STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care	209 North Ahtanum Avenue Wapato, WA 98951

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement 4 of 8 components (identify, protect, report, and investigate), of their abuse/neglect policy/procedure for 3 of 3 residents (Residents 9, 35, and 40) reviewed for allegations of abuse/neglect. This failure placed the residents at risk for unrecognized abuse and unmet care needs. Findings included .Review of a 01/2026 policy titled Abuse, Neglect and Exploitation, showed the facility would prohibit and prevent abuse, neglect, and.of residents. with ongoing oversight and supervision of staff to ensure policies were being implemented. Review of the grievance (a formal or informal complaint about care or living conditions) log, dated 07/01/2025 through 01/25/2026, showed allegations of abuse and/or neglect that had not been identified, reported, or investigated as allegations of abuse and/or neglect, nor were the resident's provided protection from further abuse and/or neglect. The logs showed: On 12/23/2025 a staff concern issue was logged for Resident 9 regarding lack of assistance/care was provided from Staff M, Licensed Practical Nurse when asked. The log showed a completed date of 01/30/2026 (seven days after concern was reported). On 12/15/2025 a staff concern issue was logged for Resident 40 regarding a verbal confrontation with Staff N, Nursing Assistant. The log showed a completed date of 12/22/2025 (seven days after concern was reported). On 12/22/2025 a staff concern issue was logged for Resident 35; the concern was made by the Resident's Representative (RR). The issue showed Resident 35 was left with a soiled face, clothing, and their brief was so wet with urine that they dripped urine all the way down the hallway. The log showed no completion date. Review of the reporting log (a record used to document incidents that may involve abuse, neglect, or mistreatment of residents), dated 07/01/2025 through 01/25/2026, showed none of the grievances for Residents 9, 35, and 40 had been logged or thoroughly investigated to rule out abuse or neglect. Therefore, Residents 9, 35, and 40 were not protected from the possibility of ongoing abuse or neglect. During an interview on 01/30/2026, Staff A, Administrator, along with Staff B, Director of Nursing Services, stated there was some confusion with what concerns should be put on the grievance log versus the Reporting log and the policies needed updated. Staff A stated the nursing staff should have been logging allegations of not receiving appropriate care concerns on the incident log, and not on the grievance log. Staff A and Staff B both stated the grievance log concerns of Residents 9, 35, and 40 were not identified as allegations of abuse and/or neglect and should have been thoroughly investigated as allegations of abuse and neglect. Reference: WAC 388-97-0640 (2)(a)(b)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Emerald Care		STREET ADDRESS, CITY, STATE, ZIP CODE 209 North Ahtanum Avenue Wapato, WA 98951	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review, the facility failed to report potential allegations of abuse and/or neglect to the State Agency (SA) for 3 of 3 residents (Residents 9, 35, and 40) reviewed for abuse/neglect. This failed practice placed the residents at risk for unidentified and ongoing abuse and/or neglect. Findings included.

Resident 9

Review of the medical record showed Resident 9 was admitted to the facility on [DATE] with a diagnosis of Amyotrophic lateral sclerosis (ALS) (a progressive, fatal, neurogenerative disease that destroys motor neurons leading to loss of movement, speech, swallowing, and breathing capabilities though cognition stays intact.) The 11/17/2025 comprehensive assessment showed Resident 9's cognition was intact and required total assistance with bed mobility, transfers, dressing, toileting, feeding, and personal hygiene.

During a concurrent observation and interview with Resident 9 on 01/26/2026 at 1:16 PM, showed them sitting upright in their bed, eyeglasses in place and eyes cast downward looking at something on their iPad (a small computer like electronic device) which was on their lap. Resident 9 communicated by shaking their head yes or no, using a thumbs up signal and indicated by tapping the iPad that they could answer questions by writing on it as well. Attempts by Resident 9 to type on the iPad showed missed letters and spacing errors made it difficult to read the meaning in the writing. Resident 9 showed facial movements and nonverbal sounds that showed frustration at not being able to communicate effectively.

Review of the facility grievance logbook on 01/27/2026 at 9:00 AM and the attached incident reports showed an incident occurred on 12/15/2025 between Resident 9 and a facility staff member. Resident 9 reported the staff member did not put their glasses on when they had requested them to do so and just held them out of reach of Resident 9 for a couple of minutes before putting them down on a table and exiting the room. The resident reported she had concerns about the way the staff member had treated them and did not want them to come into their room to provide care any longer.

Further review of the grievance report showed Staff B, Director of Nursing, stated they were notified of the incident on 12/23/2025 from Staff E, the Social Services Director (SSD). The DON stated they met with Resident 9 and the staff members that were in the resident's room that day and had gotten their statements of what happened on 12/15/2025. The DON stated they suspended the staff member on 12/23/2025 until the investigation was completed and abuse or neglect could be ruled out. The staff member returned to work on 12/30/2025.

During an interview with Staff E, SSD, on 01/28/2026 at 11:40 AM, they stated they had received an email on 12/22/2025 from a community health reporter stating that Resident 9 had made a complaint to their office that the staff at their facility did not know how to care for a person who had ALS and questioned why they had been admitted to this facility if they didn't know how to care for them. Staff E stated they had interviewed Resident 9 after receiving the email and they reported the incident with the eyeglasses at that time. Resident 9 further stated they did not feel cared for or safe in the facility and did not feel like the staff knew how to care for them. Resident 9 stated they felt they had choked several times, and staff did not know how to handle that and did not know how to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Emerald Care		STREET ADDRESS, CITY, STATE, ZIP CODE 209 North Ahtanum Avenue Wapato, WA 98951	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

position their head so it would stay in an upright position. Staff E stated they then reported the incident to the DON for a more thorough investigation and follow-up.

Review of the Reporting log from 07/01/2025 through 01/25/2026 showed Resident 9's potential allegation of abuse and/or neglect had not been logged, nor had it been reported to the SA.

Resident 35

Review of the resident's medical records showed they admitted with diagnoses to include dementia (a decline in mental function from a previously higher level that is severe enough to interfere with daily living) and Parkinson's (a progressive brain disorder that affects movement) disease. The 12/05/2025 comprehensive assessment showed Resident 35's cognition was intact and required substantial to maximum staff assistance with toileting hygiene, dressing, and partial to moderate staff assistance with personal hygiene. The assessment showed Resident 35 was frequently incontinent with their urine.

Review of a 12/23/2025 grievance (a formal or informal complaint about care or living conditions) form showed Resident 35's Representative (RR) reported an incident that occurred on 12/22/2025 while they visited the resident. The grievance showed the resident was sitting in their wheelchair in their room with dried toothpaste on their shirt, pants, and face and when the RR assisted the resident to the dayroom at the front of the building, Resident 35 was so wet with urine that they left a trail of urine down the hallway. The grievance showed the RR stated they wanted the resident treated with dignity. The allegation of neglect was investigated as a grievance.

Review of the Reporting log from 07/01/2025 through 01/25/2026 showed Resident 35's potential allegation of neglect had not been reported to the SA.

Resident 40

Review of the resident's medical records showed they admitted with diagnoses to include heart failure and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities that were once enjoyable). The 11/12/2025 comprehensive assessment showed Resident 40's cognition was intact and was independent with their toilet transfers and required substantial to maximum assistance from staff for toileting hygiene.

Review of a 12/15/2025 grievance form showed Resident 40 reported a concern with a staff member. The grievance showed the resident was upset and did not like the way a Nursing Assistant (NA) spoke to them and had blamed them for locking a shared bathroom door. The grievance showed the NA told the resident Would you stop locking the dang door? The grievance showed the resident stated the way they were spoken to by the NA was unprofessional and unnecessary. The potential allegation of verbal abuse was investigated as a grievance and not as an allegation of abuse.

Review of the Reporting log from 07/07/2025 through 01/25/2026 showed Resident 40 had no potential allegation of abuse reported to the SA.

During an interview on 01/27/2026 at 1:20 PM, Staff B, Director of Nursing Services, stated they did not report Resident 35 and Resident 40's concerns as allegations of abuse or neglect because they did not think they were allegations of abuse or neglect, allegations of abuse or neglect are purposeful and willful and I did not believe the staff were being either.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care	209 North Ahtanum Avenue Wapato, WA 98951

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: WAC 388-97-0640 (5)(a)

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER: Emerald Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 209 North Ahtanum Avenue Wapato, WA 98951	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interview and record review, the facility failed to ensure a complete and thorough investigation had been completed for reported allegations of abuse and/or neglect for 3 of 3 residents (Residents 9, 35, and 40) reviewed for abuse and neglect. The failure to conduct a thorough investigation including root cause, contributing factors, and identifying preventative measures to rule out abuse/neglect placed the residents at risk for further unmet care needs and psychosocial harm. Findings included.

Resident 9

Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including Amyotrophic lateral sclerosis (ALS) (a progressive, fatal, neurogenerative disease that destroys motor neurons leading to loss of movement, speech, swallowing, and breathing capabilities though cognition stays intact), depression, anxiety and chronic pain. The 11/17/2025 comprehensive assessment showed Resident 9's cognition was intact and required total assistance with bed mobility, transfers, dressing, toileting, feeding, and personal hygiene.

Review of a grievance form dated 12/23/2025 showed Resident 9 had shared a complaint with Staff E, Social Services Director (SSD), stating that on 12/15/2025, Staff M, Licensed Practical Nurse, (LPN), had not responded to Resident 9's request to have their glasses put on. Resident 9 said Staff M only held the glasses out towards them for several minutes without saying anything or assisting with placing them on the face. Resident 9 reported Staff M then just put the glasses down and left the room without any further explanations or offers of assistance.

Further review of the grievance form showed Staff B, Director of Nursing (DNS) wrote on the grievance form that Resident 9 reported feeling unsupported and mistreated by Staff M's interaction with them on 12/15/2025 and had educated Staff M in a one-on-one meeting on 12/29/2025 that showing empathy, resident centered care, therapeutic communication and appropriate assistance when caring for residents with significant physical limitations and communication difficulties were the expectations.

During an interview with Staff E on 01/28/2026 at 11:40 AM, they stated after receiving Resident 9's concern of neglect, they had reported the grievance to Staff B. In addition, Staff E stated they had followed up with questioning six other residents on the hallway where Resident 9 resided, asking if they had any concerns of staff members not responding to their needs and if they felt safe in the facility with all responding they had no issues.

During the same interview, Staff E stated Resident 9 reported to them they no longer wanted Staff M to come into their room or provide any care to them. Further, Staff M was removed from working in the facility from 12/23/2026 through 12/30/2026 while Staff B completed the investigation and provided staff education concerning the incident.

During an interview with Staff M on 01/28/2026 at 12:20 PM, they reported they were told on 12/23/2025 of the allegations against them and said they would be taken off the schedule until further notice. Staff M stated they were then called on 12/29/2025 to go to the facility and speak with the DNS about expectations moving forward. Staff M stated the DNS told them they were not to have further contact with Resident 9 and the allegations of abuse and neglect were unsubstantiated and they could return to work the following day.

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	505265	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care	209 North Ahtanum Avenue Wapato, WA 98951

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 35 Review of the resident's medical records showed they admitted to the facility with diagnoses to include dementia (a decline in mental function from a previously higher level that is severe enough to interfere with daily living), heart failure, and urge incontinence (a sudden, intense urge to urinate, often resulting in involuntary leakage of urine). The 12/05/2025 comprehensive assessment showed Resident 35's cognition was intact, and they required substantial to maximum staff assistance for toileting hygiene and dressing and partial staff assistance for personal hygiene. The assessment showed the resident was frequently incontinent. Review of a 12/23/2025 grievance form showed Resident 35's Representative (RR) reported an allegation that Resident 35 was found with dried toothpaste on their face, shirt, and pants when they arrived at their room to visit on 12/22/2025 at 10:00 AM. The RR reported they assisted the resident down to the day room, which was at the front of the building, and the resident's brief was so wet with urine that they leaked urine all the way down the hallway. The RR reported they wanted Resident 35 treated with dignity. The grievance showed the resident was interviewed by the Social Services (SS) staff on 12/24/2025, the day the concern was reported to them. The SS staff documented the resident had no concerns and felt their care was met timely. Staff B documented the allegation of lack of dignity and timely care could not be substantiated and that abuse and neglect were ruled out. The grievance showed no other interviews had been conducted, no other residents had been interviewed regarding timely care and dignity, no care plan (CP) changes, no alert charting was initiated, and no skin checks had been completed to ensure the resident's skin was still intact after sitting in their urine. The grievance investigation showed there had been facility wide education completed on resident dignity and a one on one write up with the staff involved. No staff member was identified on the grievance (later identified as Staff O, Nursing Assistant (NA)), and no staff statements were obtained. The grievance showed it was completed on 12/31/2025 (eight days after concern was reported to the facility) by Staff B. The grievance investigation showed no root cause or analysis as to why the resident was soaked with urine or why they went without personal hygiene. Review of a Dignity in-service that was attached to the grievance, was dated 12/16/2025, which was prior to this incident happening or being reported. During a telephone interview on 01/28/2026 at 1:56 PM, Staff O stated they did not get called or asked about the incident regarding Resident 35 until 12/29/2025 (six days after the concern was reported to the facility). Staff O stated they were not asked to complete a statement of the incident or what had happened. Staff O stated they were just asked to sign a one-on-one write-up. During an interview on 1/27/2026 at 12:20 PM, Staff B stated they did not investigate the grievance as a possible allegation of neglect because neglect would mean willful and purposeful and they knew that was not the case. Resident 40 Review of the resident's medical records showed they admitted to the facility with heart failure and a lung disease. The 11/20/2025 comprehensive assessment showed Resident 40's cognition was intact, and they were able to use the restroom independently. The assessment also showed Resident 40 was frequently incontinent of their urine. Review of a 12/15/2025 grievance form showed Resident 40 reported an allegation regarding a staff (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Emerald Care		STREET ADDRESS, CITY, STATE, ZIP CODE 209 North Ahtanum Avenue Wapato, WA 98951	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	member (later identified as Staff N, NA), and how they spoke to them. The grievance showed the resident was upset and said Staff N entered their room and told them, Would you stop locking the dang door. Resident 40 stated they did not like how Staff N talked to them or blamed them for locking the shared bathroom door. The grievance investigation showed the resident stated the way the Staff N spoke to them was unprofessional and unnecessary. The grievance conclusion was Staff N was removed from the scheduled room and on 12/16/2025 was removed off the routine schedule to that unit. The grievance showed continued education was provided about sharing info on other residents (even though the grievance did not reflect anything about sharing information about other residents). There was no root cause or analysis completed to rule out abuse or neglect, nor were other residents interviewed regarding the interactions they had with Staff N were of a professional manner, no care plan changes, no alert charting to continue to monitor any adverse reactions the resident may have had over the incident. During an interview on 01/28/2026 at 11:13 AM, Resident 40 stated they reported an incident involving Staff N. The resident stated Staff N accused them of locking the shared bathroom door when they last used the bathroom and didn't unlock it when they were finished. The resident, who became tearful during this interview, stated it upset them because Staff N had spoken to them as if they were being scolded and when they attempted to explain to staff N that they had not used the restroom that day, Staff N made them feel as if they were lying, threw their hands up in the air, and walked out of the room while they were talking to them. Resident 40 stated Staff N was removed from their room but then a few days later came back in their room again, where they had an exchange of words again. Review of the Reporting Incident Log from 07/01/2025 through 01/25/2026 showed no allegations of abuse or neglect had been reported for Resident 9, 35 or Resident 40's allegations. During an interview on 01/30/2026 at 2:09 PM, Staff A, Administrator, along with Staff B, stated there was some staff confusion with what should be reported on the grievance log and what should be on the reporting log. Staff A stated they needed to review and revise the grievance policy to ensure they were protecting the residents involved right away and thoroughly investigating allegations of abuse and/or neglect. Reference: WAC 388-97-0640 (6)(a)(b)