STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505260	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudson Bay Health and Rehabilitation	8507 Northeast 8th Way Vancouver, WA 98664

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and/or have procedures in place to assist with completing advance directives (AD); and obtaining and maintaining Durable Power of Attorney (DPOA) documentation for 2 of 7 sampled residents (Resident 10 & 6) reviewed for ADs. This failure place residents at potential risk for losing their right to have their healthcare preferences and/or decisions honored. Findings included. Review of the facility's policy titled, Advance Directives and Advance Care Planning, dated 08/28/2025, indicated Residents have the right to self-determination regarding their medical care which includes the right to execute or refuse to execute advance directive(s) Further, the facility will inform, and provide written information (if applicable), to Residents or Resident Representative regarding the Resident's right to formulate, execute, and/or refuse either of an advance directive. 10. Each time the Resident is admitted to the facility, quarterly, and when a change in condition is noted in the Resident condition, the facility should review the advance directive and advance care planning [ACP] information. a. This review should focus on whether the existing advance directives and ACP match the current goals of care for the Resident. The social services director or designee should document this conversation in the medical records and assist as needed with updating the documents that need revision in accordance with state and federal requirements. Resident 10 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS, an assessment tool), dated 01/18/2026, indicated Resident 10 was alert and oriented. Review of the electronic health record (EHR) profile section documented Resident 10's son was the Power of Attorney (POA); however, no POA paperwork was available for review in the EHR. Record review of Resident 10's Multidisciplinary Care Conference, dated 01/27/2025, showed Resident 10 did not have an advance directive. During an interview on 03/18/2026 at 8:38 AM, Staff C, Social Services Manager, said the facility was behind on advance directives. Staff C said the Multidisciplinary Care Conference, dated 01/27/2025, addressing advance directives was the only information she was able to find for Resident 10. Staff C said Resident 10's advance directives should have been reviewed quarterly. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/18/2026 at 3:17 PM, Staff B, Director of Nursing/Registered Nurse, said advance directives should be reviewed at the care conference in case there were any changes. Resident 6 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 6 was alert and oriented. Review of Resident 6's EHR indicated Resident 6 had declined to formulate an Advance Directive on admission and did not have an AD on file. Record review of Resident 6's Comprehensive Care Conferences, dated 09/22/2025 and 06/18/2025, did not indicate Resident 6's ADs were addressed, and/or Resident 6 was offered a chance to formulate them. Review of Resident 6's Quarterly Clinical Evaluations, dated 03/17/2026, 12/16/2025, and 09/16/2025 did not indicate the facility addressed his advance directives. During an interview on 03/19/2026 at 10:44 AM, Staff J, Social Services Assistant, said advanced directives were typically addressed during care conferences. Staff J stated, The resident refuses care conferences. He says nothing has changed and refuses. Staff J said, after resident refused care conferences, she would ask the resident whether he would like to formulate an advanced directive. Staff J was unable to provide documentation of offering to readdress advance directives, and stated, it's more of a verbal. I can't force them to sign it. During an interview on 03/19/2026 at 12:13 PM, Staff B, Director of Nursing Services said the facility had identified an issue with Advance Directives as part of their QA (Quality Assurance) process, and going forward, the facility will apply a new system to addressing the issues. Refer to F 553 Reference WAC: 388-97-0280(3)(c)(i)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences for 1 of 3 residents (Resident 10) reviewed for care conferences. This failure placed residents at risk of a diminished quality of life when not allowed to be involved and/or have a say in their long-term care needs.Findings included. Review of the facility's policy titled, Comprehensive Care Plans & Conference, dated 09/03/2025, indicated .4. The interdisciplinary team (IDT) responsible for developing and reviewing the care plan will include, at minimum: a. The resident's attending physician b. A registered nurse assigned to the resident c. A nurse aide familiar with the resident's cared. A member of the food and nutrition services staff e. The resident and, when appropriate, their representative .6. The facility will actively support resident engagement in the care planning process by:a. Explaining the assessment and planning process in understandable termsb. Scheduling meetings at times when the resident is most alert and able to participatec. Allowing adequate time for discussion and decision-makingd. Encouraging the resident representative to attend and contribute to care planning meetings.8. Participation may take various forms, including in-person attendance, phone calls, or video conferencing, depending on the residents' and representative's availability and preferences. Resident 10 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS, an assessment tool), dated 01/18/2026, indicated Resident 10 was alert and oriented. Record review of Resident 10's last Multidisciplinary Care Conference, dated 01/27/2025, showed Resident 10 attended with two family members. There were no care conferences for Resident 10 over the past 14 months.Record review of Resident 10's progress notes, dated 08/08/2026, documented RSA [Resident Support Services Assistant] called and spoke w/ [with] resident's son/POA [Power of Attorney] r/t [related to] CC [care conference] scheduling. Son states he will be out of town for work and unavailable for CC. Son asked RSA to call back when the next quarterly is do [sp] as he should be in town then. Record review of Resident 10's progress note, dated 01/19/2026, documented RSA called and spoke w/ resident's son/POA r/t Quarterly CC scheduling. POA stated he was in Montana for work until next month, then shortly after will be returning to Montana for work. POA stated he will call facility to schedule a CC when he isback [sp] in town. CC scheduling refused at this time.During an interview on 03/18/2026 at 2:33 PM, Staff C, Social Services Manager, said care conferences for residents were done quarterly, with a significant change, and annually. Staff C said if a POA was not available to attend we could connect with them on the phone. When asked about Resident 10's care conferences Staff C said Resident 10's son said he was out of town and wasn't available to set up a CC at that time. When asked if a CC was completed over the past year, Staff C said none had been done. Staff C said they attempted to set up one on 08/08/2025 but Resident 10's son asked if they could call back when the next quarter was due.During an interview on 03/18/2026 at 3:17 PM, Staff B, Director of Nursing/Registered Nurse, said care conferences should be done quarterly, with a change of condition, or at the resident's request.Reference WAC 388-97-1020 (2)(e)(f)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer 2 of 7 residents (Resident 7 & 13) to the appropriate state-designated authority for a Level II Preadmission Screening and Resident Review (PASARR, an in-depth, person-centered evaluation for individuals with serious mental disorders and individuals with intellectual disability). This failure placed residents at risk of not receiving specialized services and a diminished quality of life. Findings included .Review of facility policy, revised 08/29/2025, titled Pre-admission Screening & Resident Review (PASRR) Process, documented, A positive level I PASARR screen necessitates an in-dept evaluation of the individual by the state-designated authority, known as a PASARR level two (II), which is to be conducted prior to admission unless otherwise authorized by such agency .Resident 7 was admitted to the facility on [DATE] with multiple diagnosis to include bipolar disorder (a mental health condition that causes extreme mood swings) and major depressive disorders (mood disorder characterized by persistently low moods). The Quarterly Minimum Data Set (MDS), an assessment tool, dated 01/14/2026, showed Resident 7 was moderately cognitively impaired. Record review of Resident 7's PASARR, dated 05/21/2024, documented Resident 7 did not have a serious mental illness (SMI) indicator and documented that no Level II evaluation was indicated.Record review of Resident 7's PASARR, dated 11/19/2024, documented Resident 7 had a SMI, anxiety disorder, and a Level II evaluation referral was required. Review of Resident 7's electronic health record (EHR) did not show a Level II evaluation. Record review of Resident 7's PASARR, dated 12/16/2024, documented Resident 7 did not have a SMI indicator and documented that no Level II evaluation was indicated. Resident 13 was admitted to the facility on [DATE] with multiple diagnosis to include bipolar & anxiety disorder (mood disorder characterized by feelings of fear, dread, and uneasiness). The Quarterly MDS, dated [DATE], showed Resident 13 was cognitively intact. Record review of Resident 13's PASARR, dated 07/19/2023, documented Resident 13 did not have a SMI indicator and documented that no Level II evaluation was indicated.Record review of Resident 13's PASARR, dated 11/21/2023, documented Resident 13 had a SMI, bipolar disorder, and a Level II evaluation referral was required. Review of Resident 13's EHR did not show a Level II evaluation.Record review of Resident 13's PASARR ,dated 07/12/2025, documented Resident 13 had a SMI, mood disorder, and documented that no Level II evaluation was indicated.In an interview on 03/18/2026 at 2:49 PM, Staff C, Social Services Director, reviewed Resident 7's and Resident 13's PASRR evaluations and said all the evaluations were not completed correctly and Resident 7 & Resident 13 needed to have a Level II PASARR evaluation completed. Reference WAC 388-97-1915(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident care plans were revised to accurately reflect care needs for 1 of 1 sampled resident (Resident 101) reviewed for death. This failure placed residents at risk for unmet care needs and a diminished quality of life.Findings included. Resident 101 was admitted to the facility on [DATE]. The Admission/5 day Minimum Data Set (an assessment tool), dated [DATE], documented Resident 11 was severely cognitively impaired. Record review of Resident 10's POLST (Portable Orders for Life-Sustaining Treatment, a medical order that documents a person's wishes for end-of-life intervention to health care facilities), dated [DATE], documented, .YES - Attempt Resuscitation/CPR [Cardio Pulmonary Resuscitation, a life-saving emergency technique used when a person's breathing or heart stops]. Record review of Resident 101's physician orders, dated [DATE] and discontinued [DATE], documented, FULL CODE [if a patient's heart stops or they stop breathing, healthcare providers will use life saving measures to resuscitate them, including CPR] . Record review of Resident 101's physician orders, dated [DATE] and discontinued [DATE], documented, DNR (no code) [Do Not Resuscitate, instructing healthcare providers not to perform CPR if a patient's heart stops or they stop breathing] . Record review of Resident 101's physician's orders, dated [DATE], documented, FULL CODE. Record review of Resident 101's Care Plan Report, date initiated [DATE], documented a Focus, [Resident 101] has a DNR POLST in place. Further review of the Care Plan Report, date initiated [DATE], documented a Goal, If [Resident 101's] heart stops or they stop breathing, CPR will not be initiated in honor of their code status wishes. In an interview on [DATE] at 8:04 AM, Staff B, Director of Nursing/Registered Nurse, said After Resident 101 was changed back to a full code on [DATE], the care plan was not updated, and it should have been. Reference WAC 388-97-1020 (2)(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were properly labeled with open date for 1 of 2 medication storage rooms (East Medication Storage Room) and 1 of 3 medication carts (Medication Cart 4) reviewed for medication storage and labeling. This failure placed residents at risk of receiving expired and/or less effective medications, and a diminished quality of life.Findings included . Record Review of the facility's policy titled, Medication Storage & Labeling, dated [DATE], documented, .b. Multi-dose vials: i. Date when first opened; discard within 28 days unless manufacturer specifies otherwise.d. Insulin pens: .ii. Apply date opened and discard per manufacturer's timeframe (usually 28 days after open). In a joint observation and interview on [DATE] at 1:46 PM with Staff D, Resident Care Manager/Licensed Practical Nurse, in the East Medication Storage Room, the medication refrigerator was observed to have in it an undated, opened, multi-dose vial of TB protein derivative (a solution injected under the skin used to help diagnoses a TB [tuberculosis, an airborne infection primarily affecting the lungs] infection). Staff D said the TB vial should have been dated when it was opened and it was not. In a joint observation and interview on [DATE] at 9:53 AM with Staff E, Registered Nurse (RN), Medication Cart 4 was observed to have three undated, opened insulin (a medication used to lower blood sugar) pens (a device used to give insulin shots) in the top drawer of the cart. Staff E said the insulin pens were supposed to be dated when opened and they were not. In an interview on [DATE] at 12:19 PM, Staff B, Director of Nursing/RN, said it was her expectation multi-use vials and insulin pens were dated when they were opened. Reference WAC 388-97-1300 (2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 staff properly don (put on) personal protective equipment (PPE) for 2 of 3 sampled resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) reviewed for infection prevention and control. This failure placed residents at risk for the spread of infection transmission in the facility and a diminished quality of life.Findings included. Record review of the facility's policy titled, Contact Precautions [infection control measures used to prevent the spread of infections that are transmitted through direct contact with an infected person or their environment] ., dated 09/10/2025, documented, .6. When a resident is placed on contact precautions, the staff should implement the following: .f. [NAME] appropriate PPE before or upon entry into the environment (e.g., room) of resident on contact precautions. Record review of the facility's policy titled, Transmission-Based Precautions [infection control measures used in healthcare settings for people with known or suspected infections that spread easily], revision date 09/11/2025, documented, .Enhanced Barrier Precautions (EBP): Refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities . In an observation and interview on 03/18/2026 at 9:26 AM, two resident name tags, placed above and below each other, were observed on the wall to the left of the entrance of room [ROOM NUMBER]. The top name tag had Resident 59's name. The bottom name tag had Resident 21's name. A sign was observed posted on the wall below Resident 21's name tag, that showed: CONTACT PRECAUTIONS.Doctors and Staff Must: Gown and glove at door. Staff G, Certified Nursing Assistant (CNA), was observed in room [ROOM NUMBER] adjusting Resident 21's legs on the wheelchair foot rests with no gown or gloves on. Upon exiting room [ROOM NUMBER], Staff G was asked about the Contact Precautions sign hanging below Resident 21's name. Staff G said she did not realize Resident 21 was on Contact Precautions. Staff G said they were supposed to wear a gown and gloves for residents on Contact Precautions. Staff G said the Contact Precautions sign was for Resident 21 because it was placed below her name. In an interview and observation on 03/18/2026 at 9:36 AM, Staff H, Licensed Practical Nurse, when asked about the Contact Precautions sign below Resident 21's name, said she did not know what Resident 21 was on Contact Precautions for. Staff H said the Contact Precaution sign should be for Resident 59 who had wound care. Staff G was observed in room [ROOM NUMBER] assisting Resident 59 in the bathroom with gloves on and no gown. Staff H went into room [ROOM NUMBER] and told Staff G she should have a gown on for care with Resident 59. Staff G said she thought the Contact Precautions sign was for Resident 21, not Resident 59, because the sign was hanging below Resident 21's name. Staff H said staff needed to gown and glove for residents on Contact Precautions and there may have been some confusion about which resident in room [ROOM NUMBER] was on Contact Precautions. In an observation on 03/18/2026 at 11:33 AM, the contact precautions sign posted to the entrance of room [ROOM NUMBER], below Resident 21's name, was removed. An EBP sign was observed posted above Resident 59's name that showed providers and staff must wear gloves and a gown for resident care activities such as providing hygiene and assisting with toileting. In an observation and interview on 03/18/2026 at 10:33 AM, a sign was observed posted on the wall to the left of the door entrance to room [ROOM NUMBER] that showed: CONTACT PRECAUTIONS.Doctors and Staff Must: Gown and glove at door. Staff I, CNA, was observed in room [ROOM NUMBER] changing linens on the bed with no gown on. Upon exiting room [ROOM NUMBER], Staff I was asked the process for PPE use for residents on Contact Precautions. Staff I said she talked to the nurse and was told the resident in room [ROOM NUMBER] was on precautions related to his wounds. Staff I said if she was not doing anything with the resident's wounds, she did not need to put on a gown. In an interview on 03/19/2026 at 10:43 AM, Staff F, Infection Preventionist/Registered Nurse (RN), said if a resident was Contact Precautions or EBP, the sign was posted on the wall above or below the resident's name (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that was on precautions. Staff F said the wrong sign was put up for room [ROOM NUMBER]. Staff F said it should have been an EBP sign, not a Contact Precautions sign, and it was put with the wrong resident's name. When asked about Staff G assisting Resident 59 in the bathroom without a gown, Staff F said Staff G should have had a gown on. Staff F said if a resident was on Contact Precautions, the staff should put on a gown and gloves upon entering the room. Staff F said Staff I should have had a gown on while in room [ROOM NUMBER]. In an interview on 03/19/2026 at 11:11 AM, Staff B, Director of Nursing/RN, said it was her expectation staff put on a gown and gloves when entering a room for a resident on Contact Precautions and during high contact activities with residents on EBP. Reference WAC 388-97-1320 (1)(a)