

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to conduct performance reviews for 5 of 5 Certified Nursing Assistants (CNA's) (Staff M, N, O, P, & Q) at least every 12 months, as required. This failure placed residents at risk of receiving care from staff whose performance did not meet expectations and required additional training. Findings included. Review of the facility's Staff List provided on 07/21/2026 showed the following: Staff M (CNA) was hired on 09/16/2024, 22 months prior to survey. Staff N (CNA) was hired on 03/14/2024, 16 months prior to survey. Staff O (CNA) was hired on 04/20/2021, 63 months prior to survey. Staff P (CNA) was hired on 07/29/2024, 23 months prior to survey. Staff Q (CNA) was hired on 08/14/2024, 23 months prior to survey. The facility did not provide any documentation to show that performance reviews for Staff M, Staff N, Staff O, or Staff P were conducted. Review of Staff Q's Employee Performance Review, dated 11/27/2025, showed Staff Q's performance was reviewed 15 months after their date of hire. The facility did not provide any other performance review documentation for Staff Q. In an interview on 07/28/2026 at 8:28 AM, Staff R (Human Resources) stated that the facility was waiting to do annual performance reviews because the employee union was still working on new wage rates. Staff R stated they understood performance reviews were required to be done every 12 months, but they were not because employees wanted to know how their performance reviews would affect their wages. Staff R stated they could not locate any previous performance reviews for the above staff. In an interview on 07/28/2026 at 9:18 AM, Staff B (Director of Nursing) stated that they expected performance reviews to be done annually, and many were overdue. REFERENCE: WAC 388-97-1680 (2)(b)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505195	Facility ID: 505195 If continuation sheet Page 1 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 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 ensure the residents and their environment were kept safe for 2 of 4 units (Birch Hall and Cedar Hall) observed with accident hazards and for 5 of 13 residents (Residents 63, 67, 17, 94, & 28) reviewed for accidents. The facility failed to ensure their sharps containers were not overfilled (rooms & treatment carts), resident safety assessments regarding device use (Resident 6) and smoking (Resident 28) were completed, Care Plan (CP) interventions were developed and implemented to prevent falls (Resident 67), smoking materials were safekept properly (Resident 17), and residents assessed with elopement risk were provided adequate supervision (Residents 94 & 28). These failures placed residents at risk for bloodborne pathogen exposure, avoidable injury, and other negative health outcomes. Findings included.<Facility Policy>According to the undated facility policy titled, Sharps Handling and Disposal, the facility would provide for the safe handling and disposal of sharps to reduce the risk of healthcare associated infections. The policy showed staff were to replace sharps containers before the contents go above the fill line.According to the facility policy titled, Accidents and Incidents: Report, Investigate, Review, and Analysis, dated 02/03/2023, the facility would provide an environment that was free from hazards where the facility had control over with and would provide supervision and assistive devices to each resident to prevent avoidable accidents. The policy showed the facility would provide for resident safety through: Risk Reduction: Falls and Injuries Elopement Prevention Safety Devices Wheelchair Safety, and Occupational Safety and Health Administration (OSHA) Safety According to the facility policy titled, Fall and Injury: Prevention and Management Care Plan, dated 01/30/2023, the facility would revise the residents CP and/or facility practices to prevent the likelihood of another fall. The policy showed the facility would determine causal factors that led to a resident fall and provide consistent intervention to help prevent future occurrences. <Sharps Containers> <Cedar Hall> In an observation on 07/21/2026 at 8:37 AM, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/21/2026 at 8:40 AM, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/21/2026 at 8:51 AM, the sharps container in room [ROOM NUMBER] was seen observed filled over the fill line. <Birch Hall> In an observation on 07/21/2026 at 9:40 AM, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 07/21/2026 at 10:32 AM, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/21/2026 at 12:05 PM, the sharps container on a treatment cart opposite room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/22/2026 at 7:44 AM, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/22/2026 at 7:48 AM, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/22/2026 at 11:53 AM, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/22/2026 at 11:54, the sharps container in room [ROOM NUMBER] was observed filled over the fill line. In an observation on 07/22/2026 at 2:54 PM, the sharps contained on the treatment cart labelled A/B was observed filled over the fill line. In an observation and interview on 07/22/2026 at 3:04 PM, Staff C (Assistant Director of Nursing) confirmed the sharps containers in each of the observed rooms and both treatment carts were overfilled. Staff C stated it was important to replace the sharps containers before they were full to prevent infections and to provide a safe space for staff when disposing sharps after use. <Safety Device Use> <Resident 63> According to the 04/16/2026 admission Minimum Data Set &ndash; (an assessment tool), Resident 63 had severely impaired cognition and used a wheelchair. The MDS showed Resident 63's ability to move from room to room with their wheelchair was not assessed during the lookback period due to illness or injury. The MDS showed Resident 63 had a seizure disorder. Review of Resident 63's physician orders showed a 06/24/2026 order for a self-releasing seat belt to be used when the resident was up in their tilt-in-space wheelchair (a specialized wheelchair allowing the angle of the seat and back of the chair to be adjusted backwards). Record review showed a 06/24/2026 safety device assessment for Resident 63's self-releasing belt. The assessment showed the belt was needed due to tremors and was to be used when Resident 63 was in their tilt-in-space wheelchair. There was no corresponding safety device assessment of Resident 63's tilt-in-space wheelchair. Observation on 07/27/2026 at 1:13 PM showed Resident 63 ambulating in their wheelchair. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-releasing belt was across Resident 63's lap. Resident 63 ambulated in a slow, determined way. In an interview on 07/28/2026 at 8:28 AM, Staff E (Resident Care Manager) stated a tilt-in-space wheelchair could limit a resident's independent movement and required assessment to make sure the wheelchair was appropriate and safe. Staff E reviewed Resident 63's chart and confirmed no assessment was completed. <Fall Prevention> <Resident 67> According to the 06/01/2026 Annual MDS, Resident 67 admitted to the facility on [DATE] with medical diagnoses of dementia (a progressive disorder affecting memory, cognition, and the ability to do daily tasks), restlessness and agitation, and age-related physical weakness. The MDS showed that Resident 67 required supervision with all activities of daily living. The MDS showed Resident 67 had two falls during the assessment period. Review of Resident 67's fall CP showed the resident was at risk for falls related to poor safety awareness. Resident 67's fall CP included but was not limited to the following interventions: 03/11/2023 Frequent safety check related to falls 03/15/2023 Resident 67 not to be left alone in room in wheelchair 06/15/2023 Provide toileting during safety checks 01/14/2026 anti-slip matt added to wheelchair cushion 04/17/2026 therapy referral related to falls 06/03/2026 Encourage Resident 67 to wear non-skid socks Review of Resident 67's CP showed it was not updated after 06/03/2026. Review of Resident 67's 05/28/2026 fall incident investigation summary showed they had a fall in the hallway down the hall from their room. Resident 67's fall incident summary showed they were impulsive and wandered frequently, and that staff were very aware and supervised the resident when the resident was walking. The summary showed, during this fall incident, the resident was able to ambulate out of their room and down the hall before being seen by staff. In an observation on 07/22/2026 at 1:33 PM, a staff member was heard yelling into the hallway from Resident 67's room for assistance due to a fall. In an observation on 7/22/2026 at 2:23 PM, Resident 67 was observed sitting on the floor in their room, scooting on their bottom toward the door. The surveyor alerted staff that Resident 67 was on (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the floor. In an observation on 07/27/2026 at 8:06 AM, Resident 67 got up from a chair in the hallway and walk back to their room and got into bed without staff assistance or supervision. In an interview on 7/27/2026 at 8:09 AM, Staff II (Licensed Practical Nurse) stated for the successive falls on 07/22/2026, they had Resident 67 put on non-skid socks and encouraged them to use their wheelchair instead of their walker. Staff II stated there were no other interventions put in place that they were aware of regarding Resident 67's fall. In an interview on 07/27/2026 at 8:12 AM, Staff JJ (Certified Nursing Assistant) stated they were the assigned aide for Resident 67, and they were not aware of any recent care plan changes related to fall prevention. Staff JJ stated that if there was a CP change for Resident 67, someone would tell them what the change was, but there were no updates given to staff recently. In an interview on 07/27/2026 at 12:11 PM, Staff B (Director of Nursing) stated there were no care planned interventions to prevent Resident 67 from falling following the falls they had on 7/22/2026, but there should have been. Staff B stated it was important to put in an intervention after a fall to prevent reoccurrence. <Smoking Materials> <Resident 17> According to the 05/19/2026 admission MDS, Resident 17 was admitted to the facility on [DATE] with medically complex conditions, was able to understand and be understood, and currently used tobacco. Review of the facility's 07/21/2026 Active Smokers list showed four residents, including Resident 17, who currently smoked. In an interview on 07/21/2026 at 12:06 PM, Resident 17 stated they kept their smoking materials in their closet which was not locked. Resident 17 stated that confused residents wandered into their room occasionally. In an observation and interview in Resident 17's room on 07/23/2026 at 1:49 PM, Resident 17 stated they had their smoking materials in their pocket. Resident 17 stated they did not have a lock box to store them. Observation showed Resident 17 opened their closet drawer and no lock box or smoking materials were observed. Resident 17 stated they usually kept their smoking materials on their overbed table and kept them hidden. Review of Resident 17's medical records showed they signed a copy of the facility's Smoking policy on 05/18/2026 and agreed to abide by the policy. The policy showed residents who retained their own smoking materials were required to keep them in a locked cabinet when not in use. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/24/2026 at 12:50 PM, Staff A (Administrator) stated they were new to the facility and did not know if locked storage was provided for Resident 17's smoking materials but would find out. Staff A did not provide further information. In an interview on 07/27/2026 at 1:39 PM, Staff B stated they expected smoking materials to be stored in a personal locked drawer or in the nurse's medication cart, depending on the resident's assessed ability to store them safely. Staff B stated they were not aware that Resident 17 did not have locked storage available and stated they would provide locked storage for them. <Facility Document - Elopement> Observation and record review on 07/28/2026 at 11:17 AM showed an Elopement Binder at the nurse's station on a shelf available to staff. Inside the binder was a policy titled, Elopement Prevention and Management Program, revised January 2017, showed the facility would provide adequate supervision through individual assessment of a resident's needs and potential hazards. The policy showed the facility would implement an elopement care plan with interventions to mitigate the risk of resident elopement. Observed in the binder were elopement photograph sheets for seven residents of the facility who were identified as an elopement risk. <Resident 94> Review of Resident 94's 06/29/2026 Hospital Discharge Summary showed the resident was hospitalized after a ground-level fall resulting in a left hip fracture that required surgical intervention. Resident 94 had medical diagnoses including delirium (a change in mental ability with symptoms including confusion and disorientation) and advanced dementia. The discharge summary showed Resident 94 exhibited agitation, restlessness, impulsivity, removing medical devices, and was an elopement risk while in the hospital. Review of the 06/29/2026 Nursing admission Assessment showed Resident 94 was admitted for dementia on 06/29/2026. Resident 94 was assessed to require extensive assistance from staff for care and mobility needs. The assessment showed Resident 94 was not at risk for falls and was not at risk for elopement. Review of the 07/01/2026 facility investigation showed on 07/01/2026 at 7:30 AM, Resident 94 was outside the facility on the ground after an unsupervised fall. Resident 94 had exited the facility through the therapy door, without staff knowledge or supervision, stood from their wheelchair to walk outside and fell to the ground. The progress notes of the investigation showed Resident 94 was restless, agitated, physically aggressive with staff, wandering inside, and trying to leave the facility since admission on [DATE]. The investigation notes showed staff had initiated one-to-one supervision for Resident 94 on the night shift on 06/30/2026. The investigation showed Resident 94 was last seen by staff on 07/01/2026 at 7:20 AM next to the nurse's medication cart, then was outside 10 minutes later lying on the ground. In an interview on 07/28/2026 at 11:20 AM, Staff B reviewed Resident 94's electronic medical records and stated the resident discharged from the facility on 07/01/2026. Staff B reviewed the 06/29/2026 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospital discharge summary and stated Resident 94 had advanced dementia, had a prior fall at home which required hip surgery, and demonstrated restless, agitated, impulsive behaviors in the hospital, and was an elopement risk. Staff B stated the Nursing admission Assessment showed the nurse assessed Resident 94 with no risk of fall or elopement which was not accurate, and Resident 94 should have been identified as both a fall risk and elopement risk with an individualized care plan in place. Staff B stated the exit door in the therapy gym was an exit only door and had an active wander guard system (detection system to prevent resident elopement) in place. Staff B stated Resident 94 should have been identified as an elopement risk and should have a wander guard device to prevent them from leaving the facility unsupervised, but the resident did not. <Resident 28> Review of the 06/04/2026 admission MDS showed Resident 28 was admitted to the facility on [DATE] for encephalopathy (brain dysfunction), stimulant dependence, chronic respiratory disease, failure to thrive, paranoia, and anxiety. The MDS showed Resident 28 had wandering behaviors which placed them at a significant risk of getting to a dangerous place such as outside the facility. The MDS showed Resident 28 could use a manual wheelchair for mobility of 150 feet with staff supervision and assistance. Review of the 06/05/2026 CP showed Resident 28 was at risk for elopement, demonstrated exit seeking behavior, wanted to be outside and had a history of smoking. The CP showed Resident 28 used a wander guard device on their ankle, but the resident cut the device off on 06/05/2026, and it was then secured to Resident 28's wheelchair. Review of a 06/26/2026 elopement assessment showed Resident 28 was confused, expressed desire to leave the facility, was independent with mobility, and was exit seeking without supervision. Review of the 07/17/2026 incident investigation showed a witness statement that Resident 28 was seen on 07/16/2026 at 2:00 PM, on the sidewalk, two buildings away from the facility while smoking a cigarette. The facility investigation summary showed Resident 28 had a wander guard device on their wheelchair, but the device did not alert staff to Resident 28's exit outside, therefore Resident 28 was smoking outside unsupervised two buildings away. Observation and interview on 07/28/2026 at 11:10 AM showed Resident 28 was in the hallway self-propelling their wheelchair. Resident 28 stated they were going down there while pointing down the hall. Resident 28 had no recollection of leaving the facility by themselves or going outside to smoke cigarettes. Resident 28 stated they used to smoke and would like to smoke again. An observation on 07/28/2026 at 11:17 AM showed Resident 28 had an Elopement Photograph Sheet inside the elopement binder at the nurse's station. The sheet had information about Resident 28's wander guard device location and expiration date, emergency contact, physical description, and photograph. In an interview on 07/28/2026 at 11:20 AM, Staff B stated, after the facility investigation was completed, it was reasonably concluded that Resident 28 was assisted outside the main door by an (continued on next page)		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unknown person during a congested time of the day. Staff B stated the investigation could not conclude who assisted Resident 28 outside, why the wander guard system did not alarm, or how Resident 28 obtained a cigarette. Staff B stated Resident 28 was not safe to be outside the facility unsupervised and was not assessed to smoke safely without supervision. Refer to F744 – Treatment/Services for Dementia. REFERENCE: WAC 388-97-1060(3)(g).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate treatment and services were provided to attain or maintain the highest practicable physical, mental and psychological well-being for 1 of 4 residents (Resident 94) reviewed for dementia care. The failure to assess and implement a person-centered dementia care plan based on the resident's behavioral needs placed residents at risk for injury, accidents, behavioral distress, and unmet care needs. Findings included. <Facility Policy>Review of the 06/09/2023 facility policy titled Dementia Care showed the facility would take an individualized approach to meeting the health, psychosocial, and behavioral needs of all residents, especially those with dementia. The policy showed residents with dementia may exhibit behaviors to communicate underlying and unresolved medical, physical, emotional, psychiatric, or environmental issues. The facility would assess the cause of a resident's behavior and implement an individualized care plan. The policy showed the facility used a person-centered approach to reduce potentially distressing or harmful behaviors and promote quality of life for residents with dementia. <Resident 94> Review of the 06/29/2026 hospital discharge summary showed Resident 94 discharged to the facility on [DATE] after a fall at home and hospitalization for surgical repair of their hip. The discharge summary showed Resident 94's hospital stay was complicated related to their advanced dementia, persistent confusion, episodes of agitation, restlessness, impulsivity, attempts to remove medical devices, and elopement risk. The hospital summary showed Resident 94 required three different medications to manage their behavior while hospitalized . Review of the 06/29/2026 nursing admission assessment showed Resident 94's admitting diagnosis was dementia. The assessment showed Resident 94 was alert and only oriented to their name, and not oriented to the date or time, where they were, or the situation of what was going on around them. The assessment showed Resident 94 required extensive assistance from staff for all bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident 94 was assessed to require a wheelchair for mobility. The assessment showed Resident 94 was not prescribed any medications for mood or behavior. The assessment showed Resident 94 had difficulty with sleep. Resident 94's assessment showed they were not at risk for falls or elopement (leaving a safe area). A review of the 06/30/2026 admission care plan for Resident 94 showed no resident specific interventions to direct staff how to respond to Resident 94's behaviors related to the diagnosis of advanced dementia. Review of the progress notes from 06/29/2026 to 07/01/2026 showed Resident 94 resided at the facility for under 48 hours. The progress notes showed on 06/30/2026 during the early morning, Resident 94 was confused, refusing care, taking off their clothes and hitting staff, was wandering in their wheelchair and was not re-directable, the on-call provider was called and staff waited for a call back. An order for medication for anxiety was received and the staff obtained Resident 94's consent to administer. On 06/30/2026 at 8:44 AM, the staff gave Resident 94 a copy of their baseline care (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505195	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/28/2026
NAME OF PROVIDER OR SUPPLIER North Auburn Care		STREET ADDRESS, CITY, STATE, ZIP CODE 2830 I Street Northeast Auburn, WA 98002	
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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan. On 06/30/2026 at 6:56 PM, Resident 94 had aggressive behaviors toward therapy staff and punched staff in the face. On 06/30/2026 at 8:59 PM, Resident 94 was alert, confused, was wandering and attempting to get up from the wheelchair multiple times; staff tried to redirect, reorient and assist back to the wheelchair for safety. The progress note showed Resident 94 had a history of Alzheimer's dementia and was not taking medication for the condition, the nurse notified the provider of behaviors and confusion and monitored Resident 94. On 06/30/2026 at 9:44 PM, Resident 94 continued to wander in the hallway in the wheelchair going into other resident rooms, did not follow staff re-direction and staff noted Resident 94 needed one person to monitor Resident 94's behaviors. On 07/01/2026 at 12:43 AM, Staff documented Resident 94 needed, and the nurse and nurse aide provided one-to-one care. On 07/01/2026 at 5:28 AM, Resident 94's roommate complained about Resident 94's behaviors and a room change was initiated for Resident 94. Review of the 07/01/2026 incident investigation showed on 07/01/2026 at 7:30 AM Resident 94 was outside the facility on the ground after an unsupervised fall. Resident 94 had exited the facility through the therapy door, without staff knowledge or supervision, stood from their wheelchair to walk outside and fell to the ground. The progress notes of the investigation showed Resident 94 was restless, agitated, physically aggressive with staff, wandering inside, and trying to leave the facility since admission on [DATE]. The investigation notes showed staff had initiated one-to-one supervision for Resident 94 on the night shift on 06/30/2026. The investigation showed Resident 94 was last seen by staff on 07/01/2026 at 7:20 AM next to the nurse's medication cart, then was found outside 10 minutes later lying on the ground. Review of the 07/01/2026 2:15 PM progress notes showed Resident 94's representative arrived at the facility and requested to take Resident 94 home and Resident 94 was discharged on 07/01/2026 against medical advice. In an interview on 07/28/2026 at 11:20 AM, Staff B (Director of Nursing) reviewed Resident 94's hospital and facility medical records and stated the admission nursing assessment was not accurate according to the behaviors recorded in the hospital records. Staff B stated the admission nurse should have reviewed the hospital records, identified the dementia behaviors, implemented interventions to prevent falls and elopement, and created a resident specific dementia care plan for Resident 94. Staff B stated Resident 94 was not oriented to a level of being able to make decisions regarding their own safety and care. Refer to F689 Free of Accident Hazards/Supervision/Devices REFERENCE: WAC 388-97-1040(1)(a-c)(2)(b)(c)(iv).		