STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505206	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Timberline	400 East 33rd Street Vancouver, WA 98663

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive care plan for 1 of 1 sampled resident (Resident 34) reviewed for insulin (an injectable medication used to treat diabetes mellitus, a group of disorders characterized by an inability of the body to regulate its blood sugar levels). This failure placed residents at risk for injury, unmet care needs, and a diminished quality of life. Findings included. Resident 34 was admitted to the facility on [DATE] with multiple diagnoses to include Diabetes Mellitus. The Medicare - 5 Day Minimum Data Set, an assessment tool, dated 12/28/2025, showed resident 34 was cognitively intact, had a diagnosis of Diabetes Mellitus, and was on insulin injections. Record review of Resident 34's physician orders, dated 11/20/2025, documented, LN [licensed nurse] to perform Diabetic Nail Care. Record review of Resident 34's physician orders, dated 12/30/2025 showed an order for Insulin Glargine (an injectable medication for diabetes) daily at bedtime. Record review of Resident 34's Comprehensive Care Plan, date initiated 11/20/2025, did not show a Focus area or Goal for Diabetes and/or insulin use. Record review of Resident 34's Kardex (a nursing documentation system used to provide a quick summary of patient care needs), dated 03/03/2026, did not show Resident 34 was diabetic and/or LNs were to perform Diabetic Nail Care. In an interview on 03/03/2026 at 9:08 AM, Resident 34 said he had diabetes and was on insulin. In an interview on 03/03/2026 at 12:36 PM, Staff F, Certified Nursing Assistant, said they got information on care needs for residents, such as nail care or if they were diabetic, from the Kardex. In an interview on 03/03/2026 at 12:53 PM, Staff B, Director of Nursing/Registered Nurse, said information in the Kardex was triggered from the care plan. When asked about Resident 34's care plan, Staff B said she did not see a care plan for diabetes and there should have been. Reference WAC 388-97-1020(1)(2)(a)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered by professional standards of practice for 1 of 1 sampled resident (Resident 37) reviewed for medication administration. This failure placed residents at risk for medication errors, negative outcomes, and a diminished quality of life.Findings included.Review of the facility's policy titled, Self Administration of Medications, dated May 2016, showed, Purpose: To determine the ability of alert resident to participate in self-administration of medications. To Maintain the safety and accuracy of medication administration .Procedure:7. Storage and location of drug administration (e.g., resident's room, nurses' station, or activities room) will comply with state and federal requirements for medication storage. 9. Appropriate notation of these determinations will be placed in the residents [sic] care plan.Resident 37 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, an assessment tool, dated 02/07/2026, indicated Resident 37 was alert and oriented. During an observation and interview on 03/02/2026 at 11:01 AM, while in Resident 37's room, a small clear cup with several pills visible in it was sitting on top of the bedside table. Resident 37 said the nurse left them there and had gone to get some water. Resident 37 proceeded to swallow the medication without the nurse present.Record review of Resident 37's electronic health record did not show Resident 37 was approved to keep medication in the room and/or take medication without nursing supervision.During an interview on 03/05/2026 at 9:14 AM, Staff G, Licensed Practical Nurse, said nursing was supposed to stay and observe a resident take their medication. Staff G said Resident 37 mentioned to him the state surveyor had seen the medication in the room. During an interview on 03/05/2026 at 9:59 AM, Staff B, Director of Nursing/Registered Nurse, said staff were not to leave medication in a resident's room and was supposed to monitor the resident taking the medication. Staff B said a resident needed to be assessed, have an order, and care planned before a resident was able to self-administer medications. Reference WAC 388-97-1300 (1)(b)(i)(ii), (3)(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP, an infection control intervention, to include the use of gloves and a gown, during high contact care activities designed to reduce the transmission of organisms) when providing wound care for 1 of 2 sampled residents (Resident 1) reviewed for Pressure Ulcer (an injury or open wound to the skin and underlying soft tissue). This failure placed residents and staff at risk for the spread of infection transmission, and a decreased quality of life.Findings included. Resident 1 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 12/11/2025, documented Resident 1 was moderately cognitively impaired and was at risk for pressure ulcers. Record review of Resident 1's physician orders, dated 02/11/2026, showed an order, Stage 3 [a skin injury extending through all layers of the skin into the fat tissue] PU/I [pressure ulcer/injury], to mid back over bony prominence: Wound Cleansing: wound cleanser (NS [normal saline] if not available) Periwound [the skin and tissue immediately surrounding a wound] Treatment: skin prep Primary Treatment: collagen powder or sheet and calcium alginate Secondary Dressing: bordered foam Change: Daily PRN [as needed] every day shift. Record review of Resident 1's skin care plan, revised 02/25/2026, documented, Has actual impairment to skin integrity r/t [related to] -Stage 3 PU/I to mid back over bony prominence. Record review of Resident 1's Skin/Wound Note, dated 03/03/2026, documented, .Moderate amount of serosanguineous [a watery pale pink or light red fluid excreted from healing wounds] drainage.Daily Tx [treatment] in place. Review of Resident 1's Electronic Health Record did not show a physician's order or care plan for EBP. In an interview and observation on 03/04/2026 at 9:24 AM, Staff E, Wound Nurse/Licensed Practical Nurse (LPN), said Resident 1 had a Stage 3 PU to his mid back that had a scant amount of drainage. No EBP sign was observed to be posted outside Resident 1's door entrance. Staff E and Staff D, Resident Care Manager/LPN, were observed to enter Resident 1's room and performed wound care to the PU on Resident 1's back. Staff E and Staff D did not don (put on) a gown to perform wound care. When asked how it was determined if a resident was placed on EBP, Staff E looked at the entrance to Resident 1's room and said he did not have a sign up to indicate he was on EBP. Staff E said an EBP sign was posted at the door for residents when she needed to put a gown on to do wound care. Staff E then said to Staff D that Resident 1 did not have a sign for EBP. Staff D stated, Yes, I will need to get one, I need to talk to [Staff C, Infection Preventionist/LPN]. In an interview on 03/04/2026 at 1:43 PM, Staff C said if a resident had excessive wound care or had wound dressings saturated with drainage, they were placed on EBP with a sign outside their door. Staff C said she would get a physician's order for residents on EBP and add it to their care plan. Staff C said she thought if a wound was contained with drainage not soaking through a bandage, they did not need to be on EBP. Staff C said she just learned that pressure related wounds needed to be on EBP and said Resident 1 should have been on EBP. In an interview on 03/04/2026 at 3:11 PM, Staff B, Director of Nursing/Registered Nurse, said it was her expectation residents with open pressure wounds were on EBP. Reference WAC 388-97-1320 (1)(a)(2)(b)