STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505151	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cashmere Post Acute	817 Pioneer Avenue Cashmere, WA 98815

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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 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a current Clinical Laboratory Improvement Amendment (CLIA) certificate required to perform laboratory tests within the facility. This failure placed residents at risk for substandard care, delayed diagnosis and incorrect medical treatment. Findings included. During an observation and concurrent interview on [DATE] at 1:55 PM, Staff A, Administrator, stated they had noticed the facility's CLIA certification had expired on [DATE] (an elapsed period of 9 months and 10 days). Staff A stated that they recalled paying the renewal fee for the previous year. During an interview on [DATE] at 10:03 AM, Staff A stated they were aware that the CLIA certificate was expired and stated they were ultimately responsible for the compliance of the facility's certifications. Staff A stated their quality assurance team was responsible for tracking financial stuff to ensure such fees were paid. Reference: WAC 388-97-1620 (2)(b)(i)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 3 of 5 residents (Residents 81, 2, and 77) were reviewed for gradual dose reduction (GDRs- the slow, step-by-step process of decreasing a residents medication overtime), or provide a clinical rationale for its contraindication as required for the use of psychotropic medication (drugs that alter brain function used to treat mental health conditions) reviewed for unnecessary medications. This failure placed residents who used psychotropic medications at risk for adverse side effects (ASEs) which could negatively impact their overall health and quality of life. Findings included .Record review of a facility policy titled Use of Psychotropic Medications revised 01/2025 showed, residents who use psychotropic drugs shall receive gradual dose reductions unless clinically contra-indicated, to discontinue the use of these drugs. Resident 81 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening or traumatic event), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a feeling of fear, dread, and uneasiness that's acts as a natural temporary reaction to stress). The 12/02/2024 comprehensive assessment showed Resident 81 cognition was moderately impaired and received an anti-depressant (a medication used to treat symptoms of depression and anxiety) and an antipsychotic (used to manage symptoms such as delusions, hallucinations, paranoia, and disordered thoughts) medications. Record review of Resident 81's physicians orders dated March 2026 showed the resident's medications included daily use of three psychotropic medications: Aripiprazole 10 Milligrams [(mg) a unit of measure] (an antipsychotic- a class of medication used to treat symptoms of psychosis and PTSD), one time daily, with a start date of 09/20/2025, bupropion extended release 150 mg daily, with a start date of 07/25/2025 and trazodone 100 mg once daily (an anti-depressant) with a start date of 07/25/2025. Review of the Psychotropic Drug Review Meeting minutes dated 07/25/2025 (admission review), 09/24/2025, 11/26/2025, and 02/24/2026 showed no documentation to show that Resident 81 had been reviewed for GDR's related to their psychotropic medications, or that a clinical contraindication had been completed and placed in the resident's medical record. During an interview on 04/02/2026 at 3:45 PM, Staff B, Director of Nursing, DON, stated staff I, Social Service Director, SSD, was responsible for keeping track of the GDR attempts and obtaining documentation if a psychoactive medication was clinically contraindicated. Staff B stated they would expect newly admitted residents to have two different GDR attempts within the first year; if not, they would expect the contraindication to be documented in the resident's medical record. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/03/2026 at 9:52 AM, Staff B stated Resident 81 had not had any GDR attempts since admission and did not have any clinical contraindications documented in their medical record. Staff B further stated the correct process was not followed for Resident 81. Resident 2 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses which included dementia (a decline in cognitive function to include memory and reasoning), depression (a mood disorder which causes feelings of sadness), post-traumatic stress disorder (PTSD, (a mental health disorder caused by an extremely stressful event) and anxiety. The comprehensive assessment dated [DATE] showed the resident had moderate cognitive impairment and required limited assistance for transfers and mobility. Record review of Resident 2's physicians orders dated April 2026 showed the resident's medications included daily use of two psychotropic drugs, Seroquel 50 mg, three times daily (an antipsychotic a class of medication used to treat symptoms of psychotropic as hallucinations) and Venlafaxine 150 mg daily (an antidepressant (a medication used to treat symptoms of depression anxiety and PTSD). Review of the Psychotropic Drug Review Meetings minutes from January to March 2026 provided no documentation to show that Resident 2 had been reviewed for GDR's related to the use of their psychotropic medications. During an interview on 04/02/2026 at 3:27 PM, Staff I, SSD, when asked to provide documentation for a GDR review related to Resident 2's psychotropic medication Staff I stated, I don't have one we have not reviewed them for a GDR in our monthly psychotropic drug meetings. Resident 77 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses which included dementia, depression and diabetes (a chronic disease which causes elevated blood sugar). Review of the 03/06/2026 comprehensive assessment showed the resident had moderately impaired cognition and required substantial assistance from staff for daily activities to include dressing, transfers, mobility and personal hygiene. Review of the Psychotropic Drug Review Meeting minutes dated January through March 2026 showed Resident 77 had their last GDR review documented as completed on 02/11/2025 (greater than a year ago). During an interview on 04/02/2026 at 3:39 PM, Staff I stated the last GDR completed for Resident 77's antidepressant medication was on 02/11/2026 and did not meet the requirement for annual review for an antidepressant GDR. Staff I stated, I realize I am behind and need to catch up on the GDRs for the residents. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/03/2026 at 10:10 AM, Staff B, DON, stated the GDRs were not current and the facility had fallen behind. Staff B stated the facility would be auditing the residents receiving psychotropic medications and provide GDR reviews as their expectation was that the facility be following regulations for the residents' use of psychotropic drugs. Reference WAC 388-97-1060(3)(k)(i)-0620(1)(a)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide adequate supervision and implementation of care plan interventions to prevent resident-to-resident altercations for 3 of 3 residents (Residents 48, 38, and 3) reviewed for accidents. This failure placed the residents at risk for potential verbal and physical abuse, serious pain, injury, and emotional distress. Additionally, the facility failed to ensure 1 of 3 residents (Resident 77), who utilized a transfer pole, had a process in place to ensure appropriate placement of equipment for safety and to mitigate the risk of entrapment. This failure placed Resident 77 at risk for injuries if improperly placed. Findings included .Review of a policy titled, Accidents and Supervision, dated 2025, showed the resident environment would be as free from accident hazards as is possible. Each resident would receive adequate supervision (interventions and means of mitigating risk of an accident) to prevent accidents that included identifying hazards and risks, evaluating and analyzing the hazards and risks, implementing interventions to reduce them, and monitoring for effectiveness and modifying the interventions when necessary. Resident 48 Review of the medical record showed Resident 48 was admitted to the facility with diagnoses including dementia with agitation (cognitive decline with verbal aggression, physical aggression, and pacing/restlessness), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and anxiety. The 01/05/2026 comprehensive assessment showed Resident 48 required substantial/maximal assistance of one staff member for ADLs. The assessment also showed Resident 48 had a severely impaired cognition. Resident 38 Review of the medical record showed Resident 38 was admitted to the facility with diagnoses including dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), diabetes (a group of diseases that result in too much sugar in the blood), and weakness. The 03/16/2026 comprehensive assessment showed Resident 38 required moderate to substantial assistance of one staff member for ADLs. The assessment also showed Resident 38 had a moderately impaired cognition. Resident 3 Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including dementia with behavioral disturbances, diabetes, and metabolic encephalopathy (a series of brain dysfunction caused by illness). The 12/30/2025 comprehensive assessment showed Resident 3 was independent with activities of daily living (ADLs) related to personal care. The assessment also showed Resident 3 had moderately impaired cognition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 3's care plan reviewed on 01/08/2026, showed they had a crisis prevention plan related to behaviors including delusions (fixed, irrational belief that can cause significant distress or behavioral changes), hallucinations (seeing, hearing, smelling, tasting, or feeling things that seem real but are not), paranoia (an intense, irrational distrust or suspicion of others), physical/verbal aggression and sexually inappropriate behaviors. Interventions included redirecting Resident 3 to their room, providing snacks/drinks, exercise, assessing pain, calling family to talk with Resident 3, providing one-on-one supervision as needed and communicating with Resident 3 in their native language. Additionally, staff should intervene before Resident 3 agitation escalates, guide them away from the source of distress, and engage calmly in conversation. There were no interventions for supervision of Resident 3, despite their history of behaviors. Record review of a facility investigation dated 04/05/2026, showed a resident-to-resident altercation occurred on 03/02/2025 at 6:30 AM between Resident 3 and Resident 48 in the hallway outside of Resident 3's room. The investigation showed Resident 48 was self-propelling in their wheelchair down the hallway towards the nurse's station when they passed Resident 3's room. Resident 3 noticed Resident 48 passing their room, exited their room, made verbal threats and kicked Resident 48's wheelchair from behind. The residents were separated and assessed for injury, none noted. The investigation showed Staff A, Administrator, and Staff B, Director of Nursing, were notified of the incident on 04/01/2026. Record review of a facility investigation dated 03/31/2026 showed a resident-to-resident altercation occurred at 6:50 AM, between Resident 3 and Resident 38 in the hallway outside the kitchen area. The investigation showed Resident 38 was self-propelling in their wheelchair down the hallway by the kitchen door. Resident 3 had a verbal altercation with Resident 38, closed their right hand and struck Resident 38 on the left side of their face. At the same time, Resident 38 closed their right hand and struck Resident 3's right arm. A housekeeper witnessed the incident from the end of the hall, intervened, and separated the residents. During an observation on 03/30/2026 at 2:56 PM, Resident 3 was wandering, unsupervised, through the halls of the facility, glancing into various resident rooms. Resident 3 stopped at the central nursing station, continued to the television sitting area, and continued to wander the same path through the halls of the facility. There were no staff observed monitoring Resident 3's wandering. During an observation and interview on 04/01/2026 at 8:18 AM, Resident 3 was at the end of a hall, unattended, wandering past resident rooms, looking into each room as they passed the room. Staff N, Medication Assistant, stated Resident 3 constantly wandered the halls claiming they were guarding and protecting the hall. Staff N stated Resident 3 had paranoia and reported people are after them. Staff N stated Resident 3 paced around the facility and had conversations with themselves; everyone knows about (Resident 3's) tendencies and behaviors. They stated the staff tried to keep eyes on Resident 3's location. During an interview on 04/01/2026 at 11:18 AM, Staff E, Medication Assistant, stated they did not witness the resident-to-resident incident on 03/31/2026 between Resident 3 and Resident 38. They stated they were passing medications to residents on a different hallway Staff E stated there was a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	housekeeper at the end of the hall that noticed the residents fighting and alerted them. Staff E stated they had to put the medications away on the cart, lock the cart, and went to assist the housekeeper with separating the residents. During a follow-up interview on 04/01/2026 at 2:20 PM, Staff E stated they were working on 03/02/2026, passing medications, when the resident-to-resident incident occurred between Resident 3 and Resident 48. They stated Resident 3 came out of their room and yelled at Resident 48, then kicked the back of their wheelchair. Staff E stated they separated the residents and called for assistance as the residents continued to have a verbal altercation. Staff E stated they had seen Resident 3 physically and verbally attack residents, both recently and in the past. Staff E stated they tried to be aware of where Resident 3 was due to their history of altercations. During an interview on 04/02/2026 at 2:30 PM, Staff B stated Resident 3 did not have a resident-to-resident altercation for over a year. They stated they tried to ensure staff were in the halls to avoid resident-to-resident incidents with Resident 3. Staff B stated Resident 3 targeted specific male residents, the staff watched Resident 3 closely and tried to keep them separated from Resident 38 and other residents. Staff B stated they did not know what caused the incidents between Resident 3 and Resident 48 or Resident 3 and Resident 38. Staff B stated Resident 3 was care-planned for one-on-one supervision as needed in the past and had since been placed back on one-on-one supervision indefinitely following these incidents. During an interview on 04/02/2026 at 3:47 PM, Staff A stated they talked with staff about making sure Resident 3 was redirected off the hall where Resident 38 resided due to Resident 3 targeting Resident 38. They stated Resident 38 was typically escorted to the restorative gym (located on the same hall where Resident 3 resided) by the restorative aid or a nursing assistant and were unsure why they did not have an escort on the day of the incident. Resident 77 Review of the resident's medical record showed they were admitted with diagnoses which included dementia (cognitive decline that affects memory and reasoning), depression (a mood disorder which causes sadness and diabetes (too much sugar in the blood). Review of the comprehensive assessment dated [DATE] showed the resident had mild cognitive impairment and required substantial assistance from staff for activities of daily living (ADLs) including dressing, transfers, bed mobility and toileting. A concurrent observation and interview on 03/30/2026 at 1:10 PM showed Resident 77 sitting in their wheelchair beside their bed with a transfer pole positioned between their legs. The resident was leaning forward while rummaging through their nightstand drawer. When asked if the transfer pole was in the way, the resident stated, yes, it was in the way, but they used the transfer pole to help them get in and out of bed, so they wanted to keep it. The resident further stated their bed had been moved, which caused the transfer pole to improperly positioned. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same continued observation showed the bed was positioned close to the window, six inches (a unit of measurement) from the heating/cooling system, leaving insufficient room to walk between the bed and window. There were no markings on the floor to indicate proper bed placement to ensure the transfer pole remained in the optimal position for safety and to prevent gaps. Record review of the resident's care plan dated 03/20/2026 showed the resident used a transfer pole; however, there were no interventions to ensure appropriate placement of the bed in reference to the placement of the transfer pole. A concurrent observation and interview on 04/01/2026 at 12:01 PM, Staff H, Registered Nurse, Resident Care Manager, was shown the resident's bed and placement of their transfer pole. Staff H stated there should be tape on the floor to indicate the correct bed position to ensure appropriate placement of the transfer pole. Staff H confirmed that there was no tape on the floor to show the staff where the bed should be placed. During an observation on 04/02/2026 at 9:30 AM, showed Resident 77's bed was no longer straight, but slightly angled at the top half of the bed. There was still no tape to mark where the bed should be placed in reference to the transfer pole. During an interview on 04/02/2026 at 9:50 AM, Staff R Housekeeping Aide, stated they were required to move resident beds weekly and clean under them. Staff R stated they just moved beds back after cleaning and had not seen tape marking the required spot where the beds with transfer poles should be placed. During an interview on 04/02/2026 at 10:34 AM, Staff B, Director of Nursing, stated they would expect the bed placement to be marked with tape for all residents using transfer poles. Staff B stated resident 77 had moved rooms a couple of months ago and the bed and transfer pole placement should have been assessed and marked with tape following the room move to ensure appropriate placement of the equipment. Cross reference to F600 for further information. Reference: WAC 388-97-1060(3)(g)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, comfortable and sanitary environment was maintained for 1 of 1 kitchen areas (dishwasher room) and 3 of 4 utility rooms (West clean and soiled utility rooms, and the South clean utility room) reviewed for environment. This failure placed the residents at risk for potential accidents and not feeling safe/secure with their environment. Findings included . Review of the facility policy titled Safe and Homelike Environment, dated 2025, showed .In accordance with residents rights the facility will provide a safe, clean, comfortable and homelike environment. Maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment and will report any unresolved environmental concerns to the Administrator . During an observation of the Kitchen (dishwasher room) on 03/30/2026 at 9:45 AM showed: The floor beneath and surrounding the dishwasher exhibited significant peeling, chipping, and erosion of the protective sealant, exposing an un-cleanable concrete surface measuring approximatelyˆsix feet by four feet (ft, a unit of measure). A thick buildup of greasy brown debris, and splash-back residue was observed across the wall surface surrounding the dishwasher, particularly along the bottom edge where the wall meets the sink. This buildup extends across the entire span of the visible wall section. A thick buildup of dark, greasy grime, debris, and splash-back residue was observed at the floor-to-wall junctions and behind equipment legs, extendingˆthree ftˆalong the wall. The junction between the wall and the floor underneath the dishwasher area appeared eroded with visible gaps measuring up toˆ1/4 inch (in- unit of measure), creating an uncleanable surface. Cleaning supplies, including a yellow scrub brush and a chemical spray bottle with no label, observed stored directly on the floor surface underneath the dishwasher area. The floor and wall base exhibited widespread localized buildup of yellowish-brown staining. During an observation of the South Clean Utility Room on 03/30/2026 at 12:14 PM showed:The wall surfaces exhibited extensive physical damage, including a deep horizontal gouge measuringˆfour ft in lengthˆand missing plaster at the corners, exposing metal. Multiple areas showed evidence of failed or inadequate repairs, including sections of tape measuringˆtwo in. by six in.,ˆapplied directly over structural wall damage. The wall area above the backsplash and surrounding the soap dispenser exhibited extensive grey and black speckled staining and splash-back residue covering aˆ12 in. by 18 in. area. During an observation of the [NAME] Soiled Utility Room on 03/30/2026 at 12:22 PM showed:The vinyl floor tiles exhibit significant chipping and missing sections along the seams, exposing the dark subfloor and adhesive beneath. This includedˆtwo missing tile sections,ˆeach measuringˆ12 in by 12 in, creating a non-sanitary and un-cleanable surface. Multiple tile edges surrounding the chipped areas appear jagged and uneven. A section of yellow and black hazard tape, approximatelyˆ18 in, in length, had been applied across a tile seam; however, observation of the tape peeling and lifting at the edges. Visible gaps and separation exist between several floor tiles, measuringˆ1/8 in. to 1/4 in. The dark brown rubber baseboard was coated in a significant layer of white, speckled splatter, with a visible buildup of thick, dark debris where the baseboard meets the floor, extending along the room perimeter. During an observation of the [NAME] Clean Utility Room on 03/30/2026 at 12:30 PM showed:A large rectangular section of floor tiles, measuring approximatelyˆthree ft by five ft, were entirely missing, exposing a significant area of dark, uneven concrete subfloor and adhesive beneath. Several dark, damp patches were visible on the exposed concrete, with the largest patch measuringˆ10 in. The dark brown rubber baseboard were missing entirely along aˆsix ft portionˆof the wall, and the remaining wall base exhibited eroded plaster and exposed unsealed gaps of metal approximately 1 in. A heavy buildup of dark, greasy residue along the edges of the remaining baseboards 6 ft of the wall section. The caulking at the countertop-to-wall junction was significantly deteriorated with gaps measuring 1/8 inch, creating a non-cleanable surface. During an interview on 03/31/2026 at 1:10 PM, Staff C, Director of (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Maintenance, stated the facility utilized a maintenance checkbook to track facility repairs. Staff C acknowledged the poor condition of the kitchen. Staff C stated the floors and walls need to be done and it looks bad, but they believed it remained structurally sound. Regarding the west soiled utility room, Staff C stated they were aware of the missing tiles and damaged backsplash for about a year. Staff C stated they had not replaced them because the specific tiles were difficult to find. Staff C further stated that the repairs for the utility rooms were low on my priority list. During an interview on 04/02/2026 at 4:04 PM, Staff A, Administrator, stated they were aware of the various environmental issues in the kitchen and utility rooms. Staff A further stated that addressing these maintenance concerns was not a priority because it was not a resident area. Reference: WAC 388-97-3220 (1)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident received dignified care and services by ensuring delivered care from their preference of female caregivers for 1 of 3 residents (Resident 79) reviewed for resident rights. This failure placed the resident at risk for compromised dignity, diminished self-worth, decreased self-esteem, and feelings of embarrassment. Findings included Resident 79 Review of the medical record showed Resident 79 was admitted to the facility with diagnoses to include dementia (a decline in mental abilities, such as memory, thinking, and reasoning, that interferes with daily life), and diabetes (a chronic condition where blood sugar levels are too high because the body does not make enough insulin or cannot use it properly). The comprehensive assessment dated [DATE] showed Resident 79 required the assistance of one staff member for toileting, showering/bathing, and touching assistance for upper and lower dressing. The assessment showed Resident 79's cognition was intact. During an interview on 03/30/2026 at 1:25 PM, Resident 79 stated they would like female caregivers only for personal care. Resident 79 stated they have told the Nursing Assistants (NAs), but the NAs would at times tell them they only have male caregivers available to do care during the evening shift and the night shift, which occurred about two times monthly. Resident 79 further stated, I don't think that it's right. I should not have a male caregiver if I do not want one. It is embarrassing for me as a woman. Even though they are good and careful, it is still embarrassing to have my pants down and my shirt off in front of a man. Review of Resident 79's care plan dated 01/09/2026 showed no care plan had been developed addressing the resident's preference for female caregivers only. During an interview on 03/31/2026 at 2:30 PM, Staff P, NA, stated Resident 79 preferred female caregivers if it involved undressing. Staff P stated they normally would find that information on the Kardex (a clinical bedside tool used by nursing staff to provide a quick overview of a resident's daily care needs and preferences). Staff P stated Resident 79's preference for a female caregiver was not on the Kardex, and they only heard that through word of mouth. Staff P stated they had provided personal cares for Resident 79 a few times when there were no female care givers available. During an interview on 03/31/2026 at 2:36 PM, Staff O, NA, stated Resident 79 preferred only female care givers and would only allow limited care assistance with a male NA. Staff O stated Resident 79 would provide their own perineal care (cleaning of the genital and anal areas). Staff O stated if there were no female staff on the floor, Resident 79 would allow certain male staff to do their cares, and they (Staff O) were one of them and they have provided personal care to Resident 79. During an interview on 04/01/2026 at 4:09 PM, Staff G, Registered Nurse/Resident Case Manager (RCM), stated they were not aware that Resident 79 preferred female caregivers. Staff G stated they would expect this information to be included in the residents' care plan, so staff were aware of how to provide care. Staff G confirmed a breakdown in the care planning process. During an interview on 04/02/2026 at 12:51 PM, Staff B, Director of Nursing (DON), stated they would expect the RCMs to know the resident's preferences to ensure they were placed on the care plan for staff to follow. Staff B stated they were not aware of Resident 79's preference for female caregivers and acknowledged Resident 79's preference was not being honored, was not on the care plan, and the correct process had not been followed. Reference WAC 388-97-0180 (1-3)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1 of 4 residents (Resident 100) reviewed for urinary (the body's processes, organs, or functions related to the productions, storage, and discharge or urine) catheter, were fully informed of their care. This failure placed the resident at risk of poor understanding in their health care decisions and a diminished quality of life. Findings included . Review of the undated facility policy titled, Resident Rights, showed the facility will inform the resident both orally and in writing, of their rights and responsibilities in a language that the resident understands. Review of the medical records showed Resident 100 admitted to the facility on [DATE] with diagnoses to include diabetes (a chronic condition where the body cannot properly manage blood sugar levels), lymphoma (a type of blood cancer that affects the immune system), kidney stone and acute kidney failure (a serious condition where the kidneys lose their ability to filter waste products, excess water, and toxins from the blood). The comprehensive care plan dated 03/27/2026 showed their cognition was moderately impaired and required assistance of one person for daily cares and transfers. In an observation and interview on 03/30/2026 at 1:56 PM Resident 100 was sitting in their room in a wheelchair. The resident was clean, well-groomed and had a retention catheter hanging on the bottom of their wheelchair. The resident stated they were unaware of where their catheter had been placed or if they would be going home with the catheter. The resident stated they would like to go home but had not been told when they would be discharged . During an interview on 03/31/2026 at 3:43 PM, Resident representative (RR) stated Resident 100's catheter was placed in the hospital for a kidney stone that had caused an infection and was unsure if Resident 100 would be going home with the catheter. The RR stated they were not sure what was happening with Resident 100's discharge and that would like an update on Resident 100's care. The Resident and their representative stated they had not been informed of when the catheter would be removed, or when they could expect a discharge. The RR stated they would like to speak to someone about Resident 100's care and what they would need upon discharge, that they had not yet talked with anyone from the facility. During an interview on 04/01/2026 at 3:37 PM, Staff G, Registered Nurse, stated they could not find documentation that Resident 100's care had been reviewed with the resident. Staff G stated the staff member that was responsible for ensuring the care was reviewed with the resident was on vacation. Staff G stated, no excuse Resident 100 should have had their care reviewed with them to ensure they were informed. During an interview on 04/02/2026 at 5:02 PM, Staff B, Director of Nursing, stated the care review with Resident 100 was missed. Reference: WAC 388-97-0300 (3)(a)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure residents were free from abuse for 2 of 3 residents (Residents 48 and 38) reviewed for resident-to-resident altercations with Resident 3. This failure placed the residents at risk for continued abuse, injury, and emotional distress. Findings included. Review of a policy titled, Abuse, Neglect, and Exploitation, dated 2023, showed the facility would develop and implement written policies and procedures that prohibit and prevent abuse, neglect, and exploitation of residents. Resident 48Review of the medical record showed Resident 48 was admitted to the facility with diagnoses including dementia with agitation, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and anxiety. The 01/05/2026 comprehensive assessment showed Resident 48 required substantial/maximal assistance of one staff member for activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 48 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 38Review of the medical record showed Resident 38 was admitted to the facility with diagnoses including dementia with behavioral disturbance, diabetes, and weakness. The 03/16/2026 comprehensive assessment showed Resident 38 required moderate to substantial assistance of one staff member for ADLs. The assessment also showed Resident 38 had a moderately impaired cognition. Resident 3Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including dementia with behavioral disturbances (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), diabetes (a group of diseases that result in too much sugar in the blood), and metabolic encephalopathy (a series of brain dysfunction caused by illness). The 12/30/2025 comprehensive assessment showed Resident 3 was independent with ADLs. The assessment also showed Resident 3 had a severely impaired cognition. Record review of a nursing progress note (PN) dated 03/02/2026 showed Staff E, Medication Assistant, documented that Resident 3 was observed in their room. They exited their room and yelled at Resident 48, who was in the hall in their wheelchair, stating get the f**k out of here you stupid pig! I'm going to kill you and feed you to the pigs! Resident 3 kicked the back side of Resident 48's wheelchair, sending them forward about 2 feet (a unit of measurement) before Resident 48 put their feet down to stop the wheelchair. The two residents continued to have a verbal altercation. Staff F, Registered Nurse (RN), was called to assist Staff E with separating the residents. Resident 3 continued to make threats of killing Resident 48 as Staff F redirected Resident 3 back to their room. During an interview on 04/01/2026 at 2:20 PM, Staff E stated when Resident 3 had the altercation with Resident 48, they were in the hall outside of Resident 3's room. Staff E stated after the incident, Resident 3 stayed in their room for the remainder of the day and Staff E kept their medication cart parked in the hall outside of Resident 3's room so they could watch them. Review of a nursing PN dated 3/31/2026, Staff B, Director of Nursing, showed Resident 3 was wandering in the hall when they met Resident 38 outside of the kitchen area. Resident 3 yelled at Resident 38, stating you are a dog and in my workspace! Resident 3 pulled their right hand into a fist and made contact with their fist against Resident 38's face. At the same time, Resident 38 pulled their right hand into a fist and made contact with Resident 3's right arm. A housekeeper witnessed the incident and separated the two residents. Resident 3 was placed on one-to-one observation (a resident safety intervention where a staff member is assigned to continuously monitor a single high-risk resident to prevent accidents) to prevent further altercations. During an interview on 04/01/2026 at 9:37 AM, Staff B stated they were not aware of the resident-to-resident altercation that occurred on 03/02/2026. They stated both of these incidents were abuse and Resident 3 should have been placed on increased supervision at that time of the first altercation to prevent the second altercation. Reference: WAC 388-97-0640(1)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement their abuse prevention policy in the areas of identification, investigation, protection, and reporting for 2 of 3 residents (Residents 48 and 38) reviewed for altercations with Resident 3. This failure placed the residents at risk for continued unidentified abuse, fear, and dissatisfaction with their living situation.Findings included. Review of a policy titled, Abuse, Neglect, and Exploitation, dated 2023, showed the facility would develop and implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. New employees and existing staff would receive education inducing identifying abuse, neglect, exploitation and misappropriation, such as physical or psychosocial indicators; the reporting process for abuse, neglect, exploitation, and misappropriation, and understanding behavioral symptoms that may increase the risk of abuse and neglect such as aggressive reactions of residents, wandering, and outbursts or yelling out. This included staff to resident abuse and resident-to-resident altercations. An immediate investigation would be initiated when suspicion/reports of abuse occur. The facility would ensure all residents were protected from physical and psychosocial harm, and additional abuse, during and after the investigation. The facility would report all alleged violations to the Administrator, State Agency, Adult Protective Services, and law enforcement immediately, but not later than 2 hours after the allegation if the allegation was abuse, not later than 24 hours if the allegation did not involve abuse or serious bodily injury. Resident 48 Review of the medical record showed Resident 48 was admitted to the facility with diagnoses including dementia with agitation, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and anxiety. The 01/05/2026 comprehensive assessment showed Resident 48 required substantial/maximal assistance of one staff member for activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 48 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 38Review of the medical record showed Resident 38 was admitted to the facility with diagnoses including dementia with behavioral disturbance, diabetes, and weakness. The 03/16/2026 comprehensive assessment showed Resident 38 required moderate to substantial assistance of one staff member for ADLs. The assessment also showed Resident 38 had a moderately impaired cognition. Resident 3Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including dementia with behavioral disturbances (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), diabetes (a group of diseases that result in too much sugar in the blood), and metabolic encephalopathy (a series of brain dysfunction caused by illness). The 12/30/2025 comprehensive assessment showed Resident 3 was independent with ADLs. The assessment also showed Resident 3 had a moderately impaired cognition. Review of a nursing progress note (PN) dated 03/02/2026, showed Resident 3 threatened to kill Resident 48 and kicked the back of their wheelchair. Resident 3 was redirected back to their room as they continued to make threats of killing Resident 48. During an interview on 04/01/2026 at 2:20 PM, Staff E, Medication Assistant, stated they witnessed the incident between Resident 3 and Resident 48. They stated they separated the residents and reported the incident to Staff F, Registered Nurse. Staff E stated they did not report the incident to the State Agency because they thought Staff F would. During an interview on 04/03/2026 at 9:37 AM, Staff F stated Staff E called for assistance with a resident-to-resident altercation about a month ago. They stated the residents had gotten into a verbal altercation and Resident 3 had kicked the back of the wheelchair of Resident 48. Staff F stated their process for reporting incidents included obtaining an incident folder that contained the necessary forms for initiating an investigation. They would gather witness statements, write a progress note, and alert administrative staff of the incident. They stated they would also report to the State Agency. Staff F stated they did not follow this process because (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they did not feel like there was abuse in this situation. During an interview on 04/01/2026 at 9:37 AM, Staff B, Director of Nursing, stated they were not informed of the resident-to-resident altercation on 03/02/2026. They stated Staff F did not report the incident because there was no physical contact between the residents. Staff B stated the incident was abuse and it should have been reported. Review of a facility incident investigation dated 03/31/2026, showed Resident 3 had a resident-to-resident altercation with Resident 38 in the hall located outside of the kitchen area. Resident 3 stated Resident 38 was a dog and was in their workspace. Resident 3 close their right hand and made contact with Resident 38's face. Resident 38 closed their hand and made contact with Resident 3's arm. A housekeeper witnessed the event and separated the residents. During an interview on 04/02/2026 at 2:14 PM, Staff B stated staff missed steps with the first incident. They did not identify the abuse due to Staff F stating there was no physical contact so there was nothing to report. Staff B stated the process should have been to notify the administrative staff to ensure the residents were protected from further abuse. The incident needed to be investigated and reported to the State Agency. During an interview on 04/03/2026 at 8:19 AM, Staff A, Administrator, stated all staff were trained to the abuse/neglect policy. They stated staff were educated on the types and identification of abuse/neglect and competencies were completed after the training. Staff A stated any suspected or observed incidents of abuse should be immediately reported within two hours of the incident to the State Agency, local law enforcement, the provider, and the resident representative. The incident should be reported by the staff member that witnessed the event. Any alleged abuse incidents needed to have a thorough investigation initiated and completed within five working days. Staff A stated the incident on 03/02/2026 should have been reported to the State Agency and to the administrative staff to ensure the resident was protected and a proper investigation was completed. Cross reference F600 for further information.Reference: WAC 388-97-0640(1)(2)(a)(b)(5)(a)(a)(b)(c)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an incident of abuse was reported to the State Agency as required for 1 of 3 residents (Resident 48) reviewed for an altercation with Resident 3. This failure placed the residents at risk for additional/continued abuse.Findings included. Review of a policy titled, Abuse, Neglect, and Exploitation, dated 2023, showed the facility would have written procedures that included reporting of alleged violations to the administrator, State Agency, adult protective services, and all other required agencies within specified timeframes: immediately, but not greater than two hours after the allegation was made if the allegation involved abuse or serious bodily injury, or not later than 24 hours if the allegation did not involve abuse and there was no serious bodily injury. The administrator would follow up with government agencies to confirm the initial report was received and to report the results of the investigation when final, within five working days of the incident. Resident 48Review of the medical record showed Resident 48 was admitted to the facility with diagnoses including vascular dementia (a decline in thinking skills caused by condition that block or reduce blood flow to the brain, damaging brain tissue), Alzheimer's disease (a progressive, incurable disease primarily affecting memory, thinking, and behavior), and delirium (a sudden state of severe confusion and reduced awareness caused by underlying medical issues, infections, or medication side effects). The 01/05/2026 comprehensive assessment showed Resident 48 required substantial/maximal assistance of one staff member for activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 48 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 3Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), diabetes (a group of diseases that result in too much sugar in the blood), and kidney disease. The 12/30/2025 comprehensive assessment showed Resident 3 was independent with ADLs. The assessment also showed Resident 3 had a severely impaired cognition. Record review of a nursing progress note dated 03/02/2026, showed Resident 3 had a verbal and physical altercation with Resident 48 in the hall outside of Resident 3's room. Resident 3 had threatened to kill Resident 48, then kicked the back of Resident 48's wheelchair. During an interview on 04/01/2026 at 2:20 PM, Staff E, Medication Assistant, stated they witnessed the incident between Resident 3 and Resident 48. They stated they separated the residents and reported the incident to Staff F, Registered Nurse. Staff E stated they did not report the incident to administration or the State Agency because they thought Staff F would. During an interview on 04/03/2026 at 9:37 AM, Staff F stated Staff E called for assistance with a resident-to-resident altercation about a month ago. Staff F stated their process for reporting incidents included obtaining an incident folder that contained the necessary forms for initiating an investigation and reporting the incident to the State Agency. Staff F stated they did not follow this process because they did not feel like there was abuse in this situation. During an interview on 04/02/2026 at 2:14 PM, Staff B, Director of Nursing, stated Staff F should have reported to the resident-to-resident abuse incident to both the administrative staff and the State Agency. Staff B stated the incident should have been reported to the administrative staff and the State Agency as required. During an interview on 04/02/2026 at 3:39 PM, Staff A, Administrator, stated the process should have been to report the incident to the State Agency hotline and the administrative staff to ensure resident safety and to complete a proper investigation. Cross reference to F600 and F607 for further information.Reference: WAC 388-97-0640(1)(5)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to thoroughly investigate an incident of abuse for 1 of 3 residents (Resident 48) reviewed for an altercation with Resident 3. This failure placed the residents at risk for further unidentified and/or further abuse.Findings included. Review of a policy titled, Abuse, Neglect, and Exploitation, dated 2023, showed an immediate investigation was warranted when suspicion of abuse, neglect, or exploitation, or report of abuse, neglect or exploitation occurred. The investigation process included identifying staff responsible for the investigation, identifying and interviewing involved persons, including the alleged victim, alleged perpetrator, witnesses, and others that might have knowledge of the allegation, and providing complete and thorough documentation of the investigation. Resident 48Review of the medical record showed Resident 48 was admitted to the facility with diagnoses including vascular dementia (a decline in thinking skills caused by condition that block or reduce blood flow to the brain, damaging brain tissue), Alzheimer's disease (a progressive, incurable disease primarily affecting memory, thinking, and behavior), and delirium (a sudden state of severe confusion and reduced awareness caused by underlying medical issues, infections, or medication side effects). The 01/05/2026 comprehensive assessment showed Resident 48 required substantial/maximal assistance of one staff member for activities of daily living [(ADLs) activities related to personal care]. The assessment also showed Resident 48 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Resident 3Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including dementia with behavioral disturbance (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), diabetes (a group of diseases that result in too much sugar in the blood), and kidney disease. The 12/30/2025 comprehensive assessment showed Resident 3 was independent with ADLs. The assessment also showed Resident 3 had a severely impaired cognition. During an interview on 04/02/2026 at 2:14 PM, Staff B, Director of Nursing, stated a resident-to-resident incident between Resident 48 and Resident 3 on 03/02/2026 was not investigated due to Staff F, Registered Nurse, not identifying the incident as abuse. They stated the process should have been for Staff F to notify the administrative staff so a thorough investigation could have been completed. During an interview on 04/03/2026 at 8:19 AM, Staff A, Administrator, stated any suspected abuse or actual abuse needed to be thoroughly investigated, which included witness, staff, and resident statements. They stated the investigation should be initiated immediately after the incident and needed to be completed within five working days of the initial report. Cross reference F600 and F607 for further information. Reference: WAC 388-97-0640(6)(a)(c)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide a written notice of bed hold (holding or reserving a resident's bed while the resident is absent from the facility) at the time of transfer to the hospital for 1 of 3 residents (Resident 10) reviewed for hospitalization. This failure placed the residents at risk of not having the necessary information to make an informed decision regarding their ability to return to the facility.Findings included. Review of a policy titled, Bed Hold Notice, dated 2025, showed the facility would provide written information to the resident and/or their representative regarding bed hold practices both well in advance, and at the time of a transfer for hospitalization or therapeutic leave (a planned temporary absence from the facility for non-medical reasons). Review of the medical record showed Resident 10 was admitted to the facility with diagnoses including end stage renal disease (permanent kidney failure where kidney function is less than 10% and they can no longer function on their own), diabetes (a condition of having too much sugar in the blood), and muscle weakness. The 02/04/2026 comprehensive assessment showed Resident 10 required substantial/maximum assistance of one staff member for activities of daily living (activities related to personal care). The assessment also showed Resident 10 had a severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). Review of a nursing progress note dated 12/08/2025, showed Resident 10 experienced an unwitnessed fall from their chair in their room. The documentation showed Resident 10 was transferred to the local hospital for further evaluation of right hip pain and bruising to the right side of their forehead. Resident 10's Representative was present at the time Resident 10 transferred to the hospital. Record review of the medical record showed no documentation that a notice of bed hold was provided to Resident 10 or their Representative. During an interview on 04/02/2026 at 11:01 AM, Staff A, Administrator, stated they were unable to locate the required notice of bed hold for Resident 10. During an interview on 04/02/2026 at 2:39 PM, Staff B, Director of Nursing, stated the licensed nurse that completed Resident 10's transfer to the hospital should have had a conversation with the resident and/or their representative regarding bed hold, obtained a form, and had it signed by the resident/representative. They stated they had identified an issue with the facility not completing the bed hold notification upon transfer and were aware the facility was missing them. Reference: WAC 388-97-0120(3)(c)(4)

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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 residents Preadmission Screening and Resident Reviews ([PASARR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] were not inappropriately placed in nursing homes for long term care) were accurately completed prior to admission for 1 of 5 residents (Resident 81) and updated when new SMIs were identified. and had the required Level II (a comprehensive evaluation by the appropriate state-designated authority) referral if residents had a positive Level I (a pre-screening evaluation for identifying SMI/ID/DD) PASARR for 1 of 5 residents (Resident 3) reviewed for PASARR. This failure placed the residents at risk of not receiving the mental health care and services appropriate for their needs. Findings Included . Review of the facility policy titled Coordination with PASRR Program, dated 2025, showed all applicants to the facility would have a Level I PASAAR for SMI, ID/DD, and/or related conditions prior to admission to the Nursing Home (NH) and if an SMI/ID/DD should be diagnosed after admission. If the Level I showed the resident had an SMI/ID/DD, then a Level II evaluation would be completed prior to admission. The policy additionally showed any resident who was diagnosed with a SMI/ID/DD after admission would have been promptly referred for a Level II evaluation. The policy showed the Social Service Director (SSD) would be responsible for tracking resident's PASARR screening status and referrals to the appropriate authority. Resident 81 Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses to include post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening or traumatic event), dementia (loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (a feeling of fear, dread, and uneasiness that's acts as a natural temporary reaction to stress), and obsessive compulsive disorder (OCD- a mental health condiitob characterized by uncontrollable, unwanted thoughts (obsessions) and repetitive behaviors (compulsions) a person feels driven to perform to reduce anxiety). The 12/02/2024 comprehensive assessment showed Resident 81 cognition was moderately impaired and received anti-depressant and antipsychotic (used to manage symptoms such as delusions, hallucinations, paranoia, and disordered thoughts) medications. Review of the 07/18/2025 PASARR for resident 81 showed the resident had no SMI marked for PTSD or OCD on admission to the facility. During an interview on 04/02/2026 at 1:54 PM, Staff I, Social Service Director, SSD, stated they reviewed PASARRs on admission and if they were not correct, they would then complete a new one. Staff I stated, I must of just missed that one. During an interview on 04/03/2026 at 2:53 PM, Staff B, director of nursing , DON, stated the SSD was to review PASARRs prior to admission and ensure they were corrected before admitting. Staff B (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if a current resident had a new SMI diagnosis during their stay, then the SSD should have followed up on the new diagnosis and obtain an evaluation if indicated. Resident 3 Review of the medical record showed Resident 3 was admitted to the facility with diagnoses including dementia with behavioral disturbances (a progressive disease that destroys memory and other important mental functions, with agitation, physical aggression, wandering, and hoarding), diabetes (a group of diseases that result in too much sugar in the blood), and metabolic encephalopathy (a series of brain dysfunction caused by illness). The 12/30/2025 comprehensive assessment showed Resident 3 was independent with ADLs. The assessment also showed Resident 3 had a severely impaired cognition. Record review of a PASARR Level I form dated 01/28/2020, showed Resident 3 had no serious mental health indicators that would require a PASARR Level II evaluation. Review of the medical record showed a diagnosis of delusional disorder (a serious mental illness characterized by persistent, fixed false beliefs) had been added to Resident 3's diagnoses on 10/02/2025. There was no PASARR Level I update or PASARR Level II sent for evaluation related to the new diagnoses. During an interview on 04/01/2026 at 2:00 PM, Staff I, Social Services, stated when a resident was diagnosed with a new disorder that qualified for a PASARR Level II evaluation, they would complete that evaluation and submit it to the evaluator. They stated Resident 3's new diagnosis of delusional disorder was a mental health diagnosis that would have qualified for a new PASARR. Staff I stated they did not get notified of new diagnoses and would not have known that a new PASARR was needed. During an interview on 04/02/2026 at 3:49 PM, Staff A, Administrator, stated Resident 3 should have been reassessed for a PASARR Level II when they had the new mental health diagnosis. Reference: WAC 388-97-1915 (1)(2)(a-c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure fluids were readily available and provided to 1 of 3 residents (Resident 88) and to identify and monitor skin bruising for 1 of 4 residents (Resident 79) reviewed for quality of care. This failure placed the residents at risk for excessive thirst, dehydration, further skin injury and serious adverse health conditions.^ Findings included . Review of a policy titled, Provision of Quality Care, dated 2025, showed the facility would ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plans, and the residents' choices. Resident 88 Review of the medical record showed Resident 88 was admitted to the facility with diagnoses including hemiplegia and hemiparesis (complete paralysis and weakness on one side of the body) following a stroke (a medical emergency that occurs when blood flow to the brain is blocked or a vessel bursts, causing rapid brain cell death), adult failure to thrive (weight loss, malnutrition, dehydration, cognitive decline, and functional impairment), and dysphagia (difficulty swallowing). The 02/06/2026 comprehensive assessment showed Resident 88 was dependent on staff for activities of daily living (ADLs-activities related to personal care). The assessment also showed Resident 88 had a severely impaired cognition. Record review of an assessment form titled, Dehydration Risk Screener, dated 02/04/2026, showed a score of 10 or higher indicated the resident was at risk for dehydration and further assessments should be conducted to review the resident's fluid status. Resident 88 scored 16 on the Dehydration Risk Screener. Record review of an assessment form titled, At Risk for Malnutrition Clinical Evaluation, dated 02/04/2026, showed Resident 88 recently lost greater than 34 pounds and was at risk for malnutrition. Record review of Resident 88's care plan dated 02/13/2026, showed the resident did not use their call list for assistance. Staff were to monitor the residents' needs and offer fluids. An addition to the care plan, dated 02/19/2026, showed staff were to encourage fluids during the day. During an observation on 03/30/2026 at 10:47 AM, Resident 88 was lying in bed sleeping. Their mouth was open, which showed their dry tongue with thick, stringy saliva. Their lips were scaly and dry. Resident 88's eyes were sunken in. The bedside table was located across the room from Resident 88. There were no beverages/fluids or toothettes (single use, disposable foam swabs designed to clean, refresh, and moisturize the mouth) in Resident 88's room. During an observation on 03/31/2026 at 12:45 PM, Resident 88 was lying in bed on their right side, their left hand on their head, stating I want to go home. They had thick saliva on their tongue and had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dry, flakey lips. There were no fluids or toothettes in the resident's room. At 12:52 PM, as Staff J, Nursing Assistant (NA) walked by the resident's room, Resident 88 called out may I have a snack? Staff J did not respond to Resident 88. At 12:54 PM, Staff K walked past Resident 88's room as they called out where is my snack? Staff K did not acknowledge the resident calling out. During an observation on 04/01/2026 at 8:28 AM, Resident 88 was in the assisted dining room with 11 other residents. Their food and fluids were on the table in front of them. There was a NA sitting next to Resident 88 with their back to the resident. They were assisting another resident with their meal. Resident 88 called out please, I would like a snack. Resident 88 had a very dry mouth with stringy saliva between their lips. At 8:31 AM, Staff L, NA, assisted Resident 88 with their breakfast meal. Resident 88 attempted to drink thickened liquids from a cup and had difficulty swallowing. Record review of Resident 88's meal intake record dated 04/01/2026, showed they refused their meal, despite asking for a snack. During an observation on 04/01/2026 at 10:29 AM, Resident 88 was lying in bed on their back, the lights were out, and a fall mat was next to the bed. The bedside table was across the room. There were no fluids/toothettes in the resident's room. During an interview on 04/01/2026 at 10:31 AM, Staff M, NA, stated the residents received fluids at mealtimes. They stated if they did not have enough fluids with their meal, they would use a sponge swab (toothette) and try to have Resident 88 suck on that to get fluids. Staff M stated they checked on the resident frequently and tried to give them fluids, but they spit them out. Staff M stated they recorded the residents' intake with meals but there was no place to record fluid intake for any resident. During an interview on 04/01/2026 at 2:24 PM, Staff H, Resident Care Manager, stated Resident 88 needed assistance with feeding and ate in the assisted dining room. They stated the resident required thickened liquids and received them with their meal three times a day and with their medications. They stated the resident also had thickened liquids, which were available at the bedside and the NAs would help the resident with the liquids. Staff H stated they did not monitor the resident's fluid intake, despite Resident 88's high risk for dehydration assessment. During an interview on 04/02/2026 at 2:42 PM, Staff B, Director of Nursing, stated the Dehydration Risk Screener assessment form was used to identify residents at high risk for dehydration. They stated the facility did not do anything with the information collected on the assessment form. Staff B stated there was not a process for monitoring fluid intake; there was no way to track it. Staff B stated the staff should be offering the residents fluids each time they provide care to the resident. During an interview on 04/02/2026 at 3:51 PM, Staff A, Administrator, stated the facility had a hydration cart that was staffed by a NA and were expected to help with ensuring residents received fluids throughout the day. Staff A stated all staff were expected to address resident needs when they (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called out for help. Resident 79 Review of the medical record showed Resident 79 was admitted to the facility with diagnoses to include dementia (a decline in mental abilities, such as memory, thinking, and reasoning, that interferes with daily life), and diabetes (a chronic condition where blood sugar levels are too high because the body does not make enough insulin or cannot use it properly). The comprehensive assessment dated [DATE] showed Resident 79 required the assistance of one staff member ADls. The assessment showed Resident 79's cognition was intact and had no documented skin issues An observation and concurrent interview on 03/30/2026 at 1:32 PM, showed Resident 79 lying in bed. The resident stated they had bruises to their abdomen from insulin injections and were currently prescribed anticoagulant (blood thinner) medication. Resident 79 self-initiated a skin observation by lifting their shirt, revealing a large, multicolored (yellow and greenish) bruise measuring 4 centimeters (cm,-a unit of measure) x 3 cm to the right side of their abdomen. An observation and concurrent interview on 04/01/2026 at 3:47 PM, showed Resident 79 lying in bed. The resident again lifted their shirt and stated, Sometimes the bruises hurt if they give me another shot in the same spot. There was a total of 17 bruised areas across their abdomen: 13 on the right side of their abdomen and 4 on the left side of their abdomen. The bruises were observed in various sizes and stages of healing (various colors), ranging from dark purple to yellow green. Record review of the weekly skin evaluation form dated on 02/25/2026, 03/04/2026, 03/10/2026, 03/18/2026, and 03/25/2026 showed Resident 79 consistently marked as having none for current or active skin issues. Record review of the March and April 2026 treatment administration record showed no monitoring, no assessment, or documentation of the 17 bruised areas on Resident 79's abdomen. Review of Resident 79's Care Plan, revised on 02/18/2025, failed to identify the resident's current skin impairments. The Care Plan had no interventions for the assessment, monitoring, or treatment of the 17 bruised areas on Resident 79's abdomen and failed to address the resident's reports of pain related to injection sites. During an interview on 04/01/2026 at 3:56 PM, Staff H, Registered Nurse, stated they only document bruises if they were present upon admission or were large, massive, and dark. Staff H stated they had not documented the bruised areas on Resident 79's abdomen in the weekly skin assessments, because we know where they come from. When asked how the facility monitored complications or pain at these sites, Staff H stated they did not. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/02/2026 at 12:51 PM, Staff D, Resource Nurse, stated any bruising should be captured in the weekly skin assessment and formally documented in the clinical record. Staff D stated for a resident with a known risk for bruising, such as Resident 79, they would expect the bruising to be assessed, and care planned to ensure proper monitoring. Reference: WAC 388-97-1060(1)(2)(3)(h)(i)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview, and record review, the facility failed to ensure that a resident who was a trauma survivor received culturally competent, trauma-informed care in accordance with professional standards of practice by not identifying triggers (a stimulus that causes a reaction, often an emotional or physical response) regarding a resident history of Post-Traumatic Stress Disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening or traumatic event) for 1 of 5 residents (Resident 81) reviewed for trauma-informed care .This failure placed the resident at risk for unidentified triggers and re-traumatization. Findings included . Record review of the facility policy titled Trauma-Informed Care, dated 2026, showed: .The facility will recognize how trauma affects individuals through evaluation and identification of triggers during the admissions process. The facility will develop an appropriate plan of care and interventions based upon the residents' triggers and will modify the plan of care for any changes in behavior . Review of the resident's medical record showed they were admitted to the facility with diagnoses including PTSD. The 12/02/2024 comprehensive assessment showed Resident 81 required the assistance of one staff member for activities of daily living and had moderately impaired cognition. During an interview on 03/30/2026 at 1:42 PM, the Resident Representative (RR) stated that Resident 81 had a diagnosis of PTSD stemming from a history of sexual assault. The RR stated Resident 81 becomes nervous around men, specifically became very quiet, anxious and had reported a feeling as though men were following them. The RR further stated that the resident should only have female caregivers. Record review of Resident 81's care plan, dated 07/25/2025, showed no trauma-informed care plan that included Resident 81's triggers, behaviors, or person-centered interventions. Record review of Resident 81's trauma-informed care assessment, dated 08/08/2025, showed Resident 81 experienced a traumatic event of sexual assault and severe human suffering. Further review showed there were no resident-specific behaviors or triggers identified that would cause the resident to feel fear, panic, agitation, or depression. During an interview on 04/01/2026 at 2:51 PM, Staff I, Social Service Director (SSD), stated the process for trauma-informed care was to complete the assessment by answering the required questions and asking about triggers. Staff I stated they attempt to reach out to the RR if the resident cannot provide answers. Staff I stated they had not spoken to Resident 81's RR, stating, I normally consult the RR, but I did not do so in this case. Staff I further stated the resident's triggers should have been added to the care plan, stating, I did not follow the correct process for Resident 81. During an interview on 04/02/2026 at 12:51 PM, Staff D, Resource Nurse, stated the trauma-informed care assessment should have been completed with the RR upon admission. Staff D stated trauma-based triggers and interventions should have been included in Resident 81's care plan. WAC Reference: 388-97-1060 (3)(e)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure expired medications were destroyed in 1 of 1 medication room and failed to ensure refrigerated medications were stored at proper temperatures in 1 of 1 medication refrigerator. These failures placed residents at risk of receiving medications that could cause unintended outcomes due to improper storage and compromised efficacy. Findings Included. Review of the facility's undated policy titled, Medication Storage, showed to ensure all medications would be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. During an observation on 04/01/2026 at 9:37 AM, the facility medication room showed the following expired supplies and medications were identified: Three port access kits (sterile, all-in-one kit that contains all necessary components to safely access an implanted venous access device [port] for medications or fluids) with a manufacturer expiration date of 8/31/2025. A box of 4 milligram (mg) nicotine lozenge that had two different dosages of a 2 mg lozenge and 4 mg lozenge with a manufacturer expiration date of 02/2026. One bottle [NAME]-Vite tab (dietary supplement) with a manufacturer expiration date of 01/2026. 25 orange top, blood collection tubes with a manufacturer expiration date of 01/31/2026. 12 light blue top, blood collection tubes with a manufacturer expiration date of 0/28/2026. Review of the medication refrigerator temperature log dated March 2026 showed staff were instructed to document temperatures twice daily, at the beginning and end of each workday. The temperature log had 14 days without the required twice-a-day documentation of the medication refrigerator temperatures. During a concurrent observation on 04/01/2026 at 9:46 AM, staff G. Registered Nurse (RN), stated the temperatures for the medication refrigerator must be checked and documented twice daily. During an interview on 04/01/2026 at 9:51 AM, staff G stated that the expectation was for the nurses to monitor expiration dates and ensure expired items were not used and were properly destroyed Staff G further stated the nurses were responsible for monitoring and documenting refrigerator temperatures twice per day. During an interview on 04/02/2026 at 5:02 PM, Staff B, Director of Nursing, stated they had discussed the expired medications and medical supplies with Staff G. Staff B stated they understood and would be working on a better system to monitor the temperatures in the medication refrigerator. Reference: WAC 388-97-1300 (2) ˆ