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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure that unless the facility had a full-time Registered Dietician (RD), that the Dietary Manager (Staff H, Dietary Manager (DM)) had the competencies and skill sets to carry out food and nutrition services for their resident population. This failure placed residents at risk of receiving dietary services from staff who had not completed an academic program in nutrition or dietetics accredited by an appropriate national accreditation organization. Findings included. During an interview on 01/25/2026 at 9:28 AM, Staff H stated they were the DM in training. Staff H stated they would hope to have their required certification by March 2026. During an interview on 01/29/2026 at 10:23 AM, Staff I, Kitchen Manager, stated they would assist the DM if they needed help. Staff I stated they were not the oversight of the DM and that they assumed the Registered Dietitian (RD) was the DMs' oversight. Staff I stated the RD worked two to three days a week and was a consultant for the facility. Staff I stated they themselves carried no certifications. During an interview on 01/29/2026 at 1:39 PM, Staff H stated they had completed the Certified DM course, but when they took their test in September of 2025, they did not pass. Staff H stated they wanted to retake the test, but work got too busy during the holidays, and they did not have time to review or prepare for the test, so they were unable to reschedule the test. Staff H stated they had been the DM since June of 2024 with Staff I supervising them, because they have more experience. During an interview on 01/30/2026 at 9:56 AM, Staff A, Administrator, along with Staff B, Director of Nursing Services, stated Staff H had taken their Certified DM test in 09/2025 but did not pass the test. Staff A stated Staff I was the oversight of the DM. Staff A stated Staff H and Staff I worked side by side in the kitchen with the help of the RD. Staff A stated Staff H had to wait 90 days to retake the test and had not had the $500.00 it cost to reschedule the test. Staff A stated they offered to pay for Staff H to retake the test and Staff H could reimburse them, but Staff H had fears they were not ready or prepared to retake the test. Reference: WAC 388-97-1160 (2)(3)(a)(b)(i)

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 discard expired foods in 1 of 1 walk in refrigerator, 1 of 1 stand-alone refrigerator, and 1 of 1 dry storage area used to store food items for the entire resident population, reviewed for safe and sanitary kitchen. Additionally, the facility failed to follow the thawing process of foods or consistently monitor cooked food temperatures prior to serving the food. This failed practice placed residents at risk for Food borne illness (caused by consuming foods that are contaminated with harmful pathogens [bacteria that reproduce rapidly once entered in the body and can damage tissues and cause illness]).Findings included.Review of a 02/2025 policy titled Thawing Frozen Food, showed ground beef could be thawed for one to two days and then once thawed, could be kept another one to two days (a total of four days from removing from a frozen state). The policy showed bacon or sausage could be kept up to seven days. Expired Foods During the initial tour of the kitchen on 01/25/2026 at 8:50 AM showed: Stand-alone Refrigerator: four prepared plates of fruit (blueberries, strawberries, and tangerines) and cottage cheese uncovered, unlabeled, and no dates. Three chef salads, one dated for 01/21 and no use by date and the other two had no label or dates. One resident meal tray, unlabeled, with a plate that contained pasta filled with a white filling, a breadstick, condiments, and juice, undated. One clear plastic storage container with eight single serving containers of a thick brown substance dated for 01/10/2026 and no use by date, and unlabeled. One 32-ounce container of Almond mild, half full, no opened and no use by date. One five-pound tub of sour cream with an open date of 12/20/2025 and no use by date. One five-pound tub of cottage cheese opened on 01/25/2025 but expiration date showed 01/24/2025 and was three quarters full. A metal bowl with more than two cups of a white substance with a date of 01/21, unlabeled. One 46-ounce carton of cranberry cocktail thickened liquid expired on 01/20/2026, no open date, full, and one that was half full, dated 12/27/2025. One full pitcher of dark liquid, unlabeled and undated Dry Storage Area: One large white plastic food bin with a dry white powder with no label or dates One large white plastic food bin with breadcrumbs dated 04/15/2025 and no use by date One gallon of [NAME] Vinegar with expiration date of 02/2024 Walk-in Refrigerator: Five prepared cups with fruit in them, sitting on a shelf, undated or labeled Two rectangle single serving cakes next to the fruit cups, undated or labeled One gallon container of Vinaigrette salad dressing, three quarters full, dated 03/28/2025 One gallon container of Blue Cheese salad dressing, full, dated 09/12/2025 One gallon Coleslaw dressing, one quarter full, no open date One gallon of tartar sauce, one quarter full, dated 10/01 and expired 07/19/2025 One half of a 32-ounce package of roast beef lunch meat dated 01/14/2026 and no use by date. Two 32-ounce packages of Roast Beef lunch meat, undated, but freeze by date on the package showed 01/23/2026 One 15-pound box of bacon, thawed, box opened and bacon was uncovered, half full, dated 01/13/2026. One box of honey bacon, opened, and dated 01/09/2026. Thawing Process: Five-five-pound ground beef rolls, in a container on the bottom shelf, thawed with a date of 01/20/2025, no use by date. Seven packages of turkey breast sliced lunch meat, 32-ounce, thawed, dated 01/13/2025. Five packages of sliced ham lunch meat, 32-ounce, unopened, thawed, and no dates. Food Temperatures: Review of logged food temperature forms, showed pureed food for breakfast, lunch, and dinner should range between 165-170 degrees (a unit of measure) Fahrenheit (F) from 01/01/2026 through 01/29/2026 showed: 01/03/2026- No pureed (food that has been blended or processed to a smooth, creamy consistency) food temperatures for dinner. 01/05/2026 and 01/06/2026-No pureed food temperatures for breakfast or lunch. 01/07/2026-No pureed food temperatures for lunch. 01/08/2026 - no food temperatures for lunch or pureed temperatures for breakfast 01/10/2026- no pureed food temperatures for dinner 01/12/2026-no food temperatures for breakfast or lunch and only pureed food and meat temperatures for dinner 01/13/2026 through 01/15/2026-no food temperatures for breakfast or lunch 01/20/2026- no pureed food temperatures (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for lunch, and no food temperatures for dinner 01/21/2026- no pureed food temperatures for breakfast 01/22/2026- no food temperatures for breakfast other than hot cereal, no temperatures for lunch. 01/25/2026-no pureed food temperatures for dinner 01/26/2026, 01/28/2026- no food temperatures for dinner 01/27/2026- no food temperatures for dinner other than soup 01/29/2026-no pureed temperatures for breakfast, or lunch During an interview on 01/25/2026 at 9:25 AM, Staff J, Cook, stated the ground beef was supposed to be kept no more than three days and there was no process for bacon, we usually use it every day until we use it all, no specific time frame. During an interview on 01/25/2026 at 9:28 AM, Staff H, Dietary Manager (DM), stated the lunch meat should be dated with the date it is removed from the freezer and used within seven days. Staff H stated salad dressings were good for one week from opening and should be dated when they were opened. Staff H stated the dried foods in the storage bins were flour and panko breadcrumbs I think were replaced with the last delivery and should have been dated and labeled. An interview on 01/29/2026 at 10:32 AM showed Staff I, Kitchen Manager, stated salad dressings once opened should be discarded within one month of open date and without dairy, they would be good for three months. Staff I stated kitchen staff were to check and discard expired foods twice a week, on Tuesdays and Fridays and those checks were not documented anywhere. Staff I stated foods and meats should have been labeled and had open dates and use by dates. An observation and concurrent interview on 01/29/2026 at 11:56 AM, Staff J, Cook, prepared six dishes of pureed cheeseburger casserole. Staff J was about to serve the pureed casserole into the dishes without checking the temperature. At 11:59 AM, Staff J prepared the pureed cold pasta salad and again was going to serve to the dishes and had to be asked to check the temperature. The temperature of the cold pasta salad was at 69.3 F and stated cold pasta salad should be less than 70 F. Staff I, who was standing close by and stated the cold temperature for pasta should be under 41 F. Staff J did not document the temperatures on the temperature food log. During an interview on 01/30/2026, Staff A, Administrator, stated the kitchen staff should be documenting dates when they received the product, then documenting the dates when they were opened. Staff A stated when foods were thawed out, they would expect a date of when to dispose of it or when it expired. Staff A stated staff should consistently check temperatures before each meal. Reference: WAC 388-97-1100 (2)(3)

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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)

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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 position their head (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: WAC 388-97-0640 (5)(a)

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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. (continued on next page)

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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)

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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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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR) assessments were completed for residents following significant change in status or with newly evident or possible serious mental disorders for 3 of 7 residents (Resident 23, 59, and 31) reviewed for unnecessary medications. This failure resulted in a potential delay in access to Level 2 PASARR services and decreased quality of life. Findings included .Resident 31 Review of the resident's medical records showed they admitted to the facility with diagnoses to include heart failure and a stroke (when blood flow to the brain is interrupted from a blocked or burst of a blood vessel) with deficits to their right side. The 01/02/2026 comprehensive assessment showed Resident 31's cognition was severely impaired, had a diagnosis of dementia (the loss of cognitive functioning; thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), and received anti-depressant (medication to help decrease symptoms of depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]). Review of a provider note dated 07/01/2025 showed Resident 31 experienced cognitive decline and increased behaviors and there was a concern for vascular dementia (a type of dementia that leads to cognitive impairment and behavioral changes) and ordered some diagnostic tests. A note on 07/15/2025 showed Resident 31 had yelling, cussing, and hitting staff and was could not be easily redirected. The note showed the resident was refusing meals and care at times and was given a new diagnosis of vascular dementia with behavioral disturbances and an anti-depressant medication was started to help with the resident's weight loss. A note on 08/18/2025 showed the resident refused cares and experienced angry outbursts. A note on 09/23/2025 showed Resident 31 experienced behaviors of yelling, cussing, and hitting staff. The note showed the resident was agitated with the provider during their visit. The note also showed a second anti-depressant medication was started for the dementia with behaviors. Review of Resident 31's Level 1 PASARR, dated 02/03/2023, showed a new one had not been completed to reflect Resident 31's significant change, new diagnosis, behaviors, or medications. Resident 23 Review of the medical record showed Resident 23 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses of a broken right collar bone, repeated falls, and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) without behavioral disturbances. Review of the comprehensive assessment, dated 01/14/2026, showed Resident 23 had severe cognitive impairment and was taking antidepressant (medication to help decrease symptoms of depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]) medication and anticonvulsant (a type of drug that is used to prevent or treat seizures or convulsions by controlling abnormal electrical activity in the brain) medication. Review of the PASARR, dated 07/23/2025, showed Resident 23 had no indication of a serious mental illness and did not require a level 2 evaluation (a process of evaluating a resident's current behavioral health conditions to identify the need for further support services). (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility provider note, dated 07/29/2025, showed Resident 23 was started on an antipsychotic [a type of drug used to treat symptoms of psychosis such as hallucinations (sights, sounds, smells, tastes, or touches that a person believes to be real but are not real), delusions (false beliefs), and dementia] medication for the management of aggressive behaviors toward staff, refusals of care, and impulsive behaviors. A new diagnosis of dementia with behavioral disturbance was listed as the indication for use. Review of the pharmacy Medication Regime Review (MRR), dated 11/07/2025, showed the recommendation of discontinuing the antipsychotic medication for Resident 23's behaviors and initiating an antidepressant and/or an anticonvulsant medication used to treat mood disorders. The MRR showed review of Resident 23's target behaviors (impulsive, irritable, verbally and physically aggressive toward staff) were only marginally improved with the antipsychotic medication and the antidepressant medication recommended was the drug of choice to manage dementia with behaviors. Review of Resident 23's physician's orders showed a new order, dated 11/10/2025, was received to taper and discontinue the antipsychotic medication and to initiate the anticonvulsant medication for the indication of dementia with behaviors. Review of the medical record showed no other PASARR completed for Resident 23. Resident 59 Review of the medical record showed Resident 59 admitted to the facility on [DATE] with diagnoses of dementia without behavior, history of deep vein thrombosis, and arthritis. Review of the comprehensive assessment, dated 12/31/2025, showed Resident 23 had severe cognitive impairment, was taking antipsychotic, antidepressant, and anticonvulsant medications. Review of the medical record showed Resident 23's PASARR was undated and showed no indication for a level 2 screening for serious mental illness. Review of the facility provider note, dated 07/29/2025, showed Resident 23 was started on an anticonvulsant medication used to treat mood disorders with the indication of dementia with behavioral disturbance. The provider note showed Resident 23 was showing an increase in aggressive and sexual behaviors toward others. Review of the facility provider note, dated 09/02/2025, showed Resident 23 showed a continued increase in aggressive and sexual behaviors and an antidepressant medication was started with the indication of use dementia with behavioral disturbance. Review of the medical record showed no other PASARR was completed for Resident 23. During an interview, on 01/26/2026 at 5:23 PM, Staff A, Administrator, stated the facility's process for reviewing and updating residents' PASARRs after admission was when there was a significant change or a change in medications. During an interview, on 01/30/2026 at 9:39 AM, Staff E, Social Services Director, stated psychotropic medications (such as antipsychotics, antidepressants, and anticonvulsants) were used to treat the residents' behavior and not their diagnosis of dementia. Staff E stated the actual behavior diagnosis should be listed as the medication's indication for use, and this would trigger a review and update to (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident's PASARR. Staff E stated they were not aware this was being done incorrectly. Reference: WAC 388-97-1975 (7)(9)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a system to evaluate, and document demonstrated competencies (a series of knowledge, abilities, skills, experiences and behaviors, which leads to effective performance of staff regarding resident cares) and skill sets for 3 of 3 Licensed Nurses (Staff D,M and Q) reviewed for staff competencies. This deficient practice placed all residents at risk of receiving care from inadequately trained staff and unmet care needs.Findings included.Washington State Board of Nursing (an entity that regulates the competency and quality of nurses to protect the health and safety of the public) defined nurse competency in reference to [NAME] Administrative Code 246-840-210(5) titled, Continuing Competency .the ongoing ability of a nurse to maintain, updated, and demonstrate sufficient knowledge, skills, judgement, and qualifications to practice safely and ethically .Review of the Facility Assessment, updated January 2026, showed the facility maintains an ongoing process for staff training, education, and competency validation to ensure staff are prepared to meet resident care needs and regulatory requirements and staff education and competency needs are assessed through ongoing observation, quality assurance activities, incident review, and interdisciplinary team feedback.Review of staff personnel files showed the following:Staff D, Registered Nurse (RN), was hired on 10/18/2018 and had no documentation of demonstrated competencies, skills, or performance evaluations.Staff M, Licensed Practical Nurse (LPN), was hired on 12/19/2024 and had no documentation of demonstrated competencies, skills, or performance evaluations.Staff Q, LPN-Staff Development Director, was hired on 07/26/2020, and had no documentation of demonstrated competencies, skills, or performance evaluations.During an interview, on 01/27/2026 at 2:45 PM, Staff B, Director of Nursing Services (DNS), stated they were new to the DNS role and had not completed any competencies or skills evaluations of the LNs. Staff B stated they met with Human Resources (HR) staff and were unable to find any previous evaluations for the sampled LN staff. Staff B stated this was a process they needed to work on. Reference: WAC 388-97-1080(1)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the call light and bedside table was within reach and easily accessible for 1 of 3 residents (Resident 13) reviewed for reasonable accommodations. This deficient practice prevented the resident from independently accessing personal items such as their bedside beverage, using the call light, and placed them at risk for unmet care needs.Findings included .Review of the medical record showed Resident 13 had diagnoses of anoxic brain injury (occurs when the brain received no oxygen), hemiplegia (paralysis) of the left side, and loss of vision to left eye. Review of the comprehensive assessment, dated 12/31/2025, showed Resident 13 had moderate cognitive impairment and was dependent on the assistance of one to two people for dressing, hygiene, incontinent care, bathing, and transfers using a mechanical lift.Review of Resident 13's care plan, on 01/29/2026, showed Resident 13 was blind in their left eye, had limited vision in their right eye, was able to use the call light appropriately, and their call light was to be left within reach. Additionally, the care plan showed Resident 13 liked to drink a Diet Coke daily.During observations, on 01/25/2026 at 8:58 AM, 01/25/2026 at 12:59 PM, 01/26/2026 at 9:59 AM, 01/26/2026 at 1:01 PM, and 01/27/2026 at 2:37 PM, showed Resident 13 sitting in their wheelchair in their room with their left side closest to the bed and their bedside table behind them. The call light was on the bed, and their bedside beverage was on their bedside table, and both were out of Resident 13's reach.During a concurrent observation and interview, on 01/28/2026 at 10:43 AM, showed Resident 13 sitting in their wheelchair in their room with their left side next to the bed. Resident 13 stated they would use their button to request assistance from staff and let them know they were ready for their Diet Coke. Resident 13 used their right hand to reach over their lap and touch the bed on their left side while asking where the call light was. Resident 13 was unable to locate their call light and was unable to access their personal belongings on their bedside table as the table was behind Resident 13's wheelchair.During an interview, on 01/30/2026 at 12:21 PM, Staff K, Restorative Director, stated Resident 13 had decreased range of motion to both of their upper extremities, but the left side was more significant. Staff K stated Resident 13's call light would need to be intentionally placed within Resident 13's reach due to their limited reaching ability and limited vision. Staff K stated Resident 13's bedside table needed to be placed in front of them, within reach, for them to access their personal belongings such as their bedside beverage.During an interview, on 01/30/2026 at 1:10 PM, Staff B, Director of Nursing, stated all residents should have their call light and their bedside table within reach.Reference: WAC 388-97-0860 (2)

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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 review and validate the Preadmission Screening and Resident Reviews (PASARR), (an assessment to ensure individuals with serious mental illness (SMI) or intellectual/developmental disabilities are not inappropriately placed in nursing homes for long term care) were completed prior to admission and/or corrected or updated as required to reflect a Level 2 screening was completed for 2 of 7 residents, (Residents 4 and 9) reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.Findings included .Resident 4 Review of the medical record showed Resident 4 was admitted to the facility on [DATE] with diagnoses including dementia (a decline in mental abilities, characterized by the loss of memory, language, problem solving and other thinking skills), psychotic disturbance (a severe mental disruption that causes a person to lose touch with reality causing impaired thinking, emotions and behaviors), mood disturbance (a mental health condition characterized by persistent, intense, and long lasting changes in emotional states that disrupts daily life), anxiety, and Post-Traumatic Stress Disorder. (PTSD) (a mental health condition that can develop after experiencing or witnessing a traumatic event that involved the threat of death, serious injury, or sexual violence). The 01/22/2026 comprehensive assessment showed Resident 4 was cognitively intact and required minimum assistance with ADLs. Review of a Level 1 PASARR screening form for Resident 4 dated 4/18/2025 from the discharging hospital, showed Section IA had no SMI indicators checked though dementia was written to the side of the form. In addition, Section IV showed a Level 2 evaluation was not indicated. Further review showed a Level 1 PASARR was corrected by facility staff on 04/23/2025 indicating in Section A1 that Resident 4 had a diagnosis of a mood disorder and PTSD. Section IV showed a Level 2 evaluation was not indicated. 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.) depression, anxiety, and PTSD. The 11/17/2025 comprehensive assessment showed Resident 9's cognition was intact and required total assistance with ADLs. Review of a Level I PASARR screening form dated 08/21/2025, showed Resident 9 was admitted from home to the facility on [DATE] and in Section 1A had no diagnoses checked for serious mental illness by the physician who filled out the form, though diagnoses of depression, anxiety, and PTSD were listed as current diagnoses on Resident 9's admission paperwork. Section IV showed no Level 2 evaluation was indicated. Facility staff corrected the PASARR screening form on 08/21/2025 showing in Section IA that Resident 9 had diagnoses of depression, anxiety, and PTSD. Section IV showed a Level 2 evaluation was not indicated. During an interview on 01/26/2026 at 5:23 PM with Staff E, Social Services Director (SSD) and Staff A, Administrator, they stated the SSD was responsible for assuring that the PASARR forms were completed prior to admission from the hospital and corrected or updated the forms if the discharging hospital or provider were not accurate per the admission diagnoses. Staff E and Staff A stated they had received the Dear Administrator letter dated 07/06/2024 on changes to the Level 1 screening process though did not understand from the letters information that they needed to assure all residents in the facility should be evaluated with the new form for accuracy and sent out for a Level 2 assessment by evaluators if there were any diagnosis of a serious mental health indicator in Section IA of the form. During the same interview, Staff E and Staff A stated they thought they just had to assure new admissions or residents with a change in condition or medications had to have a new PASARR form be corrected or updated from their last completed form and sent to the PASSAR evaluators if necessary. Staff E stated they had not checked to see if all residents with SMI indicators needed to have an evaluation by the PASARR screeners because the facility's medical director was monitoring their mental health diagnoses and taking care of and (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluating any antipsychotic medications the residents were on and thought that was meeting the need for a Level 2 evaluation. In addition, Staff E stated they had been sending some new PASARR forms in for a Level 2 evaluation of new admissions with any mental health indicators that were not being followed by the medical director and those with a change in their mental health status and/or medications. The SSD stated the evaluators for a positive Level 1 PASARR requested a lot of resident information be sent to them and then it took them a long time to get anything back from them about a Level 2 determination of services. Reference: WAC 388-97-1915(1)(2)(a-c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Number of residents sampled: Number of residents cited: Review of the resident's medical records showed they admitted to the facility with diagnoses to include hydronephrosis (one or both kidneys cannot drain from the kidney to the bladder) with obstruction from kidney stones (hard, pebble like pieces of material that form in the kidneys) and kidney disease. Review of the 01/02/2026 significant change comprehensive assessment showed Resident 31's cognition was severely impaired, required the use of an RC, and did not experience pain. Additional review of Resident 31's medical records showed they had been admitted to Hospice services on 01/02/2026 for a primary diagnosis of Cerebrovascular disease (conditions that affect blood flow to your brain). An observation and concurrent interview at 01/26/2026 at 5:21 PM, Resident 31 was observed lying in bed with their Resident Representative (RR) sitting in a chair at their bedside. The RC tubing and bag were hanging down to the left side of the bed and hanging on the bed frame. The RC bag had less than 100 milliliters (mL, a unit of measure) of red urine, mixed with yellow color. The tubing had more than 10 inches (in, a unit of measure) of thick, white, chunky sediment that appeared to be blocking the urine from flowing downward. The tubing also had red dried specks on the inside walls of the tubing and urine above the thick white sediment. There was no urine in the tubing below the area of sediment. The RR stated the resident experienced pain when urinating, burning pain and the resident was observed with their left hand over their body, grasping the right handrail on the bed so tightly that their finger color went white in color, and wincing (reacting with a slight involuntary grimace or shrinking movement of the body) with a slight moaning sound. The RR stated the resident was urinating. The RR stated the urine symptoms were new and so was the reddish color in the urine and stated they had reported the change to the nurse currently working (later identified at Staff D, Registered Nurse (RN), and on 01/25/2026 to the Charge Nurse (later identified as Staff C, Charge Nurse (CN)). The RR stated Staff C told them on 01/25/2026 they would see if they could culture the resident's urine to rule out a possible infection, but they did not get any follow up from that. The RR stated Staff D told them that day, 01/26/2026, they were conferring with the others (Licensed Nurses (LNs)) about what they could do for the resident. During an observation on 01/27/2026 at 9:56 AM, Resident 31 was lying in bed with their left hand over their body, grasping onto the right-side bed rail with grimacing to their face and their forehead in a frowning position. The RC continued to have thick, white, chunks sediment in it as seen on 01/26/2026 which appeared to have slightly moved down the RC tubing, 300 mL of reddish/yellow urine in the bag. Review of the Nursing progress notes from 01/25/2026 to 01/27/2026 showed no progress notes pertaining to the RR's urine symptoms reported to two LNs, ongoing monitoring of the urine symptoms and increased discomfort, or the sediment and reddish/yellow urine in the RC. The progress notes showed no documentation that notification to Hospice services had been made. The notes showed the Hospice Nurse had been in to see Resident 31 on 01/27/2026 at 11:38 AM and reviewed the efficacy of the pain medication recently prescribed and no new orders. Review of the physician orders showed an order on 12/23/2025 for Acetic Acid Irrigation (a procedure used to cleanse the inside of the bladder in people who use a catheter for a long period of time to prevent infection and calcium buildup) three times a day as needed for occlusion or blockage in the RC (this had not been used since ordered on 12/23/2025). Review of the 01/02/2026 Hospice care plan showed the Hospice nurse or the facility nurse could obtain a dipstick urine test for symptom management, and the Hospice RN could flush the RC as needed. The care plan showed the resident experienced non-verbal signs of pain with repositioning and grasping at the rails. Review of the Hospice Nurse visit notes that showed no assessment or knowledge of the urine symptoms, the catheter sediment, or the reddish/yellow (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	colored urine, or the increased discomfort Resident 31 experienced. The note showed to continue the plan of care and call for changes, questions, or concerns. During an interview on 01/28/2026 at 3:29 PM, the Collateral Contact (CC) stated the communication process for changes in condition would be that the facility called Hospice and informed them of any issues the resident was having. The CC stated Resident 31's urine had been dark yellow with small bits of sediment in the RC tubing, and they had not visualized the RC on their visit on 01/27/2026. The CC stated they were not informed of the increased urine symptoms of discomfort and burning when urinating and had they known, they could have assessed the patency (the state of being opened or obstructed) of the RC and if it there was suspicion of a urine infection, they could have provided treatment without a dipstick urine test. The CC stated they were not aware the resident had an order for the Acetic Acid irrigations. The CC stated they did not plan to see the resident anymore this week and would be back to see them next Tuesday, 02/03/2026. During a telephone interview on 01/28/2026 at 3:46 PM, Staff D stated the RR reported to them that Resident 31 had experienced pain and burning when urinating. Staff D stated they assessed the RC and it had particles in the tubing. Staff D stated they attempted to give them pain medication, but the pill was too big, and Resident 31 could not swallow it. Staff D stated that 30 minutes later they returned and cut the pill in half and the resident was able to swallow it. Staff D stated the urine was blood tinged, but not blood tinged, maybe more of an amber color. Staff D stated they had notified Staff C on 01/25/2026 and had made a progress note the day before but Staff D was busy. Staff C stated they did not know Resident 31 had an Acetic Acid irrigation order and did not assess the patency of the catheter. Staff D stated their process for notification of changes in condition were to report to the CN, which they did, and then if there was no CN they were to complete a progress note. Staff D stated they were to notify Hospice if the resident needed a certain medication but did not know if they were to notify Hospice for a change in condition of the resident, I would not know that to be honest, this is a learning process for me. An observation and concurrent interview on 01/28/2026 at 5:23 PM, the RR was observed outside of the resident's room talking with a Nursing Assistant (NA). The RR stated Resident 31 was in pain when urinating and when they asked the resident if they were in pain, the resident yelled at me, yes! The RR stated the hospice nurse visited Resident 31 on 01/27/2026 and they had asked for them to be present when they visited but they did not know they would arrive earlier in the morning before they arrived. The RR stated they were sure the resident had a urine infection because they themselves had experienced one before and they were all the same symptoms, [Resident 31] needs to be treated. During an interview on 01/29/2026 at 11:13 AM, Staff K, Restorative Director, stated they observed Resident 31 in pain with repositioning, and they would also grab onto the bed rails when they were in pain, and then at the same time, deny they were in pain. Staff K stated they would have used the Acetic Acid irrigation if they had observed lower urine flow or increased sediment in the tubing. Staff K stated they did not know Resident 31 had an order for Acetic Acid. An observation and concurrent interview on 01/29/2026 at 11:33 AM, Staff L, NA, stated the nurse changed the RC this morning, 01/29/2026, and Resident 31 looked more comfortable today than they had in the past few days. The RC bag had no urine in the bag or the tube and no sediment in the tubing. The resident was lying in bed, no wincing or grabbing onto the bed rail. During an interview on 01/30/2026 at 3:06 PM, Staff C stated they were informed by Staff D that Resident 31 was having issues with their urine. Staff C stated their normal process would have been to assess the resident and communicate to Hospice, initiate alert charting and communications, but they did not follow that process this time. Staff C stated with Resident 31 and their verbal communication issues and language barrier, staff should have used the Advanced Dementia (AD, a pain assessment tool used for non-verbal pain indicators) pain tool to assess for pain and not just rely on asking them. During an interview on 01/30/2026 at 1:20 PM, Staff B, Director of Nursing Services, along with Staff A, Administrator, stated they would expect Nursing staff to communicate with Hospice any changes in condition with the resident and for there to be ongoing monitoring and charting. Staff B stated the resident had ongoing issues with their urine and catheter (continued on next page)

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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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and did not feel that there was a change in their condition. Staff B stated Resident 31 would be asked if they had pain and denied having pain unless their RR was present. Reference: WAC 388-97-1060 (1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to thoroughly assess, monitor, and identify the potential need for positioning and Range of Motion (ROM) services to prevent a contracture (a permanent tightening of the muscles, tendons, and skin often leading to rigidity of joints) or decrease in ROM to the affected hand of 1 of 2 residents (Resident 51) with hemiplegia (paralysis to one side of the body) reviewed for restorative services. This deficient practice placed residents at risk for unidentified contractures, decrease in ROM, and potentially the increase in dependence of others to complete Activities of Daily Living.Findings included.Review of the facility policy, Restorative Programs and Guidelines, dated 01/14/2026, showed all residents would be assessed for restorative potential when newly admitted to the facility, when discharged from therapy, and with every Minimum Data Set [(MDS) a standardized assessment tool that measures health status in nursing home residents] assessment.Review of the medical record showed Resident 51 admitted to the facility, on 07/22/2025, with diagnoses of left side hemiplegia and history of stroke (occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or ruptures). Review of the comprehensive assessment, dated 01/16/2026, showed Resident 51 had moderate cognitive impairment and required the assistance of one to two people with dressing, transfers, toileting, incontinent care, and bathing.Review of the Functional Safety Assessments dated 07/22/2025, 10/16/2025, and 01/16/2026, showed Resident 51 was assessed to have no contractures causing physical limitations and was at risk for developing contractures due to limited mobility.Review of the facility provider visit note, dated 07/29/2025, showed Resident 51 had some slight movement of left upper arm. (Left) hand with slight contracture. Able to move Left Lower Extremity.Review of the facility provider visit note, dated 09/23/2025, showed Resident 51's physical examination showed contracture to left hand and left arm weakness, is able to move slightly.Review of Resident 51's Restorative Program care plan, dated 11/26/2025, showed the goal of using the Omnicycle (a motorized rehabilitation device that uses a smart motor to help patients exercise when they have limited strength, endurance or muscle control) to prevent contractures and maintain upper body strength.During a concurrent observation and interview, on 01/26/2026 at 3:24 PM, Resident 51 stated they did not wear a splint or brace on their left hand and they try to remember to do the finger stretches but would forget. Resident 51 demonstrated the finger stretches to their left index, middle, ring, and pinkie finger independently, but was unable to stretch and extend their left thumb. Resident 51 stated, yep, it's starting to get stuck.During an interview, on 01/30/2026 at 12:21 PM, Staff K, Restorative Director, stated restorative programs were created by the therapy department when a resident was ready to discharge, and they implemented the program with periodic reassessments. Staff K stated Resident 51's ROM program was focused on their upper arms, and they had never assessed Resident 51's left hand for signs of contracture. Staff K stated Resident 51 was at risk for contracture due to their left side affected hemiplegia, but they did not currently have a restorative program focused specifically on Resident 51's left hand. Staff K stated they would not be able to determine if Resident 51's left hand was more or less contracted compared to when they admitted because they had never assessed it.During an interview, on 01/20/2026 at 1:21 PM, Staff B, Director of Nursing, stated Resident 51's left hand should have been assessed and monitored for potential or worsening contracture. Reference: WAC 388-97-1060(3)(d)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to provide the ordered therapeutic diet with modified texture of food and liquids for 1 of 3 residents (Resident 51) reviewed for nutrition. This deficient practice placed residents at risk of choking or aspirating (when food or liquid accidentally enters the airway and lungs instead of going into the stomach) on their food and liquids and potentially causing health complications including death.Findings included.Review of the facility policy, Diets/Diet Orders, dated 05/15/2024, showed the facility provided five modified texture food diets: mechanical soft (food made of moist and soft textures making it easier to chew and swallow), mechanical soft with chopped/shredded meats, mechanical soft with ground meats, pureed (blending or mashing cooked food into a completely smooth, thick, lump-free paste with the consistency of pudding) , and full liquid. The policy showed thickened liquids (modified liquid consistency) would be pre-made by the kitchen and placed on the residents' trays.Review of the medical record showed Resident 51 admitted to the facility, on 07/22/2025, with diagnoses of left side hemiplegia (paralysis of one side of the body) and history of stroke (occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or ruptures). Review of comprehensive assessment, dated 01/16/2026, showed Resident 51 had moderate cognitive impairment, required supervision while eating, and had coughing and choking during meals.Review of the nursing progress note (PN), dated 01/23/2026, showed Resident 51 was observed to be coughing while eating their meal near nurse's station. The PN showed Resident 51 was eating at a fast pace, required frequent cueing to slow down, and was coughing with eating and drinking. Review of Resident 51's Physician's Orders showed on 01/23/2026 a three-day trial for a downgraded (change to the next modified texture level for easier chewing and swallowing) diet of mechanical soft with ground meat and nectar thick (consistency of maple syrup or tomato juice) liquids was obtained.During an observation, on 01/25/2026 at 3:57 PM, Resident 51 was lying in bed watching TV and their bedside beverage cup was filled with ice water.Review of the nursing PN, dated 01/26/2026 at 1:30 PM, showed Staff K, Restorative Director reassessed Resident 51 after the three-day trial of the downgraded diet texture and found Resident 51 tolerated it well with less coughing while swallowing. The PN showed Resident 51 stated they liked the diet texture change and was agreeable to it ongoing. The PN showed a permanent diet order for mechanical soft with ground meat and nectar thick liquids was obtained for Resident 51 and a copy was provided to the dietary manager in the kitchen.During a concurrent observation and interview, on 01/26/2026 at 3:23 PM, Resident 51 stated they liked their new diet and had not been coughing as much during meals. Resident 51 stated they liked the nectar thick liquids because it made their drinks taste malted. When asked if their bedside beverage cup had nectar thick liquids in it, Resident 51 stated, no, its regular ice water.During a concurrent observation and interview, on 01/26/2026 at 5:41 PM, Resident 51 was sitting up in bed eating their dinner-a piece of pepperoni pizza cut into one-inch pieces, vanilla pudding, and a cup of juice. Resident 51 stated the pizza was kind of hard to chew, especially the crispy edges and the juice was not thickened.During a concurrent observation and interview, on 01/26/2026 at 5:50 PM, Staff R, Nursing Assistant (NA) reviewed and stated Resident 51's diet card from the kitchen showed the diet texture of mechanical soft and the liquid consistency of thin.During a concurrent observation and interview, on 01/27/2026 at 9:10 AM, Resident 51 was sitting up in bed and stated they just finished their breakfast. Resident 51 stated their food was chopped and easy to chew and swallow, and the beverages were thickened. When asked if their bedside beverage cup had thickened liquids, Resident 51 stated, no, its just ice water in there.During an interview, on 01/29/2026 at 1:42 PM, Staff K stated diet changes were communicated to kitchen staff with a diet change form and to nursing staff verbally or using the dashboard in the Electronic Health Record (EHR) system. Staff K stated they expected diet changes to be implemented immediately, especially when safety was a concern. Staff K stated they provided the diet change form for Resident 51 to Staff I, Kitchen (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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager, on 01/26/2026, but did not place the update on the dashboard in the EHR. Staff K stated Resident 51's bedside beverage should not have been iced water.During an interview, on 01/29/2026 at 2:30 PM, Staff B, Director of Nursing Services (DNS) stated they expected diet changes to be implemented right away, and that information was communicated to the nursing staff by writing the update on the daily assignment sheet. Staff B stated Resident 51 being served the incorrect diet texture and liquid consistency must have been a miscommunication.During an interview, on 01/30/2026 at 12:35 PM, Staff I stated they messed up and did not update Resident 51's diet card on 01/26/2026, but made sure it was fixed when they worked on 01/27/2026. Reference: WAC 388-97-1060 (3)(h)

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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 and interview, the facility failed to maintain a bedside suction machine in a clean and sanitary manner that met infection control standards of practice for 1 of 2 residents (Resident 60) reviewed for infection control related to respiratory equipment. This deficient practice placed residents at risk of the transmission of infectious organisms (germs such as bacteria, viruses, fungi or parasites) with the potential of developing Healthcare Associated Infections [(HAIs) an infection a person gets while receiving treatment for a different condition].Findings included.Review of [NAME] Manual of Nursing Practice, 11th edition, showed the standard of practice for oropharyngeal (mouth and throat) suctioning was to use a clean (reduction of germs by using soap, water, and clean gloves) technique and to replace suction tubing and attachments at least every 24 hours. Review of the medical record showed Resident 60 admitted to the facility on [DATE] with diagnoses of stroke (occurs when the blood supply to part of the brain is blocked or reduced), hemiplegia (paralysis) of the right side, and dysphagia (difficulty swallowing).Review of the Medication Administration Records (MARs) for January 2026 showed Resident 60 had orders for oral suctioning as needed for excessive secretions.Observations on 01/25/2026 at 1:37 PM, 01/26/2026 at 10:58 AM, 01/27/2026 at 10:00 AM, and 01/28/2026 at 3:39 PM showed a bedside suction machine on the nightstand next to Resident 60's bed. The canister was labeled with the date 01/01/26, and was half full (400 milliliters [(mL) unit of measure] of a light-yellow liquid with multiple white particles floating at the top.During an interview, on 01/29/2026 at 2:00 PM, Staff R, Nursing Assistant (NA), stated the Licensed Nurses (LNs) were the only staff to use the bedside suction machine and they were responsible for cleaning it.During a concurrent observation and interview, on 01/29/2026 at 5:11 PM, Staff P, Infection Preventionist (IP), stated the facility process was to discard the suction machine canister, liners, and tubing after use and replace with new ones. Staff P stated Resident 60's bedside suction machine should not have been left like that.During an interview, on 01/30/2026 at 12:27 PM, Staff B, Director of Nursing Services (DNS), stated the LNs should have disposed of and replaced the bedside suction machine's materials and set it up for the next use.Reference: WAC 388-97-1320 (1)(a)(5)(a-c)