STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505283	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkston Health and Rehab of Cascadia	1242 Eleventh Street Clarkston, WA 99403

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to post survey results in a place readily accessible and frequented by most residents, as required. This failure placed residents at risk of being unable to exercise their resident rights.Findings included .During observation on 08/11/2025 at 4:45 AM, the facility's main lobby was entered. The lobby was a small foyer and contained a reception desk to the right with a few chairs. Within of few feet of walking into the building an elevator was observed straight ahead, to the left of the elevator was a set of stairs that led downstairs to the first floor that contained resident rooms, to the left of that was a set of stairs that led upstairs to the second floor that contained resident rooms, and a binder that contained survey results was posted on the wall at the base of the stairs that led to the second floor. In an interview on 08/13/2025 at 10:06 AM, the Resident Council was asked without having to ask, are the results of our inspections available for you to read? Only one of 16 residents in attendance voiced knowing the survey results were posted in the main lobby. The Council then stated the lobby was locked because of the elevator and explained staff needed to enter an elevator code to access the lobby so residents would have to ask staff for assistance to access the lobby. The Council unanimously agreed. During an interview on 08/14/2025 at 7:20 AM Staff S, Nursing Assistant, stated the elevator only required a code to access the lobby not the floors that contained resident rooms. Staff S explained only residents who were safe enough could independently access the lobby. During observation on 08/14/2025 at 8:13 AM, the facility elevator contained a number keypad at eye level, when standing. Above the keypad was a small white label with a spelled-out number code that needed to be entered in order to access the facility's main lobby. Below the written code was a white sign that read please do not enter lobby code for residents without staff knowledge or supervision. In an interview on 08/14/2025 at 11:36 AM, Staff T, Registered Nurse, stated a code needed to be entered into the elevator to access the lobby, this was a safety measure to prevent confused residents from accidently exiting the front door. Staff T acknowledged residents typically did not frequent the lobby unless they had an appointment. Staff T further stated residents and visitors did not really see the elevator code sticker and often pressed the lobby button but did not go anywhere, they just sat there waiting for the elevator to move. Staff T stated residents had the right to see the results of the survey inspections. In an interview on 08/14/2025 at 11:52 AM, Staff E, Resident Care Manager, explained the elevator had a code for safety, to ensure residents that wandered did not get to the lobby. Staff E explained residents could move freely between the first floor and second floor, but a code was needed to access the lobby. Staff E further stated, not all residents can or should access the lobby. Staff E acknowledged residents should be able to access survey results without having to ask staff. In an interview on 08/14/2025 at 1:02 PM, Staff B, Director of Nursing, explained the purpose of the elevator code was to prevent confused residents from wandering outside because they should not be able to enter the elevator code to access the lobby. Staff B stated the survey results were posted in the lobby. Staff B further explained that the residents who could not access the lobby by themselves were also the residents that were unable to read the survey results, but they could have access to the lobby if they were accompanied by staff. In an interview on 08/18/2025 at 11:12 AM, Staff A, Administrator, stated (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the survey result binder was absolutely posted in a place that was readily accessible and frequented by residents. Reference WAC 388-97-0480

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure meals were served at palatable temperatures for 2 of 6 sampled residents (Residents 17 and 42) reviewed and 1 of 1 meal test trays sampled. This failure put residents at risk of decreased enjoyment of their meals, and possible reduced dietary intake. Findings included . According to the Washington State Food Handlers Guide Website, the Washington State Department of Health Safety and Licensing Division recommended that all potentially hazardous foods be held at a temperature of 41 degrees Fahrenheit (F) or below in commercial refrigerators and freezers. This included meats, fish, poultry, eggs, dairy products, cooked vegetables, cooked rice and pasta, cut melons, and other perishable items. All frozen foods were to be stored at 0 degrees F or below. Hot food items were to be held at a temperature of 140 degrees F or above. <Resident 17> The 08/06/2025 quarterly assessment documented Resident 17 had diagnoses which included a stroke, malnutrition and depression. The assessment further documented the resident was cognitively intact and was able to make their needs known. In an observation and interview on 08/11/2025 at 12:02 PM, Resident 17 was sitting on the side of their bed in their room. Resident 17 stated their food was always cold. In an observation and interview on 08/13/2025 at 8:19 AM, Resident 17 was lying in bed. The resident stated it was a wonder they got hot food, and it was better this morning. In an interview on 08/14/2025 at 10:02 AM, Resident 17 stated the eggs [NAME] they had for breakfast were cold. In an observation and interview on 08/15/2025 at 8:36 AM, Resident 17 was sitting up in bed eating biscuits and gravy. The resident stated it was cold, and they had to send it back. <Resident 42> The 07/09/2025 quarterly assessment documented Resident 42 had diagnoses which included heart failure, high blood pressure and diabetes. The assessment further documented the resident was cognitively intact and was able to make their needs known. In an observation and interview on 08/11/2025 at 7:02 AM, Resident 42 was sitting in their wheelchair in the hallway. The resident stated the food was usually good but it was cold. In an observation and interview on 08/13/2025 at 8:13 AM, Resident 42 was sitting in their wheelchair in the dining room eating breakfast. The resident stated the eggs were cold. In an interview on 08/18/2025 at 8:47 AM, Resident 42 stated the waffle for breakfast was cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and sampling of the lunch meal served on 08/15/2025, the temperatures of the food items were outside of the acceptable parameters and were as follows: mashed potatoes 118 degrees F and the carrots were 126 degrees F. <Resident Council> Review of May 2025 through July 2025 resident council minutes showed the council voiced concern of cold food during meals, all three months. During an interview on 08/13/2025 at 9:54 AM, the resident council stated cold food was still an ongoing issue. The council stated, today was the first day the eggs were hot and explained the food was typically lukewarm. In an interview on 08/18/2025 at 12:27 PM, Staff Z, Dietary Manager, stated it was important to serve food at appropriate temperatures to prevent foodborne illnesses. Reference: WAC 388-97-1100 (1)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety. Specifically, food was not labeled, dated or discarded when expired for 5 of 5 refrigerators, and 1 of 1 dry storage areas. The facility failed to perform hand hygiene when indicated during the meal service and to maintain a clean cooking environment. These failures placed residents at risk for foodborne illnesses.Findings included . <Expired/undated food>During an initial tour of the kitchen on 08/11/2025 at 5:38 AM, the dry storage area revealed a container of Frank's red-hot sauce that expired on 10/26/2023. An observation of the large walk in refrigerator on 08/11/2025 at 5:50 AM revealed 11 boxes of Thick and Easy (a powdered substance used to thicken liquids) that expired on 05/30/2025, a box of apples that contained two brown moldy apples, three bags of wilted spinach that was wet and soggy, two bags of brown wilted lettuce, and two bags of brown wilted salad mix. On 08/11/2025 at 6:20 AM, the refrigerator near the middle of the kitchen contained a lemon cream pie and three apple pies with no dates. The refrigerator near the back of the kitchen contained a bag of salad mix that said it was to be used by 08/07/2025. In an interview on 08/11/2025 at 6:31 AM, Staff Y, Cook, stated the dietary manager monitored the dates on the food. Staff Y stated when freight was delivered, the night shift staff dated it, and every food item should have had a received by date. Staff Y stated it was important to date food, so you knew how long you had it and when it expired. The main refrigerator had waffles and two packages of French toast with no dates. Staff Y was unable to find any dates on the packages. On 08/11/2025 at 7:52 AM, the refrigerator in the Cabin Cove dining room contained a sandwich and three fruit cups that had no date on them. There was a bag of huckleberries for Resident 75 that had no date and a chef salad for Resident 18 that had no date. On 08/18/2025 at 12:03 PM, the refrigerator in the [NAME] dining room contained a container of Med Plus 2.0 vanilla nutritional drink that was opened on 08/02/2025. Staff Y, Cook, stated the nutritional drink had to be discarded within seven days of opening it. There was a frozen chocolate milkshake in the freezer with no date or name. Staff Y stated the refrigerator was for the residents. <Food Temperatures>During an observation of the lunch meal service on 08/15/2025 at 11:18 AM, Staff Y, Cook, had checked the temperatures of the cold items. The milk was 42.8 degrees Fahrenheit (F), and the cookie dessert was 44.9 degrees F, all above the recommended food temperature of 40 degrees. At 11:27 AM, Staff Y put on gloves and plated the food, while Staff EE placed the cold items on the trays. On 08/15/2025 at 11:41 AM, Staff Y checked the temperatures of the pureed food (altered food texture that resembled the consistency of applesauce). The pureed corn chowder soup was 111 degrees F, below the recommended food temperature of 140 degrees F. On 08/15/2025 at 11:58 AM, Staff Y checked the temperature of the cheese sandwiches which was 57.3 degrees F and the chef salad was 47.4 degrees F, above the recommended temperature of 40 degrees F. On 08/15/2025 at 12:07 PM, Staff EE placed the milk on the meal tray to be served. When asked what temperature of cold items needed to be, Staff Y stated below 42 degrees, explained the temperature had to be 40 degrees F or below and they removed the milk from the meal tray. At 12:08 PM, Staff EE placed the cookie dessert on the meal tray and was going to serve it until they were asked what the temperature had to be. At 12:12 PM, Staff Y placed the cheese sandwich on the meal tray to be served. Staff Y was asked what the temperature had to be and they removed the sandwich. In an observation on 08/15/2025 at 12:21 PM, Staff Y stated they had to give a resident their chef salad because they would not eat fish. Staff Y re-temped the salad and it was 53 degrees F. Staff Y took the salad back to the kitchen. At 12:28 PM, Staff Y entered the dining room with a new chef salad and the temperature was 51 degrees F. At 12:21 PM, Staff Y rechecked the temperature of the salad and it was 50 degrees F. Staff Y served the salad to the resident despite the temperature being above the recommended temperature for cold foods. On (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	08/15/2025 at 12:44 PM, Staff Y entered the Cabin Cove dining room, which was the last dining room to be served. The temperature of the cheese sandwiches that were just made was 41 degrees which contained mayonnaise. The temperature of the soft and bite sized fish was 131 degrees F. At 12:58 PM Staff Y plated the fish and was going to serve it. When asked about the temperature of the food, Staff Y removed the fish and gave the resident soup. At 12:59 PM, Staff Y served the cheese sandwiches despite them not meeting the recommended temperature for cold food. On 08/15/2025 at 1:10 PM, during a sampling of the lunch meal, the temperature of the mashed potatoes was 118 degrees F and the carrots were 126 degrees F, all below the recommended temperature of 140 degrees F for hot food. <Hygiene>In an observation on 08/15/2025 at 11:28 AM, Staff EE took their arm and wiped their mouth while standing over the food. In an observation on 08/15/2025 at 11:29 AM, Staff Y touched a book with their gloves and then grabbed drinks for a resident and placed them on their tray. On 08/15/2025 at 11:29 AM, Staff EE left the kitchen wearing a pair of gloves. Staff EE re-entered the kitchen at 11:30 AM wearing a pair of gloves and continued to place cold items on food trays after touching the door with their gloves. At 11:31 AM, Staff EE scratched the back of their head with their gloves while they placed cold items on meal trays. On 08/15/2025 at 11:33 AM, Staff Y touched the potatoes with their gloved hands that they touched the binder with and cut the potatoes in half. At 11:36 AM, Staff Y picked up the potato they had cut in half and touched the inside of the potato the resident was going to consume. On 08/15/2025 at 11:36 AM, Staff EE removed their gloves and touched their face and rested their arms on the meal cart that contained the cold food items. On 08/15/2025 at 11:37 AM, Staff Y dropped a piece of tin foil on the ground and picked it up and did not perform hand hygiene. Staff Y wearing the same gloves loaded the leftover food and condiments into the cart. At 11:39 AM, Staff Y took the small food cart back to the kitchen and without performing hand hygiene, emptied the leftovers into the steam table (a cart to keep the food hot). On 08/15/2025 at 11:54 AM, Staff EE wiped the tip of their nose with their finger and put trays on top of the steam cart and grabbed meal cards without hand hygiene being performed. At 11:55 AM, Staff EE adjusted their hair net and put on gloves without hand hygiene being performed. At 12:05 PM, Staff EE pulled their cell phone out of their pocket with their gloved hands and without hand hygiene being performed, they continued putting cold food items on meal trays. On 08/15/2025 at 12:11 PM, Staff Y dropped some sour cream packets on the floor, picked them up with their gloved hands and put them back in the container to be served to the residents. Staff Y kept the same gloves on and then adjusted their pants and continued to serve food. On 08/15/2025 at 12:13 PM, Staff EE while wearing gloves, opened the lid to the garbage and threw away some cheese sandwiches. Staff EE wearing the same gloves continued to place cold food items on meal trays. At 12:15 PM, Staff EE wiped their forehead with their arm while putting cold food items on the trays next to Staff Y who was plating food. On 08/15/2025 at 12:17 PM, Staff Y continued cutting potatoes in half and touching the fish with the same gloved hands they used to pick up the sour cream packets from the floor. On 08/12/2025 at 12:25 PM, Staff EE rested their hands on the steam table that contained food and rubbed their nose with their gloves. On 08/15/2025 at 12:36 PM, Staff Y picked up a container of crackers that were placed on the floor in the dining room and put them at the bottom of the steam cart. On 08/15/2025 at 1:02 PM, Staff Y wiped the side of their face on their shirt while standing over the food and plating it. <Sanitary Environment>In an observation of the kitchen on 08/11/2025 at 6:18 AM, the floor under the steamer and stove were covered with food debris and dirt and the oven had thick burned food debris on the bottom. In an observation on 08/11/2025 at 6:23 AM, the outside of the ice machine had white splatter and dust on it. There was a floor mat in front of the ice machine that had dirt and debris under it and the floor around the ice machine had dirt and debris. In an observation on 08/11/2025 at 6:40 AM, the floors in the dry storage room had liquid spills, garbage, and spilled cereal on the floor. The floors in the walk-in refrigerator were dirty with spills and food debris. In an observation on 08/11/2025 at 7:52 AM, the Cabin Cove refrigerator was unclean with juice spilled on the bottom shelf. In an interview on 08/18/2025 at 12:27 PM, Staff Z, Dietary Manager, stated staff were to (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	check for dates and expired food every time they walked into the refrigerator. Staff Z stated they tried to put the old freight up front and the new freight in the back. Staff Z stated it was important to date and discard expired food to prevent foodborne illness. Staff Z stated it was important to serve food at the appropriate temperatures to prevent illness, and the food should be heated and held at the appropriate temperatures. Staff Z stated it was important to maintain the temperature of the cold food, so it did not spoil. Staff Z stated hand hygiene and gloves were to be changed when their gloves became soiled and staff should not have picked up food items off the floor and put them back in the container to be served. Staff Z stated staff were not to touch their hair, face, or anything and if they did, they needed to discard their gloves, perform hand hygiene and put a new pair on. Staff Z stated it was important to maintain hygiene to prevent food contamination and illness. Staff Z stated whoever accepted food items that needed refrigeration were responsible to label and date them and housekeeping was to keep the refrigerators clean. Staff Z stated the refrigerators and floors in the kitchen needed to be kept clean for sanitization. Reference: WAC 388-97-1100 (3), 2980

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure Pre-admission Screening and Resident Review (PASARR, an assessment completed prior to admission into a skilled nursing facility to determine whether a resident with a diagnosis of a serious mental illness needed specialized mental health services) was accurately completed prior to admission, and if indicated, a referral for a PASARR Level II (a more in-depth screening assessment) was made for 3 of 7 sampled residents (Residents 1, 24, and 70), reviewed for PASARR. Specifically, Resident 1 and 24's PASSAR Level I was inaccurately completed prior to admission. In addition, Resident 1 admitted to the facility with an exempted hospital stay and should have been referred for a Level II evaluation after they remained in the facility for more than 30 days. This failure placed the residents at risk for unidentified care needs related to their mental health and a diminished quality of life.Findings included. Review of the facility policy titled, Pre-admission Screening and Resident Review (PASARR) revised November 2024, showed a PASARR screening sheet was completed prior to admission, a negative Level 1 screen permitted admission to proceed and ended the pre-screening process unless possible serious mental disorder or intellectual disability arose later. A positive Level 1 screen required a PASARR Level II screen be conducted prior to facility admission. Individuals who had or were suspected to have a mental disorder or related conditions were not permitted for admission unless approved based on the Level II evaluation and determination. For residents admitted to the facility as an exception (an exempted hospital discharge) and was later found to require more than 30 days of nursing facility care, the State mental health or intellectual disability authority must conduct a Level II resident review within 40 calendar days of admission. <Resident 24> According to the 05/24/2025 admission assessment, Resident 24 admitted to the facility on [DATE] with diagnoses including anxiety, depression, nightmare disorder, and Post Traumatic Stress Disorder (PTSD, a condition that may develop after experiencing or witnessing a terrifying event where life was threatened or severe injury occurred). The assessment further showed Resident 24 had severe cognitive impairment. Review of the 05/20/2025 PASARR showed Resident 24 showed indicators of a serious mental illness. The PASARR identified Resident 24 as No Level II evaluation indicated related to not showing indicators of serious mental illness or related conditions. Review of May 2025 through August 2025 social service progress notes showed no documentation Resident 24's PASARR Level I was redone or referred for Level II evaluation as required. In an interview on 08/14/2025 at 9:47 AM, Staff C, Social Service Director (SSD), explained a PASARR was received with preadmission paperwork, reviewed for accuracy, fixed if inaccurate, and sent off for Level II evaluations when indicated. Staff C reviewed Resident 24's PASARR. Staff C stated they were unaware the PASARR guidance changed in July 2024. <Resident 1> According to the 06/21/2025 admission assessment, Resident 1 admitted to the facility on [DATE] with diagnoses including anxiety, depression, bipolar disorder (mental health condition that caused (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	extreme shifts in mood, energy, and ability to function, swinging between periods of elevated mood and periods of depression), suicidal ideations (thoughts or rumination of dying by suicide), and PTSD. Resident 1 was cognitively intact and able to clearly verbalize their needs. Review of the 06/17/2025 PASARR showed Resident 1 showed indicators of a serious mental illness. The PASARR identified Resident 1 as an exempted hospital stay and would likely require fewer than 30 days of nursing facility services. A Level II must be completed if scheduled discharge does not occur. Review of June 2025 through August 2025 social service progress notes showed no documentation Resident 1's PASARR Level I was redone or referred for Level II evaluation as required when they did not discharge the facility within 30 days as anticipated. In an interview on 08/14/2025 at 9:55 AM, Staff C reviewed Resident 1's medical record. Staff C stated Resident 1 admitted with an exempted hospital discharge PASARR and their planned discharge had not occurred yet. Staff C explained when a resident admitted with a hospital exempted stay, a new PASARR was not redone or referred for a Level II evaluation within the 30 days because they thought the PASARR had to be redone or referred if their normal scheduled discharge did not occur whenever that may be, even if it was beyond the 30-day hospital exemption. Staff C acknowledged Resident 1's PASARR was not redone or referred for a Level II evaluation, as required. <Resident 70> The 07/09/2025 quarterly assessment documented Resident 70 admitted to the facility on [DATE] with diagnoses which included depression and dementia. The assessment further showed Resident 70 had severe cognitive impairment. Review of the 08/22/2024 PASARR showed Resident 70 had indicators of a serious mental illness. The PASARR identified Resident 70 as No Level II evaluation indicated related to not showing indicators of serious mental illness or related conditions. Review of May 2025 through August 2025 social service progress notes showed no documentation Resident 70's PASARR Level I was redone or referred for Level II evaluation as required. In an interview on 08/14/2025 at 1:15 PM, Staff C stated Level II PASARR's were completed based on the resident's mental health, medications and diagnoses. Staff C stated Resident 70 should have had a Level II PASARR completed but was unaware the guidelines had changed. Staff C stated it was important to complete Level II PASARR's, so the residents were appropriately assessed for their mental health needs. In an interview on 08/14/2025 at 1:27 PM, Staff B, Director of Nursing, stated their expectation was for residents to be referred for Level II PASARR's when indicated and it was important so that all their mental health needs were addressed. In an interview on 08/18/2025 at 11:12 AM, Staff A, Administrator, stated they expected staff to ensure PASSAR Level I was completed accurately, exempted hospital stay PASARRS were re-done when indicated, and PASARRs referred for Level II evaluations as indicated. Refer to WAC 388-97-1915 (1)(2)(a-c)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise comprehensive care plans for 4 of 5 sampled residents (Residents 81, 5, 22 and 9) whose care plans were reviewed for pressure ulcers, restorative nursing programs, dental care, and advanced directives. Additionally, the facility failed to ensure Resident 42 and/or their representative were offered the opportunity to participate in care planning. These failures placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . <Advanced Directives> <Resident 81> Review of a 07/16/2025 quarterly assessment showed Resident 81 admitted to the facility on [DATE] with diagnoses including stroke with right-sided hemiplegia (total or partial paralysis on one side of the body). The assessment showed the resident had moderately impaired cognition. Review of a 08/03/2022 POLST (Physician Orders for Life Sustaining Treatment, a written medical order from a provider that helps give people more control over their own care by specifying the types of medical treatment they want to receive during a serious illness) showed the choice of Do Not Attempt Resuscitation [DNR] or Allow Natural Death if the staff found Resident 81 with no pulse and not breathing. Review of an 08/05/2022 care plan showed, Honor resident's code status: FULL CODE, contrary to the choice of DNR in the POLST. The above findings were shared with Staff B, Director of Nursing, on 08/13/2025 at 12:44 PM. Staff B acknowledged the care plan should have been but was not updated to show Resident 81's choice in the POLST. <Restorative Nursing Program> <Resident 22> Review of a 07/16/2025 quarterly assessment showed Resident 22 admitted to the facility on [DATE] with medically complex conditions, was cognitively impaired and had limitation in range of motion (ROM, the extent to which a joint can move) to one side of their body. An observation on 08/11/2025 at 7:13 AM showed Resident 22 sitting in a wheelchair across the nurses' station, glasses on and an orthotic brace (a custom or prefabricated device that provides support, stability, and protection to the forearm, wrist, and hand to improve function, reduce pain, and promote healing for various musculoskeletal conditions) to the right forearm. Review of the Restorative Nurse Notes of 01/15/2025, 04/16/2025 and 07/16/2025 showed Resident 22 was, not currently working with restorative. Resident was currently working with the therapy department. Will eval [evaluate] quarterly and PRN [as needed]. Review of a 03/22/2022 care plan showed Resident 22 required a ROM program r/t [related to] physical weakness, risk for contractures and Review restorative program routinely to validate (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effectiveness. Adjust program as indicated. In an interview on 08/15/2025 at 8:45 AM, Staff R, Restorative Nurse, stated Resident 22 was not on a Restorative Nursing Program (RNP) for the ROM and the RNP was resolved on 01/06/2025. Staff R acknowledged the care plan should have been but was not updated. <Denture Care> <Resident 5> A review of a 06/09/2025 Medicare 5-day assessment showed Resident 5 admitted to the facility on [DATE] with medically complex conditions and was cognitively intact. This assessment showed the resident was dependent on the staff to use use suitable items to clean teeth, to include dentures and their related care (like ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment). The assessment also showed Resident 5 was at risk for developing pressure ulcers (bed sores) and used a pressure reducing device for the bed. In an interview and observation on 08/11/2025 at 8:45 AM, a denture cup was observed sitting on Resident 5's bedside table. Inside the denture cup was a full set of dentures in water. A somewhat transparent film was observed on the water. Resident 5 was in bed sitting up and said the dentures, been sitting in that water for a long period of time. [The staff] just soak them in water. Review of Resident 5's care plan showed no recognition of the presence of dentures or their related care. In an interview on 08/18/2025 at 9:23 AM, Staff H stated they became aware of what kind of dental care a resident required by reviewing their Kardex (an abbreviated care plan for the nursing assistants). Staff H said dentures required brushing them with a denture brush and then soaking overnight. Staff H said Resident 5 owned dentures. In an interview on 08/18/2025 at 8:57 AM, Staff I, Registered Nurse, said they expected denture care to be in the care plan or in the Tasks section of the electronic record and that dentures should be cleaned on day shift and night shift, and at night placed in a denture cup soaked in water with a denture cleanser tablet. The use of denture adhesive was a resident preference. Staff I confirmed Resident 5 owned a full set of dentures and the care plan showed no indication of the existence of dentures and their required care. <Specialty Mattress Settings> In an interview and observation on 08/11/2025 at 8:54 AM, Resident 5 said, There's potholes everywhere in this mattress. Observed was a motor pump to the foot board of the bed which showed the mattress setting was set to Firm as opposed to normal pressure. Resident 5 added, I feel like I'm sitting on two cinder blocks, and I cry. This is like medieval times and I'm gonna' get one [a pressure ulcer]. Resident 5 stated their left butt bone was sore but not open. Review of Resident 5's care plan showed, Air mattress to bed but showed no direction to the setting required to provide prevention of pressure ulcers and comfort for the resident. Review of the rest of the medical record showed no instruction on the pump setting required to prevent pressure ulcers and maintain comfort. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 9> Review of an 08/06/2025 quarterly assessment showed Resident 9 admitted to the facility on [DATE] with weakness and heart and lung conditions, dementia, and seizures. This assessment showed the resident was at risk for developing pressure ulcers and was dependent on the staff for turning and repositioning. Review of Resident 9's medical record showed a 05/04/2023 Order Summary for a bariatric bed (a specialized bed designed to safely accommodate and support individuals with a higher body weight, often exceeding 350 pounds) with an air mattress to allow for more room for bed mobility and prevent skin impairments. Additionally, the care plan reiterated the use of a bariatric bed with an air mattress since 05/04/2023. No settings to ensure comfort and prevent pressure ulcer development were identified either in the order summary or the care plan. In an interview on 08/18/2025 at 9:12 AM Staff I, Registered Nurse, said information related to specialty mattress settings was found either in the care plan or the Treatment Administration Record (TAR). Staff I confirmed Resident 5's and 9's medical record showed no indication of the settings required to prevent pressure ulcers and provide comfort and that it should because, If it's at the wrong setting it could cause a sore. The above findings were shared with Staff B, Director of Nursing, on 08/18/2025 at 10:46 AM. Staff B said the care plan should show instructions for denture care. Staff B acknowledged Resident 5's and 9's medical records or care plans showed no information related to denture care or mattress settings. <Resident 42> The 07/09/2025 quarterly assessment documented Resident 42 had diagnoses which included heart failure, high blood pressure and diabetes. The resident was cognitively intact and able to make their needs known. In an interview on 08/12/2025 at 9:17 AM, Resident 42 stated they had not been invited to a care conference. A review of Resident 42's medical record showed no care conference notes from 01/01/2025 through 08/13/2025. The record showed the resident had quarterly assessments completed on 04/09/2025 and 07/09/2025. In an interview on 08/13/2025 at 2:28 PM, Staff E, Resident Care Manager, stated care conferences were held within 24 to 72 hours of admission and quarterly thereafter. Staff E stated the residents and family members were invited to attend. Staff E added the care conferences were documented under evaluations and it was important to have care conferences, so the residents and family had a say in their care and knew what was going on while in the facility. In an interview on 08/13/2025 at 2:35 PM, Staff C, Social Service Director, stated care conferences were documented under evaluations or in the progress notes. Staff C showed a psychological evaluation form dated 01/10/2025 and stated it was Resident 42's initial care conference. Staff C stated Resident 42 should have had a care conference in April, but they completed it in May. Staff C stated they discussed the resident's condition with their family member. The progress note did not address the required elements of a care plan conference. There was no mention of Resident 42's care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan, medications, or how they were doing with activities of daily living. Staff C stated Resident 42 was ill at the time. Staff C stated the resident was due for a care conference in July and they were unsure why this did not occur. Staff C checked their calendar for August and Resident 42 was not scheduled for a care conference. In an interview on 08/13/2025 at 3:13 PM, Staff B, Director of Nursing, stated care conferences needed to have the interdisciplinary team present. Staff B stated the resident's medications, code status, immunizations, therapy, and activity preferences were discussed at the care conference. Staff B stated it was important to have care conferences because it was the main source of communication with the residents and their families and to ensure the code status and goals of care had not changed. Staff B stated Resident 42 should have had care conferences in April and July. Reference: WAC 388-97-1020(5)(b)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure it implemented its protocol for the management of constipation for 2 of 5 residents (Residents 70 and 83) whose records were reviewed for constipation and to ensure physician orders were in place for specific medication dose administration (Resident 22) and wound dressings (Resident 81). These failures placed the residents at risk for medication errors, deterioration of non-pressure skin conditions, and constipation-associated complications, like fecal impaction (where hardened, dry stool accumulates in the colon or rectum, blocking the passage of waste). Findings included . <Resident 81> Review of a 07/16/2025 quarterly assessment showed Resident 81 was admitted to the facility on [DATE], the primary reason for admission was a stroke, and had moderate cognitive impairment. The assessment also showed the resident had no ulcers, wounds or skin problems, to include skin tears (a wound that occurred when the top layers of the skin ripped or pulled away from the layers underneath). An interview and observation on 08/11/2025 at 7:54 AM showed Resident 81 in bed with a breakfast tray in front of them. Two dressings were observed to the side of the right upper arm and above the elbow with no date. Resident 81 said the staff changed their dressings, Yesterday. The dressings were blood stained and dry. On 08/12/2025 at 2:53 PM, the resident was sitting in their wheelchair in front of the Nurses Station, dressed in a tie-dye tank top and shorts. The right upper arm was observed with a white bandage dated 08/11/2025 and directly below it an undated medium brown band-aid. Additionally, an undated regular sized band aid was observed to the left outer arm at the base of a large purple bruise that covered almost the entire left side of the upper arm. On 08/15/2025 at 11:17 AM, two dressings were observed to Resident 81's right arm, by the elbow and one directly above it, and showed 8-15. A dressing above the left arm elbow was partially detached and also showed 8-15. Review of the medical record showed no physician orders to instruct the staff to apply dressings to Resident 81's arms. Additionally, review of the medical record from 07/01/2025 to 08/15/2025 showed no documentation of when or why the multiple dressings were initiated or subsequently monitored by the staff. Review of Skin Inspection progress notes of 07/02/2025, 07/09/2025, 07/30/2025 and 08/14/2025 showed, No new skin issues. Review of Resident 81's care plan showed no acknowledgment of actual or current impaired skin integrity to the arms. In an interview on 08/15/2025 at 11:27 AM, Staff H, Nursing Assistant (NA), stated that, It's skin tears, under Resident 81's multiple dressings to their arms. In an interview on 08/15/2025 at 11:20 AM, Staff J, Licensed Practical Nurse, stated they became aware a resident required a change in wound dressing by completing weekly skin inspections, and being informed by the NA or the resident. Staff DD, Registered Nurse (RN), interjected and said the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treatment Administration Record (TAR) alerted the nurse of the required wound treatment and Staff J concurred. Staff J said Resident 81 required dressing changes to their arms and shins and stated they changed the dressings to the arms dated 08-15. Staff J stated Resident 81 had like a skin tear and said if there was no instruction to identify, monitor and direct the nurse to the appropriate wound care, It can get infected. <Resident 22> Review of a 07/16/2025 quarterly assessment showed Resident 22 admitted to the facility on [DATE] with a diagnosis of seizure disorder. The assessment showed the resident's cognition was severely impaired. Review of the May 2025 Medication Administration Record (MAR) showed the staff administered Fycompa [a seizure medication] at the dose of 12 milligrams (mg, a measurement) nightly at 9:00 PM from 11/26/2023 until 05/06/2025. Review of a 05/06/2025 progress note showed the staff, Received a call from [neurologist, doctor who specialized on the diagnosis, treatment, and study of disorders and diseases affecting the nervous system] office stating that resident's fycompa level was too high and they would like to decrease the fycompa from 12mg to 8mg PO [orally] QHS [at bedtime]. Review of the May 2025 MAR showed the Fycompa dose was lowered to 8mg and the staff administered it nightly at bedtime from 05/07/2025 through 05/31/2025. Although the nurses signed in the May 2025 MAR that they administered 8mg of Fycompa nightly, review of the progress notes showed they gave Resident 22 the dose of 12 mg on 05/07/2025, 05/08/2025, 05/09/2025, 05/10/2025, 05/11/2025, and 05/12/2025 until the 8mg dose arrived from the pharmacy. In an interview on 08/14/2025 at 11:31 AM, Staff DD stated the MAR should accurately reflect the dose of medication the nurse stated they gave and when the MAR did not reflect that information, the resident ran the risk of getting the wrong dose. Staff DD stated it was important to have an order with the correct dose because if a resident transferred to the hospital, it could confuse the hospital staff, and they too might give the wrong dose. Staff DD said they did not usually send progress notes to the hospital. In an interview on 08/14/2025 at 11:33 AM, Staff J stated a nurse should notify the doctor, find out what the correct dose was and write the order accordingly in the MAR. Staff J said that failure to reconcile a medication dose in the physician order could possibly result in a medication error. The above findings were shared with Staff B, Director of Nursing (DNS), on 08/14/2025 at 11:51 AM. When asked if the MAR reflected the neurologist's intent to continue with the 12 mg of the Fycompa as the nurses documented in the progress notes until arrival of the 8mg dose, Staff B said the 12 mg Fycompa dose order should have been re-instated, and The risk of missing that medication would have been worse according to [the neurologist]. <Resident 70> The 07/09/2025 quarterly assessment documented Resident 70 had diagnoses which included (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diabetes, high blood pressure and dementia. The resident was unable to make decisions regarding cares and needed moderate assistance from staff for activities of daily living, such as toileting. The 04/06/2023 alteration in bowel function related to use of narcotic medication care plan instructed nursing staff to administer medications per the physician's orders. Review of the physician's order summary documented the following orders: -04/06/2023 Miralax 17 grams as needed for bowel management -03/01/2024 Dulcolax 10 milligrams (mg) as needed for no bowel movement (BM) times three days -03/01/2024 Milk of Magnesia (MOM) 30 milliliters as needed for no BM times four days -03/01/2024 Dulcolax suppository 10mg as needed for no BM times five days -03/01/2024 Fleet enema as needed for no BM times six days and to notify the provider Review of the bowel records from 07/14/2025 through 08/11/2025, documented Resident 70 had no BMs from 07/25/2025 through 07/27/2025 (three days), 07/31/2025 through 08/05/2025 (six days), and 08/08/2025 through 08/10/2025 (three days). Additional review of the MARS for July 2025 and August 2025, documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 70's record that stated the reason for the omissions. <Resident 83> The 07/09/2025 quarterly assessment documented Resident 83 had diagnoses which included quadriplegia (partial or total loss of function of all limbs and trunk of the human body), multiple sclerosis (a disease that causes nerve damage) and opioid dependence. The resident was able to make decisions regarding cares and needed total assistance from staff for activities of daily living, such as toileting. In an interview on 08/11/2025 at 11:41 AM, Resident 83 stated they were not having regular BM's and their surgeon wanted them to have an enema daily and at least two suppositories throughout the day. The resident stated they had blockages in the past and had to have surgery. The 01/07/2025 alteration in bowel function related to use of medications and decreased mobility care plan instructed nursing staff to administer medications per the physician's orders. Review of the physician's order summary documented the following orders: -04/09/2025 Bisacodyl 5mg, give two tablets as needed for no BM times three days -04/09/2025 MOM 30 milliliters as needed for no BM times four days -04/09/2025 Dulcolax suppository 10mg as needed for no BM times five days (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-04/09/2025 Fleet enema as needed for no BM times six days and to notify the provider -07/31/2025 Miralax 17 grams every 24 hours as needed for bowel management Review of the bowel records from 07/01/2025 through 08/13/2025, documented Resident 83 had no BMs from 07/08/2025 through 07/10/2025 (three days), 07/19/2025 through 07/21/2025 (three days), 08/02/2025 through 08/04/2025 (three days) and 08/08/2025 through 08/10/2025 (three days). Additional review of the MARS for July 2025 and August 2025, documented the resident had not received the bowel medication as ordered during the above time frames, and no documentation was found in Resident 70's record that stated the reason for the omissions. In an interview on 08/14/2025 at 2:14 PM, Staff U, Nursing Assistant, stated BM's were monitored every shift and documented in the plan of care. Staff U stated they notified the nurse for signs of constipation. In an interview on 08/14/2025 at 2:16 PM, Staff T, RN, stated the bowel protocol started on two days of no BM. Staff T stated they gave the residents Bisacodyl, followed by MOM, a suppository and lastly an enema and if that was ineffective the provider was notified. In an interview on 08/14/2025 at 2:18 PM, Staff B, DNS, stated they had standing bowel protocol orders and on day three the protocol was started. Staff B stated it was important to give the bowel medications as ordered to prevent bowel obstruction and to ensure the residents had good health. Reference: WAC 388-97-1060 (1)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review the facility failed to repeatedly ensure registered nursing assistants (NAR) obtained their nursing assistant certification (NAC) within 120 days of hire and had the required paperwork on file to include a certification of completion of NAC program or Department of Health (DOH) authorization to test, passed skills test score sheet e-mail from Washington State Board of Nursing (WABON), passed online written test sheet from Credentia (a company that provided oversight and scheduling services for nurse aide certification exams), and the completed NAR certification application attestation form to continue to work beyond the 120-day deadline, as required for 6 of 6 sampled staff (Staff K, L, M, N, O, and P), reviewed for staffing. This failure placed residents at risk of receiving care from inadequately trained and/or under-qualified care staff, and a diminished quality of life.Findings included.<Staff K>Review of the facility employee list provided by the facility on 08/11/2025 showed Staff K, NAR, was hired on 09/20/2024. Review of Staff K's credentials showed they were credentialed as a Washington State NAR on 01/14/2025. No documentation was found to show Staff K received a certification of completion from an NAC training program, passed the NAC examination, or completed the NAR certification application attestation form, as required to continue to work beyond the 120-day deadline. Review of payroll/time clock data from 01/18/2025 (120 days from 09/20/2024 hire date) through 08/15/2025 showed Staff K worked on the following dates:January- 01/18/2025, 01/24/2025, 01/25/2025, 01/26/2025, 01/28/2025, and 01/31/2025February- 02/01/2025, 02/02/2025, 02/03/2025, 02/07/2025, 02/08/2025, 02/10/2025, 02/13/2025, 02/21/2025, 02/22/2025, 02/25/2025, and 02/28/2025March- 03/01/2025, 03/02/2025, 03/03/2025, 03/06/2025, 03/07/2025, 03/08/2025, 03/11/2025, 03/14/2025, 03/15/2025, 03/21/2025, 03/22/2025, 03/25/2025, 03/26/2025, 03/28/2025, and 03/29/2025April- 04/04/2025, 04/05/2025, 04/11/20258, 04/12/2025, 04/13/2025, 04/17/2025, 04/18/2025, 04/19/2025, 04/25/2025, and 04/26/2025May- 05/01/2025, 05/02/2025, 05/03/2025, 05/04/2025, 05/09/2025, 05/10/2025, 05/11/2025, 05/17/2025, 05/18/2025, 05/23/2025, 05/24/2025, and 05/31/2025June- 06/06/2025, 06/07/2025, 06/13/2025, 06/14/2025, 06/20/2025, 06/21/2025, 06/27/2025, and 06/28/2025July- 07/04/2025, 07/05/2025, 07/10/2025, 07/11/2025, 07/12/2025, 07/18/2025, 07/25/2025, and 07/26/2025August- 08/02/2025, 08/03/2025, 08/08/2025, and 08/09/2025 Review of 08/13/2025 text message correspondence between Staff K and management showed Staff K had one last chance to test for their NAC but had not scheduled the test yet, 327 days after their date of hire. <Staff L>Review of the facility employee list showed Staff L, NAR, was hired on 11/11/2024. Review of Staff L's credentials showed they were credentialed as a Washington State NAR on 12/12/2024. Review of Staff L's records showed a certification of completion of a NAC training program on 04/16/2025 and passed an out-of-state Idaho NAC examination on 05/14/2025, 184 days after their date of hire. No documentation was found to show Staff L completed the NAR certification application attestation form, as required to continue to work beyond the 120-day deadline. Review of payroll/time clock data from 03/11/2025 (120 days from 11/11/2024 hire date) through 08/15/2025 showed Staff L worked on the following dates:March- 03/11/2025, 03/12/2025, 03/15/2025, 03/17/2025, 03/18/2025, 03/19/2025, and 03/31/2025April- 04/01/2025, 04/10/2025, 04/15/2025, 04/17/2025, 04/22/2025, 04/28/2025, and 04/29/2025May- 05/01/2025, 05/08/2025, 05/12/2025, 05/13/2025, 05/15/2025, 05/18/2025, 05/19/2025, 05/20/2025, 05/21/2025, 05/28/2025, 05/29/2025, and 05/30/2025June- 06/01/2025, 06/02/2025, 06/03/2025, 06/04/2025, 06/10/2025, 06/11/2025, 06/12/2025, 06/16/2025, 06/17/2025, 06/18/2025, 06/23/2025, 06/24/2025, 06/25/2025, and 06/30/2025July- 07/03/2025, 07/06/2025, 07/07/2025, 07/08/2025, 07/09/2025, 07/16/2025, 07/17/2025, 07/20/2025, 07/21/2025, 07/22/2025, 07/23/2025, 07/24/2025, 07/29/2025, and 07/30/2025August- 08/03/2025, 08/04/2025, 08/05/2025, 08/06/2025, 08/10/2025, 08/11/2025, 08/12/2025, and 08/13/2025 <Staff M>Review of the facility employee list (continued on next page)

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	505283	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkston Health and Rehab of Cascadia	1242 Eleventh Street Clarkston, WA 99403

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed Staff M, NAR, was hired on 11/27/2024. Review of Staff M's credentials showed they were first credentialed as a Washington State NAR on 12/11/2024. Review of Staff M's records showed a certification of completion of a NAC training program on 06/09/2025 and passed an out-of-state Idaho NAC examination on 07/02/2025, 217 days after their date of hire. No documentation was found to show Staff M completed the NAR certification application attestation form, as required to continue to work beyond the 120-day deadline. Review of payroll/time clock data from 03/27/2025 (120 days from 11/27/2024 hire date) through 08/15/2025 showed Staff M worked on the following dates:March- 03/29/2025, and 03/30/2025April- 04/04/2025, 04/06/2025, 04/11/2025, 04/13/2025, 04/18/2025, 04/19/2025, 04/20/2025, 04/25/2025, and 04/27/2025May- 05/02/2025, 05/04/2025, 05/09/2025, 05/11/2025, 05/16/2025, 05/18/2025, 05/20/2025, 05/23/2025, 05/25/2025, and 05/30/2025June- 06/01/2025, 06/06/2025, 06/08/2025, 06/13/2025, 06/15/2025, 06/16/2025, 06/20/2025, 06/22/2025, 06/27/2025, 06/29/2025, and 06/30/2025July- 07/04/2025, 07/06/2025, 07/07/2025, 07/11/2025, 07/13/2025, 07/14/2025, 07/15/2025, and 07/18/2025August- 08/08/2025, 08/10/2025, and 08/11/2025 <Staff N>Review of the facility employee list showed Staff N, NAR, was hired on 04/01/2025. Review of Staff N's records showed they passed an out-of-state Idaho NAC examination on 10/25/2024. No documentation was found of a certification of completion of a NAC training program or to show Staff N completed the NAR certification application attestation form, as required to continue to work beyond the 120-day deadline. Review of Staff N's credentials showed they were credentialed as a Washington State NAR on 05/02/2025. Review of payroll/time clock data from 07/30/2025 (120 days from 04/01/2025 hire date) through 08/15/2025 showed Staff N worked on the following dates:July- 07/31/2025August- 08/01/2025, 08/04/2025, 08/06/2025, 08/08/2025, 08/11/2025, and 08/14/2025 <Staff O>Review of the facility employee list showed Staff O, NAR, was hired on 04/09/2025. Review of Staff O's credentials showed they were credentialed as a Washington State NAR on 04/06/2012 with an expiration date of 01/30/2013. No further credential documentation was provided. Review of Staff O's records showed they passed an out-of-state Idaho NAC examination on 10/16/2024. No documentation was found of the certification of completion of a NAC training program or to show Staff O completed the NAR certification application attestation form, as required to continue to work beyond the 120-day deadline. Review of payroll/time clock data from 08/07/2025 (120 days from 04/09/2025 hire date) through 08/15/2025 showed Staff O worked on the following dates:August- 08/07/2025 and 08/15/2025 <Staff P>Review of the facility employee list showed Staff P, NAR, was hired on 04/09/2025. Review of Staff P's records showed they passed an out-of-state Idaho NAC examination on 01/12/2018. No documentation was found of the certification of completion of a NAC training program or to show Staff P completed the NAR certification application attestation form, as required to continue to work beyond the 120-day deadline. Review of Staff P's credentials showed they were credentialed as a Washington State NAR on 06/16/2025. Review of payroll/time clock data from 08/07/2025 (120 days from 04/09/2025 hire date) through 08/15/2025 showed Staff P worked on the following dates:August- 08/08/2025, 08/11/2025, and 08/12/2025 On 08/15/2025 at 8:00 AM, a certification of completion of NAC program or DOH authorization to test, passed skills test score sheet e-mail from WABON, passed online written test sheet from Credentia, and the completed certification application attestation forms for Staff K, L, M, N, O, and P were requested from Staff A, Administrator. In an interview on 08/15/2025 at 8:37 AM, Staff D, Human Resources, explained Staff N, O, and P had their NAC in Idaho but only had their Washington State NAR and worked as NARs while they waited for their Washington State NAC. Staff D acknowledged Staff K's date of hire was 09/20/2024, Staff K failed the NAC test twice and had one more chance to test but had not scheduled the test yet. Staff D stated they were unsure if Staff K, L, M, N, O, or P had a completed NAR certification application attestation form on file. In a follow-up interview on 08/15/2025 at 10:52 AM, Staff D, provided NAR certification application attestation forms for Staff L, M, N, O, and P. No documentation was provided for Staff K. Staff D acknowledged the forms provided were completed on 08/15/2025 because they were unaware the form had to be (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed for an NAR to continue to work beyond the 120-day deadline until today. In an interview on 08/18/2025 at 11:12 AM, Staff A, Administrator, stated the facility was in compliance with NARs obtaining their NAC within 120 days of hire. Reference WAC 388-97-1660 (3)(a)(i)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure complete and accurate medical records for 6 of 25 sampled residents (Residents 1, 5, 8, 9, 22 and 86) whose medical records were reviewed. Specifically, the facility failed to ensure Resident 8 and 5's care conference documents (to include a complete resident identifier for Resident 5), Resident 5's visit summaries from a dental appointment, Resident 9's Psychosocial History Document (to include a complete resident identifier), Resident 22's clinic and lab results from a community provider appointment, Resident 1's smoking assessment, and Resident 86's bed hold notice were present and easily accessible in their medical records. These failures placed the residents at risk for a delay in care or services. Findings included. <Resident 5> In an interview on 08/11/2025 at 8:38 AM, Resident 5 stated they did not get invited to care planning conferences, That stopped. Review of Resident 5's electronic medical record from 01/2025 to 08/2025 showed no documentation the resident participated in care planning conferences. The above findings were shared with Staff C, Social Services Director, on 08/15/2025 at 9:26 AM. Staff C checked the folders on their desk, then went to an area inside their office closet but could not find Resident 5's care conference records. Afterwards, Staff C produced three copies of care conferences dated 08/15/2024, 02/20/2025, and 05/15/2025. None of the copies had Resident 5's last name on the forms. Review of Resident 5's medical record showed they went to dental appointments on 11/02/2024 (fitted for dentures), 11/15/2024 (returned with new dentures), and 12/06/2024. Review of the medical record showed no documentation of the visit summaries. <Resident 9> A similar finding was identified upon review of an 11/08/2022 Psychosocial History form produced by Staff C on 08/13/2025 at 12:44 PM to show the facility reviewed advance directives information with Resident 9's representative. The form had no resident identifier on it. <Resident 22> Review of Resident 22's medical record showed a 05/06/2025 progress note that showed the staff received a call from the community provider stating the blood level of a seizure medication was too high and they would like to decrease the medication dose. Record review showed no documentation what the too high results were or facility efforts to procure lab results that resulted in a seizure medication dose adjustment. In an interview on 08/14/2025 at 11:54 AM, Staff B, Director of Nursing (DNS), was asked what the process was to show continuity of care between community providers and the facility reflected in the medical record. Staff B stated visit summaries and lab results from community providers, should be uploaded [in the medical record] sooner than later. On 08/15/2025 at 10:56 AM, Staff B acknowledged Resident 5's medical record was not complete and accurate and also should have but did not include summaries of dental visits from 9 months ago. Staff B acknowledged the wait time to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procure community appointment notes and blood work results was not timely. No further information was provided. <Resident 1> According to the 06/21/2025 admission assessment, Resident 1 admitted to the facility on [DATE] with diagnoses including respiratory failure (inability to effectively exchange oxygen and carbon dioxide). Resident 1 was cognitively intact and able to clearly verbalize their needs. Review of the residents that smoke list provided to the survey team on 08/11/2025, identified Resident 1 as choosing to smoke. During observation on 08/11/2025 at 7:07 AM, Resident 1 was observed outside the facility in the designated smoking area, smoking a cigarette. A similar observation was made on 08/13/2025 at 1:39 PM. Additional review of Resident 1's medical record showed no documentation a smoking assessment or evaluation was completed. In an interview on 08/13/2025 at 1:59 PM, Staff B, DNS, stated if a resident chose to smoke, they would be assessed for safety and care planned accordingly to include any potential interventions. Staff B reviewed Resident 1's medical record. Staff B acknowledged they were unable to find documentation a smoking assessment had been completed and would check to see if they could find any additional paperwork. In a follow-up interview and record review on 08/13/2025 at 2:15 PM, Staff B, produced a 06/17/2025 smoking assessment that had been completed on a paper form. Review of the assessment provided showed Resident 1 was able to smoke independently. Staff B stated they expected staff to scan or transcribe assessments into a resident's electronic medical record to ensure a complete and accurate medical record. <Resident 8> According to the 07/02/2025 quarterly assessment, Resident 8 re-admitted to the facility on [DATE] from a visit to the hospital. The assessment further showed Resident 8 had diagnoses including ground level fall and cervical disc displacement (soft rubbery cushion between spine bones moved out of its proper place), was cognitively intact and able to clearly verbalize their needs. Review of the 04/02/2025 falls care plan showed Resident 8 was at risk for falls and instructed staff to apply Dycem (grippy, non-stick material that prevented objects from slipping and/or sliding) to the recliner and wheelchair (WC), utilize anti-roll back WC brakes, treat infections per provider orders, and ensure glasses were worn. Review of a 04/18/2025 unwitnessed fall report showed Resident 8 was found on the floor in their room covered in blood with a large gash to the top of their head, and cuts to the right side of their face near the eye. A 04/23/2025 incident summary showed Resident 8 was transported to the hospital for further evaluation. Attached to the incident report was a face sheet, post fall investigation evaluation that documented nursing interventions implemented as sent to [Emergency Department, ED], fall risk assessment, falls care plan, and a five whys root cause tool. Additional (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of the care plan showed the only intervention implemented after Resident 8 sustained a fall with head injury on 04/18/2025 was Resident sent to ED for evaluation. In an interview on 08/18/2025 at 11:17 AM, Staff B, DNS, explained the facility fall process and stated new fall interventions that attempted to address the root cause should be implemented every single time there was a new fall to prevent fall recurrence. Staff B was informed that the only documentation found for the fall intervention for the fall Resident 8 sustained on 04/18/2025 was to transport them to the ED for further evaluation. Staff B stated they would look for additional documentation. In a follow-up interview and record review on 08/18/2025 at 1:05 PM, Staff B, produced a 04/21/2025 care conference summary that had been completed on a paper form. Staff B explained that a care conference was held after Resident 8 returned from the hospital. During the care conference every care planned fall intervention implemented was reviewed with Resident 8's child in an attempt to find further potential creative fall interventions that had not been attempted or implemented yet. Review of the paper care conference form provided showed Resident 8's child stated Resident 8 had a history of falling and would continue to fall because previous fall interventions were unsuccessful, no documentation was found to show every fall intervention had been reviewed as described by Staff B. Additional review of Resident 8's medical record showed no documentation of the care conference held on 04/21/2025. <Resident 86> According to the 07/19/2025 Medicare five-day assessment, Resident 86 admitted to the facility on [DATE] with diagnoses including anemia (not enough blood cells) and gastritis (inflammation of the stomach lining) with bleeding. Resident 86 was cognitively intact and able to clearly verbalize their needs. Review of July 2025 nursing progress notes showed on 07/20/2025 Resident 86 complained of abdominal pain and informed staff that was a symptom they previously experienced when they had a gastrointestinal (GI, digestive system) bleed. The provider was notified, and Resident 86 was transported to the hospital via a facility van. No documentation was found to show a bed hold was offered at time of transfer. In an interview on 08/15/2025 at 9:49 AM, Staff E, Resident Care Manager, stated when a resident was transferred to the hospital, social services typically offered a bed hold the day of or the day following a hospital transfer. In an interview and record review on 08/15/2025 at 10:25 AM, Staff C, Social Service Director, explained when a resident was transported to the hospital, they spoke to the resident or their representative the day of or day after hospital transfer, to discuss a bed hold. Staff C reviewed Resident 8's medical record and was unable to located documentation a bed hold was offered, as required. Staff C then produced a 07/21/2025 bed hold agreement that had been completed on a paper form. Staff C acknowledged bed hold forms should be uploaded into the resident's medical record to ensure a complete and accurate record, as required. In an interview on 08/15/2025 at 10:31 AM, Staff B, stated they expected bed hold information to be uploaded into a resident's medical record to ensure a complete and accurate medical record, as (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required. In an interview on 08/18/2025 at 11:12 AM, Staff A, Administrator, stated they expected staff to ensure resident records were complete, accurate, and readily available, as required. Reference WAC 388-97-1720 (2)(a-m), -1720 (1)(a)(i-iv)(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure an allegation of staff-to-resident rough handling was reported to the Administrator or designee and to the State Agency (SA) within the required timeframe for 1 of 1 sampled residents (Resident 81) reviewed for abuse. This failure placed the resident and other residents at risk for potential physical abuse and precluded the SA from being aware of and investigating the circumstances surrounding the resident's allegation.Findings included. Review of a revised 08/01/2023 facility policy titled Identification and Investigation of Abuse, Neglect, Misappropriation, and Injuries of Unknown Origin showed the facility identified incidents and occurrences that could constitute or contribute to abuse and neglect by reviewing grievances and complaints, and reports of allegations of abuse or neglect, injuries of unknown origin, or other evidence of physical, verbal, sexual or psychological abuse. The policy showed the staff notified the Administrator, the Director of Nursing, and Social Services personnel immediately upon knowledge of an allegation of abuse or neglect, managed the incident for any immediate medical needs, evaluated the resident for signs of negative psychosocial impact, protected the residents during and after the investigation by increasing supervision of the alleged resident, making room or staffing changes if necessary to protect the residents from the alleged staff, and protecting the resident from retaliation. The policy showed that if a staff member was implicated in the allegation, the facility would protect the resident by suspending the staff pending investigation. The administrator or designee notified the SA immediately but no later than two hours after an allegation of abuse or serious bodily injury was identified. All other allegations were reported to the SA immediately but no later than 24 hours from the time the allegation was known to the staff member. Review of a 07/16/2025 quarterly assessment showed Resident 81 admitted to the facility on [DATE] with a stroke and right-sided hemiplegia (total or partial paralysis on one side of the body). The assessment showed the resident had moderately impaired cognition and required assistance from the staff for Activities of Daily Living. An observation on 08/12/2025 at 2:53 PM showed Resident 81 sitting in a wheelchair across the Nurses Station with a transfer sling underneath them. Their right upper arm showed scattered purple bruises, a white dressing dated 08/11/2025 and directly below it a brown undated dressing. Observation of the left arm showed a large purple bruise that extended from the bicep (large muscle that lies on the front of the upper arm) to the elbow, with faded yellow green discoloration to the upper edges, and a dressing above the left elbow area. In an observation and interview on 08/13/2025 at 8:19 AM, Resident 81 was in bed with their breakfast in front of them. When asked about the large bruise to the left upper arm, the resident said, Some aides got rough with me this past weekend. I was abused by a couple aides this weekend on Night Shift. Resident 81 said that when the staff provided incontinence care, How they changed me, how they cleaned me up, they pulled on my arm. Review of an 08/14/2025 Skin Inspection Evaluation completed by Staff I, Registered Nurse, showed No new concerns, no actual skin impairments and continue with current POC [plan of care]. In an interview on 08/15/2025 at 11:27 AM, Staff H, Nursing Assistant, stated they noticed the large bruise to Resident 81's left arm on 08/11/2025 when they worked on Day Shift and, I wouldn't even know how to explain that. I don't know what could have happened. Staff H said the resident told them they, already talked to management on Monday. In a follow up interview on 08/18/2025 at 9:28 AM, Staff H said there were skin tears under the dressings to Resident 81's arms. When asked what Resident 81 told them about the bruise to the left arm, Staff H said, I don't know how to even word that. [The resident] started saying something about the night shift girls being rough with [them]. But I reported it. I did mention it to [Staff I]. Staff H said they and Staff I, sat and talked about that last week and I'm sure someone must have reported it before because this happened over the weekend. Staff H said Resident 81 said two girls were the alleged (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff but was not specific if it happened in the evening hours or night shift. Staff H recognized the resident description of the incident as an allegation of physical abuse. Staff H said everyone was a mandated reporter whose responsibility was to go ahead and report it, file a report, take it further up because it's an allegation that can't be side swiped. I know I report it to the nurse. Staff H made no mention of reporting the allegation to the Administrator or their designee or the SA as a mandated reporter. In an interview on 08/18/2025 at 9:08 AM, Staff I said they were unaware of the allegation of staff-to-resident rough handling, not until this morning when the resident showed them their left arm and stated Staff H, did not report anything that happened to [Resident 81] with the night aides. There was nothing ever said to me about the bruise to the left arm. Staff I said everyone was a mandated reporter and must report to the Director of Nursing, the Administrator and the State Hotline (or SA). Review of the facility incident log and medical record showed no documentation the facility recognized and questioned the presence of a large substantial bruise to the left arm or reported the allegation of staff-to-resident rough handling to the SA within the required timeframe of two hours. The above findings were shared with Staff B, Director of Nursing, on 08/18/2025 at 11:16 AM. Staff B acknowledged the staff should have reported the allegation of staff-to-resident rough handling to the SA and the Administrator or designee on 08/11/2025 and did not. Staff B said residents were placed in similar occurrences when the staff fail to report to the Administration or the SA allegations of abuse or neglect. Reference WAC 388-97- 0640(5)(a).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the appropriate minimum information to include contact information of the practitioner responsible for the care of the resident, resident representative contact information, advanced directive information, comprehensive care plan goals, any special instructions and/or precautions for ongoing care, and all other necessary information was communicated to hospital at time of transfer, as required for 1 of 3 sampled residents (Resident 86) whose closed records were reviewed. This failure placed residents at risk of potential delays in emergent hospital treatment, potential medical complications, and diminished quality of life. Findings included.According to the 07/19/2025 Medicare five-day assessment, Resident 86 admitted to the facility on [DATE] with diagnoses including anemia (not enough blood cells) and gastritis (inflammation of the stomach lining) with bleeding. Resident 86 was cognitively intact and able to clearly verbalize their needs.Review of July 2025 nursing progress notes showed on 07/20/2025 Resident 86 complained of abdominal pain and informed staff that was a symptom they previously experienced when they had a gastrointestinal (GI, digestive system) bleed. The provider was notified, and Resident 86 was transported to the hospital via a facility van. No documentation was found to show what information was conveyed to the hospital at time of transfer, as required. In an interview on 08/15/2025 at 8:33 AM, Staff G, Registered Nurse, stated if/when a resident required hospital transport, they would assess the resident and notify the provider. Staff G explained they would then print out a face sheet (quick summary of essential medical history details for healthcare providers at a glance), most recent labs, medication list, and send a POLST (Physician Orders for Life Sustaining Treatment- a form that informed healthcare professionals of a person's wishes related to cardiopulmonary resuscitation in case of a medical emergency). Staff G further stated a report was then called to the hospital and the process documented in a progress note. In an interview on 08/15/2025 at 9:49 AM, Staff E, Resident Care Manager, stated if/when a resident required hospital transport, the nurse would assess the resident and call the provider. Staff E explained a face sheet, POLST, medication list, most recent vital signs, and progress notes were sent to the hospital upon transfer. Staff E further stated staff typically did not document what information was sent to the hospital at time of transfer but if staff called the hospital and gave a verbal report on the resident's condition, it would be documented in a progress note. Staff E reviewed Resident 86's medical record. Staff E acknowledged they were unable to find documentation of what information was conveyed to the hospital at time of transfer. In an interview on 08/15/2025 at 10:31 AM, Staff B, Director of Nursing, stated when a resident required hospital transfer, a face sheet, medication list, POLST, and any pertinent information would be printed out and physically sent with the resident to the hospital. The nurse would then call the hospital to report the resident's condition and document a summary in a progress note. Staff B further stated the facility was not electronically integrated with the hospital and did not utilize electronic forms of communication with the hospital. Staff B stated staff should document information conveyed to the hospital in a progress note. In an interview on 08/18/2025 at 11:12 AM, Staff A, Administrator, stated they expected staff to document what information was conveyed to the hospital at time of transfer, as required. No associated WAC

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan with measurable objectives and services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 3 sampled residents (Resident 1), reviewed for smoking. This failure placed residents at risk of potentially avoidable accidents, unmet care needs, and diminished quality of life. Findings included.Review of the facility policy titled, Care Plans revised October 2024, showed a comprehensive person-centered care plan was developed and implemented consistent with the resident's specific conditions, risks, needs, behaviors, and preferences within seven days after the completion of the comprehensive assessment. According to the 06/21/2025 admission assessment, Resident 1 admitted to the facility on [DATE] with diagnoses including respiratory failure (inability to effectively exchange oxygen and carbon dioxide). Resident 1 was cognitively intact and able to clearly verbalize their needs. Review of the residents that smoke list provided to the survey team on 08/11/2025, identified Resident 1 as choosing to smoke. Review of the 07/15/2025 substance use disorder care plan showed Resident 1 was alcohol and nicotine dependent, interventions instructed staff to encourage the resident to discuss their feelings, assist the resident in learning and use of relaxation skills, encourage fluids, exercise, and deep breathing to minimize withdrawals symptoms. No documentation was found to show goals and interventions were developed related to Resident 1 currently smoking. During observation on 08/11/2025 at 7:07 AM, Resident 1 was observed outside the facility in the designated smoking area, smoking a cigarette. A similar observation was made on 08/13/2025 at 1:39 PM. In an interview on 08/13/2025 at 1:53 PM, Staff U, Nursing Assistant, stated if a resident was safe and allowed to smoke, it would be documented on their care plan. Staff U acknowledged Resident 1 smoked. In an interview on 08/13/2025 at 1:55 PM, Staff V, Licensed Practical Nurse, stated if a resident was cleared to smoke, it would be documented on their care plan. Staff V stated Resident 1 was ok to smoke. In an interview on 08/13/2025 at 1:59 PM, Staff B, Director of Nursing, explained if a resident was assessed as safe to smoke, it would be documented on their care plan. Staff B reviewed Resident 1's medical record. Staff B acknowledged there was no smoking care plan in place and there should be. In an interview on 08/18/2025 at 11:12 AM, Staff A, Administrator, stated they expected staff to ensure the care plan accurately reflected the residents care needs. Refer to WAC 388-97-1020 (1), (2)(a)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the periodic review and monitoring of splint and/or brace wear and effectively address refusals of the Restorative Nursing Program (RNP) for 2 of 2 sampled residents (Residents 22 and 81) reviewed for limited range of motion (ROM, the full movement potential of a joint or series of joints). These failures placed the resident at risk of worsening contractures (a medical condition where muscle, tendon, or other soft tissue becomes abnormally tight and shortened, limiting the ROM at a joint) and diminished quality of life.Findings included.Review of a revised 01/20/2025 facility policy titled Restorative Nursing showed that RNPs, to include splint or brace (a custom or prefabricated device that provided support, immobilized or assisted movement in the hand, wrist, or fingers to heal injuries, correct deformities, prevent stiffness, or manage contractures) assistance programs, required measurable objectives and interventions that were documented in the care plan. Implementation of the interventions were recorded in the medical record. Resident tolerance and compliance were monitored to evaluate progress toward resident goals. The policy showed that while therapists might participate in the RNP, a nurse was still responsible for the overall coordination and supervision of the RNP. <Resident 81>Review of a 07/16/2025 quarterly assessment showed Resident 81 admitted to the facility on [DATE] with a stroke and associated right-sided hemiplegia (complete or partial paralysis to one side of the body). The assessment showed the resident had moderately impaired cognition, functional limitation in ROM to both upper and lower extremities to one side of the body and received no RNP or therapy services. Both the resident and the legal guardian participated in the assessment and goal setting.An observation and interview on 08/11/2025 at 7:54 AM showed Resident 81 in bed with breakfast in front of them. Resident 81 brought food to their mouth with their left hand although cutlery was present. The resident said, It sucks, as they were unable to move or use their right arm or hand. Some of the right hand fingers were observed curled inwards. In an interview on 08/15/2025 at 10:02 AM, Staff AA, Physical Therapist (PT), said that Resident 81 was released from therapy caseload to a RNP on 04/03/2024. Staff AA said the resident was to wear a right hand and knee orthotic (supportive device, like a brace or splint) every day on Saturdays, start one hour a day for two weeks and then one hour every two weeks, progress until [the resident] reached the ability to wear hand orthotics eight hours, six days a week. Review of a 10/18/2023 care plan showed Resident 81, has risk for contractures/impaired functional range of motion related to hemiplegia and that the resident would not experience any complications related to wearing a splint. The care plan instructed the staff to monitor skin condition under splint upon splint removal and report any areas of concern, provide hand hygiene prior to application and upon removal of the hand splint, refer to therapy as needed, and see restorative programs. The care plan showed no rejection or refusals to participate in the RNP. Review of Resident 81's medical record showed no splint application or other restorative programs. Review of Resident 81's medical record showed the most recent Restorative Nursing Evaluation was last completed on 02/15/2024. This evaluation showed the resident was currently on restorative and had splint/brace assistance 15 minutes a day, six days a week. The evaluation showed the resident participated in the program but chose not to wear the leg brace, only wearing a wrist/hand brace at this time and would evaluate quarterly and as needed. Review of the Restorative Progress Notes showed:- 04/03/2024 Resident continues to choose not to participate in restorative brace program. Will discontinue at this time and re-evaluate PRN (as needed).- 07/17/2024 Resident not currently on restorative. Was on programs in past that were discontinued due to non-participation. Resident offered programs again this quarter and chooses not to participate.- 10/16/2024 Resident is not currently working with restorative. Resident has had programs in the past but continues to choose not to participate. Will eval [evaluate] quarterly and PRN.Review of a 01/02/2025 facility (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	multidisciplinary evaluation report showed Resident 81 was assessed to have severely limited upper extremity (UE) ROM limitations including the right shoulder, elbow, wrist, knee, and foot, and hemiparesis (weakness on one side of the body).Continued review of the Restorative Progress Notes showed:- 01/15/2025 Resident not currently working with restorative. Has had programs in the past but continues to choose not to participate.- 04/16/2025 Resident not currently working with restorative. Has had programs in past but chooses not to participate. Will eval quarterly and PRN.- 07/16/2025 Resident not currently working with restorative. Resident has had programs in the past but continues to choose not to participate. Will eval quarterly and PRN.Review of the medical record showed no associated documentation to the quarterly Restorative Progress Notes where the facility re-assessed Resident 81 and established why the resident continued to choose not to participate in the RNP. The medical record showed no documentation that the facility involved the resident and their representative to review the potential positive and negative outcomes (risks and benefits) of Resident 81's choice not to participate in the RNP, potential alternatives or mitigation plans for risks. In an interview on 08/15/2025 at 9:15 AM, Staff BB, Restorative Aide, said Resident 81 was formerly in a RNP that included a Nustep [a cross-trainer equipment], a ROM program for the legs, and a splint to the right hand, a long time ago but not in use currently. In an interview on 08/15/2025 at 10:02 AM, Staff AA stated they expected of the staff to notify the therapy department of RNP refusals. No information was provided to show the staff notified therapy services of Resident 81's RNP refusals for re-evaluation.In an interview on 08/15/2025 at 9:01 AM, Staff R, Restorative Nurse, confirmed Resident 81 had weakness and impaired ROM to the right side of their body. Staff R said that Resident 81's RNP was discontinued and not restarted because of their refusal to participate. No information was provided to show how the facility managed Resident 81's RNP refusals, to include a review of the risks and benefits of the resident's choice with the resident and their representative and offering and trial of alternatives.In an interview on 08/18/2025 at 10:47 AM, Staff B, Director of Nursing, stated that the provider should be notified of refusals, hold a care conference to review the possible negative impacts to the resident or discuss the risks and benefits with the resident or their advocates, and address the refusals in the care plan. <Resident 22>Review of a quarterly assessment of 07/16/2025 showed Resident 22 admitted to the facility on [DATE] with seizures and hemiplegia or hemiparesis (weakness to one side of the body). The assessment showed the resident had severely impaired cognition, functional limitation in ROM to both upper and lower extremities to one side of the body, last received therapy services on 03/10/2025 by PT, and received no RNP.An observation on 08/11/2025 at 6:49 AM showed Resident 22 in bed with a brace to the right forearm. On 08/13/2025 at 11:55 AM, Resident 22 was sitting in their wheelchair in the dining room, and no brace was observed to the right forearm. On 08/13/2025 at 3:37 PM, no orthotic was observed on or to Resident 22's right arm or hand. On 08/14/2025 at 8:00 AM, the resident was in the dining room eating breakfast and a brace to the forearm was observed. Review of a 03/04/2025 PT Therapy Discharge note showed, RA staff have been trained on donning and doffing R [right] hand brace. A 04/09/2025 PT note showed continuing to wear right hand brace.Review of the August 2025 Treatment Administration Record (TAR) showed a 09/29/2024 order that instructed the staff to, Apply R [right] arm brace. place on in AM [morning at 7:00 AM and remove at 1:00 PM] Wear during the day for 6-8 hours, an opportunity of six hours. Review of the TAR showed no documentation how long Resident 22 tolerated the brace on. Review of the August 2025 TAR also showed a 02/19/2025 order that instructed the staff to apply a carrot [a device that painlessly positions the fingers away from the palm] twice a day at 3:00 PM and 7:00 PM, for a period of 60 to 90 minutes at a time. Review of the TAR showed no documentation how long Resident 22 tolerated the carrot in place. Review of the Restorative Nurse notes showed on 01/15/2025, 04/16/2025 and 07/16/2025, Resident not currently working with restorative. Resident is currently working with the therapy department. Will eval quarterly and PRN. There was no documentation to show the facility evaluated the effectiveness of the brace or carrot and if the resident met the order goals for tolerance.Review of Resident 22's care (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan showed, Review restorative program routinely to validate effectiveness. Adjust program as indicated. The care plan showed no indication what the RNP was nor acknowledgment and purpose of the right-hand carrot or arm brace. The above findings were shared with Staff R on 08/15/2025 at 8:37 AM. Staff R acknowledged the medical record showed no periodic evaluation of the right-arm brace or right-hand carrot effectiveness for Resident 22's contracture management. Reference WAC 388-97-1060 (3)(d), (j)(ix)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received appropriate care and services to minimize the risk of associated urinary tract infections for 1 of 1 sampled residents (Resident 8), reviewed for catheter (a flexible tube inserted into the bladder to drain urine) care. This failure placed the resident at risk for urinary tract infections. Findings included. Per the Lippincott Manual of Nursing Practice 10th Ed. ([NAME], 2014), infectious organisms can move into the bladder along the outside of any urinary catheter, and the catheter bag (a urine collection bag attached to the catheter) should be kept off the floor (and other unclean surfaces), to prevent bacteria from entering the bladder (pg. 781-782). The 07/02/2025 quarterly assessment documented Resident 8 had diagnoses which included benign prostatic hyperplasia (BPH, prostate gland enlargement that blocks the flow of urine out of the bladder), obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed) and a urinary tract infection (UTI). The assessment showed Resident 8 required a urinary catheter. In an observation on 08/12/2025 at 12:44 PM, Resident 8 was sitting in their wheelchair in their room eating lunch. Resident 8's catheter bag was resting on the floor. Similar observations of Resident 8's catheter bag and tubing resting on the floor were made on 08/13/2025 at 2:27 PM, 08/14/2025 at 7:15 AM, 8:35 AM, 9:30 AM and 12:33 PM. A review of Resident 8's medical record showed the resident was treated for UTI's on 06/08/2025 and 07/17/2025. The 05/19/2025 urinary catheter care plan did not instruct staff to keep the catheter bag and tubing off the floor. In an interview on 08/14/2025 at 12:46 AM, Staff W, Nursing Assistant, stated catheters were hung underneath the resident's wheelchairs and it was important to keep the collection bag and tubing off the floor to prevent contamination. In an interview on 08/14/2025 at 12:49 PM, Staff G, Registered Nurse, stated catheter bags were hooked underneath the wheelchairs, and it was important to keep the collection bags and tubing off the floor to prevent infection. When asked if Resident 8 had been treated for UTI's in the past, Staff G stated yes, they get them often. In an interview on 08/14/2025 at 12:51 PM, Staff B, Director of Nursing, stated catheters were hung underneath or on the side of the wheelchair below the level of the bladder. Staff B stated it was important to keep the tubing and collection bag off the floor to prevent infection. Staff B also stated Resident 8 has had UTI's. Reference: WAC 388-97-1060 (3)(c)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure residents were given their medications as ordered for 1 of 5 sampled residents (Resident 70) reviewed for medication management. This failure placed residents at risk of exacerbations of their chronic health conditions, and unintended consequences when doses of their medications were omitted. Findings included . The 07/09/2025 quarterly assessment documented Resident 70 had diagnoses which included arthritis, migraines and a neck fracture, and had severe cognitive impairments. The 04/06/2023 care plan documented Resident 70 was at risk for pain. Staff were instructed to give medications as ordered. A review of the August 2025 Medication Administration Record (MAR) documented medication orders and omissions:-Pregabalin 150 milligrams (mg) three times a day for neuropathy (weakness, numbness, and pain from nerve damage). The entry on 08/10/2025 and 08/11/2025 said the medication was not available. There was a progress note on 03/11/2025 that stated the medication was reordered. -Humalog insulin inject subcutaneously (under the skin) per sliding scale (a scale that determines how much insulin is needed) before meals for diabetes. The entry on 07/16/2025 and 07/29/2025 for evening shift was blank. -Humalog insulin inject 20 units before meals for diabetes, give 15 units in addition to sliding scale at meals. The entry on 07/16/2025 was blank and the entry on 07/29/2025 had a blood sugar of 135 but no insulin was administered. In an interview on 08/14/2025 at 11:15 AM, Staff G, Registered Nurse, stated medications were reordered when they had a week supply left. Staff G stated if a medication was not available, they would check their Cubex (a locked container that contained an emergency supply of medications) and if the medication was not in the Cubex they would call the pharmacy and have it delivered. Staff G stated to get the medication out of the Cubex they would phone the provider, have them send a new script to the pharmacy and they would obtain a code to pull the medication from the Cubex. They stated the process normally took a couple of hours. Staff G stated the provider should have been notified that the medication was not available. Staff G stated the outcome to the resident regarding not receiving their Gabapentin could have resulted in increased pain, numbness and tingling. In an interview on 08/14/2025 at 11:21 AM, Staff E, Resident Care Manager, stated the nurses were to order medications when they saw they were getting low and if medication was not available they needed to call the pharmacy to ensure the medication was on its way to the facility. Staff F stated they checked the Cubex to see if the medication was available. Staff F looked at the July and August 2025 MAR's and stated the Gabapentin should have been addressed immediately on 08/10/2025 when the first dose was unavailable. Staff F did not find blood sugars for 07/16/2025 and 07/29/2025 and stated that the blood sugars should have been documented and whether the insulin was given or held. Staff F added it was important to check the blood sugars related to hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar). In an interview on 08/14/2025 at 11:33 AM, Staff B, Director of Nursing, stated medications needed to be reordered, the nursing staff needed to check the Cubex for the medications, the provider needed to be notified, and the pharmacy was to be notified for a pull code to obtain medications from the Cubex. Staff B stated Resident 70 could have had increased pain related to not receiving their Gabapentin. Staff B stated their expectation was nursing staff should have documented the residents' blood sugar or that the resident refused to have their blood sugar taken. A review of the Cubex medications showed the Gabapentin and Humalog insulin was available. Reference: WAC 388-97-1060(3)(k)(iii)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure it coordinated follow-up appointments with the denturist (a person who made dentures) for 1 of 1 sampled resident (Resident 5) reviewed for dental needs. This failure placed Resident 5 at risk of discomfort or pain from ill-fitting dentures, weight loss and decreased self-esteem. Findings included. Review of an 08/13/2025 annual assessment showed Resident 5 admitted to the facility on [DATE] with medically complex conditions and was cognitively intact. This assessment showed the resident had no natural teeth or tooth fragments or abnormal mouth tissue. A care area assessment worksheet associated with the 08/13/2025 annual assessment showed Resident 5 was, having a sore on gum line that is being treated/monitored. Resident is at risk for weight changes and chewing problems. The note also showed, dental appointments as ordered or requested PRN [as needed]. In an interview and observation on 08/11/2025 at 8:45 AM, Resident 5 said the staff should have but did not set up a dental appointment in January 2025. Resident 5 explained they were fitted and received new upper and lower dentures that did not fit well and felt, the teeth need to be brought down more. Resident 5 said, I can't eat with them in my mouth. It feels really wrong, the fit is not correct, the bite. The teeth are too large on the dentures. Observed on the bedside stand was a denture cup to which Resident 5 said dentures were inside and, been sitting in that water for a long period of time. They just soak them in water. Inside the denture cup was a full set of dentures with a somewhat transparent film observed on the water.On 08/13/2025 at 12:07 PM, a peanut butter and jelly sandwich on wheat bread, a vanilla ice cream cup and a small bag of Doritos chips were served to Resident 5 for lunch. The resident said, I asked for potato chips [not Doritos] coz I can't chew!Review of a 10/18/2019 oral/dental health problems care plan showed the goal of the resident, will be free of infection, pain or bleeding in the oral cavity. An intervention instructed the staff to, Coordinate arrangements for dental care, transportation as needed/as ordered. The care plan showed Resident 5 had no teeth and no recognition of the presence of dentures.Review of the progress notes showed that on 11/02/2024, Resident 5 went to a dental clinic and was fitted for dentures, with a follow up appointment on 11/15/2024. An 11/15/2024 progress note showed the resident returned from the dental office, with [their] new dentures and had a follow-up fitting appointment on 12/06/2025. Between 11/15/2024 and 12/06/2024, the progress notes showed Resident 5 chose not to wear their dentures because they described them as too thick, wants them filed down, and was not going to wear them until their follow-up appointment on 12/06/2024. Review of the progress notes showed the resident went to their follow-up appointment of 12/06/2024 but the medical record showed no documentation of the appointment's summary. Review of progress notes of 12/07/2024 showed Resident 5 did not tolerate and was not wearing their new dentures, states they feel foreign and don't seem to fit right, upper gums are slightly inflamed and has a follow-up dentist appointment and will re-evaluate at that time. A 12/09/2024 progress note showed the resident continued to refuse to wear the dentures, as they are still uncomfortable to wear, until seen by the denturist in January 2025. The medical record showed no documentation of what efforts the facility made to notify and secure an earlier appointment with the denturist prior to the January 2025 appointment. Additionally, the medical record showed no documentation that the facility coordinated Resident 5's January 2025 follow-up appointment with the denturist. Review of the progress notes through 08/03/2025 showed Resident 5 continued to not wear the dentures (06/12/2025) or refused to wear them (08/01/2025). An 08/01/2025 progress note showed the resident reported to the nurse an open sore to bottom right inner gums from the resident picking at it and from biting down on it - has been refusing to wear dentures since [they] obtained them. Appears similar to canker sore [a small, painful sore inside the mouth on the tongue, gums, or inner cheeks]. On 08/04/2025, the progress note showed the resident reported to the staff they had pain at the site of the sore and was grinding their gums at times. On (continued on next page)

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	505283	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clarkston Health and Rehab of Cascadia	1242 Eleventh Street Clarkston, WA 99403

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	08/05/2025, an order was obtained for chlorhexidine, a prescription-strength mouth rinse used to treat gum disease. Review of the medical record showed no documentation that the facility coordinated a follow -up appointment with the denturist for Resident 5 from January 2025 to August 2025 even though they knew the resident continued to refuse to wear the dentures secondary to fit issues. In an interview on 08/18/2025 at 9:23 AM, Staff H, Nursing Assistant, stated that they were aware Resident 5 mentioned it a few times they did not like how their dentures fit them. In an interview on 08/18/2025 at 8:57 AM, Staff I, Registered Nurse, stated that if dentures did not fit correctly, the facility would get a resident to see a denturist. Staff I stated Resident 5 refused to wear their dentures because they don't fit properly and did not know what the plan was at the moment to address the ill-fitting dentures. In an interview on 08/18/2025 at 10:03 AM, Staff CC, Receptionist, confirmed they coordinated appointments and transportation for the residents in the facility. Staff CC stated Resident 5 refused to go to their January 2025 appointment because it was during the winter months and the resident, wanted to wait until the weather got better. When asked when the appointment would be coordinated in better weather, Staff CC stated, Probably March. When asked if they had any documentation to show efforts were made to reschedule or coordinate Resident 5's follow-up appointments with the denturist, Staff CC stated, Probably not. I haven't talked to [Resident 5] in a while.The above information was shared with Staff B, Director of Nursing, on 08/18/2025 at 10:46 AM. Staff B acknowledged there was no documentation to show coordination of follow-up denturist appointments for Resident 5 as planned or when they continued to refuse to wear their dentures due to poor fitting. Staff B said the January 2025 appointment with the denturist, should have stayed on our clinical follow-up tool until we obtained those [visit] documents. Reference WAC 388-97-1060 (1), (3)(j)(vii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to perform hand hygiene when indicated during 2 of 3 medication administration observations. Additionally, the facility failed to ensure enhanced barrier precautions (EBP, use of personal protective equipment such as disposable gowns and gloves when providing high contact types of care for residents with drains, tubes, or colonized with antibiotic resistant bacteria) were implemented and followed when indicated or ensure PPE was readily available for 2 of 3 sampled residents (Residents 1 and 6), reviewed for infection control. This failure placed residents at risk for potential unintended health consequences, the potential spread of infectious diseases or organisms resistant to antibiotics, and diminished quality of life.Findings included.According to The Centers for Disease Control (CDC) Implementation of Personal Protective Equipment (PPE- gloves, disposable gowns, eye protection or masks) Use in Nursing Homes to prevent Spread of Multidrug-Resistant Organisms updated July 12, 2002, retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html recommended use of EBP as an infection control intervention that employed targeted gown and glove use during high contact resident care activities when Contact Precautions do not apply for residents with wounds or indwelling medical devices such as feeding tubes (inserted tube that provides liquid nutrition) or catheters (flexible tube inserted into bladder to drain urine). EBP directs staff to put on gowns and gloves when dressing, bathing/showering, transferring, changing linens, providing hygiene, wound care and assisting with toileting.Review of the facility policy titled, Transmission-Based Precautions Conventional Plan revised June 2025, showed EBP were infection control interventions designed to reduce transmission of multi-drug-resistant organisms that employed targeted gown and glove use during high contact resident care activities. EBP were recommended for use in resident rooms when residents had open chronic wounds, indwelling medical devices such as a peripherally inserted central catheter [PICC, long term intravenous (IV) access] or colonized with a multi-drug-resistant organism. Staff was to implement precautions upon identification of high-risk residents that require EBP. High-contact care activities included dressing, bathing, transferring, providing hygiene, changing linens, device care or use, and wound care. EBP was intended for the resident's entire length of stay unless a device was removed or a wound healed. ENHANCED BARRIER PRECAUTIONS <Resident 6> According to the 07/20/2025 admission assessment, Resident 6 admitted to the facility on [DATE] with diagnoses including a non-pressure chronic right foot ulcer. The assessment further showed Resident 6 received IV medications while a resident, was cognitively intact and able to clearly verbalize their needs. Review of the 07/17/2025 hospital discharge report showed Resident 6 discharged from the hospital with a diabetic foot ulcer that required a wound vac (medical device that used gentle suction to help large or difficult wounds heal faster) application and continued IV antibiotics to treat a foot infection. Review of the 07/17/2025 care plan showed Resident 6 required EBP related to wounds and IV antibiotics. Interventions instructed staff to use a gown and gloves for high-contact resident care such as device or wound care. Review of provider orders showed active 07/17/2025 order for EBP because Resident 6 had a PICC. During observation and interview on 08/11/2025 at 6:34 AM, Resident 6 sat in their wheelchair in their (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room with an IV pump. Resident 6 stated they had a wound vac dressing to their right foot that was changed three times a week and also had a PICC to their right arm. No EBP signage or other unique signage/symbol was posted on the room door or door frame, no PPE was observed to be readily available. In a follow-up interview 08/11/2025 at 9:35 AM, Resident 6 stated staff only wore gloves, no gowns, when they changed their wound vac. No EBP signage or other unique signage/symbol was posted on the room door or door frame, no PPE was observed to be readily available. During observation on 08/11/2025 at 9:57 AM, Resident 6 had their PICC connected to IV tubing and IV medication infusing when the IV pump began to beep because the infusion was complete. Staff X, Registered Nurse (RN), entered Resident 6's room, washed their hands, put on gloves but no gown and proceeded to disconnect Resident 6 from the completed IV. Staff X proceeded to flush the PICC. During observation on 08/11/2025 at 12:22 PM, Resident 6's door frame now had a dark colored flower to the top left corner, 25 days after they admitted to the facility with a chronic wound and a PICC. No PPE was observed to be readily available. During observation on 08/12/2025 at 11:19 AM, Staff X, RN, entered Resident 6's room with IV tubing, an IV medication, IV flushes, and placed them on the table. Staff X washed their hands, put on gloves but again no gown was worn. Staff X then flushed the PICC, connected the IV medication to the resident, and began infusing the medication. <Resident 1> According to the 06/21/2025 admission assessment, Resident 1 admitted to the facility on [DATE] with diagnoses including pneumonia (lung infection). Resident 1 was cognitively intact and able to clearly verbalize their needs. Review of the 07/02/2025 care plan showed Resident 1 received antibiotics for a bladder infection, interventions instructed staff to administer medications as ordered and monitor for adverse reaction. No documentation was found for staff to implement or follow EBP related to Resident 1 having a PICC. Review of 07/09/2025 urine culture results showed handwritten provider orders on the bottom of the page that instructed Resident 1 get a PICC placed as soon as possible and start IV antibiotics for a bladder infection. Review of July 2025 medication administration record showed Resident 1 had IV access and IV antibiotics started on 07/09/2025. Review of provider orders showed active 07/15/2025 orders for Resident 1 to have their PICC dressing changed weekly and as needed when dirty or soiled. No provider orders were found for staff to implement or follow EBP related to Resident 1 having a PICC. Review of a 08/08/2025 provider order showed Resident 1's IV antibiotics ended on 08/09/2025 but the provider ordered staff to leave PICC in place for now due to recurrent bladder infections. During observation on 08/11/2025 at 6:08 AM, Resident 1 laid in bed with an IV pump to the right side (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of their bed, the trashcan contained used IV flushes and discarded IV bags. No EBP signage or other unique signage/symbol was posted on the room door or door frame, no PPE was observed to be readily available. During a follow-up observation and interview on 08/11/2025 at 7:07 AM, Resident 1 stated they received the last dose of IV antibiotics yesterday but still had the PICC in place in case they required further IV antibiotics to be administered. Resident 1 pulled down a light compression wrap on their right upper arm to expose their PICC. In a follow-up interview on 08/11/2025 at 10:19 AM, Resident 1 stated staff wore gloves and a mask when they changed the PICC dressing but staff did not wear gowns. No EBP signage or other unique signage/symbol was posted on Resident 1's room door or door frame, no PPE was observed to be readily available. During observation on 08/11/2025 at 12:21 PM, Resident 1's door frame now had a dark colored flower to the top right corner, 33 days after they had their PICC inserted. No PPE was observed to be readily available. In an interview on 08/14/2025 at 9:08 AM, Staff U, Nursing Assistant, stated EBP required the use of gloves and a gown when providing high touch resident care. Staff U explained the facility placed succulents, a flower, above the resident doors who required EBP. Staff U pointed a flower to the door frame of room [ROOM NUMBER]. Staff U explained PPE should be in the bottom nightstand drawer. Staff U did not find any gowns in any nightstand drawers but found one gown in the bathroom cabinet. Staff U acknowledged staff should implement and follow EBP when indicated to reduce the spread of infection; Resident 1 required EBP related to having a PICC and Resident 6 should be on EBP related to having a PICC and wound vac in place. In an interview on 08/14/2025 at 10:38 AM, Staff T, RN, stated EBP required the use of gloves and a gown when care was provided such as PICC management to prevent the spread of infection. Staff T explained the facility placed a flower on a resident's room door when they required EBP. Staff T acknowledged staff should implement and follow EBP when indicated. In an interview on 08/14/2025 at 11:58 AM, Staff E, Resident Care Manager, explained the facility placed succulents on the door frames to resident rooms that required EBP. Staff E stated EBP required the use of gloves and gown during high contact care activities such as accessing lines. Staff E further stated they expected staff to implement and follow EBP when indicated to prevent the spread of infection. In an interview on 08/14/2025 at 12:16 PM, Staff F, Infection Preventionist, stated EBP required the use of gloves and gowns with any high contact care activities such as changing linens or accessing a PICC. Staff F explained the facility placed succulents on resident room door frames to inform staff EBP was required in a room; gowns were stocked and stored in varying room locations depending on which staff stocked the gowns. Staff F further staff also obtained a provider order and care planned EBP. Staff F stated they expected staff to implement and follow EBP when indicated to reduce the risk of infection transmission. In an interview on 08/14/2025 at 12:57 PM, Staff B, Director of Nursing, explained the facility placed succulents on resident room door frames to indicate when EBP was required, in an attempt to create a homelike environment. Staff B stated EBP required gloves and gowns be worn during high touch (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident care for residents with chronic wounds or implanted devices. Staff B further stated they expected staff to implement and follow EBP when indicated. In an interview on 08/18/2025 at 11:12 AM, Staff A, Administrator, stated they expected staff to implement and follow EBP when indicated. HAND HYGIENE During observation on 08/14/2025 at 7:16 AM, Staff T, RN, put a pair of gloves on without performing hand hygiene, drew insulin up in a syringe, walked down the hall with their gloves on, and administered insulin to Resident 26. Staff T removed their gloves, did not perform hand hygiene and began dispensing medications for Resident 25, grabbing some over-the-counter vitamins with their bare hands to place them in the medication cup. Staff T performed hand hygiene twice, then administered the dispensed medications to Resident 25. In an interview on 08/14/2025 at 10:37 AM, Staff T, acknowledged they did not perform hand hygiene and should have prior to dispensing medications and between residents. In an interview on 08/14/2025 at 12:12 PM, Staff F, Infection Preventionist, stated hand hygiene should be preformed before glove application, after removal, before dispensing medication, after medication administration, and between residents. Staff F stated they expected staff to perform hand hygiene when indicated. During a medication administration observation on 08/14/2025 at 7:56 AM, Staff G, RN, sanitized their hands and put on gloves. Staff G then opened Resident 83's blinds, adjusted their bed, turned on their light, removed the old IV bags from the pole, and with the same gloves hung the new IV medication. Staff G wearing the same gloves then wiped the resident's IV canula with alcohol, flushed their IV line and connected the new IV bag. Staff G, wearing the same gloves adjusted Resident 83's pillow, got the resident a second pillow and administered some of the resident's medications. A cup fell on the floor and Staff G picked it up with the same pair of gloves they had been wearing and administered the rest of Resident 83's medications. In an interview on 08/14/2025 at 8:12 AM, Staff G stated they should have performed hand hygiene and put on new gloves after they had touched the things in the room prior to giving the resident the resident's medications. In an interview on 08/14/2025 at 9:51 AM, Staff F, Infection Preventionist, stated hand hygiene should have been performed after things in the room were touched and prior to administering medications and it was important to prevent infection. In an interview on 08/14/2025 at 12:55 PM, Staff B stated they expected staff to perform hand hygiene when indicated to prevent the spread of infection. In an interview on 08/18/2025 at 11:12 AM, Staff A stated they expected staff to perform hand hygiene when indicated. Reference: WAC 388-97-1320 (1)(c)(2)(b)