STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505243	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Transitional Care and Rehabilitation	430 Lilly Road Northeast Olympia, WA 98506

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to honor a resident's choice for a room change for 1 of 1 sampled resident (Resident 80) reviewed for resident rights. The facility's failure placed theses residents at risk of not exercising their resident rights, loss of autonomy, and a diminished quality of life.Findings included. Resident 80 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, MDS-an assessment tool, dated 02/24/2026, documented Resident 80 was cognitively intact. On 04/22/2026 at 8:56 AM, Resident 80 stated, They wanted me to move into this room. They did not give me a choice. I told them I liked the old room better. A review of Resident 80's census in the electronic health records (EHR) showed Resident 80's location on 08/28/2025 was room [ROOM NUMBER]-2 and on 11/03/2025 Resident 80's location was 314-2. A review of Resident 80's EHR showed a nursing progress note, dated 09/29/2025 at 11:18 AM by Staff P, Licensed Practical Nurse Supervisor, that said Resident 80 liked their room and would prefer not to move. Staff P educated Resident 80 on the risks for potential falls or other incidents if they shared the bathroom with 3 other residents. Resident 80 stated, I don't care and clarified, I didn't fall, I sat on the ground. A review of the EHR showed a follow up note with a date of service of 12/12/2025 by Staff S, Medical Director, that stated, prefers current room, declined room change for bathroom access. On 04/23/2026 12:32 PM, Staff C, Social Services Director, was asked if Resident 80 agreed to the room change and she stated, I do not have that documentation. When asked if Resident 80 was notified of the room change Staff C stated, no, it is not scanned in. I don't have that documentation. On 04/24/2026 at 11:27 AM, Staff B, Director of Nursing Services, was asked if Resident 80 agreed to the room change and she said initially Resident 80 wanted to stay in their old room. We don't have documentation that Resident 80 agreed to the change. Staff B said she did not have documentation that Resident 80 was notified of a room change or that Resident 80 was given a choice. Staff B said, If Resident 80 did not want to move they could have stayed on the 400 hall. Reference WAC 388-97-0900(1)-(4)

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 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 ensure transfer and discharge notifications to the Office of the State Long-Term Care Ombudsman (patient advocate for all residents in the nursing home) were accurate and/or contained the required copy of the notice for the transfer/discharge provided to residents/representatives, and/or that the facility maintained documentation of the transfer with the required information to be communicated to the receiving health care institution/provider for 5 of 5 residents (Residents 9, 8, 4, 84 & 86) reviewed for hospitalization and discharge. This failure placed residents at risk of lack of advocacy and a diminished quality of life. Findings included . The facility's monthly notifications to the Office of the State Long-Term Care Ombudsman were reviewed for [DATE], February 2026, and [DATE]. All months reviewed showed the resident return columns (expected or not expected) did not match the discharged to columns (acute care, psychiatric care, home, adult family home, assisted living, or expired). Most residents with resident return expected, had a discharge location that was not a hospitalization. Most residents with resident return not expected, had a hospitalization location (acute care or psychiatric care). Additionally, there was not additional information sent with the list, which meant there was no documentation that the facility was providing the required copy of the residents' transfer notice for transfers or discharges to the State Long-Term Care Ombudsman for any of the residents. Resident 9Resident 9 was admitted to the facility on [DATE].The electronic health record (EHR) showed Resident 9 was hospitalized from [DATE] to [DATE] and returned to the facility. The facility's notification to the Office of the State Long-Term Care Ombudsman for [DATE] transfers and discharges, showed Resident 9 was listed as resident return not expected with no indication of where Resident 9 went afterwards. Resident 9's transfer notice was not sent with the notification to the ombudsman. Resident 8Resident 8 was admitted to the facility on [DATE].The EHR showed Resident 8 was hospitalized from [DATE] to [DATE] and returned to the facility. The facility's notification to the Office of the State Long-Term Care Ombudsman for February 2026 transfers and discharges, showed Resident 8 was listed as resident return not expected and discharged to acute care (indicating they were hospitalized and not planned to return to the facility). Resident 8's transfer notice was not sent with the notification to the ombudsman. Resident 4Resident 4 was admitted to the facility on [DATE].The EHR showed Resident 4 was hospitalized from [DATE] to [DATE] and returned to the facility. The facility's notification to the Office of the State Long-Term Care Ombudsman for February 2026 transfers and discharges, showed Resident 4 was listed as resident return not expected and discharged to acute care. Resident 4's transfer notice was not sent with the notification to the ombudsman. The EHR also showed Resident 4 did not have an eInteract transfer form (electronic form that has key details on the resident that is pertinent to the receiving healthcare provider/institution to provide care) filled out for the [DATE] hospitalization. Resident 84Resident 84 was admitted to the facility on [DATE]. The EHR showed Resident 84 was hospitalized on [DATE] and did not return to the facility. Resident 84's transfer notice was not sent with the notification to the ombudsman. Resident 86Resident 86 was admitted to the facility on [DATE].The EHR showed Resident 86 was discharged on [DATE] and left the facility against medical advice (AMA). The facility's notification to the Office of the State Long-Term Care Ombudsman for [DATE] transfers and discharges, showed Resident 86 was listed as resident return expected and was discharged to home. Resident 86's transfer notice was not sent with the notification to the ombudsman. During an interview on [DATE] at 11:33 AM, Staff C, Social Services Director, said that social services was responsible for ombudsman notification. Staff C provided the facility's monthly notifications to the Office of the State Long-Term Care Ombudsman for [DATE], February 2026, and [DATE]. Staff C confirmed only this list was sent to the ombudsman, no other documentation. During an interview on (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] at 12:22 PM, Staff B, Director of Nursing Services, was asked to look over the three months of the facility's notifications to the Office of the State Long-Term Care Ombudsman. Staff B acknowledged the form was confusing and reversed from what it should have been and said the anticipated discharge did not match what was happening. When asked if they could tell who was hospitalized and returned to the facility, Staff B said they could only tell who was hospitalized but could not tell who had returned. When asked if Resident 9 was expected to have returned from the hospital based on their chart, Staff B said Resident 9 was expected to return to the facility and the list for the ombudsman had said Resident 9 was not expected to return. During an interview on [DATE] at 1:12 PM, Staff B was asked about Resident 4's [DATE] hospitalization. When asked if there was documentation of the required information to be provided to the hospital or for documentation the hospital was called with report on Resident 4, Staff B confirmed there was not an eInteract transfer form. Staff B said they expected the eInteract transfer form to be filled out so the hospital knew about the resident, or at least a phone report. Staff B reviewed progress notes and confirmed there was none to document report had been called. During an interview on [DATE] at 12:30 PM, Staff B when asked if it met expectations Resident 86 was not indicated to the Office of the State Long-Term Care Ombudsman as an AMA discharge, said no. Reference WAC 388-97-0120(1)(2)(a)-(d)(3)(a)(4)(b)(5)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice by ensuring nursing staff followed physicians orders, had accurate documentation, and/or by ensuring medications were observed to be taken by residents for 6 of 19 sampled residents (Resident 4, 2, 7, 3, 54 & 65) reviewed for nursing care. These failures placed residents at risk for medication errors, delay in treatment, and adverse outcomes.Findings included .Resident 4 Resident 4 was admitted to the facility on [DATE]. A provider order, dated 04/13/2026, directed licensed nurses to provide diabetic nail care every seven days and as needed. Resident 4's diabetes care plan, initiated 09/25/2025, also showed weekly nail care would be provided by the licensed nurse. On 04/21/2026 at 9:17 AM and 04/23/2026 at 11:13 AM, the toenails to the second, third and fourth digits of Resident 4's left foot were thick, yellow, untrimmed and were curved around the end of the toes to the plantar aspect (underside). The April 2026 Medication Administration Record (MAR) showed on 04/02/2026, 04/14/2026, 04/21/2026 nurses documented the resident's diabetic nail care was not provided, and the diabetic nail care scheduled for 04/09/2026 was left blank. Review of the electronic health record (EHR) showed there was no further documentation to indicate why facility nurses were not providing Resident 4's diabetic nail care as ordered. On 04/24/2026 at 7:49 AM, Staff J, MDS Coordinator, acknowledged facility nurses had documented they did not perform Resident 4's diabetic nail care as ordered and indicated it was because they were unable to. Staff J said Resident 4's toenail care needed to be provided by a podiatrist. On 04/24/2026 at 7:51 AM, when asked if nurses should notify the physician if treatment orders were unable to be carried out, Staff B, Director of Nursing Services (DNS), said yes. When asked if there was any documentation to show the physician was notified of nursing's inability to provide Resident 4's weekly diabetic nail care Staff B stated, No. Resident 2 Resident 2 was admitted to the facility on [DATE] with an order for licensed nurses to perform diabetic nail care weekly. A diabetes care plan, initiated 11/06/2024, directed licensed nurses to provide weekly diabetic foot and nail care. On 04/20/2026 at 1:58 PM, 04/22/2026 at 9:36 AM and 04/23/2026 at 1:12 PM, the fingernails on both of Resident 2's hands were greater than a centimeter long. When asked if this was his preference, Resident 2 said no and explained that facility staff had offered to trim his nails a couple of times, but he asked them to come back later. On 04/23/2026 at 3:47 PM, Staff J, MDS Coordinator, confirmed Resident 2's fingernails were long and untrimmed. Review of the April 2026 MAR showed facility nurses signed they completed Resident 2's diabetic nail care as ordered on 04/03/2026, 04/10/2026 and 04/17/2026. On 04/23/2026 at 3:52 PM, Staff B, DNS, said facility nurses erroneously signed for a task they did not complete. Resident 7 Resident 7 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident had moderate cognitive impairment, a wound infection, received opioid and antianxiety medication during the assessment period and was on Hospice services. Review of the EHR showed Resident 7 had the following orders:a) Morphine 20 milligrams (mg) every hour as needed for pain or shortness of breath (SOB), dated 04/18/2026.b) Lorazepam 0.5 mg one tablet every two hours as needed for anxiety or SOB, dated 04/01/2026.The orders did not indicate which medication, the lorazepam or the morphine, should be administered first if the resident had SOB. On 04/23/2026 at 1:25 PM, when asked if Resident 7's was experiencing SOB, which medication a nurse should (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administer first, the lorazepam or the morphine, or if it was a matter of nurse preference, Staff B, DNS, said the orders were unclear and needed to be clarified. Review of the EHR showed Resident 7 had the following as needed pain medication orders:a) Oxycodone 10 mg every four hours, as needed for pain 5-6/10.b) Morphine 20 mg every hour as needed for pain or SOB.The orders did not indicate what pain medication should be administered for a pain level of 1-4/10 or for a pain level of 7-10/10. On 04/23/2026 at 12:54 PM, when asked which as needed pain medication nurses should administer to Resident 7 for pain levels of 1-4/10 or 7-10/10, Staff B, DNS, stated, I see what you're saying, the orders need to be clarified. Resident 3 Resident 3 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus (a chronic metabolic disorder characterized by high levels of blood glucose resulting from deficiencies in insulin secretion, insulin action, or both). The admission MDS, dated [DATE], documented Resident 3 was moderately cognitively impaired and received insulin injections 6 out of 7 days. Resident 3 had an order, dated 04/06/2026, for Insulin Lispro Inject as per sliding scale:if 70 - 120 = 0 unit;121 - 150 = 2 units;151 - 200 = 4 units;201 - 250 = 6 units;251 - 300 = 8 units;301 - 350 = 10 units;351 - 450 = 15 units if over 450 call MD, subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus A Review of Resident 3's April 2026 MAR showed a blank on 04/18/2026 at 2000. On 04/23/2026 at 3:07 PM, Staff P, Licensed Practical Nurse(LPN)/Supervisor, said while looking at the April 2026 MAR, it did not look like Resident 3's blood sugar was checked as it was supposed to have been and they did not see a progress note. Staff P said her expectation was for the blood sugar to have been checked like the order instructed. On 04/24/2026 at 11:27 AM, Staff B, DNS, said they saw the blank on the April 18th MAR. Staff B said Resident 3's blood sugar should have been taken to see if they required insulin. Resident 54 Resident 54 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 54 was cognitively intact. On 04/22/2026 at 12:16 PM, a medication pass (when a licensed nurse administers medication) for Resident 54 was observed. Staff Q, LPN, poured Tylenol and Pregabalin (for chronic pain) into a medication cup. Staff Q left the medications at Resident 54's bedside and walked out of the room. On 04/22/2026 at 12:24 PM, Staff Q said they should not leave medications at the bedside. Staff Q said Resident 54 would not take their medications if they were standing there. On 04/22/2026 at 1:21 PM, Staff Q was asked if Resident 54 took their medications and Staff Q stated let's go check. Staff Q walked into Resident 54's room and asked them if they took the medications and Resident 54 stated yes. On 04/22/2026 at 1:24 PM, Staff B, DNS, said medications could not be left at the bedside unless a self-medication assessment was completed. Staff B said Staff Q had come to her, told her she left (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications at Resident 54's bedside, and Staff B said she completed a self-medication assessment after the fact. Staff B said the observed medications should not have been left at the bedside because Resident 54 had not been assessed for safety at the time. Resident 65 Resident 65 was re-admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 65 was cognitively intact. Resident 65 had an order, dated 04/17/2026, for oxygen (O2) to be administered via nasal canula at 2 liters per minute (LPM) to keep their oxygen saturation (measure of how full your blood is with oxygen) greater than 90%. On 04/20/2026 at 2:30 PM, Resident 65 was observed receiving oxygen via nasal canula at 4 LPMs. On 04/21/2026 at 12:35 PM, Resident 65 was observed receiving oxygen via nasal canula at 3 LPMs. On 04/22/2026 at 9:34 AM, Resident 65 was observed receiving oxygen via nasal canula at 3 LPMs. On 04/22/2026 at 11:56 PM, Staff Q, LPN, went into Resident 65's room and confirmed they were receiving oxygen at 3 LPM. Staff Q reviewed the orders and confirmed the order for Resident 65's oxygen was for 2 LPM. Staff Q said that Resident 65's oxygen levels had been dropping recently while he had a urinary tract infection, and he had required a higher dose of the oxygen to be delivered. On 04/23/2026 at 11:13 AM, Staff R, LPN/Supervisor, said her expectation of staff if a resident was requiring an increase of oxygen delivery was for staff to call the provider. Staff R was told of Resident 85's oxygen order was for 2 LPM and of the observations of the oxygen being delivered at 3 and 4 LPM. Staff R was then asked if Resident 85 required an increase in oxygen should staff have called the provider and had the order adjusted, Staff R said yes, sometimes staff would forget to put a new order in and she expected staff to communicate so she could assist with putting the order in. Reference WAC 388-97- 1620(2)(b)(i)(ii),(6)(b)(i)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pharmacy recommendations were either addressed or implemented for 3 of 5 sampled residents (Residents 3, 6 & 14) reviewed for unnecessary medications. These failures placed residents at risk for medication errors, adverse side effects, and a decreased quality of life.Findings included.Resident 3 Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's orders, showed PreserVision 2 capsules one time a day for supplement, dated 02/16/2026. Review of Resident 3's pharmacy Consultation Report, dated 03/02/2026, showed the pharmacist documented Resident 3's PreserVision Capsule should not be crushed when administered via feeding tube. The pharmacist recommended discussing with the provider the need for alternative therapy. On 04/23/2026 at 3:07 PM, Staff P, Licensed Practical Nurse/ Supervisor, while looking at the pharmacy consultation, said this may have been an oversite, they should have discussed it with the doctor and possibly switched to a liquid multivitamin. On 04/24/2026 at 11:27 AM, Staff B, Director of Nursing Services (DNS), said Resident 3's PreserVision was not addressed and her expectation was for pharmacy recommendations to be addressed. Resident 6 Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's pharmacy Consultation Report, dated 03/03/2026, showed the pharmacist had recommended Resident 6's topical diclofenac (a mild to moderate pain and inflammation reliever) order be updated to include the quantity in grams and the location it was being applied for joint pain. Review on 04/22/2026 of Resident 6's diclofenac order, showed it had not been updated since it was ordered on 11/07/2025 and did not have grams or location added. Resident 14 Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's pharmacy Consultation Report, dated 03/03/2026, showed the pharmacist had recommended Resident 14's as needed oxycodone (pain medication) order be updated to include a pain scale of moderate to severe pain of 5-10/10 (on a 0-10 pain scale with 0 being no pain and 10 being the worst pain). Review on 04/21/2026 of Resident 14's oxycodone order, showed it had not been updated since it was ordered on 11/05/2025 and did not have a pain scale added. During an interview on 04/24/2026 at 11:05 AM, Staff B, DNS, said their expectation regarding pharmacy recommendations, was for the provider to accept or decline and sign at the bottom of the form, or for nursing to address themselves if applicable. Regarding Resident 6, Staff B reviewed the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EHR and said the recommendation needed a response from the provider, the order was not updated to include grams or a location, and they did not see the order updated per the pharmacist recommendation. Regarding Resident 14, Staff B said the pharmacy recommendation would have been nursing's responsibility, the order was not updated, and their expectation was for the pain scale to have been updated per the pharmacy recommendation. Reference WAC 388-97-1300 (1)(c)(iv),(4)(c)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow medication parameters (provider instructions of when to hold or give a medication) and/or ensure nonpharmacological (non-medication) interventions were in place/documented on/observed for 3 of 6 residents (Resident 85, 6, and 7) reviewed for unnecessary medications. These failures resulted in residents receiving unnecessary medications and placed them at risk of hypotension (low blood pressure), falls, injuries and other medical complications. Findings included .Resident 85 Resident 85 was admitted to the facility on [DATE]. Resident 85 had a diagnosis of hypertension (high blood pressure). The Medicare 5-Day Minimum Data Set (MDS, an assessment tool), dated 11/18/2025, documented that Resident 85 was moderately cognitively impaired. Resident 85 had the following provider orders with hold parameters:1) Amlodipine Besylate, one time a day related to hypertension. Hold for SBP (systolic blood pressure, the top number in a blood pressure reading) less than 110. Order dated 12/08/2025. 2) Chlorthalidone (a diuretic, medication that helps remove excess fluid on the body and lower blood pressure), one time a day related to hypertension. Hold for SBP less than 110. Order dated 11/12/2025.3) Lisinopril, one time a day for hypertension. Hold for SBP less than 110. Order dated 11/12/2025 and discontinued 01/05/2026. Review of the Medication Administration Record (MAR) from 01/01/2026 through 01/20/2026 showed the medication Amlodipine was documented as given 8 times outside of the ordered blood pressure (BP) hold parameters. 01/01/2026- BP 98/58 dose was administered01/02/2026- BP 98/58 dose was administered01/04/2026- BP 92/59 dose was administered01/05/2026- BP 100/60 dose was administered01/06/2026- BP 100/60 dose was administered01/11/2026- BP 100/60 dose was administered01/17/2026- BP 100/60 dose was administered Review of the MAR from 01/01/2026 through 01/20/2026 showed the medication Chlorthalidone was documented as given 8 times outside of the ordered blood pressure (BP) hold parameters.01/01/2026- BP 98/58 dose was administered01/02/2026- BP 98/58 dose was administered01/04/2026- BP 92/59 dose was administered01/05/2026- BP 100/60 dose was administered01/06/2026- BP 100/60 dose was administered01/11/2026- BP 100/60 dose was administered01/17/2026- BP 100/60 dose was administered01/18/2026- BP 98/58 dose was administered Review of the MAR from 01/01/2026 through 01/20/2026 showed the medication Lisinopril was documented as given 4 times outside of the ordered blood pressure (BP) hold parameters before being discontinued.01/01/2026- BP 98/58 dose was administered01/02/2026- BP 98/58 dose was administered01/04/2026- BP 92/59 dose was administered01/05/2026- BP 100/60 dose was administered On 04/23/2026 at 12:24 PM, Staff B, Director of Nursing Services (DNS), reviewed the January 2026 MAR and acknowledged the documentation that the Amlodipine, Chlorthalidone, and Lisinopril had been administered outside of parameters. Staff B said the medications should have been held, and she did not see any progress notes regarding the administrations. Resident 6 Resident 6 was admitted to the facility on [DATE] and had a diagnosis of hypertension. The Quarterly (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS, dated [DATE], documented Resident 6 was cognitively intact. Resident 6 had the following provider order, dated 11/07/2025: Metoprolol Tartrate, give two times a day related to hypertension. Hold for systolic BP less than 110. Review of Resident 6's MAR from 04/01/2026 through 04/22/2026 showed there was no area to document Resident 6's blood pressure on the MAR. Review of Resident 6's vital signs record from 04/01/2026 through 04/22/2026 showed that the blood pressure had not been documented as being taken on the following days: 04/03/2026, 04/04/2026, 04/05/2026, 04/07/2026, 04/08/2026, 04/09/2026, 04/15/2026, 04/17/2026, 04/18/2026, 04/19/2026, and 04/20/2026. Additionally, on the dates it was obtained, there was only one BP recorded (resident 6 was scheduled to receive the medication two times daily). On 04/23/2026 at 12:00 PM, Staff B confirmed Resident 6 had Metoprolol orders with parameters to hold the medication if SBP was less than 110. When asked if she would expect the blood pressures to be documented on the MAR, Staff B confirmed Resident 6 did not have BPs associated with any of their orders and said her expectation was that BPs would have been associated with the Metoprolol order. When asked if BPs should be taken twice daily when the medication was to be given twice daily with parameters in place, Staff B said, yes. Regarding the dates the BP was not taken at all, Staff B said this did not meet her expectations. Staff B confirmed that on 04/14/2026, the medication was given two times that day with one BP recorded of 109/76, outside of the ordered parameters and said it should not have been given. Further record review showed Resident 6 had the following two active oxycodone orders: 1) Oxycodone 5 milligrams, give 1 tablet every 6 hours as needed for moderate pain (5-6). (The order indicated medication was to be given if pain number was 5 or 6, based on a pain scale used to evaluate pain with 0 being no pain and 10 being the worst pain.) Order dated 04/10/2026.2) Oxycodone 5 milligrams, give 2 tablets every 6 hours as needed for severe pain 7-10 (the order indicated the medication was to be given if pain number was 7, 8, 9, or 10) Order dated 04/10/2026. Review of the MAR from 04/01/2026 though 04/22/2026 showed the first oxycodone order for 1 tablet, for 5-6 pain had been given outside of parameters on the following dates:04/11/2026- given with pain score 304/15/2026- given with pain score of 404/16/2026- given with pain score of 304/16/2026- given with pain score of 4 (second administration that day) Review of the same MAR showed the second oxycodone order for 2 tablets, for pain 7-10 had been given outside of parameters on the following dates:04/18/2026- given with pain score of 404/22/2026- given with pain score of 3 On 04/23/2026 at 12:00 PM, Staff B confirmed the doses were given outside of ordered parameters and said this did not meet her expectations. Resident 7 Resident 7 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident had moderate cognitive impairment, received routine and PRN (as needed) pain medication including opioids (a class of drugs that manage moderate to severe pain) during the (continued on next page)

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	505243	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olympia Transitional Care and Rehabilitation	430 Lilly Road Northeast Olympia, WA 98506

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment period. Record review showed Resident 7 had the following, PRN pain medication orders:a) Morphine 5 milligrams (mg) every two hours PRN for pain or shortness of breath (SOB), order date was from 04/01/2026 - 04/18/2026.b) Morphine 20 mg every hour, PRN for pain or SOB, dated 04/18/2026.c) Oxycodone 5 mg give two tablets (10mg) every four hours PRN for pain 5-6 on a scale to 10, order date was from 03/30/2026 - 04/18/2026.d) Monitor level of pain using 0-10 scale (0=NO PAIN, 1-3= MILD PAIN, 4-5= Moderate pain, 6-9= Severe pain, 10= Excruciating pain) every shift, dated 03/30/2026. Review of the PRN pain medication orders showed for pain 5-6 on a scale to 10, staff were to administer oxycodone 10 mg every four hours PRN. The PRN pain medication orders did not indicate what pain medication (morphine or oxycodone) should be administered for a pain level of 1-4 /10 or 7-10/10 Review of the April 2026 MAR, showed facility nurses administered oxycodone 10 mg to Resident 7 outside of the of the physician ordered parameters:a) On 04/01/2026 at 4:43 AM for a pain level of 7/10.b) On 04/14/2026 at 12:58 PM for a pain level of 0/10. On 04/23/2026 at 3:58 PM, when asked if Resident 7 was administered their PRN pain medication in accordance with the provider order Staff B, DNS stated, No. When asked which PRN pain medication should be administered for a pain level of 1-4/10, or a pain level of 7-10/10 Staff B stated, I see what you are saying. Staff B then said the orders needed to be clarified. An order, dated 03/30/2026, directed nurses to attempt non-pharmacological interventions prior to administration of PRN pain medication(s), which included 0= back rub, 2= Redirect, 3=Reposition, 4= Offer Snacks/Fluids, 5= Provide a quiet environment, 6= Encourage to express Feelings, 7= Take to Activities, 8= Provide Reassurance every shift. Review of the April 2026 MAR showed facility nurses were provided with a place to document the non-pharmacological interventions that were attempted, twice a day. Once on day shift and once on night shift. The nurses recorded the numbers associated with the intervention(s) they attempted and initialed. There was no documentation of the times the nurses attempted the interventions and whether the non-pharmacological interventions were effective or ineffective. The incomplete documentation detracted from the ability to determine if the PRN doses of pain medication were warranted or unnecessary. During an interview on 04/23/2026 at 3:58 PM, when asked how one could tell if the pain non-pharmacological interventions that were attempted were effective or not; and whether the time they were attempted correlated with the administration of PRN pain medication (i.e. were non-pharmacological interventions attempted prior to each dose of PRN pain medication, and were PRN pain medications only administered after non-pharmacological interventions were attempted and were ineffective), Staff B, DNS, acknowledged one could not determine by looking at nurse documentation on the MAR what time pain non-pharmacological interventions were attempted, whether they were effective, whether they correlated (time wise) with the administration of PRN pain medication, and ultimately whether the PRN pain medications that were administered were necessary. Reference WAC 388-97-1060 (3)(k)(i)

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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 observation, interview and record, the facility failed to obtain consent from residents and/or resident representatives prior to implementing medical devices that potentially restrained movement and/or before administering psychotropic (mind altering) medication for 3 of 6 residents (Resident 7, 4 & 14) reviewed for right to be informed about treatment decisions. The failure to explain the risks and benefits associated with proposed medical devices and psychotropic medications in advance, detracted from the ability to make informed decisions about the proposed medical care/treatment, and prevented residents/resident representatives from exercising their right to decline the proposed care before it was implemented.Findings included .Resident 7 Resident 7 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 04/05/2026, showed the resident was moderately cognitively impaired, had a diagnosis of depression and received antidepressant and antianxiety medication during the assessment period. Record review showed Resident 7 had a 04/01/2026 order for lorazepam (an antianxiety medication) 0.5 milligrams (mg) every two hours as needed for anxiety or shortness of breath. The April 2026 Medication Administration Record (MAR) showed Resident 7 was administered lorazepam on 04/02/2026 at 8:01 PM. Review of the electronic health record (EHR) showed there was no documentation to show staff informed Resident 7 and/or their representative of the risks and benefits associated with lorazepam and obtained their consent prior to administering the medication. On 04/23/2026 at 12:54 PM, when asked if there was documentation to show staff educated Resident 7 and/or their representative about the risks and benefits associated with lorazepam therapy and had obtained consent for its use, Staff B, Director of Nursing Services (DNS), stated, No. Resident 4 Resident 4 was admitted to the facility on [DATE]. Review of the 5-day MDS, dated [DATE], showed the resident had moderate cognitive impairment, had fallen in the past month prior to admission/re-entry, and no bed rails or trunk or limb restraints were in use. On 04/21/2026 at 9:29 AM, Resident 4 was lying in bed on a perimeter (mattress with raised foam edges help prevent falls by creating a soft barrier around the bed) alternating low air loss mattress. Their bed had grab/mobility bars attached to the right and left side (bilateral). On 04/22/2026 at 2:55 PM, Resident 4 was working on a puzzle in the main dining room in their electric tilt-in-space wheelchair with a seatbelt fastened around their waist. Resident 4 said they had been using a seatbelt when in their wheelchair since the facility provided it quite some time ago. Review of the EHR showed a restraint safety device evaluation and consent form had been completed for a left side mobility bar on Resident 4's bed to aide with bed mobility, completed 04/05/2026. No device evaluation or consent was found for Resident 4's perimeter mattress, tilting wheelchair or seatbelt. On 04/23/2026 at 12:46 PM, when asked if there was documentation of device evaluations and resident consent for the use of the tilt-in-space wheelchair, seatbelt and the perimeter mattress, prior to the evaluations and consents staff completed on 04/22/2026, Staff B, DNS, stated, No. Resident 14 Resident 14 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 14 was severely cognitively impaired. Review of Resident 14's orders showed an order from 04/20/2026 for hydroxyzine (an antihistamine at times used to manage anxiety and related behavioral health symptoms without risks of addiction) every twelve hours as needed for agitation/anxiety for fourteen days. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 14's April MAR, showed the first dose was given on 04/20/2026. Review of Resident 14's consent for hydroxyzine, showed consent was not signed until 04/21/2026, by Resident 14's power of attorney (decision maker). During an interview on 04/23/2026 at 12:21 PM, Staff B, DNS, was unable to find documentation from the nurse that consent was obtained prior to the hydroxyzine medication being given to Resident 14. Staff B acknowledged consent should have been done before the first dose was given. Reference WAC 388-97-0300(3)(a), 0260, 1020(4)(a-b)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 5 residents (Residents 7 and 14) reviewed for unnecessary medications, were free of chemical restraints. The failure to ensure residents receiving psychotropic medications (drugs that affect behavior, mood, thoughts and perception) had identified target behaviors that were monitored and documented when observed, non-drug interventions were attempted prior to administration of as needed (PRN) psychotropic medications, and PRN psychotropic medication orders did not exceed 14 days, unless a clinical rationale was documented in the residents record by the provider. These failures placed residents at risk of receiving unnecessary psychotropic medications, experiencing adverse side effects such as sedation, a decline in physical function, and other potential negative health outcomes. Findings included . Resident 7Resident 7 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 04/05/2026, showed the resident was moderately cognitively impaired, had a diagnosis of depression and received antidepressant, antianxiety and sedative hypnotic medications during the assessment period. Record review on 04/23/2026, showed Resident 7 had a 04/01/2026 order for lorazepam (an antianxiety medication) 0.5 milligrams (mg) every two hours, as needed (PRN), for anxiety or shortness of breath that had been in place for 23 days. The PRN lorazepam order had been input without a stop date. Review of the electronic health record showed no documentation was present from Resident 7's provider indicating why it was necessary to extend Resident 7's PRN lorazepam order beyong 14 days On 04/23/2026 at 12:54 PM, when asked if the provider documented a resident specific clinical rationale indicating why Resident 7's PRN lorazepam needed to be extended beyond 14 days Staff B, Director of Nursing Service (DNS) stated, No. Review of Resident 7's comprehensive care plan, initiated on 03/30/2026, revealed Resident 7's use of PRN lorazepam, the goal of treatment and the specific behaviors the medication was initiated to target were not addressed. Review of the April 2026 Medication Administration Record (MAR), on 04/23/2026 at 9:14 PM, showed non-pharmacological interventions (NPIs) to be attempted prior to administration of PRN pain medications, sedative hypnotic medication and antidepressant medication had been identified and were in place. There were no NPIs identified for staff to attempt, prior to the administration of Resident 7's PRN lorazepam for anxiety. Nor was there direction to attempt any. The April 2026 MAR showed between 04/01/2026 - 04/21/2026, facility nurse administered the PRN lorazepam to Resident 7 eight times without attempting NPIs prior to administration. During an interview on 04/23/2026 at 12:54 AM, when asked if they could provide documentation to show facility nurses attempted NPIs prior to the administration of Resident 7's PRN lorazepam, Staff B, DNS, stated, No. Resident 14 Resident 14 was admitted to the facility on [DATE] with diagnosis that included Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (excessive, persistent, and uncontrollable fear, worry, or dread that interferes with daily life), unspecified dementia (cognitive decline) with other behavioral disturbance, and vascular dementia (decline in thinking skills caused by reduced blood flow to the brain) with psychotic disturbance (losing touch with reality). The Quarterly MDS, dated [DATE], documented Resident 14 was severely cognitively impaired. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 14 had a provider order, dated 08/19/2025, for the medication Divalproex (Depakote, anticonvulsant [anti-seizure] medication at times used as a mood stabilizer) to be given three times daily related to dementia with other behavior disturbance. Review of the April 2026 Treatment Administration Record (TAR) for Resident 14 showed that there was a behavior monitor in place for the anticonvulsant medication that listed target behaviors for the medication as follows: A. Labile [unstable] mood B. unprompted outbursts and C. agitation. The order indicated these were to be documented on every shift. The order also listed nonpharmacological (non-medication) interventions to include 1. Assist (Resident 14) back to [their] room [ROOM NUMBER]. Allow [Resident 14] to express [their] feelings 3. Assist with problem solving. Further review of the TAR showed there was no area for staff to document the target behaviors or nonpharmacological interventions. On 04/23/2026 at 12:15 PM, Staff B, DNS, was asked if resident 14 had behavior monitoring and nonpharmacological interventions in place for the Depakote, Staff B looked in the electronic health record and said, yes. When asked where the behaviors and nonpharmacological interventions were to be documented Staff B said usually there was an area for the supplementary documentation, but she did not see that it was there for Resident 14's Depakote. Reference WAC 388-97-1060(3)(k)(i), 0620(1)(a)

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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 observation, record review, and interview the facility failed to ensure resident care plans (CPs) were reviewed, revised, and accurately reflected residents' care needs for 4 of 19 sample residents (Resident 4, 2, 7, & 40) whose care plans were reviewed. These failures placed residents at risk for unmet care needs and diminished quality of life.Findings included .Resident 4Resident 4 was re-admitted to the facility on [DATE]. The 5-day Minimum Data Set (MDS, an assessment tool), dated 04/15/2026, showed the resident received intravenous (IV) medication(s) via a central line (a type of IV access that reaches a large central vein in the body) during the assessment period. Review of the hospital transfer paperwork, dated 04/13/2026, showed Resident 4 re-admitted with a central line to the right upper chest and orders for IV vancomycin (antibiotic) every other afternoon for bacteremia (bacteria in the blood). Review of the comprehensive care plan, initiated 09/25/2025, showed no care plan had been developed or implemented that addressed Resident 4's central line or IV antibiotic therapy. During an interview on 04/24/2026 at 7:49 AM, Staff B, Director of Nursing Services (DNS), confirmed there was no care plan in place that addressed Resident 4's central line access and/or IV antibiotic therapy. Staff B said Resident 4's comprehensive care plan needed to be revised to accurately reflect his current care needs. On 04/21/2026 at 9:29 AM, Resident 4 was observed lying in bed on a perimeter alternating low air loss mattress. The resident's bed had mobility bars affixed to both the right and left side. On 04/22/2026 at 2:55 PM, Resident 4 was sitting in an electric tilt-in-space wheelchair, in the main dining room with a seatbelt fastened around his waist.Review of the comprehensive care plan, initiated 09/25/2025, showed Resident 4's use of a tilt-in-space wheelchair, seatbelt and perimeter mattress had not been care planned. During an interview on 04/23/2026 at 2:46 PM, Staff B, DNS, confirmed Resident 4's use of a tilt-in-space wheelchair, seat belt and perimeter mattress were not care planned, and said the plan of care needed to be updated/revised. An activity of daily living (ADL) care plan, initiated 09/24/2025, documented that Resident 4 may use a left sided mobility bar. On 04/23/2026 at 3:18 PM, Staff J, MDS Coordinator, observed Resident 4's bed and confirmed there were both right and left side mobility bars were in place. During an interview on 04/23/2026 at 12:46 PM, Staff B, DNS, said Resident 4's ADL care plan was inaccurate and needed to be updated. Resident 2Resident 2 was admitted to the facility on [DATE]. On 04/20/2026 at 1:58 PM, Resident 2 was observed lying in bed in a hospital gown. Resident 2 explained that they wanted to be up and dressed by noon daily, but indicated their wishes were not always followed and/or honored.An ADL care plan, initiated 10/24/2024, documented Resident 2 preferred to get up after breakfast. The care plan did not include the resident's desire to be up and dressed before noon.On 04/23/2026 at 3:47 PM, Staff B, DNS, confirmed she was aware Resident 2 liked to be up and dressed before noon. When asked if being up and dressed by noon was care planned, Staff B, DNS, said no, and indicated the care plan needed to be updated to reflect Resident 2's current care preferences. Resident 7Resident 7 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident had moderate cognitive impairment, a wound infection, received opioid and antianxiety medication during the assessment period and was on Hospice services. Record review showed Resident 7 had a 04/01/2026 order for lorazepam (an antianxiety medication) every two hours, as needed, for anxiety or shortness of breath. Review of Resident 7's comprehensive care plan, initiated 09/25/2025, showed there was no care plan in place that addressed the resident's use of lorazepam, or that identified the target behavior(s) the medication was initiated to treat, and the goals of the anxiolytic therapy. During an interview on 04/23/2026 at 12:54 PM, Staff B, DNS, acknowledged Resident 4's comprehensive care plan was incomplete and should have addressed/included the residents use of an antianxiety medication(s), the goal of the medication therapy, and identified the specific target behaviors the lorazepam was (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiated to target.Resident 40Resident 40 was admitted to the facility on [DATE]. A Methicillin-Resistant Staphylococcus Aureus (MRSA, a multi drug resistant organism) care plan, initiated 03/07/2026, documented Resident 40 had a MRSA infection and directed staff to follow enhanced barrier precautions. The care plan did not identify the source (urine, blood, wound etc.) or the location of the infection (left foot, nares, etc.).On 04/23/2026 at 4:12 PM, Staff B, DNS, said resident care plans were plans that should be personalized and resident specific. When asked if the source and location of a resident's MRSA infection should be care planned, Staff B, DNS said yes. When asked if it was for Resident 40, Staff B said no.Reference WAC 388-97-1020(2)(c)(d)

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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 provide bowel care in accordance with provider orders and the facility's bowel protocol for 2 of 7 residents (Resident 3 & 7) reviewed for bowel management. This failure placed residents at risk for abdominal pain/discomfort, decreased appetite and other potential health complications.Findings included. Per the facility policy, titled Bowel Protocol, Revised 03/2026:1. Administer Miralax 17gm dissolved in 8 oz fluid as needed if no bowel movement after 3 days2. If the resident does not have a bowel movement after Miralax is given, administer Dulcolax 10mg suppository rectally as needed if Miralax is ineffective and /or no bowel movement after four days3. If Miralax and Dulcolax are ineffective, the provider must be notified for further intervention.4. Document all efforts and interventions, including successful BM or on-going efforts to achieve the goal of a healthy bowel elimination5. With residents who have specialized bowel protocol to meet their individual needs, discuss their normal bowel movements and what is a normal pattern for the resident. Discuss the risk versus benefits to resident and/or resident representatives on not following the facility bowel protocol. Preferences will be care planned to resident's individualized needs/preferences. Resident 3 Resident 3 was admitted to the facility on [DATE]. The admission Minimum Data Set, (MDS-an assessment tool), dated 02/19/2026, documented Resident 3 was moderately cognitively impaired and required set up assistance with oral hygiene and was dependent to substantial assistance with activities of daily living. A review of Resident 3's bowel record showed no bowel movement (BM) documented from 04/08/2026 – 04/11/2026 (4 days). A review of Resident 3's April 2026 Medication Administrator Record (MAR) showed no bowel protocol medications were given. On 04/23/2026 at 3:07 PM, Staff P, Licensed Practical Nurse Supervisor, said there was no documented BM and they should have offered Miralax. Staff P said her expectation was for Miralax to at least to have been offered to Resident 3. On 04/24/2026 at 11:27 AM, Staff B, Director of Nursing Services said she does not see a progress note or any documentation that Miralax was given to Resident 3. Staff B said her expectation was for Resident 3 to have received the first step of the bowel protocol on the 11th. Resident 7 Resident 7 was admitted to the facility on [DATE] with the following as needed bowel management orders:a) Miralax every 72 hours, as needed, administer if no BM after three days.b) Dulcolax suppository, insert rectally if no BM after four days. The March and April 2026 bowel records showed Resident 7 had no BM from 03/27/2026 - 03/30/2026 (4 days) and from 04/02/2026 - 04/09/2026 (8 days). Review of the March and April 2026 MARs showed Resident 7 was not administered any as needed bowel medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/2026 at 12:58 PM, when asked if facility nurses administered Resident 7 as needed Miralax after three days without a BM or an as needed Dulcolax suppository after four days without a BM as ordered Staff B, DNS, stated, No. 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 ensure 1 of 2 residents (Resident 40) reviewed for pressure ulcers (PU - injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time), was provided care and services consistent with professional standards of practice, to promote healing and prevent new pu formation. The failure to consistently implement preventative offloading measures residents were assessed to require placed residents at risk for further skin breakdown, prolonged wound healing and development of new avoidable PUs. Findings included . Resident 40 Resident 40 was admitted to the facility on [DATE]. Review of the admission minimum data set (MDS, an assessment tool), dated 03/11/2026, showed the resident was cognitively intact, and admitted with a surgical wound and pressure injury to their feet. Review of the 03/07/2026 transfer paperwork showed Resident 40 had a surgical wound to the right heel after an incision and drainage was performed due to osteomyelitis (bone infection) and abscess formation. The 03/07/2026 nursing admission assessment showed Resident 40 had a small non-blanchable area of purple/reddish discoloration to the left heel which was assessed as to be a deep tissue injury (DTI, unstageable PU). An actual skin impairment care plan, initiated 03/07/2026, documented the resident had a right heel surgical wound that was being treated with negative pressure therapy. Staff were directed to float Resident 40's heels. An actual PU and potential for development of further PU care plan, initiated 03/07/2026, showed the resident admitted with a PU to the left heel and directed staff to encourage turning and repositioning, replace the resident's heel lift boots with a wedge cushion to float bilateral (both) heels, assess the PU weekly to include measurements, wound base characteristics, drainage type/amount and a peri wound description and to notify the nurse immediately if any new areas of skin breakdown such as persistent redness, blisters or areas of discoloration were observed. Review of the electronic health record showed Resident 40 had the following wound care orders:a) Cleanse left heel surgical wound with wound cleanser, pat dry, apply skin prep to the peri wound, and then apply negative pressure wound therapy at 125 mmHg [vacuum suction measurement] suction, twice a week on Mondays and Thursday, dated 03/19/2026.b) Cleanse left heel DTI with normal saline, pat dry, and paint the area with betadine every evening.c) Alternating low air loss mattress to Resident 40's bed form offloading and pressure redistribution. Review of the weekly skin notes showed on 03/12/2026 Resident 40 had an unstageable PU (DTI) to his left heel. The area was purplish/red in color, non-blanchable and measured 0.5 cm [centimeters] x 0.7 cm. Further review showed Resident 40's left heel PU, remained virtually unchanged through 04/09/2026, when it was measured at 0.5 cm x 0.5 cm. The 04/16/2026 wound note documented Resident 40's left heel PU had deteriorated due to a marked increase in size. The purple, non-blanchable DTI now measured 5.5 cm x 6 cm but remained intact. On 04/17/2026 an order was given to cleanse the left heel with wound cleanser, pat dry, apply betadine gauze and cover with a foam dressing daily. Review of the April 2026 Treatment Administration Record (TAR) showed there was a 03/12/2026 order that read Right heel surgical wound, left heel DTI, right great toe callus, BUE [bilateral upper extremities] scattered bruises Monitor for s/sx [signs or symptoms] of infection such as purulent discharge, increase pain, redness or odor and dressing placement daily until resolved. The order did not indicate what type of dressing should be applied to which skin issue. The 04/17/2026 order to apply betadine gauze and a foam dressing daily to Resident 40's left heel, was not on the TAR. On 04/21/2026 at 9:54 AM, Resident 40 was observed lying in bed on an alternating low air loss (LAL) mattress, firmness was set to 5 green bars. Resident 40 had no footwear or socks on, and both heels were resting directly on the mattress surface. A wound vacuum was in place to the right heel, and the left heel was open to air. On 04/22/2026 at 2:27 PM, Resident 40 was observed lying in bed on an alternating low air loss (LAL) mattress, firmness was set to 5 green bars. The wound vac was no longer present in the room. Resident 40 reported they just returned from their (continued on next page)

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	505243	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wound appointment and no longer had the wound vacuum. Observation of Resident 40 showed he had no footwear or socks on, the right heel was dressed and wrapped with kerlix gauze, and the left heel was open to air. Both heels were resting directly on the mattress surface. No heel lift boots, wedge, or pillows to float Resident 40's heels were observed in the room. On 04/23/2026 at 2:54 PM, Resident 40 was observed lying in bed on an alternating low air loss (LAL) mattress, firmness was set to 5 green bars. The resident had no footwear in place and feet were bare. A dressing was noted to the resident's right posterior heel. Unable to clearly observe the dressing as the right heel was resting on the mattress. No dressing was in place to the left heel. Resident 40 reported facility staff had just finished performing the dressing to the right heel. The 04/23/2026 wound note measured the left heel PU at 6 cm x 4 cm x 0.3 cm depth, and documented the area was deteriorating with increased size and area of involvement when compared to prior assessments, The note concluded Wound characteristics show progression with increased area of involvement. The wound note did indicate why there was now a depth measurement included and did not document that the wound had opened. On 04/23/2026 at 3:48 PM, Staff J, MDS Coordinator, accompanied writer to Resident 40's room and confirmed there was not a wedge or pillows in the room to float Resident 40's heels. On 04/24/2026 at 7:27 AM, Resident 40 was lying in bed on an alternating low air loss (LAL) mattress with two pillows positioned under his lower legs to offload the heels. However, someone had placed a blue folded blanket under the resident's heels, which they were resting on. On 04/24/2026 at 12:06 PM, Staff G, Nurse Supervisor, said Resident 40 now had a clear fluid filled blister on the left heel where the previous deep purple non-blanchable area was located. Staff G indicated the depth measurement was the approximate depth of the fluid filled blister and said a new order to paint the area with betadine and cover with a foam dressing had been obtained, and staff were to continue to offload the resident's heels when in bed. On 04/24/2026 at 12:53 PM, Staff B, Director of Nursing Services, confirmed that Resident 40's 04/17/2026 to apply betadine gauze and cover with a foam dressing was not transcribed to the TAR. Staff B also said it was the expectation that staff provide care in accordance with the resident's care plan, if the resident's heels were care planned to be offloaded utilizing a foam wedge, then that's what staff were expected to do. Reference WAC 388-97-1060(3)(b)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure diabetic nail care was provided for 1 of 2 residents (Resident 4) reviewed for foot care. The failure to refer residents to a qualified specialist when staff were unable to meet a resident's diabetic foot/nail care needs, placed the resident at risk for ingrown toenails, foot ulcers, infection, pain/discomfort, and other medical complications associated with inadequate of diabetic foot care.Findings included .Resident 4 was admitted to the facility on [DATE]. A provider order, dated 04/13/2026, directed licensed nurses to provide diabetic nail care every seven days and as needed. Resident 4's diabetes care plan, initiated 09/25/2025, also showed weekly nail care would be provided by the licensed nurse. Observations on 04/21/2026 at 9:17 AM and 04/23/2026 at 11:13 AM, showed Resident 4 had a right above knee amputation and the fifth digit (pinky toe) on the right foot had been amputated. Resident 4 indicated the amputations were due to complications associated with diabetes. Resident 4's remaining four toes on the left foot showed the first, second, third and fourth digits had thick yellow brittle untrimmed toenails that curved around the end of the toes to the plantar aspect (underside) of the toes. The April 2026 Medication Administration Record (MAR) showed on 04/02/2026, 04/14/2026, 04/21/2026 nurses documented the resident's diabetic nail care was not provided, and the diabetic nail care scheduled for 04/09/2026 was left blank. The electronic health record (EHR) showed there was no documentation to indicate why facility nurses were not providing Resident 4's diabetic nail care as ordered, or that staff had notified the provider. On 04/24/2026 at 7:49 AM, Staff J, Minimum Data Set Coordinator, confirmed facility nurses documented they did not perform Resident 4's diabetic nail care as ordered in the month of April 2026 and indicated it was because the resident's toenails were too long thick and brittle for facility nurses to safely cut. Staff J said Resident 4 needed to be referred to podiatry for diabetic toenail care. Review of podiatry documents provided by Staff B, Director of Nursing Services, showed the podiatrist was last at the facility on 03/05/2026 and Resident 4 was not seen. On 04/23/2026 at 4:09 PM, Staff B explained that the facility could not find a podiatrist to service the facility for several months and were making resident podiatry appointments for individual residents on an as needed basis but recently did contract with a podiatrist who was in the facility last on 03/05/2026. Staff B said Resident 4 was hospitalized and re-admitted to the facility on [DATE] (the day before the podiatrist visited) and was not seen. On 04/24/2026 at 9:23 AM, Staff B said given Resident 4's diabetes, history of amputations, and documentation that the resident's ordered diabetic foot/nail care was not/could not be completed, that she would have expected to have been notified and a podiatry referral/appointment to already have been made, but acknowledged those things did not occur. Reference WAC 388-97-1060(3)(j)(viii)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide adequate and ordered fluids, within reach of the resident and at mealtimes, to maintain hydration for 1 of 1 sampled resident (Resident 60) when reviewed for hydration. This failure placed residents at risk for dehydration, medical complications and a diminished quality of life.Findings included. Resident 60 was admitted to the facility on [DATE] with unspecified dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities). The Significant Change Minimum Data Set (MDS, an assessment tool), dated 03/30/2026, documented Resident 60 was severely cognitive impaired and depended on staff for care. On 03/14/2026, Resident 60 was ordered to have a fortified diet (foods enhanced with additional vitamins, minerals, or other nutrients to improve overall nutritional intake and prevent deficiencies), with regular texture and thin liquids. Resident 60's at risk for potential fluid deficit care plan, dated 02/05/2026, documented Resident 60 recently had intravenous hydration and needed encouragement to drink fluids. On 04/20/2026 at 11:40 AM, Resident 60's lunch meal tray was delivered to the table. Observation of tray included tomato soup, corn bread, rice and chicken, and pudding bowl. No whole milk on the meal tray. On 04/21/2026 at 9:03 PM, Resident 60's Power of Attorney (POA, a legal document that allows you to appoint someone to make healthcare decisions on your behalf if you become unable to do so yourself) said they were concerned about Resident 60's fluid intake, that Resident 60 had not been receiving enough fluids to stay hydrated and that Resident 60 had a history of urinary tract infections related to this. Resident 60's POA pointed to the clear water mug with a straw in it, sitting in the corner of the room on the nightstand, one fourth full, and said it was out of reach of Resident 60. Resident 60's POA said the water cup had been sitting there like that since Sunday (for three days). On 04/21/2026 at 12:29 PM, observation of the clear water mug sitting on the corner nightstand had been filled. Resident 60's wheelchair had been parked between Resident 60's bed and the nightstand, still out of reach and with an obstacle between Resident 60 and the water cup. On 04/22/2026 at 9:16 AM, a clear water mug sitting on nightstand was observed. Resident 60 was unable to reach the cup on the nightstand. The water mug was full with water and had a straw in it and it was sitting in same position as the previous day. On 04/22/2026 at 11:40 AM, Resident 60's lunch meal tray was delivered to the table. Observation of the tray included a slice of pepperoni pizza, a bread stick, a green salad, cup of marinara, chicken noodle soup and the drink was coffee. No whole milk was observed on the meal tray. On 04/23/2026 at 8:13 AM, An observation of the clear water mug showed it was sitting on the corner of the nightstand. Resident 60's wheelchair had been parked between Resident 60's bed and the nightstand, still out of reach and with an obstacle between Resident 60 and the water cup. On 04/23/2026 at 8:23 AM, Staff E, Certified Nursing Assistant, said they would fill all the water cups every hour to two hours and as needed. Staff E said water cups should have been placed where residents could see it and within reach of the resident. On 04/23/2026 at 8:36 AM, Staff F, Licensed Practical Nurse (LPN), said water cups were filled as needed and at least once a shift form the aides. Staff F said a water mug should be placed at the resident's bedside, within reach of the resident, not on the nightstand. Staff F was asked to observe Resident 60's water cup. Staff F confirmed Resident 60's clear water mug was sitting on the nightstand, not within reach of the resident. When observations were explained about the wheelchair having been parked between Resident 60 and the nightstand, Staff F said even without the wheelchair being parked between them and the nightstand, Resident 60 could not reach the water mug. When asked if that was an acceptable place for the water mug, Staff F stated, no, I will move it. On 04/23/2026 at 9:20 AM, Staff G, LPN/Supervisor, said fluids were offered between meals, at snack time and as needed, which was the same as filling the water cups. When observations of the clear water mug, sitting on the nightstand for the past 4 days, was out of reach of the Resident 60 were explained, Staff G said that (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was not acceptable and it needed to be within reach of the resident. On 04/23/2026 at 10:31 AM, Staff B, Director of Nursing Services, with Staff I, Regional Clinical Resource, and Staff J, MDS Coordinator, present, said water cups should have been filled when empty or when a resident asked and should be placed within reach of the resident. When observations of clear water mug sitting on nightstand for the past 4 days was out of reach of the Resident 60 were explained, Staff B said that was not their expectation from staff. Staff I and Staff J nodded in agreement. On 04/23/2026 at 3:08 PM, Staff H, Dietary Supervisor, said with the fortified diet residents should have received whole milk with their meals. Staff H said the fortified diet food was prepared in the kitchen, but the drinks, including whole milk, were placed on the resident's meal tray by nursing staff, from the drink carts delivered to the units prior to the meal. When asked if staff should have placed whole milk on the resident's trays who have a fortified diet type, Staff H said yes. On 04/24/2026 at 10:25 AM, A full clear water mug with a straw in it was observed sitting on the bedside table, up against wall, next to the nightstand, with the resident's wheelchair parked between them and the bedside table. The water mug was not within reach and was blocked by Residents 60's wheelchair. Reference WAC 388-97 -1060 (3)(h)(i)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an effective Antibiotic Stewardship Program, to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use and decrease the development of adverse side effects and antibiotic resistance for 3 of 5 residents (Residents 9, 96, & 3) when reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics.Findings included .Review of the facility policy titled, Antibiotic Stewardship, last revision/review date of 4/2025, documented Antibiotic Stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This can be accomplished through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use to ensure that residents receive the right antibiotic for the right indication, dose, and duration. Under the section Leadership it was documented the team would Assess residents for any infection using McGeer's criteria and Require antibiotic orders to include the indication, dose, and duration.Review of the facility provided documentation of McGreer's criteria for urinary tract infection (UTI) showed UTI included only symptomatic UTIs. Surveillance for asymptomatic bacteriuria (defined as the presence of a positive urine culture in the absence of new signs and symptoms of urinary tract infection) was not recommended, as this represented baseline status for many residents. Resident 9Resident 9 was admitted to the facility on [DATE] with a diagnosis of chronic cystitis (long term inflammation of the bladder). Review of the electronic health record (EHR) showed Resident 9 had been on Cephalexin since 01/21/2026 for chronic cystitis. Review of the March 2026 Infection Prevention and Control Surveillance Log showed the signs and symptoms listed for Resident 9 were LOC (Level of consciousness, log did not indicate what the symptoms related to LOC were) and the current antibiotic order did not indicate an end date.On 04/23/2026 at 1:30 PM, Staff D, Infection Preventionist (IP), said that Resident 9 met criteria for the prescribed antibiotic when it started in January 2026 but no longer met criteria. Staff D said she had not had a conversation with the provider about the long-term antibiotic use and said she should have. Staff D acknowledged the antibiotic did not have an end date and said it should have. Resident 96Resident 96 was admitted to the facility on [DATE]. Review of the February 2026 Infection Prevention and Control Surveillance Log showed Resident 96 had listed urinary symptoms of agitation and confusion with listed treatment of Nitrofurantoin (antibiotic). Review of the March 2026 Infection Prevention and Control Surveillance Log showed Resident 96 had listed urinary symptoms of agitation, restlessness, and aggression with listed treatment of Bactrim (antibiotic). On 04/24/2026 at 11:49 AM, Staff D, IP, said that Resident 96 did not meet criteria for the prescribed February and March antibiotics and she was unable to find documentation in the EHR that she had discussed the lack of meeting criteria with the provider and it should have been discussed. Resident 3Resident 3 was admitted to the facility on [DATE] with an indwelling urinary catheter (a tube that enters the bladder and drains the urine out).Review of the February 2026 Infection Prevention and Control Surveillance Log showed Resident 3 had urinary symptoms of pain, burning, and LOC (log did not indicate what the symptoms of LOC were) and was prescribed two antibiotics, amoxicillin and Cefdinir. Review of the EHR showed that Resident 3 remained on the antibiotic Cefdinir since that time and this antibiotic did not have an end date. Further review of Resident 3's EHR showed an order, dated 02/13/2026, for Nitrofurantoin (antibiotic) for UTI, which was not found on the February 2026 Infection Prevention and Control Surveillance Log. Additionally Resident 3 had an order, dated 03/25/2026, for Gentamicin Sulfate (antibiotic) every Monday and Friday related to UTI, and the antibiotic did not have an end date and was not on the March Infection Prevention and Control Surveillance Log.Further review showed Resident 3 had another antibiotic order, dated 03/10/2026, for Ceftriaxone, for infection. This order did not indicate (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what type of infection the antibiotic was prescribed for, however the March 2026 Infection Prevention and Control Surveillance Log indicated catheter with symptoms of pain, hematuria (blood in the urine) and LOC (log did not indicate what symptoms of LOC were). On 04/24/2026 at 11:49 AM, Staff D, IP, said that Resident 3 was currently on the antibiotic Cefdinir and had been on that antibiotic since admission. When asked if Resident 3 met criteria for this antibiotic Staff D said no, she had called the provider the day before, and Resident 3 had been on antibiotics for too long, way too long. When asked if there was an end date for the current Cefdinir antibiotic, Staff D said, no and there should be. When asked if she had documentation that the Cefdinir had been reassessed since February, Staff D said not until yesterday, she had not realized it was to be a long-term antibiotic. When asked how often long-term antibiotics were reevaluated for ongoing needs, Staff D said she had no specific review plan up to that point, going forward there would be a new process and reassessments. Regarding the February Nitrofurantoin antibiotic not being on the line listing, Staff D said she missed it altogether. Regarding the Gentamicin Sulfate antibiotic not having an end date and not being on the surveillance log, she said she would expect there to be an end date and it should have been on the March log. Regarding the order for the Ceftriaxone for infection and asked if this was a complete order, Staff D said, no and it did not meet her expectations. No associated WAC