STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505289	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menus according to Resident Council Minutes for 4 of 6 months (October, November, January, and February 2026) and 1 of 1 kitchen observation (03/22/2026) when reviewed for kitchen. This failure placed residents at risk of inadequate nutritional intake, avoidable weight loss, a decline in clinical condition, and a diminished quality of life. Findings included .Review of the Resident Council meeting minutes for October 2025 showed, Would like to see honesty with the names of foods on the menus and what is served. Review of the Resident Council meeting minutes for November 2025 showed, Menu does not always seem to match what is served. Soup is frequently not what is on the menu for the day and the serving sizes vary. Sometimes the bowl is full and sometimes the bowl is half full and frequently not warm enough. If changes are to be made to the menu or brands, such as the coffee, please notify patients prior to any changes. Review of the Resident Council Minutes for January 2026 showed, Frequently do not get what is on the menu- example: western omelet, only egg and cheese, was not omelet, it was baked. Review of the Resident Council Minutes for February 2026 showed, Request notification on days when the menu needs to be changed for any reason. Review of the menu for 03/11/2026 showed chicken legs would be served as the lunch protein with 4 ounces (oz) of scalloped potatoes and 4 oz of peas. Observation on 03/11/2026 at 11:48 AM showed Staff R, Cook, serving chicken thighs, peas with a long-handled four oz scoop, and potatoes with a green handled scoop. Observation showed Staff R filled the long-handled scoop approximately two thirds full when serving. During an interview on 03/11/2026 at 1:14 PM, Staff R, Cook, stated the long-handled scoop used for peas was four oz and they believed the green handled scoop was also 4 oz. During an interview on 03/11/2026 at 1:16 PM, Staff N, Dietary Manager, stated they were unsure what size the green handled scoop was and would need to check. During an interview on 03/11/2026 at 2:38 PM, Staff U, Registered Dietician, stated the facility ensured the meals had enough nutrition by following the menu, which included portion sizes. Staff U stated the green handled scoop used to serve potatoes at lunch was two and two thirds an ounce and the grey handled scoop was four oz and should have been used. During an interview on 03/12/2026 at 1:58 PM, Staff N, Dietary Manager, stated facility kitchen staff were trained on portion sizes before working in the kitchen. Staff N stated Staff R, Cook, should have filled the long-handled scoop fully when serving. Staff N stated they were unsure whether the scoop used to serve potatoes was correct. Staff N stated chicken thighs were served instead of chicken legs because the facility could not order chicken legs and thighs were the closest they could get. During an interview on 03/12/2026 at 2:42 PM, Staff A, Administrator, stated the kitchen staff should follow the menu designated portion sizes, and the menu should be altered prior to publication if the facility was unable to purchase a product. Reference WAC 388-97-1160(1)(a)(b), -1120(3)(c)(4)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain sanitary food storage and/or preparation for 2 of 2 kitchen observations (Initial and Second) and failed to ensure resident foods were sanitarily stored for 2 of 2 resident refrigerators (North and South) when reviewed for kitchen. This failure placed residents at risk of foodborne illness, avoidable discomfort, and a diminished quality of life. Findings included.Initial Kitchen Tour on 03/08/2026 at 9:37 AMObservation showed the walk-in freezer containing a box of raw hamburger patties, bag of breaded fish fillets, bag of chicken tenders, a bag of fries, and a bag of hashbrowns opened without date label and left open to the air. Observation showed numerous boxes of food items stacked on the ground of the freezer with some boxes falling from their stack and laid haphazardly across the freezer. Observation showed a metal container of re-frozen food stacked on a frozen bag of soup which was stacked on a second open container of re-frozen food. Observation of the refrigerator units showed a bowl of tuna salad without date label, three bags of apple slices with a best by date of 03/02/2026, three bowls of salad exposed to the air without date label which appeared wilted, a plastic container of sliced tomato without date label, a cucumber in plastic with a 03/02/2026 use by date, a plastic container of olives with a 02/26/2026 use by date, a plastic container of cubed meat with no date label, hardboiled eggs left uncovered and without date label, a bottle of unknown sauce with no date label, and multiple plastic bins with food items uncovered. Observation showed a box of zucchini on the floor outside of the refrigerator with no temperature controls and two earbud containers and several phone cords next to the steamtable. Second Kitchen Tour on 03/11/2026Observation at 11:35 AM showed staff was already preparing salads and had placed cheese, cubed meat, precut vegetables, and cottage cheese on the salad preparation station. Observation at 11:35 AM showed a bag of fast food on near the steamtable. Observation at 11:38 AM showed the refrigerator had a plastic container of hardboiled eggs with no date and uncovered. Observation at 11:40 AM showed the walk-in freezer had bags of hamburger patties and hashbrown opened without date label and left exposed to the air. Observation showed a metal container of re-frozen food stacked on a frozen bag of soup which was stacked on a second open container of re-frozen food. Review of the dishwasher temperature log for March 2026 showed the washing machine should reach 180 degrees Fahrenheit (F) during the rinse cycle and 03/06/2026 and 03/07/2026 were recorded below this threshold. Observation at 11:56 AM showed Staff R, Cook, taking the temperature of the hot foods and cleaned the thermometer on a dry dishcloth between dishes. Observation at 11:59 AM showed Staff N, Dietary Manager, washing dishes and the washing machine mounted wash temperature gauge did not move and showed 128 F. Staff N ran a second load of dishes and the thermometer continued in place showing 128 F. Observation at 12:04 PM showed Staff R, Cook, continued to measure the temperature of foods on the steamtable. Staff R tested a puree, wiped the thermometer on a dry towel, tested a second puree, ran the thermometer under water at the handwashing sink, then tested a third puree. Observation at 12:08 PM showed Staff R, Cook, had a beard and was not wearing a net over the exposed hair. Observation at 12:10 PM showed the salad station continued with cheese, cubed meat, sliced vegetables, hardboiled eggs, and cottage cheese left out without temperature controls. Observation showed the prepared salads sat at the station wrapped but with no temperature controls. Observation at 12:24 PM showed staff return some items from the salad station to the refrigerator, but cubed meat, sliced vegetables, cottage cheese, and prepared salads continued at the station without temperature controls. Observation at 12:28 PM showed a cellphone stored on a small table near the salad making station. Observation at 12:47 PM showed Staff N, Dietary Manager, returned the cubed meat, sliced vegetables, and cottage cheese to the refrigerator (1 hour and 12 minutes outside temperature control). Observation at 1:06 PM showed a kitchen staff with hair and beard entered the kitchen, moved through the kitchen, moved into the dry storage, and then exited out of the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	back of the kitchen without performing hand hygiene or donning a hair/beard net. Observation at 1:07 PM showed a staff take out a stack of sliced cheese, removed a slice, and placed the stack on the salad station without temperature controls. The salad station contained two large salads with cubed meat and sliced hardboiled eggs and five side salads. Observation at 1:19 PM at the end of meal service showed one large salad and five small salads continued on the salad station (1 hour 44 minutes without temperature controls). Review of the Resident Council Minutes for September 2025 showed a concern, Salads can be better. Poor quality overall. Tomatoes are mushy, salad is warm not cold, lettuce is wilty. Review of the Resident Council Minutes for December 2025 showed a concern, Hit or miss with the quality of salads. Resident RefrigeratorsObservation on 03/11/2026 at 2:00 PM showed the North Hall resident refrigerator contained the following: three nutrient drinks frozen in the freezer which showed Do not freeze labeling, one bag of fast food with no date label, a blue bag with two containers soup and one plastic food container without date label, one plastic food container without date label, one cardboard box of Asian food with 03/07 date label, one box pecan pie opened with once slice left with no name or date label, and one Tupperware of unidentifiable food without date label. Observation showed no temperature log to monitor the temperature of the refrigerator. Observation on 03/11/2026 at 2:09 PM showed the South Hall resident refrigerator contained the following: two nutrient drinks frozen in the freezer which showed Do not freeze labeling, a large coffee cup wrapped in a plastic bag without name or date label, a bag with three plastic containers of food with a 03/07/2025 date label, a plastic bag with two takeout containers without date label, a bag of grapes dated 02/16 with white film on the product, a large bag of groceries to include cherry tomatoes, grapes, cucumber, and lunch meat without date label, a whole pizza box with three slices of pizza without date label, a box of lemon glycerin swab sticks (used for temporary oral lubrication and refreshing the mouth, often for patients with dry mouth or restricted fluid intake), a plastic container of fried rice without date label, a paper bag with sandwich and fruit with 03/01 date label, and a bag with plastic container of Asian food and chopped salad kit with a best by date of 02/26/2026. Observation showed the temperature log was for February 2026 and had a single temperature logged. During an interview on 03/12/2026 at 1:58 PM, Staff N, Dietary Manager, stated food items should not be stored on the floor of the freezer or kitchen and should be date labeled when opened. Staff N stated food items should be covered when stored and the observations of food left uncovered in the refrigerator and freezer did not meet expectations. Staff N stated personal items, such as cellphones and accessories, should not be in the kitchen. Staff N stated cold foods, such as cubed meat, hardboiled eggs, and cottage cheese should be stored with temperature controls and not left out. Staff N stated Staff R, Cook, should use sanitation wipes between foods and the observation of wiping the thermometer on a dry rag did not meet expectations. Staff N stated staff should use hair/beard nets to ensure hair did not contaminate food, and the observation of Staff R with uncovered beard did not meet expectations. Staff N stated maintenance should have been consulted after the temperatures under the expected range were logged on the washing machine log. During an interview on 03/12/2026 at 2:42 PM, Staff A, Administrator, stated food should be closed and date labeled while stored, and should not be stored on the ground. Staff A stated cold foods should be held in a temperature-controlled environment before being served and staff personal items should not be stored in the kitchen area. Staff A stated staff with beards should have them covered and sanitation wipes should be used between taking the temperature of different food items. Staff A stated when the washing machine was not reaching the required temperature, maintenance should be contacted and chemical cleaners used until repairs were made. Staff A stated nursing staff was responsible for the monitoring and cleaning of the resident refrigerators. Staff A stated the resident refrigerators should be monitored for temperature daily, and the lack of temperature monitoring did not meet expectations. Reference WAC 388-97-1100(3), -2980

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor for adverse side effects and behaviors for 3 of 5 sampled residents (Residents 26, 89, and 88) when reviewed for unnecessary medications. These failures placed the residents at risk for poor clinical outcomes and a decreased quality of life. Findings included .Resident 26 Review of the electronic health record (EHR) showed Resident 26 was admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), end stage renal disease (kidney failure), and dependence on renal dialysis (life sustaining treatment that filters waste and excess fluid from the blood). Resident 26 was able to communicate their needs. Review of the providers' orders showed Resident 26 was prescribed trazodone (antidepressant medication) dated 02/09/2026 for insomnia. Review of the EHR showed no monitoring for adverse side effects and behaviors for the use of the medication. During an interview on 03/11/2026 at 11:46 AM, Staff B, Director of Nursing Services (DNS), stated they were not sure why there was no monitoring for adverse side effects and behaviors, but there should be. Resident 89 Review of Resident 89's EHR showed the resident admitted on [DATE] with diagnoses of dementia (a group of symptoms that effects memory), depression, and bipolar disorder (a chronic mental health condition characterized by intense, long-lasting shifts in mood, energy, and activity levels). The resident was able to make needs known. Review of the provider orders for Resident 89 showed an order for quetiapine (an antipsychotic medication) with a start date of 02/10/2026 and an order to monitor orthostatic blood pressure (blood pressure taken when lying, sitting and standing) every two weeks. Review of the medication administration record for the months of January 2026 and February 2026 showed no documented orthostatic blood pressures. During an interview on 03/10/2026 at 2:43 PM, Staff B, DNS, stated it was their expectation that adverse side effects such as orthostatic blood pressures be monitored as ordered and this did not meet expectations for Resident 89. Resident 88 Review of the EHR showed Resident 88 admitted to the facility on [DATE] with diagnoses of anxiety and depression. The resident was able to make needs known. Review of the provider orders showed an order for citalopram (an antidepressant medication) with a start date of 01/30/2026 and an order for buspirone (an antianxiety medication) with a start date of 01/29/2026. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the provider orders and the medication administration record showed no documented monitoring of the adverse side effects of the medications and no documented monitoring of Resident 88's behaviors. During an interview on 03/10/2026 at 9:55 AM, Staff D, Licensed Practical Nurse, stated Resident 88 should have had orders to monitor behaviors and adverse side effects of psychotropic medications but did not. During an interview on 03/10/2026 at 2:43 PM, Staff B, DNS, stated it was their expectation that Resident 88 be monitored for adverse side effects of antianxiety and antidepressant medications and should have had a behavior monitor in place. Reference WAC 388-07-1060(3)(k)(i) -0620(1)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a thorough investigation to rule out abuse/neglect was conducted after resident accidents for 2 of 4 sampled residents (Residents 5 and 32) when reviewed for abuse/neglect. This failure placed residents at risk of continued abuse, continued neglect, and a diminished quality of life. Findings included.According to the Nursing Home Guidelines also known as the Purple Book, sixth edition, dated October 2015, All alleged incidents of abuse, neglect, abandonment, mistreatment, injuries of unknown source, personal and/or financial exploitation, or misappropriation of resident property must be thoroughly investigated . A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment, personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences. Resident 5Review of the electronic health record (EHR) showed Resident 5 admitted on [DATE] with diagnoses to include Parkinson's disease (a progressive movement disorder that occurs when nerve cells in the brain die) and adult failure to thrive. Resident 5 was able to make needs known. During an interview and observation on 03/08/2026 at 10:46 AM, Resident 5 stated a staff member had been transferring them from the bed to a wheelchair and the resident's leg had been scratched on the wheelchair. Observation showed Resident 5's leg was bandaged from ankle to knee. Review of the Accident and Incident Log showed an incident for Resident 5 on 02/27/2026 with superficial injury and related to the resident's condition. Review showed the incident was not reported to the state agency. Review of the care plan showed a focus area, initiated 02/27/2026, for skin impairment to the left lower leg with an intervention for referral to an outside wound care provider. Review of the incident report, dated 03/03/2026, showed, Nursing Description: Resident observed with a skin tear to [their] left lower leg, and Resident Description: Resident stated [they] accidently bumped [their] leg on the side of [their] bed railing. Review did not show a resident statement or witness statements were included. Review showed the conclusion was Resident 5 hit their leg on the bed rail and the new intervention was referral to an outside wound care provider. Review showed abuse/neglect was ruled out. Review of the outside wound care provider's wound assessment progress note, dated 03/04/2026, showed Resident 5 reported they were injured getting into their wheelchair. During an interview on 03/12/2026 at 8:47 AM, Resident 5 was able to accurately describe how they were injured as previously given on 03/08/2026 and stated Staff K, Certified Nursing Assistant (CNA), was the staff member assisting them when the injury occurred. During an interview on 03/12/2026 at 11:04 AM, Staff K, CNA, stated they were assisting Resident 5 transfer into a wheelchair on 02/27/2026 when the resident's leg was scratched by the wheelchair. Staff K stated they were not interviewed as part of the investigation and were not asked to write a statement of events. During an interview on 03/12/2026 at 12:29 PM, Staff B, Director of Nursing Services, stated they had started at the facility two weeks prior and had walked into about 30 investigations to complete and some of the uninvestigated incidents dated all the way back to January. Staff B stated when a resident was injured the facility would generally interview the resident and staff, collect statements, and review the record. Staff B stated abuse/neglect was ruled out by Basically, looking over the incident and data sources for making this decision was interviews and record review. Staff B stated Resident 5's incident investigation needed to be re-completed because it did not include statements from CNA. Staff B stated they felt abuse/neglect had adequately been ruled out based on the original information provided by the resident. During an interview on 03/12/2026 at 12:46 PM, Staff A, Administrator, stated the incident investigation of Resident 5's 02/27/2026 injury should have had more detail and abuse/neglect was inadequately investigated. Resident 32Review of the EHR showed Resident 32 admitted to the facility on [DATE] with diagnoses to include chronic lymphocytic leukemia (a slow-growing cancer of the blood and bone (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	marrow, primarily affecting older adults) and dementia (a decline in mental ability, such as memory loss, poor judgment, or confusion). Resident 32 was unable to make needs known. Review of the incident log showed Resident 32 had unwitnessed falls on the following dates: 10/04/2025, 10/05/2025, 10/11/2025, 10/31/2025, 11/12/2025, 11/24/2025, 12/08/2025, 12/17/2025, 12/18/2025, 12/21/2025, 12/22/2025, 12/24/2025, 01/01/2026, 01/10/2026, 01/21/2026, 01/25/2026, 01/27/2026, and 02/20/2026. Review of Resident 32's incident reports for the above dates showed the following investigations did not include witness statements and/or interviews with assigned facility staff members: 10/05/2025,10/11/2025, 11/12/2025, 11/24/2025, 12/17/2025, 12/18/2025, 12/21/2025, 12/22/2025,12/24/2025, 01/01/2026, 01/21/2026, 01/25/2026, and 01/27/2026. Review of two incident reports for unwitnessed falls by Resident 32, which were not included in the incident log, dated 12/05/2025 and 02/14/2026, showed they did not include witness statements and/or interviews with assigned facility staff members. During an interview on 03/13/2026 at 9:28 AM, Staff A, Administrator, stated staff should be interviewed after an unwitnessed fall to assist in ruling out abuse/neglect. Reference WAC 388-97-0640(6)(a)(b)

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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 screen residents for additional mental health supports on admission and/or after a change in mental health diagnoses for 7 of 8 sampled residents (Residents 32, 13, 2, 11, 88, 89, and 9) when reviewed for Pre-admission Screening and Resident Review (PASSAR, a mental health screening tool). This failure placed residents at risk of not having needed mental health supports, increased adverse behaviors, and a diminished quality of life. Findings included.During an interview on 03/11/2026 at 11:08 AM, Staff J, Social Services Director (SSD), stated residents were screened for mental health needs on admission using the PASSAR assessment. Staff J stated any resident with a mental health diagnosis would have a positive PASSAR and be referred for a level two PASSAR. Staff J stated if a hospital submitted an inaccurate PASSAR the facility would re-complete it accurately. Staff J stated the PASSAR should be re-completed if a resident received a new mental health diagnosis. Resident 32Review of the electronic health record (EHR) showed Resident 32 admitted to the facility on [DATE] with diagnoses to include chronic lymphocytic leukemia (a slow-growing cancer of the blood and bone marrow, primarily affecting older adults), dementia (a decline in mental ability, such as memory loss, poor judgment, or confusion), depression, and violent behaviors. Resident 32 was unable to make needs known. Review of a PASSAR, dated 06/13/2024, showed Resident 32 had no mental health diagnoses. Review of a PASSAR, dated 04/21/2025, showed Resident 32's PASSAR was re-completed accurately, and they were referred for a level two PASSAR (10 months after admission). Resident 13Review of the EHR showed Resident 13 admitted to the facility on [DATE] with diagnoses to include anxiety disorder, dementia (a decline in mental ability, such as memory loss, poor judgment, or confusion), and schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, and emotional responsiveness, causing individuals to lose touch with reality). Resident 13 was able to make needs known. Review of a level two PASSAR, dated 02/01/2022, showed Resident 13's diagnosis of schizophrenia was not included. Review of the diagnosis list showed Resident 13 received a diagnosis of schizophrenia on 04/29/2024. During an interview on 03/12/2026 at 11:45 AM, Staff J, SSD, stated Resident 13 was diagnosed with schizophrenia on 04/29/2024 and they could not locate a PASSAR was re-completed after this new mental health diagnosis. Resident 2Review of the EHR showed Resident 2 admitted to the facility on [DATE] with diagnoses to include cancer, kidney transplant, and anxiety. Resident 2 was able to make need known. Review of the EHR did not show a PASSAR had been completed for Resident 2's 11/22/2025 admission. During an interview on 03/12/2026 at 11:52 AM, Staff J, SSD, stated they could not locate a PASSAR for Resident 2's 11/22/2025 admission. Resident 11Review of the EHR showed Resident 11 admitted to the facility on [DATE] with diagnoses to include schizophrenia and diabetes (high blood sugar). Resident 15 was able to make needs known. Review of the PASSAR, dated 01/22/2026, showed Resident 11 was assessed approximately one year after admission. Resident 88Review of the EHR showed Resident 88 admitted to the facility on [DATE] with diagnoses to include pressure ulcer of the right buttock, anxiety, and depression. Resident 88 was able to make needs known. Review of the PASSAR, dated 01/21/2026, showed it was completed by the admitting hospital and did not include any of Resident 88's mental health diagnoses. Resident 89Review of the EHR showed Resident 89 admitted to the facility on [DATE] with diagnoses to include encephalopathy (a broad term for any disease, damage, or malfunction that affects the brain's structure or function, resulting in an altered mental state), hallucinations, depression, and bipolar disorder (a chronic mental health condition characterized by intense, alternating mood swings between extreme highs and lows). Resident 89 was able to make needs known. Review of the PASSAR, dated 10/02/2025, showed it was completed by the admitting hospital and did not include any of Resident 89's mental health diagnoses. Resident 9Review of the EHR showed Resident 9 admitted to the facility on [DATE] with diagnoses to include (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic obstructive pulmonary disease (a progressive, long-term lung disease that restricts airflow, making it difficult to breathe), depression, bipolar disorder, and post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening, or traumatic events). Resident 9 was able to make needs known. Review of the PASSAR, dated 09/18/2024, showed it was completed by the admitting hospital and referral for a level two PASSAR was not needed as the resident was expected to stay in the facility for less than 30 days. During an interview on 03/13/2026 at 9:27 AM, Staff A, Administrator, stated if the PASSAR was completed by the hospital prior to admission, the facility would re-complete the PASSAR if it was inaccurate. Staff A stated if a resident received a new mental health diagnosis, social services would re-complete the PASSAR. Reference WAC 388-97-1915(1)(2)(a)-(c)

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	505289	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to develop comprehensive care plans for 4 of 21 sampled residents (Residents 1, 9, 10, and 26) when reviewed for comprehensive care plans. Failure to develop care plans that accurately reflected resident care needs related to oxygen therapy, wound/skin impairment, use of an indwelling catheter (a thin flexible tube that is inserted through the urethra/tube like structure into the bladder to continuously drain urine), and antidepressant medication use placed residents at risk of unmet care needs and potential negative outcomes. Findings included.Resident 1 Review of the electronic health record (EHR) showed Resident 1 readmitted to the facility on [DATE] with diagnoses to include heart failure, respiratory conditions due to unspecified external agent (a lung disease or breathing problem triggered by something inhaled or exposed to from the environment), and cerebral infarction (stroke, blood flow to part of the brain is blocked preventing oxygen from reaching brain tissue, causing cells to die). Resident 1 was able to make needs known. Observation and interview on 03/08/2026 at 2:53 PM showed Resident 1 with an oxygen (O2) concentrator (a device used for O2 therapy) located in the room not in use. Resident 1 stated they did not need O2 at that time. Review of the February 2026 medication administration record (MAR) showed Resident 1 was prescribed O2 at 0-2 liters as needed (PRN) to maintain O2 saturation (Sats, measuring the percentage amount of O2 in the blood) greater than 92% for O2 maintenance. Documentation showed Resident 1 received O2 almost every shift. It further showed this order was discontinued on 03/09/2026. Review of the March 2026 MAR showed Resident 1 was prescribed continuous O2 at 2 liters to maintain O2 Sats greater than 92% for O2 maintenance. Documentation showed it was provided starting on 03/09/2026 on the evening shift. Review of the current care plan showed no documentation related to Resident 10's O2 therapy. During an interview on 03/11/2026 at 2:25 PM, Staff L, Licensed Practical Nurse/Unit Manager (LPN/UM), stated they were unable to locate a care plan for Resident 10's O2 therapy and there should have been one in place. During an interview on 03/11/2026 at 4:17 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was that residents on O2 therapy have a care plan in place. Resident 9 Review of the EHR showed Resident 9 admitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood), dementia (a decline in mental abilities, severe enough to interfere with daily life), and chronic obstructive pulmonary disease (restricted airflow making it difficult to breathe). Resident 9 was usually able to make needs known. Review of the February and March 2026 treatment administration records (TAR) showed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation that Resident 9 was being treated for a chronic ulcer/open wound to the left foot. Review of the current care plan showed there was a focused care plan for Resident 9's risk for pressure ulcers and skin impairment, initiated on 12/24/2024; however, there was no documentation to show Resident 9 had an actual skin impairment to the left foot. During an interview on 03/13/2026 at 10:03 AM, Staff M, Staff Development/Infection Preventionist (SD/IP), stated Resident 9's wound to the left foot had not been care planned and it should have been. During an interview on 03/13/2026 at 10:12 AM, Staff B, DNS, stated Resident 9 did not have a care plan for their chronic wound to the left foot and there should have been one in place when it was first identified. Resident 10 Review of the EHR showed Resident 10 readmitted to the facility on [DATE] with diagnoses of neurogenic bladder (a condition that prevents the bladder from working property, leading to poor bladder control), stage 3 chronic kidney disease (moderate kidney damage, with kidneys functioning at 30-59% capacity, causing waste to build up in the blood), and dementia. Resident 10 had an indwelling catheter in place. Review of the nursing progress note dated 03/04/2026 showed Resident 10's indwelling catheter was flushing and draining well. Review of the Admission/Readmission, progress note dated 03/07/2026 showed Resident 10 continued to have their indwelling catheter draining clear yellow urine. Review of the February and March 2026 TAR showed documentation that Resident 10 received catheter care every shift while in the facility. Review of the EHR showed a focused care plan for Resident 10's indwelling catheter had been initiated/created on 03/09/2026. During an interview on 03/11/2026 at 2:08 PM, Staff L, LPN/UM, stated Resident 10's focused care plan for their indwelling catheter was developed too late. During an interview on 03/11/2026 at 4:03 PM, Staff B, DNS, stated Resident 10's care plan for their indwelling catheter should have been initiated sooner. Resident 26 Review of the EHR showed Resident 26 was admitted to the facility on [DATE] with diagnoses to include diabetes, end stage renal disease (kidney failure), and dependence on renal dialysis (life sustaining treatment that filters waste and excess fluid from the blood). Resident 26 was able to communicate their needs. Observation on 03/08/2026 at 10:13 AM, showed Resident 26 sitting in their room, using oxygen via nasal cannula (clear tube that enters nose) taking oxygen at 2 liters per minute. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the providers' orders showed Resident 26 was prescribed trazodone (antidepressant medication) dated 02/09/2026 for insomnia. Review of Resident 26 care plan dated 01/28/2026 showed no directions or goals for oxygen use or antidepressant medication use for insomnia. During an interview on 03/11/2026 at 11:48 AM, Staff B, DNS, stated the care plan should be developed based on the assessment and needs. Reference WAC 388-07-1020(1)(2)(a)(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 3 of 3 sampled residents (Residents 1, 9, and 67) reviewed for respiratory care. Failure to obtain and/or follow provider orders for oxygen (O2) therapy, ensure O2 tubing was appropriately maintained, regularly changed and dated, and O2 concentrator (a device used for O2 therapy) filters (used to protect the resident from particulate matter) were cleaned and maintained routinely, placed residents at risk for avoidable respiratory disease, unmet needs, and potential negative outcomes. Findings included.Resident 1Review of the electronic health record (EHR) showed Resident 1 readmitted to the facility on [DATE] with diagnoses to include heart failure, respiratory conditions due to unspecified external agent (a lung disease or breathing problem triggered by something inhaled or exposed to from the environment), and cerebral infarction (stroke, blood flow to part of the brain is blocked preventing oxygen from reaching brain tissue, causing cells to die). Resident 1 was able to make needs known. Observation on 03/09/2026 at 2:00 PM showed Resident 1 lay in bed with the head of the bed elevated, O2 being delivered at 1.5 liters through a nasal canula (NC, a flexible tube with two prongs used to provide O2 through the nose) via an O2 concentrator. Review of the EHR showed Resident 1 had a provider order dated 03/09/2026 to have continuous O2 at 2 liters to maintain O2 saturation (Sats, measuring the percentage amount of O2 in the blood) greater than 92% every shift for O2 maintenance. Review showed no orders or documentation to change O2 tubing or to clean the filter on the O2 concentrator routinely. During an interview on 03/11/2026 at 2:25 PM, Staff L, Licensed Practical Nurse/Unit Manager (LPN/UM), stated O2 tubing should be changed and dated weekly; however, they were not sure where that was getting documented. Staff L stated they were not sure about the O2 concentrator filter and when or how that was cleaned. Observation and interview with Staff L, LPN/UM, on 03/11/2026 at 2:47 PM showed Resident 1 laid in bed receiving O2 at 1.5 liters through a NC via an O2 concentrator. Staff L stated the O2 liter flow should be at 2 liters and increased the liter flow per provider's order. During an interview on 03/11/2026 at 4:17 PM, Staff B, Director of Nursing Services (DNS), stated they were not aware that Resident 1 had O2 liter flow provided outside of provider's order and the expectation was that provider orders were followed. Staff B stated they were unable to locate orders or documentation for Resident 1's O2 tubing to be changed or for the O2 concentrator filter to be cleaned and there should have been. Staff B stated O2 tubing changes and O2 concentrator filter cleanings should be documented by the licensed nurse in the medication administration records (MAR) or treatment administration records (TAR). Resident 9 Review of the EHR showed Resident 9 admitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood), dementia (a decline in mental abilities, severe enough to interfere with daily life), and chronic obstructive pulmonary disease (COPD, restricted airflow making it difficult to breathe). Resident 9 was usually able to make needs known. Observations on 03/10/2026 at 10:06 AM, 03/11/2026 at 10:49 AM, 03/11/2026 at 2:53 PM and on 03/12/2026 at 11:27 AM showed Resident 9 receiving O2 at 2 liters through a NC via an O2 concentrator. Review of the EHR showed Resident 9 had a provider order dated 02/25/2026 to have O2 inhalation at 3 liters per minute to keep O2 Sats above 88% every shift. Review showed no orders or documentation to change O2 tubing or to clean the filter on the O2 concentrator routinely. During an interview on 03/11/2026 at 4:39 PM, Staff B, DNS, stated they were unable to locate provider orders for Resident 9 to have O2 tubing changed or to clean the filter on their O2 concentrator and there should have been. Observation and interview on 03/12/2026 at 11:32 AM with Staff O, Assistant Director of Nursing (ADON), showed Resident 9 laid in bed receiving O2 at 2 liters through a NC via an O2 concentrator. Staff O stated the liter flow should be at 3 liters and then increased the liter flow to 3 liters per provider's order. Resident 67 Review of the EHR showed Resident 67 admitted to the facility on [DATE] with diagnoses to include COPD, cerebral (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infarction/stroke, and chronic (lasts for an extended period or consistently recures) respiratory failure. Resident 67 was usually able to make needs known. Observation on 03/10/2026 at 11:10 AM showed Resident 67 laid in bed receiving O2 at 4 liters through a NC via an O2 concentrator. Resident 67's O2 tubing was not dated. Review of the EHR showed Resident 67 had a provider order dated 03/09/2026 to have O2 at 2-4 liters continuous via NC to keep O2 above 92% every shift. Review showed no orders or documentation to change O2 tubing or to clean the filter on the O2 concentrator routinely. During an interview on 03/11/2026 at 2:43 PM, Staff B, DNS, stated Resident 67 was missing orders to change O2 tubing and to clean the O2 concentrator filter and they needed to be obtained from the provider. Reference WAC 388-97 -1060(3)(j)(iv)-(vi)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to periodically review and provide assistance with advanced directives (legal documents that appoints a trusted person to make healthcare decisions on your behalf if you become unable to communicate or incapacitated) for 2 of 3 sampled residents (Residents 5 and 4) when reviewed for advanced directives. This failure placed residents at risk of not having a healthcare decisionmaker, inability to control care received when incapacitated, and a diminished quality of life. Findings included.Resident 5Review of the electronic health record (EHR) showed Resident 5 admitted on [DATE] with diagnoses to include Parkinson's disease (a progressive movement disorder that occurs when nerve cells in the brain die) and adult failure to thrive. Resident 5 was able to make needs known. Review of a Multidisciplinary Care Conference form, dated 07/23/2025, showed Resident 5's advanced directive was reviewed and assistance offered. Review of a progress note, dated 03/11/2026, showed Resident 5 believed they had established a durable power of attorney, but the facility had not obtained this document. Resident 4Review of the EHR showed Resident 4 admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a chronic autoimmune disease of the central nervous system) and dementia (a decline in mental ability, such as memory loss, poor judgment, or confusion). Resident 4 could not make needs known. Review of a Social Service Initial Evaluation, dated 12/03/2025, showed Resident 4 did not have an advanced directive, but would like to establish one. Review of a progress note, dated 03/11/2025, showed Resident 4 believed they had an advanced directive, but was unsure. During an interview on 03/11/2026 at 11:05 AM, Staff J, Social Services Director, stated the facility asked residents about their advanced directive during the initial care conference and would obtain a copy of any advanced directive a resident had established. Staff J stated if a resident did not have an advanced directive, they would provide information on how to establish one using an advanced directive information sheet. Staff J stated residents' advanced directive choices would be reviewed quarterly with care conferences. During a follow-up interview on 03/12/2026 at 12:13 PM, Staff J stated Resident 5 had not had an advanced directive review between 07/23/2025 and 03/11/2026 and Resident 4 had not had follow-up on their advanced directive between 12/03/2025 and 03/11/2026. During an interview on 03/13/2026 at 9:26 AM, Staff A, Administrator, stated advanced directives should be reviewed quarterly with care conferences. Reference WAC 388-97-0280(3)(c)(i)(ii), -0300(1)(b)(3)(a)-(c)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to ensure that Skilled Nursing Facility (SNF) Advanced Beneficiary Notices (ABN, a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare. Beneficiaries may choose to continue the services but may be financially liable) were provided timely and/or completed as required for 2 of 3 sampled residents (Residents 18 and 54) when reviewed for Beneficiary Notification. Failure to provide SNF ABN notification at least two calendar days before the Medicare coverage ended placed the residents and/or the residents' representative at risk of not having adequate information to make financial decisions related to a continued stay in the facility. Findings included. Resident 18Review of a Notice of Medicare Non-Coverage (NOMNC), dated 10/23/2025, showed the facility informed Resident 93 and/or representative that skilled nursing services would end on 10/27/2025. Review of Resident 18's SNF ABN dated 03/09/2025 showed, Beginning on 10/28/2026 you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. However, the section of the form that was to list Care was blank. Review showed the form was provided and signed by Resident 18 on 03/09/2026. Resident 54Review of a NOMNC, dated 02/13/2025, showed the facility informed Resident 54 that skilled nursing services would end on 02/16/2025. Review of Resident 54's SNF ABN dated 03/09/2025 showed, Beginning on 02/17/2026 you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. However, the section of the form that was to list Care was blank. Review showed the form was provided and signed by Resident 54 on 03/09/2026. During an interview on 03/11/2026 at 12:06 PM, Staff J, Director of Social Services, stated Resident 18's SNF ABN and Resident 54's SNF ABN both dated 03/09/2026 did not meet expectations because the section for Care on both forms had no care listed and should have been provided and signed by Resident 18 and Resident 54 sooner than 03/09/2026. During an interview on 03/11/2026 at 12:18 PM, Staff A, Administrator, stated Resident 18's SNF ABN dated 03/09/2026 was missing listed Care on the form and should have been provided when their NOMNC was provided on 10/23/2025. Staff A stated Resident 54's SNF ABN dated 03/09/2026 was missing listed Care on the form and should have been provided when their NOMNC was provided on 02/13/2025. Staff A stated their expectation was that SNF ABN forms were filled out completely and provided as required when NOMNCs were issued. Reference WAC 388-97-0300(1)(e)(5)(6)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to make needed repairs to maintain a homelike environment for 1 of 4 halls (200 hall) when reviewed for environment. This failure placed residents at risk of decreased mood and a diminished quality of life. Findings included.Observation and interview on 03/08/2026 at 1:07 PM showed room [ROOM NUMBER]'s bathroom with a gouge in the floor at the entry way and two large scrapes and gouges, black scrapes, and chipped paint on the wall to the right of the sink. Resident 11 stated they were surprised the gouge in the floor did not interfere with entering or leaving the bathroom when using their wheelchair. Observation of room [ROOM NUMBER] on 03/08/2026 at 1:13 PM showed Resident 31's closet was missing a door exposing all items in the closet. During an interview on 03/13/2026 at 9:14 AM, Resident 31 stated they were not aware that their closet door was missing. Observation of room [ROOM NUMBER] on 03/08/2026 at 1:18 PM showed both closets were missing doors exposing Resident 71's and Resident 98's items in the closets. During an interview on 03/13/2026 at 9:17 AM, Resident 71 stated they would prefer to have a closet door, but the closet had not had one since being admitted to the facility. During an interview on 03/13/2026 at 1:20 PM, Resident 98 stated the closets in the room had been missing for about a year. Resident 98 stated, It would be nice to have closet doors if they had any to spare. Observation and interview on 03/08/2026 at 2:22 PM showed a closet door in room [ROOM NUMBER] was missing, exposing Resident 121's personal items. Resident 121 stated they would like to have a closet door and did not know why they did not have one. During an interview on 03/13/2026 at 9:23 AM, Staff S, Certified Nursing Assistant, stated room [ROOM NUMBER]'s bathroom entry was missing a piece out of the floor and the wall was dented, had chipped paint and scrapes. Staff S stated they had not noticed it before and did not document it in TELS (electronic system to put in a work order for items/issues to be fixed, repaired, or replaced). Staff S stated that closet doors were missing in rooms [ROOM NUMBER], and that they had been that way for a while. Staff S stated they did not document it in TELS because maintenance should have been checking the environment for those issues and fixed them. During an interview on 03/13/2026 at 9:33 AM, Staff T, Maintenance Director, stated if staff were to notice items in need of repair or replacement then they should put in a work order in the TELS system. Staff T was able to show the TELS system on their mobile device and stated they checked work orders throughout the day to resolve reported issues. Staff T stated that closet doors were missing in rooms [ROOM NUMBER], and they were only aware of room [ROOM NUMBER]'s missing closet door; however, they were not aware of the other missing closet doors on the 200 hall. Staff T stated these issues did not create a homelike environment and should have been addressed sooner. During an interview on 03/13/2026 at 9:46 AM, Staff A, Administrator, stated their expectation was for staff to put in a work order into TELS when there were issues needing to be fixed/repaired or replaced. Staff A stated they were not aware of areas in need of repair in room [ROOM NUMBER]'s bathroom or of missing closet doors on the 200 hall. Staff A stated issues on the 200 hall should have been addressed with a work order completed in TELS and these issues were not their idea of a homelike environment. Reference WAC 388-97-0880, -2040

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected the status for 3 of 21 sampled residents (Residents 9, 6, and 40) when reviewed for accuracy of assessments. Failure to accurately reflect Resident 9's skin/wound status, Resident 6's mental health screening status, and Resident 40's medication use status placed the residents at risk for unmet care, inaccurate medical record data, and a diminished quality of life. Findings included.Resident 9 Review of the electronic health record (EHR) showed Resident 9 admitted to the facility on [DATE] with diagnoses of diabetes (too much sugar in the blood), dementia (a decline in mental abilities, severe enough to interfere with daily life), and chronic obstructive pulmonary disease (restricted airflow making it difficult to breathe). Resident 9 was usually able to make needs known. Review of the February 2026 and March 2026 treatment administration records showed Resident 9 was being treated for a chronic ulcer/open wound to the left foot. Review of the significant change MDS, dated [DATE], showed Resident 9 had no pressure ulcer/injuries or other wounds or skin problems. During an interview on 03/12/2026 at 2:32 PM, Staff F, MDS Coordinator/Licensed Practical Nurse (MDSC/LPN), stated Resident 9's significant change MDS, dated [DATE], should have been coded for an open lesion on the foot and needed to be modified. During an interview on 03/12/2026 at 2:39 PM Staff B, Director of Nursing Services (DNS), stated Resident 9 had a wound to the left foot and their significant change MDS, dated [DATE], should have been coded for that and needed to be modified/corrected. Resident 6 Review of the EHR showed Resident 6 admitted to the facility on [DATE] with diagnoses of bipolar disorder (a mental disorder characterized by periods of depression and abnormally elevated mood) and schizoaffective disorder (a mental health condition). The resident was able to make needs known. Review of the EHR showed Resident 6 had a level two preadmission screening and resident review (PASSAR, a screen for mental health services) completed on 07/26/2023. Review of the annual MDS, dated [DATE], showed no level 2 PASSAR was completed. During an interview on 03/12/2026 at 11:58 AM, Staff E, MDSC/Registered Nurse, stated Resident 6 should have been marked as yes for the level 2 PASARR. Resident 40 Review of the EHR showed Resident 40 admitted to the facility on [DATE] with diagnoses of stroke (when blood flow is blocked to part of the brain) and heart failure. The resident was unable to make needs known. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual MDS, dated [DATE], showed Resident 40 was taking an anticoagulant medication (blood thinning medication). Review of the provider orders showed Resident 40 had received an anticoagulant medication that was discontinued on 06/14/2021. During an interview on 03/12/2026 at 11:58 AM, Staff E, MDSC/Registered Nurse, stated Resident 40 should not have been marked Yes for anticoagulant. Reference WAC 388-97-1000(1)(a)(b)(4)(a)

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	505289	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birch Creek Post Acute & Rehabilitation	5601 S Orchard Street Tacoma, WA 98409

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure care conferences occurred timely for 1 of 3 sampled residents (Resident 32) when reviewed to care conferences and accurately reflected a resident's eating status for 1 of 3 sampled residents (Resident 87) when reviewed for tube feeding. This failure placed the residents at risk of not providing input into the plan of care, impaired nutritional status, and a diminished quality of life. Findings included. During an interview on 03/11/2026 at 11:01 AM, Staff J, Social Services Director (SSD), stated residents were able to provide input into their plan of care through care conferences. Staff J stated care conferences should occur on admission and with the minimum data set (MDS) assessment schedule (quarterly and with change of condition). Resident 32 Review of the electronic health record (EHR) showed Resident 32 admitted to the facility on [DATE] with diagnoses to include chronic lymphocytic leukemia (a slow-growing cancer of the blood and bone marrow, primarily affecting older adults) and dementia (a decline in mental ability, such as memory loss, poor judgment, or confusion). Resident 32 was unable to make needs known. Review of a Multidisciplinary Care Conference form, dated 10/02/2025, showed it was Resident 32's most recent care conference and only the Activities Department was in attendance. Review showed it was signed by Staff W, Director of Activities, on 12/12/2025. Review of the MDS schedule showed Resident 32 had a significant change MDS on 12/23/2025. During an interview on 03/12/2026 at 11:55 AM, Staff J, SSD, stated Resident 32 had their last care conference on 10/02/2025 and should have had a new care conference around 12/23/2025 with the significant change MDS. During an interview on 03/13/2026 at 9:27 AM, Staff A, Administrator, stated their expectation was care conferences would occur quarterly with the MDS. Resident 87 Review of the EHR showed Resident 87 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction (blockage of blood flow to the brain causing cell death), gastrostomy (feeding tube inserted directly into the stomach through the abdominal wall to provide nutrition and medication), anxiety, and depression. Resident 87 could not communicate their needs. Observation on 03/08/2026 at 12:20 PM, showed Resident 87 lying in bed and a pole holding tube feeding formula next to the bed. Observation on 03/10/2026 at 1:12 PM showed Resident 87 in bed with tube feeding formula being infused trough the gastrostomy. Review of the care plan with focus area enteral feeding dated 03/05/2026 with interventions Resident (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is NPO (nothing by mouth), dated 02/16/2026, and Resident receives a tray in addition to tube feedings, dated 02/16/2026. During an interview on 03/10/2026 at 1:27 PM, Staff D, Licensed Practical Nurse, stated Resident 87 was not NPO and the care plan was not updated. During an interview on 03/11/2026 at 11:52 AM, Staff B, Director of Nursing Services, stated the expectation was for the care plans to be updated timely. Reference WAC 388-07 -1020(2)(c)(d)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services that met professional standards of practice for 2 of 22 sampled residents (Residents 2 and 26) when reviewed quality of care. Failure to provide wound care for Resident 2 and failure to follow provider orders for parameters when administering blood pressure medications for Resident 26 placed the residents at risk for complications, poor clinical outcomes, and a decreased quality of life. Findings included .Resident 2 Review of the electronic health record (EHR) showed Resident 2 admitted to the facility on [DATE] with diagnoses of head/face and neck cancer. The resident was able to make needs known. Observation and interview on 03/09/2026 at 11:15 AM showed Resident 2 was pointing at bandages on their left wrist and right hand and stated that the bandages were bothering them. The bandages were undated and had hard dried drainage on them and were soiled. Review of the EHR showed orders to monitor left hand, cleans with skin prep, apply bandage and monitor left forearm, cleanse with skin prep and apply bandage with start dates of 03/05/2026. These orders did not show on the treatment administration record. Observation and interview on 03/09/2026 at 2:03 PM showed Staff H, Licensed Practical Nurse (LPN), looked at the bandages and stated the resident should have an order in place the cleanse and change the dressings to Resident 2's right and left wrist and left elbow. Staff H reviewed Resident 2's treatment administration record and stated they did not see any orders to change the bandages and Resident 2 should have had orders in place for that. During an interview on 03/09/2026 at 2:14 PM, Staff D, LPN, stated Resident 2 should have active orders that showed in the treatment administration record to care for these wounds but did not. During an interview on 03/09/2026 at 2:19 PM, Staff G, Regional Nurse Consultant, stated it was their expectation that Resident 2 had orders in place to care for the wounds on their hands, elbow and wrist, and the current orders should be clarified and scheduled for daily care. Resident 26 Review of the EHR showed Resident 26 was admitted to the facility on [DATE] with diagnoses to include heart failure, end stage renal disease (kidney failure), and dependence on renal dialysis (life sustaining treatment that filters waste and excess fluid from the blood). Resident 26 was able to communicate their needs. Review of provider orders dated 01/28/2026 showed order for: 1) Metoprolol (medication for high blood pressure) extended release 25 milligrams (mg) to be given once a day and hold when the systolic (upper) blood pressure (SBP) was less than 110 or the pulse was under 60. 2) Hydralazine (medication for high blood pressure) 10 mg to be given three times a day and hold the medicine for SBP below 110. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration record (MAR) for March 2026 showed Resident 26 was administered Metoprolol on 03/04/2026 at 8:00 AM despite SBP of 105. Hydralazine was administered two times on 03/04/2026, one time on 03/08/2026 and one time on 03/11/2026 when the SBP was under 110. Review of February 2026 MAR showed Resident 26 was administered hydralazine on seven occasions at the evening administration time when the SBP was under 110. During an interview on 03/11/2026 at 11:43 AM, Staff B, Director of Nursing Services (DNS), stated the medications were to be administered following the orders and holding the medications per the provider's order. Reference WAC 388-07- 1060(1)-(3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment conductive to healing of a pressure ulcer and failed to have documentation describing the progress of the pressure ulcer for 1 of 3 sampled residents (Resident 111) when reviewed for pressure ulcer. This failure placed residents at risk for worsening pressure ulcers and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 111 was admitted to the facility on [DATE] with diagnoses to include hospice (end of life care), senile degeneration of brain (progressive break down of nerve cells), diabetes (high blood sugar) and kidney failure. Resident 111 was not able to communicate needs. Review of the admission minimum data set (MDS) a required assessment dated [DATE], showed Resident 111 was admitted to the facility with one sacral (large triangular bone at the base of the spine) stage two pressure ulcers (loss of partial thickness of the skin related to pressure injury). Air Mattress Observation on 03/08/2026 at 12:10 PM, showed Resident 111 lying in bed with air mattress that was set at the highest pressure and had a blinking light signaling low pressure. Observation on 03/09/206 at 1:35 Pm showed Resident 111 in bed with air mattress set at the highest pressure and signaling with blinking light low pressure. During an interview on 03/09/2026 at 2:28 PM, Staff D, Licensed Practical Nurse (LPN), stated the air mattress was rental and that was set up by the company and its correct. During an observation and interview on 03/10/2026 at 9:56 AM, Resident 111 was receiving care from hospice team. Air mattress was set up on highest pressure and had blinking light about low pressure. Staff Q, Hospice RN, stated that it was in error and would contact the company. During an interview on 03/11/2026 at 11:57 AM, Staff A, Administrator, stated the air mattresses should be used according to the manufacture settings, and Resident 111 air mattress low pressure signal did not meet expectations. Lack of Documentation Review of the care plan dated 12/12/2025, showed Resident 111 had a skin impairment to the right forehead, and no pressure ulcer or potential for it. Review of the wound evaluation weekly form dated 12/22/2025, showed abrasion (skin Injury) to right side of forehead and did not show sacral pressure ulcer. Review of the weekly skin observations completed on 12/17/2026,12/25/2025, 01/01/2026, 01/08/2026, 01/21/2026, 01/29/2026 and 02/04/2026 did not describe size, color, secretion of the sacral pressure ulcer During an interview on 03/10/2026 at 1:38 PM, Staff D, Licensed Practical Nurse (LPN), stated monitoring of pressure ulcers is documented in the weekly skin observation by the nurses, and it should have measurements and appearance. During an interview on 03/11/2026 at 11:53 AM< Staff B, Director of Nursing Services, stated pressure ulcers should be assessed on admission and then weekly after to include measurements and appearance. Reference WAC 388-07-1060(3)(b)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident from continued accident risk when it failed to thoroughly investigate an accident for 1 of 4 sampled residents (Resident 5) when reviewed for accident hazards. This failure placed the resident at risk of continued risk of accident, avoidable injury, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 5 admitted on [DATE] with diagnoses to include Parkinson's disease (a progressive movement disorder that occurs when nerve cells in the brain die) and adult failure to thrive. Resident 5 was able to make needs known. During an interview and observation on 03/08/2026 at 10:46 AM, Resident 5 stated a staff member had been transferring them from the bed to a wheelchair and the resident's leg had been scratched on the wheelchair. Observation showed Resident 5's leg was bandaged from ankle to knee. Review of the Accident and Incident Log showed an incident for Resident 5 on 02/27/2026 with superficial injury, related to the resident's condition. Review of the care plan, initiated 11/18/2024, showed a focus area for skin impairment to the left lower leg with an intervention for referral to an outside wound care provider. Review of the incident report, dated 03/03/2026, showed, Nursing Description: Resident observed with a skin tear to [their] left lower leg, and Resident Description: Resident stated [they] accidently bumped [their] leg on the side of [their] bed railing. Review did not show a resident statement or witness statements were included. Review showed the conclusion was Resident 5 hit their leg on the bed rail. Review of the outside wound care provider's wound assessment progress note, dated 03/04/2026, showed Resident 5 reported they were injured getting into their wheelchair. During an interview on 03/12/2026 at 11:04 AM, Staff K, Certified Nursing Assistant (CNA), stated they were assisting Resident 5 transfer into a wheelchair on 02/27/2026 when the resident's leg was scratched by the wheelchair. Staff K stated they were not interviewed as part of the investigation and were not asked to write a statement of events. During an interview on 03/12/2026 at 12:29 PM, Staff B, Director of Nursing Services, stated when a resident was injured the facility would generally interview the resident and staff, collect statements, and review the record. Staff B stated Resident 5 was not reassessed for level of support required for transfer to reduce the likelihood of recurrence. Reference WAC 388-97-1060(3)(g)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement fluid restrictions (limits the amount of fluids a person can consume through food/drink) for 1 of 1 sampled resident (Resident 26) when reviewed for nutrition. This failure placed the resident at risk for fluid overload, medical complications, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 26 was admitted to the facility on [DATE] with diagnoses to include heart failure, end stage renal disease (kidney failure), and dependence on renal dialysis (life sustaining treatment that filters waste and excess fluid from the blood). Resident 26 was able to communicate their needs. Observation on 03/08/2026 at 10:10 AM showed Resident 26 sitting in their chair with a small water bottle on top of the overbed table. Resident 26 stated they were on a fluid restriction because of their health condition. Review of a provider's order, dated 02/18/2026, showed Resident 26 was on a fluid restriction of 1000 milliliters (ml) per day to include breakfast, lunch, dinner, and supplements, with dietary/kitchen to provide 720 ml and nursing staff to provide up to 280 ml a day. Review of the March 2026 medication administration record (MAR) showed total consumed discrepancies on the following dates:03/01/2026 - Day 1000 ml, Night 140 ml, and total consumed 420 ml.03/02/2026 - Day 140 ml, Night 1000 ml, and total consumed 1000 ml.03/03/2026 - Day 140 ml, Night 280 ml, and total consumed 300 ml.03/04/2026 - Day 300 ml, Night 240 ml, and total consumed 120 ml. Continued review of March 2026 MAR showed this discrepancy in documentation continued until 03/11/2026. During an interview on 03/11/2026 at 11:09 AM, Staff H, Licensed Practical Nurse, stated residents with fluid restrictions did not receive water pitchers and the total amount consumed was documented in the MAR. During an interview on 03/11/2026 at 11:37 AM, Staff B, Director of Nursing Services, stated license nurses were to follow the orders and document clearly in the MAR. Reference WAC 388-07-1060(3)(i)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into the stomach or small intestine) was administered in accordance with providers orders and professional standards of practice for 1 of 3 sampled residents (Resident 87) when reviewed for enteral nutrition. The facility failed to have a system in place which ensured the amount of enteral formula (liquid food product) a resident received was reconciled with the amount they were ordered to receive. This failure placed the residents at risk for inadequate nutrition, dehydration, and adverse outcomes. Findings included.Review of the electronic health record (EHR) showed Resident 87 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction (blockage of blood flow to the brain causing cell death), gastrostomy (feeding tube inserted directly into the stomach through the abdominal wall to provide nutrition and medication), anxiety, and depression. Resident 87 could not communicate their needs. Observation on 03/10/2026 at 1:12 PM showed Resident 87 in bed with tube feeding formula being infused through the gastrostomy. Review of providers orders for March 2026 showed Resident 87 to receive enteral feed with Jevity (tube feeding formula) 55 milliliters (ml) for 20 hours every day for a total of 1100 ml in 24 hours, and flush with 100 ml water every four hours for a total of 500 ml in 24 hours. Feeding started at 2:00 PM and was turned off when completing the amount at 10:00 AM. License nurses were to document totals with a start date of 02/17/2026. Review of the March 2026 medication administration record (MAR) showed the following amounts:03/01/2026 - 10:00 AM formula 1050 ml and water 300 ml and at 2:00 PM formula 1050 ml and water 300 ml (total of 2100 ml of formula and 600 ml of water).03/02/2026 - 10:00 AM formula 1050 ml and water 300 ml and at 2:00 PM formula 1050 ml and water 300 ml (total of 2100 ml of formula and 600 ml of water).03/03/2026 - 10:00 AM formula 825 ml and water 300 ml and at 2:00 PM formula 1050 ml and water 300 ml (total of 1875 ml of formula and 600 ml of water). Review of the March 2026 MAR showed similar documentation through 03/10/2026. During an interview on 03/10/2026 at 1:12 PM, Staff P, Registered Nurse (RN), stated Resident 87 received nutrition for 20 hours a day and the documentation was at 10:00 AM when the LPN documented what the amount was based on the infusion amount on the machine. Staff P could not explain why there was documentation at 2:00 PM and stated that it should be zero. During an interview on 03/10/2026 at 1:29 PM, Staff D, Licensed Practical Nurse, stated that the machine was making the nurses document the amount. During an interview on 03/11/2026 at 10:50 AM, Staff B, Director of Nursing Services, stated the tube feeding should be administered by the orders and should have a clear amount. Reference WAC 388-07-1060(3)(f)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pain management that was consistent with professional standards for 2 of 3 sampled residents (Residents 2 and 26) when reviewed for pain management. Failure to assess and monitor Resident 2's pain and provide nonpharmacological interventions for Resident 26 placed the residents at risk for uncontrolled pain and a decreased quality of life. Findings included .Resident 2 Review of the electronic health record (EHR) showed Resident 2 admitted to the facility on [DATE] with diagnoses of head/face and neck cancer. The resident was able to make needs known. Observation and interview on 03/09/2026 at 11:15 AM, showed Resident 2 laid in bed with bandages to their right ear. Resident 2 pointed to the bandages and stated, It hurts all the time. Review of the initial nursing assessment showed Resident 2 reported pain at a 8 on a scale of 0 to 10 on 11/22/2025. No other pain assessments were found in the EHR. No orders or documentation was found in the EHR that Resident 2's pain level was being monitored daily. Review of the provider orders showed an order for oxycodone (a narcotic pain medication) as needed two to three times a day for pain levels of 4 to 10 with a start date of 11/23/2025. During an interview on 03/10/2026 at 2:43 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that residents with pain should be monitored daily for pain and a pain assessment should be done quarterly and as needed. Staff B stated Resident 2's pain monitoring and assessments did not meet expectations. Resident 26 Review of the EHR showed Resident 26 was admitted to the facility on [DATE] with diagnoses to include heart failure, end stage renal disease (kidney failure), and dependence on renal dialysis (life sustaining treatment that filters waste and excess fluid from the blood). Resident 26 was able to communicate their needs. Review of provider's orders showed Resident 26 was prescribed hydromorphone (strong pain medication) every six hours as needed for severe pain, dated 01/28/2026. In addition, Resident 26 had order for non-pharmacological intervention (NPI) to be offered and documented every shift, dated 01/27/2026. Review of February 2026 medication administration record (MAR) showed Resident 26 was administered hydromorphone 27 days of the month, and NPI was documented on four days out of 28. Review of MAR from 03/01/2026 through 03/11/2026 showed Resident 26 was administered hydromorphone for the 11 of 11 days, and no NPI was offered or documented. During an interview on 03/11/2026 at 11:09 AM, Staff H, Licensed Practical Nurse (LPN), stated NPI was documented in the MAR in a separate box. During an interview on 03/11/2026 at 11:40 AM, Staff B, DNS, stated the interventions were to be (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented in the MAR. Reference WAC 388-07-1060(1), -1620(2)(b)(i)(ii)

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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 interview and record review, the facility failed to promptly provide denture care when requested for 1 of 3 sampled residents (Resident 13) when reviewed for dental. This failure placed residents at risk for unmet dental needs, inability to eat, avoidable weight loss, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 13 admitted to the facility on [DATE] with diagnoses to include anxiety disorder, dementia (a decline in mental ability, such as memory loss, poor judgment, or confusion), and schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, and emotional responsiveness, causing individuals to lose touch with reality). Resident 13 was able to make needs known. During an interview on 03/08/2026 at 12:25 PM, Resident 13 stated their dentures had been left in their rental when they moved into the facility and there was no way for them to retrieve them. Review of a Preventative Report from an outside dental provider, dated 06/05/2025, showed, [Resident 13] would like to enroll to see if [they] can get a new set of dentures and based on clinical need it was ASAP (as soon as possible). Review of the care plan, initiated 11/23/2021, showed Resident 13 had no teeth with an intervention to refer to dentist as needed. Review showed no documentation of Resident 13's need for dentures. During an interview on 03/12/2026 at 1:15 PM, Staff O, Assistant Director of Nursing (ADON), stated Resident 13 had a dental report from 06/05/2025 which showed the resident requested new dentures. Staff O stated they were unsure if this request had follow-up. During an interview on 03/13/2026 at 10:22 AM, Staff V, Transportation Aid, stated they scheduled follow-up dental appointments for residents. Staff V stated Resident 13 did not have any dental appointments after 06/05/2025. During an interview on 03/13/2026 at 10:33 AM, Staff B, Director of Nursing Services, stated when a resident needed dentures they would be referred to a dentist as soon as the facility was aware. Staff B stated dental services should be provided at the time the resident requests it. During an interview on 03/12/2026 at 10:53 AM, Staff O, ADON, stated the facility did not follow up on Resident 13's request for dentures. Reference WAC 388-97-1060(1)(3)(j)(vii)