 AM, Staff D, Registered Nurse, stated they had experience transporting residents to the hospital but had not notified the Ombudsman as part of the process. During an interview on 09/09/2025 at 11:04 AM, Staff H, RCM, stated they were unsure who was responsible for notifying the Ombudsman of hospital transfers. During an interview on 09/09/2025 at 11:07 AM, Staff B, Director of Nursing, stated Social Services notified the Ombudsman of hospital transfers. A 09/10/2025 at 11:53 AM e-mail correspondence from Staff A confirmed hospital transfer notices were not being sent to the Ombudsman, as required. No associated WAC

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete interdisciplinary team (IDT, at a minimum consisting of the resident's attending physician, nurse and nurse aide responsible for the resident, a member of food and nutrition services, the resident and/or the resident representative) care planning conference meetings to enable resident and/or the resident representative participation in development, review, and revision of the plan of care for 9 of 9 sampled residents (Resident 5, 7, 9, 27, 41, 43, 44, 48 and 63), reviewed for care conferences. This failure placed residents at risk of unmet care needs, and diminished quality of life. Findings included. Review of the facility policy titled, Care Conferences revised May 2023, showed the social worker would encourage the resident and/or their legal representative to attend care plan conferences. Care conferences would be scheduled based on identified needs and regulatory standards. The policy further showed care conferences would be scheduled upon admission, quarterly, with significant changes of condition, and as requested by the resident, family, or other team members. Staff were to notify the resident and resident representative of the next scheduled care conference and document method of notification in the medical record. After a care conference was held, a summary of the meeting's outcome was to be documented in a note. <Resident 9> According to a comprehensive assessment, dated 07/17/2025, Resident 9 had a diagnosis of dementia (a disorder that caused impaired memory and reasoning) with psychotic disturbance (hallucinations-sensing things that seemed real but actually are not and delusions-false beliefs that conflicted with reality). They made their basic needs known and had a guardian for medical decisions. During an interview on 09/04/2025 at 10:35 AM, Resident 9 stated staff did what they wanted and explained staff did not tell them anything about their plan of care. Review of a 07/19/2024, over 14 months prior, care conference progress note documented that the resident had not participated in the care conference, but their guardian did. Additional review of the medical record showed no documentation care conferences were held quarterly after 07/19/2024. Any care conference notes for Resident 9 were requested from Staff A, Administrator on 09/10/2025 at 10:20 AM. No documentation was provided. <Resident 27> According to a comprehensive assessment, dated 07/06/2025, Resident 27 had diagnoses which included diabetes and depression. They were alert, oriented and made their needs known. During an interview on 09/03/2025 at 2:38 PM, Resident 27 stated that they had never had a care conference. Review of a 07/09/2024,14 months prior, care conference evaluation note, documented the resident had attended the care conference. Additional review of the medical record showed no documentation care conferences were held quarterly after 07/09/2024. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Any care conference notes for Resident 27 were requested from Staff A, Administrator on 09/10/2025 at 10:20 AM. No documentation was provided. <Resident 44> According to the 07/22/2025 quarterly assessment, Resident 44 admitted to the facility on [DATE] with diagnoses including medically complex conditions. The assessment further showed Resident 44 was cognitively intact and able to clearly verbalize their needs. Review of the 06/18/2024 care conference evaluation showed a quarterly care conference was held with the resident representative, social services, and nurse manager. No documentation was found to show a member of nutrition services attended the meeting. Further review of the record showed no documentation care conferences were held quarterly. Review of June 2024 through September 2025 social service progress notes showed no documentation care conferences were completed quarterly. <Resident 43> According to the 08/21/2025 quarterly assessment, Resident 43 admitted to the facility on [DATE] with diagnoses including dementia. The assessment further showed Resident 43 was cognitively intact and able to clearly verbalize their needs. Review of the 11/15/2024 care conference evaluation showed an initial care conference was held and a member of nutrition services was not present at care conference. Further review of the record showed no documentation care conferences were held quarterly. Review of November 2024 through September 2025 social service progress notes showed no documentation care conferences were completed quarterly. <Resident 41> The 06/27/2025 quarterly assessment documented Resident 41 admitted to the facility 09/17/2024 with diagnoses including anxiety and depression. Resident 41 had moderate cognitive impairment and was able to make their needs known. In an interview on 09/03/2025 at 10:44 AM, Resident 41 was asked if the facility kept them informed about their plan of care or had care conference meetings to inform them of any changes. Resident 41 stated they were not informed about changes with their medications, unless they asked. Review of a Care Conference Evaluation form documented a care conference occurred on 09/24/2024 and included Resident 41 and their representative. No other documentation of a care conference after 09/24/2024 was found. Review of the Social Services Quarterly Evaluation forms documented the evaluation was completed quarterly on 12/23/2024, 03/25/2025, and 06/26/2025, but all evaluations documented a care plan review was not completed and the text boxes for documenting the date and time the resident and/or representative were invited to participate in the care conference were blank. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the progress notes from 09/01/2024 through 09/10/2025 found no documentation that care conference or care planning meetings had occurred after 09/24/2024. <Resident 48> The 08/11/2025 quarterly assessment documented Resident 48 admitted to the facility on [DATE] with diagnoses including stroke and depression. Resident 48 was cognitively intact to make decisions regarding their care. In an interview on 09/03/2025 at 2:00 PM, Resident 48 was asked if the facility kept them informed about their plan of care or had meetings to discuss their care. Resident 48 stated no, they were not informed about changes, like with the medications, or their plan of care unless they asked. Review of the Care Conference Evaluation form documented a care conferences was held on 06/27/2024 which included Resident 48 and their representative. No other documentation of a care conference after 06/27/2024 was found. Review of the Social Services Quarterly Evaluation forms dated 08/08/2025 and 02/10/2025 documented Resident 48 was well adjusted to the facility, had not brought up wanting to discharge lately, and there were no concerns identified at the time of the evaluation. Both evaluation forms documented a care plan review was not completed and the text boxes for documenting the date and time of the invitation was made to resident and/or representative to participate in the care conference were blank. Review of the progress notes from 05/01/2025 through 09/10/2025 found no documentation that any care conference or care planning meetings had occurred. <Resident 5> According to the 08/16/2025 quarterly assessment, Resident 5 admitted to the facility on [DATE] and had diagnoses which included high blood pressure, diabetes and depression. The resident was able to make their needs known. In an interview on 09/03/2025 at 11:47 AM, Resident 5 stated they had not had a care conference meeting. A review of Resident 5's record showed no documentation a care conferences had occurred. <Resident 7> According to the 08/21/2025 quarterly assessment, Resident 43 admitted to the facility on [DATE] and had diagnoses which included Multiple Sclerosis (a disease that caused nerve damage and disrupted communication between the brain and body). The resident was able to make their needs known. In an interview on 09/04/2025 at 8:57 AM, Resident 7 stated they had never had a care conference and did not know what that was. Review of the care conference evaluation form showed an initial care conference was held on (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/20/2024. Additional record review showed no documentation care conferences were held quarterly thereafter. <Resident 63> According to the 08/08/2025 quarterly assessment, Resident 63 admitted to the facility on [DATE] and had diagnoses which included a stroke, diabetes and high blood pressure. The resident was able to make their needs known. In an interview on 09/03/2025 at 10:43 AM, Resident 63 stated they had never had a care conference. Review of the care conference evaluation form showed an initial care conference was held on 05/06/2025. Additional review of the record showed no documentation care conferences were held quarterly thereafter. In an interview on 09/11/2025 at 10:33 AM, Staff C, Social Service Director, stated care conferences were held within seven days of admission and quarterly thereafter. Staff C stated Social Services, nursing and therapy attended the care conference and the family and resident representative were invited to attend. Staff C acknowledged care conferences were not being held quarterly, and they recently hired an assistant. Staff C stated it was important to hold care conferences to keep the residents informed of their care and allow families to give input. In an interview on 09/11/2025 at 10:47 AM, Staff B, Director of Nursing, stated care conferences were held when requested and quarterly. Staff B acknowledged care conferences were not occurring quarterly and recently hired another Social Worker to assist with completing them. Reference: WAC 388-97-1020 (2)(f), (4)(b)

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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 consistently provide assistance with bathing, nail care, and eating for 7 of 9 sampled residents (Residents 5, 7, 17, 19, 29, 43 and 48) reviewed for activities of daily living (ADLs) for dependent residents. Those failures placed the residents at risk for diminished quality of life and unmet care needs. Findings included… <Resident 29> The 09/03/2025 quarterly assessment documented Resident 29 was cognitively intact to make decisions regarding their care, and had diagnoses which included stroke and diabetes. In addition, the assessment documented the resident needed assistance from nursing staff to complete ADLs for personal hygiene tasks such as nail care. On 09/03/2025 at 3:49 PM, Resident 29 was observed lying in bed watching television and eating a chocolate snack cake with their left hand. The fingernails of both hands were observed to be long with black debris underneath them. On 09/05/2025 at 8:56 AM, 10:53 AM, and 1:55 PM, Resident 29 was again observed with long fingernails with black debris underneath them. Additional observations of Resident 29 with long, dirty fingernails were made on 09/08/2025 at 9:05 AM and 11:15 AM. Review of the 03/05/2025 ADL care plan documented Resident 29 was dependent on staff to complete personal hygiene, and interventions informed nursing staff to the resident's nails were to be cleaned as needed on their bath day and trimmed by the nurse. In addition, the skin care plan had interventions implemented on 04/19/2024 that informed the nursing staff that Resident 29 had dry skin and to reduce the risk of injury from scratching, Resident 29's nails were to be kept clean and short. Review of the Treatment Administration Records (TARS) from June 2025 through September 2025 documented diabetic nail care was done weekly, and all nail care during the four-month period reviewed was documented as being refused by Resident 29. On 09/10/2025 at 9:25 AM, Resident 29 was observed lying in bed watching television, the fingernails of both hands were still long with black debris underneath. When asked about the condition of their fingernails being long and dirty, Resident 29 looked at the fingernails on their right hand and stated, “I like manicures, they are nice.” When asked if they ever refused to have their nails cleaned or trimmed, Resident 29 stated, they did not refuse, they liked their nails short, but long enough to be able to open their soda cans. Resident 29 then again stated manicures were nice. In an interview on 09/11/2025 at 10:55 AM, Staff R, Licensed Practical Nurse, stated Resident 29 consistently refused nail care. When asked if other interventions are done when resident refuses nail care, Staff R stated, they try and soak the resident's hands to get them clean, and they inform the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provider of the refusals by writing in the communication book. Review of the provider communication books from 06/30/2025 through 09/11/2025 found entries related to Resident 29 refusal of nail care were made on 09/03/2025 and 09/10/2025, no other entries were made. <Resident 48> The 08/11/2025 quarterly assessment documented Resident 48 was cognitively intact to make decisions regarding their care, had diagnoses which included stroke, and needed moderate assistance from nursing staff to complete ADLS for personal hygiene. On 09/03/2025 at 11:47 AM, Resident 48 was observed lying in bed eating pie with their hands. The fingernails of both hands were observed to be long with brown matter underneath them. Subsequent observations of Resident 48 with long, dirty fingernails were made on 09/04/2025 at 10:36 AM, and 1:30 PM, 09/05/2025 at 8:54 AM and 10:51 AM, and 09/08/2025 at 8:59 AM. Review of the ADL care plan, last revised 08/22/2025, found interventions that informed nursing staff of Resident 48's personal hygiene care needs related to bathing, oral care and dressing, but no interventions or instructions related to nail care were included. Review of the nail care record from 08/12/2025 through 09/10/2025 documented no nail care was provided to Resident 48 and during the 30-day time frame, no documentation was found that showed Resident 48 had refused to have nail care done. In an interview on 09/11/2025 at 10:42 AM, Staff I, Nursing Assistant, stated nail care was done on a resident's bath day, or as needed, unless they were diabetic, and then the nurses did the nail care. In an interview on 09/11/2025 at 10:59 AM, Staff R, Licensed Practical Nurse, stated Resident 48 had recently transferred to the unit from the short stay unit, would refuse cares at times, and refusals should be documented when it occurred. In an interview on 09/11/2025 at 12:27 PM, when informed of the concern related to nail care not being provided consistently for Residents 29 and 48, Staff E, Resident Care Manager, stated they were not aware there was an issue. In an interview on 09/12/2025 at 11:21, Staff B, Director of Nursing, stated the facility expectation was that nail care was completed and documented and when a resident refused, then it was reoffered and followed up on. <Resident 17> The 08/25/2025 comprehensive assessment documented Resident 17 had diagnoses that included paralysis on one side of the body from a stroke and contractures (shortening or hardening of muscles that led to joint immobility). The resident was cognitively intact and required partial staff assistance for personal hygiene and substantial assistance for showering/bathing. The 08/19/2025 care plan documented Resident 17 had a self-care deficit; required extensive (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance of 1 staff for bathing twice weekly and set-up assistance for personal hygiene. The active KARDEX (Nursing Assistant, NAC, care instructions) documented Resident 17 was to be showered twice weekly. The care plan and the KARDEX did not have instructions or interventions for nail care for the resident. A provider progress note dated 08/20/2025 documented Resident 17 was slumped over in bed, was disheveled and withdrawn with minimal eye contact. The resident's left upper extremity was contracted with overgrown fingernails. They noted they were going to request nursing to trim. The resident was moderately uncooperative. A review of the NAC nail care task from 08/19/2025 through 09/04/2025 showed Resident 17 had no nail care. There were no refusals documented. The NAC shower task documentation showed Resident 17 was showered on 08/28/2025, and on 09/04/2025. The resident refused showers on 09/01/2025 and 09/08/2025. On 09/03/2025 at 9:50 AM, Resident 17 was observed in their room in their wheelchair. Their hair was uncombed, and their fingernails were long, jagged, and had dark brown/black material under them. Additional observations of the resident's jagged fingernails with dark matter under them were made on 09/05/2025 at 8:15 AM and 12:12 PM, 09/08/2025 at 9:10 AM, 09/10/2025 at 9:57 AM, and 09/11/2025 at 10:26 AM. On 09/05/2025 until the survey exit, Resident 17 was supervised by a NAC 1 to 1 for the resident's safety. On 09/11/2025 at 10:26, Staff T, NAC, stated they had not offered to clean Resident 17's nails on 09/10/2025 or 09/11/2025 when they sat with the resident 1 to 1. They stated they noticed the nails were dirty. Staff T stated they were going to give Resident 17 a shower and would provide nail care at that time. Resident 17 requested to have their beard shaved off during their shower as well; they stated they'd like it shaved once more before they grew it out for the winter. On 09/12/2025 at 1:10 PM, Resident 17 was observed; their fingernails had been clipped. There continued to be dark matter under the nails. They had been shaved as requested. On 09/12/2025 at 1:15 PM, Staff U, NAC, stated they were aware Resident 17 needed their nail care done since the resident first came to the facility. They stated nail care was done on shower days or if needed. They were unsure why the resident's nails had been clipped but not cleaned underneath. If a resident refused care, the refusal was documented in the NAC tasks. <Resident 5> The 08/16/2025 quarterly assessment documented Resident 5 had diagnoses that included a stroke, diabetes and seizures. The resident was able to make their needs known and required total assistance for bathing. In an interview on 09/03/2025 at 11:52 AM, Resident 5 stated they were not getting their showers twice a week. The 02/07/2024 care plan documented Resident 5 required extensive assistance for bathing twice weekly and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The shower task documentation reviewed from 07/01/2025 through 09/04/2025 showed Resident 5 was showered on 07/02/2025, 07/05/2025, 07/12/2025, 07/16/2025, 07/26/2025, 07/30/2025, 08/02/2025, 08/09/2025, 08/24/2025, 08/27/2024 and 09/04/2025, not consistently twice weekly as care planned. <Resident 43> The 08/21/2025 quarterly assessment documented Resident 43 had diagnoses that included heart failure, dementia, and diabetes. The resident was able to make their needs known and required partial to moderate assistance for bathing and extensive assistance with nail care. In an observation 09/03/2025 at 12:05 PM, Resident 43 was sitting in their wheelchair in the doorway of their room. The resident's shirt was soiled and they only had a brief on. Resident 43's nails were very long. In an observation on 09/04/2025 at 11:21 AM, Resident 43 was sitting on the edge of their bed with a strong body odor. The resident's nails remained long, and they stated they did not like their nails that way. When Resident 43 was asked if they would allow staff to cut their nails, they stated they would. In an observation on 09/05/2025 at 9:38 AM, Resident 43 was sitting in their wheelchair. The resident was wearing the same shirt from the prior day, their nails were long, and their hair was unclean. Similar observations of Resident 43 with long nails were made on 09/08/2025 at 8:51 AM and 09/09/2025 at 9:33 AM. The 11/11/2024 care plan had a goal of the resident would be neat, clean and well groomed daily. The care plan instructed nursing staff to assist with bathing and personal hygiene. The shower task documentation reviewed from 07/01/2025 through 09/04/2025 showed Resident 43 was showered twice weekly in July with exception of 07/06/2025 to 07/13/2025, 07/16/2025 said refused and the next shower was given on 07/20/2025. In August the resident was showered on 08/02/2025, 08/09/2025, 08/13/2025, 08/20/2025 said non applicable, 08/24/2025, 08/27/2024 stated resident refused, and the next shower was on 09/04/2025, not consistently twice weekly as care planned. The nail care documentation in the Medication Administration Record showed Resident 43 had nail care completed weekly. In an observation on 09/12/2025 at 2:23 PM, Resident 43 held out their hands and showed their nails were trimmed and stated they were happy about it. <Resident 7> The 07/17/2025 quarterly assessment documented Resident 7 had diagnoses that included Multiple Sclerosis (a disease that damaged nerves and disrupted the communication between the brain and body) and anxiety. The resident was able to make their needs known and required substantial to maximum assistance for bathing. In an observation and interview on 09/11/2025 at 8:59 AM, Resident 7 was lying in bed and their hair was greasy. The resident stated it had been a while since they had a shower and said they had body odor and smelled. The resident stated they were told there were no towels or washcloths. The (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident added they bathed themselves and all the staff had to do was supervise, so there was no reason they should not be able to shower. The 12/16/2025 care plan instructed nursing staff to assist the resident with bathing. The shower task documentation reviewed from 07/01/2025 through 09/04/2025 showed Resident 5 was showered on 07/02/2025, 07/05/2025, refused 07/09/2025, 07/16/2025 and 07/19/2025 stated non applicable, res was given a shower on 07/20/2025, 07/23/2025, 07/26/2025, 07/30/2025 stated resident refused, resident had a shower on 08/02/2025, refused on 08/06/2025, had a shower on 08/09/2025, 08/13/2025, shower on 08/16/2025 said refused, had a shower on 08/20/2025, 08/23/2025, refused on 08/27/2025, 08/30/2025 said non applicable and the next shower on 09/09/2025 said refused. In an interview on 09/08/2025 at 11:52 AM, Staff U, Nursing Assistant, stated they tried to complete nail care when they could and if the resident was diabetic they notified the nurse. Staff U stated ideally the residents got two showers per week, but showers did not happen near as often as they needed to be and this was related to inadequate staffing. Staff U stated occasionally they had a shower aide and would benefit from a permanent shower aide. Staff U stated it was important to provide nail care and showers for infection control, hygiene and dignity. In an interview on 09/08/2025 at 12:00 PM, Staff D [NAME], Registered Nurse, stated they thought showers were given three times per week and the nurse did diabetic nail care. In an interview on 09/08/2025 at 12:30 PM, Staff B, Director of Nursing, stated showers were given per the resident's preference, generally twice per week and nail care was done with weekly skin checks or during their shower. Staff B stated it was important to do routine bathing and nail care for cleanliness and dignity. Staff B added if the resident refused cares it was documented and a refusal sheet was filled out and placed in the medical record. <Resident 19> The 07/23/2025 quarterly assessment documented Resident 19 had diagnoses that included dementia and failure to thrive. The resident had severe cognitive impairments and required partial to moderate assistance for bathing and set up and clean up assistance with eating. In an observation on 09/03/2025 at 10:22 AM, Resident 19 was sitting in their wheelchair in their room with a glass of juice. The juice had spilled on the tray table, and the resident was wiping it with a paper towel and was confused. In an observation on 09/05/2025 at 12:08 PM, Resident 19 was sitting in the dining room with a bowl of soup in front of them. The resident held the spoon in the same position, was not moving their hand and no staff assisted them to eat. In an observation on 09/10/2025 at 8:45 AM, Resident 19 was sitting in the dining room eating breakfast. The resident used their fingers to feel around the plate for food and when they found food they placed it on their fork, no staff member was assisting the resident to eat. At 9:06 AM, Resident 19 sat at the table with another resident and Staff Z, Nursing Assistant. The resident had nasal drainage that hung approximately two inches out of their nose over their plate of food. Staff Z got up and assisted the other resident away from the table but did not assist Resident 19 with their nose. (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 observation on 09/11/2025 at 8:35 AM to 8:42 AM, Resident 19 sat at a dining room table consuming breakfast. The resident's nose was dripping, and they continued eating and consuming fluids and the nasal drainage came in contact with their cup and spoon. The staff did not assist the resident until 8:43 AM with the nasal drainage. Resident 19 used their fingers to feel around their plate for food and placed the food into their mouth when they found it and was not assisted by staff. At 8:52 AM, the resident was trying to scoop food off the tablecloth. In an observation on 09/11/2025 at 12:52 PM, Resident 19 was sitting in the dining room and was taking small bites of food. The resident then tried to scoop some food and rubbed their butter knife against their fork and was unable to put the food onto the utensils. Resident 19 then lifted an empty spoon to their mouth, no staff assisted the resident. At 12:59 PM, Staff I, Nursing Assistant, walked over to the resident, looked at them and walked away. At 1:01 PM, Staff GG, Restorative Aide, asked Staff I to tell Resident 19 to take a bite because they were not getting anything on their spoon. Staff I told the resident not to use their hands and to use the spoon. In an interview on 09/11/2025 at 2:04 PM, Staff NN, Nursing Assistant, stated they looked at the care plan to know what care the residents needed. Staff NN stated if a resident was feeling around their plate with their fingers they should have been assisted to eat. Staff NN stated if they saw a resident with nasal drainage they would immediately assist them. In an interview on 09/11/2025 at 2:16 PM, Staff OO, Licensed Practical Nurse, stated residents required assistance with eating when they could not feed themselves, had poor coordination or problems with swallowing. Staff OO stated residents who feel around their plate for food may have vision problems and needed assistance with eating. Staff OO stated staff needed to intervene when a resident had nasal drainage during the meal service. In an interview on 09/11/2025 at 2:20 PM, Staff A, Administrator, stated residents required assistance with eating if they showed a change in their abilities. Staff A stated the staff needed to intervene when a resident put their fingers in their plate and felt around for food and had nasal drainage as they had assisted the resident multiple times with this and it was a dignity issue. Staff A added Resident 19 needed someone sitting with them or near them to assist them with meals. Reference: WAC 388-97-1060 (2)(c)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review the facility failed to implement and oversee a comprehensive restorative nursing program for 3 of 3 sampled residents (Resident 44, 43, and 19), reviewed for restorative services. This failure placed residents at risk for complications and diminished quality of life. Findings included. <Resident 44> According to the 07/22/2025 quarterly assessment, Resident 44 had diagnoses including stroke with weakness on one side of the body and a contracture of the left hand. The assessment further showed Resident 44 had functional limitations in range of motion to one arm and leg and received range of motion via a restorative nursing program. Review of the limited physical mobility care plan revised 01/31/2025 showed Resident 44 was to have gentle passive range of motion (PROM, joints moved by an outside source such as a staff, rather than independently) stretching performed to the joints in their left arm and leg, with participation documented. Review of the September 2024 through August 2025 PROM program documentation showed the following: - September 2024: response not required, not applicable, and/or 0 documented 19 times. - October 2024: response not required, not applicable, and/or 0 documented 11 times. - November 2024: response not required, not applicable, and/or 0 documented 17 times. - December 2024: response not required, not applicable, and/or 0 documented 10 times. - January 2025: response not required, not applicable, and/or 0 documented 14 times. - February 2025: response not required, not applicable, and/or 0 documented 13 times. - March 2025: response not required, not applicable, and/or 0 documented 14 times. - April 2025: response not required, not applicable, and/or 0 documented 18 times. - May 2025: response not required, not applicable, and/or 0 documented seven times. - July 2025: response not required, not applicable, and/or 0 documented six times. - August 2025: response not required, not applicable, and/or 0 documented 14 times. Review of September 2024 through August 2025 restorative program quarterly evaluations showed the following: -09/03/2024: Resident 44 PROM has been seldomly conducted due to restorative staffing. The PROM (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was reassigned to be performed by the nursing assistant working the floor. -12/03/2024: Resident 44 participated regularly in PROM to the left arm and leg. -03/14/2025: Resident 44 participated regularly in PROM to the left arm and leg. -06/12/2025: PROM was seldomly conducted and Resident 44 has had some recent functional decline with increased incidences of falls. A therapy screen was requested. -08/20/2025: Resident 44 completed physical therapy, and a restorative walking maintenance program was recommended and implemented. <Resident 43> According to the 08/21/2025 quarterly assessment, Resident 43 had diagnoses including non-traumatic brain injury (brain damage that occurred without an external physical force). The assessment further showed Resident 43 had no range of motion limitations and did not participate in a restorative nursing program. Resident 43 was cognitively intact and able to clearly verbalize their needs. Review of the 01/07/2025 limited physical mobility care plan showed Resident 43 was on a walking maintenance program. Resident 43 was to walk to and from the shower room, a distance of up to 150 feet, two to three times weekly, with participation documented. Review of the January 2025 through August 2025 walking maintenance program documentation showed the following: -January: response not required and/or not applicable documented 25 times. No documentation was found to show Resident 43 walked. -February: response not required and/or not applicable documented 23 times. Resident 43 walked once. -March: response not required and/or not applicable documented 29 times. Resident 43 walked twice. -April: response not required and/or not applicable documented 11 times. Resident 43 walked 19 times. -May: response not required and/or not applicable documented 26 times. Resident 43 walked eight times. -June: response not required and/or not applicable documented 16 times. Resident 43 walked 13 times. -July: response not required and/or not applicable documented 23 times. Resident 43 walked four times. -August: response not required and/or not applicable documented 26 times. Resident 43 walked five times. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of January 2025 through August 2025 restorative program quarterly evaluations showed the following: -01/07/2025: Resident 43 was discharged from skilled therapy services with recommendations to participate in a walking program to maintain their current level of mobility. A care plan was initiated for Resident 43 to ambulate up to 150 feet, two to three times a week. -02/18/2025: Resident 43 participated fairly regularly with walking activity conducted three times during the previous 14 days. The care plan was to be continued to provide formal practice in walking. -05/19/2025: Resident 43 participated fairly regularly with walking activity conducted three times during the previous 14 days. The care plan was to be continued to provide formal practice in walking. -08/25/2025L Resident 43 participated regularly with walking. The care plan was to be continued to provide formal practice in walking. <Resident 19> The 07/23/2025 quarterly assessment documented Resident 19 had diagnoses which included dementia, failure to thrive and malnutrition. The assessment further showed Resident 19 had functional limitations in range of motion to bilateral upper and lower extremities and was not on a restorative nursing program. A review of the limited physical mobility care plan revised 01/31/2025 showed Resident 19 was to have gentle PROM stretching performed to the joints in their knees with each lower extremity dressing or toileting need, with participation documented. Review of the August 2025 through September 2025 PROM program documentation showed the following: - August: NO (did not occur), not applicable documented 40 times. - September: NO, not applicable documented 13 times. Review of August 2025 through September 2025 restorative program quarterly evaluations showed the following: -08/19/2025: Resident participating well without declines to ROM this quarter, continue program as recommended and monitor reviewed with restorative aids. -04/22/2025: Resident has participated regularly in PROM activities, tolerated it well, care plan continued. In an interview on 09/10/2025 at 10:18 AM, Staff EE, Nursing Assistant, stated they believed Resident 19 was on a restorative program for ROM that was completed by the Restorative Aids. In an interview on 09/10/2025 at 10:35 AM, Staff L, Occupational Therapist, stated Resident 19 was placed on a restorative program on 01/22/2025 for lower extremity ROM. Staff L stated they filled out a sheet with the program and gave it to the nurse to put it in the system. Staff L stated residents (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were placed on restorative programs for maintenance and they did quarterly assessments for changes in their baseline. In an interview on 09/10/2025 at 10:42 AM, Staff FF, Restorative Registered Nurse, stated Resident 19 was on a restorative program with the Nursing Assistants for ROM to their bilateral lower extremities. Staff FF stated Resident 19 refused the program once in the past 14 days. When asked if Resident 14 had a decline in their abilities, Staff FF stated not that they were aware of. Staff FF stated the Nurse Manager oversaw the programs, they only entered them and reviewed the programs quarterly or as needed. When asked who determined if the residents were maintaining their abilities, Staff FF stated they were not totally uninvolved, if they suspected a decline, they referred the residents to therapy. When asked who monitored to ensure Resident 19 maintained their ability to extend their knees 80 degrees, Staff FF stated the Restorative Aids if they were on a program with them and if it was completed by the Nursing Assistants it was by the Nurse Manager. Staff FF stated they completed the restorative evaluations and if they did not have a reason to suspect a change then they would enter a note that said the resident was tolerating the program well. Staff FF stated the programs should been conducted as written and the documentation should never say the program did not occur. Staff FF reviewed the restorative documentation and acknowledged it said the program did not occur, several times. In an interview on 09/10/2025 at 11:00 AM, Staff B, Director of Nursing, stated Staff FF, the Restorative Registered Nurse, monitored the therapy recommended programs and ensured residents maintained their abilities. In an interview on 09/11/2025 at 9:11 AM, Staff I, Nursing Assistant, stated they knew when a resident was on a restorative program by looking at their care plan. Staff I stated the Restorative Aids did the programs but if they did not have time to complete, then nursing assistant working the floor was to perform the program activities. Staff I stated the restorative aids had more skills than them. In an interview on 09/11/2025 at 9:15 AM, Staff GG, Restorative Aid, stated there were programs they did and programs the Nursing Assistant's did. Staff GG stated on the charting it showed who was supposed to do the program. When asked who was responsible for Resident 19's program, Staff GG stated the Nursing Assistants working the floor. In an interview and observation on 09/11/2025 at 11:42 AM, Staff M, Physical Assistant, entered Resident 19's room and performed ROM on their knees. Staff M stated the resident was probably ranging between 70-80 degrees. Staff M stated they needed their measuring tool. At 11:49 AM, Staff M and an assistant entered the resident's room with a goniometer (a measuring device to see how far a limb can extend). Resident 19's right knee extended to 78 degrees, not 80 degrees as care planned. In an interview on 09/11/2025 at 11:43 AM, Staff E, Resident Care Manager, stated Staff FF was in charge of maintaining the restorative programs. In an interview on 09/11/2025 at 12:07 PM, Staff A, Administrator, stated restorative programs were important to prevent declines in the resident's abilities. Staff A stated Staff FF oversaw the restorative programs for both the Restorative Aids and the Nursing Assistants working the floor, ensured residents' maintained their abilities, and care planned the programs for staff to reference. Staff A acknowledged they were aware there was a problem with the restorative nursing programs because the Nursing Assistants working the floor were providing the programs because the facility did not have a Restorative Aid for a long time. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: WAC 388-97-1060 (3)(d) (j)(ix) Refer to F725 for additional information

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to administer medication according to provider orders for 3 of 5 residents (Resident 9, 43, and 63) reviewed for unnecessary medications. This failure placed residents at risk for medical complications and diminished quality of life. Findings included. <Resident 9> According to a comprehensive assessment, dated 07/17/2025, Resident 9 had diagnoses which included dementia (a disorder that caused impaired memory and reasoning), high blood pressure and heart failure (a condition where the heart muscle does not pump enough blood for the body's needs). They were alert and made their basic needs known. A review of the medical record documented a current order for Losartan (a medication to lower blood pressure) 100 milligrams (mg, a unit of measure) in the morning for high blood pressure. The order further showed the medication should not be given (held) if the systolic blood pressure (SBP, the top number of a blood pressure reading) was less than 110. A review of the Medication Administration Record (MAR) for August, 2025, documented the following instances when the medication was not administered according to the provider order: 1) On 08/09/2025 the blood pressure (BP) was 108/61 and Losartan was given. 2) On 08/21/2025 the BP was 116/79 and Losartan was held. 3) On 08/23/2025 the BP was 113/53 and Losartan was held. During an interview on 09/11/2025 at 12:23 PM, Staff K, Licensed Practical Nurse (LPN) stated that if an order for medication had parameters for when it should be given or held, those parameters showed up on the computer where the medication was documented on the MAR. They further stated that the medication should not be given if outside of the parameters, and those are set by the provider. During an interview on 09/11/2025 at 3:30 PM, Staff B, Director of Nursing, pulled Resident 9's August 2025 MAR up on their computer screen. After looking at the order and documentation, Staff B stated that the medication was not given on those days according to the provider order and staff needed to look closely at the parameters on the order and follow them. <Resident 43> The 08/21/2025 quarterly assessment documented Resident 43 had diagnoses that included heart failure and high blood pressure. The assessment further showed the resident was able to make their needs known. A review of the provider's orders documented Resident 43 received the following medications: -Amlodipine 5 mg twice daily for high blood pressure; hold medication if the SBP was below 110 and if (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the heart rate was less than 60. -Metoprolol Succinate 24 hour extended release 25 mg once daily for high blood pressure; hold medication if SBP was less than 110 and heart rate less than 60. The 08/2025 MAR showed Resident 43's blood pressure medication was given inappropriately on the following dates: Amlodipine: -08/01/2025 through 08/07/2025 the medication was given at night without a blood pressure and pulse being obtained prior to administration. -08/08/2025 the SBP in the morning was 103 and the medication was given; the medication was given at night without a blood pressure and pulse being obtained prior to administration. -08/09/2025 through 08/10/2025 the medication was given at night without a blood pressure and pulse being obtained prior to administration. -08/13/2025 the SBP was 109 and the medication was given. -08/15/2025 the SBP was 114 and the medication was not given. -08/26/2025 the SBP was 112 and the pulse was 76 and the medication was not given. -08/27/2025 the SBP was 101 and the pulse was 74 in the morning and the SBP was 105 and the pulse was 73 at night and the medication was given both times. -09/01/2025 the SBP at night was 101 and the pulse was 75 and the medication was given. -09/05/2025 there was an X in the box for the morning administration, and no vital signs were found. -09/08/2025 there was an X in the box for the night administration, and no vital signs were found. Metoprolol: -08/08/2025 the box said NA and the medication was given, no vital signs were found. -08/09/2025 the SBP was 103 and the pulse was 78, medication was given. -08/25/2025 the SBP was 112 and the pulse was 76, medication was not given. -08/26/2025 the SBP was 117 and the pulse was 71, medication was not given. -08/30/2025 there was an X in the box, and the medication was not given, and no vitals were found. -09/05/2025 the SBP was 117 and the pulse was 76, the medication was not given. -09/08/2025 the SBP was 103 and the medication was given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 63> The 08/08/2025 quarterly assessment documented Resident 63 had diagnoses that included a stroke and high blood pressure. The assessment further showed the resident was able to make their needs known. A review of the provider's orders documented Resident 63 received the following medications: -Amlodipine 10 mg once daily in the morning for high blood pressure; hold medication if the SBP was below 120 and if the heart rate was less than 60. -Hydralazine 50 mg three times daily for high blood pressure; hold medication if SBP was less than 120 and heart rate less than 60. -Lidocaine patches four percent, applied to the lower back in the morning for pain and was not to exceed three patches for up to 12 hours within a 24 hour period. The 08/2025 and 09/2025 MAR showed Resident 43's blood pressure medication was given inappropriately on the following dates: Amlodipine: -08/02/2025 the pulse was 54 and the medication was given. -08/02/2025 the SBP was 112 and the medication was given. -08/08/2025 there was an X in the box, and the medication was not given, and no vitals were found. -08/28/2025 there was an X in the box, and the medication was not given, and no vitals were found. -09/02/2025 the SBP was 117 and the medication was given. -09/09/2025 the SBP was 118 and the medication was given. -09/10/2025 the SBP was 101 and the medication was given. Hydralazine: -08/02/2025 the pulse in the morning was 54 and the medication was given. -08/04/2025 the SPB at night was 109 and the medication was given. -08/07/2025 the SBP in the morning was 112 and the medication was given, at noon there was an X in the box, and the medication was not given, and no vitals were found. -08/08/2025 there was an X in the box for noon, and the medication was not given, and no vitals were found. -08/12/2025 there was an X in the box for noon, and the medication was not given, and no vitals were (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	found, the SBP at night was 118 and the medication was given. -08/14/2025 the SBP at noon was 136 and the pulse was 67, the medication was not given. -08/16/2025 the SBP at night was 114 and the medication was given. -08/17/2025 the SBP at night was 116 and the medication was given. -08/20/2025 the SBP at night was 119 and the medication was given. -08/25/2025 the SBP at night was 118 and the medication was given. -08/27/2025 the SBP at noon was 103 and the medication was given. -09/01/2025 the SBP at noon was 104 and the medication was given. -09/02/2025 there was an X in the box for noon, and the medication was not given, and no vitals were found. -09/06/2025 the SBP in the morning and night was 55 and the medication was given both times. -09/07/2025 the SBP at night was 111 and the pulse was 59, the medication was given. -09/08/2025 the SBP at noon was 104 and the medication was given. -09/09/2025 the SBP in the morning was 118, at noon it was 116 and the medication was given both times. -09/10/2025 the SBP in the morning was 101, at noon it was 101, and the medication was given both times. Lidocaine Patches: The August 2025 MARs showed the following: -08/02/2024 NA -08/07/2025 NA 100 -08/09/2025 NA -08/10/2025 NA 120 -08/27/2025 NA -09/07/2025 NA 100 -09/10/2025 NA 120 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/08/2025 at 12:00 PM, Staff D, Registered Nurse, stated when a blood pressure medication was given you needed to obtain a blood pressure, review the parameters and if the blood pressure and pulse were out of the parameters you were to hold the medication and notify the provider. Staff D was asked to read the blood pressure orders and how they understood them. Staff D stated that meant you were to hold the medication when both the pulse and blood pressure was out of the parameters. Staff D stated it was important to administer the medication as ordered to prevent complications of high blood pressure such as a stroke. Staff D was asked what NA meant in the MAR and they stated it meant non applicable. Staff D stated they had an emergency supply of medications in the PIXUS (a machine that held medications) and when a medication was not available they would check their overflow medications and call the pharmacy to have the medication sent as soon as possible. In an interview on 09/08/2025 at 12:30 PM, Staff B, Director of Nursing, stated they would hold the blood pressure medication if the SBP or the pulse were out of the parameters and notify the physician. Staff B reviewed the medications above and stated they should have been given as ordered. Staff B stated they were unaware of what NA meant on the MAR because they had never seen that before. Staff B stated medications were reordered just before they ran out, within three to five days. Staff B stated the nursing staff should have checked the emergency medication supply when they were out of a medication and called the pharmacy. Staff B stated they were able to request a stat delivery. Staff B stated their expectation was for nursing to reorder the medications in a timely manner and to notify them if they were not receiving the medications. In an interview on 09/09/2025 at 9:50 AM, Staff PP, Medical Director, stated their expectation was for nursing staff to hold the blood pressure medication if either the SBP or the pulse was out of the parameters. Staff PP stated they did not expect the nurses to notify them when the medications were held because the medical record was set up so that they were notified automatically. In an interview on 09/11/2025 at 10:51 AM, Staff B stated Resident 63 should have received their lidocaine patches as ordered and it was important for pain management. Reference: WAC 388-97-1060 (3)(k)(iii)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to provide evidence that the Medical Director received and reviewed the content of Quality Assurance & Performance Improvement (QAPI) meetings when they were not present, communicated with and participated in the QAPI process, as required. This failure minimized the effectiveness of the interdisciplinary Quality Assessment & Assurance (QAA) team's ability to identify potential quality of care deficiencies and develop and implement corrective action. This failure placed residents at risk for complications, unmet needs, and diminished quality of life.Findings included.An undated facility policy titled Aurora Valley Care QAA Committee, showed the purpose was to coordinate and evaluate activities under the QAPI program. The policy further showed the following data would be reviewed at the meetings: 3 months of QAPI minutes/data, risk managements incident reports, grievance log, survey results, staff turnover, staff and resident satisfaction, infection control and facility quality measure triggers.Review of the facility policy titled QAPI Plan policy revised May of 2023, showed responsibilities of QAA members included reviewing data, suggestions and input from residents, staff, family members and other stakeholders. Additionally, they would determine performance improvement plans (PIPS), how to correct issues or problems, monitor progress and provide input.During an interview on 09/12/2025 at 3:12 PM, Staff A, Administrator, explained the QAPI team included the QAA team as well as department heads of the facility included Staff PP, Medical Director and met quarterly (every three months). During a follow-up interview on 09/15/2025 at 9:48 AM, Staff A stated QAPI data has been uploaded into the cloud (platform utilized to save electronic data) since May 2025 and committee members had access to it. Staff A did not provide any evidence that showed the members read the uploaded QAPI meeting data. During a follow-up interview on 09/15/2025 at 10:14 AM, Staff A acknowledged the medical director did not attend QAA meetings in December 2024, February 2025, May 2025 or August 2025. Staff A further stated that it was important for the medical director to attend the meetings to provide input, be aware of failed practices and to ensure potential identified issues in the facility were being worked on.A review of a 09/15/2025 e-mail correspondence between Staff A and a survey team showed the surveyor requested copies of the QAPI/QAA meetings sign-in sheets from August 2024 through August 2025. Staff A provided sign-in sheets for 08/29/2024 and 12/04/2024. Review of the documentation provided showed it did not include a signature from the medical director to show their attendance or participation. Staff A reported they misplaced the sheets for February or March of 2025. Staff A was asked when the last time the medical director was involved with QAPI by physically attending, by phone, or other methods. Staff A acknowledged Staff PP attended the February 2025 meeting, approximately 7 months ago.No further documentation was provided.Reference: WAC 388-97-1760(1)(2)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and record review the facility failed to ensure direct care staff received training on effective communication, as required. This failure placed residents at risk of unmet care needs and diminished quality of life. Findings included.Review of the staff list provided to the survey team on 09/03/2025 showed the facility employed 89 direct care staff. Effective communication training for all direct care staff was requested from Staff A, Administrator, on 09/15/2025 at 9:08 AM. Review of documentation provided showed only eight out of 89 direct care staff completed training on effective communication. In an interview on 09/15/2025 at 12:40 PM, Staff AA, Nursing Assistant, stated if they received training on effective communication, it would be documented in the electronic training records. In an interview on 09/15/2025 at 12:56 PM, Staff R, Licensed Practical Nurse, stated if they received training on effective communication, it would be documented in the electronic training records. In an interview on 09/15/2025 at 12:59 PM, Staff A, stated training on effective communication was new to the facility this year, and was scheduled to begin November 2025. Staff A acknowledged staff had not received training on effective communication. Staff A stated they expected staff to receive training on effective communication, as required. Reference WAC 388-97-1680

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and record review the facility failed to ensure all staff received training on the Quality Assurance and Performance Improvement (QAPI, a systemic interdisciplinary comprehensive data-driven approach to maintaining and improving safety and quality in nursing homes) program, as required. This failure placed residents at risk of unmet care needs and diminished quality of life. Findings included.Review of the staff list provided to the survey team on 09/03/2025 showed the facility employed 109 staff. QAPI training for all staff was requested from Staff A, Administrator, on 09/15/2025 at 9:08 AM. No documentation was provided. In an interview on 09/15/2025 at 12:40 PM, Staff AA, Nursing Assistant, stated if they received training on the facility's QAPI program, it would be documented in the electronic training records. In an interview on 09/15/2025 at 12:41 PM, Staff BB, Receptionist, stated I don't know what QAPI is. Should I know what that is? In an interview on 09/15/2025 at 12:47 PM, Staff CC, Maintenance Assistant, explained QAPI was a way for quality improvement through standardized metrics and achievable goals. Staff CC further stated they were unsure of the facility's QAPI process. In an interview on 09/15/2025 at 12:55 PM, Staff N, Housekeeping Manager, stated if they received training on the facility's QAPI program, it would be documented in the electronic training records. In an interview on 09/15/2025 at 12:56 PM, Staff R, Licensed Practical Nurse, stated if they received training on the facility's QAPI program, it would be documented in the electronic training records. In an interview on 09/15/2025 at 12:59 PM, Staff A, Administrator, acknowledged all staff had not received training on QAPI. Staff A stated they expected staff to receive training on QAPI, as required. No associated WAC

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure informed consents that explained the potential risks and benefits associated with the use of psychotropic medications (medications that affected mood or emotions) were obtained from the resident or their representative prior to their administration for 2 of 5 sampled residents (Residents 27 and 63) reviewed for unnecessary medications. This failure placed the residents and/or their representatives at risk of not being fully informed of the potential risks and benefits of receiving the medications. Findings included. <Resident 27> The 07/06/2025 quarterly assessment documented Resident 27 had diagnoses that included depression and received psychotropic medication to treat the symptoms of the depression. Review of the Medication Administration Records (MARs) for August and September 2025 documented the psychotropic medication, Escitalopram, was prescribed by the physician on 04/12/2025, and Resident 27 received the medication daily as ordered. Review of Resident 27's record from 04/12/2025 through 09/08/2025 found an informed consent for the Escitalopram was completed on 08/27/2025, 45 days after the medication had been prescribed and administered to Resident 27. During an interview on 09/08/2025 at 1:42 PM, Staff D, Registered Nurse, stated informed consents needed to be obtained when the medication was prescribed and prior to the medication being administered to the resident. During an interview on 09/08/2025 at 3:00 PM, Staff C, Social Services Director, stated informed consents for psychotropic medications needed to be obtained prior to a resident receiving the medication, and after review of Resident 27's record, confirmed the consent had not been obtained timely. <Resident 63> The 08/08/2025 quarterly assessment documented Resident 63 had diagnoses that included restlessness and agitation and received psychotropic medications daily. The Order Summary Report documented on 08/08/2025, Resident 63 was prescribed Duloxetine to treat depression, and on 05/30/2025 Seroquel to treat anxiety and restlessness. Review of the May and August 2025 MARs documented Resident 18 received the first dose of Duloxetine on 08/08/2025 and Seroquel on 05/30/2025. Review of the Psychoactive Medication Informed Consent documented Resident 63 signed the consent for Duloxetine on 08/20/2025, twelve days after the medication was first administered and Seroquel on 07/16/2025, forty-seven days after the medication was first administered. Further review of Resident 63's record did not show any additional documentation, either verbally or (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	written, that the resident was educated regarding the reason the medications were prescribed and the risks/benefits expected from taking the medications had occurred. During an interview on 09/09/2025 at 11:38 AM, Staff D stated psychotropic medication informed consents were to be obtained prior to the first dose being given. During an interview on 09/11/2025 at 10:51 AM, Staff B, Director of Nursing, stated psychotropic informed consents were to be obtained prior to giving the first dose. This was important so residents were aware of the risks of the medications. Reference: WAC 388-97-1020(4)(a-b)

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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 a Pre-admission Screening and Resident Review [PASARR, an assessment used to identify people referred to nursing facilities with mental illness, intellectual disabilities, or related conditions] was completed after an exempted hospital stay (when the resident remained in the facility longer than thirty days) finished for 1 of 5 sampled residents (Resident 43), reviewed for PASARR services. This failure placed the residents at risk for inappropriate placement, and/or not receiving timely and necessary services to meet mental health care needs. Findings included .<Resident 43>The 08/21/2025 quarterly assessment documented Resident 43 was admitted on [DATE] with diagnoses post-traumatic stress disorder (PTSD, a disorder in which a person had difficulty recovering after experiencing or witnessing a terrifying event) and received psychotropic medication, (medications that affect the mind, emotions, and behavior).Review of Resident 43's Level I PASARR showed it was completed and signed by the hospital prior to admission on [DATE]. A new Level I PASARR was completed by the facility on 05/12/2025, four months and thirteen days after the exempted hospital stay ended.In an interview on 09/09/2025 at 11:10 AM, Staff A, Administrator, stated the PASARR needed to be completed after the 30 day stay ended. Staff A acknowledged the PASARR was not completed timely and it was important to ensure mental health services were obtained if needed. Reference: WAC 388-97-1915 (1)(2)(a-c)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview and record review, the facility failed to ensure that residents received proper foot care in accordance with professional standards for 1 of 5 sampled residents (Resident 27) reviewed for skin care concerns. Specifically, Resident 27 had diagnoses and conditions that made them prone to the development of foot problems and had extremely dry, flaky skin on their feet. This failure put this high-risk resident at increased risk of complications and unmet care needs.Findings included .The 07/06/2025 comprehensive assessment documented Resident 27 had diagnoses that included diabetes and history of a stroke that affected their left side. Resident 27 was fully dependent on staff for bathing, dressing their lower body and transferring out of bed with a mechanical lift. They were alert, oriented and made their needs known.On 09/03/2025 at 2:57 PM, Resident 27 was observed lying in bed with their feet uncovered. Both of their feet were very dry and scaly on the bottom.Similar observations of Resident 27's dry, scaly feet were made on 09/05/2025 at 11:01 AM, 09/08/2025 at 12:15 PM, 09/10/2025 at 3:24 PM and 09/12/2025 at 11:45 AM.A 03/27/2025 consult note from the podiatrist (physician who specialized in the care of the feet), documented that the resident had diagnoses of diabetes, peripheral neuropathy (decreased feeling in the feet) and peripheral vascular disease (poor circulation to and from the feet) that were high risk conditions for foot problems. The note further documented recommendations to keep the skin soft with moisturizer, to avoid cracks and fissures and follow up in two to three months or earlier if needed.There were no other podiatrist progress notes, or other referrals for podiatry concerns.Resident 27 had provider orders for diabetic foot checks weekly on Wednesdays and notify the provider if skin issues were noted, and diabetic nail care weekly on Wednesdays. The September 2025 Treatment Administration Record (TAR) documented the orders were completed with no omissions.There were no other concerns regarding Resident 27's feet in the record. During an interview on 09/08/2025 at 12:15 PM, Resident 27 stated staff did not put anything on their feet (such as lotion). During an interview on 09/11/2025 at 1:25 PM, Staff K, Licensed Practical Nurse (LPN) stated that for diabetic foot checks, they made sure toenails were not digging into the skin, checked for any redness or open areas and applied lotion if the skin was dry or calloused.On 09/11/2025 at 1:32 PM, Resident 27's feet were observed with Staff D, Registered Nurse (RN). Staff D stated that for diabetic foot checks, if the skin was dry and flaky as Resident 27's feet were, lotion would be applied. During this exchange, the resident stated that at times, the nursing assistants applied lotion to their feet after a shower, but they only showered every 12 days or so. Resident 27 clarified that shower frequency was their preference, not the staff, and lotion was not applied to their feet at any other time.During an interview on 09/12/2025 at 9:47 AM, Staff I, Nursing Assistant (NA) stated that they were not sure if the other NA's applied lotion after showering residents. They further stated that Resident 27's feet did not look any different recently.During an interview and observation of Resident 27's feet on 09/12/2025 at 2:28 PM, Staff B, Director of Nursing stated that it was important for Resident 27 to keep the skin of their feet in good condition and thought that they were seen by podiatry the day prior. They stated the resident's feet should have lotion applied regularly as they were at risk for foot complications.References: WAC 388-97-1060(3)(j)(viii)

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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 observation, interview and record review, the facility failed to evaluate and assess a resident for safe smoking abilities for 1 of 5 sampled residents (Resident 54), reviewed for accident hazards and supervision. This failure placed residents at risk for potentially avoidable accidents, unmet care needs, and diminished quality of life. Review of the facility policy titled, Smoking-[NAME] Center No Smoking revised June 2023, documented smoking tobacco or tobacco related products or substitutes were not permitted on the facility property. The policy further documented that all residents were screened for smoking when admitted to the facility and those residents who decided to continue smoking would have their decision included in their care plan.Findings included .The 07/17/2025 admission assessment documented Resident 54 was cognitively intact to make decisions regarding their care and had diagnoses which included nicotine dependence. Review of the 07/11/2025 admission evaluation form documented Resident 54 recently quit smoking and used to smoke a pack of cigarettes a day. Review of the July 2025 Medication Administration Records (MAR) documented the physician had prescribed nicotine patches daily for 15 days on 07/12/2025 to assist with managing the cravings associated with nicotine dependence, Resident 54 refused the patches eight out of the 15 days, and the order was discontinued on 07/27/2025. Review of progress notes from 07/11/2025 through 09/08/2025 documented on 07/25/2025, during a provider visit, Resident 54 had stated they planned to go outside and smoke a cigarette. Smoking cessation education was provided at that time, and Resident 54 stated they would refuse nicotine patches and continue to smoke. In addition, a 09/02/2025 provider note documented the nicotine patches were discontinued due to the resident routinely going outside to smoke. In an observation on 09/09/2025 at 8:05 AM, Resident 54 was observed smoking a cigarette as they were walked on the sidewalk across the street from the facility.In an interview on 09/09/2025 at 1:21 PM, Resident 54 was observed lying in bed watching television. When asked if they smoked, Resident 54 stated yes, but stated they did not want to answer any questions regarding smoking or the facility's smoking policy. Review of Resident 54's record found no documentation a smoking assessment to determine if the resident was able to safely smoke was completed when the facility became aware Resident 54 was smoking. Review of the safety care plan found no interventions or information related to smoking. In an interview on 09/11/2025 at 10:52 AM Staff R, Licensed Practical Nurse, stated smoking assessments were completed at admission to the facility, and if a resident chose to smoke, then a nicotine patch was ordered. Staff R further stated if a resident later decided to smoke, then a smoking assessment needed to be done. In an interview on 09/12/2025 at 10:52 AM, Staff B, Director of Nursing, confirmed Resident 54 smoked. After discussion and review of Resident 54's record, Staff B stated a smoking assessment should have been completed once staff became aware the resident was smoking, and acknowledged it had not been done, nor had the care plan been updated. Reference (WAC): 388-97-1060(3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review, the facility failed to provide care and services necessary to improve bowel and bladder functions for 1 of 2 residents (Resident 63), reviewed for incontinence care. This failure placed the resident at risk for skin and medical complications.Findings included .The 08/08/2025 quarterly assessment documented Resident 63 admitted with diagnoses including back fractures and a stroke with hemiplegia (paralysis on one side of the body). The resident was able to make their needs known and required total staff assistance for toileting. The assessment further showed Resident 63 was always incontinent of bowel and bladder was not on a toileting program. The 05/01/2025 care plan documented Resident 63 was incontinent of bowel and bladder related to a stroke. Interventions instructed staff to provide care after each incontinent episode and for the resident to wear incontinence briefs. An 08/08/2025 quarterly bowel and bladder evaluation documented Resident 63 was not appropriate for a toileting program due to spasticity and inability to sit on the toilet or commode.Review of the bowel and bladder flow sheets from 08/09/2025 to 09/06/2025 documented Resident 63 experienced bowel incontinence, was changed as needed, and used the bed pan on two occasions. Review of the medical record showed no documentation the facility evaluated and subsequently developed effective and resident-centered interventions to address Resident 63's episodes of bowel and bladder incontinence.In an interview on 09/03/2025 at 11:30, Resident 63 stated they thought it was a good idea to sit on the toilet throughout the day. The resident stated the aides used the hoyer (a machine used for full body lift transfers) to transfer them and the staff could transfer them onto the toilet. In an interview on 09/08/2025 at 1:41 PM, Resident 63 stated they had been incontinent since their stroke. Resident 63 stated no one in the facility spoke to them about improving their incontinence. Resident 63 stated they would be okay with a bed pan but would rather be put on the toilet. Resident stated it took the staff too long to get them up and they had already been incontinent. Resident 63 further stated being incontinent made them sad. In an interview on 09/09/2025 at 11:18 AM, Staff T, Nursing Assistant, stated bed pans were offered to residents who preferred to stay in bed and none of the residents had refused the bed pan. Staff T stated Resident 63 usually used a brief and would notify staff after they urinated or had a bowel movement. Staff T stated Resident 63 knew when they needed to use the bathroom and could not always hold it because of the amount of fluids they consumed during a two-hour period. Staff T added the resident was transferred via hoyer and did not refuse to get out of bed.In an interview on 09/09/2025 at 11:27 AM, Staff E, Resident Care Manager, stated Resident 63's incontinence was identified upon admission and was never placed on a toileting program. Staff E stated a care plan was developed for the resident's incontinence.In an interview on 09/11/2025 at 10:51 AM, Staff B, Director of Nursing, stated a resident's bowel and bladder function was evaluated upon admission and if appropriate they were placed on a toileting program. Staff B stated Resident 63 had spasticity and the inability to sit on a commode. Staff B acknowledged that the resident should have been placed on a toileting program using the bed pan and that it was important to maintain or regain someone's incontinence for dignity.Reference WAC 388-97-1060 (3)(c).

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed maintain intravenous (IV) access consistent with professional standards of practice to include obtaining and implementing orders for saline flushes (a syringe of saline used to clear the IV and prevent it from clogging) and IV dressing changes (a transparent dressing over the insertion site) for 1 of 1 residents (Resident 35), reviewed for IV access maintenance. This failure placed resident at risk for medical complications, and diminished quality of life.Findings included.Review of comprehensive assessment dated [DATE], Resident 35 had diagnoses of diabetes and osteomyelitis (bone infection) of the spine. The resident was alert, oriented and made their needs known.During observation and interview on 09/05/2025 at 9:58 AM, Resident 35 stated that the facility nurse changed their IV dressing. An IV access was observed in the resident's right chest. The access had an intact, transparent dressing over the insertion site, which was labeled with a smudged date, possibly 09/01. The insertion site was without signs of complications.A review of Resident 35's orders documented they received IV antibiotics three times a week since 07/19/2025. The final ordered dose of the medication was administered on 09/02/2025. Additional review of the record showed no documentation orders for IV site dressing changes or routine saline flushes were obtained or implemented.During an interview on 09/08/2025 at 3:36 PM, Staff S, Licensed Practical Nurse (LPN), stated for residents with IV's, access lines were flushed every shift (twice daily,) and before and after any medication was given through the IV. They further stated IV dressing changes were done by the facility staff and both would be documented on the Medication Administration Record (MAR). When asked to show the documentation in the computer, they were not able to find the documentation.During an interview on 09/09/2025 at 11:08 AM, Staff K, LPN, stated that they flushed the resident's IV to ensure it was functional before they went to dialysis (a process of using a machine to filter the blood of persons with kidney failure) and every shift. IV dressing changes were done weekly. When Staff K looked for the documentation in the MAR, they noticed that the orders for saline flushes and IV dressing changes were initiated yesterday, after the surveyor had interviewed Staff S.During an interview on 09/11/2025 at 3:30 PM, Staff B, Director of Nursing, stated when a resident had an IV access, weekly dressing changes and saline flushes should be entered into the medical record as orders and documented when completed. Staff B acknowledged this was missed and was failed practice.References: WAC 388-97-1060(3)(j)(ii)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure respiratory equipment was implemented as ordered, functional and maintained in a clean manner for 2 of 2 residents (Resident 43 and 27), reviewed for respiratory care. Specifically, Resident 27's continuous positive airway pressure machine (CPAP, machine that helped people breathe by delivering pressurized air into their lungs through their nose, or nose and mouth) was not implemented as ordered by the physician or maintained in a functional manner. In addition, Resident 43's oxygen tubing and oxygen concentrator (a machine that delivers oxygen) were not maintained in a clean and sanitary manner. These failures placed residents at risk for impaired sleep, infections, unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Oxygen Mangement revised [DATE], showed the facility required a physician order for administration of oxygen. Oxygen tubing was to be changed weekly or when soiled, had impaired integrity or as needed. Filters on concentrator oxygen machines were to be cleaned weekly or per manufacturer's recommendations. No documentation was found to show how the facility was to maintain CPAP machines. <Resident 27> According to a [DATE] comprehensive assessment, Resident 27 had diagnoses which included diabetes and Obstructive Sleep Apnea (OSA, a disorder that caused repeated breathing interruptions during sleep.) Resident 27 was fully dependent on staff for bathing, changing their position and transferring out of bed with a mechanical lift. They were alert, oriented and made their needs known. A review of the medical record showed an order on [DATE], for Resident 27 to utilize a CPAP every night shift, related to obstructive sleep apnea. The Medication Administration Record (MAR) for [DATE], documented that the CPAP machine was used on [DATE] through [DATE], was not used from [DATE] through [DATE], and was again used on [DATE] through [DATE]. During an interview on [DATE] at 2:57 PM, Resident 27 stated that they did not wear their CPAP every night because they often forgot to remind the staff to put it on them. During a follow-up interview on [DATE] at 9:02 AM, Resident 27 stated they forgot to ask staff to place their CPAP last night. During a follow-up interview [DATE] at 12:15 PM, Resident 27 stated that they did not wear their CPAP last night. Resident 27 explained they activated their call light to ask staff for help to put it on, but when staff arrived, they had forgotten why they had pushed the call light button. During an observation on [DATE] at 1:44 PM, Resident 27's CPAP was lying in an opened drawer of their nightstand, with a mask attached to it for the first time. During an interview on [DATE] at 9:26 AM, Resident 27 stated that someone had come in yesterday (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to fix their CPAP, but they did not have the strap that held the mask in place. Per the resident, the staff member did not return with a strap. Resident 27 stated they would raise the head of the bed up high and would pray for the best, because they heard about people who died in their sleep. On [DATE] at 9:10 AM, observed the CPAP on Resident 27's nightstand, with no strap on the mask. During an interview on [DATE] at 1:32 PM, Resident 27 stated that they did not use their CPAP often, maybe only 15 percent of the time and explained they needed help to get it on, staff did not offer or remind them, and they cannot reach it on their own. Noted that the nightstand that held the CPAP was out the resident's reach. On [DATE] at 11:45 AM, Resident 27 stated that they did not use their CPAP last night because they still did not have a strap to hold the mask in place. The CPAP machine was on their nightstand connected to tubing and a mask, but no strap was on the mask. There was a clear bag with some other tubing and another mask also on his nightstand, but it did not contain a strap. During an interview on [DATE] at 2:28 PM, Staff B, Director of Nursing, DNS, was asked about Resident 27's CPAP use, Staff B stated they received a message from the night nurse that the mask strap was too tight, and it could not be used. Staff B stated that Staff E, Resident Care Manager (RCM), got Resident 27 a new strap. Staff B pulled up Resident 27's MAR on the computer to review the CPAP orders, which showed that the night nurse (who notified Staff B of the issue with the CPAP strap) documented that they did not use it that night on [DATE], but it was charted as in use on 09/08, 09/09 and [DATE]. Staff B and this surveyor entered Resident 27's room, the resident informed Staff B that they had not been using the CPAP and why. Staff B searched through the CPAP parts at the resident's bedside, and acknowledged that they could not have been using the CPAP as documented, as they did not have all the parts available <Resident 43> The [DATE] quarterly assessment documented Resident 43 had diagnoses which included heart failure, diabetes and a stroke. The resident was cognitively intact and was dependent on supplemental oxygen. An [DATE] provider order instructed staff to change the oxygen tubing weekly. The [DATE] care plan documented Resident 43 required oxygen related respiratory failure, and staff were instructed to monitor for signs and symptoms of infection. In an observation on [DATE] at 10:02 AM, Resident 43's oxygen tubing was dated [DATE], 17 days prior. The oxygen concentrator was unclean with white splatter and the filter area on the back of the machine had thick dust debris. The [DATE] Medication Administration Record documented the oxygen tubing was not changed on [DATE], but was changed on [DATE], however, the tubing had the date of [DATE]. Similar observations of Resident 43's oxygen tubing with the date [DATE] were made on [DATE] at 12:05 PM, [DATE] at 11:21 AM, [DATE] at 9:38 AM, 11:05 AM and 2:28 PM. Similar observations of Resident 43's oxygen concentrator being unclean with white splatter and debris were made on [DATE] at 12:05 PM, [DATE] at 11:21 AM, [DATE] at 9:38 AM, 11:05 AM, 12:19 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, and 2:28 PM, [DATE] at 8:51 AM and 3:44 PM, [DATE] at 11:43 AM, [DATE] at 9:33 AM, [DATE] at 9:02 AM, [DATE] at 9:00 AM, and [DATE] at 9:27 AM. In an interview on [DATE] at 12:00 PM, Staff D, Registered Nurse, stated oxygen tubing was changed weekly, and the concentrators were wiped down nightly and when dirty. Staff D stated it was important to keep the concentrator clean and change oxygen tubing to ensure residents were not breathing in dirt and to prevent infections. In an interview on [DATE] at 11:02 AM, Staff B, DNS, stated oxygen tubing was changed weekly. Staff B acknowledged it was important to change oxygen tubing and maintain oxygen concentrator in a clean manner to prevent infection. Reference: WAC 388-97-1060(3)(j)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure safety measures were in place and followed for 1 of 3 residents (Resident 35), reviewed for dialysis (a process of using a machine to filter the blood from excess fluid or waste when the kidneys were unable to do so). Staff often checked Resident 35's blood pressure on the same arm as their dialysis fistula (an access made by joining an artery and vein in the arm). This failure placed residents at risk for medical complications and diminished quality of life.Findings included.Review of the National Kidney Foundation (an organization dedicated to education about kidney disease and advocacy for patients) website Kidney.org documented to keep the fistula access working, a blood pressure cuff should never be used on the access arm.According to a 09/02/2025 comprehensive assessment, Resident 35 had diagnoses of diabetes, high blood pressure and dialysis dependent end stage kidney disease. The resident was alert, oriented and made their needs known.During observation and interview on 09/05/2025 at 9:58 AM, Resident 35 stated that they had dialysis three times a week. The resident further stated they just had the fistula surgery last week (7 days ago). An intact incision was observed on their left arm in the bend of their elbow. There was no signage in the room that showed not to use the Resident 35's left arm to draw labs or to obtain blood pressures.A surgical note dated 08/29/2025, documented the resident had a fistula created in their left arm. Additional review of the record showed no orders or warnings to inform staff not to not use the left arm to obtain blood pressures.During an interview on 09/08/2025 at 3:45 PM, Staff J, Nursing Assistant (NA), stated that residents told the NA's which arm to use to obtain blood pressures.During an interview on 09/08/2025 at 3:49 PM, Resident 35 was asked since the surgery, which arm do they check your blood pressure on? Resident 35 responded that sometimes staff would check it on the left arm but were unaware the blood pressure should not be checked on the left arm, only that they got better readings on the right arm.During an interview on 09/09/2025 at 11:08 AM, Staff K, Licensed Practical Nurse (LPN), stated for dialysis residents with a fistula, it did not matter which arm they checked the blood pressure on, since the facility utilized a wrist cuff to obtain the blood pressure reading.During an interview on 09/11/2025 at 3:30 PM, Staff B, Director of Nursing, acknowledged when a dialysis resident had a fistula, that arm should not be used to obtain blood pressures.Reference: WAC 388-97-1900(1), (6)(a-c)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a psychological evaluation was completed and behavioral health services were offered as recommended to 1 of 2 sampled residents (Resident 1) reviewed for mood and behavior. This finding placed the resident of unmet care needs.Findings included .Review of admission Comprehensive assessment dated [DATE], Documented Resident 1 was admitted [DATE]. Resident 1 had diagnoses that included anxiety and depression. The resident had pain almost constantly, that interfered with day-to-day activities and affected sleep, and took scheduled and as needed pain medications, and antidepressant medications daily. Resident 1 was cognitively intact. An evaluation of the resident's mood documented a score of 12, moderate severity and frequency of depression symptoms.On 03/07/2025, a Level I Pre-admission Screening and Resident Review (PASRR, an evaluation that determined if a person met criteria for nursing home level care, had a serious mental illness, and might benefit from behavioral health services. If identified, a Level II evaluation was required to determine behavioral health needs while residing at the nursing facility) documented Resident 1 had anxiety and mood disorders and required a Level II evaluation.On 3/10/2025, a Level II behavioral health evaluator documented Resident 1 had a long history of pain and became verbally aggressive and agitated. Failures to acknowledge the resident's pain increased those behaviors. After initially agreeing to the evaluation, the resident took a phone call and no longer answered questions or made eye contact with the evaluator. The rest of the evaluation was completed via record review. The evaluator determined Resident 1 needed further psychiatric assessment based on their behaviors and mood lability and was not currently connected with a mental health service. On 07/29/2025 a provider order was given to refer Resident 1 to Behavioral Health Solutions for psychiatric and psychological evaluation and treatment as indicated.The 07/30/2025 Care Plan documented Resident 1 had a depression diagnosis. Staff were to monitor and report signs or symptoms of depression, the target mood was sadness, irritability and crying. On 08/21/25, the care plan was updated to arrange a psychiatric consultation and follow up as necessary. On 08/26/2025, the care was updated again to include Resident 1 demonstrated verbally abusive behaviors to staff, was resistive to care related to ongoing mood instability and had a Level II PASRR evaluation related to anxiety and depression. Staff were to follow up timely on any recommendation made and see PASRR in the chart. There were no behavioral health provider progress notes, assessments or referrals documented in Resident 1's record. During an interview on 09/03/2025 at 12:28 PM, Resident 1 was in their bed. The room was dark with no lights on and the window shade was closed. Resident 1 reported they were in constant pain and they stated the only thing that would make it better was for them to have surgery on their hip. They stated they were unable to return to their current home as it was on the second level and there were many stairs. As they talked, they became fretful, agitated, and began to raise their voice and cry. When asked, Resident 1 stated they were not seeing anyone to help their mood, and they were uncertain which medication they took, if any, for depression. During a follow-up observation and interview on 09/10/2025 at 3:04 PM, Resident 1 was lying in bed and rummaged through the belongings in their purse. The lights were off and the window shade was closed. When asked how the resident was doing, they stated they were ok, but felt they were unable to make progress unless their hip was operated on. Resident 1 stated they were told therapy was finished for some stupid reason. During an interview on 09/11/2025 at 9:50 AM with Staff L, Occupational Therapist, and Staff M, Physical Therapy Assistant, they stated Resident 1 was no longer a candidate for therapy related to their unwillingness to follow safety measures needed for the therapy sessions to occur. They stated the resident refused to get out of bed or insisted on transfers from bed without the use of a gait belt or handrails in the presence of a very unsteady gait and balance. Resident 1 was unable to focus on (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy because of their focus on their pain or their thought that they were not going to make progress without surgery. Staff L stated Resident 1 became tearful and got agitated or angry when they attempted to work with the resident and this prevented any further progress. On 09/11/2025 at10:04 AM, Resident 1 was observed in their room, lying in bed. Again, the lights were off and the window shade was closed so the room was dark. Resident 1 was asked if anyone had offered counseling or services to help them cope with their concerns and emotions regarding their pain. Resident 1 replied that none had been offered. Resident 1 stated they knew they were depressed and had taken medications for it in the past but did not think that worked for them anymore. They stated they had not been sleeping well, and it was catching up to them. During an interview on 09/12/2025 at 11:01 AM, Staff C, Director of Social Work, stated they had not sent a referral for behavioral health for Resident 1. They stated the PASRRs were reviewed by the Administrator. During an interview on 09/12/2025 at 11:08 AM, Staff Q, Nurse Technician, stated Resident 1's mood fluctuated and they became agitated easily. Staff Q stated Resident 1 had been crying that morning, so Staff Q left their room, and had to reapproach them at a later time.During an interview on 09/12/2025 at 2:14 PM, Staff A, Administrator, stated they were aware Resident 1 had a Level II evaluation completed in March of 2025 but had not communicated that to Staff C. Staff A stated their process would be to facilitate getting behavioral health services for Resident 1, and then the resident could decide if they wanted to participate, but Resident 1 would likely benefit if they did choose to participate. Reference: No Associated WAC

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review the facility failed to timely act upon the pharmacist's monthly medication regimen review recommendations for identified irregularities for 1 of 5 sampled residents (Resident 63), reviewed for unnecessary medications. This failure placed residents at risk of receiving unnecessary medications, medication complications, and a diminished quality of life.Findings included .Review of the facility policy titled, Medication Regimen Review revised 11/28/2016, documented a pharmacist consultant reviewed the resident's medication regimen as described in their pharmacy consultant agreement and irregularities reported to the attending physician, medical director, and Director of Nursing (DNS). If an irregularity did not require urgent action, the recommendation needed to be completed by the next monthly review. The 08/08/2025 quarterly assessment documented Resident 63 had diagnoses which included a stroke, restlessness and agitation. The resident received an antipsychotic (a medication that affected the brain, mind, mood, and behaviors used to treat mental health conditions) medication and was able to make their needs known. A review of the provider's orders showed a 05/30/2025 order for staff to administer Seroquel (antipsychotic) to Resident 63 daily. A review of the May 2025 pharmacy medication review note to the attending prescriber showed Resident 63 took Seroquel. The consultant pharmacist recommended orthostatic blood pressures (blood pressure and heart rate measurements taken while lying down then sitting up and lastly standing) and behavior monitoring. A review of the Medication and Treatment Administration record for June and July 2025 showed orders to obtain orthostatic blood pressures or for behavior monitoring were not obtained or implemented, as recommended. Further review of Resident 63's record showed no documentation why the pharmacy recommendation was not followed.In an interview on 09/11/2025 at 10:51 AM, Staff B, Director of Nursing, stated they never thought of doing orthostatic blood pressures on Resident 63 because they could not stand. Staff B acknowledged Resident 63 could go from a lying to a sitting position. Staff B stated it was important to monitor behaviors to see if the resident had a change from their baseline.Reference WAC 388-97-1300 (4)(c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure medications were discarded appropriately in 1 of 2 medication rooms (North) observed. In addition, the facility failed to ensure temperatures in the medication room and medication refrigerator were consistently monitored in 1 of 2 medication rooms (TCU) observed. This failure placed residents at risk of unmet care needs.Findings included.<North Medication Cart and Room> During observation of the North medication cart on 09/12/2025 at 10:23 AM, with Staff S, Licensed Practical Nurse (LPN), the following was noted:1) Lispro insulin pen for a current resident, labeled with an opened date of 08/05/2025, 38 days prior. There was a note taped to the bottom of the drawer where the pens were stored that showed discard insulin pens 30 days after opened.2) Lispro insulin pen for another resident that had been used and the date opened was blank.During a concurrent interview, Staff S stated insulin pens should be discarded one month after opening and since the open date was unknown on one pen, both insulin pens observed should be discarded. They further stated that the Resident Care Managers checked the carts periodically for expired medications.During an observation of the North medication storage room on 09/12/2025 at 11:56 AM, with Staff S, the following was found: A full bottle of Lorazepam (a controlled anti-anxiety medication) 2mg/ml (measurement of the concentration) liquid labeled for Resident 24, was in an unlocked upper cabinet with other discontinued medications. #7 was written in black marker on the medication. Staff S stated that number referred to the page number on the narcotic count book, where the medication was counted every shift and further stated the liquid Lorazepam should be refrigerated.After the inspection of the medication room, Staff S opened the narcotic count book to page 7, which was for another resident and medication, the page was crossed out. Staff S stated it was likely in an older narcotic count book and confirmed that they had not been counting the Lorazepam in the medication room as it was not logged into the current medication book, nor stored in the locked medication refrigerator. Staff S stated that Lorazepam was a controlled medication that was required to be included in the narcotic count.A review of the medical record for Resident 24 showed that the Lorazepam was discontinued on 02/27/2025, over six months ago.<TCU Medication Room>During observation of the TCU medication room on 09/12/2025 at 1:16 PM, showed a log sheet secured to the medication refrigerator door for September 2025. The log sheet had columns for the refrigerator temperature, room temperature and staff initials for twice daily, in the morning and evening, monitoring. There were parameters on the bottom of the sheet with acceptable ranges for the temperature readings. The last reading listed was 09/08/2025, four days earlier. No readings were done on 09/07/2024 and only an evening reading on 09/08/2025. Four of the room readings on evenings were outside of the parameters listed, without any explanation of what was done about it in the comments section.During an interview and observation on 09/12/2025 at 2:18 PM, Staff B, Director of Nursing, stated that refrigerator and room temperature logs in the medication room should be accurate and that insulin pens should be discarded 28 days after opening. Staff B further stated liquid Lorazepam should be stored in the refrigerator and included in the narcotic count. Staff B acknowledged the discontinued Lorazepam should have been destroyed.Reference: WAC 388-97-1300(2)

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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 timely follow-up dental appointments for 2 of 3 sampled residents (Residents 41, 29), reviewed for dental care. This failure placed residents at risk for diminished quality of life.Findings included.<Resident 41>The 06/27/2025 quarterly assessment documented Resident 41 was independent with eating and performing oral hygiene with set-up assistance from staff. The assessment further showed Resident 41 was moderately cognitively impaired, but able to make their needs known.On 09/03/2025 at 10:05 AM, Resident 41 was observed sitting upright in bed, using their iPad. When asked if they had any concerns regarding their care, Resident 41 stated they had a dental bridge that was broken, and nobody was doing anything to get it repaired. Resident 41 then took their left hand and moved their upper lip up to show the area where the bridge would be worn. Review of notes from the dental care provider who performed services in the facility showed Resident 41's teeth were cleaned on 04/17/2025, the resident expressed no concerns, no emergent dental issues were identified at that time, and the resident was to have a follow-up appointment in three months. Review of Resident 41's record which included progress notes written from 04/17/2025 through 09/102025, found no documentation that indicated the facility had been informed of the resident's dental bridge being broken and in need of repair. In addition, no documentation was found that showed the follow-up appointment with the in-house dental care provider had been scheduled as of 09/11/2025 <Resident 29> The 09/03/2025 quarterly assessment documented Resident 29 had diagnoses which included stroke and diabetes. Resident 29 was cognitively intact to make decisions regarding their care. In addition, the assessment documented the resident had mouth and/or facial pain and difficulty chewing at the time of the assessment. During an interview on 09/03/2025 at 4:01 PM, Resident 29 stated there was a dental hygienist that came into the facility, and a referral was supposed to have been made to get their teeth cleaned, but that was at least two months ago. Review of notes from the dental care provider who performed services in the facility showed Resident 29's teeth were cleaned on 04/17/2025. The provider noted there were no emergent dental needs identified, a follow up appointment would be scheduled in three months, and the facility was asked to refer the resident to a dentist as they had requested to see an outside provider to have some tooth root tips extracted.Additional review of Resident 29's record found no documentation that a referral to a dentist for the dental extractions, or a follow-up appointment for the in-house dental care provider for teeth cleaning had been made as of 09/11/2025. In an interview on 09/11/2025 at 12:15 PM, Staff R, Licensed Practical Nurse, stated when a resident expressed a need for dental services Staff E, Resident Care Manager, was informed so the resident was added to the list for the in-house dental provider, or if needed, an appointment arranged with an outside dental provider. In an interview on 09/11/2025 at 12:27 PM, Staff E stated once informed a resident needed dental services, they notified Staff W, Medical Records, if the service needed was for the in-house dental provider, or Staff V, Transportation, if an outside dental provider appointment was needed. When asked if they were provided with a list of residents that the in-house dental provider was scheduled to provide services for, Staff E stated they were not given a list, they were only notified which residents received dental services if there were orders or follow-up care was needed afterwards. Staff E stated they would enter the orders in the resident's record and notify either Staff W or Staff V to arrange any appointments. Staff E was asked if follow-up appointments were made within three months of the 04/17/2025 appointments for Residents 29 and 41 as instructed in the in-house providers notes. Staff E reviewed Resident 29 and 41's records and acknowledged there was no documentation that showed follow-up appointments had been made. In an interview on 09/11/2025 at 1:04 PM, Staff W was asked about the process for adding a resident to the list to be seen by the in-house dental provider. Staff W stated they were on the email correspondence list for appointments, but that was not part of their job (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibilities, and they were not sure who arranged the appointments. Staff F, Staffing Coordinator, was present at the time of the interview, and stated Staff C, Social Services, arranged the appointments for the in-house dental provider. In an interview on 09/11/2025 at 1:11 PM, Staff C stated prior to coming to the facility, the in-house dental provider emailed and asked for a current resident census, the provider reviewed the census and highlighted any residents that would receive dental care and then sent the census back to Staff C. Staff C would follow up with each resident highlighted to see if they still wanted dental services, and once all residents had been interviewed, the census was sent back to the provider. When asked if there was any tracking to ensure residents who were identified as needing follow up appointments were scheduled, Staff C stated they did not track the appointments, and if a resident was identified as needing a follow up appointment, they thought the in-house provider noted it and then highlighted the resident on the census sheet to be seen within the follow up time frame. When informed of the missed follow-up appointments for Resident 29 and 41, Staff C reviewed their email correspondence from the in-house provider for the visit to the facility on [DATE] and confirmed that neither resident was highlighted to be seen. Staff C stated they would follow up with both Staff E and the in-house provider to see what changes could be done to fix the issue. Reference WAC 388-97-1060 (3)(j)(vii).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to perform hand hygiene when indicated during the meal service. This failure placed residents at risk for foodborne illnesses.Findings included . In an observation on 09/10/2025 at 11:59 AM, Staff HH, Cook, touched the meat with their gloved hands, then touched the meal ticket, and continued to serve food without hand hygiene being performed. Prior to the meal service, the dietary aids sorted out the meal tickets. In an observation on 09/10/2025 at 12:00 PM, Staff KK, Dietary Aide, placed cold items on the meal trays, scratched their head with their bare hand, and continued putting plates of food on trays without hand hygiene being performed. In an observation on 09/10/2025 at 12:02 PM, Staff HH touched the meat and vegetables they placed on the resident's plate with gloved hands, then grabbed a meal ticket and served the next plate without hand hygiene being performed.In an observation on 09/10/2025 at 12:04 PM, Staff HH touched the meat with their gloved hands, grabbed a roll, opened the oven warmer, then grabbed a meal ticket, and continued serving food without hand hygiene being performed.In an observation on 09/10/2025 at 12:06 PM, Staff HH touched the vegetables on a resident's plate, grabbed a roll, touched the meal ticket and served food without hand hygiene being performed.In an observation on 09/10/2025 at 12:07 PM, Staff HH touched a resident's portion of meat with their gloved hands, grabbed a roll, took zucchini off the resident's plate and put it back into the pan, opened the oven warmer, grabbed the meal ticket and kept serving without performing hand hygiene.In an observation on 09/10/2025 at 12:08 PM, Staff HH grabbed a large piece of meat out of the pan and broke it with their gloved hands, grabbed a roll, placed the plate on the counter, grabbed the meal ticket and continued serving without performing hand hygiene.In an observation on 09/10/2025 at 12:12 PM, Staff HH sorted through the meal tickets, touched the meat with gloved hands, grabbed a roll with gloved hands, opened the steamer, put a plate on the counter with a meal ticket without hand hygiene being performed.Subsequent observations of Staff HH touching the meat, vegetables, rolls, oven warmer, steamer and meal tickets without hand hygiene being performed were made on 09/10/2025 at 12:13 PM, 12:16 PM, 12:19 PM, 12:21 PM, 12:25 PM, 12:28 PM, 12:31 PM, 12:32 PM, 12:36 PM, 12:37 PM, 12:38 PM, 12:42 PM, 12:44 PM and 12:47 PM.In an interview on 09/10/2025 at 2:22 PM, with Staff II, Dietary Manager, and Staff JJ, Registered Dietician. Staff II stated Staff KK should have performed hand hygiene after they scratched their head. Staff JJ, Registered Dietician, stated staff needed to use utensils to handle the food, not their hands. Both Staff II and Staff JJ agreed hand hygiene should have been performed after Staff HH touched the over warmer, steamer, meal tickets, and prior to serving the food. Staff II acknowledged it was important to maintain good hand hygiene during the meal service to prevent cross contamination and illness. Reference: WAC 388-97-1100 (3), 2980

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505114	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Valley Care	414 S University Rd Spokane, WA 99206

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 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on observations, interviews and record reviews, the governing body failed to ensure the facility had resources to supply residents with an adequate supply of clean linens. Additionally, the governing body failed to respond to repeated staff concerns about insufficient quantity of linens, poor quality of current laundry service, requests for resources and/or a change in laundry vendors in a timely manner. This failure impacted all residents and placed them at risk for diminished quality of life. Findings included.During interviews on 09/03/2025, 09/04/2025, 09/08/2025, 09/09/2025, 09/10/2025, 09/12/2025 and 09/15/2025, as well as in the resident council meeting on 09/05/2025, multiple residents and staff members stated that not having enough bed linens and towels was a frequent issue at the facility.During an interview on 09/12/2025 at 3:12 PM, Staff A, Administrator stated that as part of their Quality Assurance and Performance Improvement (QAPI) program, each department head chose a problem to work on and developed a performance improvement plan (PIP). Staff A further stated they had already identified that linen service was an issue, and the housekeeping department had done a PIP on it. As a result, the facility did end up changing vendors and the new vendor started on 09/02/2025, the day before this survey started.During a follow-up interview on 09/15/2025 at 9:48 AM, Staff A stated that even before they became the administrator in 2023, the laundry had been done at another skilled nursing facility across town, and the poor quality of service had been an ongoing issue. Specifically, the facility did not receive all the linens/clothing back that they sent and laundry was returned stained and wet. Staff A further stated that the PIP done about the laundry/linen issue was done in December of 2024, approximately nine months ago. Staff A stated that Since May of 2025, the QAPI meeting information has been loaded into the cloud, where the governing body members were able to access it, which included Staff X, Regional Director of Operations (RDO) and Staff Y, [NAME] President of Operations. When asked about findings of the laundry/linen PIP and what had been done, Staff A they had been trying to move more control of the process back to their own facility within limitations and requested a different vendor. Per Staff A, the response they received from Staff Y, was a barrier to changing linen supply process was financial and all issues impacting the budget went through Staff Y.Review of correspondence communication on 09/14/2024 and 04/13/2025 through 09/03/2025, showed Staff A had notified the corporate office of issues with their current laundry service (clothing, tablecloths returned stained; resident clothing returned bagged, instead of hung up on provided hangers and rack; linens returned wet and clean towels smelled of feces.) The communication threads documented Staff A's repeated attempts to get assistance, as stated.See F584 and F835 for further informationReference: WAC 388-97-1620(2)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505114	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aurora Valley Care	414 S University Rd Spokane, WA 99206

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to identify a designated interdisciplinary team member, to act as a liaison for coordinating care and communication with the hospice provider for 1 of 1 sampled residents (Resident 61), reviewed for hospice services. This failure placed the resident at risk for unmet care needs and diminished quality of life. Findings included Review of the 03/30/2022 agreement between the hospice provider and the facility documented services that were the responsibility of the facility and the services that were provided by the hospice agency. The agreement showed that the facility would designate an interdisciplinary team member that worked with the hospice staff to coordinate care of the hospice residents in the facility. The agreement did not identify who that staff member was, their title, nor the department where they worked.A review of the facility policy titled Hospice-Admission, Discharge, Care and Treatment dated December 2024 did not include documentation of who the designated facility liaison was that was responsible for collaborating in the development and care of the resident. According to a 07/17/2025 comprehensive assessment, Resident 61 had a diagnoses which included dementia and cancer of the pancreas. The assessment further showed Resident 61 had severe cognitive impairment and was placed on Hospice services for end-of-life care.Review of the medical record showed that Resident 61 received hospice services since 07/10/2025.During an interview on 09/11/2025 at 1:51 PM, Staff G, Nursing Assistant (NA), stated they were unsure who the hospice liaison was but thought it was Staff B, Director of Nursing or Staff H, Resident Care Manager.During an interview on 09/12/2025 at 9:47 AM, Staff I, NA stated that they were not 100% sure who the facility hospice liaison was and stated it probably was Staff B or the resident's nurse.During an interview on 09/12/2025 at 2:58 PM, Staff A, Administrator, stated Staff C, Social Services Director, handled coordination with hospice providers. Staff A acknowledged the facility policy did not list a team member as a hospice liaison, as required.No associated WAC