STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Post Acute	21400 72nd Avenue West Edmonds, WA 98026

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 laundry was handled, stored and processed in a sanitary manner for 1 of 1 laundry room, reviewed for infection control. In addition, the facility failed to ensure Contact Enteric Precautions (measures put in place to prevent spread of infection by direct or indirect contact with the resident or environment by staff wearing gown and gloves before entering a resident's room or environment and washing hands with soap and water when leaving the room) practices were followed for 1 of 7 staff (Staff JJ) and 1 of 1 resident (Resident 25), reviewed for transmission based precautions (measures put in place to prevent spread of infection by staff wearing Personal Protective Equipment [PPE-use of gown, gloves, mask and/or face shield] before entering a resident's room or environment). These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included. Review of the facility's policy titled, Policies and Practices-Infection Control, revised in October 2018, showed This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. LAUNDRY ROOMIn an interview and joint observation on 03/02/2026 at 1:11 PM, Staff DD, Housekeeper, stated they were responsible for the laundry today. A joint observation showed three yellow bins of soiled laundry inside the laundry room next to a rack of clean linens. It showed that one yellow soiled bin was touching a bin of clean housekeeping rags. Staff E, Housekeeping Director, stated dirty items should not be touching clean items. When asked what they used for disinfecting the washing machines, Staff DD showed an unlabeled spray bottle with blue liquid in it. Staff E stated that every cleaner should be labeled and we're [we are] replacing these now, we can't [cannot] use them. Another joint observation showed a pile of wet clothes placed on top of a rolling cart that had dirty items, including dirty shoes on the bottom rack. Staff DD stated that yes the items on the bottom rack were dirty. Staff E stated that the wet clothes would need to be rewashed. In an interview on 03/03/2026 at 1:30 PM, Staff F, Infection Preventionist, stated that their expectations in the laundry room included, separating the dirty and clean areas, dirty laundry should not be touching clean items, and clean laundry should not be placed on a cart with dirty items on the bottom. Staff F stated that laundry should be transferred right from the washer to the dryer. Staff F further stated that laundry staff should not use unlabeled chemicals and that every chemical in the building should be labeled. In an interview on 03/04/2026 at 8:18 AM, Staff B, Director of Nursing, stated that their expectation in the laundry room was that the clean [should be] separate from dirty. Staff B stated that they expected laundry staff to transfer laundry directly from the washer to the dryer. Staff B further stated that all chemicals should be labeled. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CONTACT ENTERIC PRECAUTIONSReview of the facility's policy titled, Isolation-Categories of Transmission-Based Precautions, revised in September 2022, showed that Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. Review of the Centers for Disease Control Prevention (CDC) online article titled, Clinical Guidance for C. diff [Clostridium Difficile – is a highly contagious bacterial infection that can cause severe diarrhea] Infection Prevention in Acute Care Facilities, dated on 03/08/2024, showed, For patients [residents] with confirmed CDI [Clostridioides Difficile Infection], maintain contact precautions for at least 48 hours after diarrhea [loose, watery stools and urgent bowel movements] has resolved, or longer. STAFF JJObservation on 02/27/2026 at 11:53 AM, showed signage that room [ROOM NUMBER] was a contact enteric precautions room. It showed Staff JJ, Certified Nursing Assistant (CNA), put on a gown and gloves to enter room [ROOM NUMBER] to bring juice to Resident 25. Staff JJ took off their gown and gloves prior to leaving the room, used hand sanitizer, and did not use soap and water to wash their hands. At 12:20 PM, Staff JJ entered room [ROOM NUMBER] to take a meal tray to Resident 25. Staff JJ took off their gown and gloves prior to leaving the room, used hand sanitizer, and did not use soap and water to wash their hands. In an interview and joint observation on 02/27/2026 at 12:25 PM, Staff JJ stated that they knew what isolation precautions a resident was on by the sign at the door. Staff JJ stated that if a resident was on contact enteric precautions they would wear a gown and gloves and use hand sanitizer when leaving the resident's room. A joint observation of the signage at room [ROOM NUMBER]'s door showed to use soap and water upon leaving the room. Staff JJ stated that they did not use soap and water when leaving room [ROOM NUMBER] because there is no sink close by, it's [it is] all the way at the nurses station. In an interview on 03/03/2026 at 1:30 PM, Staff F stated that contact enteric precautions would be used if a resident was having diarrhea, three or four in a day or if a resident had C-diff. Staff F further stated that they expected staff to wash their hands with soap and water when leaving a contact enteric precautions room. In an interview on 03/04/2026 at 8:18 AM, Staff B stated that they expected staff to wash their hands with soap and water when leaving a contact enteric precautions room. RESIDENT 25Review of a face sheet printed on 02/25/2026 showed that Resident 25 readmitted to the facility on [DATE] with diagnoses that included diarrhea. Observation on 02/23/2026 at 10:31 AM, showed a contact enteric precaution signage outside Resident 25's door. In an interview on 02/23/2026 at 10:40 AM, Staff L, Registered Nurse, stated that Resident 25 was on contact enteric precaution for C-diff. On 02/23/2026 at 3:20 PM, Resident 25 stated that they were still having diarrhea. Observation on 02/25/2026 at 10:38 AM, showed an enhanced barrier precaution (EBP -to protect (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections) signage outside Resident 25's door. On 02/25/2026 at 12:01 PM, Resident 25 stated that they still had diarrhea and that they had loose stools today, most of the night and morning. Review of Resident 15's Lab [laboratory] Results Report, dated 12/24/2025 showed that their stool sample was positive for C-diff. Review of Resident 25's February 2026 medication administration record showed an order for Rifaximin (antibiotic medication that treat infections) oral tablet give 550 milligrams (a unit of measurement) by mouth two times a day for C-diff for 10 days. Further review showed that Resident 25 completed their medication on 02/16/2026. Review of the Task: Bowel Movements from 02/13/2026 through 02/25/2026 showed that Resident 25 had loose/diarrhea from 02/13/2026 through 02/23/2026 and on 02/25/2026. In an interview on 02/26/2026 at 9:19 AM, Staff JJ stated that they changed Resident 25 today and that their bowel movement was loose. Staff JJ stated, It's [it is] always loose. In an interview on 02/26/2026 at 10:18 AM, Staff F stated that they followed CDC recommendations for infection control and prevention. Staff F stated that contact enteric precaution would be re-assessed once the resident had completed their antibiotics. Staff F stated that Resident 25 was admitted with C-diff and had a history of recurrent C-diff. Staff F stated their gastrointestinal doctor (specialist who focuses on the health of the digestive system and liver) would put them on antibiotics and that the resident would be placed on contact enteric precautions. When Resident 25 completed their antibiotics, they would be reassessed if they were still having diarrhea. If they continued to have diarrhea, they would continue to be placed on contact enteric precautions. Staff F stated that to get off contact enteric precaution, they need to have no diarrhea for 48 hours. Staff F stated that they had changed Resident 25's contact enteric precaution yesterday [02/25/2026] to EBP because Resident 25 had completed their antibiotics last week and that they had kept them on contact enteric precaution. Staff F stated that their provider thought that Resident 25 was colonized with C-diff and that Resident 25 was not tested for C-diff [after they had completed their antibiotics]. A joint record review of the Task: Bowel Movements from 02/13/2026 through 02/25/2026 showed that Resident 25 had loose/diarrhea except on 02/24/2025. Staff F stated that they changed Resident 25's precaution to EBP because they had completed their antibiotics, got an okay from the provider and that the provider believed they were colonized. A joint record review of Resident 25's Lab Results Report dated 12/24/2025 showed that Resident 25 was positive for C-diff. Staff F stated, technically we could have kept her on contact enteric precautions and that they should have tested them because they were sharing a room with two other residents. Staff F stated that they thought EBP would be appropriate at this point because they had done multiple education with the staff because of their recurrent diarrhea. In an interview on 03/04/2026 at 11:12 AM, Staff B stated that residents would be on contact enteric precautions for residents with any contact transmitted associated bacteria like C-diff. Staff B stated that residents could be colonized with C-diff and that they made sure that a laboratory test would be completed. If the test was negative, the resident could be taken off contact enteric precautions. If they continued to have loose stools and if they were colonized, they needed to have documentation. Staff B stated that if they continued to have new loose stools, they had to continue to be on contact enteric precautions. Staff B further stated that the provider felt it was unnecessary to test Resident 25 for C-diff and that they believed Resident 25 was colonized with C-diff. Cross Reference: F908.Reference: (WAC) 388-97-1320(1)(a)(c)(3).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure a homelike environment when medications were administered in the common area for 2 of 5 residents (Resident 47 &16), reviewed for medication administration. In addition, the facility failed to ensure a clean, safe, and homelike environment for 4 of 7 residents (23, 20, 27 & 65), reviewed for environment. These failures placed the residents at risk for injury, a less than homelike environment, and a diminished quality of life.Findings included. Review of the facility's policy titled, Maintenance Service, revised in December 2009, showed that Maintenance service shall be provided to all areas of the building, grounds, and equipment. Review of the facility's policy titled, Homelike Environment, revised in February 2021, showed that Residents are provided with a safe, clean, comfortable and homelike environment. MEDICATIONS GIVEN IN COMMON AREASRESIDENT 47Observation on 02/25/2026 at 11:31 AM, showed Staff PP, Licensed Practical Nurse (LPN), administered medication to Resident 47 in the common area in front of the [NAME] Nurse Station. In an interview on 02/25/2026 at 12:32 PM, Staff PP stated that they gave Resident 47 their morning medications in the common area in front of the [NAME] Nurse Station because she needed her morning meds and she was behind time. Staff PP further stated that we're [we are] not supposed to [give medications in common areas] for privacy reasons. RESIDENT 16Observation on 02/26/2026 at 9:28 AM, showed Staff QQ, LPN, administered medication to Resident 16 in the common area in front of the [NAME] Nurse Station. In an interview on 02/26/2026 at 9:36 AM, Staff QQ stated that as far as I know, it's [it is] ok to give pills outside the room. Staff QQ further stated that they gave Resident 16 their medications in the common area in front of the [NAME] Nurse Station. In an interview on 03/04/2026 at 8:18 AM, Staff B, Director of Nursing, stated that they did not expect medications to be administered to residents in common areas. BASEBOARD HEATERRESIDENT 23Observation on 02/24/2026 at 8:57 AM, showed the baseboard heater was coming away from the wall in Resident 23's room. Resident 23 stated it's [it has] been like that forever and stated that they had told staff about it. Observation on 02/25/2026 at 11:18 AM, showed the baseboard heater was coming away from the wall in Resident 23's room. In an interview and joint observation on 02/25/2026 at 12:05 PM, Staff JJ, Certified Nursing Assistant (CNA), stated that if they noticed something in disrepair in a resident's room, they would notify maintenance through an online software program. A joint observation of Resident 23's room showed the baseboard heater was coming away from the wall. Staff JJ stated that the baseboard heater was coming loose off the wall, you can see the nails or screws and that it needed to be reported to maintenance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint observation and interview on 02/25/2026 at 2:16 PM with Staff OO, Regional Maintenance, showed the baseboard heater was coming away from the wall in Resident 23's room. Staff OO stated that it's [it is] coming off [of the wall]. In an interview on 03/04/2026 at 9:44 AM, Staff A, Executive Director, stated that maintenance was responsible for maintaining resident rooms. Staff A stated that they expected staff to communicate to maintenance if they noticed anything in disrepair in a resident's room. Staff A further stated that they would not expect a baseboard heater to be coming away from the wall. RESIDENT 20On 02/24/2026 at 8:51 AM, Resident 20 stated that they were told by staff that they could not place anything inside the red marker that was placed around the baseboard heater. Resident 20 stated that they did not have anywhere to place their wheelchair and commode and that the only place they could place it was on the right side of their bed. Observation showed Resident 20's wheelchair was parked on the right side by the foot of the resident's bed, and their commode was by the wall. Resident 20's wheelchair and commode were inside the red marker by the baseboard heater. Observations on 02/27/2026 at 3:28 PM and on 03/02/2026 at 11:45 AM, showed Resident 20's wheelchair was parked by the foot of their bed on the right side, and their commode was by the wall. Resident 20's wheelchair and commode were inside the red marker by the baseboard heater. In an interview and joint observation on 03/03/2026 at 10:45 AM, Staff D, Maintenance Director, stated that the red marker by the baseboard heater was a reminder to keep things away from it. Staff D stated, nothing should be in that area and that if it was in that area, it had to be UL certified [Underwriters Laboratories- a critical standard for ensuring safety and reliability of fire protection products]. Staff D stated that they were potentially a fire risk because it's [it is] a heater. A joint observation showed Resident 20's wheelchair, commode and trash can were inside the red marker. Staff D stated that the garbage that was there would be a risk. A joint observation showed a wooden box by the wall on the left side of the baseboard heater. Staff D stated it was a risk but not an immediate risk and that technically should not be there. In an interview on 03/04/2026 at 11:53 AM, Staff A stated that they expected a safe home environment. Staff A further stated that staff had to ensure that resident equipment was outside the red marker for safety. BED LINENRESIDENT 27Observation on 02/23/2026 at 12:11 PM showed Resident 27's bed sheet had a medium round spot of brown dry stain on the left upper side and two streaks of parallel light greenish-yellowish stains on the right middle side. The bed was unkempt and not made. Resident 27 stated the bed had not been made for a whole week or even since admission, and had received several showers. Observation on 02/24/2026 at 9:38 AM showed the same brown stain on the left upper side and greenish-yellowish stain on the right middle side of the bed sheet. A joint observation and interview on 02/24/2026 at 9:43 AM with Staff LL, CNA, stated that there were brown and greenish-yellow stains on the bed sheet. Staff LL stated that the bed should be changed when visibly soiled, dirty, wet, or after the resident had a shower. Staff LL stated the bed should have been changed and it was not. In an interview on 03/03/2026 at 10:32 AM, Staff G, Resident Care Manager, stated that if a bed was (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visibly soiled or wet, staff were expected to change it. Staff G further stated that two staff members normally do rounds at the beginning and end of each shift to ensure residents were clean and dry, and they were expected to change the bed sheets after a shower. In an interview on 03/03/2026 at 11:15 AM, Staff B stated that it was their expectation that the residents' bed were clean, well-made, and remained dry every shift. BED FOOTBOARDRESIDENT 65Observations on 02/25/2026 at 1:10 PM, on 02/26/2026 at 12:15 PM, and on 02/27/2026 at 12:00 PM, showed a medium oval dark brownish red dry substance on the left inner side of Resident 65's bed footboard. Resident 65 stated that the staff needed to clean the footboard. In an interview and joint observation on 02/27/2026 at 2:25 PM, Staff S, Housekeeper, stated that housekeeping were responsible for cleaning the residents' headboard and footboard. A joint observation of Resident 65's footboard showed dark brownish red dry substance on the left inner side of the resident's bed footboard. Staff S stated that the dry substance looked like blood and that it should not be there. In a joint observation and interview on 02/27/2026 at 2:30 PM, Staff E, Housekeeper Director, showed a dark brownish red dry substance to Resident 65's footboard. Staff E stated that the dark brownish red dry substance looked like blood and that it should have been cleaned. In an interview on 03/03/2026 at 3:45 PM, Staff A stated that they expected staff to report any housekeeping needs and to clean them. Staff A further stated that they expected Resident 65's footboard to have been cleaned. Reference: (WAC) 388-97-0880 (1)(2) .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written transfer/discharge notice to the residents and/or their representatives with the required information for 4 of 4 residents (Residents 30, 25, 52 & 14) and failed to provide a bed hold notice for 2 of 4 residents (Residents 52 & 14), reviewed for hospitalizations. These failures placed the residents at risk for not having opportunities to make informed decisions about transfer/discharge.Findings included. Review of the facility's policy titled, Transfer or Discharge Notice, revised in March 2021, showed that Residents and/or representatives are notified in writing, and in a language and format they understand. It showed that the resident and/or representative are notified of the specific reason for the transfer or discharge, date of the transfer or discharge, the location of where they are being transferred or discharged , and an explanation of the resident's rights to appeal the transfer or discharge. TRANSFER/DISCHARGE NOTICERESIDENT 30Review of the discharge Minimum Data Set (MDS-an assessment tool), dated 02/15/2026, showed that Resident 30 admitted to the facility on [DATE] and discharged to an acute hospital on [DATE]. Review of the Electronic Health Record (EHR-progress notes, assessments, and attachments) showed that Resident 30 was discharged from the facility on 02/15/2026. Further review of Resident 30's EHR showed no documentation that a written transfer/discharge notice was provided to Resident 30 and/or their representative. In an interview on 03/03/2026 at 9:05 AM, Staff I, Resident Care Manager (RCM), stated that when a resident discharged to the hospital they would usually call the family. Staff I further stated that they were unsure if a written transfer/discharge notice was provided to the resident and/or their representative. In an interview and joint record review on 03/04/2026 at 9:44 AM, Staff A, Executive Director, stated that we should be providing a written [transfer/discharge] notice. Staff A stated that Resident 30 went to the hospital. A joint record review of Resident 30's EHR showed no documentation that a written transfer/discharge notice was provided to Resident 30 and/or their representative. Staff A stated that I don't [do not] see anything, nothing like that for Resident 30. RESIDENT 25Review of the quarterly/discharge MDS dated [DATE] showed that Resident 25 was admitted to a Short-Term General Hospital. Review of the facility's Transfer Form dated 08/09/2025 showed that Resident 25 was transferred to the hospital related to abnormal laboratory results. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the EHR showed no documentation that a written transfer/discharge notice was provided to Resident 25 and/or their representative. RESIDENT 52Review of the discharge MDS dated [DATE] showed that Resident 52 was admitted to a (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Short-Term General Hospital. Review of the discharge MDS dated [DATE] showed that Resident 52 was admitted to a Short-Term General Hospital. Review of the discharge MDS dated [DATE] showed that Resident 52 was admitted to a Short-Term General Hospital. Review of the facility's Transfer Form dated 09/07/2025 showed that Resident 52 was transferred to the hospital for chest pain. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the facility's Transfer Form dated 10/31/2025 showed that Resident 52 was transferred to the hospital for uncontrolled pain. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the facility's Transfer Form dated 01/26/2026 showed that Resident 52 was transferred to the hospital for shortness of breath. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the EHR showed no documentation that a written transfer/discharge notice was provided to Resident 52 and/or their representative. RESIDENT 14Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital. Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital. Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital. Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital. Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital. Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital. Review of the facility's Transfer Form dated 06/09/2025 showed that Resident 14 was transferred to the hospital for surgery. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the facility's Transfer Form dated 08/08/2025 showed that Resident 14 was transferred to the hospital for abnormal vital signs (essential body functions) and no urinary [urine] output in their left nephrostomy (a thin plastic tube inserted through the back to drain urine directly from the kidney into a bag outside the body). Further review of the Transfer Form did not show that it included a (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	statement of the resident's appeal rights and Ombudsman contact information as required. Review of the facility's Transfer Form dated 10/23/2025 showed that Resident 14 was transferred to the hospital for increase temperature and increase heart rate. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the facility's Transfer Form dated 11/17/2025 showed that Resident 14 was transferred to the hospital for increase temperature and increase heart rate. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the facility's Transfer Form dated 01/05/2026 showed that Resident 14 was transferred to the hospital for suspected kidney infection. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the facility's Transfer Form dated 02/02/2026 showed that Resident 14 was transferred to the hospital for unresponsiveness. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required. Review of the EHR showed no documentation that a written transfer/discharge notice was provided to Resident 14 and/or their representative. In an interview on 03/03/2026 at 9:18 AM, Staff L, Registered Nurse, stated that when a resident was transferred to the hospital, they completed the transfer form/packet and would make and give a copy to the resident. Staff L further stated that if the resident was alert, they would notify them of the bed hold, if they were not, they would notify their representative. In an interview and joint record review on 03/03/2026 at 3:10 PM, Staff I was asked if they provided the resident or their representative with a transfer/discharge notice that informed them of appeal rights/Ombudsman contact information when they were transferred to the hospital, Staff I stated that they have never done that. A joint record review of Resident 25's Transfer Form dated 08/09/2026, did no show that it contained appeal rights and Ombudsman contact information as required. Staff I stated that there were no appeal rights and Ombudsman contact information on the transfer form. Staff I stated that all the forms they completed when a resident transferred to the hospital was the transfer form, bed hold notice and paperwork that were provided to the paramedics. Staff I further stated that they did not provide any documents to the resident and/or their representative. In an interview on 03/04/2026 at 11:56 AM, Staff A stated that they expected residents and their representative to receive a written transfer/discharge notice. Staff A stated that the facility used the transfer form and that when they reviewed the form, it did not contain the appeal rights and ombudsman notification as required. When Staff A was requested to do a record review for Resident 52 and Resident 14, Staff A declined and stated, if it's [it is] not there, it's not there. BED HOLD NOTICEReview of the facility's policy titled, Bed-Holds and Returns, revised in October 2022, showed, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payor source, are provided written notice about these policies at least twice: a. notice 1 [one]: well in advance of any transfer (e.g. [example] in the admission packet; and b. notice 2 [two]: at the time of transfer (or if the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	transfer was an emergency, within 24 hours). RESIDENT 52Review of the discharge MDS dated [DATE] showed that Resident 52 was admitted to a Short-Term General Hospital. On 02/24/2026 at 10:54 AM, Resident 52 stated that they were not notified of a bed hold. Review of Resident 52's facility's undated document titled, Bed-Hold and Return Agreement, showed that it was not completed. Review of Resident 52's EHR did not show documentation that a bed hold notice was provided to the resident and/or their representative. In a joint record review and interview on 03/03/2026 at 11:27 AM, Staff Y, Medical Records Director, showed that Resident 52's undated Bed-Hold and Return Agreement, showed that it was not completed. Staff Y stated that it was loaded with nothing complete. Staff Y stated that staff should have followed up with a progress note that a bed hold notice was provided to Resident 52. A joint record review of Resident 52's progress notes showed no documentation that a bed hold notice was provided to the resident and/or their representative. Staff Y stated that they did not see a progress note. RESIDENT 14Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital. On 02/27/2026 at 1:20 PM, Resident 14's representative stated that they were not notified of a bed hold. Review of Resident 14's EHR did not show documentation that a bed hold notice was provided to the resident and/or their representative. In an interview on 03/03/2026 at 9:18 AM, Staff L stated that if the resident was alert, they would notify them of the bed hold notice, and if they were not, they would notify their representative. In an interview on 03/03/2026 at 11:00 AM, Staff J, Social Service Director, stated that nursing would notify the resident of a bed hold and if they were unable to, Staff Z, Business Office Manager, would follow up and call the resident's representative. Staff J further stated that at a minimum [there] should be a progress note. In an interview on 03/03/2026 at 11:38 AM, Staff Z stated that if they were unable to provide a bed hold notice to the resident, they would follow up with the resident and/or their representative. Staff Z stated that they would document under progress notes. Staff Z stated that there was a bed hold form that would be provided to the resident. Staff Z stated that they would call the resident's representative and would write a progress note. Staff Z stated that they did not find a progress note that a bed hold notice was provided to Resident 52 and Resident 14 and/or their representative. Staff Z further stated that Resident 52 and Resident 14 and/or their representative should have been notified of a bed hold notice and that it should have been documented. In an interview on 03/04/2026 at 11:56 AM, Staff A stated that their expectation was for staff to offer a bed hold notice when a resident was discharged to the hospital and if they were unable to provide one, they would follow up as soon as possible if they want to do a bed hold. Staff A further stated that they expected it to be documented. Reference: (WAC) 388-97-0120(2)(a-d)(4).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident assessments were completed accurately for 6 of 29 residents (Residents 4, 7, 103, 11,14, & 133), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments were marked on the MDS regarding indwelling catheter (a flexible, hollow tube inserted into the bladder to continuously drain urine into an external collection bag), insulin injections (medication used to manage blood sugar levels), ostomy (surgically created opening on the abdomen that allows waste to leave the body), turning/repositioning program, hospice (specialized care for people with a terminal illness) and prognosis placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life.Findings included . According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. Further review of the RAI manual showed, The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [for example], reposition on side, pillows between knees) and frequency (e.g., every 2 [two] hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period).INDWELLING CATHETERRESIDENT 4Observation and interview on 02/24/2026 at 10:38 AM, showed Resident 4 did not have an indwelling catheter. Resident 4 stated they did not have an indwelling catheter and that it was removed last year in July. Review of the quarterly MDS dated [DATE], showed Resident 4 was marked for indwelling catheter in Section H (Bladder and Bowel - under H0100A). Review of Resident 4's January 2026 progress notes and physician orders printed on 02/24/2026 showed Resident 4's indwelling catheter was discontinued on 07/24/2025. In an interview and joint record review on 03/03/2026 at 11:30 AM with Staff K, MDS Coordinator, stated that they follow the RAI manual for MDS accuracy. A joint record review of Resident 4's quarterly MDS dated [DATE] showed indwelling catheter was marked in Section H. Further joint record review of the January 2026 progress notes and physician orders showed Resident 4's indwelling catheter was discontinued on 07/24/2025. Staff K stated that Resident 4's indwelling (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	patient's [Resident 133] prognosis is six months or less if the disease runs its normal course. Review of the admission MDS dated [DATE] showed that hospice care was not marked in Section O (Special Treatments, Procedures, and Programs). It further showed that Section J1400 (Prognosis) was marked no for the question Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 [six] months? In an interview and joint record review on 03/03/2026 at 3:04 PM, Staff K stated that they follow the RAI Manual for MDS accuracy. A joint record review of Resident 133's EHR showed they were admitted to hospice on 11/14/2025. A joint record review of the admission MDS dated [DATE], showed that hospice was not marked in Section O. Staff K stated that it should be. It further showed that that Section J1400 was marked no. Staff K stated that it should be marked yes. Staff K further stated that Resident 133's MDS was not accurate. In an interview on 03/04/2026 at 8:18 AM, Staff B stated that they expected the MDS to be accurate. Reference: (WAC) 388-97-1000 (1)(b) .

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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 foods were handled appropriately in accordance with professional standards of food safety for 1 of 2 Refrigerators (Kitchen Walk-in Refrigerator), 1 of 1 Dry Storage Room, and 2 of 4 Staff (Staff GG & HH), reviewed for food services. The failure to label and discard food items past the use by date, perform hand hygiene and properly sanitized equipment, placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life.Findings included.Review of the facility's policy titled, Food Receiving and Storage, revised in November 2022, showed, Dry foods and goods are handled and stored in a manner that maintains the integrity of the packing until they are ready to use. The policy showed, All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). The policy further showed, Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in August 2019, showed, The facility considers hand hygiene the primary means to prevent the spread of infections. The policy showed to use an alcohol-based hand rub or soap and water before donning (put on) sterile gloves, after removing gloves, before and after eating or handling food. The policy showed, Hand hygiene is the final step after removing and disposing of personal protective equipment [mask, gloves and gown]. It further showed, The use of gloves does not replace hand washing/hand hygiene. Integration of glove along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.KITCHEN WALK-IN REFRIGERATOR Observation of the Kitchen Walk-in Refrigerator on 02/23/2026 at 8:24 AM, showed the following food items:-one plastic container labeled Pineapple dated 2/20/26 [02/20/2026] with no use by date.-one metal container of chopped red onions with no label and use by date. In an interview and joint observation on 02/23/2026 at 8:47 AM, Staff C, Dietary Manager, stated that food items were to be labeled what it is and that it would be good for seven days. A joint observation showed one plastic container of Pineapple dated 2/20/26 with no use by date. Staff C stated that the pineapple was good for seven days. When asked if they expected staff to label it with the use by date, Staff C stated that they did not expect them to label with the use the by date because they can count. In another joint observation showed one metal container of chopped red onions with no label and use by date. Staff C stated that it should have been labeled with what it was and dated.In another observation on 02/27/2026 at 9:36 AM, showed one metal container labeled lettuce with use by date of 2/12 [02/12/2026].In a joint observation and interview on 02/27/2026 at 2:25 PM with Staff C, showed one metal container labeled lettuce with use by date of 2/12. Staff C stated that it should have been discarded. DRY STORAGE ROOMObservation of the Dry Storage Room on 02/23/2026 at 8:34 AM, showed one opened uncapped container of [NAME] Distilled Vinegar, dated 09/09/2025.In an interview and joint observation on 02/23/2026 at 8:55 AM, Staff C stated that they expected food items to be capped/covered. A joint observation showed one opened uncapped container of [NAME] Distilled Vinegar, dated 09/09/2025. Staff C stated that it should have had a cap.HAND HYGIENE/GLOVE USE/SANITIZATIONSTAFF GGObservation on 02/27/2026 at 8:57 AM, showed Staff GG, Cook, was at the sink in the dish washing area and were removing food scraps off a large tray with their bare hands. Staff GG washed their hands with water (no soap) and went to the preparation station and told an unknown male staff that had entered the kitchen with a machinery to go the other way as they were trying to pass through the kitchen. Staff GG went out of the kitchen with the unknown male staff. Staff GG entered the kitchen shortly after and went to the dishwashing area and proceeded to scrub the sink with their bare hands. Staff GG did not perform hand hygiene when they left and entered the kitchen.In another observation on 02/27/2026 at 9:14 AM, Staff GG entered the kitchen and went to the dishwashing area without performing hand hygiene. Staff GG were assisting Staff II, Dietary Aide, with the dishes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:20 AM, Staff GG took a scrub from a plastic container with their bare hands and gave it to Staff II. Staff GG then took a clean dishware and stored them away. Staff GG stated that they took the scrub from the container with sanitizer water. The container with sanitizer water was murky and had used utensils, floating lids and food debris. Staff GG was asked if they considered their hands clean after getting the scrub from the container, Staff FF stated that it was sanitizer water. In an interview on 02/27/2026 at 12:23 PM, Staff GG stated that they would wash hand first, gloves second and that if they touched anything with bacteria or surface debris, they would perform hand hygiene. Staff GG stated that they would perform hand hygiene before entering the kitchen and stated, of course, that's [that is] mandatory. When asked if they would perform hand hygiene between dirty to clean task, Staff GG, stated, of course. Staff GG stated that the whole dishwashing area is dirty. When asked if the clean dishes would be considered dirty, Staff GG stated, no. Staff GG further stated that they should have performed hand hygiene when they were done cleaning the metal pan, when they went to put the clean dishes away, and after they took a scrub in the container with used utensils and food debris. STAFF HHObservation on 02/27/2026 at 9:14 AM, showed Staff HH, Cook, was in the preparation station preparing meatloaf and was working on top of a cutting board. Staff HH were touching raw meat with their gloves and then took a Grill & Griddle Cooking Spray that was on the table and sprayed a metal pan. Staff HH took the raw meat from a large tray and placed it onto a smaller metal tray. Staff HH removed their gloves and applied new gloves without performing hand hygiene. Staff HH applied mittens and took a tray out of the oven and placed it on top of the oven. Staff HH then placed it into a small metal pan, covered it with foil and placed it in the oven under the stove. Staff HH removed their gloves and applied new gloves without performing hand hygiene. Staff HH went back to the preparation station and covered a container of raw meat with foil. At 9:21 AM, Staff HH placed all the raw meat in a pan, removed their gloves (did not perform hand hygiene), and covered the pan with foil. Staff HH wore mittens and opened the top oven and placed the pan inside. Staff GG did not perform hand hygiene between glove use and touched the cooking spray with soiled gloves.Further observations on 02/27/2026 at 9:42 AM showed Staff GG pureeing food items in the preparation area with a cutting board on top of a white towel with raw meat drippings on the far left of the table. Staff GG placed trays on top of the cutting board as they mixed and covered the trays with foil. When they were done, they placed the trays in the oven. Staff GG cleaned the area they used to puree and left the area with the cutting board. Staff GG then took a metal container and sprayed the container with the Grill & Griddle Cooking Spray with bare hands, placed frozen vegetables in the tray and placed it on top of the oven. The Grill & Griddle Cooking Spray had red remnants from the raw meat on the bottle.In an interview and joint observation on 02/27/2026 at 10:05 AM, Staff GG stated that they would perform hand hygiene every time they changed their gloves/between glove use, when they entered the kitchen, and when they did a different task. Staff GG stated that they would clean the preparation area every time they were done, and when they get a chance, and that they cleaned it right away. Staff GG stated that they performed hand hygiene when they went out the kitchen and comes back inside, but when they were preparing food, they just change their gloves [did not perform hand hygiene between glove use]. A joint observation of the preparation station showed a cutting board on top of a white towel that had raw meat drippings. Staff GG stated that they used it to cut onions and that they would put it away. Staff GG touched the cooking spray that had remnants of raw meat with their bare hands, and they did not sanitize their preparation station after use.In an interview on 02/27/2026 at 1:58 PM, Staff C stated that they expected staff to perform hand hygiene before their shift, when they leave the kitchen, return to the kitchen, between glove use and from dirty to clean task. Staff C stated that Staff GG should have performed hand hygiene and that Staff HH should have performed hand hygiene between glove use, she needs to be washing her hands. Staff C further stated that Staff HH should not have handled the cooking spray with gloves with raw meat. Staff C further stated that they needed to get rid of the raw meat, clean the area and perform hand hygiene.In an interview on 03/03/2026 at 10:20 AM, Staff F, Infection Control, stated that they (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expected kitchen staff to perform hand hygiene before they started their shift, before handling food, before entering the kitchen, going from dirty to clean task and between glove use. Staff F stated that Staff GG should have performed hand hygiene and that Staff HH should have performed hand hygiene between gloves. Staff F further stated that Staff HH should not have touched the cooking spray with their gloves that they had used with raw meat.In an interview on 03/04/2026 at 11:44 AM, Staff A, Executive Director, stated that they expected food items to be stored and labeled correctly and that staff would follow proper hand hygiene practices. In a follow up interview at 1:41 PM, Staff A stated that if food items were past the use by date, they would expect staff to throw it out. Staff A further stated that they would expect staff to follow food safety procedures. Reference: (WAC) 388-97-1100 (3).

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure an effective pest control system was in place for 1 of 1 kitchen and 1 of 29 residents (Resident 140), reviewed for pest control. This failure placed the residents at risk for unsafe living conditions, emotional distress, and a diminished quality of life.Findings included . Review of the facility's policy titled, Pest Control, revised in May 2008, showed, Our facility shall maintain an effective pest control program. The policy further showed, This facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. KITCHENObservation on 02/23/2026 at 8:58 AM, showed two small black flies flying around the ceiling of the dish washing area and by the back entrance door. Further observation showed 50 small black flies that were stationary on the ceiling, wall and cabinet doors by the back entrance door. Observation on 02/24/2026 at 3:34 PM, showed one small black fly flying around by the back entrance door of the kitchen. Further observation showed 75 small black flies that were stationary on the ceiling, wall and cabinet doors by the back entrance door. In an interview and joint observation on 02/24/2026 at 3:37 PM, Staff Q, Dietary Aide, stated that they would put a request on TELS (a tool used to create, track and complete works orders) if they saw flies or rodents in the kitchen and would let Staff C, Dietary Manager, know. Staff Q stated that Staff C knew about the bugs flying around and that they were trying to get it taken care of. A joint observation showed small black flies on the ceiling. Staff Q stated that they were fruit flies and that they're [they are] too much and they're everywhere. Staff R, Cook, stated that they had this problem for at least two months, maybe a little less and that suddenly they're everywhere. In an interview on 02/27/2026 at 2:02 PM, Staff C stated that if there were a pest problem, staff would need to let them know and that they would let maintenance know. Staff C stated that they were aware of the flies and that they've [they have-maintenance and pest control staff] been putting stuff, some kind of chemical down the drain and spraying. Staff C further stated that it had been a couple weeks and that last week they started to congregate more by the back entrance. In an interview on 03/03/2026 at 10:40 AM, Staff D, Maintenance Director, stated that their expectation was for staff to put in a TELS request if they observed flies or rodents and that they would call their exterminator. When asked if they were aware of the flies in the kitchen, Staff D stated that Staff C had put in a work order last Wednesday [02/25/2026]. Staff D stated that once they got that request, they called their exterminator and that they came the next day. Staff D further stated they could not remember if it was Tuesday or Wednesday but that it was last week and that they had not received a maintenance work order prior to that. Review of the facility's maintenance log from September 2025 through February 2026 showed a work order for so many gnats (small flying insects) in the kitchen submitted on 02/24/2026 at 5:22 AM and was requested by Staff C. Further review did not show documentation that a work order was submitted prior to 02/24/2026. In an interview on 03/04/2026 at 11:44 AM, Staff A, Executive Director, stated that they expected staff to clean so that they don't [do not] attract flies and that if they noticed the flies, they should let them or maintenance know. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 140Observation and interview on 02/23/2026 at 12:33 PM, showed six fruit flies on Resident 140's window curtain, one fruit fly on their bedside table, and one fruit fly on top of a sandwich bag. Resident 140 stated that the bugs bothered them a lot and that they had informed a nurse aide and a housekeeper two weeks ago and no action had been taken. A joint observation and interview on 02/25/2026 at 12:48 PM with Staff E, Housekeeping Director, showed fruit flies on Resident 140's window curtain and bedside table. Resident 140 stated the situation was grossing them out. Staff E was asked if a resident's room should have fruit flies and they stated, no. A joint observation and interview on 02/25/2026 at 12:52 PM with Staff F, Infection Preventionist, showed four fruit flies on Resident 140's window curtain and one fruit fly on top of a sandwich. Staff F was asked if the resident's room should have fruit flies and they stated, no. In an interview on 03/03/2026 at 11:22 AM, Staff B, Director of Nursing, stated that bugs should not be in resident's room. Reference: (WAC) 388-97-3360(1)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain resident dignity for 3 of 29 residents (Resident 106, 121 & 60), reviewed for dignity. This failure placed the residents at risk for diminished self-worth, potential embarrassment, and diminished quality of life.Findings included. Review of the facility's policy titled, Privacy, revised in February 2021, showed the residents are to be always treated with dignity and respect. Staff are expected to knock and request permission before entering residents' rooms and explain procedures before they are performed. Review of the facility's policy titled, Dignity, revised in February 2021, showed, When assisting with care, residents are supported in exercising their rights. For example, resident are .provided with a dignified dining experience. RESIDENT 106Observations on 02/27/2026 at 9:13 AM, at 9:19 AM, and at 9:23 AM, showed Staff KK, Licensed Practical Nurse, walked into Resident 106's room shared with one other resident without knocking at the resident's door, introducing themselves, or stating their intentions. In an interview on 02/27/2026 at 9:27 AM, Staff KK stated that it was expected that they knock at the door, introduce themselves, and tell the residents who they were and what they were going to do. Staff KK stated that they normally knock most of the time and could not remember if they knocked during these specific instances. In an interview on 03/03/2026 at 10:47 AM, Staff G, Resident Care Manager (RCM), stated that they expected staff to sanitize their hands, knock at the door, introduce themselves, and let the residents know what they were going to do. In an interview on 03/03/2026 11:23 AM, Staff B, Director of Nursing, stated that all staff should knock at the door, announce their name, use hand sanitizer, and tell the resident what they were going to do. RESIDENT 121Review of the admission MDS, dated [DATE], showed that Resident 121 was moderate cognitively impaired and was dependent (helper does all the effort) for personal hygiene. Review of Resident 121's comprehensive care plan, printed on 02/25/2026, showed no documentation of Resident 121's preference for facial hair. Observations on 02/23/2026 at 10:29 AM, on 02/24/2026 at 10:42 AM, on 02/25/2026 at 10:56 AM showed Resident 121 with many long whiskers on their chin. In an interview and joint observation on 02/26/2026 at 1:12 PM, Staff BB, Certified Nursing Assistant (CNA), stated that if they noticed that a female resident had facial hair they would ask the resident if they wanted them to shave it. Staff BB stated that if the resident was unable to communicate, they would help them shave. Staff BB stated that Resident 121 needed assistance with personal hygiene. A joint observation showed Resident 121 with many long whiskers on their chin. Staff BB stated, she has whiskers and that they would not expect that on a female resident. Staff BB stated, it should be trimmed and we can do [it] for her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/03/2026 at 9:05 AM, Staff I, RCM, stated that the top priority was providing dignity to residents, and they would not expect a female resident to have facial hair unless they refused to have it shaved. Staff I further stated that they would not expect Resident 121 to have facial hair and that it was a dignity issue. In an interview and joint record review on 03/04/2026 at 8:18 AM, Staff B stated that they would not expect facial hair on women residents unless it was their preference, unless it was documented that they want it. A joint record review of Resident 121's comprehensive care plan showed no documentation that Resident 121 wanted facial hair. Staff B stated there was nothing about [Resident 121's] preference for facial hair. RESIDENT 60 Observation on 02/25/2026 at 12:50 PM, showed Staff M, CNA, standing on the left side of Resident 20's bed and was not eye level as they assisted them to eat their lunch. In an interview on 02/25/2026 at 12:58 PM, Staff M stated that Resident 60 was dependent with eating and that they encouraged/cued them to eat. Staff M stated that they knew that they should be sitting down while assisting Resident 60 to eat. Staff M stated that with Resident 60 you have to stand because there are other things around [in their room] and that they did not find it comfortable to sit down, but that I know I need to sit down. In an interview on 03/03/2026 at 9:10 AM, Staff L, Registered Nurse, stated that when CNAs were assisting residents who need one-to-one assistance with eating and that the expectation was for staff to sit down and be eye to eye when assisting the residents. In an interview on 03/03/2026 at 3:00 PM, Staff I stated that their expectation when assisting residents with their meals was for CNAs to sit down next to the resident, communicate with the resident, observe how the resident swallowed and to alternate between a bite and a drink. In an interview on 03/04/2026 at 11:11 AM, Staff B stated that they expected CNAs to sit down when assisting residents to eat their meals. Reference: (WAC) 388-97-0180 (2).

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure privacy and confidentiality of resident's medical information were maintained for 1 of 3 Unit Resident List/Document (Midwest [MW] 2 Unit), reviewed for confidentiality of records. This failure placed the residents at risk of having their medical and personal information compromised and a diminished quality of life.Findings included.Review of the facility's policy titled, Confidentiality of information and personal privacy, revised October 2017, showed, The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. The policy further stated, access to resident personal and medical records will be limited to authorized staff and business associates.Observation on 02/27/2026 at 9:18 AM showed a paper document titled MW2 UNIT on top of the medication cart. The list contained residents' names and nursing notes regarding the medication pass (the process of preparing and administering medications) visible to anyone in the hallway.A joint observation and interview on 02/27/2026 at 9:24 AM with Staff KK, Licensed Practical Nurse (LPN), showed the MW2 Unit contained residents' Personal Health Information (PHI) and was placed on top of the medication cart, visible to people walking in the MW hallway. Staff KK stated that people walking in the hallway could see the PHI and stated the document should not have been left visible.In an interview on 03/03/2026 at 10:36 AM, Staff G, Resident Care Manager, stated that PHI should be kept private. Staff G further stated that if staff utilized a list, they should ensure the paper was flipped over to ensure information was not visible and placed in a shredder box at the end of the shift.In an interview on 03/03/2026 at 11:18 AM, Staff B, Director of Nursing, stated that resident documents should be kept in compliance with the Health Insurance Portability and Accountability Act (law protecting patient [resident] privacy by securing health data). Staff B further stated that documents should be flipped over, have a cover, or be appropriately stored to prevent exposure of resident information.Reference: (WAC) 388-97- 0360 (1)(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 initiate and resolve a grievance for 1 of 2 residents (Resident 52), reviewed for grievances. The failure to initiate, investigate, and resolve grievances for missing personal item placed the resident at risk for feelings of frustration, unmet care needs, and a diminished quality of life.Findings included .Review of the facility's policy titled, Grievance, dated in March 2025, showed, To assure that concerns are quickly and thoroughly evaluated and acted upon in order to resolve issues which affect the quality of life and care for residents in our facility. The policy further showed, When a concern is voiced to a facility employee, the resident, family, guest or fellow employee is directed to the appropriate department supervisor to evaluate and resolve the issue.Review of the quarterly Minimum Data Set (an assessment tool) dated 01/06/2026 showed that Resident 52 was readmitted to the facility on [DATE] and was cognitively intact.On 02/24/2026 at 10:52 AM, Resident 52 stated that their phone charger and documents were missing after their things were packed away when they were hospitalized . Resident 52 stated that the facility had not replaced their charger or found their documents. Resident 52 further stated that their representative spoke about it to Staff J, Social Service Director.Review of the facility's grievance log from September 2025 through February 2026 did not show that a grievance was logged for Resident 52's missing charger/documents, or that an investigation was completed.In an interview on 02/26/2026 at 11:40 AM, Staff J stated that they had grievance forms throughout the building that resident, family and staff had access to and could complete. Staff J stated that when residents or a resident's representative reported missing personal property, they would start a grievance and would investigate. Staff J stated that they were not aware of Resident 52's missing charger. Staff J stated that they had spoken to Resident 52's representative and that Resident 52's representative had spoken to Staff A, Executive Director, about a missing bag that Resident 52's representative had packed when Resident 52 was hospitalized . Staff J stated that they could not confirm what was in the bag and that the bag was probably thrown away. Staff J further stated that a grievance should have been filed for Resident 52's missing bag.In an interview on 02/27/2026 at 3:37 PM, Staff A stated that they expected a grievance form to be completed when residents or their representative reported a missing personal property and that they would expect it to be logged in the facility's grievance log. Staff A stated that Resident 52's representative informed them that they were missing a bag and that they had spoken to the housekeeper about it and that they could not find it. Staff A further stated that they should have filed a grievance, but I didn't [I did not].Reference: (WAC) 388-97-0460 (1)(2).

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure admission Minimum Data Set (MDS-an assessment tool) was completed timely for 1 of 21 residents (Resident 4), reviewed for comprehensive assessments. This failure placed the resident at risk for delayed and/or unmet care needs and a diminished quality of life.Findings included .Review of the Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide directing staff on how to accurately assess the status of residents), Version 1.20.1, revised in October 2025, showed that the admission assessment must be completed by the end of day 14, counting the date of admission to the nursing home as day 1.Review of the facility's policy titled, MDS Assessment Coordinator, revised in November 2019, showed that the A Registered Nurse (RN) shall be responsible for conducting and coordinating the development and completion of the resident assessment.The Resident Assessment Coordinator must date and sign each assessment to certify that the assessment has been completed.Review of Resident 4's admission Record printed on 02/23/2026 showed that Resident 4 was admitted to the facility on [DATE].Review of Resident 4's admission MDS dated [DATE], showed that it was completed on 08/05/2025 (12 days late).In an interview and joint record review on 03/03/2026 at 11:30 AM with Staff K, MDS Coordinator, stated that they followed the RAI manual for MDS completion. Staff K stated that an admission MDS was to be completed on day 14 of admission. A joint record review of Resident 4's admission MDS showed that it was completed on 08/05/2025. Staff K stated that the MDS was not completed timely and that it should have been completed by 07/28/2025.In an interview on 03/04/2026 at 9:08 AM, Staff B, Director of Nursing, stated that they expected Resident 4's admission MDS to have been completed timely.Reference: (WAC) 388-97-1000(1)(b)(3)(a)(5)(a).

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on interview and record review, the facility failed to complete Quarterly Minimum Data Set (MDS - an assessment tool) assessments within the regulatory timeframe for 1 of 18 residents (Resident 25), reviewed for resident assessments. This failure placed the resident at risk for delayed care planning, unidentified care needs and services, and a diminished quality of life.Findings included .Review of the Long-Term Care Facility Resident Assessment Instrument (RAI-instructional guidelines for MDS completion) 3.0 User's Manual Version 1.20.1, revised in October 2025, showed a Quarterly MDS was a non-comprehensive assessment used to track the resident's status between comprehensive assessments that ensured residents were monitored for critical indicators of a gradual change in a resident's status are monitored. The RAI further showed that the quarterly MDS completion date must be no later than 14 days after the Assessment Reference Date (ARD-look back period).Review of Resident 25's quarterly/discharge MDS with an ARD of 08/09/2025, showed that it was completed on 05/25/2025 (three days late).In an interview and joint record review on 03/02/2026 at 1:12 PM, Staff K, MDS Coordinator, stated that they followed the RAI manual for MDS completion. Staff K stated that a quarterly MDS was due 14 days from the ARD. A joint record review of Resident 25's quarterly/discharge MDS with an ARD of 08/09/2025, showed it was completed on 05/25/2025. Staff C stated that it was completed late.In an interview on 03/04/2026 at 11:41 AM, Staff B, Director of Nursing, stated that they expected MDS assessments to be completed timely.Reference: (WAC) 388-97-1000 (4)(a).

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to transmit the resident Minimum Data Set (MDS-an assessment tool) to the Centers for Medicare & Medicaid Service within the required timeframe for 1 of 29 residents (Resident 14), reviewed for resident assessments. This failure placed the resident at risk for unmet care needs and diminished quality of life. Findings included .Review of the Long-Term Care Facility Resident Assessment Instrument [RAI-instructional guidelines for MDS completion] 3.0 User's Manual Version 1.20.1, revised in October 2025, showed that a discharge (non-comprehensive) MDS must be completed no later than 14 days after the Assessment Reference Date (ARD-look back period), and it must be submitted/transmitted within 14 days of the MDS completion date to the database as required.Review of Resident 14's discharge MDS with an ARD of 01/17/2025 showed that it was completed on 02/03/2025 (three days late).Review of Resident 14's discharge MDS with an ARD of 05/03/2025 showed that it was completed on 05/20/2025 (three days late).In an interview and joint record review on 03/02/2026 at 1:12 PM, Staff K, MDS Coordinator, stated that they followed the RAI manual. Staff K stated that the discharge assessment was due 14 days from the ARD. A joint record review of Resident 14's discharge MDS with an ARD of 01/17/2025 showed that it was three days late. In another joint record review of Resident 14's discharge MDS with an ARD of 05/03/20225 showed that it was three days late. Staff K stated that Resident 14's discharge MDS were late and should have been completed on time.In an interview on 03/04/2026 at 11:41 AM, Staff B, Director of Nursing, stated that they expected MDS assessments to be completed timely.Reference: (WAC) 388-97-1000(5)(a)(e)(i)(iii).

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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. Based on observation, interview, and record review, the facility failed to develop and/or implement care plans for 2 of 29 residents (Residents 7 & 121), reviewed for comprehensive care plans. The failure to develop/implement care plans for anticoagulant (medications that helps prevent blood clots) usage and Activities of Daily Living (ADL) placed the residents at risk for unmet care needs and a diminished quality of life.Findings included . Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, showed that, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. RESIDENT 7Review of Resident 7's physician orders showed an order for rivaroxaban (anticoagulant medication) 20 milligrams (mg – a unit of measurement) by mouth for deep vein thrombosis (DVT – blood clot that forms in a deep vein), started on 01/17/2026. Review of Resident 7's January 2026 and February 2026 Medication Administration Record (MAR) showed Resident 7 received rivaroxaban daily. Review of Resident 7's comprehensive care plan printed on 02/25/2026, showed no care plan for anticoagulant usage. In an interview and joint record review on 03/03/2026 at 11:30 AM, Staff G, Resident Care Manager (RCM), stated that when residents were receiving anticoagulants, they monitor them for bleeding and did labs. A joint observation of Resident 7's comprehensive care plan showed no care plan regarding anticoagulant usage. Staff G stated that there should be a care plan for anticoagulants. In an interview on 03/04/2026 at 9:08 AM, Staff B, Director of Nursing, stated that they would expect Resident 7 to have a care plan for anticoagulant. RESIDENT 121Review of the admission Minimum Data Set (an assessment tool), dated 12/26/2025, showed that Resident 121 was dependent (helper does all the effort) for personal hygiene. Review of Resident 121's ADL care plan, revised on 12/19/2025, showed that Resident 121 requires one person staff total assist with personal hygiene. It further showed to clean and trim nails on bath day and as necessary. Trimming to be done by CNA [Certified Nursing Assistant]. Observations on 02/23/2026 at 10:29 AM, on 02/24/2026 at 10:42 AM, on 02/25/2026 at 10:56 AM, and on 02/26/2026 at 11:34 AM, showed Resident 121 with long fingernails and brown material underneath the fingernails on both hands. In an interview and joint observation on 02/26/2026 at 1:12 PM, Staff BB, CNA, stated that Resident 121 needed help with ADLs and she can't [cannot] clean under her nails and could not trim their fingernails. A joint observation showed Resident 121 with long fingernails and brown material underneath the fingernails on both hands. Staff BB stated that Resident 121's fingernails need to be trimmed and looks like some food underneath the nails. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 03/03/2026, Staff I, RCM, stated that they expected staff to follow the care plan/Kardex (care guide for CNAs) for residents. A joint record review of Resident 121's ADL care plan showed the intervention to clean and trim nails on bath day and as necessary. Trimming to be done by CNA. Staff I stated that they expected CNAs to follow the care plan/Kardex for Resident 121 and clean and trim their fingernails. In an interview on 03/04/2026 at 8:18 AM, Staff B stated that they expected staff to follow care plans and if it says to provide assistance with personal hygiene including nail care, then staff should be providing that. Reference: (WAC) 388-97-1020(1)(2)(a)(b) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to facilitate quarterly care conferences or care plan meetings for 1 of 1 resident (Resident 25), reviewed for care planning. In addition, the facility failed to ensure care plans were revised timely and accurately to reflect shower preferences for 1 of 5 residents (Resident 6), reviewed for Activities of Daily Living. These failures placed the residents at risk for unidentified and unmet care needs, and a diminished quality of life.Findings included .Review of the facility's policy titled, Care Planning-Interdisciplinary Team, revised in March 2022, showed, The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. The policy showed, Care plan meetings are scheduled at the best time of the day for the resident and family when possible. The policy further showed, If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record.Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, showed, The resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences. The policy showed, If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. The policy further showed, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. RESIDENT 25Review of Resident 25's quarterly Minimum Data Set (MDS-an assessment tool) dated 02/05/2026, showed that they were admitted to the facility on [DATE] and that they were cognitively intact. On 02/23/2026 at 3:26 PM, Resident 25 stated that they did not remember attending a care conference meeting. Review of Resident 25's Electronic Health Record (MDS assessment, progress notes, evaluations, miscellaneous files) showed that a quarterly MDS was completed on 02/08/2025, 08/09/2025, 11/09/2025 and 02/05/2026. Further review showed no documentation that Resident 25 attended or was offered a care conference meeting and showed no documentation that Resident 25 declined to attend their care conference meeting. In an interview and joint record review on 02/26/2026 at 2:54 PM, Staff J, Social Service Director, stated that care plan meetings/care conference started on admission. When a resident was admitted to the facility, they meet with them within 48 hours, establish a baseline care plan and schedule their first care conference within the week. Staff J stated that care conference was offered quarterly and as needed, and that they would discuss the resident's plan of care. Staff J stated that they would document whether they had a care conference or if they declined under Social Services note in the progress note. A joint record review of Resident 25's progress notes showed no documentation that a care conference was offered or that Resident 25 had declined to attend. Staff J stated that Staff N, Social Service Assistant, did not document that they offered a care conference and whether Resident 25 accepted or not. Staff J further stated that Staff N should have offered Resident 25 a care conference meeting and that they should have documented whether they accepted or not. In an interview on 02/27/2026 at 3:41 PM, Staff A, Executive Director, stated they expected Social Services to invite residents to care conference quarterly and annually. Staff A stated that they would document that a care conference was offered and/or if they declined. Staff A further stated that they expected Resident 25 to have been offered a care conference and documentation if they or their representative declined to attend. RESIDENT 6On 02/26/2026 at 9:35 AM, Resident 6 stated that they preferred their shower on day shift and that they had told the shower aide about wanting to have two showers a week. Review of the Shower Sheet Check-Off dated 12/18/2025 and 01/15/2026, showed that Resident 6 preferred (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their shower in the mornings. Review of the Bathing/Shower task printed on 02/25/2026 showed, Shower schedule: Monday and Thursday evening and as needed.Review of Resident 6's comprehensive care plan printed on 02/25/2026, showed, BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannotbe tolerated.In an interview on 02/26/2026 at 1:27 PM, Staff O, CNA/Shower Aide, stated that they provided showers to the residents and followed a shower schedule. Staff O stated that they would try to accommodate shower preferences, that they would make sure to fit the residents in their schedule and let the Resident Care Manager (RCM) know. Staff O stated that the RCMs created the shower schedule. Staff O stated that when they first started working in the facility, the care plan matched what was on the shower schedule. Staff O stated that Resident 6 preferred their shower in the morning and that they were scheduled for an evening shower. In an interview on 02/26/2026 at 3:10 PM, Staff P, CNA/Shower Aide, stated that Resident 6 had told them that they wanted a shower on day shift and that they spoke to Staff O if they could give Resident 6 a shower in the morning. Staff P stated that they did not notify the RCM and that they had written it on the Shower Sheet Check-Off that they preferred morning showers. In an interview and joint record review on 03/04/2026 at 9:32 AM, Staff I, RCM, stated that residents' received two showers a week and as needed. Staff I stated that Staff F, Infection Control, initially did the shower schedule and that the RCMs can change it based on residents' request. Staff I stated that shower preferences would be care planned. A joint record review of the shower schedule showed that Resident 6 was scheduled for evening showers. A joint record review of the Bathing/Shower task showed, Shower Schedule: Monday and Thursday evening and as needed. A joint record review of Resident 6's comprehensive care plan showed no documentation that reflected Resident 6's shower preference. Staff I stated that Resident 6's care plan did not have documentation that they preferred morning showers and that their care plan should have been revised. In an interview on 03/04/2026 at 11:21 AM, Staff B, Director of Nursing, stated that shower preferences should be honored and that Resident 6's care plan should have been revised to reflect their shower preference. Reference: (WAC) 388-97-1020 (2)(e)(f)(5)(b).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary assistance with Activities of Daily Living (ADL) for 2 of 6 residents (Residents 121 & 13), reviewed for ADLs. The failure to provide assistance with personal and oral hygiene placed the residents at risk for unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy titled, Activities of Daily Living (ADLs), Supporting, revised in March 2018, showed Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. RESIDENT 121Review of the admission Minimum Data Set (MDS-an assessment tool), dated 12/26/2025, showed that Resident 121 was dependent (helper does all the effort) for personal hygiene. Review of Resident 121's ADL care plan, revised on 12/19/2025, showed that Resident 121 requires one person staff total assist with personal hygiene. It further showed to clean and trim nails on bath day and as necessary. Trimming to be done by CNA [Certified Nursing Assistant]. Observations on 02/23/2026 at 10:29 AM, on 02/24/2026 at 10:42 AM, and on 02/25/2026 at 10:56 AM, showed Resident 121 with long fingernails and brown material underneath the fingernails on both hands. Additional observation on 02/25/2026 at 11:44 AM, showed Resident 121 with long fingernails and brown material underneath the fingernails on both hands. It further showed that a hospice shower aide had just finished giving Resident 121 a bed bath. In an interview and joint observation on 02/26/2026 at 1:12 PM, Staff BB, CNA, stated that Resident 121 needed help with ADLs and she can't [cannot] clean under her nails and could not trim their fingernails. A joint observation showed Resident 121 with long fingernails and brown material underneath the fingernails on both hands. Staff BB stated that Resident 121's fingernails need to be trimmed and looks like some food underneath the nails. Staff BB further stated that Resident 121's nails should have been cleaned and trimmed during the bed bath from the hospice shower aide yesterday [02/25/2026]. In an interview on 03/03/2026 at 9:05 AM, Staff I, Resident Care Manager (RCM), stated that CNAs were responsible for trimming/cleaning fingernails, unless the resident had diabetes (a disease where sugar in the blood is too high). Staff I further stated that Resident 121 needed help with ADLs including nail care and would expect CNAs to provide that for them. In an interview on 03/04/2026 at 8:18 AM, Staff B, Director of Nursing, stated that they expected staff to provide nail care for dependent residents. RESIDENT 13Review of Resident 13's quarterly MDS dated [DATE], showed Resident 13 needed substantial/maximal assistance (helper does more than half the effort) for nail care and oral care. Review of the care plan showed Resident 13 required assistance with oral care every morning, after meals, at bedtime, and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 02/26/2026 at 11:47 AM, showed Resident 13 had long nails with brown material underneath the nails on both hands. Resident 13 stated their nails were too long and dirty and they would like staff to trim them. Resident 13 stated they had asked staff for help, but staff were busy. Observation and interview on 02/26/2026 at 11:52 AM, showed Resident 13's teeth had yellow-brown crust deposits near the gum line. Resident 13 stated they had not brushed their teeth for nearly a week. Resident 13 further stated that staff were supposed to brush their teeth twice a day, in the morning and evening, but they had not received requested help. A joint observation and interview on 02/26/2026 at 11:55 AM with Staff LL, CNA, showed Resident 13's fingernails on both hands were long and unclean with brown material underneath. Staff LL stated that nail care was done during shower days, and aides would perform it unless the resident had diabetes, in which a nurse would perform the task. During a joint interview and observation on 02/26/2026 at 11:56 AM, Staff MM, Registered Nurse, stated Resident 13's fingernails were long and dirty, and the teeth had yellow food deposits and needed cleaning. Staff MM further stated that aides were responsible for nail care and oral hygiene, but the nurse would trim nails if the resident had diabetes. In an interview on 03/03/2026 at 10:48 AM, Staff G, RCM stated that Resident 13's fingernails should have been kept short and clean. Staff G stated that aides were responsible for providing nail care and oral hygiene and residents needing help should be offered assistance. In an interview on 03/03/2026 at 11:24 AM, Staff B stated that nursing staff and aides help with ADLs. Staff B stated if the resident had diabetes, the nurse would help with clipping nails and if not, the aides were responsible including providing help with oral care in the morning, night, and as needed. Reference: (WAC) 388-97-1060 (2)(c) .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently monitor and manage constipation (passing fewer than three bowel movements a week or having a difficult time passing bowel movement) in accordance with professional standards of practice for 1 of 5 residents (Residents 52), reviewed for quality of care. In addition, the facility failed to ensure consistent communication and collaboration of care occurred between the facility and hospice staff for 1 of 2 residents (Resident 121), reviewed for hospice services. These failures placed the residents at risk for unmet care needs, related complications, not receiving necessary comfort care, services and a diminished quality of life.Findings included . Review of the facility's policy titled, Bowel (Lower Gastrointestinal Tract [the final part of the digestive system, consisting of the large intestine and anus, and is responsible for water absorption and waste elimination]) Disorders- Clinical Protocol, revised in September 2017, showed, As part of the initial assessment, the staff and physician will help identify individuals with previously identified lower gastrointestinal tract conditions and symptoms. The policy showed, Examples of lower gastrointestinal tract conditions and symptoms include:.Alteration in bowel movements. The policy further showed, The staff and physician will monitor the individual's response to interventions and overall progress; for example, overall degree of comfort or distress, frequency and consistency of bowel movements, and the frequency, severity and duration of abdominal pain, etc [et cetera]. BOWEL MANAGEMENTRESIDENT 52Review of a face sheet printed on 02/24/2026 showed that Resident 52 readmitted to the facility on [DATE] with diagnoses that included constipation and unspecified intestinal obstruction (blockage that prevents food or liquid from passing through the stomach to the anus). On 02/24/2026 at 10:57 AM, Resident 52 stated that they had a bowel obstruction in January 2026 and that staff were not tracking their bowel movement. Resident 52 stated that it had been four days since they had a bowel movement and that they had told the nurse about it. Review of Resident 52's physician's orders printed on 02/24/2026 showed the following orders:-Polyethylene Glycol Powder (medication for constipation) give 17 grams (a unit of measurement) by mouth every 24 hours as needed (PRN).-Milk of Magnesia (MOM) Suspension (medication for constipation) Give 30 milliliters (a unit of measurement) by mouth PRN. Give at bedtime or at the resident's preferred time if no bowel movement on the third day.-Bisacodyl (medication for constipation) 10 milligrams (a unit of measurement) insert one suppository (medication that you insert inside your body that melts at body temperature) rectally [anus] QDPRN [everyday as needed]. Give if MOM is ineffective.-Sodium Phosphates Rectal Enema (medication for constipation) insert one application rectally daily PRN. Review of the Documentation Survey Report from August 2025 through February 2026 showed that Resident 52 did not have Bowel Movements for the following days:-August 2025-08/24/2025 through 08/27/2025 (four days)-September 2025-09/01/2025 through 09/04/2025 (four days) and 09/06/2025 through 09/11/2025 (six days).-October 2025-10/01/2025 through 10/08/2025 (eight days).-December 2025-12/07/2025 through 12/13/2025 (seven days). Review of Resident 52's Medication Administration Record (MAR) from August 2025 through February 2026 showed the following:-August 2025- Resident 52 received PRN bowel medications on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/28/2025 (day five of no bowel movement).-September 2025- Resident 52 did not receive PRN bowel medications from 09/01/2025 through 09/04/2025. Resident 52 received PRN bowel medications on 09/08/2025 (day three of no bowel movement), on 09/10/2025 (day five of no bowel movement) and did not receive any follow up PRN bowel medications when the medication was ineffective.-October 2025- Resident 52 received PRN bowel medications on 10/09/2025 (day nine of no bowel movement).-December 2025- Resident 52 did not receive any PRN bowel medications from 12/07/20206 through 12/13/2026. In an interview on 03/02/2026 at 12:01 PM, Staff X, Certified Nursing Assistant, stated that they monitored the resident's bowel movements and that if they did not have a bowel movement, they would report it to the nurse and chart it in their Electronic Health Record (EHR). In an interview on 03/03/2026 at 9:04 AM, Staff L, Registered Nurse, stated that their EHR system would alert them if the resident did not have a bowel movement and they would assess the resident and give the resident bowel medications as needed. Staff L stated that if the resident had not had a bowel movement for three days after we do our interventions. Report it to the provider. Staff L stated that if the resident continued to have no bowel movement after receiving prn bowel medications, they would report it to the provider and go from there. Staff L further stated that Resident 52 had constipation and that they took Miralax and Lactulose [medications to treat constipation]. In an interview and joint record review on 03/03/2026 at 3:12 PM, Staff I, Resident Care Manager, stated that they had a bowel protocol and that all the residents had PRN bowel medications in place. Staff I stated that it was important to monitor the resident's bowel movement because residents were at risk for dehydration (when the body loses more fluids than it takes in) and bowel obstruction. Staff I stated that if a resident did not have a bowel movement for three days, it would alert the nurses, and the nurses were responsible to follow that alert, and provide PRN bowel medications as ordered. A joint record review of the Documentation Survey Report from August 2025 through February 2026 showed that Resident 52 did not have a Bowel Movements from 08/24/2025 through 08/27/2025 (4 days), on 09/01/2025 through 09/04/2025 (four days), on 09/06/2025 through 09/11/2025 (six days), on 10/01/2025 through 10/08/2025 (eight days), on 12/07/20206 through 12/13/2026 (seven days). A joint record review of Resident 52's MAR from August 2025 through February 2026 showed that they received PRN bowel medications on 08/28/2025 (day five of no bowel movement), on 09/08/2025 and 09/10/2025 (day three and day five of no bowel movement with no follow up PRN bowel medications given when the medication was ineffective), and on 10/09/2025 (day nine of no bowel movement). Further review of the MAR showed that Resident 52 did not receive PRN bowel medications from 09/01/2025 through 09/04/2025 and 12/07/20206 through 12/13/2026. Staff I stated that nursing staff should have caught Resident 52's bowel concerns and addressed it. Staff I further stated that they should have followed their bowel protocol. In an interview on 03/04/2026 at 11:23 AM, Staff B stated that they expected staff to follow their bowel protocol and expected them to implement it. HOSPICE CARERESIDENT 121Review of the facility's policy titled, Hospice Program, revised in July 2017, showed that Hospice services are available to residents at the end of life. It further showed Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility.in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. Review of the admission Minimum Data Set (an assessment tool) dated 12/26/2025, showed that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 121 was receiving hospice services. Review of Resident 121's comprehensive care plan printed on 02/25/2026, showed an intervention to incorporate Hospice Plan of Care into resident's care plan to provide end of life care. It further showed no resident specific interventions designating hospice's role and collaboration with the facility regarding Resident 121's care. Review of Resident 121's EHR showed no documentation of a hospice plan of care from the hospice provider or hospice visit notes. Observation on 02/25/2026 at 11:07 AM, showed a hospice shower aide at the facility to give Resident 121 a bed bath. The hospice shower aide stated that they came to give Resident 121 a bed bath twice a week. In an interview on 02/26/2026 at 1:06 PM, Staff FF, Certified Nursing Assistant (CNA), stated that they knew which residents were on hospice by asking the nurses or looking at the Kardex (care guide for CNAs). When asked how they knew what services hospice provided and what the facility provided, Staff FF stated they communicated with the facility's shower aide, and they would tell them if a resident was on hospice and if they would be getting a shower/bed bath from the hospice shower aide. In an interview and joint record review on 03/03/2026 at 9:05 AM, Staff I stated that if [hospice] sends a plan of care, we implement it in our care plan. A joint record review of Resident 121's comprehensive care plan showed no documentation of what services hospice would provide and what services the facility would provide. Staff I stated that there was nothing about who was providing what services, including when the hospice shower aides would provide services. Staff I stated that it should be in Resident 121's EHR. A joint record review of Resident 121's EHR showed no hospice plan of care or hospice visit notes. Staff I stated that I don't [do not] see anything. I would expect them to be uploaded into Resident 121's EHR. In an interview and joint record review on 03/03/2026 at 9:57 AM, Staff Y, Medical Records Director, stated that when they received faxes from hospice services they would upload documents into residents' medical records. Staff Y stated that there were no documents that still needed to be uploaded. A joint record review of Resident 121's EHR showed no documentation of a hospice plan of care from the hospice provider or hospice visit notes. In an interview and joint record review on 03/04/2026 at 8:18 AM, Staff B stated that they expected there to be coordination between the facility and hospice services, including a coordinated plan of care. Staff B stated that they expected hospice visit notes to be available to staff and would expect the notes to be uploaded in the residents' hospital record. Staff B stated that when hospice visited a resident they would expect a note after each visit and that the facility should contact hospice to get the notes if they had not already been sent. A joint review of Resident 121's EHR showed that Resident 121 was on hospice services. It showed no documentation of a hospice plan of care from the hospice provider or hospice visit notes. Staff B stated that there should have been documentation from hospice in Resident 121's EHR. Reference: (WAC) 388-97- 1060 (1) .

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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 ensure ongoing assessment, monitoring, and documentation of an identified pressure ulcer/injury (damage to the skin and underlying tissue, usually over a bony area, caused by prolonged pressure) were conducted for 1 of 4 residents (Resident 11), reviewed for pressure ulcer/injury. The failure to routinely assess and monitor pressure ulcer/injurie's characteristics and response to treatment placed the resident at risk for unidentified wound decline, delays in treatment, prolonged wound healing, and diminished quality of life.Findings included .Review of the facility's policy titled, Prevention of Pressure Injuries, revised in April 2020, stated that the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors.Monitoring, evaluate, report and document potential changes in the skin. Review the interventions and strategies for effectiveness and on an ongoing basis.Review of Resident 11's comprehensive care plan printed on 02/25/2026 showed that a registered nurse would assess, record, monitor wound healing weekly and as needed. The care plan further showed that a registered nurse would assess and document status of wound perimeter, wound bed (the surface, base, or open area of a wound) and healing progress and report improvement and declines to the physician.Review of Resident 11's physician orders printed on 02/27/2026 showed an active order for Resident 11's right heel stage two (patrial-thickness skin injuries that involve the epidermis [top layer of skin] and superficial dermis [second layer of skin], presenting as shallow/open) wound.Review of Resident 11's Total body skin evaluation weekly assessment, dated 12/21/2025, printed on 03/04/2026, showed that Resident 11 had a right heel pressure wound that measuring 3.5 centimeters (cm- a unit of measurement) by 4 cm. A review of the Total body skin evaluation weekly assessment, dated 12/28/2025 showed right heel pressure wound dressing changed. Further review of the Total body skin evaluation weekly assessment, dated 01/04/2026, 01/15/2026, 01/18/2026, 01/25/2026, 02/08/2026, 02/15/2026, and 02/22/2026 showed no ongoing assessment, monitoring, or documentation of Resident 11's right heel pressure ulcer/injury.Review of Resident 11's progress notes from December 2025 through February 2026 showed no ongoing assessment, monitoring, or documentation of Resident 11's right heel pressure ulcer/injury. Further review showed Resident 11 was seen and followed by the wound provider (United Wound Healing) for a right lower leg wound and not the right heel pressure ulcer/injury.Observations on 02/25/2026 at 8:00 AM, 02/27/2026 at 11:34 AM, and 03/02/2026 at 10:19 AM showed Resident 11's right heel pressure ulcer/injury dressing was changed and was clean, dry, and intact.In an interview and joint record review on 03/03/2026 at 2:07 PM with Staff G, Resident Care Manager, stated that they would monitor a resident's wound progress weekly as a facility and when the wound care provider comes to the facility. Staff G stated that they would document what they saw and describe the wound in the progress notes and/or weekly skin assessment. A joint record review of Resident 11's progress notes and total body skin evaluation weekly assessments from December 2025 through February 2026 showed no ongoing assessment, monitoring, or documentation of right heel pressure ulcer/injury. Staff G stated they could not find documentation for the right heel pressure ulcer/injury after the initial assessment on 12/21/2025 and that there should have been.In an interview on 03/04/2026 at 9:08 AM, Staff B, Director of Nursing, stated that they expected there to have been ongoing assessments, monitoring, and/or documentation of Resident 11's right heel pressure ulcer/injury.Reference: (WAC) 388-97-1060(3)(b).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure smoking materials were properly stored for 1 of 4 residents (Resident 77), reviewed for accident hazards. This failure placed the resident at risk for injury and a diminished quality of life.Findings included.Review of the facility's policy titled, No Smoking Policy, signed by Resident 77 on 01/16/2026, showed that Residents who smoke can leave the facility and be off the property to smoke. It further showed that Individuals [residents] retaining their own smoking materials must keep items in a locked cabinet when not in use, with the key in possession of the resident.Review of the Smoking and Safety assessment dated [DATE], showed that Resident 77 used cigarettes.Observation on 02/23/2026 at 2:17 PM showed a lighter and pipe on Resident 77's bedside table. Resident 77 stated that they smoked and that they were allowed to have their smoking materials with them.In an interview and joint observation on 02/23/2026 at 2:42 PM, Staff EE, Certified Nursing Assistant, stated that they were unsure if residents could have their smoking materials with them. A joint observation showed Resident 77 had a lighter and a pipe on their bedside table. Staff EE stated that Resident 77 had a lighter and a pipe on their bedside table and stated I don't [do not] know if Resident 77 should have them. Resident 77 stated yes, they are mine. It's [it is] a lighter and a tobacco pipe.In an interview on 02/23/2026 at 2:48 PM, Staff I, Resident Care Manager (RCM), stated that residents could keep their smoking materials and that they would give them a locked box to keep in their room.In an interview on 02/23/2026 at 2:53 PM, Staff H, RCM, stated that it was a no smoking facility. Staff H stated that some residents smoked and could do so off the facility property. Staff H stated that residents' smoking materials had to be in locked box. Staff H further stated that they did not expect smoking materials to be on the bedside table and that it was a safety issue.In a joint observation and interview on 02/23/2026 at 3:10 PM with Staff I, showed no locked box in Resident 77's room. Resident 77 stated that they did not have a locked box. Staff I stated I'll [I will] get you a locked box. Staff I further stated, I'm [I am] going to talk to maintenance to give him a locked box.In an interview on 03/04/2026 at 8:18 AM, Staff B, Director of Nursing, stated that they provide a secure box in the room for residents who have smoking materials. Staff B further stated that smoking materials should be secured.In an interview on 03/04/2026 at 9:44 AM, Staff A, Executive Director, stated that there were residents that smoked at the facility. Staff A stated that residents could have their smoking materials with them if they've [they have] been assessed and that they would be offered a lock box/drawer. Staff A further stated that they expected a resident's smoking materials to be in a locked box/drawer.Reference: (WAC) 388-97-1060(3)(g).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly store respiratory mask when not in use and ensure timely changing of oxygen (O2) tubing for 1 of 3 residents (Resident 27), reviewed for respiratory care. This failure placed the resident at risk of respiratory infection, related complications, and a diminished quality of life.Findings included.Review of the facility's policy, Oxygen Administration, revised in October 2010, showed, Oxygen therapy is administered by way of oxygen mask, nasal cannula (a small flexible tube used to deliver supplemental oxygen through the nose), and/or nasal catheter. The policy further showed that staff would check the tubing connection to the oxygen cylinder and ensure it is adjusted to the flow rate as prescribed.Review of a face sheet printed on 02/23/2026 showed Resident 27 was admitted to the facility on [DATE] with diagnoses that included Sleep Apnea (a disorder where breathing repeatedly stops and starts during sleep) and acute respiratory failure with hypoxia (a condition characterized by low levels of O2 in the blood).Review of Resident 27's February 2026 Medication Administration Record, printed on 03/03/2026, showed an order for three liters (unit of measurement) of O2 continuously for shortness of breath and use of Bilevel Positive Airway Pressure (BIPAP-a device that helps people with breathing difficulties) at night.Observation and interview on 02/23/2026 at 12:08 PM, showed the BIPAP machine mask lying on top of a pillow with no cover. The O2 concentrator (a device that used to generate oxygen) was set at two and one half liters. Resident 27 stated they used the BIPAP at night and during naps, and it was required to be connected to the O2 concentrator.Observations on 02/24/2026 at 9:38 AM and on 02/25/2026 at 10:40 AM, showed the BIPAP face mask lying on top of the pillow with nothing to cover or store it. The tubing connecting the BIPAP to the O2 concentrator was disconnected and was marked as changed on 02/09/2026.A joint observation and interview on 02/26/2026 at 9:20 AM with Staff MM, Registered Nurse, showed the BIPAP mask lying on the pillow with no cover, the O2 tubing was disconnected, and dated 02/09/2026. Staff MM stated the mask should be stored in a plastic bag, the O2 tubing should be connected, and changed once a week. Staff MM stated that the O2 tubing was more than two weeks old.In an interview on 03/03/2026 at 10:41 AM, Staff G, Resident Care Manager, stated nurses were responsible for ensuring O2 tubing was connected to the BIPAP, O2 tubing changed once a week, and stored in a clear plastic bag labeled with a date and initials.In an interview on 03/03/2026 at 11:18 AM, Staff B, Director of Nursing, stated the expectation was for staff to ensure tubing was dated, initialed, and changed weekly, and BIPAP masks be kept in a clear bag when not in use.Reference: (WAC) 388-97-1060(3)(j)(vi).

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were trauma survivors and diagnosed with Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by a terrifying event that was either experienced or witnessed) received culturally competent, trauma-informed care and services in accordance with professional standards of practice for 1 of 2 residents (Resident 76), reviewed for mood/behavior. This failure placed the resident at risk for unidentified triggers, re-traumatization, and a diminished quality of life.Findings included .Review of the facility's policy titled, Trauma-Informed and Culturally Competent Care, revised in August 2022, showed, Develop individualized care plans that address past trauma in collaboration with the resident and family, as appropriate. The policy further showed, Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values.Review of Resident 76's admission Minimum Data Set (an assessment tool) dated 02/06/2026, showed that they admitted to the facility on [DATE] with diagnosis that included PTSD.Review of the comprehensive care plan printed on 02/24/2026 did not show documentation that addresses Resident 76's PTSD, history of trauma and/or triggers.In an interview and joint record review on 03/03/2026 at 1:48 PM, Staff I, Resident Care Manager, stated when caring for a resident with PTSD, they care planned and monitored for any PTSD behaviors. Staff I stated that most residents would come with medications and that they would monitor for side effects and would provide interventions like reassurance and snacks. A joint record review of Resident 76's diagnoses list showed a diagnosis of PTSD. A joint record review of Resident 76's comprehensive care plan showed no care plan that addresses PTSD. Staff I stated, It's [it is] not in their care plan and that it should have been care planned.In an interview on 03/04/2026 at 10:09 AM, Staff W, Certified Nursing Assistant, stated that they looked at the care plan and the Kardex (a care guide on how to care for residents) when caring for residents. Staff W stated that they did not know that Resident 76 had a diagnosis of PTSD.In an interview on 03/04/2026 at 11:29 AM, Staff B, Director of Nursing, stated that they expected residents with a diagnosis of PTSD to have a care plan and full interventions in place. Staff B further stated that Resident 76 should have had a care plan in place.Reference: (WAC) 388-97-1060(3)(e).

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure the daily nurse staffing was posted for 2 of 7 days (02/28/2026 and 03/01/2026), reviewed for posted nurse staffing information. The failure to post a complete and accurate form daily placed the residents, family members, and visitors, at risk of not being fully informed of the current staffing levels.Findings included.Review of the facility's policy titled, Daily Nurse Staffing Posting, revised in June 2024, showed that the Daily Nurse Staffing is completed at the beginning of each shift to post nurse-staffing data for the licensed and unlicensed staff directly responsible for resident care in the facility. It further showed, Daily Nurse Staffing Posting will include the following .Enter the actual number and shift (including split shifts) of licensed and unlicensed nursing staff directly responsible for the care of residents for that particular day on each shift .post each shift staff number very close to the beginning of the shift in order to ensure that the posted numbers are actual staff working the shift .if any changes to the information posted are needed, they must be made as soon as possible.Observation on 03/02/2026 at 5:12 AM, showed the Daily Nursing Staffing Report was dated 02/27/2026.In an interview and joint observation on 03/02/2026 at 5:43 AM, Staff Y, Medical Records, stated that the nurse staffing posting should be filled out and posted daily. Staff Y stated that on the weekends, the nurse staffing posting would be completed on Friday and would be placed behind Friday's posting. Staff Y stated the weekend receptionist would post the current (Saturday or Sunday) posting. A joint observation at 6:12 AM showed the nurse staffing posting was dated 02/27/2026 (Friday). It further showed that there were no other postings behind the 02/27/2026 posting. Staff Y stated that there should have been and that the receptionist should have posted the current postings for Saturday and Sunday.In an interview on 03/03/2026 at 9:49 AM, Staff CC, Staffing Coordinator, stated that they were responsible for updating and posting the nurse staffing posting on the weekdays and reception was responsible on the weekends. Staff CC stated that the process for the weekend was they would prepare the nurse staff postings for Saturday and Sunday on Friday. Staff CC would place the postings for Saturday and Sunday behind the Friday posting, then the receptionist would post the daily nurse staffing posting for the correct day and any changes would be made by the weekend nurse manager or whoever gets the call [for call outs] makes the changes. When asked about the Friday 02/27/2026 posting observed on Monday 03/02/2026 at 6:12 AM, Staff CC stated that it should have been the Sunday posting. Staff CC further stated that the nurse staffing posting for Saturday and Sunday were not available to residents and/or their families.In an interview on 03/04/2026 at 8:18 AM, Staff B, Director of Nursing, stated they expected that the nurse staffing posting would be posted and updated daily. Staff B stated that on the weekend the receptionist or weekend manager would post it. Staff B further stated that the nurse staffing posting should have been posted and updated for 02/28/2026 (Saturday) and 03/01/2026 (Sunday).Reference: (WAC) 388-97-1620(2)(b)(i).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure expired medications were discarded for 1 of 3 medication carts (Midwest [MW] 1 Cart), 1 of 2 medication rooms (West Medication Room), and failed to ensure medications were properly stored and secured for 1 of 1 residents (Resident 65), reviewed for medication storage. These failures placed the residents at risk of receiving compromised medications and unsafe storage practices.Findings included. Review of the facility's policy titled, Storage of Medication, revised in November 2020, showed that the facility would store all drugs in a safe, secure, and orderly manner. Drugs used in the facility are stored in locked compartments under proper temperature, light and humidity controls, and only persons authorized to prepare and administer medications have access to locked medications. The policy further showed that discontinued, outdated, or deteriorated drugs would be returned to the dispensing pharmacy or destroyed. MW 1 MEDICATION [NAME] joint observation and interview on 02/27/2026 at 11:49 AM with Staff NN, Registered Nurse, showed that MW 1 Cart had one opened Haloperidol (medication used for certain mental/mood disorders) with an expiration date of January 2026. Staff NN stated that the medication was expired and should have been discarded according to facility policy. WEST MEDICATION ROOMA joint observation and interview on 02/27/2026 at 12:20 PM with Staff OO, Licensed Practical Nurse (LPN), showed one unopened (plastic bottle) Fiber Lax [Laxative-stool softener] with an expiration date of January 2026 and one unopened Povidone-Iodine Swab sticks (antiseptic used to prevent infection) with an expiration of May 2022. Staff OO stated that the medications were expired and should have been thrown away or returned to the pharmacy. In an interview on 03/03/2026 at 10:58 AM, Staff G, Resident Care Manager, stated that expired medications should not be kept in the medication cart or medication room and must be destroyed in a drug buster [a container used to chemically neutralize medications] by a nurse. In an interview on 03/03/2026 at 11:27 AM, Staff B, Director of Nursing, stated that expired medications should be destroyed using a drug buster and nurses were responsible for this process. RESIDENT 65Observation on 02/25/2026 at 12:35 PM, showed one opened package of Lidocaine patch (medicated adhesive patch applied to the skin to provide localized pain relief) sitting on top of Resident 65's dresser to the right side of the bed. Resident 65 stated the nurse had left the Lidocaine patch there and that they would come back to put it on their right knee. In an interview and joint observation on 02/25/2026 at 2:51 PM, Staff V, LPN, stated medications and patches were stored in the medication cart. A joint observation showed one opened package of Lidocaine patch sitting on top of Resident 65's dresser to the right side of the bed. Staff V stated that the Lidocaine patch should not have been left on Resident 65's dresser. In an interview on 03/04/2026 at 9:08 AM, Staff B stated that they expected the Lidocaine patch on Resident 65's dresser to not have been left there. Reference: (WAC) 388-97-1300(2)(3)(a).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident records were accurate for 1 of 5 residents (Resident 88), reviewed for Activities of Daily Living (ADL). The failure to accurately document ADL care placed the resident at risk for unmet care needs, inaccurate monitoring, and a diminished quality of life. Findings included .Review of a face sheet printed on 02/26/2026 showed that Resident 88 was readmitted to the facility on [DATE] with diagnoses that included dementia (memory loss) with other behavior disturbance.Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 01/18/2026 showed that Resident 88 required setup or clean-up assistance for upper and lower body dressing.Observations on 02/25/2026 at 12:05 PM, on 03/02/2026 at 1:26 PM, on 03/03/2026 at 4:19 PM, and on 03/04/2026 at 8:24 AM, showed Resident 88 was wearing pink pants, a purple long sleeve shirt and a purple vest.Further observations on 02/26/2026 at 2:26 PM and on 02/27/2026 at 3:13 PM, showed Resident 88 was lying in bed with a blanket over them up to their waist. Resident 88 was wearing a purple long sleeve shirt and a purple vest. Review of Resident 88's upper body dressing task from 02/25/2026 through 03/03/2026 showed the following documentation of staff assistance provided:02/25/2026- independent (resident completed the activities by themselves with no assistance from a helper) and substantial/maximum assistant (if the helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort)02/26/2026- independent and substantial/maximum assistant02/27/2026- independent and substantial/maximum assistant02/28/2026- independent and substantial/maximum assistant03/01/2026- substantial/maximum assistant and dependent (if the helper does all of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers required for the resident to complete the activity)03/02/2026- substantial/maximum assistant03/03/2026- independent and dependentReview of Resident 88's lower body dressing task from 02/25/2026 through 03/03/2026 showed the following documentation of staff assistance provided:02/25/2026-independent and substantial/maximum assistant02/26/2026- independent and substantial/maximum assistant02/27/2026- independent and substantial/maximum assistant02/28/2026- substantial/maximum assistant03/01/2026- substantial/maximum assistant and dependent03/02/2026- substantial/maximum assistant03/03/2026- independent, substantial/maximum assistant and dependentIn an interview on 02/27/2026 at 4:03 PM, Staff AA, Certified Nursing Assistant (CNA), stated that they looked at the care plan on how they care for residents. Staff AA stated that Resident 88 was pretty much independent and that they still have to check on them. Staff AA stated that Resident 88 did not like to be touched and that they needed to supervise and remind them. When Staff AA was informed that Resident 88 had been wearing the same clothing since 02/25/2026, Staff AA stated that they had offered to change Resident 88 and that they had shown them an outfit, asked if they wanted to change, but Resident 88 refused. Staff AA stated that they documented independent because Resident 88 could do it themselves. When asked what if they refused, Staff AA stated that it should have been documented that they refused.In an interview on 03/02/2026 at 1:35 PM, Staff BB, CNA, stated that they assisted with dressing if Resident 88 lets them and that Resident 88 was able to help and did the task themselves. Staff BB stated that they asked Resident 88 to change their clothes and give them a choice. Staff BB stated that there were days that they could do it themselves, and that if they were not able to, they assisted Resident 88. Staff BB stated that they did not help Resident 88 with dressing because Resident 88 refused and would kick us out. Staff BB stated that if Resident 88 was refusing, they were supposed to document refused and that if the resident changed themselves independently, they could document independent. Staff BB further stated, we have to chart correctly.In an interview on 03/03/2026 at 9:38 AM, Staff K, MDS Coordinator, stated that the CNAs chart every shift and that they were expected to chart (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	immediately after the service was provided and chart how much assistance the resident required. Staff K stated that they could document from dependent to independent. If the resident refused, there was an option for refusal. Staff K stated that if the resident refused, they expected staff to document refused and to notify the nurse. Staff K stated that the CNAs documented how much assistance they provided. If the CNA completed the task, they would document dependent and that if the resident did the task, they would document independent. When asked what if the staff did not do the task, Staff K stated that they should have a reason. If they tried to do it, and the resident refused, they would have an option to document, not available, activity did not occur, resident refused and not applicable. Staff K stated that if the resident did not participate in the dressing activity and staff did not help, the CNAs need to choose one of the four options to document. A joint record review of Resident 88's upper and lower body dressing task dated 02/25/2026 through 03/03/2026 showed documentation that staff provided assistance ranging from substantial/maximum assistance to dependent. Staff K stated that if they chart substantial/maximum assistance, but the resident refused, the CNAs should have documented refused. Staff K stated, if you see the same clothes, she refused. That one should be charted refusal.In an interview and joint record review on 03/04/2026 at 9:10 AM, Staff BB stated that Resident 88 had refused to be changed and that Resident 88 kicked me out. A joint record review of Resident 88's upper dressing task showed that they documented independent on 03/03/2026. Staff BB stated that it was a mistake, it's [it is] wrong, it should be refused.In an interview on 03/04/2026 at 9:48 AM, Staff I, Resident Care Manager, stated that they expected CNAs to document ADL care provided to residents before they went home. Staff I stated that they would expect CNAs to document accurately. Staff I stated that if a staff offered Resident 88 to get dressed and they refused, staff should document refused.In an interview on 03/04/2026 at 11:31 AM, Staff B, Director of Nursing, stated that they preferred CNAs to document ADL care when they completed a task and at a minimum before they leave work. Staff B further stated that they expected staff to document accurately and that it should be accurate documentation.Reference: (WAC) 388-97-1720 (1)(a)(ii).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure essential equipment was in operating condition for 1 of 2 dryers (Uni-Dryer Model), reviewed for laundry equipment. This failure placed the residents at risk for shortage of clean linens, delay in laundry turnaround, and a diminished quality of life.Findings included.Review of the facility's policy titled, Maintenance Service, revised in December 2009, showed that Maintenance service shall be provided to all areas of the building, grounds, and equipment.In a joint observation and interview on 03/02/2026 at 1:11 PM with Staff DD, Housekeeper, and Staff E, Housekeeping Director, showed a pile of wet clothes placed on top of a rolling cart next to two dryers, with one dryer in use. Staff DD stated that the dryer [older Uni-Dryer Model] that was not in use was broken and had been for a while. Staff E stated that they were waiting for a motor.In an interview on 03/03/2026 at 11:35 AM, Staff D, Maintenance Director, stated that they were aware that one of the dryers had not been working for a long time. Staff D stated the previous company (the facility's corporate company) had ordered a new motor but it never showed up. Staff D further stated that they let [the new facility's corporate company] know about it, nothing really happened with it. There's [there has] been one dryer since then until now.In an interview on 03/04/2026 at 9:44 AM, Staff A, Executive Director, stated that they expected maintenance to maintain essential equipment in the facility and that laundry equipment was considered essential equipment. Staff A stated that it sounds like [Staff D] put in a request a year ago and the old company didn't [did not] do anything. Staff A stated, I don't [do not] remember [Staff D] telling me about it [the broken dryer] and based off what [Staff D] said, I think [the new company] knew [about it] last summer. Staff A stated that a company was coming this week to look at the broken dryer and it shouldn't [should not] have taken that long. Staff A further stated that we need both dryers.Reference: (WAC) 388-97-2100(1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Post Acute	21400 72nd Avenue West Edmonds, WA 98026

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 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, interview, and record review, the facility failed to ensure a safe, comfortable and sanitary environment was maintained for 1 of 3 shower rooms (Southwest Hallway Shower Room), reviewed for environment. This failure placed residents at risk for infections, related complications, and a diminished quality of life.Findings included.Review of the facility's policy titled, Homelike Environment, revised in February 2021, showed that facility staff and management maximizes, to the extent possible, the characteristics of the facility which include a clean, sanitary and orderly environment.During a joint observation and interview on 02/26/2026 at 10:16 AM with Staff D, Maintenance Director, showed the Southwest Hallway Shower Room had a brownish red substance on the walls and ground around the shower area, dark grey spots on the ceiling above the shower, and hair on the ground throughout the shower room. It further showed a shower chair with a dark grey substance on the legs. Staff D stated that housekeeping was responsible for cleaning the shower rooms. Staff D stated that the brownish red substance around the shower area and the spots on the ceiling looks like mildew, a process of mold. Staff D further stated it could be mildew or soap scum.In an interview and joint observation on 02/26/2026 at 10:26 AM, Staff E, Housekeeper Director, stated that housekeeping was responsible for cleaning the shower rooms. When asked when the last time the Southwest Hallway Shower Room was cleaned, Staff E stated there was sign-off sheet. A joint observation of the sign-off sheet by the door, showed the last date the shower room was signed off as cleaned was 1/26/16 [unknown/unclear date]. Staff E stated that it was hard to tell when the last day the shower room was cleaned. Staff E stated that it looked like 1/26/16. A joint observation showed the Southwest Hallway Shower Room had a brownish red substance on the walls and ground around the shower area, dark grey spots on the ceiling above the shower, and hair on the ground throughout the shower room. It further showed a shower chair with a dark grey substance on the legs. Staff E stated that they do not expect any of this. Staff E stated that the red color was soap scum and around the edge [of the shower] looks like mold. Staff E stated the dark grey substance on the shower chair was mold and after every use the aides should be disinfecting that. Staff E stated the hair on the floor should not be there. Staff E further stated that the shower room should be cleaned daily and based on what it looks like it had not been.In an interview on 02/26/2026 at 10:40 AM, Staff O, Certified Nursing Assistant/Shower Aide, stated that the last shower they gave in the Southwest Hallway Shower Room was yesterday, around 2:40 PM. Staff O stated that they used the shower chair and that they sanitized it between residents. Staff O further stated that deep cleaning was done by housekeeping.In an interview on 03/03/2026 at 1:30 PM, Staff F, Infection Preventionist, stated that they expected the shower rooms to be clean. Staff F stated that the housekeepers should clean before shower aids get here and they should clean at the end of the day.In an interview on 03/04/2026 at 8:18 AM, Staff B, Director of Nursing, stated that they expected shower rooms to be clean.In an interview on 03/04/2026 at 9:44 AM, Staff A, Executive Director, stated that housekeeping was responsible for cleaning the shower rooms and they should be cleaned daily. Staff A further stated that they expected the Southwest Hallway Shower Room to be clean.Reference: (WAC) 388-97-3220(1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Post Acute	21400 72nd Avenue West Edmonds, WA 98026

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) had the required 12 hours of training annually for 1 of 5 staff (Staff U). This failure placed the residents at risk for potential negative outcomes and unmet care needs.Findings included.Review of the facility's assessment, reviewed on 01/20/2026, showed required training for nurse aides must be sufficient to ensure the continuing competence of nurse aides and must be no less than 12 hours per year.Review of the facility's policy titled, Sufficient, Competent and Qualified Staff, revised in September 2024, showed that Nursing assistants will have a minimum of 12 hours of continuing education in a 12 month period.Review of the facility's employee record for Staff U, CNA, showed they were hired on 05/16/2023. It further showed no documentation that Staff U received the required 12 hours of annual training.In an interview on 03/03/2026 at 2:24 PM, Staff F, Staff Development, stated that CNAs needed 12 hours of training yearly. Staff F stated that Staff U had the required training, but there's [there is] no way of tracking the actual hours.In an interview on 03/04/2026 at 8:18 AM, Staff B, Director of Nursing, stated they expected that CNAs had 12 hours of required annual training. Staff B further stated that they did not have a system to track the hours.In a follow up interview and joint record review on 03/04/2026 at 2:50 PM, Staff F provided Staff U's training record from 01/01/2025 to 01/01/2026 which showed they received 10.25 hours of training. Staff F stated that Staff U did not have 12 hours of annual training.Reference: (WAC) 388-97-1680 (2)(b).