STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505276	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frontier Rehabilitation and Extended Care	1500 3rd Avenue Longview, WA 98632

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or resident representatives received information about the risk and benefits and obtain informed consent prior to the use of a Wander Guard (a device that detects when a resident approaches or passes through a monitored exit door, preventing elopement) for 1 of 2 sampled residents (Resident 102) reviewed for Wander Guard use. These failures placed residents and/or their representatives at risk of not being fully informed about the care and treatment related to the risks and benefits associated with the use of a Wander Guard.Findings Included.Review of the facility's Elopement/Wandering policy, dated February 2025, documented, if monitoring systems are used: 1. If it is determined that the resident is at risk for elopement and the center has a resident monitoring system installed, the following protocol is followed: a. The center notifies the resident or resident's responsible party of the results of the evaluation.Resident 102 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, an assessment tool, dated 02/23/2026, indicated Resident 102 was severely cognitively impaired.Review of Resident 102's Elopement Risk Evaluation, dated 02/23/2026, indicated Resident 102 was at risk for elopement related to (r/t) dementia.Review of Resident 102's care plan, dated 03/09/2026, indicated the problem: Resident 102 has impaired cognitive function or impaired thought processes, short term memory loss r/t metabolic encephalopathy [an acute brain dysfunction], dementia [a decline in cognitive function severe enough to impair daily life, caused by progressive brain damage]. The intervention: Resident uses Wander Guard for safety.Review of Resident 102's Electronic Health Records (EHR) progress notes did not show a consent for the Wander Guard.In an interview on 04/22/2026 at 1:36 PM, Staff H, Resident Care Manager/Licensed Practical Nurse, said if a resident appeared to be an elopement risk the facility would do an evaluation, get an order, get a consent, and put on the care plan. Staff H said the consent was verbal and would cover the risk and benefits of the Wander Guard. Staff H said staff would document the conversation in the progress notes.In an interview on 04/22/2026 at 2:01 PM, Staff B, Director of Nursing/Registered Nurse, said the facility would do an elopement evaluation, get an order and put on the care plan if the resident was deemed to be an elopement/wander risk. Staff B said they would get consent from the responsible part. Staff B said it should be documented in the progress notes.Reference WAC 388-97-0260 (2)(a)(b)(c)(d) & (3)(a)(b)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505276	A. Building B. Wing	04/23/2026

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Frontier Rehabilitation and Extended Care	1500 3rd Avenue Longview, WA 98632

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and/or maintain Advance Directives (AD) and/or Guardianship for 1 of 6 sampled residents (Resident 14) reviewed for AD. This failure placed residents at risk of not having their healthcare preferences honored and a diminished quality of life.Findings included. Resident 14 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated [DATE], documented Resident 14 had a diagnosis of Alzheimer's disease (a progressive disease that causes dementia, a decline in cognitive function), Non-Alzheimer's Dementia, Down Syndrome (a genetic condition that affects brain and body development leading to intellectual disabilities), and was severely cognitively impaired. Review of Resident 14's Electronic Health Record (EHR) showed Resident 14 had a Letter of Guardianship / Conservatorship from the Superior Court of [NAME], County of Cowlitz, dated [DATE]. Further review of Resident 14's EHR showed The Letter of Guardianship/Conservatorship expired on [DATE]. In an interview on [DATE] at 10:36 AM, Staff F, Social Services (SS) Assistant, said she did not have a process to get renewed guardianship papers after they expired. When asked about Resident 14's expired guardianship papers, Staff F said Resident 14 did not have a current guardianship in place. In an interview on [DATE] at 10:44 AM, Staff G, Community Relations/SS Director, said after Resident 14's guardianship expired, they should have obtained a new guardianship. In an interview on [DATE] at 1:37 PM, Staff B, Director of Nursing/Registered Nurse, said Resident 14 had a long-term guardianship in place, to include prior to admission to the facility. Staff B said they should have pursued a new guardianship for Resident 14 after it expired. Reference WAC 388-97-0280 (1)

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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 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 observation, 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 2 of 2 sampled residents (Residents 102 and 9) reviewed for accidents. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life.Findings included . Resident 102 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS - an assessment tool), dated 02/23/2026, indicated Resident 102 was severely cognitively impaired. Record review of Resident 102's Elopement Risk Evaluation, dated 02/23/2026, indicated Resident 102 was at risk for elopement related to (r/t) dementia (a decline in cognitive function severe enough to impair daily life, caused by progressive brain damage). Record review of Resident 102's care plan, dated 03/09/2026, indicated the problem, Resident 102 has impaired cognitive function or impaired thought processes, short term memory loss r/t metabolic encephalopathy [brain dysfunction caused by systemic illness, such as liver/kidney failure, diabetes, or infections rather than direct brain damage] dementia. The intervention, Resident uses Wander Guard [a security system that uses a wearable tag and/or sensor designed to prevent people with cognitive impairments from leaving secure areas to ensure their safety, by triggering alerts to caregivers] for safety. Record review of Resident 102's MDS, dated [DATE], under the Restraints and Alarms section did not indicate whether a Wander/elopement alarm was used. In an interview on 04/22/2026 at 1:27 PM, Staff K, MDS Coordinator/Registered Nurse, said there was a section on the MDS to identify if a resident was using a Wander Guard. Staff K said Resident 102 was not identified as using a Wander Guard. When asked how they would find out if a resident was currently on a Wander Guard, Staff K said they would look it up on the Medication Administration Record (MAR). After reviewing Resident 102's MAR, Staff K said the MDS should have identified the use of the Wander Guard. Resident 9 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 9 was severely cognitively impaired, had Non-Alzheimer's Dementia (a type of dementia, a decline in mental ability), and did not use a wander/elopement alarm (Wander Guard). Record review of Resident 9's elopement risk care plan, dated 05/23/2025, documented an Intervention/Task area, revised 04/01/2026, .WANDER [Guard] ALERT.This will be on his w/c [wheelchair]. In an observation on 04/22/2026 at 3:09 PM, Resident 9 was observed in his w/c in the dining room with a Wander Guard alarm attached to the right underside of the w/c frame. In an interview on 04/23/2026 at 8:30 AM, Staff H, Resident Care Manager/Licensed Practical Nurse, said Resident 9 had a Wander Guard alarm. Staff H said use of a Wander Guard alarm should have been captured on the MDS and it was not. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/23/2026 at 8:59 AM, Staff B, Director of Nursing/Registered Nurse, said it was her expectation there was a physician's order for use of a Wander Guard and it was captured on the MDS. Refer to F552 Reference WAC 388-97-1000 (1)(b), (2)(o)

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	505276	A. Building B. Wing	04/23/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I, a screening tool used to identify mental health needs, was requested upon a significant change of condition for 1 of 5 residents (Resident 12) reviewed for PASRR. This failure placed the residents at risk of unidentified mental health needs, and a diminished quality of life. Findings included . Record Review of the facility's policy, titled, PASRR Process Policy and Procedure, revised January 2025, documented, .4. If there is a significant change of condition that affects their diagnosed need for a PASRR II, staff refer for a NEW PASRR level II. Resident 12 was admitted to the facility on [DATE], with multiple diagnoses to include major depressive disorder (mood disorder characterized by persistent depressed mood), anxiety disorder (disorder characterized by excessive fear and worry), and psychotic disorder (severe mental illness causing to lose touch with reality). The Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/23/2026, showed Resident 12 was severely cognitively impaired and was exhibiting signs of physical and mental decline. Record review of Resident 12's Level I PASRR, dated 01/04/2018, documented Resident 12 did not require Level II PASRR. Record review of Resident 12's EHR (Electronic Health Record), documented Resident 12 was assessed for change of condition and started hospice care on 09/20/2024. Record review of Resident 12's EHR did not show documentation that a new Level I PASRR was completed upon Resident 12's significant change of condition. In an interview on 04/22/2026 at 9:42 AM, Staff F, Social Services Assistant, said the facility's practice was to complete a new PASRR following a significant change in condition. Staff F stated, We should have done a new one after significant change - especially when she went on hospice. During an interview on 04/22/2026 at 10:29 AM, Staff K, MDS Coordinator and Registered Nurse, said Resident 12 had a significant change assessment completed in 2024, due to a payor change and going on hospice services. In an interview on 04/03/2026 at 01:18 PM, Staff B, Director of Nursing and Registered Nurse, said it was the facility's practice to send new PASRR referrals following a significant change in condition. Staff B said Resident 12's new PASRR referral was not completed per facility policy. Reference WAC 388-97-1915 (4)

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	505276	A. Building B. Wing	04/23/2026

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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 observation, interview and record review, the facility failed to provide restorative nursing services for 1 of 2 sampled residents (Resident 106) reviewed for Rehabilitation and Restorative. This failure placed residents at risk for avoidable decline in function and a diminished quality of life.Findings Included. Resident 106 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 02/03/2026, documented Resident 9 was cognitively intact. In an interview on 04/20/2026 at 12:07 PM, Resident 106 said he was concerned about his hip. Resident 106 said he needed a Hoyer lift (a mechanical device that uses a sling to safely lift and transfer people with limited mobility between surfaces) for transfers. Resident 106 said he was not getting any rehabilitation or restorative services. In an observation and interview on 04/22/2026 at 12:56 PM, Resident 106 was observed sitting up in bed eating lunch. Resident 106 said he still had not received any restorative therapy and he should have. Record review of Resident 106's Impaired Mobility care plan, revised 02/25/2026, documented a Goal, revised 10/08/2025, Resident will not demonstrate evidence of contracture [a permanent abnormal tightening of muscles, tendon and/or ligaments resulting in stiff often painful joints and range of motion] to LE [lower extremity] with ROM [range of motion] program through next quarter. Further record review of the care plan documented an Intervention/Task, revised 10/31/2025, NURSING REHAB/RESTORATIVE: ACTIVE ROM Program ACTIVE ASSIST ROM TO LEFT knee 20 REPS [repetitions] FOR 2 SETS. Record review of Resident 106's Electronic Health Record (EHR) POC (point of care) Response History for Intervention: NURSING REHAB/RESTORATIVE: ACTIVE ROM Program ACTIVE ASSIST ROM TO LEFT knee 20 REPS FOR 2 SETS, dated 03/24/2026 through 04/22/2026, showed Resident 106's restorative program was provided on 03/27/2026, 03/29/2026, and 04/04/2026; 24 days since the last program was provided. Further review of Resident 106's EHR did not show any refusals of the restorative program. In an interview on 04/22/2026 at 1:00 PM, Staff H, Resident Care Manager/Licensed Practical Nurse, said the facility had their own restorative department. Staff H said all long-term care residents were on a restorative program unless they refused. Staff H said they documented the restorative program under the POC charting. After looking at Resident 106's EHR, Staff H said he had not recently received restorative services. In an interview on 04/22/2026 at 1:04 PM, Staff I, Restorative Aide/Certified Nursing Assistant, said Resident 106 was on a restorative program. Staff I said residents on a restorative program were supposed to be seen three times per week. Staff I said she had not seen Resident 106 this week for restorative. After looking at Resident 106's health record, Staff I said the last time Resident 106 got restorative was on 04/04/2026. Staff I said she did not see any refusals from Resident 106 for restorative. In an interview on 04/22/2026 at 1:29 PM, Staff B, Director of Nursing/Registered Nurse, said the restorative schedule was for three times per week. Staff B said Resident 106 was out of the facility frequently and they did not work with him on a regular basis. Staff B said they should be trying to provide restorative services around his schedule. Reference WAC 388-97-1060(1)

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	505276	A. Building B. Wing	04/23/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide activities of daily living (ADL) care for dependent residents to include nail care for 1 of 2 residents (Resident 67), reviewed for ADLs. This failure placed residents at risk of not receiving the care and services needed.Findings included . Resident 67 was admitted on [DATE]. Record review of Resident 67's care plan, dated 04/08/2026, documented the problem for Resident 67 was an ADL [activities of daily living - basic self-care task to include nail care] self-care performance deficit r/t [related to] Dementia [a decline in cognitive function-memory, thinking, and behavior-severe enough to impair daily life, caused by progressive brain damage]. The care plan intervention - Diabetic Nail care by LN [licensed nurse]. Record review of Resident 67's Kardex (a centralized record of resident's care plan), dated 04/08/2026, indicated Diabetic Nail care by LN. Record review of Resident 67's Treatment Administration Record's, dated 04/06/2026, 04/13/2026, and 04/20/2026, weekly skin audit documented the audits were completed but no documentation nail care had been performed. In an interview and observation on 04/20/2026 at 10:56 AM, Resident 67's fingernails were observed to be about an 1/8 inch long. When asked if he liked long fingernails, Resident 67 said he liked them short. Resident 67's said they told the facility his toenails needed clipped as well. In an interview and observation on 04/23/2026 at 8:12 AM, when asked if his nail care had been done, Resident 67 said no and showed his long fingernails. In an interview and observation on 04/23/2026 at 8:18 AM, Staff L, Resident Care Manager/License Practice Nurse, said diabetic nail care should be completed during the weekly skin assessment. When asked to look at Resident 67's toenails, Staff L removed Resident 67's right sock, with Resident 67's approval, the toenails were observed to be about 1/4 inch long. Reference WAC 388-97-1060 (2)(c)

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	505276	A. Building B. Wing	04/23/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain and/or initiate physician orders for use of a Wander Guard alarm (a security system that uses a wearable tag and/or sensor designed to prevent people with cognitive impairments from leaving secure areas to ensure their safety, by triggering alerts to caregivers) for 1 of 2 sampled residents (Resident 9) reviewed for accidents. This failure placed residents at risk of injury, unmet care needs, and a diminished quality of life.Findings included. Record Review of the facility's policy titled, Elopement/Wandering, updated February 2025, documented, . If monitoring systems are used: . b. The center obtains a physician's order for the use of the device prior to application. c. The LN [Licensed Nurse] also obtains an order to complete an evaluation for placement and function every shift. Documentation to occur on the MAR [Medication Administration Record] or TAR [Treatment Administration Record] . Resident 9 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/17/2026, documented Resident 9 was severely cognitively impaired and had Non-Alzheimer's Dementia (a type of dementia, a decline in mental ability). Record review of Resident 9's elopement risk care plan, dated 05/23/2025, documented an Intervention/Task area, revised 04/01/2026, .WANDER [Guard] ALERT.This will be on his w/c [wheelchair]. In an observation on 04/22/2026 at 3:09 PM, Resident 9 was observed in his w/c in the dining room with a Wander Guard alarm attached to the right underside of the w/c frame. Record Review of Resident 9's active physician orders, dated 04/21/2026, did not show an order for the use of a Wander Guard alarm and/or evaluation by the LN to check for placement and function every shift. Record Review of Resident 9's April 2026 MAR and TAR did not show documentation of evaluation for placement and function of a Wander Guard alarm. In an interview on 04/23/2026 at 8:30 AM, Staff H, Resident Care Manager/Licensed Practical Nurse, said Resident 9 had a Wander Guard alarm. Staff H said residents that used a Wander Guard needed a physician's order for use and to check for placement and functioning every shift that the nurses signed off. Staff H said Resident 9 did not have a current order for the Wander Guard and there should have been. In an interview on 04/23/2026 at 8:59 AM, Staff B, Director of Nursing/Registered Nurse, said it was her expectation there was a physician's order for use of a Wander Guard and it was captured on the MDS. Reference WAC 388-97-1060 (3)(g)

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	505276	A. Building B. Wing	04/23/2026

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing information was accurately posted and/or updated daily with resident census for 5 of 5 observed days posted, and with the facility name for 34 of 34 days reviewed for nurse staff postings. This failure placed residents, resident representatives, and visitors at risk of not being fully informed of current staffing level and facility information.Findings included. In an observation on 04/20/2026 at 10:14 AM, two Daily Nursing Staffing Information postings, dated 04/19/2026 and 04/20/2026, were observed posted on the wall in the entrance lobby of the facility. There was no title and/or label observed on the wall near the postings with the facility name. Further review of both postings showed the resident census was blank and the facility name was not on the postings. In an observation on 04/21/2026 at 8:10 AM, two Daily Nursing Staffing Information postings, dated 04/20/2026 and 04/21/2026, were observed posted on the wall in the entrance lobby of the facility. Further review of both postings showed the resident census was blank and the facility name was not on the postings. In an observation on 04/22/2026 at 4:00 PM, two Daily Nursing Staffing Information postings, dated 04/21/2026 and 04/22/2026, were observed posted on the wall in the entrance lobby of the facility. Further review of both postings showed the resident census was blank and the facility name was not on the postings. In an observation on 04/23/2026 at 8:46 AM, two Daily Nursing Staffing Information postings, dated 04/22/2026 and 04/23/2026, were observed posted on the wall in the entrance lobby of the facility. Further review of both postings showed the resident census was blank and the facility name was not on the postings. Record review of the Daily Nursing Staffing Information postings, dated 03/21/2026 through 04/18/2026, showed no facility name on the postings. In an interview on 04/23/2026 at 11:11 AM, Staff J, Receptionist/Staffing, said she did not get the census information for the facility until the next day. Staff J said she received yesterday's census information this morning. Staff J said she would add the previous day's census information to the posting the next day. Staff J said she did not know the daily nurse staff postings were supposed to have the current day's census and name of the facility on it. In an observation and interview on 04/23/2026 at 11:21 AM with Staff C, Divisional [NAME] President of Operations, Staff C observed the two Daily Nursing Staffing Information postings, dated 04/22/2026 and 04/23/2026, on the wall in the entrance lobby of the facility with the resident census blank and no facility name on the postings. Staff C said he expected the title of the facility was on the nurse staff postings and the daily census was posted for the current day. No WAC Reference