| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505254 | A. Building<br>B. Wing | 01/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Crystal Cove Post Acute | 1505 Carpenter Road SE<br>Lacey, WA 98503 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the shower rooms were clean and in good condition, for 4 of 4 shower rooms (Hall A & Hall C [two shower rooms each]) reviewed. This failure placed residents at risk of feeling their showers were not homelike or clean, and a diminished quality of life. Findings included.During an interview on 01/05/2026 at 1:02 PM, Resident 66 said the shower rooms were dirty, that if you went into any of the shower rooms you would see how dirty they were. Resident 66 said they asked for garbage bags to be put on their feet because of how gross the shower rooms were. During an observation on 01/05/2026 at 1:25 PM, Hall A's shower, between rooms [ROOM NUMBERS], were checked. Observation showed the painted tiles were peeling, near the shower controls, bar, and sides. Paint along the baseboard was peeling. Two pieces of trash were seen on the floor, one appeared to be a seal flap (of an opened container), and the other object was a thin peel of debris (looked like it had come from the wall peeling). The flooring material appeared to have been put over a tiled floor, which led to square outlines that were stained by a dark brown/black appearance (resembling dirt). The shower room on Hall C, between rooms [ROOM NUMBERS], was observed to have the same dark brown/black staining between the texture of the flooring. The flooring, between the wall with the shower head and drain on the floor, had a large stain noted. The shower knobs/controls had a yellow stain going down the wall. Peeling of the painted tiles was noted to be prevalent near the base of the shower, with dark brown/black appearance between the shower tiles.During an observation on 01/12/2026 at 9:40 AM, Staff T, Certified Nursing Assistant, had been seen taking a resident out of the Hall A shower room, between rooms [ROOM NUMBERS]. The shower room door was left opened, and the room was observed to have towels draped over the shower wall side, a plastic cup was on the ground on the right side of the shower room on the floor, and a small brown item, with the appearance of stool, was seen near the shower drain (the room had not yet been cleaned). The shower chair was currently in the resident's room as staff assisted them. During an observation and interview on 01/12/2026 at 11:09 AM, Staff S, Maintenance Director, reviewed two shower rooms on Hall A. The first shower room reviewed was between rooms [ROOM NUMBERS]. The baseboards were peeling around the perimeter of the room, and the peeling painted shower tiles was confirmed by Staff S. The next shower room reviewed was between rooms [ROOM NUMBERS]. The tile's paint was observed to be peeling and the floor had brown/black staining between the texture lines. Staff S said the floor needed deep cleaning, needed to be cleaned better or deep cleaned or resealed. The room had appeared to have been cleaned since the prior observation, as the towels had been removed, the plastic cup had been removed, and the shower chair had been returned to the shower room. However, the small brown item was seen on the floor of the shower room, under the shower chair. Staff S told Staff E, Registered Nurse, that it looked like stool was on the floor in the shower room. Staff E stated, Yeah it looks like it. Staff S removed the item. During an interview on 01/12/2026 at 11:23, Staff T said they had cleaned the shower after the prior resident's shower and had not seen the brown item. During an observation on 01/12/2026 at 12:10 PM, Hall C showers were observed. The shower room, between rooms [ROOM NUMBERS], was still how it looked on<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 01/05/2026. The shower room, between rooms [ROOM NUMBERS], had a necklace/jewelry hanging in the corner of the room. The shower had blue paint that was peeling off the shower walls/tiles. The baseboards were noted to be missing some paint. The right corner of the room had baseboards with a large brown stain on it. The baseboard on the other side of the shower room also had the same stained appearance. During an observation and interview on 01/12/2026 at 12:23 PM, Staff B, Director of Nursing Services, reviewed Hall A's showers. Staff B confirmed the baseboards paint was peeling for the shower room between rooms [ROOM NUMBERS]. Staff B confirmed the tile was peeling paint for the shower between rooms [ROOM NUMBERS], and said the floors needed to be fixed. Both the C hall showers were reviewed with Staff B. Staff B said the tile's paint peeling needed to be fixed, needed more paint. Staff B said the floors needed to be cleaned with the stains, especially the shower room between 22 and 23. Regarding the jewelry, Staff B said they would need to check to see if someone left it in there. When asked if Staff B considered these shower rooms to be homelike, Staff B said yes. Reference WAC 388-97 -0880 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medications (any drug that alters the brain affecting mood, behavior, perception and thought processes) were regularly monitored and documented on for 3 of 5 residents (Residents 22, 6, and 9) reviewed for unnecessary medication. This failure placed residents at risk of unnecessary medication usage and a diminished quality of life.Findings included .Resident 22<br><br>Resident 22 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 10/16/2025, showed the resident was cognitively intact, had diagnoses of post-traumatic stress disorder (a psychiatric condition that may occur in people who have experienced or witnessed a traumatic event or series of traumatic events), bipolar disorder (mental health condition causing extreme mood swings), depression (persistent feelings of sadness and loss of interest), and anxiety (intense, excessive and persistent worry or fear). The MDS showed Resident 22 was administered antipsychotic (used to treat psychotic disorders), antidepressant (used to alleviate depression), and sedative hypnotic medications (class of drugs that depress the activity of the central nervous system to produce calming or drowsy effects) during the assessment period.<br><br>Record review showed Resident 22 had orders for the following psychotropic medication (drugs that alter brain chemistry to treat mental illness by affecting the central nervous system) and monitoring orders.<br><br>Psychotropic Medication orders:<br><br>- Wellbutrin (an antidepressant) once daily for major depressive disorder, dated 11/12/2024.<br><br>- Lexapro (an antidepressant and anxiolytic) once daily for depression, dated 10/08/2024<br><br>- Eszopiclone (a sedative hypnotic) once daily at bedtime for insomnia, dated 09/25/2025.<br><br>- Seroquel (an antipsychotic) twice daily for bipolar disorder, dated 02/04/2025.<br><br>-Melatonin (sedative hypnotic) once daily at bedtime for insomnia, dated 08/20/2025<br><br>Monitoring orders:<br><br>- Monitor for adverse side effects of antidepressant medications twice daily for the use of Wellbutrin, Lexapro and trazadone. If side effects are observed, enter a chart note and notify the physician, dated 10/08/2024.<br><br>- Monitor for adverse side effects of antipsychotic medications twice daily for the use of Abilify (an antipsychotic). If side effects are observed, enter a chart note and notify the physician, dated 10/08/2024.<br><br>-Monitor for adverse side effects of sedative hypnotic medications twice daily for the use of sedative hypnotics. If side effects are observed, enter a chart note and notify the physician, dated 11/01/2025.<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Behavior Monitor: monitor for 1) tearfulness 2) unrealistic worries 3) refusing care 4) no behaviors observed, every shift related to obsessive-compulsive disorder, anxiety disorder, bipolar disorder, and major depressive disorder.<br><br>A mood problem related to post-traumatic stress disorder, depression, anxiety disorder, obsessive compulsive disorder, panic disorder and insomnia care plan, target date 03/27/2026, documented that Resident 22 was prescribed Abilify, melatonin, Lexapro and Wellbutrin. The identified goal of the psychotropic medication use was for Resident 22 to have an improved mood state, be happier, have a calmer appearance and have no signs and symptoms of depression, anxiety or sadness through the next review. Staff were directed to monitor the following target behaviors: tearfulness; unrealistic worries; and refusal of care, and to monitor the resident's hours of sleep.<br><br>The mood care plan cited the same three target behaviors to justify the use of multiple psychotropic medications initiated to treat the behavioral symptoms of multiple psychiatric diagnoses. The care plan did not include any diagnosis-specific symptom identification and did not include Resident 22's diagnosis of bipolar disorder or the behavioral manifestations associated with it.<br><br>A psychotropic medication use for bipolar disorder care plan, target date 03/27/2026, identified a goal that Resident 22 would not experience adverse side effects through the next review. No goal was identified for the use of the unidentified psychotropic medications, nor were the behaviors that the psychotropic medications were targeting. The care plan did not include diagnosis-specific symptom identification. There was no identification of what resident specific behaviors were demonstrated during mania (e.g. elevated mood, reduced sleep, impulsivity etc.) versus their behavioral symptoms when depressed.<br><br>On 01/12/2026 at 10:24 AM, Staff C, Infection Preventionist (IP), explained the purpose of identifying specific target behaviors that a medication was initiated to treat, was to, through behavior monitoring, be able to objectively assess the effectiveness of the medication by determining if a resident's target behaviors were decreasing in frequency. When asked what behaviors Resident 22 demonstrated when manic, Staff C said Resident 22 would become hyper focused on things. An example provided was that Resident 22 would see a medication commercial and become hyper focused on obtaining an order for the medication approaching staff multiple times a day. When asked if that type of resident specific symptom of bipolar should have been included in the care plan and identified as a target behavior, Staff C said yes, and acknowledged it was not.<br><br>On 01/12/2026 at 11:00 AM, when asked how staff could assess the effectiveness of each psychotropic medication and determine if there was an indication for continued use if each medication had the same behaviors, Staff C, IP, indicated it would be difficult to determine which medication, if any, was effective. When asked if continued intermittent refusals of showers (refusal of care was identified as a target behavior for all psychotropic medications with exception of sedative hypnotics) would justify the continued use of Seroquel, Lexapro and Wellbutrin, Staff C stated, I see what you are saying. Staff C acknowledged the facility did not identify the diagnosis-specific symptoms that each psychotropic medication was introduced to target which detracted from the ability to determine each medications effectiveness and/or need for continued use.<br><br>On 01/12/2026 at 11:27 AM, Staff Z, Social Worker, said when Resident 22 was manic, they would become more sexual, in the sense that they would become very focused on their appearance, applying makeup every day, wouldn't sleep very much etc., and when depressed would sleep in late. When asked if that type of resident specific bipolar behavior should have been identified on the care plan<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | and identified as a target behavior, Staff Z said that it should have and acknowledged it was not.<br><br>Resident 6<br><br>Resident 6 was admitted to the facility on [DATE], with diagnoses of bipolar disorder, depression, and anxiety. Review of the Quarterly MDS, dated [DATE], showed Resident 6 was cognitively intact.<br><br>Review of Resident 6's medications on 01/06/2026, showed they currently had the following orders:<br><br>1. Zoloft, an antidepressant, being used to treat depression and anxiety.<br><br>2. propranolol, a beta blocker, being used to treat anxiety.<br><br>3. Seroquel, an antipsychotic.<br><br>Review of Resident 6's behavior monitors, ordered 07/24/2025, showed they only had one behavior monitor in place, which did not differentiate which medication (antidepressant, anti-anxiety, or antipsychotic) was treating which behavior. The behavior monitor showed they were monitoring for:<br><br>1. Upset<br><br>2. Un-redirectable<br><br>3. Sleeplessness<br><br>4. Sad<br><br>5. Sleeplessness<br><br>6. No behavior observed<br><br>The behavior monitor showed staff interventions, non-pharmacological interventions (NPIs, interventions that were not medication), were to encourage Resident 6 to listen to their music album, offer them to go outside if weather and time permitted, and to offer ear plugs.<br><br>Review of the December 2025 Treatment Administration Record (TAR), showed there was no area for licensed nurses to document NPIs provided. Behaviors were noted on 12/01/2025, 12/17/2025, and 12/18/2025. No documentation was found for 12/10/2025 (day shift), 12/16/2025 (day shift), 12/26/2025 (night shift), and 12/30/2025 (day shift).<br><br>Review of Resident 6's Abnormal Involuntary Movement Scale (AIMS, used for monitoring for side effects [dyskinesias, orofacial movements and extremity and truncal movements] for residents on antipsychotics) assessments, found no AIMS assessment was done around admission [DATE]), not until 09/29/2025.<br><br>During an interview on 01/07/2026 at 1:39 PM, Staff D, Resident Care Manager/Registered Nurse, said Resident 6 was being monitored for target behaviors related to being upset, un-directable, sleeplessness, and sadness. Staff D said this resident was admitted before they had started working at this facility, behavior monitors was a topic they were working on, and it looked like Resident 6's<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | behavior monitor order had not been updated yet. Staff D confirmed there was no behavior monitor for propranolol being used for anxiety. Regarding the behavior monitor charting for December 2025, Staff D acknowledged that behaviors were noted and no NPI was documented, and that there were blanks (no documentation by the licensed nurses) for the 10th, 16th, 26th, and 30th. Staff D said AIMS should be done on admission, to know a baseline score. Staff D confirmed Resident 6 was on an antipsychotic medication during admission, and they were not yet working at this facility to have caught this.<br><br>During an interview on 01/12/2026 at 2:11 PM, Staff B, Director of Nursing Services, said their expectation for target behaviors for psychotropic medications, was for them to be individualized. When asked if there should be separate target behaviors for different classes of drugs, such as antidepressants or antianxiety medications, Staff B said for target behaviors they had one order and they put numbers for the behavior being monitored. Regarding how the facility knows which medication needed to be adjusted, Staff B said they had numbers so they could easily tell. Staff B said Resident 6's number 5 was insomnia/sleeplessness, which helps them tell. Staff B was unable to find a current medication that sleeplessness was being monitored for as a target behavior. Staff B said Resident 6 was taking a stimulant, which could affect sleep. When asked if that would be a side effect monitor (not a target behavior), Staff B stated, It can affect sleep. Staff B said AIMS assessments should be done on admission.<br><br>Resident 9<br><br>Resident 9 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, major depressive disorder and anxiety. Review of the Significant Change MDS, dated [DATE], showed Resident 9 was cognitively intact.<br><br>Review of the orders for Resident 9 showed they had orders for hydroxyzine (antihistamine often used to treat anxiety), dated 12/31/2025, three times a day for pruritis (itching)/anxiety and mirtazapine (antidepressant), dated 12/31/2025, one time a day for depressive disorder.<br><br>Review of Resident 9's Electronic Health Record (EHR) did not show documentation that target behaviors were being monitored for the hydroxyzine or the mirtazapine.<br><br>On 01/12/2026 at 12:41 PM, Staff D, Resident Care Manager/Registered Nurse, said for psychotropic medications they would expect adverse side effect monitoring and monitoring of behavior interventions and this included monitoring of target behaviors. When asked if Resident 9 was being monitored for target behaviors for the prescribed hydroxyzine, Staff D looked in the EHR and said there was nothing there for target behaviors and they should have been monitored. When asked if Resident 9 had target behaviors being monitored for the prescribed mirtazapine, Staff D said it did not look like it and they should have been.<br><br>Reference F656<br><br>Reference WAC 388-97-0620 (1)(a) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 7 of 21 sampled residents (Resident 22, 8, 12, 11, 15, 6 & 94) reviewed care plans. This failure placed residents at risk of not receiving needed services, unmet care needs and a diminished quality of care.Findings included .Resident 22Resident 22 was admitted to the facility on [DATE]. Review of the electronic health record (EHR) showed Resident 22 had orders for the following psychotropic medications (drugs that alter brain chemistry to treat mental illness by affecting the central nervous system).- Wellbutrin (an antidepressant) once daily for major depressive disorder, dated 11/12/2024.- Lexapro (an antidepressant and anxiolytic) once daily for depression, dated 10/08/2024- Eszopiclone (a sedative hypnotic) once daily at bedtime for insomnia, dated 09/25/2025.- Seroquel (an antipsychotic) twice daily for bipolar disorder, dated 02/04/2025. A psychotropic medication used for bipolar (a mental health condition characterized by significant mood swings, including manic (or hypomanic) episodes and depressive episodes) disorder care plan, target date 03/27/2026, identified a goal that Resident 22 would not experience adverse side effects associated with psychotropic medication. The care plan failed to identify what the goal of psychotropic medication therapy was, to identify what psychotropic medication the resident received, and the specific target behaviors the medication was initiated to target. During an interview on 11/12/2026 at 10:24 AM, Staff C, Infection Preventionist (IP), confirmed the care plan should have identified what the goal of the psychotropic medication therapy was, what psychotropic medication the resident received (Seroquel) and what behavior(s) the medication was initiated to target. A mood problem related post-traumatic stress disorder (a mental health condition that's caused by an extremely stressful or terrifying event — either being part of it or witnessing it ), depression (serious mood disorder characterized by persistent feelings of sadness, loss of interest, and a range of emotional and physical problems), anxiety (a mental health condition characterized by excessive, uncontrollable worry about everyday issues, affecting daily functioning and quality of life) disorder, obsessive compulsive disorder (features a pattern of unwanted thoughts and fears known as obsessions), panic disorder (are sudden, intense feelings of fear that cause physical symptoms like a racing heart, fast breathing and sweating) and insomnia (common sleep disorder that can make it hard to fall asleep or stay asleep) care plan, target date 03/27/2026, documented Resident 22 was prescribed Abilify (an antipsychotic), melatonin (a sedative hypnotic), Lexapro and Wellbutrin. The identified goal was for Resident 22 to have an improved mood state, be happier, have a calmer appearance and have no signs and symptoms of depression, anxiety or sadness through the next review. Staff were directed to monitor for the following target behaviors: tearfulness; unrealistic worries; and refusal of care. The care plan did not identify what diagnosis each medication was associated with or the specific behaviors they were initiated to target. Additionally, review of the EHR showed Resident 22's Abilify order was discontinued on 11/12/2025.<br><br>During an interview on 11/12/2026 at 10:24 AM, Staff C, IP, said the care plan needed to be updated to reflect the residents current medication orders and should have identified what medication(s), were associated with what diagnosis, and identified what behavior(s) each medication was initiated to target. Staff C acknowledged Resident 22's target behaviors did not accurately reflect the behaviors associated with their bipolar diagnosis, noting that, when manic, Resident 22 would become hyper-focused or perseverate on something, such as obtaining an order for a medication they saw on a commercial. Staff C acknowledged those types of resident specific behavioral manifestations that should be identified in the plan of care. Staff C confirmed multiple different psychiatric diagnoses, treated with multiple different psychotropic medications, should not have the exact same three target (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | behaviors.<br><br>Review of the comprehensive care plan, initiated 08/02/2024, showed there was no direction to staff that Abnormal Involuntary Movement Scale (AIMS) testing was required a minimum of every six months due to antipsychotic medication use, and the residents use of Eszopiclone and Seroquel were not identified or addressed.<br><br>During an interview on 11/12/2026 at 10:24 AM, Staff C, IP, said because the resident received an antipsychotic medication, and AIMS testing was required, it should have been care planned.<br><br>An antibiotic use for an infection to the second toe on the left foot care plan, initiated 11/20/2025, had an identified goal that Resident 22 would be free from discomfort and adverse side effects of antibiotic therapy through the next review. No goal was established for the use of an antibiotic medication (e.g. the resident's infection to left foot second toe will resolve without complication by next review).<br><br>Review of the EHR showed Resident 22's order for doxycycline for an infected second toe on the left foot was completed on 11/30/2025. During an interview on 11/12/2026 at 10:24 AM, Staff C, IP, said the care plan needed to be updated.<br><br>Resident 8<br><br>Resident 8 was admitted to the facility on [DATE], with diagnoses that included unspecified dementia (the specific type of dementia cannot be clearly identified, despite the presence of cognitive decline and memory loss) and major depressive disorder. The admission MDS, dated [DATE], documented Resident 8 was cognitively intact and had current tobacco use.<br><br>Mental Health Care Plan<br><br>Review of Resident 8's mental health care plan, initiated on 10/31/2025, showed no mental health care plans for unspecified dementia or major depressive disorder.<br><br>On 01/08/2026 at 12:04 PM, Staff M, Licensed Practical Nurse (LPN), with Staff N, Market Resource/Registered Nurse (RN) present, were asked to review Resident 8's mental health care plan that included unspecified dementia and major depressive disorder. Staff M and Staff N confirmed they could not find a care plan regarding either mental health diagnoses. When asked if there should have been care plans for both diagnoses, both Staff M and Staff M said yes.<br><br>On 01/12/2026 at 9:58 AM, Staff B, Director of Nursing Services (DNS), with Staff O, Market Resource Leader present, was asked to review Resident 8's mental health care plans that included unspecified dementia and major depressive disorder. Staff B confirmed they could not find a care plan regarding either mental health diagnoses. When asked if there should have been care plans for both diagnoses, Staff B said yes.<br><br>Smoking Care Plan<br><br>A review of Resident 8's care plan did not show a focus, goal, or intervention for smoking.<br><br>On 01/12/2026 at 8:30 AM, Staff D, Resident Care Manager (RCM)/(RN) said there should have been a<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | smoking care plan and he created and saved a smoking care plan at that moment.<br><br>Resident 12<br><br>Resident 12 was admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the legs or lower body), fracture to left tibia and Schizophrenia (a severe mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). The admission MDS, dated [DATE], documented Resident 12 was cognitively intact.<br><br>Review of Resident 12's mental health care plan, initiated on 11/11/2025, showed no mental health care plan for schizophrenia diagnosis.<br><br>Review of Resident 12's restorative care plan, initiated on 12/29/2025, documented Resident 12 would participate in restorative services 5 days a week for upper extremity strengthening. No other details provided.<br><br>On 01/08/2026 at 12:04 PM, Staff M, LPN, with Staff N, Market Resource/RN present, were asked to review Resident 12's mental health schizophrenia care plan. Staff M and Staff N confirmed they could not find a care plan regarding schizophrenia. When asked if there should have been care plan for Resident 12's schizophrenia diagnoses, both Staff M and Staff N said yes. Staff M and Staff N were asked to review Resident 12's restorative care plan. Staff M read Resident 12's restorative care plan aloud. When asked if the care plan was individualized or person-centered, with goals/dates, both Staff M and Staff N said no and that it should have been.<br><br>On 01/12/2026 at 9:58 AM, Staff B, DNS, with Staff O, Market Resource Leader present, was asked to review Resident 12's mental health schizophrenia care plan. Staff B confirmed they could not find a care plan regarding schizophrenia. When asked if there should have been care plan for Resident 12's schizophrenia diagnoses, both Staff B said yes, there should have been a care plan. Staff B was asked to review Resident 12's restorative care plan. When asked if the care plan was individualized or person centered, with goals/dates, both Staff B said Resident 12's restorative was not individualized or person-centered and it should have been.<br><br>Resident 11<br><br>Resident 11 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented the resident was severely cognitively impaired and needed substantial to maximal assistance with activities of daily living including eating.<br><br>On 01/06/2026 at 8:21 AM, an observation of a sign posted about Resident 11's bed read Head of bed elevated 30 degrees or higher at all times.<br><br>A review of Resident 11's care plan did not show a focus, goal, or intervention for the head of bed to be elevated.<br><br>On 01/12/2026 at 8:33 AM, Staff D, RCM/RN, acknowledged the sign in Resident 11's room and said, yes it should be in the care plan especially since it was part of Resident 11's plan of care. Staff D said he added it to the care plan at that moment under activities of daily living (ADLs).<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 01/06/2026 at 8:58 AM, a staff person was observed one-on-one feeding Resident 11.<br><br>Resident 11's ADL care plan initiated on 11/18/2021 said Resident 11 needed to be supervised/assisted to eat at mealtimes, assisted with setup of their tray and seasoning added to their meal with salt/pepper/butter. The care plan documented Resident 11 could feed themselves finger foods.<br><br>On 01/12/2026 at 8:33 AM, Staff D, RCM/RN said Resident 11's ADL care plan had not been updated, and he said he would correct it at that moment.<br><br>Resident 15<br><br>Resident 15 was admitted to the facility on [DATE], with a diagnosis of end stage renal disease (where the kidneys were no longer able to filter the blood). The admission MDS, dated [DATE], showed Resident 15 was cognitively intact.<br><br>Review of Resident 15's dialysis (procedure that uses a machine to filter the blood) order, dated 12/15/2025, showed they were going to dialysis on Monday, Wednesdays, and Fridays from 6:00 PM to 11:00 PM.<br><br>Review of Resident 15's dialysis care plan, dated 12/05/2025, showed their dialysis schedule was Monday, Wednesday, and Friday from 6:00 AM to 11:00 PM. The care plan documented, Do not draw blood or take BP [blood pressure] in arm with graft and When resident returns from dialysis, evaluate blood flow for Fistula or Grafts on either side of dressing. (To assure that dressing is not too tight) Palpate side of Fistula or Graft for thrill.<br><br>During an interview on 01/08/2026 at 2:30 PM, Staff D, RCM/RN, acknowledged Resident 15's dialysis care plan did not have an accurate schedule, as Resident 15 went to dialysis in the evenings from 6:00 PM to 11:00 PM. Staff D said Resident 15 did not have a graft or fistula for access. Staff D acknowledged the care plan did not have details of Resident 15's port (access for dialysis).<br><br>During an interview on 01/12/2026 at 2:11 PM, Staff B, DNS, said their expectation for dialysis care plans was for it to have included the dialysis center, the date and time they went to dialysis, pickup time, dialysis site with interventions to check the dressing and site, vitals, bloodwork, follow up appointments, to check for edema, and the name and phone number if they have a nephrologist.<br><br>Resident 6<br><br>Resident 6 was admitted to the facility on [DATE], with diagnoses of bipolar disorder, depression and anxiety. Review of the Quarterly MDS, dated [DATE], showed Resident 6 was cognitively intact.<br><br>Review of Resident 6's medications on 01/06/2026, showed they currently had orders for an antidepressant for depression and anxiety, a beta blocker for anxiety, and an antipsychotic (used to treat psychosis, which could include delusions, hallucinations, paranoia, or disordered thought) used to treat bipolar disorder.<br><br>Review of Resident 6's psychotropic medication care plan for behavior management, showed it was initiated on 07/09/2025. This care plan included information on anti-psychotic medication usage, however, it did not specify any antianxiety medication. Resident 6 also had an antidepressant care<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | plan for depression (did not list it was also for anxiety), initiated on 07/09/2025. Both care plans were found to have the same behaviors observed and non-pharmacological interventions listed for the antidepressant and antipsychotic medications. Both said behavior observed: sadness, tearful, isolation, exit seeking, wandering, resisting care, inappropriate touching staff/other residents, sexually inappropriate statements, aggressive behavior, and statements of self-harm, with only auditory/visual hallucinations listed under the antipsychotic care plan. Both had the interventions of redirect, remove from situation/ensure safety, calm environment, activity, reapproach, one on one staff to resident interaction, food/drink, toileting, repositioning, and not applicable.<br><br>During an interview on 01/07/2026 at 1:39 PM, Staff D, RCM/RN, said care plans for psychotropic medications need to be able to identify specific behaviors and interventions, should be individualized. Staff D acknowledged there should have been an individualized care plan based on what medication was being treated, including an antianxiety care plan when taking beta blockers for anxiety or an antipsychotic care plan if taking for bipolar disorder. Staff D confirmed there was no care plan for Resident 6's anxiety/beta blocker usage. When looking at the psychotropic care plan, Staff D said it should have been changed to clearly say antipsychotic. When asked if they would expect Resident 6's diagnosis of bipolar disorder to be mentioned on the care plan, Staff D said they would expect it, the care plan said behavior management and was not specific for bipolar behaviors. Staff D said the behaviors on the care plan should also be listed in the physician's order.<br><br>During an interview on 01/12/2026 at 2:11 PM, Staff B, DNS, said their expectation for psychotropic care plans was for them to be specific of the medication. For Resident 6, Staff B said the care plans should have been specific with listing the medication, behavior, diagnosis and use.<br><br>Resident 94Resident 94 was admitted to the facility on [DATE]. Record review showed a physician's order, dated 09/29/2025, that directed staff to monitor closely for signs of fluid overload twice a day. Review of the comprehensive care plan, initiated 04/09/2025, showed there was no direction to staff to monitor the residents for signs and symptoms of fluid volume overload. On 01/12/2025 at 10:34 AM, Staff C, IP, said monitoring the resident for signs and symptoms of fluid volume overload, should have been incorporated into the comprehensive care plan.<br><br>Reference F605, F698<br><br>Reference WAC 388-97 -1020(1), (2)(a)(b) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents remained free of unnecessary drugs for 3 of 5 residents (7, 22, and 6) reviewed for unnecessary drugs. This failure placed residents at risk for increased sedation, inadequate pain relief, and a decreased quality of life.Findings included .Resident 7Resident 7 was admitted to the facility on [DATE] with a malignant neoplasm (cancerous tumor) of the large intestines. The admission Minimum Data Set (MDS- an assessment tool), dated 12/11/2025 documented Resident 7 was cognitively intact and had pain that occasionally affected sleep, therapy and day to day activities.<br><br>A review of the electronic health record (EHR) showed orders:-Monitor pain every shift and non-pharmacological interventions for pain management A -Reposition; B -Rest; C - Apply Ice (with MD [Medical Director] order); D -Quiet Environment; E – Other (Document in progress note) dated 12/25/2025.-Hydromorphone give 3 tablets by mouth every 4 hours as needed for pain and non-pharmacological interventions: 1. reposition, 2 Apply ice, 3 apply warm compress. 4, Other dated 12/31/2025.<br><br>A review of January 2026 medication administration record (MAR) showed no documentation on both orders of non-pharmacological interventions (NPIs) had been provided.<br><br>On 01/13/2026 at 8:04 AM, Staff B, Director of Nursing Services said the staff were not documenting non-pharmacological interventions and they should be.<br><br>Resident 22<br><br>Resident 22 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact at intact, had a diagnosis of chronic lung disease and received oxygen (O2) therapy during the assessment period.<br><br>Record review showed Resident 22 had the following oxygen therapy orders:- O2 at two liters per minute via nasal canula (2L/min via NC), dated 12/08/2025.- Administer O2 to maintain oxygen saturation (SpO2) greater than 90%, dated 10/08/2024. - Check SpO2 on room air (RA) on the 27th and 28th of every month, dated 10/27/2024.<br><br>Review of the November 2025 Medication and Treatment Administration Record (MAR/TAR) showed on 11/28/2025 Resident 22's Spo2 was 94% on RA. Review of the December 2025 MAR/TAR showed on 12/28/2025 Resident 22's SpO2 was 95% on RA. Review of the SpO2's recorded on the vital sign flowsheet in the EHR showed from 11/02/2025 - 01/13/2026, Resident 22's SpO2 was checked on RA on the following dates:11/03/2025- 95% on RA11/04/2025- 97% on RA11/07/2025- 97% on RA11/08/2025- 94% on RA11/14/2025- 96% on RA.11/17/2025- 97% on RA.11/21/2025- 95% on RA.11/26/2025- 96% on RA11/28/2025- 95% on RA12/01/2025- 97% on RA12/08/2025- 95% on RA12/14/2025- 95% on RA12/23/2025- 91% on RA12/28/2025- 95% on RA01/01/2026- 91% on RA.01/05/2026- 96% on RA.01/08/2026- 93% on RA.01/12/2026- 95% on RA.01/13/2026- 98% on RA.<br><br>During an interview on 01/08/2026 at 9:25 AM, when asked how the facility assessed a resident's need for continuous O2 therapy, Staff M, Resident Care Manager, explained that residents receiving supplemental oxygen, periodically would have the O2 removed and their SpO2 checked on RA. If the resident maintained a SpO2 (in this case greater than 90% as ordered by the physician), then the (continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | physician would be contacted to trial the resident on RA. When asked if that occurred for Resident 22, whose SpO2 was checked on RA and remained above 90% 19 consecutive times, between 11/02/2025 - 01/13/2026, Staff M stated, No.<br><br>Resident 6<br><br>Resident 6 was admitted to the facility on [DATE], with a diagnosis of chronic pain. Review of the Quarterly MDS, dated [DATE], showed Resident 6 was cognitively intact.<br><br>Review of Resident 6's orders, ordered on 10/29/2025, showed they were taking oxycodone (a strong pain medication), ordered for two tablets to be given for pain management of pain 7-10/10 (on a scale of 0-10, with zero being no pain and 10 being worst pain) or one tablet for pain of 3-6/10. The order specified for NPIs to be attempted, such as applying ice, redirecting, repositioning, and a quiet environment.<br><br>Resident 6's Medication Administration Record (MAR) was reviewed for November 2025, which showed oxycodone, one tablet, was only given one time for pain of 3-6/10. Resident 6's oxycodone, two tablets, was given outside of the ordered 7-10/10 pain parameters. The following dates Resident 6 received two tablets for less than 7/10 pain:<br><br>1. 11/02/2025, 6/10<br><br>2.11/11/2025, 0/10<br><br>3. 11/12/2025, 6/10<br><br>4. 11/16/2025 6/10<br><br>Further review of this MAR showed although the oxycodone order had a location for interventions, an x showed for each administration for NPIs.<br><br>Resident 6's Medication Administration Record (MAR) was reviewed for December 2025, which showed oxycodone, one tablet, was not given for pain of 3-6/10. Resident 6's oxycodone, two tablets, was given outside of the ordered 7-10/10 pain parameters. The following dates Resident 6 received 2 tablets for less than 7/10 pain:<br><br>1. 12/04/2025, 4/10<br><br>2. 12/15/2025, 6/10<br><br>3. 12/16/2025, 6/10<br><br>4. 12/21/2025, 6/10<br><br>5. 12/31/2025, 5/10<br><br>Further review of this MAR showed there was no location for licensed nursing staff to document NPI interventions. This MAR showed there was an order for nursing to document on a monitor for pain, with NA [not applicable] written under NPI, despite pain scores of 2 on this monitor and receiving<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | pain medications.<br><br>During an interview on 01/07/2026 at 1:39 PM, Staff D, Resident Care Manager/Registered Nurse, said NPIs should be done with pain medication administration and documented on the order. When asked to confirm the oxycodone was given outside of parameters in December, Staff D confirmed this and said staff were not paying attention to the verbiage.<br><br>During an interview on 01/12/2026 at 2:11 PM, Staff B, Director of Nursing Services, said their expectation for NPI and documentation for pain meds, was for NPI to be attempted before giving medications if the resident agreed to them, for staff to document that they were used or if NPIs were refused. Staff B said their expectation for pain medications with parameters, was for the staff to follow the order.<br><br>Reference WAC 388-97-1060 (3)(k)(i) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>Based on observation, interview, and record review, the facility failed to ensure medication was stored in manners that met professional standards of practice, for 1 of 1 medication storage rooms (A&B Medication Room) and 2 of 2 medication carts (Halls C &B) reviewed. This failure placed residents at risk of receiving expired medications, cross-contamination, and a diminished quality of life. Findings included.During an observation of the A&B Medication Room on 01/06/2026 at 9:26 AM, Staff C, Infection Preventionist/ Licensed Practical Nurse (LPN), was present for review of the medications. A purified protein derivative (PPD, a test for Tuberculosis) multiuse vial was missing an open date. Staff C confirmed this and said it looked empty (had been used). An emergency kit, with medication in it, had an expiration date listed of 12/2025. Staff C confirmed this. The posted medication refrigerator log for January 2026, had columns that specified staff were to check temperature in the morning and at night due to the Centers of Disease Control and Prevention recommendation for if vaccines were present (vaccines were kept in this refrigerator), and showed there was no morning temperature recorded for the 1st, 3rd, or 4th. Staff C acknowledged the holes seen on the log. During an observation of the C Hall Medication Cart on 01/06/2026 at 9:46 AM, Staff P, LPN, was present. In the top drawer, one container had rectal suppositories (stimulate a bowel movement) that were being stored with three different oral medications. Staff P confirmed the suppository box had been previously opened and was not new. The bottom drawer was reviewed and had 7 pill packets for a resident being stored in this drawer, along with treatment cart supply items with creams. Staff P said the resident had gone to the hospital and came back, and they did not know why these pills were being stored in the bottom drawer. In the narcotic drawer, a liquid pain medication had been opened, without an open date listed on it. During an observation of the B Hall Medication Cart on 01/06/2026 at 10:10 AM, Staff Q, LPN, was present. In the top drawer, a container had batteries kept with two oral medications. The top drawer, storing medications, also had tape and scissors kept in it. In a middle drawer, a confiscated hair, skin, and nails gummies container was being stored, without a label on it to identify which resident it belonged to. Staff Q said they were storing them there until they could confirm with the doctor if the resident could have them. In the bottom drawer, this was observed to have treatment supplies in it. One resident's six boxes of eye drops were being kept in this drawer, not separated from the treatment supplies. Staff Q said they had moved the boxes to the medication room, but someone had brought them back out to the cart. Staff Q acknowledged the bottom drawer was being used as a treatment drawer. During an interview on 01/07/2026 at 11:11 AM, Staff B, Director of Nursing Services, was told of the observations from the previous day. Staff B said the PPD vial should have been dated, and the emergency kit was replaced yesterday (after the observation). Staff B said the expectation for suppository and oral medication storage was for them to have been separated by route of administration (oral, topical, etc.). Staff B said the bottom drawer of the carts should not have had treatment supplies, staff should have used a treatment cart instead. Staff B said that medication should not have been stored on the bottom drawer with treatment supplies present. Staff B said the pain medication should have been dated with the date opened, batteries should not have been in the medication cart, and neither should the tape/scissors have been stored in the medication drawer. Staff B said the confiscated vitamin gummies should have had a label with the resident's name. Reference WAC 388-97 -1300 (2),-1300 (2) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>Based on interview and record review, the facility failed to ensure residents approved of a 15-hour mealtime gap and were served a nourishing snack at bedtime, when the time between the dinner and breakfast meals was increased to 15 hours. This failure placed residents at risk of feelings of hunger and inadequate nutrition.Findings included.Review of the Resident Council (a self-governed, resident-led group) Minutes, dated 08/07/2025, included the following mealtime schedule:a) The Main Dining room was served dinner at 4:30 PM and breakfast at 7:30 AM (for a total of 15 hours in between meals).b) The A Hall was served dinner at 5:00 PM and breakfast at 8:00 AM (15 hours in between meals).c) The B Hall was served dinner at 5:20 PM and breakfast at 8:20 AM (15 hours in between meals).d) The C Hall was served dinner at 5:40 PM and breakfast at 8:40 AM (15 hours in between meals).e) The D hall was served dinner at 6:00 PM and breakfast at 9:00 AM (15 hours in between meals).Further review of the Resident Council Minutes, dated 08/07/2025, showed the dining time had been changed, and a flyer had been passed out and explained to each resident, done by Staff H, Activity Director. On 01/12/2026 at 9:04 AM, Resident 6, a member of Resident Council, was asked if the 15-hour gap between meals was voted on by resident council or if they were informed of the change. Resident 6 said the resident council was just told what the new mealtimes would be. Resident 6 said the facility told them the change was happening, the council did not vote, and if voting had been an option they would have voted against it. Resident 6 said this was why the facility put out snacks, but the residents had to ask for the snacks. On 01/12/2026 at 9:45 AM, Resident 25, when asked if they were offered a snack every evening said, it was hit and miss, and staff would say there were no snacks available.On 01/12/2026 at 12:38 PM, Resident 66, when asked if they were offered a snack every evening, said they had to ask for snacks and they never got them, staff would say they were out. On 01/08/2026 at 2:50 PM, Staff G, Dietary Manager, when asked about snacks said Certified Nursing Assistants (CNAs) and residents could come to the kitchen door to request them. Staff G said they would put a snack tray out after breakfast where the coffee was at the front desk and again at night before the last people leave. When asked about residents that were bed bound, Staff G said they were trying to think of a great system, CNAs or nurses could come get snacks for residents, but she would like to start a program for people that they did not see.On 01/09/2025 at 9:54 AM, Staff G was asked about the 15-hour gap between meals and if a substantial snack was offered, Staff G said that sandwiches, juice, milk were available. When asked if these were offered to residents in their rooms, Staff G said in the evening the CNA or nurse would get the sandwich for the residents, and she did not know if staff was going room to room offering them.On 01/12/2026 at 9:35 AM, Staff H, Activities Director, with Staff J, Activity Aide, present for interview. When asked if snacks were offered to residents in the evening, Staff H said she offered snacks throughout the day from her activities cart, at about 11:00 AM and 2:00 PM and that Staff J, would be doing it again at 6:00 PM. Staff H said there was a refrigerator that was stocked at night for the residents that they had access to with sandwiches and items for diabetics. On 01/12/2026 at 11:44 AM, Staff A, Administrator, when asked if a nourishing snack was served at bedtime, said yes, we have a cart, after dinner at 8:00 PM. When told residents reported they had to request a snack, Staff A said, they had got hit with this before and that was part of the adjustment, now CNAs and activities handed out snacks. Staff A said CNAs were supposed to go around with water and offer snacks, and activities went around with snacks at 8:00 PM. Staff A said Staff J, Activity Aide, would do an offering at 8-8:30 PM. When asked if there was documentation of the 8-8:30 PM snack, Staff A said there was no documentation.On 01/12/2026 at 12:23 PM, Staff J, Staff H, and Staff I, Admissions Coordinator, were interviewed. Staff J said they would do a snack cart at 3:00 PM and 8:00 PM. Staff H then said they just implemented new snack times, they would be 10:00 AM, 3:00 PM, and 8:00 PM.<br>(continued on next page) |

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| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Staff H confirmed these new times were started that day.On 01/12/2026 at 12:30 PM, Staff K, Registered Dietician, when told the facility had 15 hours between dinner and breakfast and asked if anyone had made her aware of that, Staff K said no, but she knew the facility had evening snacks available. Staff K said she was unaware that when the time between mealtimes goes beyond 14 hours a nourishing snack must be served.On 01/13/2026 at 9:13 AM, an email request for facility policies to include snack policy was sent. At 11:54 AM, a return email was received from the facility that the policy for snacks was not included, due to them currently revising the offering/serving bedtimes snacks policy. Reference WAC 388-97-1120(1)(3)(a)(b) |

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| NAME OF PROVIDER OR SUPPLIER Crystal Cove Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 1505 Carpenter Road SE Lacey, WA 98503 | |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a system that ensured residents were screened, educated and offered the COVID-19 (a contagious disease caused by the coronavirus SARS-CoV-2) vaccine for 2 of 5 residents (Residents 15 & 7) when reviewed for immunizations. This failure precluded residents from the opportunity to make an informed decision regarding receiving Covid-19 vaccines. Findings included . Review of the facility's undated Infection Prevention and Control Program policy showed residents would be screened to see if they were prior immunized or had medical contraindications prior to being offered the COVID-19 vaccination. Once screened, education about the vaccine, risks, benefits, and potential side effects would be given to the resident/resident representative and the COVID vaccination offered. If the resident/resident representative consented, the COVID vaccination would be administered. The resident's electronic health record (EHR) would include documentation that indicated, at a minimum, the resident /resident representative was provided education about the risks and benefits associated with the vaccine, whether the resident did not receive the vaccine due to contraindications or refusal, and/or documentation of each COVID-19 vaccination that was administered.1) Resident 7 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS, an assessment tool), dated 12/11/2025, showed the resident was cognitively intact and their COVID-19 vaccination was not up to date.Review of Resident 7's EHR showed no documentation present that the resident was provided education about the risks and benefits of the COVID-19 vaccination.2) Resident 15 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact and their COVID-19 vaccination was not up to date.Review of Resident 15's EHR showed no documentation present that the resident was provided education about the risks and benefits of the COVID-19 vaccination.On 01/13/2025 at 12:48 PM, when asked if there was documentation to show Resident 7 and Resident 15 were provided education about the risks and benefits of the COVID-19 vaccination, Staff C, Infection Preventionist, stated, No. Staff C said a COVID-19 vaccination informed consent form should have been completed and filed in Resident 15 and Resident 7's EHR but acknowledged that did not occur.Reference WAC 388-97-1320 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure dignity was provided to 2 of 2 Residents (6 & 79) reviewed for resident rights during a meeting with Resident Counsel. This failure placed the residents at risk for diminished self-worth and a decreased quality of life.Findings Included.Resident 6Resident 6 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS-an assessment tool), dated 12/16/2025, documented Resident 6 was cognitively intact. On 01/07/2026 at 11:00 AM Resident 6 said they felt harassed when Staff R, Business Office Manager, asked them why aren't you paying your bill? Resident 6 said if your bill is not paid [Staff R] will hassle you. Resident 79Resident 79 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 79 was cognitively intact.On 01/07/2026 at 11:00 AM Resident 79 said they also felt harassed by Staff R, Business Office Manager, when they had asked about a bill not being paid one month. On 01/07/2026 at 3:14 PM Staff R, Business Office Manager was asked what their process was when a resident had a bill. Staff R said on the third and fifth of the month they would jokingly say I want your money, it is rent day.The facility investigation dated, 01/7/2026, documented, It was discovered through the investigation process that [Staff R, Business Office Manager] could benefit from additional training regarding the language [Staff R] uses when discussing the billing process with resident and resident representatives.On 01/09/2026 at 10:00 AM, Staff O, Market Resource Leader/Acting Administrator, said they discussed customer service practices and provided training with Staff R on the facility's policies and expectations.Reference WAC 388-97-0180(1-4) |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>Based on interview and record review, the facility failed to communicate resolutions about the concerns brought forward by the resident council (RC) for 6 of 6 months (July, August, September, October, November and December 2025) of RC minutes reviewed. These failures resulted in RC members feeling frustrated, unheard and powerless to affect their care.Findings included .Review of the facility's Resident and Family Grievances policy, dated 2025, showed In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:i. The date the grievance was received. ii. The steps taken to investigate the grievance.iii. A summary of the pertinent findings or conclusions regarding the resident's concern(s).iv. A statement as to whether the grievance was confirmed or not confirmed.v. Any corrective action taken or to be taken by the facility as a result of the grievance.vi. The date the written decision was issued.During a meeting with the RC on 01/07/2026 at 11:00 AM, when asked if the facility considered concerns brought up in RC, Resident 6, RC President, said Staff H, Activities Director, notified the facility of the RC's concerns, but they were not informed of what happened, what the results were, and if there were any changes. On 01/09/2026 at 10:00 AM, Staff A, Administrator and Staff O, Market Resource Leader were asked if they notified the RC of the results of the grievances, they both replied no, and said they could start having another meeting with the residents in RC to go over the results of their specific concerns in the grievances.On 01/13/2026 at 11:15 AM, Staff A, Administrator, Staff H, Activities Director, and Staff Z, Social Services, were asked if they had documentation that they went over the results of the specific grievances from RC. Staff H said they would go over old business and new business at every RC meeting. On 01/13/2026 at 2:31 PM, an observation with Staff H, Activities Director, of the RC meeting minutes, dated 12/26/2025, 11/17/2025, 10/13/2025, 09/15/2025, 8/18/2025, and 07/17/2025 showed the Discussion of Old Business and Discussion of New Business sheets were blank with nothing written on them.On 01/13/2026 at Staff 2:31 PM, Staff H, Activities Director, said while looking at the RC meeting minutes, she did not fill out the Discussion of Old Business form. Staff H said, I don't document anything on that form about the concerns from the previous month. And Staff H said What I do is take the minutes from the previous RC and ask the RC, for that month, if they still have the same concerns. Staff H said she was going to start documenting this on the Discussion of Old Business form.On 01/13/2026 at 2:53 PM, Staff H, Activities Director, provided copies of the form titled Discussion of Old Business for the dates 12/26/2025, 11/17/2025, 10/13/2025, 09/15/2025, 8/18/2025, and 07/17/2025 which now had documentation not previously observed. The first sentence on the form Old Business: Minutes of Last month's meeting were read aloud and were approved was now circled yes and a handwritten statement had been added Read Previous/Follow up Form.Reference WAC 388-97-0920(1-6) |

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| F 0569<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.<br><br>Based on interview and record review, the facility failed to ensure residents received their personal funds (money kept for the resident by the facility) within 30 days of discharge for 1 of 1 residents (Resident 107) reviewed for personal funds with discharge. This failure placed residents at risk of delay in access to their money and a diminished quality of life. Findings included .Review of the facility policy titled Resident Personal Funds, dated 2025, showed upon discharge, eviction, or death, a resident with personal funds deposited with the facility, would receive from the facility within 30 days, their funds and a final account of those funds. Review of the refund request form for Resident 107, showed they were discharged on 06/24/2025. Review of the facility's copy of the check they provided Resident 107 to return their money after discharge, showed the check was written on 07/29/2025. During an interview on 01/07/2026 at 9:38 AM, Staff R, Business Office Manager, confirmed Resident 107 was discharged on 06/24/2025 and was not written a check within 30 days, until 07/29/2025.During an interview on 01/12/2026 at 3:04 PM, Staff A, Administrator, said their expectation regarding personal funds being released back to the residents after discharge, was for it to be returned within 30 days. Staff A reviewed the calendar and confirmed that Resident 107's personal funds were not released within 30 days.Reference WAC 388-97-0340(5) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to thoroughly investigate a fall with injury for 1 of 2 residents (Resident 52) reviewed for falls. The facility's failure to identify and assess the location where a fall occurred, to identify and consider what environmental factors such as uneven surfaces, and insufficient lighting, were present at the time of the fall and to interview all residents and staff with knowledge about the incident, prevented facility staff from identifying the external factors that were present and led to the residents fall. These failures detracted from the ability to identify what interventions needed to be implemented to prevent reoccurrence and placed residents at risk for continued falls and injuries. Findings included . Resident 52 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 11/10/2025, showed the resident was cognitively intact, was independent with activities of daily living, able to ambulate at least 150 feet independently with walker, and had fallen once since the prior assessment.On 01/07/2026 at 12:33 PM, Staff CC, Helping Hands (supervises resident smoking), reported management had turned off the lights to the smoking area due to the behaviors of a few residents. Staff CC said the first night the lights were off Resident 52 fell while walking back from the smoking area. Staff CC indicated they were not present at the time of the fall but Resident 52 told them the next day. Resident 52, who was present and listening, said they were walking back from the smoking area, and it was pitch black because the lights were off and then suddenly, they were on the ground, and a female came and helped them. Resident 52 said they were not sure why or what caused them to fall because they couldn't see.A progress note, dated 12/18/2025, showed when the nurse came on shift, they were notified that Resident 52 had an unwitnessed fall outside, and had already been assisted up, and was being wheeled back to their room by a nursing assistant. Resident 52 said they did not know or remember how they fell but reported it happened while they were ambulating back from the smoking area, then suddenly, they were on the ground. Resident 52 was assessed with mild swelling and scrapes above the left eyebrow, an abrasion to the left deltoid, a small bump on the left elbow, and a minor cut on the left knee. Neuro checks were initiated per facility protocol, the provider was notified and no new orders were given.A provider note, dated12/18/2025, documented Resident 52 fell on his left side in the parking lot on 12/17/2025, when his walker got caught and sustained mild abrasions to his left temple, shoulder, elbow and knee.A level two preadmission screening and resident review care plan, initiated 05/20/2025, directed staff to ensure Resident 52 was in a well-lit space as he was a high fall risk since his stroke.Review of the facility's December 2025 incident log showed on 12/17/2025 Resident 52 fell outside, sustained superficial injuries, the cause of the fall was established, and that care plan revisions were made.The facility's fall investigation, dated 12/17/2025, documented Resident 52 fell at 6:10 PM. The nurse was notified by Staff FF, Certified Nursing Assistant, that Resident 52 fell outside. The nurses post fall assessment showed Resident 52 reported they fell while walking back from the smoking area. They were alert and oriented to person, place, time and situation, and had mild swelling and scrapes above the left eyebrow, an abrasion to the left deltoid, a small bump on the left elbow, and a minor cut on the left knee. A statement provided by Staff FF said they were approached by a (unidentified) resident who informed them Resident 52 fell outside. When Staff FF arrived in the courtyard, Resident 52 was already up and then the nurse came and assessed him. Under the investigative sections titled Injuries Observed at Time of Incident and Injuries Reported Post Incident staff documented no injuries were observed. Under the section Predisposing environmental factors staff documented none were present. The investigation concluded the cause of Resident 52's fall was unknown. The intervention implemented to prevent recurrence was patient education about changing positions slowly. The investigation did not include, identify or address: a statement from the resident who initially found Resident 52 and reported the fall to Staff FF; Resident 52's statement to the provider that his walker<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | got caught causing/contributing to the fall; identify where along the path back from the smoking area the fall occurred; identify and address that the fall occurred after dark on the night the facility stopped turning lights on for the smoking area; assess if there were uneven surfaces or tripping hazards on the path back from the smoking area; or include interviews with other staff or residents (smokers) who may have knowledge or information about the incidentOn 01/13/2026 at 2:28 PM, Staff A, Administrator, acknowledged the facility stopped turning on the lights for the smoking area but said prior to doing so, they placed solar lights in the courtyard so residents would have light and could still safely access the smoking area but indicated the solar lights malfunctioned. When asked why this was not addressed in the investigation, Staff A indicated they were unsure what date the facility stopped turning the smoking area lights on and stated, We didn't document it. No response was provided for why the investigation didn't identify the location of the fall, why the resident who reported the incident was not identified or interviewed, or why other residents (who smoke) or staff who may have had knowledge of the incident were not interviewed. Receipts for the solar lights the facility reportedly placed to ensure residents could safely access the smoking area were requested. On 01/15/2025 at 3:19 PM, an email was received from Staff B, Director of Nursing Services, with an attached statement from Staff FF dated 01/15/2025. The statement was the same as the statement attached to the fall investigation except it now included a statement that The sidewalk night light was on.On 01/15/2026 at 4:36 PM, an email was received with two attached receipts. One receipt showed a four pack of solar path lights that was purchased on 01/09/2026 and the other showed a two head motion sensor light that was purchased on 01/14/2026. These purchases occurred after the lighting for the smoking area had been reinstated. Refer to F689Reference WAC 388-97-0640 (6)(a)(b) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for 2 of 21 sampled residents (Resident 33 & 6) reviewed. This failure placed residents at risk of a lack of care or services related to the assessments, and a diminished quality of life. Findings included .Resident 33<br><br>Resident 33 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 33 was cognitively intact and relied on staff for all cares. The MDS documented Resident 33 did not complain, have difficulty and or pain with swallowing or chewing food.<br><br>On 01/05/2026 at 3:10 PM, Resident 33 reported they had missing and broken teeth and a number of their teeth had fallen out. Resident 33 said it had been almost a year since they had been to a dentist and they wanted to get their teeth fixed, because it was causing pain when they ate. Resident 33 said they could not chew meat, it had to be cut up very small, or sugar, due to causing pain and missing fillings, and this had been going on for months with no follow up.<br><br>Review of the electronic health record (EHR) showed Residents 33's last dental visit was on 05/09/2025. It was documented Resident 33 had five decayed teeth, one broken tooth, with nine lower teeth and five upper teeth missing. Referral for X-rays, evaluations and extraction for all upper teeth was recommended.<br><br>Review of Resident 33's dental care plan, revised 09/15/2025, documented Resident 33 had swallowing problems related to (r/t) complaints of difficulty or pain with chewing/swallowing. Resident 33 has potential/oral/dental health problems r/t he has his own natural teeth; they are in poor condition.<br><br>On 01/08/2026 at 9:40 AM, Staff L, MDS Coordinator/Licensed Practical Nurse, said when they completed section L of the MDS (dental), they would go directly to the resident to obtain information, they would also review nursing assessments, dietary assessments and any other assessments that pertain to that care area. Staff L was asked to review Resident 33's dental care plan and Section L of the MDS. Staff L confirmed Resident 33's care plan documented Resident 33 was having pain and difficulty chewing/swallowing. Staff L said the MDS was incorrect, it should have documented that Resident 33 was having pain and difficulty swallowing when chewing.<br><br>On 01/08/2026 at 12:04 PM, when asked who reviewed care plans after updates were made, Staff M, Licensed Practical Nurse, with Staff N, Market Resource/Registered Nurse present, said the whole interdisciplinary team (IDT) that included the Assistant Director of Nursing, Resident Care Managers, and the MDS Coordinator. Staff M and Staff N were asked to review Resident 33's dental care plan and most current MDS. When asked if the MDS was accurate, Staff M, said they could not answer the question, they did not complete MDSs, Staff N interjected and said no, the MDS was incorrect.<br><br>On 01/12/2026 at 9:58 AM, Staff B, Director of Nursing Services (DNS), with Staff O, Market Resource Leader present, said when a dental care plan was updated, the entire IDT would review the update and act accordingly to the update, including setting up dental appointments, notifying the transport manager, and speaking with the Registered Dietitian (RD) about dietary changes. Staff B was asked to review Resident 33's dental care plan and the most recent MDS, Staff B confirmed the dental care plan was updated in September 2025 with reports that Resident 33 was having pain and<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | difficulty chewing. Staff B said the MDS only looks at a specific time frame, the look back period and if Resident 33 did not report concerns during that time, then the MDS would be correct. When Resident 33's interview was explained, he was still reporting pain and the documentation supported that Resident 33 had reported pain and difficulty chewing since September 2025, Staff B said yes, the MDS was incorrect and it should have been documented correctly.<br><br>Resident 6<br><br>Resident 6 was admitted to the facility on [DATE]. Review of their Quarterly MDS, dated [DATE], showed they were not receiving any therapy, including occupational therapy (OT).<br><br>Review of December 2025 OT sessions for Resident 6, showed they had received OT sessions on the 1st, 3rd, 5th, 8th, 10th, 12th, and 15th.<br><br>During an interview on 01/12/2026 at 8:58 AM, Staff L, MDS Coordinator/ Licensed Practical Nurse, said the observation window for therapy services for Resident 6 would have been the 16th of December and seven days prior. Staff L said Resident 6's therapy minutes should have shown up, and they would have to amend the MDS assessment (12/16/2025).<br><br>During an interview on 01/12/2026 at 2:11PM, Staff B, DNS, when asked their expectation for Resident 6's 12/16/2025 MDS recording OT sessions, Staff B confirmed the MDS should have shown Resident 6 was receiving OT services.<br><br>Reference WAC 388-97- 1000 (1)(b) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**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 for 6 of 21 sample residents (Resident 22, 87, 21, 8, 12 & 72) reviewed. The failure to obtain, follow and/or clarify physician's orders when indicated, and to only sign for tasks they completed, placed residents at risk for medication errors, respiratory infections, unmet care needs and other adverse health outcomes.Findings included Resident 22<br><br>Resident 22 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated10/16/2025, showed the resident was cognitively intact, had a diagnosis of chronic lung disease and received oxygen therapy during the assessment period. On 01/05/2026 at 2:38 PM, Resident 22 was observed lying in bed receiving O2 at 3L(liters)/min (minute) via NC (nasal cannula). Record review showed Resident 22 had an order for continuous oxygen at 2L/min via NC, dated 2/08/2025, and a 10/08/2024 order that directed nurses to document twice a day how many L/min of O2 was administered to Resident 22. Review of the January 2026 Medication and Treatment Administration Records (MAR/TAR) showed facility nurses documented they administered Resident 22's O2 at 3L/min via NC on the following dates/shifts.- 01/01/2026 day shift.- 01/04/2026 evening shift.- 01/05/2026 day shift.- 01/07/2026 day and evening shift.- 01/08/2025 day and evening shift Further review showed the same nurses on the same dates/shifts also signed that they administered Resident 22 O2 at 2L/min via NC as ordered. On 01/08/2026 at 9:25 AM, Staff M, Resident Care Manager (RCM), confirmed on the above referenced occasions, facility nurses signed they administered O2 at 2L/min as ordered, when they administered O2 at 3L/min via NC, without a physicians order, or documented respiratory assessment to indicate why it was clinically indicated to exceed the physician ordered rate. Resident 22 had an order, dated 12/04/2024, that directed nursing to change and date the O2 tubing and NC every Wednesday on night shift. On 01/05/2026 at 2:38 PM, Resident 22's O2 tubing was dated 12/17/2025. Review of the December 2025 MAR/TAR showed facility nurses signed that they changed and dated Resident 22's O2 tubing /NC on 12/24/2025 and 12/31/2025 as ordered. During an interview on 01/08/2026 at 9:25 AM, Staff M, RCM, acknowledged the nurses erroneously signed they changed and dated Resident 22's O2 tubing as ordered on 12/24/2025 and 12/31/2025, when they did not.<br><br>Resident 87<br><br>Resident 87 was admitted to the facility on [DATE]. Record review showed a physician's order, dated 04/24/2025, for propranolol (a blood pressure medication) by mouth two times a day, with instruction to hold the medication for a systolic blood pressure (SBP) less than 110 or a pulse (P) less than 60.<br><br>Review of the December 2025 MAR showed on the following dates Resident 87 was administered propranolol outside of the physician ordered parameters:<br><br>- 12/08/2025 evening dose SBP= 109; medication was administered instead of being held as ordered.<br><br>- 12/09/2025 evening dose SBP= 101; medication was administered instead of being held as ordered.<br><br>- 12/12/2025 evening dose SBP= 109; medication was administered instead of being held as ordered.<br><br>- 12/13/2025 evening dose SBP= 109; medication was administered instead of being held as ordered.<br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Crystal Cove Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE: 1505 Carpenter Road SE Lacey, WA 98503 | |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 12/15/2025 day and evening dose SBP= 109; medication was administered instead of being held as ordered.<br><br>On 01/12/2026 at 10:37 AM, Staff C, Infection Preventionist, said on the above referenced occasions facility nurses should have held Resident 87's propranolol, but did not, and administered it outside of the physician ordered parameters.<br><br>Resident 21<br><br>Resident 21 was admitted to the facility on [DATE] with a diagnosis of schizoaffective disorder (a serious chronic mental illness blending symptoms of schizophrenia (like hallucinations, delusions, disorganized thinking) with a mood disorder (major depression or bipolar mania)). The Quarterly MDS, dated [DATE], documented the resident was severely cognitively impaired and required substantial assistance with activities of daily living (ADLs).<br><br>A review of the electronic health record (EHR) show an order, dated 03/18/2025, for anti-psychotic (prescription psychiatric drugs that manage psychosis (hallucinations, delusions, disordered thinking)) monitor episodes of target behaviors on every shift everyday: A. hallucinations(sensory experiences (seeing, hearing, smelling, tasting, or feeling things) that seem real but aren't), B. paranoid (intense, irrational, and persistent distrust and suspicion of others) C. delusions (a fixed, false belief held with strong conviction despite evidence to the contrary), with non-pharmacological interventions (healthcare approaches that don't involve medication) as back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/flid/milk, assess for pain and provide a quiet environment.<br><br>A review of the January 2026 Medication Admiration Record (MAR) from 01/01/2026 – 01/05/2026 showed the nursing staff were documenting administered on all 3-shifts everyday but no documentation of the specific behavior or intervention.<br><br>On 01/12/2026 at 8:00 AM, Staff B, Director of Nursing Services (DNS) said he would like the nursing staff to put in a progress note when they document that the resident had a specific behavior on the MAR.<br><br>On 01/13/2026 at 8:04 AM, Staff B, DNS said his expectation was that the nursing staff document the specific behaviors and interventions in the supplemental documentation. Staff B looked at the progress notes for Resident 21 and said the nursing staff were not documenting the target behaviors and interventions used on the MAR.<br><br>Resident 8<br><br>Resident 8 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 8 was cognitively intact.<br><br>Resident 8 had an order, dated 10/31/2025, for Rivaroxaban (an anticoagulant, blood thinner) one time a day. Resident 8's anticoagulant monitoring order, dated 10/31/2025, stated, Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings two times a day.<br><br>Review of Resident 8's December 2025 and January 2026 MAR documented staff had signed off they<br>(continued on next page) |

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F 0658

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

had completed the task, but did not write Y or N, indicating if observations were observed or not.

On 01/08/2026 at 12:04 PM, when asked what staff should be monitoring for when a resident was on an anticoagulant, Staff M, Licensed Practical Nurse (LPN), with Staff N, Market Resource/Registered Nurse (RN) present, said nursing staff should have been monitoring for anticoagulant side effects that included change in urine or stool color, bruising and bleeding. Staff M was asked to review Resident 8's anticoagulant monitoring order and the January 2026 MAR. Staff M confirmed staff did not sign Y or N, indicating if observations of any anticoagulant side effects had been observed. When asked how would you know if the resident was having side effects, Staff M said they would not be able to tell if the resident had had anticoagulant side effects.

On 01/12/2026 at 9:58 AM, Staff B, DNS, with Staff O, Market Resource Leader present, was asked to review Resident 8's anticoagulant monitoring order and the January 2026 MAR. Staff B confirmed staff did not sign Y or N, indicating if observations of any anticoagulant side effects had been observed. When asked how would you know if the resident was having side effects, Staff M said there was no way to know, because staff did not document Y or N and there were no progress notes.

Resident 12

Resident 12 was admitted to the facility on [DATE] with diagnoses that included paraplegia (paralysis of the legs or lower body) and fracture to left tibia. The admission MDS, dated [DATE], documented Resident 12 was cognitively intact.

On 01/06/2026 at 9:35 AM, Resident 12 said the first time they had gone to dialysis, it was raining and the splints had been damaged by the rain, and they had not worn the splints since then. Resident 12 said the splints are under the bed. Splints observed under Resident 12's bed.

On 01/08/2026 at 9:19 AM, observation of splint under Resident 12's bed. Resident 12 confirmed they had not worn the splints in weeks.

Resident 12's long leg splint order, dated 11/15/2025, documented staff were to remove the splints daily to evaluate skin and then reapply them for 8 weeks.

Review of Resident 12's December 2025 and January 2026 TAR's showed staff documented everyday they had taken off the splints, access Resident 12's skin and then reapplied the splints.

On 01/08/2026 at 12:04 PM, Staff M, LPN, with Staff N, Market Resource/RN present, was asked to review Resident 12's splint order and review the January 2026 TAR. Staff M read the order aloud and confirmed staff had signed they had taken the splints off and then replied to them daily. When observations were reported that the splints had been stored underneath Resident 12's bed, Staff M and Staff N said staff should not have signed for things they have not completed.

On 01/12/2026 at 9:58 AM, Staff B, DNS with Staff O, Market Resource Leader present, confirmed Resident 12 had an order for daily splint removal and then to be reapplied. When observations of the splints had been stored underneath Resident 12's bed were reported, Staff B said staff should not have signed for things they have not completed.

Resident 72
(continued on next page)

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 72 was admitted to the facility on [DATE].<br><br>Review of Resident 72's orders showed they had an order for high protein snack two times a day, ordered since 06/17/2025. The order was for supplement PB [peanut butter] and saltines at 10:00 AM and Tuna Salad and Saltines at 2:00 PM.<br><br>Review of Resident 72's MAR from 01/01/2026 to 01/11/2026, showed this snack had been checked off every day for the morning and midday. Staff E, RN, had signed off on this snack twice each day on 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2025, 01/09/2026, 01/10/2026, and 01/11/2026, for a total of 14 times.<br><br>During an interview on 01/12/2026 at 9:34 AM, when asked about charting of snacks for Resident 72, Staff E said they would sometimes grab Resident 72 a PB sandwich, would not get Resident 72 a tuna salad, but would sometimes get them a chef salad. Staff E said Resident 72 would only agree to a PB sandwich once or twice a week.<br><br>During an interview on 01/12/2026 at 10:07 AM, Staff D, RCM/RN, said Resident 72 should be getting high protein snacks twice a day. Staff D confirmed the MAR for January had been signed off by nursing staff for morning and midday high protein snacks. Staff D said their expectation was for Resident 72 to get their snacks according to what the order said, and if they did not get them, it should be documented appropriately.<br><br>Reference F686<br><br>Reference WAC 388-97 -1620(2)(b)(i)(ii),(6)(b)(i) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure interventions to prevent development or promote pressure ulcer healing were implemented as ordered for 1 of 3 residents (Resident 72) reviewed for pressure ulcers. This failure placed residents at risk of worsening wounds, delay in care, and a diminished quality of life. Findings included.Review of the facility policy titled, Pressure Injury Prevention and Management, dated 03/19/2025, showed the facility were to implement interventions for preventing/managing pressure ulcers which included: pressure redistribution (including redistribution support surfaces [mattresses]), minimizing exposure to moisture, and maintaining or improving nutrition status when applicable.Resident 72 was admitted to the facility on [DATE] with diagnoses of malnutrition (body gets too few nutrients), spinal stenosis (narrowing within the spinal canal), anemia (abnormally low level of red blood cells, impacting oxygen delivery), paraplegia (loss of motor and sensory function to the legs), and multiple sclerosis (disease that causes breakdown of the protective covering of nerves). The Medicare 5 Day Minimum Data Set assessment, dated 12/02/2025, showed Resident 72 was cognitively intact, and had two stage 4 pressure ulcers (severe wounds with full-thickness tissue loss, revealing exposed muscle, tendons, ligaments, or bone, often appearing as deep craters with dead tissue). MATTRESS SETTINGS:Review of the Medline 9P-047020 User Manual for the alternating pressure relief system (mattress), showed for the type of bed Resident 72 had, the pump would have a yellow LED light for abnormal low pressure. If this were to occur, then connections should be checked. For persistent low-pressure levels, then leakage should be checked from the tubing or connecting hoses, and any damaged tubes or hoses should be replaced. When appropriate pressure was reached, the low-pressure light would go off and the normal pressure indicator, a green light, would light up. Review of Resident 72's orders, showed they had an order for a low air loss mattress, ordered on 11/21/2024, related to spine surgery and a sacral wound. Resident 72 had an order for licensed nurses to check that Resident 72's air mattress was functioning properly every shift (twice a day total), ordered on 12/04/2025.During an observation and interview on 01/05/2026 at 2:25 PM, Resident 72's mattress settings showed their pump, with a posted serial number of 9P-047020, was set between a weight of 160-240 pounds (lbs). Resident 72 said they only weighted 126 lbs. The mattress was set to static. Resident 72 said the mattress was not keeping pressure. Resident 72 said they were paralyzed and unable to feel their lower body. During an observation on 01/07/2026 at 11:08 PM, Resident 72's mattress was seen with the same settings, set between 160-240 lbs., static, and the low-pressure light was on.During an observation on 01/08/2026 at 1:00 PM, Resident 72's mattress was seen with the same settings, set between 160-240 lbs., static, and the low-pressure light was on.During an observation on 01/09/2026 from 09:55 AM to 10:56 AM, Resident 72 had wound care with five staff in total entering the room, with no changes to the mattress observed. At 11:30 AM, Resident 72's mattress was seen with the same settings, set between 160-240 lbs., static, and the low-pressure light was on.During an interview and observation on 01/09/2026 at 11:45 AM, Staff E, Registered Nurse (RN), said when they sign off that they did a validation check on the mattress, they would make sure it was functioning properly and not alarming; if it alarmed it would tell them if it was not inflated enough. Staff E said they would check to make sure the firmness was correct and the weight was right, they did this every this every shift, and the mattress pump would beep if not working correctly. When asked what does proper function mean for an air loss mattresses, Staff E said they all look a little different, just the firmness related to the weight, and they would want to match the resident's weight. Staff E said it would say alternating, which was a setting that would be locked so other people could not change the setting. Staff E said that for a low pressure light, this would mean the mattress was not inflating correctly, and it could make the patient go down onto the bed frame. Staff E said for Resident 72, their weight was 124 lbs., they usually put Resident 72 in that range, usually the mattress would be in<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | an alternating mode, normal pressure, and locked. Staff E then went into Resident 72's room and confirmed their mattress settings were: set between 160-240 lbs., static, and the low pressure light was on, without any alarm heard. Staff E lowered the mattress weight setting to under 160 lbs. and switched the mode from static to alternating. Staff E confirmed that the pump had no lock on it. At 12:16 PM, Staff E said they had checked to see if the changes made the pump go to normal pressure, and it was now green (normal pressure), and they did not know why the pump did not make any beeping noise, stating, I guess some of them don't. At 2:55 PM, the pump was observed to be back to reading low pressure and Staff E said this would need to be fixed. During an observation and interview on 01/12/2026 at 8:34 AM, Resident 72's pump was green for normal pressure, then went back to low pressure during their interview. Resident 72 said the mattress was feeling alright now, but they had not been taken off the bed yet for the mattress to be fixed. During an interview on 01/12/2026 at 8:35 AM, Staff E said the mattress was fluctuating between saying normal to low pressure, so they would need to get Resident 72 out of bed today to replace or fix the mattress.During an interview on 01/12/2026 at 10:07 AM, Staff D, Resident Care Manager (RCM)/RN, said the static mode meant the pressure remained the same, while the alternating mode was when the pressure would give some leeway and cycle to get firm and then loosen up, to not make any type of (consistent) pressure like in a firm mode. Staff D said the low pressure meant there was not enough pressure in the mattress to sustain either a static or alternating pressure. When asked about Resident 72 being observed in static mode, observed from Monday to Friday in this setting, Staff D said there was no specific order for if it should have been in static or alternating modality. HIGH PROTEIN SNACK:Review of Resident 72's orders showed they had an order for a high protein snack two times a day, ordered since 06/17/2025. The order was for supplement PB [peanut butter] and saltines at 10:00 AM and Tuna Salad and Saltines at 2:00 PM.Review of Resident 72's nutrition evaluation, dated 11/30/2025, showed they had increased protein needs related to wound healing.During an interview on 01/12/2026 at 8:34 AM, Resident 72 said they did not get 10:00 AM or 2:00 PM snacks. Resident 72 said they typically liked tuna sandwiches but was unsure of how they would taste here as they had not gotten any. Resident 72 said they would prefer a tuna sandwich over a salad. During an interview on 01/12/2026 at 9:34 AM, after being asked about what snacks Resident 72 was offered during the day, Staff E, RN, said potato chips were usually what they got Resident 72, they sometimes offered yogurt although Resident 72 did not like it, they sometimes would help Resident 72 with Resident 72's own supply of candies or a sandwich, but usually Resident 72 just wanted chips. Staff E said they would sometimes grab Resident 72 a PB sandwich, would not get Resident 72 a tuna salad, but would sometimes get them a chef salad. Staff E said Resident 72 would only agree to a PB sandwich once or twice a week.During an interview on 01/12/2026 at 10:07 AM, Staff D, RCM/RN, said Resident 72 should be getting high protein snacks twice a day. Staff D said their expectation was for Resident 72 to get their snacks according to what the order said, and if they did not get them, it should be documented appropriately. Reference F658Reference WAC 388-97-1060 (3)(b) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to secure cigarettes and failed to complete a smoking assessment for 1 of 3 residents (8) reviewed for accident hazards. The facility also failed to maintain an environment with adequate lighting (the lights were turned off) related to resident safety for 31 for 31 residents utilizing the smoking area. These failures placed residents at risk for accidents, injury and a diminished quality of life. Findings included .Resident 8<br><br>Resident 8 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 11/07/2025, documented the resident was cognitively intact and had current tobacco use.<br><br>Unsecured Cigarettes<br><br>On 01/05/2026 at 12:11 PM, Resident 8 said I have my cigarettes in my drawer. Cigarettes were observed in the top drawer of the cabinet by Resident 8's bed.<br><br>On 01/06/2026 at 12:59 PM, Staff Q, Licensed Practical Nurse, went into Resident 8's room and collected the cigarettes from the drawer by the bed. Staff Q said they should have been locked in the treatment cart with Resident 8's name on it.<br><br>On 01/13/2026 at 8:04 AM, Staff B, Director of Nursing Services said he spoke to Resident 8 and Resident 8 said they recently purchased the cigarettes. Staff B said his expectation was for the residents to give staff their cigarettes when they purchased them so they could be locked up in the treatment cart.<br><br>Smoking Assessment<br><br>A review of Resident 8's smoking assessment, dated 11/01/2025, showed blanks (no documentation) for headings: medications, resident behaviors, and nursing assessment of smoking safety.<br><br>On 01/12/2026 at 8:30 AM, Staff D, Resident Care Manager/Registered Nurse said Resident 8's smoking assessment was not complete and said they would have to go back and reevaluate Resident 8.<br><br>Adequate Lighting in Smoking Area<br><br>On 01/07/2026 at 12:30 PM, the resident smoking area was observed. To access the resident smoking area, residents exited the building through the dining room door, proceeded down a wide concrete area that led to the back of the building, then turned left down on the sidewalk that ran between the back of the facility and a wood fence (a string of flood lights were observed running along the top of the fence). The sidewalk was straight with exception of a small left, right, S curve at the end that had to be navigated before reaching the smoking area which consisted of three freestanding canopies. On the right side of the S curve, there was a 4-6 inch drop off or rut between the edge of the sidewalk and a large planter that was positioned next to the sidewalk. Tracks from wheels were visible in the dirt/mud at the bottom of the rut.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/07/2026 at 12:33 PM, Staff CC, Helping Hands, who supervises smoking, and Residents 52, 19 and 89 were in the smoking area. When asked if there had been any issues with lighting Staff CC said yes and explained some residents were smoking pot and a whiskey bottle was found near the smoking area. Due to this, facility management decided to stop turning the flood lights on that provided lighting for the smoking area after dark. When asked if residents still used the area after dark and whether it created a safety hazard, Resident 19 called out Yes, I am lucky I didn't flip over and hit my head and motioned to the rut along the edge of the sidewalk on the S curve. Residents 19 and 89 both indicated it was dangerous due to the narrow sidewalk, uneven surfaces and it was pitch black. Staff CC confirmed residents continued to use the smoking area in the dark and reported that the first night the lights were off Resident 52 fell while walking back from the smoking area. Staff CC said she was not present at the time of the fall, but Resident 52 told her the next day while he was smoking. Resident 52, who was present and listening, said he was walking back from the smoking area, and it was pitch black because the lights were off and then suddenly, he was on the ground and a girl came and helped him. Resident 52 said he wasn't sure why or what caused him to fall because he couldn't see.<br><br>On 01/08/2026 at 4:45 AM, the string of flood lights along the top of the fence were on and effectively lit the pathway and smoking area. Two weathered solar lights were observed by the center smoking canopy but projected only a very faint glow. No lighting was present on the back of the building. The sole source of light was provided by the string of flood lights. On 01/13/2026 at 1:13 PM, while observing multiple areas along the sidewalk where there were immediate 2–6-inch drop-offs, Staff CC approached and reported that residents had gone off the edge and got stuck. Staff CC explained the ruts along the sidewalk leading to the front of the building were where Residents 86 and 69's electric wheelchairs would go off the edge because the sidewalk was too narrow and indicated sometimes, they could get out on their own with their electric wheelchairs and sometimes they needed assistance. Tracks from wheels were visible in the mud at the bottom of the ruts. On 01/13/2026 at 1:58 PM, Staff B, Director of Nursing Services, toured the courtyard and confirmed the ruts along the edge of the sidewalk.<br><br>On 01/13/2026 at 2:28 PM, Staff A, Administrator, acknowledged the facility stopped turning on the lights for the smoking area but said prior to doing so, they placed solar lights in the courtyard so residents would have light and could still safely access the smoking area but indicated the solar lights malfunctioned.<br><br>On 01/15/2026 two receipts for solar lights were received via email at 4:36 PM. One receipt showed a four pack of solar path lights that was purchased on 01/09/2026 and the other showed a two head motion sensor light that was purchased on 01/14/2026. These purchases occurred after the lighting for the smoking area had been reinstated.<br><br>Reference WAC 388-97-1060 (3)(g) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow a prescribed therapeutic diet or offer alternatives to residents on a therapeutic diet and monitor and document fluid restrictions (a diet which limits the amount of daily fluid intake) for 2 of 3 sampled residents (Resident 12 & 94), reviewed for nutrition/hydration. This failure placed the residents at risk of inadequate diet, fluid overload, medical complications, and a diminished quality of life. Findings included.Resident 12-Renal Diet<br><br>Resident 12 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 11/18/2025, documented Resident 12 was cognitively intact and was placed on a renal diet (designed to support kidney health by limiting certain nutrients, particularly sodium, potassium, phosphorus, and protein, to help manage kidney disease and prevent further damage).<br><br>Review of Resident 12's Nutritional Assessment, dated 11/17/2025, under food preferences documented, see food preference eval. Review of Resident 12's electronic health record (EHR) showed no food preference evaluation had ever been completed.<br><br>A Nutrition progress note, dated 12/23/2025, stated, Rt [Resident] is reviewed for monthly f/u [follow up] on HD [hemodialysis]. He is reportedly non-compliant with their renal diet, becoming upset with the kitchen about contents of his dialysis lunch bags.<br><br>On 01/06/2026 at 9:42 AM, Resident 12 said the dialysis meal sent every dialysis day was a turkey sandwich (only two pieces of turkey, nothing else on the sandwich), some type of crackers or a cereal bar, a Nutri grain bar, one cup of Jello and a small bottle of water. Resident 12 said they do not eat poultry and have complained to the facility about the dialysis sack lunch, but the facility refused to offer an alternative meal. Resident 12 said the facility never monitors their daily fluid intake<br><br>On 01/06/2026 at 11:14 AM, when asked what was sent with a resident when they go to dialysis, Staff B, Director of Nursing Services (DNS), said the pre-dialysis paperwork and a sack lunch. When asked what was in the lunch, Staff B said the residents were sent with an appropriate dialysis lunch (but was not able to report what specifically was included in the lunch bag) and it had been assessed and approved by the Dietary manager and Registered Dietitian (RD). Resident 12 was asked to show Staff B the sack lunch that was provided. Resident 12 unpacked the provided lunch: 1) a turkey sandwich (two pieces of deli turkey meat between to pieces of wheat bread) no condiments, 2) a Cinnamon Toast Crunch cereal bar, 3) a Nutri-grain bar, 4) 1 cup of Jello and 5) an 8-ounce bottle of water. When it was explained that Resident 12 did not eat poultry and asked why the resident would have a turkey sandwich instead of an alternative, Staff B said that was what was required per the renal diet. When it was reported that Resident 12 was unable to chew the Cinnamon Toast Crunch cereal bar and asked should the resident have had an alternative, Staff B said that was the required meal for renal diet. When asked if a Nutri-grain bar, a cup of Jello and a small bottle of water was a sufficient lunch meal for a resident going to dialysis, Staff B said no, that was not appropriate. Staff B said Resident 12 was eating outside the recommended renal diet, there was paperwork Resident 12 signed, and they would provide the signed documentation.<br><br>On 01/06/2026 at 1:04 PM, Staff O, Market Resource Leader, emailed a copy of Resident 12's Refusal of Recommended Diet Restriction, dated 12/30/2025. Resident 12 acknowledged they were aware of the risk and benefits of eating outside of the recommended diet type.<br>(continued on next page) |

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| Crystal Cove Post Acute | 1505 Carpenter Road SE<br>Lacey, WA 98503 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/07/2026 at 8:37 AM, an email was sent to Staff B, DNS, and Staff O, Market Resource Leader, that requested all of Resident 12's food preference evaluations, including before and after signing the Refusal of Recommended Diet Restriction form. A food preference evaluation, dated/created on 01/07/2026 at 4:47 PM, was provided and documented Resident 12 did not eat poultry.<br><br>On 01/08/2026 at 12:04 PM, Staff M, Licensed Practical Nurse (LPN), with Staff N, Market Resource/Registered Nurse (RN) present, said food preference evaluations were completed with each resident upon admission. Staff M was asked to find Resident 12's food preference evaluation upon admit, Staff M pulled up the 01/07/2026 food preference evaluation. When asked the date on the evaluation, Staff M confirmed 01/07/2026 and confirmed. Staff N said the food preference evaluation was handwritten on a piece of paper and transcribed into the EHR the day prior. A copy of the handwritten food preference evaluation was requested. Staff M said Resident 12 was on a renal diet but wanted to go off the recommended renal diet, the facility explained this to the provider, who instructed the facility to complete a refusal of recommended diet type with Resident 12. When asked if Resident 12 was offered an alternate meal for the renal diet type, Staff M did not respond. Staff N said no. When asked if they were aware of the contents of the renal diet dialysis lunch, Staff M and Staff N said no. When informed about the posting on the kitchen wall for the dialysis lunch, Staff N said they were not aware of any posting. Staff N was escorted to the kitchen and observed a piece of paper taped on the kitchen door that documented:<br><br>DIALYSIS LUNCH<br><br>TURKEY SANDWICH, NO CHEESE!!!<br><br>2 PKS GRAHAM CRACKERS<br><br>1 JELLO OR APPLE SAUCE<br><br>1 BOTTLE OF WATER<br><br>THESE ARE THE ONLY THINGS ALLOWED IN DIALYSIS LUNCH BAGS!!<br><br>THANK YOU!<br><br>Staff N said they were concerned about the dialysis lunch bags after seeing that posting on the wall. When asked if giving a turkey sandwich to a resident who does not eat poultry or was unable to chew the cereal bar was acceptable, Staff N said no. When asked if a Nutri-grain bar, a cup of Jello and a small bottle of water were adequate nutrition for a dialysis resident, Staff N stated, I am not a [registered dietician], but as a nurse, no. When asked if Resident 12 should have been offered an alternative sandwich, Staff N said yes and confirmed Resident was never offered an alternative meal. When asked if Resident 12 should have had a food preference evaluation completed, prior to signing the Refusal of Recommended Diet Restriction form, Staff M and Staff N said yes, that was not acceptable and needed to be addressed.<br><br>On 01/12/2026 at 9:58 AM, Staff B, DNS with Staff O, Market Resource Leader present, said a food preference evaluation was not completed and should have been. Staff O said they had no handwritten copy of the food preference evaluation and confirmed the food preference evaluation provided was completed on 01/07/2026.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/12/2026 at 12:52 PM, Staff K, Registered Dietician (RD), said when a resident was admitted to the facility on dialysis, they would check in with the resident/initiate the diet interview, educate/answer questions about the renal diet and communicate with the dialysis RD about the resident's diet. Staff K said they were only at the facility once a week, they did not go over resident food preferences, that was the responsibility of the dietary manager, but they would follow up after the initial food preference interview. When asked to discuss Resident 12's dialysis renal diet, Staff K said the diet was too restrictive for Resident 12, they would refuse to eat the recommended renal diet. Staff K said there was discussion about having the resident sign Refusal of Recommended Diet Restriction form but did not believe that had happened. When asked if they were aware of Resident 12's food preferences, Staff K said no. Staff K confirmed all dialysis lunches included a turkey sandwich (two pieces of deli turkey meat between to pieces of wheat bread) no condiments, crackers or a cereal bar, a Nutri-grain bar, 1 cup of Jello and a small bottle of water. When it was explained that Resident 12 does not eat poultry and they were unable to chew the cereal bar, Staff K said the expectation was that the resident would have been offered an alternative meal, within the renal diet, like a tuna sandwich. Staff K was informed that the facility had Resident 12 sign the Refusal of Recommended Diet Restriction form without offering Resident 12 an alternate dialysis meal. Staff K said they were not aware that had happened. When asked if a Nutri-grain bar, 1 cup of Jello and a small bottle of water (8oz) was adequate nutrition for a resident on dialysis, Staff K did not answer directly but said they would have recommended two alternative sandwiches.<br><br>Fluid Restriction<br><br>A physician's order, dated 11/12/2025, directed staff to monitor Resident 12's fluid intake, no more than 1500 milliliters (ml) of fluid in a 24-hour period, broke down into 250 ml at breakfast, lunch and dinner.<br><br>The January 2026 Treatment Administration Record (TAR) showed only entries for day and evening fluid intake, not accounting for night shift documentation. The January 2026 TAR, documented staff were monitoring Resident 12's fluid intake at 250ml for day and evening shifts.<br><br>Resident 94Resident 94 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of end stage kidney disease and received dialysis services during the assessment.<br><br>Record review showed an order, dated 03/19/2025, for a 1200 milliliter (ml) per day fluid restriction. Nursing was to provide 200 ml per shift (day, evening, night) for a total of 600 ml, and dietary would provide the other 600 ml (200 ml per meal, breakfast, lunch, dinner) for a total of 1200 ml per day.<br><br>Review of Resident 94's nutritional needs care plan, revised 11/25/2025, showed they were on a 1200 ml per day fluid restriction.<br><br>A dialysis care plan, with a target date of 02/21/2026, documented Resident 94 was frequently non-compliant with their fluid restriction. On 01/06/2026 at 10:16 AM, a plastic water pitcher containing clear liquid was observed on Resident 94's overbed table. Review of the December 2025 Medication Administration Record (MAR) showed facility nurses recorded the amount of fluid they provided Resident 94 each shift. The order did not include direction to staff to add the total amount of fluid provided by nursing with the total fluid intake at meals, to identify Resident 94's total 24-hour fluid intake.<br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 94's meal monitor showed staff were not recording Resident 94's fluid intake with meals.<br><br>On 01/08/2025 at 11:33 AM, when asked if there was any documentation to show staff had recorded Resident 94's fluid intake with meals, and/or reconciled it with the fluids provided by nursing to calculate what Resident 94's total 24-hour fluid intake was Staff M, Resident Care Manager, stated, No.<br><br>On 01/15/2025 at 2:45 PM, when asked if there was any documentation to show staff had recorded Resident 12's fluid intake with meals, and/or reconciled it with the fluids provided by nursing to calculate what Resident 12's total 24-hour fluid intake was Staff C, Registered Nurse/Infection Preventionist, stated, No.<br><br>Reference WAC 388-97-1060 (1). |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Peripherally Inserted Central Cather (PICC) line Intravenous (IV) treatments were provided consistent with professional standards of practice for 1 of 1 resident (Resident 76) reviewed. These failures placed the resident who required IV services at risk for loss of vascular access and complications related to IV therapy.Findings included .A review of the facility policy titled, Peripherally Inserted Central Catheter Flushing, Locking, Removal, dated 2025, stated, It is the policy of this facility to ensure that peripherally inserted central catheters (PICC) are flushed, locked and removed with current standards if practice. And under the Flushing heading it documented 7. Slowly aspirate [withdraw fluid] for a blood return to confirm device patency.Resident 76Resident 76 was admitted to the facility on [DATE] with a diagnosis of Methicillin Resistant Staphylococcus Aureus Infection (a staph infection resistant to common antibiotics). The admission Minimum Data Set (an assessment tool), dated 12/18/2025, documented Resident 76 was moderately cognitively impaired and had a central line IV access and was receiving IV medications.An observation on 01/08/2026 at 8:09 AM, Staff AA, Licensed Practical Nurse (LPN), provided Resident 76 their antibiotic through their PICC line. Staff AA did not aspirate to check for blood return before administering the IV antibiotic. On 01/08/2026 at 8:27 AM, Staff AA, LPN, said she flushes with the start stop, push and go method to check for patency and make sure it is not clotted. Staff AA also said she looks for skin changes to see if the skin is red and irritated. On 01/13/2026 at 8:04 AM, Staff B, Director of Nursing Services, said Staff AA should have also aspirated for blood return, according to the facility policy for a resident that had a PICC line.Reference WAC 388-97- 1060 (3)(j)(ii) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen therapy was provided in accordance with physician's orders and accepted professional standards of practice for 1 of 1 resident (Resident 22) reviewed for respiratory care. Facility staffs' failure to administer oxygen at the physician ordered rate and to change oxygen tubing as the frequency ordered, placed residents at risk for respiratory infections and unmet respiratory needs. Findings included .Review of the facility's Oxygen Administration policy, copyright 2025, O2 (oxygen) would be administered to residents who needed it. O2 would be administered in accordance with physician's orders except in the case of an emergency. In such case, O2 would be administered and orders for the oxygen/rate would be obtained as soon as practicable and staff would document the initial and ongoing assessment of the resident's condition that warranted O2 administration and the resident's response. O2 tubing/NC (nasal cannula) would be changed weekly and as needed if it became soiled or contaminated. Resident 22 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 10/16/2025, showed the resident was cognitively intact at intact, had a diagnosis of chronic lung disease and received oxygen therapy during the assessment period. On 01/05/2026 at 2:38 PM, Resident 22 was observed lying in bed receiving O2 at 3L (liters)/min (minute) via NC. The resident's O2 tubing was dated 12/17/2025. When asked how often the O2 tubing was changed Resident 22 stated, Once a month I think. An altered respiratory status care plan, revised 05/06/2025, directed staff to provide continuous O2 at 2-3L/min via NC and to monitor for signs and symptoms of respiratory distress. Record review showed Resident 22 had the following oxygen therapy orders:- O2 at two liters per minute via nasal canula (2L/min via NC), dated 12/08/2025.- Chart L/min twice a day if O2 is administered, dated 10/08/2024- Check O2 saturation (SpO2) two times a day, dated 10/08/2024.- O2 to maintain SpO2 greater than 90%, dated 10/08/2024. - Check SpO2 on room air the 27th and 28th of every month, dated10/27/2024.- Change and date O2 tubing and NC every Wednesday on night shift, dated 12/04/2024. On 01/08/2025 at 8:53 AM, Resident 22 was observed lying in bed receiving O2 at 3L/min via NC. The O2 tubing/NC was dated 01/06/2026. Review of the January 2026 Medication and Treatment Administration Records (MAR/TARs) showed that facility nurses documented they administered O2 at 3L/min via NC on the following dates between 01/01/2026 - 01/08/2026.- 01/01/2026 day shift.- 01/04/2026 evening shift.- 01/05/2026 day shift.- 01/07/2026 day and evening shift.- 01/08/2025 day and evening shift. Review of Resident 22's progress notes showed there was no documented respiratory assessments to indicate why nurses administered O2 at higher rate than was ordered. Review of Resident 22's vitals sign flowsheet and the MAR showed there were no SpO2s recorded that were less than 90%. The SpO2s ranged from 91 - 98 %, with the majority being in the mid to high 90s. Review of the December 2025 MAR/TAR showed that facility nurses signed that they changed and dated Resident 22's O2 tubing/NC on 12 24/2025 and 12/31/2025 as ordered. On 01/08/2026 at 9:25 AM, Staff M, Resident Care Manager, confirmed Resident 22's O2 order was for continuous O2 at 2L/min via NC and the resident did not have an order to titrate (to given O2 based on SpO2). After reviewing the January 2026 MAR/TAR, Staff M confirmed facility nurses administered O2 at 3L/min without a documented respiratory assessment/clinical indication and without a physician's order. Reference WAC 388-97-1060 (3)(j)(iv) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure ongoing communication and collaboration with Hemodialysis (dialysis, a machine that is used to remove waste and extra fluid from blood and return the filtered blood into the body), receive/obtain dialysis communication documentation including resident's plan of care and post dialysis communication, and/or follow up on dialysis recommendations for 2 of 3 sampled residents (Resident 15 &12) reviewed for dialysis. This failure placed residents at risk for medical complications, missed dialysis treatments and a decreased quality of life. Findings included.Review of the facility polity titled, Hemodialysis, dated 2024, showed the facility was to communicate with the dialysis facility, such as using a dialysis communication form or other form, that would include: bloodwork results, vital signs, nutritional/fluid management (including resident compliance with food/fluid restrictions, and monitoring fluid intake and output measurements as ordered),and dialysis recommendations for follow up observations and monitoring. The facility would provide care and services that included ongoing communication and collaboration with the dialysis facility regarding dialysis care and services, and ongoing assessment and oversight of the resident before, during, and after dialysis treatments. The facility would ensure the physician's order for dialysis would include the nephrologist's name and number and any fluid restriction if ordered by the physician.<br><br>Resident 15<br><br>Resident 15 was admitted to the facility on [DATE], with a diagnosis of end stage renal disease (where the kidneys were no longer able to filter the blood). The admission Minimum Data Set (MDS, an assessment tool), dated 12/12/2025, showed Resident 15 was cognitively intact.<br><br>Review of Resident 15's dialysis (procedure that uses a machine to filter the blood) order, dated 12/15/2025, showed they were going to dialysis on Monday, Wednesdays, and Fridays from 6:00 PM to 11:00 PM.<br><br>Review of Resident 15's dialysis transfer forms, showed they were not fully completed. The review showed the following dates had missing information:<br><br>1. 12/10/2025: the post-dialysis nursing evaluation was missing resident mentation (mental status) upon return.<br><br>2. 12/12/2025: the center (facility) report was missing information such as medication changes since last dialysis appointment, medication administration record attachment yes or no, laboratory testing since last dialysis appointment, any changes in medical or mental status. The post-dialysis nursing evaluation was missing resident mentation upon return.<br><br>3: 12/15/2025: the center report mentioned blood work had been done, but they did not attach it to provide to the dialysis center. The dialysis report was missing a pre-dialysis weight.<br><br>4. 12/19/2025: the center report was missing information such as medication changes since last dialysis appointment, medication administration record attachment yes or no, laboratory testing since last dialysis appointment, any changes in medical or mental status. The dialysis report section was empty (no pre-dialysis weight, post-dialysis weight, etc.). The post-dialysis nursing evaluation was missing resident mentation upon return.<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. 12/21/2025: The post-dialysis nursing evaluation was missing resident mentation upon return.<br><br>6. 01/02/2026: the center report was missing information such as medication changes since last dialysis appointment, medication administration record attachment yes or no, laboratory testing since last dialysis appointment, any changes in medical or mental status. The dialysis report section was empty (no pre-dialysis weight, post-dialysis weight, etc.). The post-dialysis nursing evaluation was missing resident mentation upon return.<br><br>7. 01/05/2026: the dialysis report section was empty (no pre-dialysis weight, post-dialysis weight, etc.). The post-dialysis nursing evaluation was missing resident mentation upon return.<br><br>Review of Resident 15's dialysis transfer form, dated 12/10/2025, showed dialysis made recommendations to limit oral fluid intake, limit/avoid foods high in potassium. Review of Resident 15's dialysis transfer form, dated 12/17/2025, showed dialysis made recommendations to limit oral fluid intake. Review of Resident 15's nutrition assessment, dated 12/08/2025, showed Resident 15 was to have their fluid intake and output monitored. Review of Resident 15's electronic health record (EHR), showed there was no fluid intake monitor and no fluid restriction.<br><br>During an interview on 01/05/2026 at 12:35 PM, Resident 15 said they did not know if they were on a fluid restriction.<br><br>During an interview on 01/08/2026 at 2:00 PM, Staff D, Resident Care Manager/Registered Nurse (RN), said they were only able to find one dialysis transfer form for 01/02/2026 for Resident 15, in the pile to be uploaded into the EHR, and it only had a pre-dialysis weight with nothing else filled out. Staff D said their expectation was for the nurse to have called the dialysis center for the rest of the information, to fill out the form fully.<br><br>On 01/08/2026 at 2:21 PM, Staff D provided an update. Staff D said they had reopened the forms so they could update them with dialysis information and they had reached out the dialysis center.<br><br>During an interview on 01/08/2026 at 2:30 PM, Staff D was unable to find a fluid monitor for Resident 15. Regarding the dialysis center and the nutrition assessment recommendations, Staff D said yes of course they should do that (fluid monitor/fluid restriction) if there were recommendations. Staff D said unless they were specifically told by the registered dietician, they would not know they wanted a fluid monitor. When asked if there should have been follow-up to the dialysis recommendations for limiting fluids for Resident 15, Staff D said absolutely. Staff D said their expectation for documenting dialysis appointments, was for staff to complete the dialysis evaluation prior to the resident leaving, for staff to print this off and send with the resident to go to the dialysis center to fill out, and when the resident returns they should take vitals and do an evaluation, along with making sure the documentation was complete. When asked how the facility knew what meds were given by dialysis, as this was not recorded on dialysis transfer form, Staff D said the dialysis center should document what they were giving, and if they were not, then the facility should probably call them to ask. Regarding the 12/15/2025 dialysis transfer form saying there had been bloodwork but not attaching the results, Staff D said the staff should have attached a copy of the bloodwork results. After reviewing dialysis transfer forms, Staff D acknowledged the documentation was not complete. Staff D was unable to find in the care plan or under Resident 15's listed medical professionals who their nephrologist was, and they would need to validate and update this.<br><br>During an interview on 01/12/2026 at 2:11 PM, Staff B, Director of Nursing Services (DNS), when<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | asked if they expected residents receiving dialysis to be on a fluid monitor if the nutrition assessment said they should be, said yes, if there was an order. Staff B looked in Resident 15's EHR and said the nutritional dietician assessment was not a doctor's order. Regarding Resident 15's dialysis communication saying they should be on a fluid restriction and their expectation for the facility to follow up on this, Staff B said they should put in an order, they should follow the dialysis order. Staff B said follow up should have clarification with dialysis, as it did not specify the amount for the fluid restriction. Staff B said their expectation for dialysis transfer forms regarding documentation, was for them to be filled out before dialysis, given to the resident to take to dialysis, it would then be filled out by dialysis and comes back with the resident. If it did not come back with the resident, then they should call and get the information. Staff B said the dialysis documents should be completed when the resident returned, but if they did not have it, the dialysis center might be closed the following day, so when the information was available. Resident 15's dialysis transfer form, dated 01/02/2026, was reviewed with Staff B and the blanks for documentation were shown. Staff B said the form was complete since no documentation meant there was no change, they did not expect staff to fill out the form, but staff could write no change if no change.<br><br>Resident 12<br><br>Resident 12 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 12 was cognitively intact and was receiving dialysis.<br><br>A Physician's order, dated 11/13/2025, documented the facility was to obtain the information sheet from dialysis center, documenting pre and post dialysis weights. If the information sheet was not obtained, the facility was to call the dialysis center and obtain the information or the facility could proceed with obtaining weights.<br><br>Review of the EHR documented Resident 12 had dialysis on the following days, but no dialysis communication form was documented:<br><br>11/13/2025<br><br>11/15/2025<br><br>11/18/2025<br><br>11/20/2025<br><br>11/21/2025<br><br>11/25/2025<br><br>11/29/2025<br><br>12/07/2025<br><br>12/30/2025<br><br>01/06/2026<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505254 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/13/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Crystal Cove Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 1505 Carpenter Road SE Lacey, WA 98503 | |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the EHR documented Resident 12 had dialysis on the following days and dialysis transfer forms had been obtained on 01/05/2026 and uploaded in the EHR on 01/07/2026:<br><br>12/02/2025<br><br>12/09/2025<br><br>12/11/2025<br><br>12/13/2025<br><br>12/20/2025<br><br>12/23/2025<br><br>12/24/2025<br><br>12/27/2025<br><br>01/01/2026<br><br>01/03/2026<br><br>Review of the EHR showed Resident 12 had no dialysis Plan of Care.<br><br>On 01/08/2026 at 12:04 PM, Staff M, Licensed Practical Nurse, with Staff N, Market Resource/RN present, said they do not have a communication dialysis binder. Staff M checked the nurses' stations. Staff M said they would need to follow up if they had dialysis communication documentation. Staff N said dialysis communication documentation had been identified as a concern in the facility and Staff O, Market Resource Leader, had conducted audits of dialysis communication to address the concern. No dialysis communication documentation was provided.<br><br>On 01/09/2026 at 12:54 PM, Staff B, DNS, confirmed the facility did not have a copy of Resident's Plan of Care from the dialysis center.<br><br>On 01/12/2026 at 9:58 AM, Staff B, DNS with Staff O, Market Resource Leader present, said the process for dialysis communication was to send the dialysis transfer sheet with the resident, if the resident brings the sheet back, the facility would enter the information into the EHR. If the dialysis transfer sheet did not return with the resident, then the facility was to call the dialysis center and request a copy of the information, via fax. Staff B was shown the dates listed above where no documentation was obtained from the dialysis center, Staff B said post dialysis weights were obtained by the facility. Staff B was shown the only three dates (12/04/2025, 12/16/2025 & 12/18/2025) where dialysis communication documentation was obtained, Staff B confirmed no other dialysis communication had been obtained by the facility. When asked if all dialysis days should have dialysis communication documentation (obtained prior to 01/05/2026), Staff B said yes but would double check with medical records to ensure no other communication had been provided. No other dialysis communication documentation was provided.<br><br>Reference F656<br>(continued on next page) |

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| Crystal Cove Post Acute | 1505 Carpenter Road SE<br>Lacey, WA 98503 |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reference WAC 388-97-1900 (1), (6)(a-c) |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observe each nurse aide's job performance and give regular training.<br><br>Based on interview and record review the facility failed to complete annual staff performance reviews yearly as required and provide education based on the outcome of these reviews for 1 of 1 sampled veteran staff (Staff BB) reviewed for performance reviews. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, and a diminished quality of life.Findings included .Review of Staff BB's, Nursing Assistant personnel file showed they were hired on 07/18/2023. Review of Staff BBs personnel file showed no annual performance review had been completed from July 2024 - July 2025On 01/12/2026 at 12:50 PM, Staff A, Administrator, said there was not a performance review for Staff BB as required. Reference WAC 388-97-1680 (1), (2)(a-c) |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide or obtain dental services for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure prompt dental services were provided for 2 of 2 sampled residents (Residents 33 &11) reviewed for dental services. This failure placed residents at risk for difficulty chewing, pain/discomfort due to unmet dental needs, and a diminished quality of life. Findings included .Resident 33<br><br>Resident 33 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 11/09/2025, documented Resident 33 was cognitively intact and relied on staff for all cares.<br><br>On 01/05/2026 at 3:10 PM, Resident 33 reported they had missing, and broken teeth and a number of their teeth had fallen out. Resident 33 said it had been almost a year since they had been to a dentist and they wanted to get their teeth fixed, because it was causing pain when they ate. Resident 33 said they could not chew meat, it had to be cut up very small, or sugar, due to causing pain and missing fillings, and this had been going on for months with no follow up.<br><br>Review of the electronic health record (EHR) showed Residents 33's last dental visit was on 05/09/2025. It was documented Resident 33 had five decayed teeth, one broken tooth, with nine lower teeth and five upper teeth missing. Referral for X-rays, evaluations and extraction for all upper teeth was recommended.<br><br>Review of Resident 33's dental care plan, revised 09/15/2025, documented Resident 33 had swallowing problems related to (r/t) complaints of difficulty or pain with chewing/swallowing. Resident 33 has potential/oral/dental health problems r/t he has his own natural teeth; they are in poor condition.<br><br>On 01/08/2026 at 12:04 PM, Staff M, Licensed Practical Nurse (LPN), with Staff N, Market Resource/Registered Nurse present, reviewed Resident 33's dental evaluation reported dated 05/09/2025. Staff N read the report out loud. When asked if they had been any follow up to the recommendation made, Staff M and Staff N said no but there should have been follow up.<br><br>On 01/12/2026 at 9:58 AM, Staff B, Director of Nursing Services (DNS), with Staff O, Market Resource Leader present, were asked to review Resident 33's dental evaluation reported dated 05/09/2025. Staff B confirmed there had been no follow up for Resident 33's dental concerns and said there should have been.<br><br>Resident 11Resident 11 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented the resident was severely cognitively impaired and needed substantial to maximal assistance with activities of daily living including eating.<br><br>On 01/05/2026 at 11:28 AM, Resident 11's family member said Resident 11 had a tooth abscess (infection) and was on an antibiotic. The family member said Resident 11 was supposed to go to the dentist and get x-rays.<br><br>A progress note, dated 12/29/2025 at 5:40 PM, by Staff Q, LPN documented swelling on the right side of Resident 11's face nonverbal signs of pain such as grimacing, groaning and holding the right side of the face when trying to chew food.<br>(continued on next page) |

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|---|---|---|---|
| | 505254 | A. Building<br>B. Wing | 01/13/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Crystal Cove Post Acute | 1505 Carpenter Road SE<br>Lacey, WA 98503 |

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| F 0791<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A progress note dated 12/30/2025 at 2:53 PM by Staff Q, LPN documented Resident 11 was started on an antibiotic.<br><br>A progress note dated 12/31/2025 at 8:20 AM by Staff D, Resident Care Manager (RCM)/Registered Nurse (RN) documented referrals would be sent out and Resident 11's family member would like to accompany Resident 11 to the appointment once it was scheduled.<br><br>A progress note dated 01/02/2026 at 1:48 PM by Staff D, RCM/RN documented a pain medication was ordered for Resident 11 to be given 1 hour before meals.<br><br>On 01/09/2026 at 12:13 PM, Staff Z, Social Services said she scheduled appointments with the inhouse dentist only and Staff D, RCM/RN and Staff X, Certified Nursing Assistant (CNA) would call to set up a dental consult for Resident 11.<br><br>On 01/09/2026 at 2:03 PM, Staff X, CNA, said her job title was transportation, and she did not know that Resident 11 needed an appointment for a dental consult.<br><br>On 01/09/2026 at 2:05 PM Staff D, RCM/RN said he does not have an appointment for Resident 11 and said I should have an appointment. Honestly, I thought Staff X was doing it.<br><br>A progress note dated 01/09/2026 at 2:17 PM by Staff X, CNA documented she left a voice mail at the dentist to schedule a new patient consult.<br><br>On 01/13/2026 at 8:04 AM Staff B, DNS, said there was a communication breakdown, and they did not know who was doing what. Staff B's expectation was that they had decided who was going to call the dental appointment for Resident 11.<br><br>Reference WAC 388-97-1060 (3)(j)(vii) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received foods that accommodated the residents' preferences, diet types and tolerances for 3 of 8 sampled residents (Resident 12, 66 & 15) reviewed for preferences. This failure placed residents at risk for meal dissatisfaction, nutrition at risk, and a diminished quality of life.Findings included .Resident 12<br><br>Resident 12 was admitted to the facility on [DATE]. The admission Minimum Data Set (MDS, an assessment tool), dated 11/18/2025, documented Resident 12 was cognitively intact and was placed on a renal diet (designed to support kidney health by limiting certain nutrients, particularly sodium, potassium, phosphorus, and protein, to help manage kidney disease and prevent further damage).<br><br>On 01/06/2026 at 9:42 AM, Resident 12 said the dialysis meal sent every dialysis day was a turkey sandwich (only two pieces of turkey, nothing else on the sandwich), some type of crackers or cereal bar, a Nutri grain bar, a cup of Jello and a small bottle of water. Resident 12 said they do not eat poultry and have complained to the facility about the dialysis sack lunch, saying the facility refused to offer an alternative meal.<br><br>On 01/06/2026 at 11:14 AM, Resident 12 was asked to share the sack lunch that was provided with Staff B, Director of Nursing Services (DNS). Resident 12 unpacked the provided lunch: 1) a turkey sandwich (two pieces of deli turkey meat between to pieces of wheat bread) no condiments, 2) a Cinnamon Toast Crunch cereal bar, 3) a Nutri-grain bar, 4) 1 cup of Jello and 5) a small bottle of water (8oz). When it was explained that Resident 12 did not eat poultry and asked why the resident would have a turkey sandwich instead of an alternative, Staff B said that was what was required per the renal diet type. When it was reported that Resident 12 was unable to chew the Cinnamon Toast Crunch cereal bar, should the resident have an alternative snack, Staff B again said that was the required meal for renal diet. When it was explained Resident 12 would not eat the sandwich and could not eat the cereal bar, leaving only a Nutri-grain bar, a cup of Jello and a small bottle of water, if that was a sufficient lunch meal and if that was honoring the resident's preferences, Staff B said no, that was not appropriate and it needed to be addressed.<br><br>Review of Resident 12's Nutritional Assessment, dated 11/17/2025, under food preferences documented, see food preference eval. Review of Resident 12's electronic health record (EHR) showed no food preference evaluations had ever been completed.<br><br>On 01/07/2026 at 8:37 AM, an email was sent to Staff B, DNS, and Staff O, Market Resource Leader, that requested all of Resident 12's food preference evaluations. A food preference evaluation, dated/created on 01/07/2026 at 4:47 PM, was provided and documented Resident 12 did not eat poultry.<br><br>On 01/08/2026 at 12:04 PM, Staff M, Licensed Practical Nurse (LPN), with Staff N, Market Resource/Registered Nurse (RN) present, said food preference evaluations were completed when a resident was admitted to the facility. When asked to show Resident 12's food preference evaluation upon admit, Staff M pulled up the 01/07/2026 Food preference evaluation. When asked the date on the evaluation, Staff M confirmed 01/07/2026. Staff M confirmed no food preference evaluation had been completed upon admit. When asked if Resident 12 had been offered an alternate meal, Staff M did not answer. Staff N said no.<br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/12/2026 at 9:58 AM, Staff B, DNS with Staff O, Market Resource Leader present, said a food preference evaluation was not completed and should have been.<br><br>Resident 66<br><br>Resident 66 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 66 was cognitively intact.<br><br>Review of Resident 66's orders showed they had a diet order, ordered on 12/15/2025, for whole milk for breakfast and lunch.<br><br>Review of Resident 66's nutrition assessment, dated 12/22/2025, showed Resident 66 had a preference for whole milk with breakfast and lunch.<br><br>During an interview and observation on 01/05/2026 at 1:07 PM, Resident 66 was seen in their room with only orange juice on their tray. Resident 66 said they only gave them one drink on their trays, and they would often go to the cafeteria so they could get more drinks with their meals.<br><br>During an observation on 01/07/2026 at 12:07 PM, Resident 66 was seen in the dining room and was provided with 2% milk and orange juice. When Resident 66 was given their meal, their meal ticket was observed to not have any mention about whole milk. Resident 66 reported their orange juice was warm (the jar of orange juice had been observed to not be kept in ice or anything to cool it).<br><br>During an observation on 01/08/2026 at 8:07 AM, Resident 66 was seen in the dining room, and was served 2% milk.<br><br>During an observation and interview on 01/08/2026 at 12:38 PM, Resident 66 was seen eating lunch in their room, with only orange juice and water, no milk seen on the tray. When asked about the 2% milk provided in the dining room, if they would prefer to get whole milk, Resident 66 said they would prefer whole milk.<br><br>During an interview on 01/08/2026 at 2:58 PM, Staff D, Resident Care Manager/Registered Nurse, confirmed the diet order said whole milk for breakfast and lunch for Resident 66. When asked if they would expect Resident 66 to get whole milk for breakfast and lunch, Staff D said yes, that was Resident 66's preference. When told of the observations in Resident 66's room without milk, and in the dining room with 2% milk, Staff D said they hoped staff were paying attention to that, they would update the diet sheet and update the kitchen.<br><br>Resident 15<br><br>Resident 15 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 15 was cognitively intact.<br><br>Review of Resident 15's orders, dated 12/15/2025, showed they were receiving dialysis treatments (where a machine filters the blood to remove waste products, which is needed to remove potassium from the blood) three days a week. Review of their diet order, showed they had a renal diet (diet to support kidney health by limiting certain nutrients, including potassium), ordered on 12/07/2025.<br><br>During an observation on 01/07/2026 at 12:59 PM, Resident 15 was seen in the dining room, with<br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | sweet potato (source of potassium) pieces seen on their tray. Their meal ticket was reviewed, no sweet potato was listed on it.<br><br>During an interview on 01/12/2026 at 1:39 PM, Staff K, Registered Dietician, said that the sweet potatoes would be an issue if it did not match what was on the meal ticket. After being read what was written on Resident 15's meal ticket on 01/07/2026, Staff K confirmed that the sweet potatoes should not have been on there.<br><br>Reference WAC 388-97 -1120 (3)(a),1 100(1), 1140 (6) |

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| | 505254 | A. Building<br>B. Wing | 01/13/2026 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation and interview, the facility failed to ensure food was stored under sanitary conditions by not ensuring a resident refrigerator maintained cold food at or below 41 degrees Fahrenheit. This failure created the potential to expose residents to improperly stored food and increased risk of foodborne illness.Findings included .During an observation of the dining room resident refrigerator on 01/06/2026 at 11:09 AM, the refrigerator thermometer red indicator line showed a reading of 51 degrees, Staff G confirmed that the reading was 51 degrees. When asked what steps she would take now that it had been identified the refrigerator was above 41 degrees, Staff G said she would throw everything away and began removing food items from the refrigerator. On 01/07/2026 at 2:20 PM, Staff G showed there was a new resident refrigerator saying it had been placed on 01/06/2026. When asked to see the thermometer, Staff G was unable to locate it in the refrigerator and said it had been there in the morning. Staff G then asked Staff I, Admissions Director, about the thermometer and Staff I said they had dropped the thermometer that morning, had placed it on top of the refrigerator with the intention of cleaning it and putting it back, however she had forgotten to do so.On 01/12/2026 at 2:21 PM, Staff G, when asked if it met expectations that the resident refrigerator temperature had been 51 degrees, Staff G said no. When asked if the thermometer for the resident refrigerator not being in place met her expectations, Staff G said, no. With regards to the inner kitchen refrigerator thermometer that did not function and asked if this met expectations, Staff G said, no. Reference WAC 388-97-1100(3) |

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| F 0847<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>Based on interview and record review, the facility failed to ensure the facility's binding arbitration agreements (legal document that required the use of a third party to resolve disputes) was reviewed and explained in a form, manner, and/or language understood by the resident and/or their legal representative for 3 of 3 sampled residents (Resident 46, 60 & 79) reviewed for binding arbitration agreements. This failure placed residents at risk for lacking understanding of the legal document signed, forfeiture (loss or giving up of something) of the right to a jury or court, and a diminished quality of life. Findings included .On 01/12/2026 at 2:16 PM, when asked what their understanding of the arbitration process was, Resident 46 stated, what is that? Resident 46 said they did not know they were giving up their right to pursue litigation in a court proceeding or that they could terminate the arbitration agreement within 30 days. When it was explained they had signed the facility's arbitration agreement when they admitted to the building, Resident 46 stated, when I was admitted I was not alert or aware. On 01/12/2026 at 2:40 PM, Resident 60 said they did not know they had given up their right to take legal action against the facility or that they had the right to cancel the arbitration agreement within 30 days. Resident 60 said they came from the hospital and stated, I don't remember what I filled out, it was just sign here, here and here. When asked if the arbitration agreement was explained in a way that they understood, Resident 60 said no, they were not aware about any of that. On 01/12/2026 at 3:25 PM, when asked what their understanding of the arbitration process was, Resident 79 stated. I don't know if they covered it. Resident 79 said they were not aware they were giving up any rights to court action, they were handed a stack of papers and asked to sign them. Resident 79 said they were not aware they had 30 days to terminate the agreement. Resident 79 said the staff member who had them fill out the paperwork, told them, Just sign it, if you don't understand it, I'll explain it to you later. When asked if the arbitration agreement was explained in a way that they understood, Resident 79 said if they had explained it the way you did just did, I would not have signed it. On 01/12/2026 at 3:43 PM, Staff I, admission Coordinator, said as part of the admission packet, the residents have the right to sign or decline signing the arbitration agreement. When asked how the arbitration agreement was explained to the residents in a language and manner they understood, Staff I said we just explain it to them, it is usually at the end of the packet, and the facility would say that we like to handle things in house, with our own layers and representatives verse bringing in outside resources. Staff I said they try to complete the arbitration agreement within about 72 hours of admission. Staff I said they would answer questions and break down wording to make sure the residents understood, to ensure resident understood they had the right to terminate it within 30 days, and it was not part of the agreement for admission to the facility. When asked if it was acceptable for a staff to say, 'sign this and I will explain it later,' Staff I stated, Absolutely not. When it was explained that 3 of 3 residents reviewed for arbitration reported they did not understand they were giving up their right to court litigation or that they only had 30 days to terminate the agreement, Staff I said they did not know that. No Reference WAC. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a system in place that ensured effective communication, collaboration, and coordination of care occurred between the facility and the hospice provider for 1 of 1 resident (Resident 87) reviewed for hospice services.The facility failed to designate a staff member to be responsible for coordinating care with hospice staff, to obtain and maintain a current copy of the coordinated hospice plan of care, and to have a system/ documentation of what hospice staff had visited (e.g., registered nurse, chaplain, certified nursing assistant, massage therapist), when they visited, and what care was provided. These failures detracted from staffs' ability to effectively communicate collaborate and coordinate care with the Hospice provider, and placed residents at risk for not receiving necessary care and services and/or unmet care needs. Findings included .Resident 87 was admitted to the facility on [DATE]. Review of a Significant Change Minimum Data Set (MDS, an assessment tool), dated 05/28/2025, showed the resident had a terminal diagnosis (life expectancy of less than six months) and received Hospice services. Record review showed a physician's order, dated 05/16/2025, to refer Resident 87 for Hospice services. Review of the initial Hospice coordinated plan of care, dated 05/28/2025 showed Resident 87 was admitted to Hospice services with a primary diagnosis of dementia. The resident's Hospice team included a Registered Nurse Case Manager (unidentified) who would visit one time a week and as needed, a Hospice aide (unidentified), who would visit two times a week, a named Hospice Social Worker and a named Hospice Chaplain, would both visit per resident need. This Hospice coordinated plan of care was for the certification period of 05/28/2025 - 08/25/2025. Review of Resident 87's electronic health record (EHR) showed there was no current coordinated Hospice plan of care (for the certification period of 11/24/2025 - 01/22/2026) present, nor was there a copy of the Hospice coordinated plan of care for the previous certification period of 08/26/2025 - 11/24/2025. Hospice medication orders dated 05/28/2025, 06/05/2025, 10/21/2025 and 11/28/2025 were present in Resident 87's EHR, but no visit notes from the Hospice Registered Nurse, Hospice aide, Chaplain or Social Worker were found. On 01/08/2026 at 9:13 AM, when asked how the facility knew what Hospice services Resident 87 was to receive, and what disciplines (Nurse, Aide, SW etc.) were to be visiting and at what frequency, Staff M, Resident Care Manager, indicated the facility might have a Hospice binder. On 01/09/2026 at 10:27 AM, Staff C, Infection Preventionist, confirmed the facility did not have a copy of Resident 87's current coordinated Hospice plan of care, or copies Hospice personnel's visit notes. When asked if Hospice personnel signed in somewhere when they visited Staff C stated, No. The visit notes from each Hospice discipline that had visited from 12/01/2025 - 01/12/2026 were requested at that time. The requested documents were not provided. On 01/09/2026 at 10:58 AM, Staff M said the facility did not have a Hospice binder. On 01/12/2026 at 11:07 AM, when asked who the facility's identified Hospice liaison was, Staff C, Infection Preventionist, and Staff D, Resident Care Manager, indicated there was not one. Staff C and D explained communication with Hospice could occur from the resident's floor nurse and/or Resident Care Manager. When asked who was responsible for ensuring the facility had a copy of the current coordinated Hospice plan of care, or ensured residents were visited by the Hospice personnel (identified disciplines) at the frequency they were assessed to require, no response was provided. Staff C acknowledged due to not having a copy of the current coordinated Hospice plan of care and lack of documentation present in the EHR, one could not tell what Hospice disciplines should have been visiting, at what frequency, when they last visited, if at all, or what was done during the visit. No associated WAC |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to operationalize an effective Infection Prevention and Control Program (IPCP) in accordance with facility policy, state, federal and or local infection control guidelines, regulations and practices when facility staff failed: to performed required hand hygiene and gloves changes with wound care; to ensure urinals were emptied/rinsed after use; to follow standard precautions (common sense practices to prevent the spread of infection in healthcare), enhanced barrier precautions (EBP, a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs) and transmission based precautions used when someone has confirmed or suspected infections) for 2 of 3 (Residents 66 & 72) and reviewed for infection control. These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications and a decreased quality of life. Findings included .WOUND CARE OBSERVATION<br><br>Resident 32 was admitted to the facility on [DATE]. The Medicare 5-Day Minimum Data Set (MDS, an assessment tool) documented Resident 32 had a pressure ulcer/injury (damage to the skin and/or underlying soft tissue) and was cognitively intact.<br><br>Review of Resident 32's orders showed an order, dated 01/08/2025, for wound care to the coccyx (tailbone) pressure ulcer/injury.<br><br>An observation of wound care on 01/12/2026 at 1:53 PM showed Staff E, Registered Nurse, removed the dirty/soiled coccyx wound bandage and discarded it in a nearby garbage can. Without removing gloves, performing hand hygiene, and putting on new gloves, Staff E then began wound care, cleansing the wound with gauze and normal saline.<br><br>On 01/12/2026 at 1:57 PM, Staff E completed wound care. When asked what should be done after removing a dirty/soiled bandage, Staff E asked, are you supposed to wash your hands? Staff E said, she did not know with wound care to wash hands after removing a dirty/soiled bandage.<br><br>On 01/15/2026 at 2:45 PM, Staff C, Infection Preventionist, Licensed Practical Nurse, when asked if staff was performing a dressing change, after removal of the old dressing what should occur, Staff C said remove gloves, wash hands and reapply gloves.<br><br>CONTACT PRECAUTIONS<br><br>Review of the Centers for Disease Control and Prevention (CDC) webpage titled, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, showed it had a section on what was the difference between Enhanced Barrier Precautions (EBP) and contact precautions. For EBP, gowns and gloves were only for high-contact resident care activities, residents were not to be restricted to their rooms and did not require placement in a private room. The CDC said that because EBP did not have the same activity and room placement restrictions as contact precautions, they could be intended for the duration of the resident's stay. EBPs were intended for residents with colonized or infected with a multidrug resistant organism (MDRO), and residents at higher risk of acquiring an MDRO such as residents with wounds or indwelling medical devices. The CDC said for contact precautions, the use of gowns and gloves were required upon entry into the resident's room, regardless of what care was being provided. The resident would be given dedicated equipment and would be placed in a private room or roomed with someone with a the same organism. Residents on<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | contact were recommended to be restricted to their rooms, except for medically necessary care, including restriction from group activities. Contact precautions were to be time limited, and when implemented, and should have a plan for discontinuation. There was another section on when should the nursing home use contact precautions verses EBP for residents with a MDRO, which specified contact was recommended for residents with acute diarrhea, draining wounds, or other sites of secretions/excretions that were unable to be covered or contained for a limited period of time during a suspected or confirmed MDRO outbreak investigation.<br><br>Review of the CDC's webpage titled, Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions. showed there was only one kind of contact precaution recommended, there was not both a contact and a strict contact precaution, it only had Contact mentioned.<br><br>Resident 66<br><br>Resident 66 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], showed Resident 66 was cognitively intact.<br><br>During an observation on 01/05/2026 at 11:05 AM, a contact sign was observed for Resident 66's room (both beds). At 12:47 PM, Staff V, Certified Nursing Assistant (CNA), wheeled Resident 66 back into their room. During an observation and interview at 1:18 PM, Staff V came into the room without a gown to deliver a drink pitcher for bed B. Resident 66 stated, See that? They always do that. Come into the room without gowns. At 1:19 PM, Staff V came back into the room without gloves or a gown to deliver a snack to bed B. When asked why they were on contact, Resident 66 said they did not know why they were on contact, the CNA had just entered the room twice without a gown on, and said this happened all day long.<br><br>During an observation on 01/07/2026 at 11:45 AM, Resident 66 was seen using the handrails on the walls to move themselves in their wheelchair down the hallway. At 11:47 AM, Resident 66 was seen entering the dining room and sitting at a table. At 12:07 PM, Resident 66 was observed to have moved to the other side of the table, and a new resident was sitting at the table where Resident 66 had been sitting (cloth table clothes were noted to be used on this table).<br><br>During an observation on 01/08/2026 at 8:07 AM, Resident 66 was seen in the dining room.<br><br>During an observation on 01/08/2026 at 9:43 AM, Resident 66 was seen getting therapy services by Staff W, Occupational Therapist, in the therapy room. Resident 66 was seen using a foot pedal and exercise ball. Staff W was seen touching the exercise ball, taking it from the resident and putting it down. Then Staff W was seen to touch Resident 66, and then touch their jacket tied around their waist. Staff W was not wearing a gown or gloves.<br><br>During an observation on 01/09/2026 at 12:25 PM, Resident 66 was seen in the hallway.<br><br>During an interview on 01/13/2026 at 8:56 AM, Staff C, Infection Preventionist/Licensed Practical Nurse (IP/LPN), and Staff U, Assistant Director of Nursing/Registered Nurse (ADON/RN), were interviewed on contact precautions. Staff C said that for contact rooms, staff were expected to gown up no matter what when they went into the room. Staff C said for EBP, staff were only expected to gown up and put on personal protective equipment when providing direct care. When asked if residents on contact precautions were allowed to leave their rooms, Staff C said that residents on (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | contact were encouraged to stay in their rooms, but they should not leave their rooms, and if they were on strict contact, they should not leave their rooms but staff should encourage them. When asked what they were defining as strict contact, Staff C said it was when residents had a MDRO that was highly contagious. Staff U said it was for an active infection that was being treated. When asked how that was different from regular contact precautions, Staff C said if residents were still contagious, but if treating for a while it was more likely to be contained, and they did not have any strict contact at that time. Regarding staff in the therapy room and if they should or should not wear gowns while providing therapy to residents on contact, Staff U said they did not expect staff to take them to the therapy room with an active infection. When asked how the staff would know if it was an active infection, Staff U said they would communicate it with staff. During this interview, when asked about Resident 66, Staff C said they were on contact for open wounds and a history of Methicillin-resistant Staphylococcus aureus (MRSA, and MDRO). Staff C said Resident 66 had an active case of MRSA for their wounds while at the hospital, and they considered it active until their wounds were healed. Staff C said they were not currently receiving treatment for MRSA, as it was already treated with antibiotics while at the hospital. Staff C said they encouraged people to stay in their room, but it was okay for Resident 66 to leave their room as long as their wound was covered, due to it not draining or being saturated. Staff U said Resident 66 was colonized with MRSA, which was why they were on contact, that for patients like Resident 66 who was very active, it was hard to keep them in their room. Staff U said Resident 66 was there for therapy, and was not actively being treated for a MRSA infection. When told of observations of Resident 66 getting therapy services with the staff not wearing a gown, Staff C said they would not need to wear a gown. When asked about therapy being a potential for full contact of the therapists body with the resident bodies, Staff C said staff should have a gown on then. When told of the observation of Resident 66 moving seats in the dining room, Staff C said they should clean in between moving, they should encourage Resident 66 to not move about (in the dining room) and to stay in their room.<br><br>Resident 72<br><br>Resident 72 was admitted to the facility on [DATE]. The Medicare 5 Day Minimum Data Set (MDS) assessment, dated 12/02/2025, showed Resident 72 was cognitively intact, and had two stage 4 pressure ulcers.<br><br>During an interview on 01/05/2026 at 11:07 AM, Staff E, RN, said Resident 72 was on contact precautions.<br><br>During an observation on 01/09/2026 at 9:53 AM, Staff Y, Medical Doctor, was seen to enter Resident 72's room without wearing a gown or gloves to talk to the resident. Staff Y left the room without performing hand hygiene, and touched their computer. At 9:58, Staff Y entered Resident 72's room during while the wound care team was in the room. Staff Y was observed to wear the gown, with the sleeves dangling a few inches over their hands. Staff Y assisted with moving pillows, as they were handed pillows that had been under Resident 72. Staff Y left the room. When Staff Y returned, they still had their gown sleeves dangling over their hands. The ties from the gown were untied, and seen to be dragging on the floor. Staff Y left the room. When Staff Y came back into the room, their gown ties were again seen dragging on the floor.<br><br>During an interview on 01/13/2026 at 8:56 AM, Staff C, IP/LPN, and Staff U, ADON/RN, when asked about Staff Y's gown usage, Staff C said they had already talked to the provider about proper technique for wearing the gown, and they would have another discussion about the straps on the floor and going into the room without personal protective equipment on.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PRECAUTION SIGNAGE:<br><br>During an observation and interview on 01/05/2026 at 10:57 AM, Staff B Director of Nursing Services was present. room [ROOM NUMBER]'s EBP signage posted outside of the room, was observed to have only one resident listed on EBP precautions, indicating Resident 108 was on precautions. Staff B said the EBP sign should indicate Resident 32 was on EBP for dialysis (a procedure needed to filter the blood, residents receiving dialysis typically have an indwelling access line for the procedure). When asked about Resident 108 being listed as on EBP, Staff B said they would have to go check. At 11:06, Staff B confirmed Resident 108 was not supposed to be on EBP, but Resident 32 was supposed to be.<br><br>CATHETER MAINTENANCE:<br><br>Resident 72 was admitted to the facility on [DATE]. The Medicare 5 Day Minimum Data Set (MDS) assessment, dated 12/02/2025, showed Resident 72 was cognitively intact, and had an indwelling catheter (thin tube that drains urine).<br><br>Review of Resident 72's electronic health record, showed they had an order, ordered on 08/15/2025, for their urine output to be recorded every shift, three times a day (meaning staff would empty the urinary catheter drainage bag at least three times a day into the urinal to empty it).<br><br>During an observation on 01/05/2026 at 2:21 PM, Resident 72's urinal was seen in the bathroom, it was undated, with a small amount of urine still at the bottom of it. Dark brown dots were seen on the inside of the bottom of the urinal (under the urine). Staff E, Registered Nurse (RN), said the urinal was undated, they should be replaced weekly, and it should be thrown out. Staff E said the spots on the bottom of urinal looked like mold.<br><br>During an interview on 01/12/2026 at 10:01 AM, Staff D, Resident Care Manager/RN, said their expectation for urinals being used for emptying catheter bags, related to infection control, was for them to be emptied after use, and they should be rinsed out. Staff D said staff should make sure there was nothing left in them.<br><br>During an interview on 01/12/2026 at 2:11 PM, Staff B, Director of Nursing Services, said their expectation for urinals, used for emptying urinary catheter bags, was for them to be cleaned every time they were used. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**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 (ASP), to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use and decrease the development of antibiotic resistance and adverse side effects for 3 of 5 residents (Residents 74, 25 & 32) reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics and a decreased quality of life.Findings included . 1) Resident 74 was admitted to the facility on [DATE]. Review of Resident 74's electronic health record (EHR) showed a urinalysis, dated 11/05/2025, that documented Resident 74's urine was positive for Many! bacteria. The lab did not include a culture and sensitivity (C&S, identifies the specific bacteria or fungi causing an infection and identifies which antibiotics or antifungal drugs will effectively kill or inhibit them.) On 11/08/2025 Resident 74 was started on Bactrim DS (an antibiotic) for urinary tract infection (UTI) / kidney infection. Review of the facility's infection control line listing for the month of November 2025, showed the causative bacteria/ organism was not identified. During an interview on 01/13/2025 at 1:06 PM, when asked if Resident 74 had a C&S performed Staff C, IP, said she could not find a C&S. Staff C said a C&S should have been performed to ensure the bacteria causing the UTI was susceptible to Bactrim. 2) Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's physicians' orders showed on 11/28/2025 the resident was started on Cefpodoxime (an antibiotic) daily for 14 days for a UTI. Review of Resident 25's EHR showed a urinalysis (UA) had not performed and there were documented McGeer's criteria of urinary tract infection (UTI). During an interview on 01/13/2025 at 1:06 PM, Staff C, IP, confirmed Resident 25 did not have a UA performed and had no documented signs and symptoms of a UTI. Staff C reported that the resident had a virtual appointment with his urologist, and the urologist prescribed the antibiotic. Staff C indicated, she informed the facility provider that the criteria for a UTI was not met, but the provider chose to continue the antibiotic treatment. Documentation of the notification was not provided. 3) Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's physicians' orders showed a 11/26/2025 order to start Augmentin (an antibiotic) once daily times five day for a UTI. Review of Resident 25's EHR showed a UA with C&S was not performed and there were documented McGeer's criteria of urinary tract infection (UTI). Review of the facility's infection control line listing for the month of November 2025, showed the causative bacteria was not identified. During an interview on 01/13/2025 at 1:06 PM, when asked if Resident 32 had a UA and C&S was performed Staff C, IP, confirmed they had not, and said she believed the order for Augmentin came from dialysis. Staff C, IP, acknowledged a UA with C&S should have been done to determine if the resident had a UTI and to ensure the causative bacteria susceptible to Augmentin. No Associated WAC |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on interview and record review the facility failed to ensure Nursing Assistants (NA) received a minimum of 12 hours of required in-service training per year which was to include dementia management, abuse prevention, and caring for individuals with cognitive impairment for 1 of 1 sampled veteran NA, (Staff BB), reviewed for staff training. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff. Findings included .Review of the personnel file for Staff BB, NA, showed they were hired on 07/18/2023. Review of Staff BB's training records showed she received 6 hours of in-service training from July 2024 - July 2025 and it did not include abuse prevention.On 01/12/2026 at 12:50 PM, Staff A, Administrator, said Staff BB only received 6 of the 12 required in-service hours from July 2024 - July 2025.Reference WAC 388-97-1680 (2)(a-c) |