

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505226	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Sunnyside Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 721 Otis Avenue Sunnyside, WA 98944	
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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review and validate the Preadmission Screening and Resident Reviews ([PASRR], an assessment to ensure individuals with serious mental illness [SMI] or intellectual/developmental disabilities [ID/DD] are not inappropriately placed in nursing homes for long term care) accuracy prior to admission and have the required Level 2 referral sent if the residents had a positive Level 1 PASRR as required for 3 of 5 residents (Resident 62, 33 and 8) reviewed for PASRR. This failure placed the residents at risk for inappropriate long term care placement and not receiving necessary mental health care and services. Findings included . Review of an undated policy titled PASRR (Pre-admission Screening & Resident Review, showed every resident would be screened for mental illness or ID prior to admission. The policy showed if a Level 2 referral was required, that had to be completed prior to admission by the designated authority. Resident 62 Review of the residents' medical records showed they were admitted on [DATE] with diagnoses to include substance use disorder and anxiety. The 09/23/2025 comprehensive assessment showed Resident 62 was cognitively intact, and the resident admitted with psychotropic medications. Review of Resident 62's Level 1 PASRR, dated 06/23/2025, showed no SMI indicators or SMI diagnoses and a Level 2 referral had not been completed. Review of Resident 62's Level 1 PASRR, dated 06/27/2025, showed after the resident admitted , the SSD completed the PASRR again and identified the anxiety diagnosis under SMI indicators but not the SUD. The PASRR showed a Level 2 referral was required. Review of an electronic mail (email) dated 07/25/2025 (28 days after the updated PASRR Level 2 referral was required) the referral was sent to the PASRR department for review. Resident 33 Review of the residents' medical records showed they were admitted on [DATE] with diagnoses to include dementia, anxiety, and insomnia and insomnia (the inability of a normal sleep pattern). The 11/11/2025 comprehensive assessment showed Resident 33's cognition was moderately impaired, and the resident admitted with psychotropic medications. Review of Resident 33's Level 1 PASRR, dated 11/05/2025, showed the resident did not have any SMI indicators or SMI diagnoses and a Level 2 referral had not been completed prior to admission. Review of Resident 33's Level 1 PASRR, dated 11/14/2025 (nine days after admission), showed (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses to include anxiety, dementia, and a substance use disorder (SUD, a complex condition in which there is uncontrolled use of a substance despite harmful consequences), which the resident did not have a diagnosis of, and the resident received an antidepressant. The PASRR showed a Level 2 referral was required. Review of an email dated 11/26/2025 (12 days after the determination of a Level 2 referral was required) the referral was sent to the PASRR department for review. Resident 8 Review of the medical record showed the resident was admitted on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions) with agitation, anxiety (a feeling of worry, nervousness, or unease about something with an uncertain outcome), and heart complications. The 04/28/2025 comprehensive assessment showed the resident had severely impaired cognition and admitted on psychotropic medications (medications capable of affecting the mind, emotions, and behavior). Review of Resident 8's Level 1 PASRR, dated 04/22/2025, showed the resident did not have any SMI indicators and a Level 2 evaluation was required, and the referral had not been completed. The PASRR did not include documentation of the resident's diagnosis of anxiety. Review of Resident 8's Level 1 PASRR, dated 05/01/2025, showed Staff D, Social Services Director (SSD), completed Resident 8's PASRR again, stating the resident was on psychotropic medications for their dementia/ anxiety and that a Level 2 referral would be completed (nine days after the resident was admitted). Review of an email dated 05/13/2025 (12 days after the updated PASRR Level 2 referral was required) the referral was sent to the PASRR department for review. During an interview on 12/11/2025 at 4:22 PM, Staff D stated they did not review PASRRs until the resident arrived at the facility. Staff D stated they did not know it was a requirement to review the PASRRs prior to the residents' admission. Staff D stated they had trained a few months ago on PASRRs and used the updated form. Staff D stated the Admissions Director (AD) was responsible for reviewing residents prior to admission and thought they were reviewing the PASRRs during that time. During an interview on 12/11/2025 at 5:04 PM, Staff I, AD, stated they reviewed PASRRs prior to admission and as far as they were aware, they were correct. Staff I stated the hospital must have incorrectly completed them and I missed that. During an interview on 12/12/2025 at 2:36 PM, Staff A, Administrator, stated the process was to review the PASRRs for accuracy and completion prior to the residents' admission. Staff A stated the facility would review them and update them upon admission if they were incorrect or if they needed to be changed. Reference: WAC 388-97-1975(1)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure cleanliness, discard expired foods, and to follow the thawing and cooling process of foods in 1 of 1 kitchen reviewed for safe and sanitary kitchen. This failed practice placed all residents at risk for Food borne illness (caused by consuming foods that are contaminated with harmful pathogens [bacteria that reproduce rapidly once entered in the body and can damage tissues and cause illness]). Findings included . Review of the July 2024 Food and Drug Administration code showed bacteria grew quickly when food was not properly cooled. The code showed hot food should be cooled in a two-step process in order to reach 70 degrees Fahrenheit (a unit of measure) over a two-hour period to be free of bacterial growth, and then further cooled to 41 degrees Fahrenheit or less before storing. During an initial tour of the kitchen on 12/08/2025 at 9:10 AM, showed: the four refrigerator and freezers against the wall inside the door with dried, stuck on white fingerprint smears on the door handles and the doors. Inside the first refrigerator was a deep, full sheet metal pan that had thawed pork and juices with a pull date (the date the food was taken out of the freezer to start the thawing process) of 11/29/2025 (nine days past the pull date) and no use by date. On top of the pork (mentioned above), was a deep, half sheet metal pan with thawed chicken and was over filled with blood and juices that were dripping down into the pan of thawed pork. The chicken had a pull date of 12/02/2025 and a for use date of 12/06/2025 (six days past the pull date). There were two full bags of chicken pieces with no pull date or no use by dates. There were three 10-pound (a unit of measure) rolls of ground beef, with no pull date or use by date. There was a bag of diced pork sausage with an open date of 08/18/2025, and no use by date (112 days after open date). On the shelf above the thawed meat was a resident's breakfast tray that was still warm to the touch On the shelf to the right of the breakfast tray was a clear container of chilaquiles (a Mexican breakfast dish made with tortillas) that was unlabeled and undated and still hot to the touch. A clear dish with scrambled eggs, dated 12/08/2025, still hot to the touch A clear dish with ground up sausage, dated 12/08/2025, still hot to the touch One gallon of Thousand Island salad dressing, one quarter full, with two opened dates of 07/23/2025 and 08/08/2025 and no expiration date was on the container or use by date. One opened gallon of mustard, half full, with no open date, expiration date, or used by date. Inside the 2nd freezer showed: A plastic bag of meat, unlabeled, dated 12/07/2025, and no expiration or use by date. Opened cinnamon rolls dated 03/13/2025 with no expiration or use by date. Five rolls of Chorizo (a spicy pork sausage) meat with no open date or use by date. Eight round meat patties, unlabeled, and no open or use by date. A 27-ounce (a unit of measure) coconut cream pie with no dates at all. An observation of the dry storage area in the kitchen on the same day, 12/08/2025 at 9:35 AM showed a black rack to the right of the doorway, with clean dishes on it. The rack had personal staff items placed on the top shelf, lotion bottles, two spiral binders, open bags of candy, a bottle of salsa, a pink water cup, a bottle of lens cleaner, and a bottle of tums (medication used for stomach acid). Further observation showed: A bag of Turkey gravy mix, opened, half full, with, no opened or use by date or expiration date. A three-pound (unit of measure) bag of almonds with an open date of 07/01/2025 and no expiration or use by date. A box of corn flakes cereal, the bag was not sealed closed and had no dates. A 28-ounce (a unit of measure) bag of vanilla pudding pie filling, opened, with no dates. During an interview on 12/08/2025 at 10:01 AM, Staff V, Cook, stated after the Surveyor's observations, they had cleaned out the refrigerator with the thawed-out meats. Staff V stated they discarded the pork and the chicken in the half sheet metal pan. Staff V stated they did not discard the bags of chicken because they had worked on 12/05/2025 when the two bags of chicken pieces were pulled from the freezer. Staff V stated they should have been dated. During an interview on 12/08/2025 at 10:17 AM, Staff L, Food Service Manager, stated the process for thawing meats was to pull the meat out of the freezer three days before using it and put it in the refrigerator to thaw out. Staff L stated (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff should have documented on the food or the container, the date the food was pulled out of the freezer and the use by date. Staff L stated they would ensure the thawed meats were discarded because they were past the date it would be safe to use them and/or there was no pull date for when they were pulled. Staff L stated the dried foods should have an open date and they should be sealed closed in between uses. Staff L stated cooked food that was placed in the refrigerator should be labeled and have a date on them. Staff L stated the cooked food goes from the food warmers straight to the refrigerator and they did not have a process for cooling food down prior to placing in the refrigerator. Staff L stated they did not keep salad dressings long because they got used up quickly but the Thousand Island dressing did not get used as often as the other dressings and should have been discarded. Staff L stated they had been present when the three rolls of ground beef had been pulled on Friday, 12/05/2025, and they had watched the staff member pull them. Staff L stated they should have been dated. On an additional visit to the kitchen on 12/11/2025 at 11:21 AM, showed in the middle refrigerator, there was two 2-pound bags of thawed out turkey breast lunch meat that had no pull date and a use for dinner date of 12/09/2025. In an additional refrigerator by the laundry room area, there were two blocks of Swiss cheese with an open date of 11/04/2025 in a plastic bag with no expiration date or use by date and a 24-ounce package of cream cheese with an open date of 11/16/2025 and no use by or expiration date. During an interview on 12/11/2025 at 12:42 PM, Staff W, Cook, stated they would not know when meats were pulled from the freezer or if they were still good to eat without a pull date documented. Staff W prepared a resident's lunch tray and placed it directly into the refrigerator. Staff W stated the resident stayed awake all night and wanted their food at different times than the time they were served so they would either put their tray in the warmer or the refrigerator and reheat it when they got up. Staff W stated they did not have a cool down process for placing hot foods into the refrigerator. During an interview on 12/12/2025 at 2:54 PM, Staff A, Administrator, stated they would expect the kitchen staff to have followed the process for thawing out foods and dating foods. Staff A stated expired foods, and undated foods should have been checked and discarded daily. Staff A was not aware the kitchen staff did not have a process for cooling foods prior to refrigerating them, there's a process, they just aren't following it. Reference: WAC 388-97-1100 (3)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure staff maintained components of an infection prevention control program to prevent the development and transmission of infections for, 1) hand hygiene and glove change for 5 of 9 staff (Staff Q, P, K, F, and R) reviewed during resident cares and meal service and, 2) use of Personal Protective Equipment (PPE) in an enhanced barrier precaution (EBP, indicated with high contact resident care activities with an infection, a long term wound, central line device or colonization [the presence of a bacteria that has not yet started its infection process] of an multi drug resistant organism) room for 1 of 3 residents (Resident 44) reviewed for infection control. This failure placed residents at an increased risk for exposure to cross contamination (harmful spread of diseases) and transmission of infectious diseases. Findings included . Review of Centers for Disease Control and Prevention (CDC) recommendations titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 02/27/2024 showed that hand hygiene was to be implemented to reduce the harmful spread of infections in the healthcare setting. Common situations that required staff to perform hand hygiene were before/after contact with a resident, before handling clean or soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after touching a resident or their surroundings, and immediately after glove removal. Review of CDC recommendations titled, Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs, bacteria that has become resistant to certain antibiotic medications), dated 04/02/2024 showed EBP was the implementation of putting on PPE, a gown and gloves, for high-contact resident care activities, which included dressing, bathing/showering, transferring, providing hygiene, and when changing linens/briefs or assisting with toileting. Additionally, EBP's were to be used with residents that had indwelling devices like urinary catheters (device that can be placed with the bladder to drain urine) or any skin opening that required a dressing. Hand Hygiene Observations on 12/08/2025 at 12:27 PM showed meal trays being delivered to residents on the 300 hallways by Staff Q, Nursing Assistant (NA), and Staff P, NA. Staff Q was observed entering a resident's room to deliver them their lunch meal tray and did not perform hand hygiene prior to entering or when they exited. Staff Q then grabbed another meal tray and entered another resident room and proceeded to set up the meal tray for the resident to eat. Staff Q observed touching the resident beside table and used the resident's utensils to cut up their food without gloves or performing hand hygiene. After, Staff Q proceeded to pull the resident's curtain back to the closed position and exited the room without performing hand hygiene to grab another resident's meal tray. Staff P observed entering a resident room to deliver a meal tray, without performing hand hygiene, touched the bedside table and set up meal for resident then exited the room and grabbed another meal tray to head into another resident's room without performing hand hygiene. During an interview on 12/08/2025 at 12:41 PM, Staff Q stated there were no hand sanitizing stations that were convenient or in all the resident rooms and they would usually have put hand sanitizer in their pocket so they could perform hand hygiene before and after delivering resident meal trays. Staff Q stated they did not perform hand hygiene in-between delivering resident meal trays. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/11/2025 at 8:57 AM, Staff B, Director of Nursing Services, stated that staff should be performing hand hygiene any time before entering and when exiting a resident room when passing meal trays. Staff B stated the correct process was not followed by staff delivering meal trays. Resident 92 Review of the resident's medical record showed they were admitted to the facility with diagnoses of a below the knee amputation of their right leg and diabetes. The 12/07/2025 comprehensive assessment showed Resident 92's cognition was moderately impaired and had an unhealed unstageable pressure injury (PI, full-thickness skin/tissue loss where the base of the ulcer is obscured by non-viable tissue) to their left heel. An observation and concurrent interview on 12/09/2025 at 3:38 PM, showed Staff K, Licensed Practical Nurse (LPN), providing wound care to Resident 92. Staff K placed a brown bath towel (used as a barrier) underneath a surgical incision to the right leg amputation site. The incision was reddened, had staples in place, and was not previously covered. Staff K applied gloves, and clean wound supplies were placed on Resident 92's bed without a barrier. Staff K cleansed the incision site and then placed the soiled gauze onto the bed with the clean gauze. Staff K, without changing their gloves, then place a non-stick dressing, followed by rolled gauze. Staff K, without changing their gloves, reached into their shirt pocket and pulled out a pen to put their date and initials on the dressing, then placed the pen back into their pocket. Staff K then removed gloves, did not perform hand hygiene, placed a new pair of gloves and moved to the PI to the left heel. Staff K placed the same brown bath towel used for the incision site, underneath the left heel, the heel had no dressing in place to remove, and Staff K cleansed the heel with wound cleanser. Staff K, without changing their gloves, applied a protective coating to the wound bed, then a foam dressing. Staff K exited the room to get Resident 92 pain medications, removed their gloves, and did not perform hand hygiene. Resident 60 Review of the resident's medical records showed they were admitted with diagnoses of kyphosis (excessive curving of the spine causing a hunch back) and Spondylosis (degeneration of the spinal column). The 11/11/2025 comprehensive assessment showed Resident 60's cognition was intact and required substantial to maximum assistance with toileting. During an observation on 12/10/2025 at 11:49 AM, Staff R, NA, assisted Resident 60 to the bedside commode. Staff R donned gloves to clean the resident after they had a bowel movement, removed their soiled gloves, donned a new pair and did not perform hand hygiene. Staff R then called Staff F, Registered Nurse, into the room for assistance, Staff F donned gloves, assessed open areas to the area to the top of their right buttock, and then Staff R applied pink barrier cream to that area. Staff F then removed a brown protective wound dressing from Resident 60's lower back, assessed an open area, then reapplied a new patch without cleansing the area or changing gloves and performing hand hygiene, and then applied a new patch to the area above the right buttock with the same gloves. Staff R and Staff F then assisted the resident from the commode without either removing their soiled gloves or performing hand hygiene. During an interview on 12/12/2025 at 1:44 PM, Staff C, Infection Preventionist, stated staff had yearly hand hygiene training and when they completed audit rounds and competencies. Staff C stated Staff F, Staff R, and Staff K should have removed their gloves after completing dirty tasks and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	performed hand hygiene and then applied new gloves. During an interview on 12/12/2025 at 2:12 PM, Staff B, Director of Nursing Services, stated the process for hand hygiene was to perform hand hygiene, don gloves, perform dirty tasks, remove gloves, perform hand hygiene, and then don new gloves before moving on to clean tasks. Staff A stated Staff F, Staff R, and Staff K did not follow the correct process. EBP Precautions Resident 44 Review of the resident's medical records showed they were admitted on [DATE] with diagnoses to include a blood clot in the lungs and obstructive uropathy (a blockage of the urine) with the use of an indwelling catheter (a tube inserted into the bladder to drain urine). The 11/30/2025 comprehensive assessment showed Resident 44's cognition was moderately impaired. During an observation and concurrent interview on 12/09/2025 at 3:57 PM Staff U, NA, entered Resident 44's room to provide personal care and clean them up. Staff U stated Resident 44 had an indwelling catheter and used a small leg bag (a medical device used to drain urine) attached to their right leg. Staff U had no PPE on while providing personal care and catheter care. Resident 44 had no sign for EBP on the outside of their door to notify staff they were required PPE, and no PPE bin was outside of their door. During an observation on 12/10/2025 at 12:11 PM, showed Staff R entered Resident 44's room and provided catheter care and transferred them to their wheelchair. Staff R had no PPE on and there were no EBP precautions posted on the outside of Resident 44's room. During an interview on 12/12/2025 at 1:44 PM, Staff C stated any resident with an indwelling catheter, whether they used a regular drainage bag or a leg drainage bag, should be on EBP. Staff C stated NAs were aware they were to wear PPE when providing care to anyone with a catheter. Staff C stated they thought they had placed EBP signage on Resident 44's door but I must have missed that. Reference: WAC 388-97-1320 (1)(a)(c)(2)(b)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure grievances (resident and/or resident representative concerns that can be voiced or written), conveyed by the resident, underwent prompt resolution through to their conclusion nor were residents appropriately updated on their grievance progress/conclusion for 2 of 5 residents (Residents 8 and 62) reviewed for the grievance process. This failure placed residents at risk for unresolved concerns and unmet care needs. Findings included. Review of the facility policy titled, Grievances, dated 08/01/2024, showed the facility .actively seeks resolution to concerns and attempt to keep the individual who filed grievance updated on progress toward resolution. The policy showed that residents could convey grievances verbally or in writing and the grievance officer would be responsible for overseeing the receiving, investigating, and tracking the grievances through to their conclusion. The policy showed that grievances would be documented on the grievance logbook, have a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the finding or conclusions and that follow-up with the resident would be completed to communicate a resolution. Resident 8 Review of the medical record showed the resident was admitted on [DATE] with diagnoses including dementia (a progressive disease that destroys memory and other important mental functions), anxiety, and heart complications. The 10/28/2025 comprehensive assessment showed the resident had severely impaired cognition and a resident representative (RR) was involved in their care. During an interview on 12/09/2025 at 10:31 AM, Resident 8's RR stated they had reported a grievance about the resident's sweaters and a donut style pillow had gone missing from their personal belongings. The RR stated the facility staff were unable to find the four sweaters or pillow and the RR had not been updated on the progress toward resolution of their grievance from the facility staff since they reported it months ago, and not sure if they were going to get reimbursed for the missing items. Review of the grievance log for July 2025 through October 2025 showed that a grievance was filed on 07/10/2025 for four missing sweaters and the resolution was .If not found facility will reimburse . On 10/14/2025 a grievance was filed for a white pillow with a hole in the middle and the resolution was .pillow has not been found, facility will reimburse . Review of Resident 8's grievance investigations showed that on 07/10/2025 the RR had conveyed that four of Resident 8's sweaters had gone missing and Staff D, Social Service Director, documented on 07/15/2025 the resolution of the grievance was for the facility to reimburse the RR if the sweaters were not found. The grievance investigation on 10/15/2025 showed the RR reported that a donut pillow had gone missing from the resident's personal belongings. Staff D documented a resolution on 10/20/2025 as .Pillow has not been found, facility will reimburse. During an interview on 12/12/2025 at 11:12 AM, Staff D, stated they were the grievance officer and was responsible for overseeing the receiving, investigating, and tracking the grievances through to their conclusion and conveying the resolution to the individual that had reported the grievance. Staff D stated that the grievance process for a missing resident item would take around five days and then if the item was not found the resident or their RR would be reimbursed. Staff D stated they had been (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	waiting on Resident 8's RR to bring in a receipt for the cost of the four sweaters and donut pillow. Staff D stated that a conclusion/resolution had not been completed since the RR had not been reimbursed yet. Staff D stated the RR should have been reimbursed since it had now been 150 days since Resident 8's four sweaters had gone missing and 58 days since the donut pillow had was missing. During an interview on 12/12/2025 at 12:49 PM, Staff A, Administrator, stated that Resident 8's RR should have been reimbursed for the items, and the grievance process was not being completed correctly. Staff A stated the resolution, and conclusion would have been the facility completing the reimbursement with the RR. Resident 62^ Review of the resident's medical records showed they were admitted to the facility with diagnoses to include a stroke (when part of the brain does not receive adequate blood flow) affecting their right side, respiratory and heart failure, and nicotine dependence. The 09/23/2025 comprehensive assessment showed Resident 62's cognition was intact and independent for their activities of daily living (ADLs, basic self-care tasks to maintain their health and well-being).^ ^^ During an interview on 12/08/2025 at 3:32 PM, Resident 62 stated they were frustrated because they had ordered a package that arrived at the facility, but the resident never received the package. Resident 62 stated they reported it to the facility in writing and to the activities department verbally and no one has ever done anything about it. Resident 62 stated they had all the tracking information for the package in their personal cell phone that showed the package was delivered to the facility but still had not heard anything. Resident 62 stated it happened weeks ago but had recently (within the last few weeks) reported it to the activities department since they were the department that handled passing out the mail and still had not heard anything.^ ^ Review of the grievance log showed on 10/06/2025 an unknown [resident] grievance was written up by Staff D, Social Services Director. The grievance showed a resident had documented on a piece of paper that was dated 08/05/2025, they were missing a package that had been delivered to the facility three days prior. The resident also wrote they were missing a vape (an electronic device used for inhaling vapor juice such as nicotine) device that they believed the staff took and lost. The grievance showed the resident was pissed off and wanted the issue to be fixed promptly. Staff D wrote on the grievance that management was aware, and the grievance was discussed in the morning meeting.^ ^ During an interview on 12/12/2025 at 9:05 AM, Staff J, Activities Director, stated the mail and packages would go to the Business Office Manager (BOM), sorted, and then brought to activities for delivery to the residents. Staff J stated Resident 62 had reported a missing package to the Activities Assistant who then reported it to Staff D and Staff D would then write up the grievance. Staff J stated they could also write up a grievance, but for this particular resident, it was verbally reported to Staff D.^ (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	^ During an interview on 12/12/2025 at 12:07 PM, Staff D stated they were not aware of any missing packages for Resident 62 nor did they recall the activities department reporting a missing package to them. Staff D then checked the grievance logs and did not find a report of a missing package that had been logged. Staff D was given a copy of the unknown resident 08/05/2025 grievance that they had completed themselves and stated they remembered that grievance and had found it in their mailbox, but they did not know who had written it and did not do any further follow-up to investigate who could have possibly written it. Staff D stated they discussed all concerns/complaints/grievances in their morning meeting, and Staff D did not realize the two grievances were connected when the Activities Director brought it up, if they brought it up.^ ^ During an interview on 12/12/2025 at 2:49 PM, Staff A, Administrator, stated they had not heard about any missing packages for Resident 62 or for an unknown resident. Staff A stated they would have expected Staff D to do some further investigating/follow-up on the unknown resident grievance and had they been made aware of it, that would have been done. Staff A stated they could have interviewed all the residents that used a vape, which were very few, to figure out who the grievance was from. Staff A stated anyone could write up a grievance, as it was not something only Social Services had to do.^ Reference: WAC 388-97-0460(2)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure psychotropic medications (medications capable of affecting the mind, emotions, and behavior) had specific person-centered behaviors being monitored to reflect adequate need of the medication for 2 of 5 residents (Residents 33 and 62) and failed to obtain informed consents prior to administering psychotropic medications for 1 of 5 residents (Resident 33) reviewed for unnecessary medications. This failed practice placed residents at an increased risk for duplicate therapy, receiving medications they no longer needed and/or increased behaviors due to inadequate dosing of medication. Findings included. Resident 33 Review of the resident's medical records showed they were admitted to the facility on [DATE] with diagnoses to include dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities), anxiety (a feeling of worry, nervousness, or unease about something with an uncertain outcome), and insomnia (the inability of a normal sleep pattern). The 11/11/2025 comprehensive assessment showed Resident 33's cognition was moderately impaired, and no behaviors had been exhibited. The assessment showed Resident 33 received an anti-depressant medication. During an observation and concurrent interview on 12/09/2025, Resident 33 was lying in bed, eyes droopy, and the resident could barely stay awake to have a conversation with me. The Resident Representative (RR) was at bedside and stated the resident was shaky, did not eat breakfast, and was not feeling well. Resident 33 appeared sleepier than when seen on 12/08/2025 when they were alert, talkative, and socializing with their visitors. Review of Resident 33's November 2025 Medication Administration Record (MAR), showed on 11/05/2025 two orders; 1) Temazepam (a brand of anti-anxiety medication used for Insomnia as needed) and 2) Alprazolam (a brand of anti-anxiety medication used for anxiety as needed), on 11/06/2025 an order for Duloxetine (a brand of anti-depressant medication used for anxiety), and on 11/13/2025 an order for Trazodone (a brand of anti-depression medication used for insomnia) and Melatonin (an over the counter sleep aid). The November 2025 MAR showed no sleep pattern monitoring to show how effective the Temazepam or Trazodone was, and the behavior monitoring and non-pharmacological interventions were not individualized and specific to the resident. The MAR showed the monitoring for side effects of the anti-depressant and hypnotic/sedative medications did not start until 11/10/2025 and no monitoring of side effects for the anti-anxiety medications. An observation and concurrent interview on 12/10/2025 at 3:35 PM, the RR stated they were not aware the resident had started two medications that were considered anti-depressant medications, and they were not talked to regarding risks and benefits, nor did they sign a consent for Resident 33 to receive the medications. When the RR asked Resident 33 about the two medications, the resident shook their head from left to right (indicating no) and did not know anything about them either. Review of Resident 33's medical records showed informed consents were not obtained for the use of the Duloxetine or the Trazodone prior to the resident receiving the psychotropic medications. During an interview on 12/11/2025 at 3:49 PM, Staff G, Licensed Practical Nurse/Resident Care Manager, stated the provider started the Duloxetine for Resident 33's anxiety. Staff G stated the resident had Xanax and Temazepam for their anxiety and the provider decided to go with the anti-depressant instead. Staff G stated they were informed in a psychotropic meeting they no longer had to monitor the sleep pattern of a resident when using a psychotropic medication for insomnia, so they were not monitoring the effectiveness of the Trazodone. Staff G reviewed Resident 33's record and stated there were no consents, verbally or signed, in the record and they must have overlooked them. Staff G stated the behaviors and care plans were completed by the Social Services Director (SSD). Resident 62 Review of the resident's medical records showed they admitted to the facility on [DATE] with diagnoses to include anxiety and substance use of opioids (a class of drugs that are used for pain), nicotine, and other stimulants (a substance that increases the activity of the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	central nervous system). The 09/23/2025 comprehensive assessment showed Resident 62's cognition was intact, and they were independent for most activities of daily living (ADLs). The assessment showed the resident displayed no behaviors and received anti-depressant medication. An observation on 12/08/2025 at 3:32 PM showed Resident 62 lying in bed, the room was dark, they were still in night clothes and appeared sleepy. The resident's oxygen tubing was lying on the floor, and the humidified water container was on the floor in front of the oxygen machine. An observation and concurrent interview on 12/09/2025 at 11:38 AM showed Resident 62 lying in bed, the room was dark, and the resident stated they were sleeping and did not want to answer any questions. An observation on 12/10/2025 at 9:33 AM showed Resident 62 lying in bed, the room was dark, the resident was still in their night clothes, not fully alert/awake and had their cell phone up to their ear. Resident 62 did not want to answer any questions. An observation and concurrent interview on 12/12/2025 at 1:26 PM, showed Resident 62 lying in bed, sleeping, and the room was dark. Upon knocking, the resident stated they did not want to answer any questions. Review of the resident's July 2025 MAR showed an order dated 06/27/2025 for Sertraline (a brand of anti-depressant medication) 50 milligrams (mg, a unit of measure) daily and behavior monitoring for agitation, hallucinations, and delusions. The MAR showed two times in the month of July the resident experienced behaviors, once on 07/01/2025 with no documented behavior, intervention, or effectiveness and again on 07/16/2025 with agitation and the intervention was effective. Review of August 2025 and September 2025 MARS showed Resident 62 experienced no behaviors. Review of the October 2025 MAR showed one documented behavior of the resident wanting their medication from the morning, given in the evening and redirection was effective. The MAR also showed a new order to increase the Sertraline from 50 mg to 100 mg without any progress note to show who ordered the increase or why the increase was ordered. Review of November 2025 MAR showed Resident 62 had no documented behaviors. The MAR showed on 11/20/2025 (26 days after the Sertraline was increased) the provider added Buspirone (a brand of anti-depressant medication) for anxiety (without documented change or increase in behaviors). Review of the 12/01/2025 through 12/11/2025 December MAR showed the resident had no documented behaviors. Review of Resident 62's nursing progress notes showed no additional behaviors were documented other than those listed on the July 2025 through December 2025 MARS. The nursing progress notes showed no documented behaviors for Resident 62's Sertraline to be increased or the Buspirone to be added. During an interview on 12/11/2025 at 4:22 PM, Staff D, SSD, stated they were responsible for completing behavior monitors for the residents on psychotropic medications. Staff D stated they were not aware that behaviors were to be specific to each individual resident. Staff D stated the Nursing Assistants (NA) would not all know what specific delusions, hallucinations, or agitation behaviors were. Review of a provider note on 11/18/2025 showed the provider seen Resident 62 for increased anxiety (no documented anxiety in the behaviors or nursing progress notes) and gave new orders for the Buspirone twice daily to augment (the combination of two or more drugs to achieve better treatment results). The note showed Appetite, mood, sleep, mentation, bowel movement, weight remains stable and at baseline. The note showed for the facility to monitor depression (persistent feelings of sadness, low mood, and a lack of interest in activities that one usually enjoys), anxiety, and effectiveness of the new medication. During an interview on 12/12/2025 at 12:15 PM, the Contracted Physician (CP), stated they got their information from talking with the staff and on 11/18/2025, Resident 62 called the CP into their room with increased anxiety. The CP stated they worried about the non-socialization of the resident and was aware they were sleeping all the time. The CP stated the Buspirone was started for their depression, breathing, and panic attacks and would have expected those to be monitored. During an interview on 12/12/2025 at 1:56 PM, Staff B, Director of Nursing Services, stated their expectations would be for resident behaviors to be more specific than just delusions, hallucinations, or agitation. Staff B stated they would have expected informed consents to be completed prior to a resident starting a psychotropic medication and for the consent to be in the medical record and if they (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were not able to obtain them, the medication should have been held until the consent was obtained. Staff B stated there should have been increased behaviors, monitored behaviors, or a reason as to why a medication had been increased, and then documented in the resident's record. Reference: WAC 388-97-1060 (3)(k)(i)		

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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 observation, interview and record review the facility failed to develop comprehensive resident centered care plans for 2 of 6 residents (Residents 52 and 30) reviewed for care plan development. This failure placed residents at risk for unmet care needs. Findings included .Resident 52 Review of the resident's medical record showed they were admitted to the facility with diagnoses to include benign prostatic hyperplasia (BPH a condition in which the prostate gland is enlarged and blocks urine flow), respiratory disease, and diabetes. Review of the comprehensive assessment dated [DATE] showed the resident had moderately impaired cognition, required total staff assistance for dressing and transferring and utilized a retention catheter (a flexible plastic or rubber tube inserted into the bladder to drain urine) for urinary elimination needs. Record review of Resident 52's physician orders dated September 2025 to December 2025 showed medical orders for use and justification of the retention catheter related to the resident's BPH diagnosis. Review of the resident's care plan dated 10/20/2025 showed no directions for care and monitoring of the resident's retention catheter. During an interview on 12/10/2025 at 2:40 PM, Staff T, Resident Care Manager (RCM), stated they had not developed Resident 52's care plan for use and care of their retention catheter as they had overlooked it. Resident 30 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a bone infection after a right and left partial foot amputation with surgical aftercare. The 10/15/2025 comprehensive assessment showed the resident was receiving antibiotic therapy, had moderately impaired cognition and was able to make their needs known. During a concurrent observation and interview on 12/08/2025 at 11:40 AM, showed Resident 30 in their room with a peripherally inserted central line catheter (PICC, a thin, soft tube that is inserted into a main vein in the arm, leg, or neck for long-term administration of antibiotics, medication, nutrition, and/or blood draws) in their right upper arm. The dressing was soiled (in a dirty state or stained) and falling off. The date and time of the last dressing change was not noted on the dressing. The resident stated the last time the PICC line dressing change was preformed was two to three weeks ago. Review of Resident 30's care plan, last completed 10/14/2025, showed no resident focused goals or interventions related to their PICC line. During an interview on 12/19/2025 at 4:09 PM, Staff L, Infection Control Nurse, stated they were also the RCM for Resident 30 and when reviewing the resident's care plan, did not see goals nor interventions that pertained to resident CPAP device use. Staff L stated that Resident 30's CPAP device should have been care planned and the correct process was not followed. During an interview on 12/10/2025 at 2:53 PM, Staff C, Infection Preventionist, stated that Resident 30's PICC line was originally placed on 11/12/2025. Staff C stated that Resident 30's PICC line had (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not been care planned. Staff C stated they would have expected that a care plan would have been developed for the resident specific goals and interventions regarding specifics like changing the PICC lines dressing weekly and monitoring for complications at the insertion site and with the dressing. During an interview on 12/11/2025 at 8:57 AM, Staff B, Director of Nursing Services, stated that care planning of Resident 30's PICC line had been missed. Staff B stated the correct process was not followed. Reference: WAC 388-97-1020(1)(2)(a)		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide the necessary care and services to maintain communication abilities for 1 of 3 residents (Resident 13) reviewed for the use of hearing aid (HA) devices. This failure placed the resident at risk for unmet care needs and the inability to participate in daily activities to the highest extent possible. Findings included . ^Based on observation, interview and record review the facility failed to provide the necessary care and services to maintain communication abilities for 1 of 3 residents (Resident 13) reviewed for the use of hearing aid (HA) devices. This failure placed the resident at risk for unmet care needs and their inability to participate fully in daily activities to the highest extent possible. ^Findings included . Resident 13 Review of the resident's medical record showed they were admitted to the facility with diagnoses which included. Alzheimer disease (a progressive brain disorder that slowly destroys memory) and congestive heart failure (the heart is unable to keep up with the needs of the body). Review of the comprehensive assessment dated [DATE] showed the resident had impaired cognition and used a hearing device to enhance their hearing ability. Additionally, the resident required substantial staff assistance for dressing, grooming, toileting and personal hygiene. ^ ^During a concurrent observation and interview on 12/08/2025 at 1:50 PM, showed Resident 13 in their room resting and they were not wearing their HAs. The Collateral Contact (CC) stated they thought the resident's HAs were kept in the nurse's cart. The CC further stated that Resident 13's confusion was definitely worse when they were not wearing their HAs and was not sure why staff did not put them in the resident's ears daily. The CC stated they had the HAs serviced recently at an audiology clinic and changed the batteries to ensure they were in good order. ^During an observation on 12/09/2025 at 9:30 AM, showed Resident 13 in the hallway at the nurse's station sitting in their wheelchair without their HA's. Further observation showed the resident place their hands behind their ears to push them forward in a cupping motion to enhance hearing when conversing with staff. ^ During an interview on 12/10/2025 at 10:50 AM, Staff S, Licensed Practical Nurse, stated that Resident 13 was supposed to wear their HAs daily and that they were kept in the nurse's cart to be placed in the morning and removed at bedtime. ^ ^ In an interview on 12/10/2025 at 2:30 PM, Resident 13 stated they liked to wear their HAs so they could hear better and were not sure where they were. During the conversation the surveyor was required to speak in a loud tone so the resident could hear as they had no HAs in. The resident again placed their hands behind their ears and cupped them forward during the conversation to enhance their ability to hear. ^ During an interview on 12/10/2025 at 4:21 PM, Staff T, Resident Care Manager, stated the resident had their HAs recently serviced and they were working. Staff T stated the HAs were kept on the nurse's medication cart and placed in the morning by the nurse on duty and removed at bedtime and placed back in the cart. ^ During an interview on 12/12/2025 at 10:10 AM, Staff B, Director of Nursing Services, stated they did expect the nurses to ensure Resident 13 had their HAs in daily so they could enhance their ability to hear and communicate better with staff. ^ Reference WAC 388-97-1060(2)(a)(v)		

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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 residents received treatment and care in accordance with professional standards of practice regarding a residents central venous access device (CVAD, also known as a central line, is a thin, soft tube that is inserted into a main vein in the arm, leg, or neck for long-term administration of antibiotics, medication, nutrition, and/or blood draws) for 1 of 2 residents (Resident 30) reviewed for quality of care. This failed practice placed residents at risk of further infection, a delay in treatment, and adverse outcomes regarding their CVAD. Findings included .Review of the facility's guidance titled, Central Venous Catheter Care and Dressing Change, revised June 2025, showed the facility's purpose was to prevent complications associated with intravenous therapy (IV, the administration of medications or fluids directly into a person's vein) and central line related infections .with contaminated, loosened, soiled, or wet dressings. The policy showed a CVAD dressing should be changed .at least every seven days . or if it becomes loosened/visibly soiled. The policy showed that peripherally inserted central line catheter (PICC, a specific type of central line) needed monitoring for the arm circumference (a measurement around the arm, used to compare with a baseline measurement to detect possible swelling or blood clots) and external catheter length measurement (a measurement that can show if the catheter has been pulled out or not) with each dressing change or if suspected dislodgement. Additionally, monitoring of the CVAD site was to be completed with assessing for complication like dislodgement, redness, tenderness, swelling of the site or loosened, damp, soiled, wet dressing that could require a change. Resident 30 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including a bone infection after right and left partial foot amputation with surgical aftercare. The 10/15/2025 comprehensive assessment showed the resident was receiving antibiotic therapy, had moderately impaired cognition, but was able to make their needs known. Review of the Resident 30's physician's orders for November 2025 through December 2025, showed the resident had been receiving IV antibiotics therapy, a replacement of the resident's PICC line was ordered on 11/12/2025 and a dressing change was completed one time when it was replaced. No orders for monitoring of PICC line site/dressing complications, external catheter length, arm circumference nor weekly changing of the dressing were noted. During a concurrent observation and interview on 12/08/2025 at 11:40 AM, showed Resident 30 in their room with a PICC line in their right upper arm. The dressing was saturated in a reddish/brown liquid and was falling off on the sides of the dressing, unable to stick to the resident arm anymore. The external catheter length, arm circumference and time of the dressing had been changed were not noted on the dressing. The resident stated the last time the PICC line dressing change was preformed was two to three weeks ago. During an interview on 12/10/2025 at 1:43 PM, Staff C, Infection Preventionist (IP), stated the process for residents with PICC line was to have the dressing changed once a week and daily monitoring of the PICC line for complications at the insertion site or with the dressing. Staff C stated with each dressing change the external catheter length and arm circumference were to be measured and checked with a resident's baseline measurements to rule out the PICC line migration (move or pulling out of the catheter line) or swelling complications. Additionally, with each dressing change the nursing staff would label the date it was changed. During an interview on 12/10/2025 at 2:11 PM, Staff F, Licensed Practical Nurse, stated they had been working with Resident 30 since 12/08/2025 and decided to change Resident 30's PICC line dressing on 12/09/2025. Staff F stated the dressing was soiled (unclean), wet and had been falling off the resident's arm. Staff F did not know when the last PICC line dressing changed had been performed on the resident nor had they measured the external catheter length or arm circumference. Additionally, Staff F was unaware of the resident's baseline external catheter length or arm circumference and where they would find it. During an interview on 12/10/2025 at 2:53 PM, Staff C stated that Resident 30's PICC line was originally placed (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 11/05/2025. Staff C stated that Resident 30's PICC line needed to be replaced on 11/12/2025 and no orders were assigned for dressing changes, monitoring of complications, the external catheter length monitoring nor the arm circumference measurement monitoring. Staff C stated they would have expected nursing staff to have been performing dressing changes weekly with Resident 30 PICC line, but it had not been changed since 11/12/2025 (three weeks and six days after being placed). During an interview on 12/11/2025 at 8:57 AM, Staff B, Director of Nursing Services, stated that three weekly dressing changes had been missed on Resident 30's PICC line and nursing staff should have been monitoring and documenting the external length/arm circumference. Staff B stated that it had been missed by multiple staff and the correct process was not followed. Reference: WAC 388-97-1060(3)(j)(ii)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to assess, monitor, or treat new skin issues to prevent the worsening of two facility-acquired pressure injuries (PIs, sores (ulcers) that happen on areas of the skin that are under pressure) for 1 of 3 residents (Resident 60) reviewed for PIs. This failed practice placed residents at risk for worsening or new PIs, increased pain, and unmet care needs. Findings included .Review of the 09/2020 policy titled Skin at Risk/Skin Breakdown showed when a resident has a PI, they were to receive treatment and services to promote healing, prevent infection, and prevent worsening or new PIs. The policy showed when a new PI was identified the Licensed Nurse (LN) would document the skin impairment (measurements, size, and description), assess pain, document on the skin form, notify the provider and obtain new orders, update the Treatment Administration Record (TAR), and notify the Resident Representative (RR). Additionally, the policy showed if the PI was identified after admission, the LN was to initiate alert charting, assess skin risk and current interventions and implement new ones as needed, update the care plan, and notify the dietician, supervisor, and Resident Care Manager (RCM). Resident 60 Review of the resident's medical records showed they admitted with diagnoses to include spondylosis (degeneration of the spinal column) and kyphosis (excessive outward curvature of the spine, causing hunching of the back). The 11/25/2025 comprehensive assessment showed Resident 60 was cognitively intact and during the seven days of the assessment period, the resident had not been rolled from their left to their right side for repositioning. The assessment showed Resident 60 was at risk for developing pressure injuries and used a pressure reduction device for their chair and their bed. An observation and concurrent interview on 12/08/2025 at 11:11 AM, showed Resident 60 sitting in their recliner alongside their bed. Resident 60 had the chair in a reclined position with feet resting on the foot stool of the chair and sitting on their bottom. Resident 60 stated they had a sore on their bottom that started out to be small but had gotten out of hand. Resident 60 stated the sore was very painful but received pain medication that was effective. An observation on 12/09/2025 at 9:07 AM, showed Resident 60 sitting in their reclined chair, on their bottom, with their feet on the footrest of the chair, visiting with a visitor. An observation on 12/09/2025 at 3:31 PM, showed Resident 60 lying back in their recliner chair, on their bottom, sleeping. Resident 60 had their chin and head rested into their chest. An observation and concurrent interview on 12/10/2025 at 11:49 AM, Staff R, Nursing Assistant, stated Resident 60 preferred to stay in their recliner chair 24 hours a day due to their back and neck pain. Staff R stated they did not encourage or assist Resident 60 to reposition themselves because they were in the recliner. Staff R stated if Resident 60 needed or wanted to reposition, they would ask the staff for assistance. Staff R stated Resident 60 had two opened areas to their right side above their buttock, and there was a scab (a dry, rough protective crust that forms over a cut or wound) in the middle of the two opened areas. Staff R, along with Staff F, Registered Nurse, assisted the resident to the commode and there was an area the size of an index finger in length, and at each end there was an open area slightly smaller than a dime, and in the middle of both opened areas was a scabbed over area with a thick application of pink barrier cream over the entire area. Additionally, there was a brown wound dressing (undated and no initials) applied to the middle of the spine and Staff F stated that was just a protective barrier patch. Staff F removed the patch and towards the lower part of the spine was an open area the size of a dime on a bony area of the spine. Staff R applied more pink cream to the open area on the bottom and Staff F replaced the patch on the spine and placed a patch to the bottom. There was no patch to the bottom prior to providing toileting assistance. An observation on 12/11/2025 at 8:51 AM, showed Resident 60 sitting in their chair, slightly reclined back, sitting on their bottom with their feet resting on the footrest. Review of Resident 60's December 2025 Treatment Administration Record (TAR) showed an order on 01/31/2025 to apply a protective dressing to prevent opening of the skin every three days. The order showed no location where the protective dressing was to be applied and showed it was last changed (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 12/09/2025 by Staff F. The TAR showed on 03/06/2024 an order to monitor a red pressure area to the lower back/spine for worsening once a week on Wednesday. The TAR showed an order on 07/05/2023 for a weekly skin assessment to be completed every Wednesday and if there was a skin issue, a skin form and incident report was to be completed, the resident/family and provider were to be notified, the TAR updated with new orders, and a progress note completed, Follow Skin at Risk policy. Lastly, an order on 01/30/2025 showed an ointment was to be applied to the buttocks twice daily and as needed for excoriation (scratching or rubbing of the skin causing the skin to wear). Additional review of the 12/10/2025 (Wednesday) and 12/11/2025 (Thursday) TAR showed Staff F did not complete their scheduled skin assessment or document the lower spine monitoring. Both orders were not signed as completed. Furthermore, there were no new orders for the new skin issues that were identified on 12/10/2025. Review of the 12/10/2025 and 12/11/2025 nursing progress notes showed Staff F had no documentation of the new skin issues that were observed on 12/10/2025, nor a documented notification to the resident/family, or provider. Review of Resident 60's 02/01/2024 (last revised) skin care plan showed the resident was at risk for new or unavoidable skin impairment due to their risk factors, had a score of 20 (which meant they had low risk for skin breakdown) for their skin risk assessment, was to be encouraged to change position as frequently as they allowed (with no schedule initiated as to how frequent), and to float heels while in their recliner as they allowed. Review of Resident 60's skin/wound assessments showed the last assessment completed was 10/29/2024. An observation and concurrent interview on 12/11/2025 at 9:00 AM, Resident 60 was sitting on their bottom in their reclined chair with their feet resting on the footrest. Resident 60 stated they did not like to call staff for assistance because they knew they were too busy. Resident 60 stated they felt like they might be able to move themselves from side to side off their bottom in their recliner. Resident 60 demonstrated repositioning themselves and could make small, slight adjustments but did not have the energy to move completely off their bottom or their spine. Staff R entered the room and stated the NAs did not have a schedule to encourage turning and repositioning for Resident 60 and if the resident asked them to, they would. Staff R stated, we needed to offer it (repositioning) to [Resident 60] rather than waiting for [Resident 60] to ask. During an interview on 12/11/2025 at 3:49 PM, Staff G, Licensed Practical Nurse (LPN)/RCM, stated when new skin issues were identified, the nurse should call to notify the RR and the provider and obtain new orders. Staff G stated an incident report and skin assessment should have been done with measurements and documented in the progress notes. Staff G stated Staff A, Director of Nursing Services, should have been notified, the LPN/RCM should have been notified, and the care plan updated, none of which had been completed at that time. During an interview on 12/12/2025 at 1:56 PM, Staff A stated they were not aware of the new skin issues Resident 60 had until after Staff G was made aware by the Surveyor. Staff A stated Staff F did not follow the correct process. Reference: WAC 388-97-1060 (3)(b)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 1 of 3 residents (Resident 52) with a retention catheter (a small plastic or rubber tube inserted into the bladder to drain urine) reviewed for catheter care, received appropriate care and services to mitigate the risk of infection in the urinary tract. This failure placed residents at risk for illness and a decline in health status. Findings included . Record review of the facility's policy titled Catheter Care, Urinary dated 08/2022 showed that staff were to always position the drainage bag lower than the resident's bladder to prevent urine from flowing back into the urinary bladder. Review of Lippincott's Essentials for Nursing Assistants 4th edition page 574 showed, * Raising the urine drainage bag up higher than the bladder can cause old, contaminated urine to run back into the bladder, which can lead to infection. * Always make sure that the drainage bag is placed at a level lower than the person's bladder. Resident 52 Review of Resident 52's medical record showed they were admitted with diagnoses including congestive heart failure (the heart is unable to keep up with the needs of the body), diabetes, benign prostatic hyperplasia (BPH enlargement of the prostate gland) and urinary tract infection (UTI an infection in the urinary system). The comprehensive assessment dated [DATE] showed the resident had moderate cognitive impairment, required total staff assistance with dressing, grooming and utilized a mechanical lift for transfers. Additionally, the assessment showed the resident utilized an indwelling retention catheter for urinary elimination needs. During an observation on 12/08/2025 at 9:25 AM, showed Staff Y and Staff Z, Nursing Assistants (NAs) prepare the resident for transfer from their wheelchair to the bed using a mechanical lift. The NAs hooked the resident up to the lift with a specialized sling. Staff Y then unhooked the resident's catheter drainage bag and hung it five inches above the resident's bladder on the transfer sling as they were lifted onto the bed. The resident's catheter tubing was observed to have yellow urine which flowed back into their bladder as they were lifted out of the wheelchair onto the bed. During an observation and concurrent interview on 12/11/2025 at 9:54 AM, Staff AA, NA, and Staff BB, NA, prepared Resident 52 for transfer from their bed to the wheelchair. Staff AA and Staff BB hooked the resident up to the mechanical lift with the sling. Staff AA then hung the resident's catheter drainage bag on the sling four inches above their bladder during the lift. Urine was observed flowing backwards from the tube into the resident's bladder. During an interview Staff AA stated they placed the urine bag on the mechanical lift sling during transfers to avoid it getting tangled up when lifting the resident from the wheelchair to the bed. During an interview on 12/12/2025 at 9:16 AM, Staff B, Director of Nursing Services, stated the appropriate way to transfer a resident with a catheter was to keep the drainage bag at or below the level of the resident's bladder. Staff B stated their expectation was for staff to not hang the catheter bag above the resident's bladder to avoid the risk of a UTI. 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 - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, functional, and sanitary environment for 1 of 2 shower rooms (100 hall), 1 of 1 weight room, 1 of 1 laundry room, and 5 of 3 Hoyer (a type of device that safely transfers a resident with limited mobility, such as inability to stand safely) lifts reviewed for a safe and sanitary environment. This failure placed residents at an increased risk of not feeling safe and secure with their environment and unmet care needs. Findings included . Laundry Room During a concurrent observation and interview on 12/10/2025 at 4:30 PM, Staff E, Maintenance Director, was in the laundry's dirty linen sorting room with the surveyor. On the wall, by the door that entered the rest of the laundry area, was a six inch (a unit of measure) long by five inches wide hole in the dry wall behind the rubber base board that was peeling off. The section of missing dry wall had been broken into numerous pieces that lay in a pile below the hole in the wall. Staff E stated they were unsure of what happened, but it needed to be fixed and was an area that would not be able to be cleaned until it was fixed.^^ 100 Hall Shower Room During a concurrent observation and interview with Staff V, Nursing Assistant (NA) and shower aide, on 12/11/2025 at 11:01 AM, showed the shower stall part of the room had broken off caulking (a waterproof filler and sealant) all around the bottom of the shower stall and on top of the tiles that were halfway up the wall in the shower stall. There were areas of a black substance on the shower stall floor and the top of the tiles, and the room had a wet moldy odor to it. Staff V stated they used the shower room daily and the shower stall had been that way for a long time. Staff V stated water seeped from both the floor of the shower stall and the top of the tiles in the shower stall to under the plastic walls of the shower stall and into the adjacent weight room. Observation of the wall behind the shower stall in the weight room showed approximately four inches up from the floor where the sheetrock was wet and broken off in multiple places. There were four batteries in the weight room that were plugged into a wall outlet where the area was wet and approximately 10 batteries sitting on the wet floor of the room. Staff V stated all the batteries in the room were for charging the facility Hoyer lifts and sit to stand lifts (mechanical devices used to safely lift and transfer residents with limited mobility from one surface to another) and the batteries that were unplugged from the outlet were broken and would no longer take a charge. During the same observation and interview, a large metal weighing surface that wheelchairs could be rolled up on to weigh a resident in a wheelchair or shower chair showed to take up most of the floor surface of the room. The machine was noted to be in two pieces, one to roll the chair onto the weight machine and the weight machine itself. There was an uneven gap between the two pieces making the weight machine higher than the rolling on surface. Staff V stated they had noticed the floor under the weight machine would get wet from the leaking shower room and over time had made the weight machine uneven and leaving a gap between the two pieces made it unsafe to roll the residents up on to it. During a concurrent observation and interview on 12/12/2025 at 9:09 AM, showed the resident shower room on the 100's hallways was still wet from being utilized from a resident shower. The (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower room had a musty (having a stale, moldy, or damp smell) odor upon entering. The top half of the shower walls were tiled along with the floors, while the bottom half of the walls were a hard plastic sheet that had been seemed together with the tiled sections by caulking. Along the top and bottom caulking seams were holes and missing section of caulking where water had been getting into the back of the plastic shower walls. Black growth was noted all along the caulking and the sections of silver handles, which were attached to the shower walls for support, had the same black growth around the connection of the handle to the wall. The back top section of plastic wall was unattached from the wall and the wall behind the plastic was a dark black color and smelled of mold. When Staff E observed the black growth along the caulked seams of the shower, .possible growing something . Staff E looked behind the plastic section of the shower wall and noted the dark black growth and stated the black growth was not cleanable and that it was not safe for residents to be taking showers in the room. Observations of the wall in the adjacent room from the resident shower room showed previous water damage (an accidental leakage or discharge of water that caused possible losses or value of materials) to the floor beneath the linoleum (a common floor covering). Staff E stated they had replaced the top flooring but did not replace the bottom wood sheet that had water damage and laid the new flooring on top of it. Staff E did not remember when the shower leak was first fixed after being brought to the staff members attention, but they had redone the caulking on the shower seams a couple of months ago and they did not see the black growth at that time.^^ ^ During an interview on 12/12/2025 at 9:53 AM, Staff C, Infection Preventionist, observed the 100-hallway shower room with the surveyor. Staff C stated the black growth looked like mold and that the mold growth was spreading to behind the shower walls, was no longer a cleanable surface, not safe for residents nor a homelike environment. Staff C stated the shower stall needed to be fixed and no longer used by residents.^ During an interview on 12/12/2025 at 12:49 PM, Staff A, Administrator, stated the 100-hallway resident shower room was not clean or safe and the correct process for providing a comfortable homelike environment was not being followed with the shower room.^ Hoyer Lifts During an observation on 12/11/2025 at 3:37 PM showed a Hoyer lift sitting in the 200 Hall. The base of the lift had crushed debris including food crumbs. The legs had a black grime substance covering both legs and the body of the lift was dusty and dirty. ^ During an observation on 12/12/2025 at 1:07 PM showed a Hoyer lift and a sit to stand lift (a lift which assists the resident to stand during the transfer process) sitting in the hallway. The Hoyer lift showed crushed food debris and black grime on the legs of the lift. The sit to stand showed a white dried substance on the body of the lift which appeared to be dried milk. ^ During an observation on 12/12/2025 at 1:22 PM, the Hoyer lift on the 100 Hall showed food crumbs crushed into the base of the lift, black grime on the legs and dust on the body of the lift. The sit to stand lift showed dust and dirt on the base. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	^ During a concurrent observation and interview on 12/12/2025 at 2:52 PM Staff S, Licensed Practical Nurse, acknowledged the lift equipment was dirty and stated the lift equipment was supposed to be cleaned by the nursing assistants. ^ During an interview on 12/12/2025 at 3:00 PM, Staff A, Administrator stated the facility did not have a schedule for cleaning the resident lift equipment and that the NA staff were supposed to clean them.^ Reference: WAC 388-97-3220(1)		