STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505269	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vancouver Specialty and Rehab Care	1015 North Garrison Road Vancouver, WA 98664

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient weekend staffing as identified by the PBJ (payroll-based journal) to provide necessary care and services for 24 of 26 weekend days review for excessively low weekend staffing during the fourth quarter 2025. This failure placed residents at risk for unmet care needs and a diminished quality of life.Findings included.Record review of the PBJ Staffing Data Report, FY [fiscal year] Quarter 4, 2025 (July 1 - September 30), indicated the facility had excessively low weekend staffing.Record review of the facility's staff Hours Summary Report, and the Daily Staffing Form, showed the facility did not have the 3.4 hours of direct care per resident days, from 07/05/2025 through 09/21/2025. In an interview on 02/24/2026 at 1:32 PM, Staff A, Administrator, said they were aware of the low staffing levels during that period. Staff A said to make up for the low staffing they started using agency staff and began onboarding new employees.Reference WAC 388-97-1090 (1)

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

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

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	505269	A. Building B. Wing	02/24/2026

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the binding arbitration agreement (a legally enforceable contract where parties agree to resolve disputes through a private arbitrator [an impartial third party] rather than the court system) included documentation that the facility would ensure the selection of a convenient venue that was convenient to both parties (facility and resident/resident representative) in which to carry out arbitration proceedings for 3 of 3 residents (Resident 10, 21 & 50) reviewed for arbitration. This failure placed residents at risk of not being fully informed of the arbitration process. Findings included.Record review of the facility's arbitration agreement, titled, Voluntary Arbitration Agreement, revised on 08/23/2023, did not show documentation that the residents or their representatives were provided with the opportunity to select a convenient venue to carry out the arbitration proceedings. Resident 10 was admitted to the facility on [DATE]. Record review of Resident 10's Voluntary Arbitration Agreement signed on 09/30/2024 did not show that the agreement informed Resident 10 of the opportunity to select a convenient venue for the arbitration process. Resident 21 was admitted to the facility on [DATE]. Record review of Resident 21's Voluntary Arbitration Agreement signed on 02/06/2024 did not show that the agreement informed Resident 21 of the opportunity to select a convenient venue for the arbitration process.Resident 50 was admitted to the facility on [DATE]. Record review of Resident 50's Voluntary Arbitration Agreement signed on 04/13/2025 did not show that the agreement informed Resident 50 of the opportunity to select a convenient venue for the arbitration process.In an interview on 02/24/2026 at 1:10 PM, Staff A, Administrator, reviewed the facility's arbitration agreement but was unable to show documentation that the facility would ensure a convenient venue would be selected for the arbitration process. Reference WAC 388-97-1780 (1)(2)(d)

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	505269	A. Building B. Wing	02/24/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff properly donned (putting on) gloves during administration of a medication by injection (a medical procedure that involves administering medication directly into the body using a needle which allows the medication to enter the bloodstream or tissues rapidly) for 1 of 2 sampled residents (Resident 47) reviewed for injectable medication administration; and the facility failed to ensure staff properly stored and/or transported dirty laundry bins for 1 of 4 laundry bins reviewed for infection prevention. This failure placed residents and staff at risk for the spread of communicable diseases and a diminished quality of life. Findings included. Record review of the facility's policy titled, Administration of Injections, dated 03/04/2025, documented, .4. Gloves and other PPE [Personal Protective Equipment] are not required for preparing the medications, but are required for administering medications that might involve contact with blood or body fluids. Resident 47 was admitted to the facility on [DATE], discharged with return anticipated on 01/09/2026, and re-admitted on [DATE] with multiple diagnosis to include Diabetes Mellitus (a group of disorders characterized by an inability of the body to regulate its blood sugar levels), and Embolism (occurs when a blood clot breaks off and travels through the bloodstream and lodges elsewhere) and Thrombosis (formation of a blood clot inside a blood vessel) of Left Lower Extremity (leg). The Medicare – 5 Day Minimum Data Set, an assessment tool, dated 01/18/2026, showed Resident 47 was moderately cognitively impaired and was receiving insulin (a medication used to treat diabetes) injections and antiplatelet (medication that prevent blood clots from forming) medication. In an observation and interview on 02/20/2026 at 11:49 AM, Staff F, Charge Nurse/Licensed Practical Nurse, was observed administering an insulin medication injection to Resident 47 in his upper right arm. Staff F was observed to not have gloves on when she administered the injection. When Staff F was asked what the process was for glove usage during administration of injections, Staff F raised her hands up without gloves on, stating, Oh, yes, we are supposed to be wearing gloves. In an interview on 02/20/2026 at 12:17 PM, Staff B, Director of Nursing/Registered Nurse (RN) said she expected staff followed the policy they had for administration of injections. In an interview on 02/20/2026 at 12:22 PM with Staff G, Infection Preventionist/RN, when asked what the process was for administration of injections, Staff G stated staff, Should be washing hands beforehand, wearing gloves, cleansing site beforehand, and administer injections. When asked Staff G if Staff F should have been wearing gloves when she administered the insulin injection, Staff G nodded her head up and down. During an observation and interview on 02/23/2026 at 2:26 PM, four trash cans were observed in the vestibule between rooms [ROOM NUMBERS] on the wall along room [ROOM NUMBER] and about two steps in from the 200 hallway, near the exit leading to the residents' smoking area. One of the bins had two plastic bags of what appeared to be linen sticking out of the top of the barrel. Staff I, Nursing Assistant (NA), walked down the 200-hallway with a tied-up plastic bag in his right hand and placed it (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in one of the bins. After Staff I placed the bag in the bin, Staff I and an unidentified NA, pushed the bins outside of the door to the outside of the building. When Staff I entered the building, he was asked what was in the bins, Staff I said the bins contained dirty laundry. During an interview on 02/23/2026 at 2:45 PM, Staff I said he believed the bins were taken to the vestibule during mealtime so the bins would not be in the way. During an interview on 02/23/2026 at 2:57 PM, Staff G, said dirty linen was supposed to be bagged up and put in a big bin outside. Staff G said she expected staff to not allow the bins to be overfilled but to take them outside right away before they became overfilled. During an interview on 02/23/2026 at 3:08 PM, Staff B, said the hallway dirty bins should be moved before mealtimes. Staff B said the laundry bins should be removed before they became full and taken outside. Reference WAC 388-97-1320 (1)(a) & 388-97-1860 (1)(a) & (b)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and record review, the facility failed to convey the trust account for 1 of 4 residents (Resident 112) reviewed for trust funds. This failure placed the residents and/or their representatives at risk for loss of funds.Findings included.Resident 112 had a trust account while a resident in the facility. Resident 112 discharged from the facility on 12/09/2025. Review of the facility's Trial Balance form, balance dated 02/19/2026, indicated Resident 112 had a trust account that was closed on 01/20/2026, approximately 42 days after discharge. During an interview on 02/19/2026 at 1:04 PM, Staff H, Business Office Manager, said discharged resident accounts were supposed to be conveyed within 30 days from discharge.During an interview on 02/19/2026 at 2:14 PM, Staff H said Resident 112 discharged on 12/09/2025 but they did not close the account until 01/20/2026. Staff H said it should have been closed sooner. Reference WAC 388-97-0340 (5)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) test (a rating scale used to assess the severity of involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications [drugs used primarily to treat symptoms such as hallucinations and delusions]) for 1 of 5 sampled residents (Resident 111). The facility failed to monitor for adverse side effects (ASE) of psychotropic medications (any drug that alters the brain affecting mood, behavior, perception and thought processes) and Opiate medication (pain medication) for 1 of 5 sampled residents (Resident 111) reviewed for unnecessary medications. This failure placed residents at risk for adverse medication side effects and a diminished quality of life. Findings included.Record review of facility's policy for psychotropic medications, undated, documented, .16. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician .Resident 111 was admitted to the facility on [DATE] with multiple diagnoses to include paranoid schizophrenia (a chronic mental health condition characterized by intense, irrational, and persistent distrust, suspicion, and fear of others) and major depressive disorder (mood disorder, characterized by persistent sadness, loss of interest in activities). Record review of Resident 111's 5-Day Minimum Data Set, an assessment tool, dated 02/06/2026, documented Resident 111 was moderately cognitively impaired.Record review of Resident 111's physician orders, dated 01/30/2026, showed Resident 111 was prescribed Quetiapine Fumarate (an antipsychotic medication) oral tablet 25 MG (milligrams) by mouth three times a day. The February 2026 Electronic Medication Administration Record (EMAR) showed Resident 111 was receiving Quetiapine Fumarate as ordered. Record review of Resident 111's Electronic Health Record (EHR) did not show documentation of an AIMS test completed for the administration of Quetiapine Fumarate.Record review of Resident 111's physician orders, dated 01/30/2026, showed Resident 111 was prescribed Bupropion HCl (Hydrochloride, an anti-depressant) oral tablet 100 MG by mouth in the morning. Record review of the February 2026 EMAR showed Resident 111 was receiving Bupropion HCl every morning. Record review of Resident 111's physician orders, dated 01/30/2026, showed Resident 111 was prescribed Oxycodone HCl (pain medication) oral tablet 5 MG by mouth every four hours. Record review of the February 2026 EMAR showed Resident 111 was receiving Oxycodone as ordered. Record review of Resident 111's EHR did not show documentation of staff monitoring for adverse medication side effects while Resident 111 was receiving opiate, antidepressant and antipsychotic medications. In an interview on 02/20/2026 at 9:27 AM, Staff D, Resident Care Manager/Licensed Practical Nurse, reviewed Resident 111's EHR and said an AIMS test was not done. Staff D reviewed Resident 111's EHR and said there was no order or documentation monitoring for adverse side effects for Resident 111's opiate, anti-depressant or antipsychotic medications.In an interview on 02/24/2026 at 11:15 AM, Staff B, Director of Nursing/Registered Nurse, said she expected an AIMS test to be completed upon admission for residents taking antipsychotic medications. Staff B said she expected ASE were monitored for residents taking opiate, antidepressant and antipsychotic medications.Reference WAC 388-97-1060 (3)(k)(i)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) was completed accurately to reflect a resident's health status and/or care needs for 1 of 5 sampled residents (Resident 6) reviewed for unnecessary medications. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life.Findings included. Resident 6 was admitted to the facility on [DATE] with multiple diagnosis to include anxiety disorder (a group of mental health conditions that cause fear, dread, and other symptoms that are out of proportion to the situation) and post-traumatic stress disorder (PTSD, a mental health condition caused by an extremely stressful or terrifying event). The Quarterly MDS, dated [DATE], documented Resident 6 was cognitively intact, had anxiety disorder and PTSD, and was not taking antianxiety medications. Review of Resident 6's Electronic Health Record (EHR) showed a physician's order, dated 05/02/2025, for Buspirone HCL (hydrochloride, an antianxiety medication used to treat anxiety disorders) 10 milligrams (mg) three times a day. Review of the February 2025 Electronic Medication Administration Record showed Resident 6 was receiving Buspirone HCL 10 mg three times a day. In an interview on 02/24/2026 at 10:16 AM, Staff C, MDS Nurse/Registered Nurse (RN), said when completing the MDS, they would gather information by interviewing the resident and would look at medical records from the hospital and the facility. After looking at Resident 6's EHR, Staff C said Resident 6 was taking an antianxiety medication. Staff C said antianxiety medication use was not coded on the MDS and it should have been, stating, It looks like it was just missed. In an interview on 02/24/2026 at 10:38 AM, Staff B, Director of Nursing/RN, said it was her expectation the MDS was coded accurately to reflect medications taken by the residents. Reference WAC 388-97-1000 (2)(n)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received restorative aid (RA) services for 1 of 3 residents (Resident 10) reviewed for restorative services. These failures placed residents at risk for further decline and a diminished quality of life. Findings included .Resident 10 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, an assessment tool, dated 01/13/2026, indicated Resident 10 was severely cognitively impaired.Review of Resident 10's Restorative Ambulation care plan, dated 10/10/2025, showed Ambulation 3x/week with FWW (front-wheeled walker) and SBA (stand-by-assist) up to 300 ft. (feet) verbal cues to promote safety. Review of Resident 10's restorative range of motion care plan (passive), dated 10/02/2025, indicated AROM (active range of motion) to BUE (bilateral upper extremity) using orange band and provided handout. PT (physical therapy/ist) to complete 1 set of 10 reps of each exercise 3-5 x/week as tolerated.Record review of Resident 10's ambulation task sheet, dated 01/25/2026 to 02/23/2026, documented Resident 10 participated twice in one day on 02/20/2026, and refused four times on 01/26/2026, 02/04/2026, 02/07/2026, and 02/09/2026.Record review of Resident 10's AROM task sheet, dated 01/25/2026 to 02/23/2026, documented Resident 10 participated twice on 02/20/2026 and refused five times on 01/26/2026. 02/04/2026, 02/07/2026, 02/09/2026, and 02/11/2026.Review of Resident 10's electronic health record (EHR) progress notes, dated 02/18/2026 at 3:20 PM documented, Patient has refused RA program on multiple occasions. RA program D/C [discontinued] at this time for lack of participation.During an interview on 02/24/2026 at 1:42 PM, Staff B, Director of Nursing/Registered Nurse, said Resident 10 refused often. Staff B said RAs should be documenting the refusal in the EHR. Staff B said it looked as if Resident 10 only participated a couple of time. Staff B said RAs should have been offering services at least three times per week. Reference WAC 388-97-1060 (2)(a)(b)

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	505269	A. Building B. Wing	02/24/2026

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician's orders were updated to accurately reflect the resident's choices regarding code status for 1 of 2 residents (Resident 72) reviewed for Cardiopulmonary Resuscitation (CPR, an emergency lifesaving procedure that maintains blood flow and oxygenation to vital organs when the heart stops beating or breathing ceases). This failure placed the resident at risk of not having their end-of-life wishes honored and decreased quality of life.Findings included . Record review of the facility's policy titled, Communication of Code Status, dated [DATE], stated, .this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. Resident 72 was admitted to the facility on [DATE]. The admission Minimum Data Set, an assessment tool, dated [DATE], indicated Resident 72 was moderately cognitively impaired. Record review of Resident 72's physician order, dated [DATE], documented, Code Status: CPR, Full treatment, avoid TF [tube feeding, method of delivering nutrients directly into the stomach through a tube]. Record review of Resident 72's [NAME] POLST (Portable Orders for Life-Sustaining Treatment, a medical form that specifies a patient's wishes for emergency and end-of-life care), dated [DATE], was marked: Do not attempt resuscitation and Allow Natural Death.Record review of Resident 72's Order Summary Report/Active Orders as of [DATE], stated, Code Status: CPR, Full treatment, avoid TF, with an order date of [DATE].In an interview on [DATE] at 11:10 AM, Staff E, Registered Nurse, said she could find a resident's code status in PCC (Point Click Care, an electronic health records used by the facility), and explained that it's usually in the top margin under the resident's name. Staff E also said she usually started her shift by looking up what the resident's POLST directed, because sometimes the PCC orders for code status were not updated. In a combined interview on [DATE] at 11:20 AM, Staff B, Director of Nursing, and Staff D, Resident Care Manager, said staff could find a resident's code status in the header of PCC when they look up a specific resident. Staff B and Staff D said the PCC code status coincides with the resident's POLST. After Staff B and Staff D reviewed Resident 72's POLST, dated [DATE], both said Resident 72's code status should have been changed to DNR (Do Not Resuscitate) in PCC. Reference WAC 388-97-0280

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505269	A. Building B. Wing	02/24/2026

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain resident care equipment in a functional and safe manner, for 2 of 4 Mechanical Lifts (Hall 200). This failure placed residents who were dependent for transfers at risk for falls, avoidable injury, and a diminished quality of life.Findings Included. In an interview and observation on 02/19/2026 at 9:09 AM, Staff K, Certified Nursing Assistant (CNA), was observed to be pushing a Reliant Mechanical Lift (battery-powered, mobile floor lift designed to safely transfer residents from beds, chairs, toilets, or the floor) out of room [ROOM NUMBER]. Staff K said that particular lift appeared to be broken and pointed towards a broken off plastic part measuring approximately six inches by three inches in diameter, designed to encase/ cover the hydraulic pump/or motor at the center of the lift. Staff K said, there is another one down the hall. The legs keep coming together and is not safe with a heavy resident. When asked whether the maintenance department was aware of the lifts, Staff K said that they had been. Staff K said she preferred to use any other lifts if they were available. In an interview and observation on 02/19/2026 at 9:38 AM, Staff N, Resident Care Manager/ Licensed Practical Nurse, was asked to inspect the Mechanical Lifts on Hall 200 and demonstrate their proper function. Staff N observed the broken cover, and promptly took the lift off the hall, and notified the maintenance director directly. Staff N said it was the expectation for staff to report any equipment malfunctions to the maintenance department by submitting an electronic work order via Direct Supply TELS [cloud-based management system, designed to report, track, and prioritize facility repairs], although some report verbally. In an interview on 02/23/2026 at 2:03 PM, Staff K stated, They (Mechanical lifts) have not worked in a very long time. Staff K said she had not used TELS to report the malfunctions to the maintenance department and had informed them verbally. Staff K was unable to provide a time frame, or any additional information. In an interview and observation on 02/23/2026 at 3:16 PM, Staff M, Director of Maintenance, said no work orders had come in regarding Mechanical Lifts and provided a log of reported TELS work orders for the last 30 days. Staff M said the facility preferred to use TELS work orders, but some people did report work orders to the maintenance department verbally. When asked whether he was notified of concerns with Mechanical Lifts, Staff M stated, No. Staff M said he was notified today by Staff N, inspected both mechanical lifts, and deemed both unsafe. Staff M stated, they are both going into the dumpster. In an interview on 02/23/2026 at 2:03 PM, Staff A, Administrator, said staff are instructed to use the TELS to place work orders and was unaware of the any lifts malfunctioning. Reference WAC 388-97-2100(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505269	A. Building B. Wing	02/24/2026

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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 0910 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure resident rooms meet each resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure resident rooms provided enough space for comfort and privacy for 2 of 3 residents (Resident 1 & 24) reviewed for resident rooms. This failure to provide enough room could lead to a disruption of comfort and a diminished quality of life.Findings included.Resident 1 was admitted to the facility on [DATE]. The 5-Day Minimum Data Set (MDS), an assessment tool, dated 11/21/2025, indicated Resident 1 was dependent with transfers to and from a bed to a chair (or wheelchair), and was severely cognitively impaired.Record review of Resident 1's transfer care plan, dated 11/16/2025, indicated, Uses Hoyer lift [a mechanical patient lifting device used to transfer individuals with limited mobility safely between a bed & wheelchair] assistive device to transfer. Resident 24 was admitted to the facility on [DATE]. The Admission/Medicare - 5 Day MDS, dated [DATE], indicated Resident 24 was alert and oriented. During an observation on 02/18/2026 at 1:49 PM, room [ROOM NUMBER] had three beds in the room. Resident 1 had the bed next to the window. Resident 24 was in the middle bed, and one other resident had the bed closest to the door. Resident 1 and Resident 24 were lying in their beds.During an interview on 02/18/2026 at 2:28 PM, Collateral Contact 1, said Resident 1's room did not have enough room for a Hoyer lift. She said she would like Resident 1 to be in a double room.During an interview on 02/20/2026 at 9:50 AM, Resident 24 said the nursing assistants (NA) had to move his bed to get a Hoyer lift under Resident 1's bed. Resident 24 said the NA's had to disrupt him when they had to move his bed to make room for the Hoyer lift.During an observation on 02/20/2026 at 9:56 AM, Staff J, NA & Staff K, NA moved Resident 24's bed (Resident 24 was not in his bed at the time) to get the Hoyer lift positioned near Resident 1's bed. Once Resident 1 was up in the lift they pushed Resident 1's bed towards the window (making more room to get Resident 1's wheelchair next to the bed and Hoyer lift).During an interview on 02/20/2026 at 10:25 AM, Staff J said they had to move Resident 1's bed because of the limited space to get Resident 1 out of his bed and into his wheelchair.During an interview on 02/20/2026 at 4:06 PM, Staff A, Administrator, when asked about the limited space for the Hoyer lift use in Resident 1 and Resident 24's room, Staff A said the expectation was not to create an environment that makes residents feel like they don't have their own space for comfort. Reference WAC 388-97-2460