STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505257	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Manor	3600 East Hartson Avenue Spokane, WA 99202

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure hand hygiene was completed when indicated for 2 of 4 staff (Staff members W and R) observed during medication administration and failed to ensure enhanced barrier precautions (EBP, the use of gowns and gloves during high-contact care activities for residents infected or colonized with multi-drug-resistant organisms, or those with chronic wounds or indwelling medical devices) were implemented when indicated for 2 of 6 sampled residents (Resident 61 and 48) reviewed. Additionally, the facility failed to ensure interventions were developed and completed to prevent the growth of waterborne bacteria or Legionella (a contagious bacteria that caused respiratory illness when water droplets or mist containing the bacteria were inhaled) as part of the Water Management Plan as required. These failures placed all residents and staff at risk of spreading multi-drug-resistant organisms, cross-contamination, or risk of developing severe respiratory illnesses. Findings included.<Water Management Plan> Review of the 08/22/2025 Water Management Plan showed areas in the facility identified that could encourage growth and spread of water borne bacteria or Legionella included rooms vacant over seven days, eye wash stations, ice machines, standing water coolers, unused unit whirlpool bathtub, and various locations in the facility basement that included an unused shower, toilet, and sink. Specific measures currently used to control the spread included: Wipe down water dispenser daily, Run water in unused sinks weekly, Flush unused toilets weekly, and Clean ice machines monthly During interview and record review on 02/11/2026 at 12:55 PM, Staff A, Administrator, reviewed the water management plan. Staff A explained there were some capped off waterlines in the basement that could also be a potential hot spot for water borne bacteria growth, but those were unable to be flushed and required removal. Staff A stated housekeeping ran water in unused showers and flushed unused toilets weekly. Logs that contained the water flushes was requested at this time. The Administrator stated the facility had no documentation to show routine measures to minimize the risk of Legionella were completed. Staff A acknowledged if it wasn't documented then it wasn't done.< <Medication Administration> (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an observation on 02/09/2026 at 9:50 AM, Staff W, Registered Nurse, prepared Resident 8's medications. At 10:00 AM, Staff W sanitized their hands, put on a gown, gloves and entered Resident 8's room. Staff W then assisted the nursing assistant to remove Resident 8's unclean shirt and put on a clean shirt. Staff W, wearing the same gloves, then placed Resident 8's breathing mask on their face. Staff W then accessed Resident 8's gastrostomy tube, (g-tube, a device surgically inserted into one's abdomen that was used to administer liquid food or medications when one was unable to swallow) stopped their tube feeding, pulled up their liquid medication in a syringe, and assisted the nursing assistant to pull the resident up in bed using their incontinence pad. Staff W wearing those same gloves, connected the syringe of medications to the resident's g-tube and administered their medication. In an interview on 02/10/2026 at 10:18 AM, Staff W stated hand hygiene was to be completed prior to the medication pass and after. When Staff W was asked if they should have removed their gloves and performed hand hygiene after they removed Resident 8's unclean shirt and touched their incontinence pad, Staff W stated yes and this was important to prevent cross contamination. In an observation on 02/09/2026 at 4:48 AM, Staff R, Licensed Practical Nurse (LPN), prepared medications for Resident 15. Staff R pulled up the medication list on the computer screen, took a cup with two small syringes out of a drawer in the medication cart and brought them into the medication room. They took the liquid pain medication from the refrigerator and withdrew a measured amount with a syringe and did the same with the liquid anti-anxiety medication. Staff R wrote in the narcotic count book before bringing them back to the med cart. They then took a medication card from the drawer and placed one pill in a pill cup and brought the three medications into Resident 15's room and administered them. After leaving the resident's room. Staff R went into the medication room briefly, then returned and began preparing medications for another resident at 5:08 AM. Staff R did not perform hand hygiene during these observations. When interviewed immediately after the observations, Staff R stated hand hygiene was to be performed in-between residents or after touching unclean surfaces. During an interview on 02/13/2026 at 1:00 PM, Staff B, Director of Nursing, was informed of the observations during the medication administration. Staff B acknowledged that hand hygiene was not completed when indicated. ENHANCED BARRIER PRECAUTIONS < EBP Observations During Meal Service> During observation on 02/05/2026 at 12:29 PM, room [ROOM NUMBER] had an EBP sign posted outside the room door with a tote filled with personal protective equipment (PPE- gloves, gowns, mask and eye protection) readily available outside the room. Staff F, Nursing Assistant, put on a pair of gloves and a gown to deliver a lunch tray to the first resident in the room. Staff F remained in the room, did not remove their gloves or gown, an unidentified staff handed Staff F the meal tray for the second resident in room [ROOM NUMBER]. Without changing PPE or performing hand hygiene between different residents, Staff F delivered and set up the second tray. During observation and interview on 02/09/2026 at 8:40 AM, room [ROOM NUMBER] had an EBP sign posted outside the room door with a tote filled with PPE readily available outside the room. Staff G, Nursing Assistant, put on a pair of gloves and a gown to deliver a breakfast tray to the resident with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the window bed. Staff G removed their gloves but did not remove their gown and performed hand hygiene. While still wearing the same gown, Staff F handed Staff G the breakfast tray for the other resident in room [ROOM NUMBER], Staff G delivered and set up the second tray. At 8:42 AM, Staff G acknowledged they did not change gowns between residents and should change out PPE when providing care to different residents. In an interview on 02/09/2026 at 8:47 AM, Staff F, acknowledged they should change PPE when providing care to different residents. In an interview on 02/11/2026 at 3:22 PM, Staff C, Infection Preventionist, stated EBP were implemented to protect residents with artificially implanted devices such as catheters and feeding tubes. Staff C explained EBP was the use of gloves and gowns during direct patient contact and was not required when dropping off a meal tray. Staff C further stated if staff chose to utilize PPE, then it needed to be changed between residents. Staff C stated they expect staff to implement and follow EBP when required. <Resident 48> According to the 12/10/2025 admission assessment, Resident 48 admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD). The assessment further showed Resident 48 received dialysis (medical treatment that removed waste, toxins and excess fluid from the blood when the kidneys were unable to do so) upon admission and while a resident. Review of the 12/04/2025 hospital discharge summary showed Resident 48 admitted to the hospital with worsening kidney disease, a tunneled line (long-term intravenous tube inserted into a large vein, usually in the neck or chest, and then tunneled under the skin to exit a few inches away on the chest or shoulder) was placed, and dialysis was initiated. Review of the 12/04/2025 admission assessment showed Resident 48 admitted related to ESRD, had a dialysis catheter (tube placed into a large vein to act as a temporary or sometimes long-term access point for cleaning the blood), and received dialysis. An included progress note showed Resident 48 had a hemodialysis catheter placed 11/26/2025. Review of the care plan initiated 01/01/2026 showed Resident 48 had a tunneled vascular device to their right chest for dialysis use. A 01/07/2026 intervention instructed staff to follow EBP related to an indwelling medical device (dialysis catheter). A 01/15/2026 provider order instructed staff to assess Resident 48's right chest dialysis catheter site for bleeding, signs and symptoms of infection. No documentation was found to show Resident 48 required EBP. In an observation on 02/05/2026 at 9:35 AM, no EBP signage was observed to be posted and a tote containing PPE was not readily available outside of Resident 48's room. Similar observations were made at 10:54 AM, on 02/16/2026 at 8:45 AM and 2:24 PM, on 02/09/2026 at 8:47 AM, on 02/10/2026 at 9:04 AM and 12:56 PM, on 02/11/2026 at 8:38 AM, on 02/12/2026 at 1:24 PM, and on 02/13/2026 at 10:10 AM. During observation and interview on 02/13/2026 at 11:00 AM, Staff D, Resident Care Manager, stated Resident 48 had a dialysis access line to their right chest that exited their body. Staff D (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	acknowledged EBP was indicated but had not been implemented. <Resident 61> According to the 01/29/2026 admission assessment, Resident 61 admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and malnutrition. The assessment further showed Resident 61 received nutrition via a feeding tube (tube placed into the stomach or intestine to deliver liquid nutrition when a person was unable to swallow safely) while a resident. Review of the 01/23/2026 hospital discharge summary showed Resident 61 was only to receive ice chips orally and received liquid nutrition via their tube feeding. A 01/23/2026 provider order instructed staff to assess Resident 61's skin integrity of the abdomen around the feeding tube insertion site for signs and symptoms of infection. No documentation was found to show Resident 61 required EBP. Review of the care plan initiated 01/23/2026 showed Resident 61 received nutrition via a feeding tube related to swallowing difficulties and instructed staff to follow EBP. In an interview on 02/05/2026 at 8:57 AM, Resident 61 stated they received nutrition via a feeding tube because of difficulty swallowing. Resident 61 further stated staff wore gloves but did not wear gowns when managing their feeding tube. During observation on 02/05/2026 at 11:13 AM, no EBP signage was observed to be posted and a tote containing PPE was not readily available outside of Resident 61's room. Similar observations were made at 2:34 PM, on 02/06/2026 at 8:43 AM and 2:51 PM, on 02/09/2026 at 4:46 AM, and on 02/10/2026 at 8:48 AM. In an interview on 02/10/2026 at 1:06 PM, Staff E, Registered Nurse, explained that residents that had an indwelling medical device such as a catheter or feeding tube required the use of EBP. Staff E was unsure why Resident 61 was not on EBP as required. In an interview on 02/11/2026 at 3:47 PM, Staff A, Administrator, stated they expected staff to implement and follow EBP when required. Staff A further stated if staff chose to wear PPE when it was not required then they expected staff to utilize PPE properly. Reference WAC 388-97-1320 (1)(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently monitor a resident for latent injuries after numerous falls for 1 of 5 residents (Resident 10), reviewed for accidents/falls. Specifically, the facility did not complete vital signs (VS- temperature, heart rate, respiratory rate and blood pressure) and neurological checks (neuro checks, an assessment used to evaluate the residents' level of consciousness, movement, hand grasps, pupil size and reaction) after unwitnessed falls, nor consistently monitored the residents' condition after each fall. This failed practice placed residents at risk for unidentified injuries and diminished quality of life.Findings included .A review of the facility policy titled, Fall Management reviewed September 2025, showed how to identify fall risk and monitor resident indicators of falls. The document did not include the process of what staff were to do after a resident fell. A review of the facility document titled Neurological Checks on 02/10/2026 showed that VS and neuro checks should be completed when a provider ordered them or when indicated by the resident's assessment, such as a head injury or fall. The form specified that VS and neuro checks were to be completed every 15 minutes for one hour, then every 30 minutes for one hour, then every hour for four hours, then every four hours for 24 hours. According to a comprehensive assessment dated [DATE], Resident 10 had diagnoses that included dementia and repeat falls. The assessment further showed they had some moderate cognitive impairment and rejected cares numerous times per week. The assessment further showed Resident 10 was independent with transfers and walking but required supervision for longer distances.Review of the 12/08/2023 care plan documented Resident 10 was at risk for falls related to shuffling gait, weakness, and a history of falls. On 11/27/2025 the care plan was updated, and staff were instructed to observe and monitor the resident for 72 hours such for latent injuries such as a change in mental status. A review of the facility Accident/Incident log from August 2025 through February 2026 showed Resident 10 sustained 15 falls, which included four falls on the same day.A review of the fall investigations referenced in the Accident/Incident log and Resident 10's medical record showed the following:VS and neuro checks were not done per the flowsheet timeline for falls on 08/11/2025, 08/13/2025, 10/23/2025, 12/12/2025,12/13/2025, 01/02/2026, and numerous falls on 01/15/2025.Alert or progress notes were not completed every shift, for at least 72 hours after falls, on 10/23/2025, 12/12/2025, 12/13/2025, 01/02/2026, 01/04/2026 and numerous falls on 01/15/2026. No progress/alert notes after a fall were found after 72 hours.VS and neuro checks were not restarted at every 15-minute intervals (when the resident fell again while on VS and neuro checks) on 12/13/2025 and after numerous falls on 01/15/2026. During an interview on 02/10/2026 at 2:57 PM, Staff Q, Licensed Practical Nurse, stated that if a resident fell and hit their head or if the fall was unwitnessed, the resident was to have neuro checks implemented. Staff Q reviewed the form Neurological Flow Sheet and said the staff followed the instructions for the frequency and duration of when to do the VS and neuro checks. During an interview on 02/10/2026 at 3:07 PM, Staff B, Director of Nursing, stated that after an unwitnessed resident fall, neuro checks needed to be done according to the schedule on the neuro flow sheet for 24 hours. Additionally, after any fall, the resident was put on alert charting for seven days. Staff B explained that alert charting meant that staff needed to make a progress note every shift, to monitor for any latent injuries that may not have been noticed immediately after the fall. During a follow-up interview on 02/11/2026 at 10:03 AM, Staff B stated that if the resident had another fall before the neuro checks were completed, that the checks should be restarted at every 15 minutes. Staff B was informed of the missing VS and neuro checks, missing alert notes after falls and that checks were not restarted after additional falls for Resident 10. Staff B acknowledged that nursing staff did not follow the facility process for monitoring the resident's condition after their falls.Reference: WAC 388-97-1060 (3)(g)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were given as ordered on days the residents were out of the facility for dialysis treatments (a mechanical way of eliminating waste from the body when the kidneys no longer functioned) for 3 of 3 sampled residents (Residents 4, 5 and 48) reviewed for dialysis care. Additionally, fluid restrictions (when oral fluid intake was limited to a specific amount daily by the provider to help maintain fluid balance for those that required dialysis) for Residents 5 and 48 were not documented or monitored for accuracy as ordered. This failure placed the residents at risk for unintended health consequences and decreased quality of life. Findings included .Review of the facility policy titled, Hemodialysis Offsite Policy dated September 2024, showed the facility was to assure each resident received care and services for the provision of offsite dialysis to include arrangements for safe transportation, ongoing assessments of the resident's condition, monitoring for complications before and after dialysis treatments, and ongoing communication and collaboration with the dialysis facility. The facility and dialysis center dieticians were to coordinate nutritional care including monitoring, documenting, and deciding how and when to address weight changes and nutrition issues to include identifying weight fluctuations due to fluid retention between sessions, possible fluid volume depletions and observe fluid restrictions as ordered by the provider. Communication between the dialysis center and the facility should include and document medication administered, held or discontinued by the nursing home and/or dialysis center, nutritional/fluid management including weights, and a resident's compliance with food/fluid restrictions. The policy instructed staff to follow physician orders regarding medication administration pre [before] and post [after] dialysis, especially blood pressure and cardiac medications. <Resident 48> According to the 12/10/2025 admission assessment, Resident 48 admitted to the facility on [DATE] with diagnoses including ischemic cardiomyopathy (weak and enlarged heart due to lack of oxygen rich blood caused by blockage, narrowed vessels, or heart attack damage), heart failure (when the heart was too weak to pump blood efficiently failing to meet the body's needs), and end stage renal disease (ESRD). The assessment further showed Resident 48 received dialysis treatments from admission. Review of the ESRD care plan initiated 12/05/2025 showed Resident 48 received dialysis treatments three times weekly on Mondays, Wednesdays and Fridays and was at risk for weight fluctuations. A 01/21/2026 intervention showed Resident 48 was to follow a 1800 milliliters (ml)/day fluid restriction. The dietary department was to provide 240 ml per meal for a total of 720 ml dispensed, leaving a balance of 1080 ml fluid intake allowed. Review of January 2026 nursing progress notes showed on 01/07/2026 Resident 48 was hospitalized for pulmonary edema (abnormal buildup of excess fluid in the lungs) with shortness of breath and chest discomfort. On 01/14/2026 the administration time of some medications was changed due to dialysis schedule. On 01/21/2026 daily weights and an 1800 ml/day fluid restriction were implemented for closer fluid monitoring related to dialysis recommendation and resident refusing multiple dialysis days. Review of a 01/12/2026 provider order showed Resident 48 was to receive dialysis treatments three times weekly. A 01/21/2026 provider order showed Resident 48 was to follow an 1800 ml per day (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fluid restriction related to ESRD. Review of the January through February 2026 medication administration records (MAR) showed the following: In January, Resident 48 did not receive Isosorbide (medication used to treat chest pain caused by heart disease) or Sevelamer (phosphate binding vitamin) on Friday 01/16/2026, Monday 01/19/2026, 01/20/2026, or on Friday 01/23/2026. Resident 48 did not receive Metoprolol (medication used to treat heart failure) on Friday 01/02/2026, Wednesday 01/07/2026, Friday 01/16/2026, Monday 01/19/2026, Friday 01/23/2026, Wednesday 01/28/2026 or on Friday 01/30/2026. A fluid restriction intake monitor showed Resident 48 consumed a total of 490 ml on 01/22/2026, 320 ml on 01/23/2026, 390 ml on 01/24/2026, 360 ml on 01/25/2026 and 01/26/2026, 490 ml on 01/27/2026, 440 ml on 01/28/2026 and 01/29/2026, 480 ml on 01/30/2026, and 860 ml on 01/31/2026. All intake documented was significantly below the 1800 ml/day fluid restriction ordered. In February, Resident 48 did not receive Metoprolol on Friday 02/06/2026, or Sevelamer on Wednesday 02/24/2026, Friday 02/06/2026, or on Wednesday 02/11/2026. Tramadol (pain medication) was not administered on Friday 02/06/2026 or on Wednesday 02/11/2026. Fluid restriction intake monitor showed Resident 48 consumed a total of 360 ml on 02/01/2026, 340 ml on 02/02/2026, 240 ml on 02/03/2026, 360 ml on 02/04/2026, 560 ml on 02/05/2026, 480 ml on 02/06/2026, 440 ml on 02/07/2026, 360 ml on 02/08/2026, 340 ml on 02/09/2026, 600 ml on 02/10/2026, 480 ml on 02/11/2026, and 350 ml on 02/12/2026. All intake documented was significantly below the 1800 ml/day fluid restriction ordered. <Resident 5> The 01/06/2026 quarterly assessment documented Resident 5 had diagnoses including ESRD, heart failure and diabetes. The assessment further showed Resident 5 was dependent on renal dialysis. A 01/15/2026 provider order showed Resident 8 was to receive dialysis treatments three times per week. A 04/17/2025 provider order showed Resident 8 was on a 1,200 ml fluid restriction. The dietary department was to provide 120 ml for breakfast, lunch and dinner. The nursing department was to provide 360 ml on day and evening shift and 120 ml on night shift. The 01/26/2024 ESRD care plan showed Resident 5 received dialysis treatments three times weekly on Mondays, Wednesdays and Fridays and instructed nursing staff to document before and after treatments in a dialysis book (a book that contained a form to document the resident's vital signs, lung sounds, if the resident was on an antibiotic, and whether or not the resident had been given medications or a meal to eat while at dialysis). The form also had a section for dialysis to fill out after the resident's treatment that listed vital signs, weights, condition of the resident's dialysis access site, type of access, and if the resident ate lunch at the center and how much they consumed). A 06/19/2024 intervention instructed nursing staff to follow the fluid restriction as ordered. Review of the dialysis communication book from 01/01/2026 through 02/09/2026 showed the dialysis portion of the form was blank on 01/02/2026, 01/07/2026, 02/04/2026 and 02/06/2026. The facility portion of the form was blank on 02/02/2026, and on an unknown date as this area was not filled out. There were no communication sheets for 01/28/2026 and 01/30/2026. A review of the January through February 2026 MAR showed the following for Resident 5's Calcium (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Acetate (phosphate binder): The following dates had code 5, which meant the resident was absent from the facility without their medication: -01/07/2026, 01/09/2026, 01/12/2026, 01/14/2026, and 01/20/2026. The following dates had code 10, which meant a progress note should have been made: 02/06/2026, 02/07/2026, 02/08/2026, 02/09/2026, 02/10/2026 and 02/11/2026. On 02/10/2026 and 02/11/2026 there was a progress note that said the medication was unavailable. Resident 8's Xarelto (a blood thinning medication): A code 10 was present on 01/19/2026, 01/20/2026 and 02/08/2026. On 01/20/2026 there was a progress note that stated the medication was on order. Resident 8's Calcium Carbonate (antacid medications): A code 5 was present 01/02/2026, 01/05/2026, 01/07/2026 and 01/09/2026. Resident 8's Restasis (medication used to treat dry eyes): A code 7 was present on 01/14/2026 and the progress note stated the medication was on order. Resident 8's Reglan (medication used to treat heartburn): A code 5 was present on 02/07/2026 and a code 10 on 02/08/2026. A review of the January through February 2026 MAR's showed the following for Resident 5's fluid restriction: Resident 8 had an order for 120 ml of 2cal med pass (nutritional supplement) daily and consumed 50-100 percent. The nursing assistant task record from 01/17/2026 through 02/12/2026 showed Resident 8 received fluids ranging from 240 ml to 1,770 ml daily. The January through February 2026 MAR showed nursing administered fluids ranging from 360 ml to 1,160 ml daily. There was no total to show the amount of fluids Resident 8 consumed each day. <Resident 4> The 01/13/2026 quarterly assessment documented Resident 4 had diagnoses including ESRD, diabetes and was dependent on renal dialysis. A 01/05/2026 provider order showed Resident 4's medications were to be given two hours before or after dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 09/27/2024 ESRD care plan showed Resident 4 received dialysis treatments three times weekly on Mondays, Wednesdays and Fridays and instructed nursing staff to administer medications as ordered. A review of the January through February 2026 MAR showed the following for Resident 4's Velphoro (phosphate binder): A code 5 was present on 01/05/2026, 01/07/2026, 01/09/2026, 01/14/2026, 01/21/2026, 01/23/2026, and 02/07/2026 at 8:00 AM. A code 10 was present on 01/19.2026, 02/04/2026, 02/05/2026, 02/07/2026 at 12:00 PM and 5:00 PM, 02/08/2026, and 02/10/2026. Resident 4's warfarin (blood thinning medication): A code 10 was present on 02/08/2026. Resident 4's Prosource (nutritional supplement): A code 5 was present on 02/04/2026, 02/06/2026, 02/07/2026, and 02/08/2026. Resident 4's Amlodipine (used to treat high blood pressure): A code 10 was present on 02/08/2026. Resident 4's artificial tears (used to treat dry eyes): A code 5 was present on 02/07/2026 and a code 10 was present on 02/08/2026. Resident 4's Atorvastatin (used to treat high cholesterol levels): A code 10 was present on 02/08/2026. Resident 4's Hydralazine (used to treat high blood pressure): A code 5 was present on 01/09/2026, 01/14/2026, 01/21/2026, 01/23/2026, 01/28/2026, and 02/07/2026. Resident 4's Omeprazole (used to treat heartburn): A code 5 was present on 01/05/2026, 01/07/2026, 01/09/2026, and 02/07/2026. A code 10 was present on 01/13/2026. Resident 4's Renal vitamin (multivitamin given to residents with kidney disease): A code 5 was present on 01/09/2026 and 01/14/2026. A code 10 was present on 02/08/2026. Resident 4's Thiamine (vitamin B vitamin): (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Manor	3600 East Hartson Avenue Spokane, WA 99202

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A code 5 was present on 01/05/2026, 01/07/2026, 01/09/2026, 01/13/2026 and 01/15/2026. A code 10 was present on 02/08/2026. Resident 4's insulin (used to treat high or low blood sugars): A code 5 was present on 01/02/2026, 01/07/2026 and 01/09/2026. Resident 4's Systane eye drops (used to treat dry eye): A code 5 was present on 01/09/2026 and a code 10 was present on 01/10/2026. Resident 4's skin prep to their left third distal finger: The MAR was blank on 01/10/2026, 01/18/2026, 01/30/2026, 02/02/2026 and 02/07/2026. There was a code 10 on 02/08/2026. Resident 4's betadine to their right hand and palm: The MAR was blank on 01/10/2026, 01/18/2026, 02/02/2026, 02/03/2026 and 02/07/2026. There were code 10's on 02/05/2026 and 02/08/2026. Resident 4's skin prep to their left knee/shin: The MAR was blank on 01/18/2026, 01/19/2026, 01/30/2026, 02/02/2026, 02/03/2026, and 02/07/2026. There was a code 10 on 02/08/2026. In an interview on 02/12/2026 at 8:15 AM, Staff N, Nursing Assistant (NA), stated they knew when a resident was on a fluid restriction by looking at their Kardex (part of the resident's plan of care). Staff N stated they gave Resident 5 a cup of coffee at breakfast time and documented the amount in the plan of care. In an interview on 02/13/2026 at 9:53 AM, Staff BB, NA, stated they served meal trays in the dining room where Resident 5 ate. Staff BB stated there were no residents on a fluid restriction. Staff BB stated they gave Resident 5 a cup of coffee and did not document the amount of fluids consumed. In an interview on 02/12/2026 at 12:07 PM, Staff W, Registered Nurse, stated medications for dialysis residents were tailored to their schedule. Staff W stated Resident 4 left very early in the morning, so the night nurse administered some of their medications. Staff W stated the other dialysis residents received their medications before they left and when they returned from dialysis. Staff W stated the amount of fluids consumed by dialysis residents were documented in the MAR. Staff W explained that the fluids came on the resident's meal trays and nursing had a certain amount they were able to provide. Staff W stated nursing assistants were not to give dialysis residents any fluids. Staff W was unaware Resident 5 had a large blue cup in their room and a can of beer. Staff W stated they relied on the documentation in the MAR for the amount of fluids consumed by Resident 5 and did not have a good reliable way to know how much water they drank daily. Staff W stated it was important to get the dialysis communication sheets back from the dialysis facility because they had good information including vital signs (blood pressure, heart rate, respiratory rate and temperature), weights, and if there were any complications during their treatment. At 10:01 AM, Staff W acknowledged Resident 4 and 5 were not getting their medications as ordered and there needed to be a progress note explaining (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	why. Staff W stated medications needed to be reordered when they had three to seven pills left. Staff W explained nursing staff reordered medication via the computer. Staff W stated it was important for the residents to receive their medications for their overall health. In an interview on 02/13/2026 at 11:53 AM, Staff B, Director of Nursing, stated it was important to fill out the dialysis pre/post visit forms and ensure the forms were returned back to the facility so they could ensure orders were processed, and weights and vital signs were monitored. Staff B stated the nurse on the cart was responsible for filling out the dialysis communication form and notifying the Resident Care Manager if the form was not returned. Staff B stated medications were scheduled around dialysis treatments to ensure residents received their medications. Staff B acknowledged Residents 4 and 5 did not receive their medications as ordered and should have for their health and wellness. Staff B stated they combined the total amount of fluids sent on the meal tray and what was given by nursing. Staff B stated it was important to give the amount of fluids ordered to prevent fluid overload. Staff B stated the total amount of fluids consumed needed to be calculated at the end of the day and if there were inaccuracies, follow-up needed to be completed. Reference WAC 388-97-1900(1)(6)(a-c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observation, interview and record review, the facility failed to ensure expired medications were disposed of timely, in accordance with currently accepted professional standards, in 1 of 2 medication storage rooms. Additionally, the facility failed to maintain appropriate temperatures in 2 of 2 medication rooms to ensure medications were properly stored. This failure placed residents at risk for receiving compromised or ineffective medication.Findings included .The United States Pharmacopeia retrieved from http: www.USP.org documented medications were to be stored at controlled room temperatures of 20 degrees Celsius (C) to 25 C (68 degrees Fahrenheit (F) to 77 F), with excursions permitted between 15 C and 30 C (between 59 F and 86 F) and brief exposure to temperatures up to 40 C (104 F) may be tolerated provided the mean temperature did not exceed 25 C (77 F); however, such exposure was to be minimized. During an observation of the [NAME] Medication room on 02/06/2026 at 12:35 PM, with Staff AA, Licensed Practical Nurse, there was a fan blowing and the temperature of the medication room was 82 degrees Fahrenheit (F), higher than the recommended range. Review of the refrigerator temperature logs from September 2025 through February 2026 showed the temperatures were not monitored consistently as required. In an observation of the East Medication room on 02/06/2026 at 1:06 PM, with Staff W, Registered Nurse, the refrigerator contained influenza, hepatitis and respiratory syncytial virus (RSV) vaccines. The RSV vaccines had expired on 10/25/2025. Review of the refrigerator temperature logs from November 2025 through February 2026 showed the temperatures were not monitored consistently as required. In an interview on 02/06/2026 at 12:45 PM, Staff AA stated it was important to monitor the temperature of the refrigerator because medications were kept in there and the temperature had to stay within range or the effectiveness of the medication could be altered. At 12:54 PM, Staff AA stated it was important to keep the medication room at an appropriate temperature to prevent the medications from losing their effectiveness. In an interview on 02/06/2026 at 1:13 PM, Staff W stated audits were completed on the medication rooms monthly. Also, expired vaccines were at risk for losing their efficacy. In an interview on 02/06/2026 at 1:18 PM, Staff B, Director of Nursing, stated they had provided education to the staff and were trying to correct the issue of the temperatures not being monitored. Staff B stated it was important to monitor the refrigerator temperatures because it rendered the vaccines useless when not stored at the correct temperature. Staff B added the temperature of the medication room needed to be within normal limits because it may alter the effectiveness of the medications. In an observation on 02/12/2026 at 10:53 AM with Staff B, vaccines remained present and available for use in the refrigerators that had not had the temperatures monitored. In an observation on 02/12/2026 at 10:56 AM with Staff C, Infection Preventionist, the [NAME] Medication room temperature was 80 degrees F, higher than the recommended range. Reference: WAC 388-97-1300 (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to follow food code regulations that prevent the potential of foodborne illness. Specifically, the kitchen was not maintained in a clean manner, dietary staff did not perform hand hygiene when indicated during food services and 2 of 2 nourishment refrigerators were not consistently monitored for appropriate temperatures and contained unlabeled and expired food. These failures placed residents at risk for foodborne illness.Findings included. A review of the facility policy Food from Outside Sources revised July 2025 documented foods stored in designated refrigerators were to be labeled with the resident name and room number and discarded if past the expiration date. Additionally, the refrigerator temperature was not to exceed 41 degrees Fahrenheit (F) and the freezer temperature was not to exceed 0 degrees F.<Kitchen Cleanliness>On 02/05/2026 at 8:48 AM, the kitchen floor was observed to be grimy and dingy with crumbs and food debris. There were also crumbs and food debris on the counter containing the toaster. The wall to the right of the stove was dirty with dried splashes of food debris and grease.During a subsequent visit to the kitchen on 02/11/2026 at 11:27 AM, the wall next to the stove and the counter with the toaster were again observed with crumbs and food debris, dried splashes and grease. The plate warmer that contained the clean plates being used for the lunch service and the surrounding area contained food crumbs. Plastic drawers/storage bins that contained utensils in the small pantry on the right side of the stove were soiled on the fronts and handles.<Hand Hygiene>On 02/11/2026 at 11:27 AM, dietary staff were observed preparing plates of food for the resident's lunch. On 02/11/2026 at 12:05 PM, Staff U, Nutrition Coordinator, stopped plating the food, put oven mitts on over their plastic gloves and took a foiled wrapped portion of food out of the oven. They closed the oven door, removed the foil and put the food on a plate, then removed the oven mitts, and changed their plastic gloves. They did not complete hand hygiene before they put on new gloves and resumed the meal service.On 02/11/2026 at 12:45 PM, Staff U put on oven mitts over their plastic gloves, retrieved another pan of meatloaf from the oven and placed it on the steam table, before removing the oven mitts and changing their gloves. Hand hygiene was not performed with the glove change, and Staff U resumed plating the food.On 02/11/2026 at 1:00 PM, Staff U opened one of the plastic drawers/bins next to the oven, took out a needed utensil and closed the drawer then resumed serving the food with the same gloves. The drawer front and handle were visibly dirty. During an interview immediately following the meal service when asked about hand hygiene in the kitchen, Staff U stated they were told they could just change gloves.<Nourishment Refrigerators>On 02/12/2026 at 7:55 AM, during an inspection of the refrigerator in the east nourishment room, the following was noted: The February 2026 temperature log was missing entries for six of 12 days. The refrigerator contained a box of Lunchables with a first name and date of 11/19/2025 in black marker.There was an unlabeled glass container with noodles and sauce, and an unlabeled plastic bag of slimy chicken. The freezer had containers of sherbet and pistachio ice cream, neither labeled with a name or date.On 02/12/2026 at 8:18 AM, during an inspection of the refrigerator in the west nourishment room, the following was noted:The February 2026 temperature log was missing entries for four of 12 days.The refrigerator contained 3 small plastic containers of a clear red substance, in a gift bag, with a resident name but no date.In the lower left crisper drawer, was a greasy looking paper napkin wrapped around chicken strips. The napkin was stuck and dried to the food. There was no name or date.During an interview on 02/12/2026 at 2:01 PM, Staff V, Registered Dietician, stated that dietary staff were expected to wash their hands before handling food, and after touching their face, body or any surface that could be contaminated, such as a door handle. They further stated that they always needed to perform hand hygiene (handwashing or hand sanitizer) with glove changes.During an interview on 02/12/2026 at 2:31 PM, Staff T, Dietary Kitchen Manager, was informed of unclean areas in the kitchen, observations of the nourishment refrigerators and observations of gloves changes during the meal (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preparation visit. Staff T stated they expected the kitchen to be clean, dietary staff to log refrigerator temperatures and to discard expired food. Staff T also expected staff to wash their hands with any glove changes.Reference: WAC 388-97-1100(3), 2980

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F 0887 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide education regarding the risks versus benefits and offer the COVID (a highly contagious viral illness that caused fever, breathing difficulty and potential hospitalization) vaccine if desired to 4 of 7 sampled staff (Staff F, I, J, and K) and 1 of 5 sampled residents (Resident 63), reviewed for immunizations. This failure placed staff and residents at risk of exposure to and illness from COVID-19.Findings included .According to The Centers for Disease Control and Prevention website www.cdc.org Recommended Adult Immunization Schedule 2026 for ages 19 years or older adults age [AGE]-64 years, or adults age [AGE] or older who were unvaccinated for COVID-19, were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of COVID-19 vaccine unless contraindicated. Those previously vaccinated before 2024-2025 were recommended to receive 1 or 2 doses (dependent on the vaccine brand) of 2025-2026 COVID-19 vaccine unless contraindicated.<Staff F>Review of Staff F's employee file showed no documentation Staff F was provided education on the potential risks versus benefits or offered the COVID vaccination.<Staff I>Review of Staff I's employee file showed no documentation Staff I was provided education on the potential risks versus benefits or offered the COVID vaccination.<Staff J>Review of Staff J's employee file showed no documentation Staff J was provided education on the potential risks versus benefits or offered the COVID vaccination.<Staff K>Review of Staff K's employee file showed no documentation Staff K was provided education on the potential risks versus benefits or offered the COVID vaccination.<Resident 63>According to the 11/11/2025 quarterly assessment, Resident 63's most recent admission to the facility was on 06/06/2025.Additional review of Resident 63's medical record showed no documentation Resident 63 was provided education on the potential risks versus benefits or offered the COVID vaccination.In an interview and record review on 02/11/2026 at 1:24 PM, Staff H, Staff Development Coordinator, explained when new staff were hired, they completed a vaccination questionnaire, the completed questionnaire was reviewed, printed and placed in the employee file. Staff H reviewed Staff F, I, J, and K's employee files. Staff H acknowledged the employees files contained no documentation employees were provided education on the potential risks versus benefits or offered the COVID vaccination, as required.In an interview on 02/11/2026 at 3:18 PM, Staff C, Infection Preventionist, explained employees were educated and offered vaccines during new employee orientation, residents were educated and offered vaccines upon admission, and residents/staff were again educated and offered the COVID vaccine yearly, in October, when the facility held an immunization clinic. Staff C further stated the facility was able to obtain the COVID vaccine but required a minimum of 10 staff to obtain and administer the vaccine. Staff C stated the facility was unable to hold their immunization clinic last October related to a facility illness outbreak. Staff C acknowledged documentation of education and vaccine consent or declination should be documented, as required.In an interview on 02/11/2026 at 3:44 PM, Staff A, Administrator, stated the facility typically held a vaccination clinic in October but were unable to hold it last October due to an illness outbreak. Staff A acknowledged vaccine education and vaccine consent or declination should be documented, as required.Reference: WAC 388-97-1320(1)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to maintain urinary catheters (a tube inserted in the bladder that drained urine into an external collection bag)in a dignified manner for 2 of 5 sampled residents (Residents 8 and 65) reviewed for dignity. This failure put the residents at risk for loss of dignity and decreased quality of life. Findings included .Review of the facility policy titled, Indwelling Urinary Catheter Management reviewed on 09/04/2025, instructed staff to keep the catheter bag off the floor. The policy did not address concerns regarding a resident's dignity when catheters were required. <Resident 8>The 01/13/2026 admission assessment documented Resident 8 had diagnoses that included cancer, respiratory failure and obstructive uropathy (a blockage that made it difficult to urinate). The resident had an indwelling urinary catheter, was dependent on staff for toileting and had severe cognitive impairments. In an observation on 02/05/2026 at 11:31 AM, Resident 8 was lying in bed. Their urine collection bag was seen from the doorway and was not covered by a privacy bag. Subsequent observations of Resident 8's urine collection bag without a privacy bag were made on 02/06/2026 at 10:59 AM, and 02/10/2026 at 3:12 PM. <Resident 65>The 02/02/2026 quarterly assessment documented Resident 65 had diagnoses that included benign prostatic hyperplasia (BPH, age-associated prostate gland enlargement) and obstructive uropathy. The resident had an indwelling urinary catheter, was dependent on staff for toileting and was able to make their needs known. In an observation on 02/05/2026 at 9:49 AM, Resident 65 was lying in bed. Their urine collection bag was hung on the side of the bed, not in a privacy bag. In an observation on 02/06/2026 at 2:39 AM, Resident 65 was sitting in their room in their wheelchair. Their urine collection bag was not in a privacy bag and could be seen from the doorway. In an observation and interview on 02/10/2026 at 08:56 AM, Resident 65 was sitting up in bed. Their urine collection bag was hung on the side of the bed, not in a privacy bag. Resident 65 stated they got into their wheelchair daily and preferred the staff covered their catheter if they had something to cover it with. In an observation on 02/10/2026 at 12:35 PM, Resident 65 sat in the dining room at the table. The urine collection bag was not in a privacy bag and touched the ground. In an observation on 02/10/2026 at 12:46 PM, Resident 65 wheeled out of the dining room and their urine collection bag dragged on the ground.In an observation and interview on 02/11/2026 at 8:41 AM, Resident 65 was sitting up in bed. Their urine collection bag was not in a privacy bag. Resident 65 had a privacy bag under their wheelchair and stated it was probably there now because the surveyor had asked about it. In an interview on 02/12/2026 at 7:50 AM, Staff N, Nursing Assistant, stated urinary catheters were to be stored in a privacy bag and it was important for dignity and cleanliness. In an interview on 02/12/2026 at 1:49 PM, Staff W, Registered Nurse, stated urinary catheters were kept in privacy bags and it was important for dignity. In an interview on 02/12/2026 at 2:47 PM, Staff B, Director of Nursing, stated urinary catheters were stored in privacy bags and it was important to maintain a resident's dignity. Reference: WAC 388-97-0180(1-4)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to exercise reasonable care for the protection of residents' property from loss or theft for 1 of 3 sampled residents (Resident 17), reviewed for personal property. This failure placed residents at risk of loss or theft of property and did not create a homelike environment.Findings included.Review of the facility policy titled, Inventory of Personal Effects dated August 2025, showed the facility would protect residents' personal property and prevent loss. Items brought into the facility would be documented on an inventory of personal effects form upon admission. The form was to be updated if/when additional items were brought into the facility. Upon discharge, the resident and/or responsible party was to verify and sign that personal property was received. According to the 01/23/2026 admission assessment, Resident 17 admitted to the facility on [DATE] with diagnoses that included cancer. The assessment further showed it was very important for Resident 17 to choose what clothes to wear and take care of their personal belongings. Resident 17 was cognitively intact and able to clearly verbalize their needs. In an interview on 02/05/2026 at 1:48 PM, Resident 17 stated they had a bag of clothes go missing, they informed staff, but items were not found, replaced, or reimbursed.Review of Resident 17's medical record showed no documentation of a personal effects inventory form on file.Review of the inventory sheet binder, on each unit, showed no documentation of a personal inventory sheet for Resident 17 on file. Review of the August 2025 through January 2026 grievance log showed 12 out of 16 grievances filed were related to missing items. No documentation of Resident 17's missing clothing was found.In an interview on 02/12/2026 at 1:09 PM, Staff N, Nursing Assistant, explained the facility tracked resident items by completing an inventory sheet of personal possessions upon admission. The form was to be updated when items were brought in or removed from the facility. Staff N further stated if a resident reported missing items, a missing item form was completed and turned in. If the missing item was clothing, they spoke with laundry.In an interview on 02/12/2026 at 1:47 PM, Staff P, Social Service Assistant, stated a resident inventory sheet was completed upon admission and kept in an inventory sheet book on each unit. Staff P explained a missing item form was completed if/when items were reported missing, staff searched for the items, and item replaced or reimbursed if unable to be located. Staff P further explained each resident should have a personal inventory sheet on file, the inventory sheet was reviewed to determine if the item was brought into the facility, if the item was not listed on the inventory sheet then the facility would have to decide if the item would be replaced or reimbursed.During an interview and record review on 02/12/2026 at 2:31 PM, Staff D, Resident Care Manager, explained that a personal possession inventory sheet was completed upon admission and kept in a book on each unit; the form was to be updated if/or when items were brought in or removed from the facility. If items were reported missing, a missing item form was completed and submitted to social services for follow up. Staff D stated the inventory sheet would be reviewed to attempt to determine if the missing items were brought into the facility. Staff D reviewed the personal inventory sheet binder. Staff D acknowledged they were unable to find a personal possession inventory sheet for Resident 17, and they should have one on file.In an interview on 02/12/2026 at 2:41 PM, Staff B, Director of Nursing, explained the facility tracked resident property by completing an inventory sheet upon admission and updating the form if/when items were brought in or removed from the facility after. Staff B further stated each resident should have a personal inventory sheet on file that the facility referred to if/when items were reported missing. Staff B acknowledged it's mostly clothing that goes missing if things go missing.Reference WAC 388-97-2040

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **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 baseline care plan that included instructions needed to provide effective and person-centered care for 2 of 4 sampled residents (Residents 8 and 73), reviewed for admission baseline care planning. This failure placed residents at risk of not receiving needed care, potentially avoidable accidents, and diminished quality of life.Findings included.Review of the facility policy titled, Baseline Care Plan dated August 2025, showed a baseline care plan would be developed for each resident within 48 hours of admission to provide an initial set of instructions needed to provide effective and person-centered care. The baseline care plan was to be updated as needed to reflect current needs until the comprehensive care plan was developed. The baseline care plan was to be reviewed with the resident and/or representative and a copy provided.<Resident 8> The 01/13/2026 admission assessment, documented Resident 8 admitted to the facility on [DATE] with diagnoses including respiratory failure, obstructive uropathy (a blockage that made it difficult to urinate) and had an indwelling catheter (a tube inserted in the bladder that drained urine into an external collection bag). Resident 8 admitted with the following orders on 01/08/2026: -Catheter care every shift -Flush foley catheter with normal saline twice a day -Indwelling catheter to straight drainage, change for infection, obstruction or when the closed system was compromised as needed -Oxygen at 3L per minute via nasal cannula Review of the baseline care plan initiated 01/08/2026 showed no documentation Resident 8 was at risk for respiratory complications and had a foley catheter. There were no interventions on the baseline care plan for staff to implement. <Resident 73> According to the 01/16/2026 admission assessment, Resident 73 entered the facility on 01/13/2026 with diagnoses that included muscle weakness and difficulty walking. The assessment further showed Resident 73 sustained falls in the month prior to admission and sustained fractures related to falls in the six months prior to facility admission. Resident 73 was cognitively intact. Review of the 01/13/2026 hospital discharge summary showed Resident 73 had a history of multiple falls with worsening shortness of breath over the past couple of days. Review of the care plan initiated 01/13/2026 showed no documentation Resident 73 was at risk for falls, had a history of falls, or fall prevention interventions for staff to implement. Review of the January 2026 facility incident log showed Resident 73 sustained a fall on 01/25/2026. (continued on next page)

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	505257	A. Building B. Wing	02/13/2026

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of January 2026 nursing progress notes showed Resident 73 had a history of orthostatic hypotension (sudden drop in blood pressure when standing up from sitting or lying position) and noted residual debility that required therapy services. On 01/25/2026 Resident 73 was found sitting on the floor in their bathroom calling for help. In an interview on 02/12/2026 at 11:01 AM, Staff B, Director of Nursing, explained a baseline care plan that covered the residents' allergies, transfer status, diet, pain, falls, and any other important resident care needs staff needed to be informed of to immediately provide safe care to the resident, was initiated within 24 hours of an admission; staff should not leave the building without it being done. Staff B further stated falls should have been addressed in Resident 73's care plan. During interview and record review on 02/12/2026 at 2:30 PM, Staff D, Resident Care Manager, reviewed Resident 73's care plan initiated 01/13/2026. Staff D acknowledged Resident 73 was a high fall risk, falls were not addressed in the care plan and should have been. In an interview on 02/13/2026 at 12:03 PM, Staff A, Administrator, stated they expected staff to develop and implement an effective and person-centered baseline care plan for each resident, as required. Reference WAC 388-97-1020 (3)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain respiratory care equipment in a sanitary manner for 2 of 3 sampled residents (Residents 8 and 12), reviewed for respiratory care. This failure placed the residents at risk for respiratory infections and decreased quality of life.Findings included .<Resident 8> The 01/13/2026 admission assessment documented Resident 8 had diagnoses that included cancer, pneumonia and respiratory failure. The assessment further showed the resident required continuous oxygen. In an observation on 02/05/2026 at 11:31 AM, Resident 8's oxygen concentrator filter was covered in thick dust debris. A provider order dated 12/31/2025 instructed nursing staff to clean the oxygen concentrator filter with soap and water and to let it air dry weekly on Sundays. The 01/15/2026 care plan instructed staff to administer oxygen therapy as ordered. Subsequent observations of Resident 8's oxygen concentrator filter covered in thick dust debris were made on 02/06/2026 at 10:59 AM and 2:50 PM, 02/09/2026 at 7:53 AM, 02/10/2026 at 9:02 AM and 3:12 PM, 02/11/2026 at 8:54 AM and 12:55 PM, and 02/12/2026 at 8:38 AM. In an interview on 02/13/2026 at 11:44 AM, Staff Z, Registered Nurse (RN), stated oxygen filters were cleaned every 72 hours, and it was important to ensure the residents were getting the cleanest oxygen and to decrease respiratory infections. In an interview on 02/13/2026 at 11:48 AM, Staff B, Director of Nursing (DNS), stated oxygen filters were cleaned weekly, and it was important to keep the oxygen filters clean to prevent dust debris from entering the machine. <Resident 12> An admission assessment dated [DATE], documented Resident 12 had diagnoses that included respiratory failure which required use of supplemental oxygen equipment. The care plan dated 12/21/2025 instructed staff to administer oxygen therapy and to apply a CPAP (continuous positive airway pressure, a machine that used a hose and mask to deliver a steady, continuous stream of pressurized air that kept the airway open during sleep) nightly for Resident 12 per orders. Review of Resident 12's provider orders documented staff were to change oxygen tubing weekly every Sunday on night shift, clean CPAP reservoir every 7 days, and clean CPAP mask as needed. Review of Resident 12's TAR (treatment administration record) showed no documentation of oxygen tubing being replaced or CPAP being cleaned on 12/14/2025, 12/28/2025, 01/11/2026, 01/25/2026, and 02/08/2026. Review of the January 2026 TAR showed the mask had not been cleaned all month. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2026 at 9:05 AM, Resident 12 was observed lying in bed wearing a nasal cannula that delivered oxygen. A CPAP machine and mask were observed on a cluttered nightstand. At 1:45 PM the CPAP mask was observed on the nightstand to have a greasy like film on it and the front of the CPAP machine was covered with dust and debris. Resident 12 stated staff did not wash the mask. On 02/09/2026 at 8:23 AM Resident 12 was observed sleeping with their CPAP mask on and it was cloudy and unclean. Similar observations were made on 02/09/2026 at 9:02 AM and on 02/12/2026 at 7:13 AM. In an interview on 02/10/2026 at 9:10 AM Resident 12 stated staff did not change the oxygen tubing or clean their CPAP machine on Sunday. In an interview on 02/10/2026 at 9:10 AM with Staff X, Licensed Practical Nurse, stated oxygen tubing was changed weekly by the night shift and documented on the TAR. In an interview on 02/12/2026 at 6:59 AM, Staff R, RN, stated oxygen tubing and CPAP cleaning was assigned to the RN. If Resident 12 wore their CPAP mask and oxygen at night when the order directed staff to change the tubing and mask, the time frame did not work to change and clean them. Staff R stated they would not want to wake Resident 12 to clean and change oxygen equipment during the night. Staff R stated if completed the documentation would have been on the TAR. In an interview on 02/12/2026 at 10:56 AM Staff B, DNS, stated nurses on the evening shift were responsible for changing oxygen tubing and cleaning CPAP equipment. They stated it would be a good idea to change oxygen tubing and clean CPAP equipment during the day when residents were not using them. Reference: WAC 388-97-1060(3)(j)(vi)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the pharmacist's recommendation for a resident's inhaler (a medication that helped ease the effort of breathing) was addressed timely for 1 of 5 residents (Resident 11) reviewed for monthly medication regimen reviews. This failure placed the resident at risk for unintended side effects of the medication, and decreased quality of life. Findings included .The 12/08/2025 annual assessment documented Resident 11 had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that caused inflammation and difficulty breathing). Review of Resident 11's record showed a physician order dated 11/12/2025 for Arnuity Ellipta (an inhaled medication for asthma, a chronic disease of the lungs that caused episodes of wheezing, coughing, chest tightness, and shortness of breath) to be given once daily beginning on 11/13/2025.A pharmacy consultation report dated 12/17/2025 recommended the Arnuity Ellipta order be updated to include rinsing the mouth with water after use to prevent thrush (a painful mouth and tongue yeast infection).Further review of orders on 02/10/2026 revealed the pharmacy recommendation had not been implemented.In an interview on 02/10/2026 at 11:58 AM, Staff B, Director of Nursing, acknowledged that some of the pharmacy recommendations had been missed. Staff B planned on completing audits for the previous months and assessing residents for any adverse side effects. Staff B stated they expected timely implementations of pharmacy recommendations. Reference: WAC 388-97-1300(4)(c)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to maintain a total medication error rate of five percent or less for 3 of 7 sampled residents (Residents 76, 42, and 8) observed during medication administration. Specifically, 3 of 25 medications were observed to be given incorrectly for an error rate of 12 percent. This failure placed residents at risk of medication errors, adverse side effects, and potential medical complications. Findings included.<Resident 42> The 02/04/2026 admission assessment documented Resident 42 had diagnoses that included cancer, heart failure and diabetes. The resident was cognitively intact and able to make their needs known. Review of the 01/22/2026 provider order instructed nursing staff to administer Preservision AREDS (medication used to slow the progression of vision loss) two tablets to Resident 42 daily. During an observation on 02/09/2026 at 8:12 AM, Staff Y, Registered Nurse (RN), administered a multivitamin with minerals instead of the Preservision AREDS to Resident 42. In an interview on 02/12/2026 at 10:46 AM, Staff B, Director of Nursing, stated Preservision AREDS and multi vitamins with minerals were two different medications. Staff B stated they had communication with the providers and were told they could substitute the medication for something comparable. Documentation of the provider's communication was requested from Staff B but was not provided. Staff B stated it was important to give the Preservision instead of the multi vitamins with minerals because if an equivalent medication was not given it did not address the resident's needs. <Resident 8> The 01/13/2026 admission assessment documented Resident 8 had diagnoses that included cancer, respiratory failure and obstructive uropathy (a blockage that made it difficult to urinate). Review of the 01/08/2026 provider order instructed staff to administer Lansoprazole Delayed Release Disintegrating tablets (medication with a special coating that slowed absorption, that was not able to be crushed and was used to decrease acid in the stomach) one tablet to Resident 8 twice daily. During an observation on 02/09/2026 at 9:50 AM, Staff W, RN, placed Resident 8's Lansoprazole Delayed Release Disintegrating tablet into a medication cup. Staff W then placed the Lansoprazole and another medication into a plastic bag and crushed the medications. At 10:00 AM, Staff W administered Resident 8 their medications. In an interview on 02/12/2026 at 10:46 AM, Staff B, Director of Nursing, stated the nurses needed to look up medications to determine if they could be crushed and would hope the provider order explained that in the order. Staff B stated it was important not to crush the medication because that caused the medication to be absorbed too quickly. <Resident 76> According to the 02/09/2026 admission assessment, Resident 76 admitted to the facility on Tuesday 02/03/2026. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 02/05/2026 provider order instructed staff to administer Alendronate (medication used to strengthen bones and prevent fractures) to Resident 76 once weekly on Mondays. During observation and interview on Monday 02/09/2026 at 5:04 AM, Staff S, RN, attempted to dispense Alendronate to Resident 76 but was unable to locate the medication to administer. Staff S attempted to obtain the medication from the facility's electronic emergency medication machine, but it was not available and the dose was omitted. Staff S stated they would have to call the pharmacy to inquire about the medication and notify the provider that the medication was unavailable to administer. In an interview on 02/10/2026 at 1:18 PM, Staff B, DNS, explained the facility medication delivery process and stated if a medication was unavailable for administration staff could access the electronic emergency medication machine and obtain the medication if it was in stock. Staff B was unsure why Resident 76's weekly Alendronate was not available for administration. Staff B stated they expected staff to administer medications as ordered. In an interview on 02/13/2026 at 12:03 PM, Staff A, Administrator, stated they expected staff to administer medications as ordered. Reference WAC: 388-97-1060 (3)(k)(ii)