STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505239	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Rose Care Center	3919 South 19th Street Tacoma, WA 98405

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to have signed consent prior to administering mood altering medication for 1 of 5 sampled residents (Resident 98) when reviewed for unnecessary medication use. This failure placed the resident or their legal representative at risk of receiving medications without knowledge to make informed decisions regarding the use of the medication, adverse side effects, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 98 was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (brain disorder caused by chemical imbalances), anxiety and depression. Resident 98 was able to communicate their needs. Review of the medication administration record (MAR) for June 2025 showed Resident 98 had an order dated 05/12/2025 for Buspirone (anti-anxiety mood altering medication) twice a day. Review of the MAR for June 2025 showed an order dated 04/26/2025 for Duloxetine (antidepressant mood altering medication) once a day. Review of the EHR showed Resident 98 had no consents for the use of Buspirone and Duloxetine. During an interview on 06/26/2025 at 12:41 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), reviewed the EHR for Resident 98 and was not able to locate consents for the two medications. Staff D stated Resident 98 should have had informed consents prior to the administration of the medications. During an interview on 07/02/2025 at 10:29 AM, Staff B, Director of Nursing Services (DNS), stated Resident 98's lack of consents for mood stabilizing medications did not meet expectations. Reference WAC 399-97-0300(3)(a) .

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to timely complete an investigation for 1 of 3 sampled residents (Resident 95) when reviewed for accidents related to falls. Failure to ensure Resident 95's fall incident report interventions, investigation summary, and conclusion were completed timely placed the resident at risk for delay in providing interventions, unmet needs, subsequent falls, and a decrease in quality of life. Findings included . According to the Nursing Home Guidelines, also known as the Purple Book, sixth edition, dated October 2015, showed, The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Review of the electronic health record (EHR) showed Resident 95 admitted to the facility on [DATE] with diagnoses to include respiratory failure, hemiplegia (paralysis/loss of muscle function) and hemiparesis (partial paralysis or muscle weakness) of one side of the body following a stroke (blood flow to the brain suddenly interrupted). Resident 95 was able to make needs known. During an interview on 06/25/2025 at 10:33 AM, Resident 95 stated they had fallen out of their wheelchair when trying to get back into bed. Review of the facility's incident report log dated June 2025 showed Resident 95 had a fall in their room on 06/19/2025. Review of the incident report initiated on 06/19/2025 showed Resident 95's documented interventions, investigation summary, and the conclusion of the fall were dated 06/26/2025 (seven days after the fall). During an interview on 06/27/2025 at 11:49 AM, Staff E, Resident Care Manager (RCM), stated they tried to complete incident investigations within three days; however, sometimes the weekend could push out the timeline to five days. Staff E stated Resident 95's fall incident report investigation dated 06/19/2025 should have been completed prior to 06/26/2025 and this did not meet their expectations. During an interview on 06/27/2025 at 12:07 PM, Staff B, Director of Nursing Services, stated incident report investigations were to be completed within five days. Staff B stated Resident 95's fall incident report investigation initiated on 06/19/2025 did not meet expectations because it should have been completed within five days and that did not happen. Please refer to F657 for additional information. Reference WAC 388-97-0640 (6)(a)(b)(c) (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on record review and interview, the facility failed to provide written bed hold notice at the time of transfer to the hospital for 1 of 2 sampled residents (Resident 12) reviewed for hospitalization. This failure placed the residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 12 admitted to the facility on [DATE] with diagnoses that included chronic pain, diabetes (too much sugar in the blood) and dementia (a decline in mental ability that interferes with daily life). Resident 12 was able to make needs known. Review of Resident 12's EHR showed hospitalization on 03/09/2025 and readmission to the facility on [DATE]. There was no documentation showing a bed hold was offered. Review showed a hospitalization on 03/20/2025 and readmission to the facility on [DATE]. There was no documentation showing a bed hold was offered. During an interview on 06/30/2025 at 12:49 PM, Staff H, Business Office Manager, stated they did not offer Resident 12 a bed holds on either date but should have. During an interview on 06/30/2025 at 12:56 PM, Staff A, Administrator, stated the expectation was for bed holds to be offered and documented when a resident was transferred to the hospital. Reference WAC 388-91-0120(4) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected the status for 1 of 20 sampled residents (Resident 14) reviewed for accuracy of assessments. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the electronic health record showed Resident 14 admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), and chronic pain. Resident 14 was able to make needs known. Resident 14 had a decrease in upper and lower extremity mobility. Observation and interview on 06/25/2025 at 11:42 AM showed Resident 14 in a wheelchair with a bent inward left hand. Resident 14 stated they were no longer receiving restorative services and staff was no longer assisting with putting on their hand splint. Review of Resident 14's quarterly MDS dated [DATE] showed the Upper Extremity section A. marked No Impairment. During an interview on 06/27/2025 at 12:53 PM, Staff F, Minimum Data Set/Licensed Practical Nurse, stated the Upper Extremity was coded incorrectly. During an interview on 07/02/2025 at 12:53 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was the MDS assessments were coded accurately. Reference WAC 388-97-1000 (1)(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 ensure a care plan was reviewed and revised timely for 1 of 3 sampled residents (Resident 95) reviewed for accidents related to falls. Failure to timely revise/update Resident 95's care plan after a fall placed the resident at risk of subsequent falls, injuries, unmet needs, and a diminished quality of life Findings included . Review of the facility's policy and procedure titled, Incident Documentation and Investigation, revision dated 10/2022, showed an incident report was to be completed for falls, and Interventions implemented to prevent future events and address resident care needs. Review of the electronic health record (EHR) showed Resident 95 admitted to the facility on [DATE] with diagnoses to include respiratory failure, hemiplegia (paralysis/loss of muscle function) and hemiparesis (partial paralysis or muscle weakness) of one side of the body following a stroke (blood flow to the brain suddenly interrupted). Resident 95 was able to make needs known. During an interview on 06/25/2025 at 10:33 AM, Resident 95 stated they had fallen out of their wheelchair when trying to get back into bed. Review of the facility's incident report log dated June 2025 showed Resident 95 had a fall in their room on 06/19/2025. Review of Resident 95's care plan, dated 05/09/2025, showed no interventions had been created/initiated after the resident's fall on 06/19/2025. During an interview on 06/27/2025 at 11:49 AM, Staff E, Resident Care Manager (RCM), stated Resident 95's care plan did not meet their expectations because it did not show interventions were put into place after the resident's fall on 06/19/2025. Staff E stated interventions should have been put into place on Resident 95's care plan shortly after the fall on 06/19/2025 or within the three-to-five-day window period to prevent subsequent falls. Staff E stated the delay in initiating interventions after Resident 95's fall did not meet expectations. During an interview on 06/27/2025 at 12:07 PM, Staff B, Director of Nursing Services, stated Resident 95's care plan was not updated timely after the resident's fall on 06/19/2025, and should have been. Please refer to F610 for additional information. Reference WAC 388-97-1020 2(c)(d), 5(b) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident 34 Resident 34 admitted to the facility on [DATE] with diagnoses that included aphasia (a language disorder that affects communication due to brain injury or stroke) chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) depression and dementia (a decline in mental ability that interferes with daily life). Resident 34's daily decision making was severely impaired. Review of Resident 34's EHR showed a provider's order dated 03/24/2022, for citalopram (an antidepressant medication) for major depressive disorder. The EHR also showed a provider's order, dated 02/20/2025, for Seroquel (an antipsychotic mediation) for dementia with behavioral disturbance. Observations on 06/25/2025 at 9:20 AM, 12:43 PM and 2:45 PM showed Resident 34 slept in bed. Observations on 06/27/2025 at 8:45 AM and 12:07 PM showed Resident 34 slept in bed. Observations on 06/30/2025 at 8:20 AM and 9:48 AM showed Resident 34 slept in bed. Review of Resident 34's EHR showed a provider's order dated 05/06/2022 to monitor sleep patterns and document number of hours of sleep every shift. Review of Resident 34's June 2025 MAR on 06/30/2025 at 10:45 AM showed the dayshift hours for sleep had been completed with number two prior to the completion of the staff's shift. Review showed documentation of zero hours of sleep on dayshift for 06/03/2025, 06/11/2025, 6/17/2025, and 06/25/2025. During an interview on 06/30/2025 at 10:59 AM, Staff G, Licensed Practical Nurse (LPN), stated day shift hours were from 6:00 AM to 6:00 PM. Staff G stated they documented sleep hours during their first break which was usually at 11:00 AM. During an interview on 06/30/2025 at 11:35 AM, Staff D, RCM/LPN, stated nursing staff should only be documenting sleep monitoring at the end of their shift for accuracy. During an interview on 07/02/2025 at 3:57 PM, Staff B, DNS, stated the expectation was that all monitoring was to be documented at the end of shift and reflect the accurate amount of hours Resident 34 slept. Reference WAC 388-97-1060 (3)(k)(i) Based on observation, interview, and record review, the facility failed to ensure nursing staff were following provider's orders for medication administration or sleep monitoring for 3 of 5 sampled residents (Residents 34, 74 and 98) when reviewed for unnecessary medication use. This failure placed the residents at risk of having adverse side effects, medication errors and unmet care services. Findings included . Resident 74 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the electronic health record (EHR) showed Resident 74 was admitted to the facility on [DATE] with diagnoses to include quadriplegia (paralysis that affects the ability to move upper and lower body), dependance on vent (person relies on mechanical ventilator to breath), depression and anxiety. Resident 74 was able to communicate needs. Review of the medication administration record (MAR) for June 2025 showed Resident 74 had an order dated 04/01/2025 for midodrine (medication given for low blood pressure) to be given three times a day and to hold when systolic (upper number) blood pressure (SBP) was above 120. Review of the June MAR showed Resident 74 was administered midodrine four times when their SBP was above 120. Review of May 2025 MAR showed Resident 74 was administered midodrine on two occasions (27 and 28th) despite the SBP been above 120. During an interview on 06/30/2025 at 9:40 AM, Staff O, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), reviewed the EHR for Resident 74 and stated the nurses were to follow the providers orders, and hold the medication. During an interview on 07/02/2025 at 10:26 AM, Staff B, Director of Nursing Services (DNS), stated Resident 74's blood pressure medication administration did not meet expectations. Resident 98 Review of the EHR showed Resident 98 was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (brain disorder caused by chemical imbalances), anxiety and depression. Resident 98 was able to communicate their needs. Review of the MAR for June 2025 showed Resident 98 had an order dated 06/05/2025 for lidocaine cream five percent to lower back four times a day, and a second order dated 06/16/2025 for lidocaine four percent to lower back four times a day. During an interview on 06/26/2025 at 12:44 PM, Staff D, RCM/LPN, stated the nurses that took the order for lidocaine four percent should have followed the provider's instruction and discontinued the lidocaine five percent order. Staff D stated Resident 98 was on lidocaine four percent. During an interview on 07/02/2025 at 10:29 AM, Staff B, DNS, stated Resident 98's orders did not meet expectations.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to apply a brace/splint (a device used to immobilize and support a body part) and an offloading boot (a specialized orthopedic device designed to reduce wight bearing pressure on a specific area of the foot or ankle) per provider orders and comprehensive care plan for 1 of 4 sampled residents (Resident 95) reviewed for position/mobility. These failures placed Resident 95 at risk for medical complications, unmet needs, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 95 admitted to the facility on [DATE] with diagnoses to include respiratory failure, hemiplegia (paralysis/loss of muscle function) and hemiparesis (partial paralysis or muscle weakness) of one side of the body following a stroke (blood flow to the brain suddenly interrupted). Resident 95 was able to make needs known. Multiple observations on 06/25/2025 at 10:39 AM, 06/25/2025 at 2:42 PM, 06/26/2025 at 12:59 PM, 06/27/2025 at 8:10 AM, 06/27/2025 at 12:33 PM, and 06/30/2025 at 9:01 AM showed Resident 95 with no brace/splint and/or an offloading boot in place. During an interview and observation on 06/27/2025 at 12:33 PM, Resident 95 stated they had no brace/splint, or anything applied to their feet. Resident 95 stated they could not remember the last time they wore a brace or an offloading boot. Resident 95 stated they usually wore non-skid socks or tennis shoes when up in their wheelchair. There were no foot brace/splint or offloading boots visible in Resident 95's room. Review of Resident 95's June 2025 treatment administration record (TAR) showed an order with a start date of 05/09/2025 to apply a left foot brace splint every shift for protection. Review showed an order with a start date of 05/09/2025 for an offloading boot to be applied to the left foot every shift for skin protection. Documentation showed both orders were documented as completed per provider orders. Review of the care plan initiated on 05/09/2025 of Resident 95's focused care plan for Dressing, performance deficit due to left sided weakness, included an intervention which showed, Make sure shoes are comfortable and not slippery. Resident prefers to wear brace and offloading boots. Review showed interventions dated 05/12/2025 for brace to left foot, and offloading boot when in bed. Resident 95 had a Bed Mobility focused care plan with an intervention dated 05/09/2025 that showed the resident was dependent on one person assistance with bed mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation on 06/30/2025 at 9:04 AM, Staff P, Certified Nursing Assistant, stated Resident 95 did not wear a brace/splint or a boot on their feet; but, if they did it would be on their care plan and Kardex (directions and information to provide care). Staff P stated Resident 95's Kardex showed that the resident was to have a brace to the left foot, preferred to wear a brace and offloading boots, and they had not been aware of this previously. Staff P stated Resident 95 did not have anything on their feet; however, they were able to locate a brace on the bottom of Resident 95's closet. Resident 95 told Staff P they could not recall the last time they had the brace on and that the brace was to be applied to the left foot. During an interview and observation on 06/30/2025 at 9:56 AM, Staff E, Resident Care Manager, stated Resident 95 had an ankle-foot orthotic (AFO, brace) on their left foot; however, they were unable to locate an offloading boot. Staff E asked Resident 95 if they ever wore a pillowy boot/offloading boot. Resident 95 responded by saying yes, but did not know what happened to it. Staff E removed Resident 95's brace and stated the resident should have an offloading boot on the left foot when in bed and the brace/AFO when up in their wheelchair. In continued interview on 06/30/2025 at 9:56 AM, after reviewing Resident 95's June 2025 TAR, Staff E stated the resident's orders for brace and offloading boots were documented that they were in place; however, the orders needed to be clarified with the provider because Resident 95 cannot wear the brace and offloading boot on the left foot at the same time. Staff E stated nursing should have written refusal on the TAR if Resident 95 refused to have the brace and offloading boot in place. Staff E stated the care plan showed Resident 95 was to have the brace/splint to the left foot and the offloading boot when in bed and that did not happen for Resident 95. During an interview on 06/30/2025 at 12:10 PM, Staff B, Director of Nursing Services, stated their expectation was provider's orders to be followed, and care plans implemented. Staff B stated they had not been aware Resident 95's offloading boot was missing, and their brace had not been in place on their left foot per provider's order. Staff B stated nurses should have verified placement and documented in the EHR if Resident 95 had refused to wear their brace and/or offloading boot and not document the devices were in place if they were not. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to provide an environment conducive to healing of a pressure ulcer for 1 of 3 sampled residents (Resident 37) when reviewed for pressure ulcer. This failure placed residents at risk of difficulty healing, worsening pressure ulcers, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 37 readmitted to the facility on [DATE] with diagnoses to include chronic kidney disease, diabetes (too much sugar in the blood), and depression. The resident was able to make needs known. During an interview and observation on 06/24/2025 at 12:52 PM, Resident 37 stated they had a pressure ulcer (PU) on their heel which had started as a bruise. Observation showed Resident 37's feet touched the footboard of the bed, there was a gap between the mattress and the footboard, and there was a rolled-up blanket in the gap. Resident 37 stated their feet always touched the footboard, but the facility did not have a longer bed. Observation on 06/25/2025 at 11:39 AM showed Resident 37 sat in bed with their legs bent to the right sides and balls of their feet pressed against the footboard. Observation and interview on 06/30/2025 at 12:20 PM showed Resident 37 laid in bed with their feet touching the footboard. Resident 37 stated they were 75 and a half inches tall (6'3.5). Observation on 07/02/2025 at 9:03 AM showed Resident 37 in bed with an inflatable boot applied to the foot with the PU which kept it from pressing against the footboard. Review of Resident 37's provider's orders, dated 06/18/2025, showed for staff to ensure Resident 37's mattress function and their body position while in bed. During an interview on 07/02/2025 at 9:06 AM, Staff D, Resident Care Manager, stated PU development was investigated by creating a risk management. Staff D stated feet pressing against a footboard could be a factor in PU development. Staff D stated Resident 37 was 75 inches tall (6'3) and they were unaware the resident's feet touched the footboard. Staff D stated Resident 37's footboard should have been included in a risk management to rule it out as a factor in the resident's PU development. During an interview on 07/02/2025 at 2:24 PM, Staff B, Director of Nursing Services, stated PU development was investigated with an incident report to determine the root cause. Staff B stated feet pressing against a footboard could be a factor in developing a PU and should be considered in the incident report. Staff B stated the facility should have implemented interventions to ensure Resident 37's foot did not press against the footboard prior to 07/02/2025. Reference WAC 388-97-1060 (3)(b) .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident 95 Review of the EHR showed Resident 95 admitted to the facility on [DATE] with diagnoses to include respiratory failure, hemiplegia (paralysis/loss of muscle function) and (partial paralysis or muscle weakness) of one side of the body following a stroke (blood flow to the brain suddenly interrupted). Resident 95 was able to make needs known. During an interview on 06/25/2025 at 10:39 AM, Resident 95 stated they had a stroke and the left side of their body was weak. Review of the minimum data set (MDS, a required assessment tool) dated 05/14/2025 showed Resident 95 received occupational therapy (OT) and physical therapy (PT) services and did not receive restorative nursing services. Review showed Resident 95 was dependent on staff for dressing the upper and lower body to include putting on and taking off footwear. It showed Resident 95 utilized a manual wheelchair for mobility and was dependent on staff for transfers from bed to wheelchair and back. Review of Resident 95's care plan initiated on 05/09/2025 showed a focused care plan for Dressing, performance deficit due to left sided weakness which included an intervention to, Make sure shoes are comfortable and not slippery. Resident prefers to wear brace and offloading boots. Review showed interventions dated 05/12/2025 for brace to left foot, and offloading boot when in bed. Resident 95 had a Bed Mobility focused care plan with an intervention dated 05/09/2025 that showed the resident was dependent on one person assistance with bed mobility. During an interview on 06/30/2025 at 9:56 AM, Staff E, Resident Care Manager (RCM), stated Resident 95 was not currently on the therapy caseload (receiving therapy services) or on a restorative nursing program. During an interview on 06/30/2025 at 10:27 AM, Staff C, Director of Rehabilitation, stated Resident 95 came off OT and PT services on 06/04/2025, and PT had recommended home range of motion (ROM, the full movement potential of a joint) exercises, and OT did not indicate a home exercise or a referral for a restorative nursing program. Staff C stated Resident 95 should have been referred to a restorative nursing program when they came off therapy services and remained in the facility. Staff C stated a referral for a nursing restorative program got missed by therapy and Resident 95 needed to be followed up on for either a referral back to therapy or a restorative nursing program. During an interview on 06/30/2025 at 11:17 AM, Staff F, MDS/LPN, stated therapy did not make a referral for Resident 95 to have a restorative nursing program and should have. During an interview on 06/30/2025 at 12:10 PM, Staff B, DNS, stated when Resident 95 came off therapy services there should have been a referral for a restorative nursing program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure residents consistently received restorative services (movement of joints to maintain range of motion) and/or splint brace assistance to maintain or prevent declines in mobility for 3 of 4 sampled residents (Residents 14, 35 and 95) reviewed for range of motion (ROM)/mobility. This failure placed residents at risk of decreased motion, mobility and a diminished quality of life. Findings included . Resident 14 Review of the electronic health record (EHR) showed Resident 14 admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease), chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs) and chronic pain. Resident 14 was able to make needs known. Observation and interview on 06/25/2025 at 11:42 AM showed Resident 14 in a wheelchair with a bent inward left hand. Resident 14 stated they were no longer receiving restorative services and staff was no longer assisting with putting on their hand splint. Review of the care plan initiated 03/03/2023 showed Resident 14 was not receiving restorative services. Review of the care plan history showed restorative services were resolved on 01/05/2024. Review of form Physical Therapy Discharge Summary, dated and signed 04/19/2024, showed, Discharge instructions=Resident will transition to Restorative Nursing Program (RNP) for sit to stand in parallel bars and bilateral lower extremity (BLU) hip and knee stretches. Discharge Recommendation= Other Restorative Program. Review of form Occupational Therapy Summary, dated and signed 08/14/2023, showed, Discharge Recommendation=Restorative Range of Motion Program, Restorative Splint and Brace program. Left resting hand splint as tolerated, likely at night. Review of a provider's comprehensive exam note dated 12/13/2024 showed Resident 14 reported their left hand and left leg needed to be loosened up and were willing to do restorative therapy to maintain current mobility. During an interview on 06/27/2025 at 12:50 PM, Staff D, Resident Care Manager/ Licensed Practical Nurse (RCM/LPN), stated it was the RCM's responsibility to follow up on any recommendations from providers. Staff D stated a referral should have been made to the RNP but was not. During an interview on 06/27/2025 at 12:55 PM, Staff F, Minimum Data Set/Licensed Practical Nurse (MDS/LPN), stated they assessed Resident 14 on 05/26/2025 and determined Resident 14 was not appropriate for the RNP. Staff F stated they did not note any issues with Resident 14's left hand at the time of the visual assessment. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/02/2025 at 11:36 AM, Staff C, Director of Rehabilitation, stated Resident 14 fell through the cracks and was not receiving restorative services as they should have been. Staff C stated they were unable to locate discharge notes on why the program was discontinued on 01/2024. Staff C stated based on the most recent physical therapy evaluation completed 07/01/2025 Resident 14 had a decline in functional mobility related to transfers as their prior level of functioning related to sit to stand was partial/moderate assistance and was currently substantial/maximal assistance. Chair/bed-chair transfer prior level of functioning was substantial/maximal assistance and was currently dependent. Staff C stated they were unable to locate Resident 14's splint, so a new one was ordered. During an interview on 07/02/2025 at 12:53 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was Resident 14 should have been referred to therapy timely. Resident 35 Review of the EHR showed Resident 35 was originally admitted to the facility on [DATE] with diagnoses to include muscle wasting, anxiety, acute/chronic respiratory failure, and tracheostomy (opening in windpipe through the neck). Resident 35 was able to communicate their needs. Observation on 06/25/2025 at 10:01 AM showed Resident 35 in bed with their upper arms folded in front of them. During an interview on 06/26/2025 at 9:29 AM, Resident 35 stated the restorative program was not done, and they wanted to work with them. Resident 35 stated, My arm is getting worse and they had a brace. Review of Resident 35's EHR showed a contracture screening assessment dated [DATE] with functional limitation to upper and lower extremity and restorative program. Review of Resident 35's OT Discharge summary dated [DATE] with discharge instructions for restorative range of motion program with splint/brace. Review of Resident 35's PT Discharge summary dated [DATE] with discharge instruction for restorative program. Review of Resident 35's EHR showed no order or care plan for restorative program. During an interview on 06/30/2025 at 11:08 AM, Staff F, MDS/LPN, stated the general process was for therapy to put a referral to nursing about a restorative program, and Staff F would add the restorative program in the individual resident's care plan. Staff F reviewed Resident 35's EHR and stated the restorative referral was missing. During an interview on 07/02/2025 at 10:32 AM, Staff B, DNS, stated Resident 35's missed restorative program did not meet expectations. Reference WAC 399-97-1060(3)(d),(j)(ix) .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to ensure new interventions were developed to reduce fall incidents for 1 of 3 sampled residents (Resident 12), failed to ensure elopement precautions were in place for 1 of 3 halls (100 Hall), and failed to ensure medication carts were secured for 1 of 6 medication carts (300 Hall) when reviewed for accident hazards. These failures placed residents at risk of continual falls, avoidable injury, elopement, unintended access to medications, and a diminished quality of life. Findings included . Resident 12 Review of the electronic health record (EHR) showed Resident 12 admitted to the facility on [DATE] with diagnoses that included chronic pain, diabetes (too much sugar in the blood) and dementia (a decline in mental ability that interferes with daily life). Resident 12 was able to make needs known. Review of Resident 12's incident report, dated 03/20/2025, showed Resident 12 had an unwitnessed fall. Resident 12 was found lying on the floor near the bed. Resident 12 stated they fell on to their left leg and were unable to move it. Emergency medical services (EMS) was called and Resident 12 was transported to the hospital. Review of the March 2025 incident log showed no documentation of Resident 12's 03/20/2025 fall. Review of a document titled Post Acute and Transition of Care Orders dated 03/27/2025 showed Resident 12 had surgery related to a left femur fracture. Review of Resident 12's care plan dated 08/21/2024 showed no interventions were added following the fall on 03/20/2025. Review of the April 2025 incident log showed Resident 12 had an additional fall on 04/29/2025. Review of Resident 12's incident report, dated 04/29/2025, showed Resident 34 had a unwitnessed fall. Resident 12 was heard yelling and when staff entered the room. Resident 12 was on the floor near the bed and no injuries were reported. An intervention to encourage Resident 12 to use the call light for assistance to transfer was added to the care plan on 04/30/2025. During an interview on 06/30/2025 at 1:45 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated the care plan was not revised and no interventions were put in place after the 03/20/2025 fall but should have been. During an interview on 07/02/2025 at 12:38 PM, Staff B, Director of Nursing Services (DNS), stated the intervention after the 03/20/2025 fall was missed but one should have been implemented. <100 HALL ELOPEMENT RISK> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note, dated 05/25/2025, showed Resident 49 exited the facility via the back door of the gym and was found outside the building. Review showed Resident 49 was encouraged to not go outside the facility without informing staff and the resident was placed on alert for elopement. Observation on 06/26/2025 at 9:13 AM showed a therapy gym near the 100 Hall with an exit to an outdoor patio area with a canopy and outdoor chairs. Exiting to the patio did not cause an alarm. The left-side of the patio had an unlocked gate leading to the facility parking lot and the right-side led around the building to an unlocked gate to a city street. During an interview and observation on 06/26/2025 at 10:40 AM, Staff N, Maintenance Director, stated the door to the patio was alarmed. Observation showed Staff N opened the patio door and an alarm did not sound. Staff N stated the gates to the parking lot and city street were not locked and residents could use them to exit the property from the patio area. During an interview on 06/30/2025 at 10:08 AM, Staff A, Administrator, stated the alarm on the door to the patio was not alarming. Staff A stated the door to the therapy gym, not back patio, should be alarmed and the current alarm situation did not meet her expectations. <MEDICATION CART> Observation on 07/02/2025 at 12:52 PM showed an unsecured medication cart on the 300 Hall with residents sitting nearby in wheelchairs. During an interview on 07/02/2025 at 12:55 PM, Staff O, RCM/LPN, stated the medication cart was left unsecured and the medications were accessible to residents and visitors. Staff O stated the medication cart should not be left unsecured. During an interview on 07/02/2025 at 2:22 PM, Staff B, DNS, stated medication carts were secured with a key to ensure residents and visitors did not have access to the medications. Staff B stated the unsecured medication cart on the 300 Hall did not meet their expectations. Reference WAC 388-97-1060 (3)(g) .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to ensure residents' nutritional status was accurately monitored for 3 of 5 sampled residents (Residents 16, 51, and 44) when reviewed for nutrition. This failure placed residents at risk of unintended wight loss, fluid overload, and a diminished quality of life. Findings included . Resident 16 Review of the electronic health record (EHR) showed Resident 16 admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, a disease that causes obstructed airflow from the lungs), diabetes (too much sugar in the blood), and dementia (a decline in mental ability severe enough to interfere with daily life). Resident 16 was not able to make needs known. Observation on 06/24/2025 at 12:13 AM showed Resident 13 in bed with their lunch tray on the overbed table. Resident 13 was attempting to put a straw into a plastic cup with dried cereal with no liquid available. Observation on 06/25/2025 at 12:19 PM showed Resident 13 in bed with their lunch tray on the overbed table. Resident 13 was leaning to the right side using their fingers to pick up and place individual pieces of food into a small pile on their food tray. Resident 13 had food items on the front of their clothing. Resident 13 then attempted to use the spoon to self-feed, but was unable to balance the food on the spoon and it fell to the bed. Resident 13 smiled and appeared pleasantly confused. In continued observation on 06/25/2025 at 2:15 PM, Resident 13 laid in bed and leaned to the right side away from their meal tray. Resident 13's eyes were closed, and they had consumed approximately 5% of their lunch meal. Review of the 30-day lookback of meal intake showed Resident 13 ate 50-75% of their lunch meal on 06/25/2025. Observation on 06/26/2025 at 12:47 PM showed Resident 13 in the main dining room with a lunch food tray on the table in front of them. Resident 13 had consumed the piece of cake provided with the meal (approximately 5% of the meal) and left the rest. Review of the 30-day lookback of meal intake showed Resident 13 ate 50-75% of their lunch meal on 06/26/2025. Observation on 06/30/2025 at 12:35 PM showed Resident 13 in bed with the lunch meal tray on the overbed table. Resident 13 was taking food and placing it into different piles. Resident 13 was leaning to the right, away from their lunch tray and had consumed approximately 10% of the meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/30/2025 at 1:11 PM showed Resident 13's meal tray on a cart of used trays waiting to be washed. The meal tray had approximately 95% of food unconsumed. Review of the 30-day lookback of meal intake showed Resident 13 ate 50-75% of their lunch meal on 06/30/2025. Review of Resident 13's 08/27/2018 initiated care plan showed Resident 13 was at nutritional risk and had a history of significant weight loss. Review of the Registered Dietician annual review, dated 06/13/2025, showed Resident 13 had good intake and ate 50-75% of their meals regularly. Observation on 07/02/2025 at 12:10 PM showed Resident 13 in bed leaning to the right and the bed at a 20-degree angle. Resident 13 had not touched the food but had drunk a glass of milk. During an interview on 07/02/2025 at 1:28 PM, Staff S, Certified Nursing Assistant, stated they would observe how much a resident ate at meals then input it into the 30-day lookback of meal intake. Staff S stated Resident 13 had drank milk and juice and eaten a few bites of corn, so they had coded Resident 13 as having consumed 50-75% of their lunch for 07/02/2025. During an interview on 07/02/2025 at 1:37 PM, Staff D, Resident Care Manager (RCM), stated the facility ensured residents maintained weight by monitoring meal intake and having the registered dietician perform regular reviews. Staff D stated only food should be considered when tracking meal intake and Resident 13's lack of accurate monitoring of meal intake did not meet expectations. During an interview on 07/02/2025 at 2:40 PM, Staff B, Director of Nursing Services (DNS), stated resident weights and food intake were monitored and the registered dietician performed periodic reviews to ensure residents maintained their nutritional status. Staff B stated Resident 13's meal tracking did not meet expectations. Resident 51 Review of the EHR showed Resident 51 admitted to the facility on [DATE] with diagnoses to include COPD, diabetes, and atrial fibrillation (a heart condition characterized by an irregular and often rapid heartbeat). Resident 51 was able to make needs known. Review of a provider's order, dated 06/02/2025, showed Resident 51 was on a fluid restriction of 2000 milliliter (ml) with dietary to provide 1520 ml. Observation on 06/25/2025 at 12:43 PM showed Resident 51 in bed with their meal tray. Resident 51 had been provided coffee, two clear cups which were empty, and a plastic cup of water with a straw. Review of the meal ticket showed Resident 51 was on a 2000 ml fluid restriction, but did not specify how much dietary was to provide. Review of the medication administration record (MAR) for June 2025 showed the nurses documented the amount of fluid they provided and the total amount for the day, but it did not include the amount provided by dietary. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/30/2025 at 2:08 PM, Staff L, Dietary Manager, stated they were aware of resident fluid restrictions by receiving meal slips from nursing which would then be uploaded into the kitchen software and printed on the resident's meal ticket. Staff L stated Resident 51 was on a 2000 ml fluid restriction. Staff L stated they did not know how much of the 2000 ml should be provided by dietary, so they only provided one 4 fluid ounce (approximately 180 ml) cup of juice to Resident 51 with meals. During an interview on 07/02/2025 at 12:40 PM, Staff D, RCM/Licensed Practical Nurse (LPN), stated Resident 51's fluid restriction had been changed recently and the orders had not been updated in the EHR. Staff D stated Resident 51's fluid restriction did not meet expectations. During an interview on 07/02/2025 at 2:45 PM, Staff B, DNS, stated Resident 51's fluid restriction was not adequately communicated to the kitchen, and this did not meet expectations. Resident 44 Review of the EHR showed Resident 44 admitted to the facility on [DATE] with diagnoses to include end stage renal disease (the final, irreversible stage of chronic kidney disease), diabetes, and atrial fibrillation. Resident 44 was able to make needs known. During an interview and observation on 07/02/2025 at 11:23 AM, Resident 44 stated the facility had attempted to limit their fluid intake, but now they managed their own fluid intake. Observation showed Resident 44 had a 20 fluid ounce plastic bottle of water half full and a plastic measured cup with 650 ml of clear liquid on the bedside table. Review of a provider's order, dated 12/02/2024, showed Resident 44 was on a 1500 ml fluid restriction and to notify the provider, RCM, and DNS if the resident was noncompliant. Review of the MAR for June 2025 showed the nurses documented the amount of fluid they provided and the total amount for the day, but it did not include the amount provided by dietary. Review of the care plan, initiated 09/30/2025, showed Resident 44 was on a fluid restriction of 1500 ml with nursing to provide 200 ml and dietary to provide 1200 ml, but refused to follow it. During an interview on 07/02/2025 at 11:46 AM, Staff L, Dietary Manager, stated Resident 44 was not on a fluid restriction. During an interview on 07/02/2025 at 1:02 PM, Staff E, RCM, stated Resident 44 was on a 1500 ml fluid restriction which they did not follow. Staff E stated Resident 44's fluid restriction was not monitored if the resident had unrestricted fluids at bedside. During an interview on 07/02/2025 at 2:33 PM, Staff B, DNS, stated fluid restrictions were ordered and specified how much nursing and dietary should be providing, which was documented in the MAR. Staff B stated Resident 44 was on a fluid restriction, but noncompliant. Reference WAC 388-97-1060 (3)(h) .

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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** Resident 12 Review of the EHR showed Resident 12 admitted to the facility on [DATE] with diagnoses that included chronic pain, diabetes (too much sugar in the blood) and dementia (a decline in mental ability that interferes with daily life). Resident 12 was able to make needs known. Observation on 06/24/2025 at 9:49 AM and 06/25/2025 at 2:28 PM showed Resident 12 sat in their wheelchair with oxygen being administered at two liters via nasal canula connected to an oxygen concentrator (medical device that provides supplemental oxygen). Review of Resident 12's provider's orders showed no order for oxygen. During an interview on 06/25/2025 at 12:34 PM, Staff D, RCM/LPN, reviewed the EHR and stated there was no provider's order and it must have been missed when Resident 12 returned from the hospital. During an interview on 07/02/2025 at 12:40 PM, Staff B, DNS, stated Resident 12 required a provider's order for oxygen use. Reference WAC 388-97-1060 (3)(j)(vi) Based on observation, interview and record review, the facility failed to ensure orders for oxygen were in place and residents were receiving the ordered amount of oxygen for 2 of 5 sampled residents (Residents 48 and 12) when reviewed for respiratory care. This failure placed the residents at risk for respiratory complications, unmet needs and diminished quality of life. Findings included . Resident 48 Review of the electronic health record (EHR) showed Resident 48 was admitted to the facility on [DATE] with diagnoses to include acute/chronic respiratory failure, chronic obstructive pulmonary disease (COPD, lung disease that blocks the airflow and make it difficult to breathe), heart failure and anxiety. Resident 48 was able to communicate their needs. Observation and interview on 06/25/2025 at 9:42 AM showed Resident 48 in their room, using oxygen via nasal cannula (plastic tube device that gives additional oxygen in nose) set to provide six liters of oxygen per minute. Resident 48 stated they were using oxygen at six liters. Review of a provider's order, dated 05/20/2025, showed to provide Resident 48 oxygen at two liters per minute. Review of the June 2025 treatment administration record (TAR) showed Resident 48 used oxygen from two to eight liters a minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/30/2025 at 9:45 AM, Staff O, Resident Care Manager/Licensed Practical Nurse (RCM/LPN), stated Resident 48 received six liters of oxygen per minute, and the order needed to be clarified. During an interview on 07/02/2025 at 10:30 AM, Staff B, Director of Nursing Services (DNS), stated the oxygen order for Resident 48 did not meet expectation.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to manage pain by inconsistently monitoring and/or providing non-pharmacological interventions (NPI, health interventions/approaches used instead of medication) for 4 of 6 sampled residents (Residents 95, 99, 98, and 74) reviewed for unnecessary medications and/or pain management. This failure placed the residents at risk of having unmet pain needs, receiving unnecessary medications, avoidable medication side effects, and a diminished quality of life. Findings included . Resident 95 Review of the electronic health record (EHR) showed Resident 95 admitted to the facility on [DATE] with diagnoses to include respiratory failure, stroke (blood flow to the brain suddenly interrupted), and anxiety disorder. Resident 95 was able to make needs known. Review of Resident 95's June 2025 medication administration record (MAR) from 06/01/2025 - 06/30/2025 showed an order with a start date of 05/09/2025 to monitor for pain prior to giving pain medication and to document pain using a numerical scale (0 = no pain and 10 = worst pain imaginable) or a pain assessment in advanced dementia (PAINAD scale, pain evaluation based on observations) scale for the cognitively impaired (decline in a person's mental abilities) every shift. Review showed no documentation on 06/07/2025 and 06/09/2025 on the day shift, and multiple dashes (-), NAs, and Xs documented for pain code and site/location when there were pain numerical numbers documented ranging from 1 to 5, three times on day shift and seven times on the night shift. In continued review of June 2025 MAR, Resident 95 had an order with a start date of 05/09/2025 for acetaminophen (used to treat minor aches and pain) two tablets every six hours as needed for pain in conjunction with administering pain medication, utilize NPI for pain management and there were listed interventions to document when used. It showed to see progress note, and to document pain site location. Documentation showed Resident 95 received acetaminophen on 06/12/2025 and 06/22/2025 and showed no NPI were documented as provided. During an interview on 06/30/2025 at 9:50 PM, Staff E, Resident Care Manager (RCM), stated the expectation was NPI were offered/provided prior to giving an as needed pain medication and documented. Staff E stated Resident 95's June 2025 MAR did not meet expectation because the documented coding was not correct for attempts for NPI and for the site/pain location. Staff E stated NPIs were not documented for Resident 95's acetaminophen provided on 06/12/2025 and 06/22/2025 and should have been. During an interview on 06/30/2025 at 12:25 PM, Staff B, Director of Nursing Services (DNS), stated Resident 95's June 2025 MAR should have had the pain location and interventions tried documented and this did not meet their expectations. Staff B stated NPIs were to be offered/provided prior to giving a resident an as needed pain medication. Resident 99 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of EHR showed Resident 99 admitted to the facility on [DATE] with diagnoses to include respiratory failure, stroke, and anxiety disorder. Resident 99 was able to make needs known. Review of a provider's order, dated 05/29/2025, showed oxycodone (a narcotic pain medication) was prescribed. Review of the June 2025 MAR showed Resident 99 was administered oxycodone 13 times between 06/01/2025 and 06/30/2025 without offering/documenting NPI prior to use of the medication. During an interview on 07/02/2025 at 3:30 PM, Staff E, RCM, stated the expectation was that NPIs were offered and accurately documented prior to administering as needed pain medications. Resident 74 Review of the EHR showed Resident 74 was admitted to the facility on [DATE] with diagnoses to include quadriplegia (paralysis that affects the ability to move upper and lower body), dependance on vent (person relies on mechanical ventilator to breath), depression and anxiety. Resident 74 was able to communicate needs. Review of the MAR for June 2025 showed Resident 74 had an order dated 06/11/2025 for oxycodone as needed. Review of the June 2025 MAR showed Resident 74 was administered oxycodone 47 times from 06/11/2025-06/26/2025 without documenting NPI prior to use of the medication. During an interview on 06/30/2025 at 9:40 AM, Staff O, RCM/Licensed Practical Nurse (LPN), reviewed the EHR for Resident 74 and stated the nurse that initiated the order was missing the codes for the NPIs. During an interview on 07/02/2025 at 10:26 AM, Staff B, DNS, stated Resident 74's oxycodone medication administration did not meet expectations. Resident 98 Review of the EHR showed Resident 98 was admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (brain disorder caused by chemical imbalances), anxiety and depression. Resident 98 was able to communicate their needs. Review of the MAR for June 2025 showed Resident 98 had order dated 05/22/2025 for oxycodone as needed without documented NPI prior to use on 7 occasions. Review showed Resident 98 had order dated 05/22/2025 for tramadol (pain medication) as needed without NPI documented prior to administration on 21 occasions. During an interview on 06/26/2025 at 12:44 PM, Staff D, RCM/LPN, stated the nurses missed the NPIs for Resident 98. During an interview on 07/02/2025 at 10:29 AM, Staff B, DNS, stated Resident 98's orders did not meet expectations. Reference WAC 399-97-1060(1) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to have sufficient staff to ensure residents received timely call light responses for 3 or 3 sampled hallways (100, 300 and 400) when reviewed for staffing. This failure placed residents at risk for accidents, injuries and diminished quality of life. Findings included . Observation on 07/02/2025 at 2:22 PM showed a panel at the 400 hall nurses' station with a call light displaying for room [ROOM NUMBER]. No audible sound was heard. Observation on 07/02/2025 at 2:33 PM showed call lights on for rooms 416, 408 and 419 but no tone was heard. <RESIDENT INTERVIEWS> Resident 72 During an interview on 06/24/2025 at 1:43 PM, Resident 72 stated there were long call wait times during evening and dayshift, and sometimes the wait was 45 minutes. Resident 27 During an interview on 06/24/2025 at 11:00 AM, Resident 27 stated, Sometimes the wait time is over an hour for help; I'm scared I'll get trapped. Resident 75 During an interview on 06/25/2025 at 10:36 AM, Resident 75 stated, Staff on night shift are lazy and don't answer call lights for a long time. Resident 4 During an interview on 06/25/2025 at 10:21 AM, Resident 4 stated, Staff take a long time to answer my light, wait time has been up to an hour. Resident 64 During an interview on 06/24/2025 at 1:02 PM, Resident 64 stated nighttime was the worst, and sometimes the call light was not answered for hours. Resident 64 stated after 2:00 AM nobody answered call lights. <RESIDENT COUNCIL> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 01/30/2025 Resident Council meeting minutes showed a resident stated they had to wait a long time for their call light to be answered. Another resident stated they pressed their call light but had to wait a long time and they needed a quick response due to oxygen. Review of the 02/13/2025 Resident Council meeting minutes showed a resident stated they were having an issue with staff answering their call light. Staff would come in and turn off the light and not return. Review of the 03/13/2025 Resident Council meeting minutes showed a resident stated there were still ongoing issues with call light response and when residents were in the bathroom it seemed to take longer for staff to respond. Review of the 04/24/2025 Resident Council meeting minutes showed a resident stated call lights were an issue and it took so long for someone to show up every day and every night. Review of the 06/06/2025 Resident Council meeting minutes showed one resident stated they had to wait four hours for a call light response. Two other residents stated they had to wait over an hour for staff to respond to their call lights. Review of the 06/26/2025 Resident Council meeting minutes showed a resident stated they were having issues with staff answering their call light on night shift. <GRIEVANCE LOG> Review of the grievance log dated January 2025 showed there were two grievances related to call light wait times. Review of the grievance log dated February 2025 showed there were six grievances related to call light wait times. Review of the grievance log dated March 2025 showed there were four grievances related to call light wait times. Review of the grievance log dated April 2025 showed there were five grievances related to call light wait times. Review of the grievance log dated May 2025 showed there were seven grievances related to call light wait times. During an interview on 07/02/2025 at 2:33 PM, Staff K, Maintenance Assistant, stated the 400 hall call lights were not audible. During an interview on 07/02/2025 at 4:57 PM, Staff A, Administrator, stated it was their expectation 300 and 400 hall call lights should light and sound at the panel. Staff A stated they were aware of staffing issues related to long call light waiting times and had implemented a Performance Improvement Plan (PIP, a structured process used to address performance issues in an individual or an organization) on 06/10/2025. Staff A stated prior to the PIP they had provided staff education related to call lights concerns. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1080(1), 1090(1) .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. . Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing was consistently posted to include the actual nursing staff hours worked. This failure caused the facility's staffing information not to be readily available to residents and visitors who may wish to review it. Findings included . Observations on 06/27/2025 at 10:56 AM, 06/28/2025 at 8:30 AM, 06/30/2025 at 1:34 PM, and 07/02/2025 at 9:19 AM, showed the Daily Nurse Staffing Form posted near the facility's entrance had total staff scheduled hours documented; however, it did not show actual hours worked. During an interview on 07/02/2025 at 1:52 PM, Staff R, Staffing Coordinator (SC), stated they were not aware the postings needed to show scheduled and actual hours. During an interview on 07/02/2025 at 4:32 PM, Staff A, Administrator, stated they were just made aware the actual hours were not posted daily and it did not meet expectations. No reference WAC .

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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. . Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of insulin (injectable medication that regulates blood sugar) in 1 of 3 medication carts (300 hall/front cart) when reviewed for medication storage. This failure placed residents at risk of receiving expired medications, ineffective treatment, and diminished quality of life. Findings included . Observation of the medication cart in the 300 hall/front cart on 06/30/2025 at 12:52 PM, with Staff Q, Licensed Practical Nurse (LPN), showed Lispro insulin with an open date of 05/15/2025, and Lantus insulin without an open date. Staff Q stated the insulins were to stay in the cart for 28 days and after that they were expired. During an interview on 06/30/2025 at 2:10 PM, Staff B, Director of Nursing Services, stated the insulin storage did not meet expectations. Reference WAC 399-97-1300(2) .

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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 sanitary food storage in the facility kitchen and 1 of 2 resident refrigerators (400 Hall) when reviewed for safe/sanitary food storage. This failure placed residents at risk of consuming expired food goods, foodborne illness, and a diminished quality of life. Findings included . <KITCHEN> Observation and interview on 06/30/2025 at 10:33 AM showed a freestanding fridge with uncovered trays of egg, sliced ham, and cooked bacon. A kitchen staff member stated the eggs, bacon, and ham were cooling, but was unsure when they were placed in the refrigerator and did not know of a cooling log. Observation and interview on 06/30/2025 at 10:48 AM showed Staff M, Housekeeping Supervisor, removing two large metal containers covered with metal foil labeled potluck. Staff M stated the metal containers contained beef and chicken cooked at home the night before to be used at a potluck for facility staff members. Staff M stated the meat prepared at home should not have been stored in the kitchen facility refrigerator. Observation on 06/30/2025 at 11:02 AM showed two dented cans of pineapple and one dented can of cream of mushroom soup stored on shelving in the dry storage area. During an interview on 06/30/2025 at 2:00 PM, Staff L, Dietary Manager, stated the facility cooled food over six hours and should be labeled with the time placed in the refrigerator to monitor this timeline. Staff L stated they did not maintain a cooling log for the freestanding refrigerator used for cooling foods. Staff L stated foods that were not prepared in the kitchen should not be stored in the kitchen refrigerator and the meat for the potluck should not have been stored in the kitchen refrigerator. Staff L stated dented cans were removed from shelving, so they were not used, and three dented cans being stored on the dry storage shelving did not meet expectations. During an interview on 06/30/2025 at 2:12 PM, Staff A, Administrator, stated the kitchen was expected to follow the food code. Staff A stated the observations of lack of monitoring of cooling foods, outside food stored in the kitchen refrigerator, and dented cans stored on dry storage shelving did not meet expectations. <400 HALL REFRIGERATOR> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and record review on 06/25/2025 at 10:14 AM showed the 400 Hall resident refrigerator was 44 Fahrenheit (F). Review of the refrigerator temperature log showed five of 24 days logged with a temperature greater than 40F, no corrective action taken, and directed staff to report to maintenance any temperatures greater than 39F. Observation showed a strawberry fruit drink with a use by date of 04/09/2025 and a buttermilk ranch dressing with a use by date of 04/06/2025. Observation showed sticky brown/yellow food residue had dried to the shelving. During an interview on 06/25/2025 at 10:39 AM, Staff L, Dietary Manager, stated the kitchen staff monitored the resident refrigerators for temperatures and expired foods. Staff L stated if a refrigerator was out of range the maintenance department would be contacted for repair, but this was not needed recently as the refrigerators were holding temperatures. Staff L stated the 400 Hall refrigerator had dates out of temperature range and they were not informed, and maintenance had not been contacted. Staff L stated the refrigerator had items past their use by date and the shelving was not clean. Staff L stated the 400 Hall resident refrigerator did not meet expectations for sanitary food storage. During an interview on 06/25/2025 at 12:53 AM, Staff A, Administrator, stated the 400 Hall resident refrigerator was monitored by kitchen staff for cleanliness, temperature, and expired foods. Staff A stated the temperatures above 40F, expired food, and dirty shelving did not meet expectations. Reference WAC 388-97-1100 (3), -2980 .

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. . Based on interview and record review, the facility failed to ensure the Quality Assessment and Performance Improvement (QAPI) program self-identified deficiencies and failed to develop/implement effective plans of action to sustain plan of corrections for previous deficiencies. Failure to have an effectively functioning QAPI program that consistently self-identified deficient practices led to repeated deficiencies, and a pattern of deficiencies that placed residents at repeated risk for unmet needs that could negatively impact their safety, quality of life and quality of care. Findings included . Review of the facility's policy and procedure titled, Quality Assurance and Performance Improvement, revision dated 03/2025, showed QAPI would oversee the identification and correction of quality issues. Effective QAPI would help lead to resident-centered care, satisfied customers, outstanding survey outcomes, and positive financial performance. Review showed, Improvements realized as the result of quality improvement plans will be monitored and sustained. During the entrance conference interview on 06/24/2025 at 9:36 AM, Staff A, Administrator, stated they were familiar with the [NAME] report (a report with previously cited deficiencies) to identify any repeat deficiencies that needed to be addressed. A copy of the [NAME] report dated 06/18/2025 was provided to Staff A during the interview for review. During an interview on 07/02/2025 at 4:57 PM, Staff A, Administrator, stated they were not aware of issues found during survey related to the restorative nursing program, nutrition issues related to fluid restrictions and inaccurate consumption documentation, or pain management issues related to non-pharmacological interventions (NPI, health interventions/approaches used instead of medication). Staff A did not provide an explanation as to why these issues were not identified by the facility prior to survey. Staff A stated they were aware of staffing issues related to long call light waiting times and had implemented a Performance Improvement Plan (PIP, a structured process used to address performance issues in an individual or an organization) that was initiated on 06/10/2025. When asked why the PIP was not established sooner since there were grievances related to call lights since January 2025, Staff A stated they had provided staff education related to call lights previously and thought that would help; however, it did not, so then the PIP was put in place. The facility had the following repeated citations: F688 - Increase/Prevent Decrease in ROM/Mobility (05/2022 and 10/2024). F692 - Nutrition/Hydration Status Maintenance (07/2019 and 08/2023). F725 - Sufficient Nursing Staff (07/2019). Review of the current QAPI program documentation, year 2025, showed the facility conducted QAPI meetings, but the facility failed to self-identify deficiencies, identify they did not sustain corrections of previously identified deficiencies, and/or make timely revisions to previous action plans to ensure corrections were sustained. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Refer to the following citations from the current survey cycle which were not identified, were identified and not addressed, or had ineffective plans of correction to sustain correction by the QAPI program which led to repeated pattern of deficiencies. (D = Isolated and E = Pattern). REFER TO F688 (E) Increase/Prevent Decrease in ROM/Mobility: Previous deficiency dated 05/2022 (D) and 10/24/2024 (D) REFER TO F692 (E) Nutrition/Hydration Status Maintenance: Previous deficiency dated 07/2019 (D) and 08/2023 (E) REFER TO F697 (E) Pain Management REFER TO F725 (E) Sufficient Nursing Staff: Previous deficiency dated 07/2019 (D) Reference WAC 388-97-1760(1)(2) .