STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505290	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard Bremerton, WA 98310

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, as required, for 2 of 2 residents (Residents 18 & 56) reviewed for provision of SNF ABN. This failure placed residents at risk of not having adequate information to make care and financial decisions during their continued stay.Findings included . Resident 56Record review showed Resident 56's Medicare Part A stay started on 11/07/2025 and had a last covered day of 01/21/2026. Resident 56 remained in the facility after the services ended. No SNF ABN was found in Resident 56's record. On 02/26/2026 at 4:13 PM, when asked if a SNF ABN was provided to Resident 56 Staff P, Social Services Director (SSD), stated, No. Resident 18Record review showed Resident 18's Medicare Part A stay started on 12/24/2025 and had a last covered day of 01/29/2026. Resident 18 remained in the facility after the services ended. No SNF ABN was found in Resident 18's record. During an interview on 2/26/2026 at 4:13 PM, Staff P, SSD, said a SNF ABN was not provided to Resident 18 and explained they were informed SNF ABNs were only provided to residents whose Medicare Part A services ended, remained in the facility, and were private pay. Reference WAC 388-97-0300 (1)(e), (5), (6)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview and record review the facility failed to maintain a homelike environment regarding noise levels for 1 of 4 halls (Mountain View Hall) reviewed for a homelike environment. The failure to ensure appropriate noise levels placed residents at risk for not having a homelike environment, a decreased quality of life, and potential health concerns. Findings included .On 02/23/2026 at 10:33 AM, Resident 30 said the kitchen door was always slamming and the kitchen staff were very loud and she could hear the conversation from across the hall. Resident 30 said the facility was always telling us this is our home, but this does not feel like my home, because there would not be all the yelling and slamming of the doors in my home. Resident 30 said there was a resident on the hall that yelled all day and all night long and staff could not stop them. Resident 30 said they would keep the door shut due to the noise level. Resident 30 said they had written grievances and brought the concern to Resident Council, but they had stopped doing that, because nothing ever happened with their concerns. On 02/23/2026 at 11:20 AM, Resident 44 said the doors in the hall were always slamming shut, including the kitchen door and the housekeeping door. Resident 44 said they often kept the door shut because of the noise level in the hall.On 02/23/2026 at 2:08 PM, Resident 35 said there was a resident on the hall that continued to scream all day and night, to the point Resident 35 had yelled back at them to stop.Observations of Kitchen door (across from room [ROOM NUMBER]), Housekeeping door (across from room [ROOM NUMBER]) and Social Services (SS) door (next to room [ROOM NUMBER]) slamming shut on Mountain View Hall:02/24/2026 8:26 AM, Kitchen door (x2 Maintenance walked in and then out).02/24/2026 8:26 AM, Housekeeping door (staff member put away vacuum cleaner).02/24/2026 8:29 AM, Kitchen door. Resident 30 pointed out slamming kitchen door.02/24/2026 8:32 AM, Kitchen door, staff member entered.02/24/2026 8:33 AM, Kitchen door.02/24/2026 8:34 AM, staff member walked out the Kitchen door. 02/24/2026 8:34 AM, Kitchen door, staff member entered. 02/24/2026 8:37 AM, Kitchen door, staff member exited with meal cart.02/24/2026 8:41 AM, Social Service door, Staff C, Licensed Practical Nurse/Resident Care Manager entered. 02/24/2026 11:23 AM, Kitchen door, staffed member entered. 02/24/2026 11:25 AM, SS door, staff member exited.02/24/2026 11:28 AM, Kitchen door, staff member entered.02/24/2026 11:31 AM, Housekeeping door, staff member exited. 02/24/2026 11:35 AM, Housekeeping door, staff member exited.02/25/2026 11:45 AM, SS door, Staff B, Director of Nursing Services (DNS) entered.02/25/2026 11:53 AM, Kitchen door, two staff entered in the same minute, both slamming the door.02/25/2026 12:00 PM, Resident room [ROOM NUMBER] door slammed shut by Staff H, Certified Nursing Assistant, entered room.02/25/2026 12:04 PM, Kitchen door, staff member entered. 02/25/2026 12:08 PM, Kitchen door, staff member exited.02/25/2026 12:12 PM, SS Door. Staff B, DNS exited.On 02/26/2026 at 12:46 PM, when asked about the noise level related to residents' yelling, Staff EE, Licensed Practical Nurse, said there was a particular resident that constantly hollers out all the time including during the day and night. Staff EE said other residents have complained of the constant hollering, especially rooms next to the hollering residents'. On 02/26/2026, the previous six months (September 2025-February 2026) of Grievances were reviewed and documented the following:09/23/2025 grievance filed by Resident 30 & Resident 52, Noisy outside the kitchen which is right opposite resident's room.10/15/2025 grievance filed by Resident 44, Resident reports concern about neighbor yelling.02/03/2026 grievance filed Resident 35, Resident reports noise concerns about her next-door neighbor.On 02/26/2026, the Resident Council Meeting Minutes were reviewed and showed in February 2026 there was a noise complaint from residents about the kitchen, There is too much noise coming from the kitchen! Voices are too loud, banging, dishes, etc. that echoes throughout the hall.On 02/27/2026 at 10:50 AM, when asked about the complaints regarding noise levels on Mountain View Hall, Staff B, DNS, said they were not aware of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any complaints about the noise levels. When asked about the doors on Mountain View Hall, Staff B said there had been complaints about the doors slamming but said they did not know how to fix the issue. When asked about residents hollering out, Staff B said they thought they had fixed it. Staff B was asked what was fixed. Staff B explained there had been a resident always hollering out day and night and they had implemented interventions to address the concern. When it was explained that other residents have continued to experience side effects from the residents' hollering out including not sleeping, frustration and yelling back at the specific resident, Staff B said they were not aware this had started up again and it needed to be addressed.Reference WAC 388-97-0880

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 offer a bed hold upon transfer to the hospital for 1 of 2 residents (Resident 7), and to communicate required/necessary information to the receiving hospital to ensure continuity of care for 2 of 2 residents (Resident 7 & 80) and 4 of 4 discharges reviewed for hospitalization. Failure to offer bed holds placed residents and their representatives at risk of not being informed of their right to, and the cost of holding the resident's bed while hospitalized . The failure to ensure necessary information was communicated to the receiving hospital detracted from continuity of care and placed residents at risk of receiving incoherent, fragmented, or redundant care.Findings included.BED HOLDResident 7Review of the 01/20/2026 Discharge Minimum Data Set (MDS - an assessment tool) showed Resident 7 was transferred to an acute care hospital on [DATE] with their return anticipated. Review of the electronic health record (EHR) showed there was no documentation Resident 7 was offered a bed hold.On 03/02/2026 at 9:23 AM, when asked if there was documentation to show Resident 7 was offered a bed hold Staff B, Director of Nursing Services (DNS) and Registered Nurse (RN), stated, No. COMMUNICATON WITH RECEIVING FACILITYResident 7 was admitted to the facility 09/19/2025. Record review showed Resident 7 was transferred to the hospital on three separate occasions.a) Review of the 11/19/2025 Discharge MDS showed Resident 7 was transferred to an acute care hospital on [DATE] with their return anticipated. Review of the EHR showed no documentation that facility staff called report to the receiving hospital, and no e-interact transfer form (a document completed by staff that includes documentation on who staff called report to and what documents were sent with the resident at discharge) was completed. b) Review of the 12/24/2025 Discharge MDS showed Resident 7 was transferred to an acute care hospital on [DATE] with their return anticipated. Review of the EHR showed no documentation that facility staff called report to the receiving hospital, and no e-interact transfer form (a document completed by staff that includes documentation on who staff called report to and what documents were sent with the resident at discharge) was completed. c) Review of the 01/20/2026 Discharge MDS showed Resident 7 was transferred to an acute care hospital on [DATE] with their return anticipated. Review of the EHR showed no documentation of what documents, if any, were sent with the resident, that staff called report to the receiving hospital, or that an e-interact transfer form (a document completed by staff that includes documentation on who staff called report to and what documents were sent with the resident at discharge) was completed. On 03/02/2026 at 9:23 AM, when asked if there documentation to show staff called report to the hospital, or otherwise communicated the resident condition to the receiving facility and that identified what documents, if any, were sent with Resident 7 at the time of the above referenced discharges, Staff B, DNS, said no. Resident 80.Review of the 11/25/2025 Discharge MDS showed Resident 80 was transferred to an acute care hospital on [DATE] with their return anticipated. Review of the EHR showed an e-interact transfer form, dated 11/25/2025, that documented report was called to 911 not the receiving facility. The document had a section at the bottom for nurses to check-off the documents that were sent with Resident 80 and for the transporting EMTs to sign that the documents were received, but the section was not completed. On 03/02/2026 at 9:12 AM, Staff B, DNS, said they could not find documentation that staff called report to the receiving hospital, or what documents, if any, were sent with the resident.Reference WAC 388-97-0120 (2)(a-d), -0140 (1)(a)(b)(c)(i-iii)

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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 quality of care was provided for insulin administration for 1 of 1 resident (Resident 44), bowel management for 2 of 5 residents (Resident 36 & 85), physical therapy evaluation for 1 of 1 resident (Resident 23) reviewed to Activities of Daily Living (ADLs), oxygen administration for 1 of 1 residents (Resident 85) and edema and weight monitoring for 1 of 1 resident (Resident 80). These failures placed residents at risk of medical complications, unmet care needs and a diminished quality of life. Findings included .Resident 44 Resident 44 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (MDS, an assessment tool) dated 12/17/2025, documented Resident 44 was cognitively intact. On 02/23/2026 at 11:15 AM, Resident 44 said they had missed 3 days of their insulin, due to the facility not having it in supply. Review of Resident 44's February 2026 Medication Administration Record (MAR) documented the following: 02/05/2026- code 2 (meant medication was held) 02/06/2026- medication was given 02/07/2026- code 7 (meant see progress note for details) 02/08/2029- medication given 02/09/2026- medication given 02/10/2026- medication given 02/11/2026- medication given A progress note dated 02/05/2026 at 8:00 PM, documented Tresiba (a long acting insulin used to help control blood sugar) was not given due to not being available, instead another long-acting insulin was provided. No progress notes from 02/06/2026 were found indicating whether the Tresiba had been given or was out of stock. A progress note dated 02/07/2026 at 1:34 PM, documented Tresiba was not given due to being not available. No progress notes from 02/08/2026 were found indicating whether the Tresiba had been given or was out of stock. A progress note, dated 02/09/2026 documented the pharmacy was sending the medication that day. Resident 44 was given the Tresiba at 8:02 PM on 02/09/2026. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/26/2026 at 2:40 PM, in a joint interview with Staff B, Director of Nursing Services (DNS) and Staff C, Licensed Practical Nurse (LNP)/Resident Care Manager (RCM), Staff C pulled up Resident 44's MAR and confirmed the documentation showed Tresiba had been given per the dates listed. Staff B and Staff C then reviewed the progress notes from 02/05/2026 - 02/10/2026. Staff C confirmed the progress notes documented Tresiba had not being given and was unable to determine if on 02/06/2026 and 02/08/2026 the Tresiba had been given (due to previous notes stating it was unavailable). When shown the contradictory documentation about the medication (MAR documented it was given and progress notes documented it was not given), Staff B said there was not way to confirm if the resident received the medication or not. Staff B said the expectation for unavailable medication was for staff to contact the provider for further instruction. Resident 36 Resident 36 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 36 was cognitively intact and on continuous oxygen therapy. On 02/23/2026 at 3:07 PM, Resident 36 was observed receiving oxygen by nasal cannula (NC - flexible tube with two prongs inserted into the nostrils to deliver supplemental oxygen) at 2 liters (L -a metric unit) per minute and there was no humidifier. On 02/24/2026 at 1:30 PM, Resident 36 was observed receiving oxygen by NC at 2L and there was no humidifier. An order, dated 01/23/2026, said to change Resident 36's oxygen humidifier every Sunday on night shift. A review of Resident 36's MAR documented that the humidifier was changed 02/22/2026. On 02/24/2026 at 2:27 PM, Staff AA, Licensed Practical Nurse(LPN), said Resident 36 did not have a oxygen humidifier while looking at the oxygen concentrator at Resident 36's bedside. Staff AA reviewed Resident 36's order and said they should have had a humidifier. On 02/24/2026 at 2:31 PM, Staff B, DNS, said Resident 36 does not need a humidifier because their oxygen was at 2L. Staff B said Resident 36's order did not indicate this, but he would have the order changed. On 02/24/2026 at 3:09 PM, Staff AA, LPN, said they had called the doctor and had the oxygen order for Resident 36 changed to add humidifier if oxygen was above 4L. Resident 85 Resident 85 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact and was constipated during the assessment period. Review of the electronic health record showed Resident 85 had the following as needed bowel orders: - MiraLax (a laxative) as needed, If no bowel movement after 3 days. - Bisacodyl suppository rectally as needed, if no or small results 12 hours after Miralax was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered. - Fleet Enema rectally as needed, If no results 12 hours after Bisacodyl suppository was administered; notify the provider if no results after 8 hours after enema. On 02/24/2026 at 10:02 AM, Resident 85 indicated they periodically still struggled with constipation. Review of the bowel record showed Resident 85 went from 02/20/2026- 02/25/2026 (6 days), without a bowel movement. Review of the February 2025 MAR showed Resident 85 was not administered as needed bowel medication until 02/25/2026, the sixth day without a bowel movement. On 03/02/2026 at 9:45 AM, when asked if facility nurses administered Resident 85's Miralax after three days without a bowel movement, as ordered Staff B, DNS, stated, No. Resident 80 Resident 80 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of renal disease and received diuretic medication during the assessment period. Record review showed Resident 80 had the following 11/14/2025 orders: Furosemide (a diuretic) daily for edema (swelling caused by excess fluid trapped in the body's tissues), Daily weights, for three days, weekly for four weeks. Review of the comprehensive care plan, initiated 11/14/2025, showed no care plan was developed/implemented that addressed the resident's diuretic use or edema. On 02/27/2025 at 12:52 PM, the facility's edema monitoring policy was requested. Staff B, DNS, said he was not sure the facility had a policy, but explained they used the 0-4+ pitting edema scale, unless the provider specifically ordered daily weights or circumference measurements. The November 2025 Treatment Administration Record (TAR) showed Resident 80's daily weights for three days were scheduled to be obtained on 11/15/2025, 11/16/2025 and 11/17/2025. Review of the TAR showed facility nurses failed to obtain the weights as ordered, all three days were blank. Further review of the MAR and TAR showed there was no direction to staff to monitor Resident 80's edema. On 03/02/2026 at 09:12 AM, Staff B, DNS, confirmed facility nurses failed to obtain daily weights for three days as ordered and indicated instruction to monitor Resident 80's edema and a place to record it should have been included. Review of the electronic health record (EHR) showed provider notes dated 11/20/2025 and 11/21/2025, documented Resident 80 had no peripheral edema. Review of Resident 80's weight record showed on 11/14/2025 the resident weighed 275 Lbs. and on 11/24/2025 weighed 285.4 Lbs., a weight gain of 10.4 Lbs. in 10 days. Review of the EHR showed there was no documentation present that showed the provider was notified. A provider note, dated 11/25/2025, documented Resident 80 was significantly short of breath at rest and with speaking. During the evaluation, she reported she needed to use the bathroom and was assisted by the provider and a Certified Nursing Assistant. Physical exam revealed plus four pitting edema of the lower extremities and course breath sounds bilaterally. Nursing and the patient deny recent fever, chills, or upper respiratory symptoms. Assessment is significant breathing issues concerning for acute pulmonary edema or pneumonia. Resident 80 required artificial respirations and oxygen support and was subsequently transferred to the hospital. On 03/02/2026 at 9:15 AM, when asked if staff should have notified the provider of the 10.4 Lbs. weight gain in 10 days Staff B, DNS, stated, yes. When asked if there was any documentation to show the provider was notified Staff B, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DNS said no. Resident 23 Resident 23 was admitted to the facility 05/06/2024. The Quarterly MDS, dated [DATE], documented Resident 23 used a manual wheelchair. On 02/23/2026 at 11:44 AM, Resident 23 said they got out of bed very little, saying they needed a lift to get out of bed and their wheelchair did not fit them, it was too small and they were long and their wheelchair did not fit long people. Resident 23 said if they got a new wheelchair they would get up more, and they had been waiting for a year for a new wheelchair. On 02/26/2026 at 8:53 AM, Resident 23 was in bed eating breakfast. Observed next to the bed was a wheelchair with pillows and towels stacked on it. Resident 23 said the wheelchair did not fit them, it was too small and they brought this up to people all the time, but they were not sure who they had talked to. Resident 23 had a provider order, dated 08/29/2025, addressed to the physical therapy department. The order read: the patient stated that his chair is too small and wants a different one. Kindly evaluate if his chair is appropriate or not and respond as warranted. On 02/26/2026 at 9:15 AM, Staff L, Rehabilitation Director, was told Resident 23 reported his wheelchair did not fit him well and that he had been waiting for a year for a new wheelchair. Staff L said they had swapped out Resident 23's wheelchair a few times within house wheelchairs. When asked when the swaps happened, Staff L said when in house swaps were done they would swap out the wheelchair but did not document this and she did not have documentation of when Resident 23's wheelchair had been swapped. On 02/26/2026 at 12:13 PM, Staff L confirmed the order, dated 08/29/2025, for physical therapy to evaluate Resident 23's wheelchair fit. When asked if an evaluation or screen was completed at that time, Staff L looked in the electronic health record and said, no, Resident 23 had not been seen and there was no documentation. When asked if this met her expectations, Staff L said it did not. When asked if an order for physical therapy to evaluate was in place there should have been a formal evaluation done and documented in the electronic health record. Reference WAC 388-97-1060 (1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to ensure restorative nursing programs were provided at the frequency residents were assessed to require, for 6 of 7 residents (Resident 15, 26, 30, 32, 9 & 24) reviewed for restorative services. This failure placed residents at risk for decline in functional mobility, range of motion (ROM), contracture (a permanent tightening or shortening of muscles, tendons, skin, or other tissues that causes joints to become stiff) formation and diminished quality of life.Findings included . Resident 15 Resident 15 was admitted to the facility on [DATE]. A restorative nursing program care plan, initiated 08/15/2024, showed the resident had the following restorative program(s): Restorative walking program with front wheeled walker for 15 minutes as tolerated, up to three times per week. Active ROM program to bilateral upper and lower extremities using the Omni cycle for 15 minutes as tolerated, up to three times per week. Review of the restorative documentation from 02/02/2026 - 03/02/2026 (28 days) showed Resident 15 was offered/provided the restorative walking program two times with one refusal, and the active ROM program six times with no refusals. Resident 26 Resident 26 was admitted to the facility on [DATE]. A restorative nursing program care plan, initiated 08/15/2024, showed the resident had the following restorative program(s): Restorative gait training program using the parallel bars or front wheeled walker up to 20 feet, follow with wheelchair for 15 minutes as tolerated, up to three times per week. Active ROM program to bilateral upper and lower extremities using the Omni cycle on level 1 for 15 minutes as tolerated, up to three times per week. Review of the restorative documentation from 02/02/2026 - 03/02/2026 (28 days) showed Resident 26 was offered the restorative gait training program three times with one refusal, and the active ROM program six times with one refusal. Resident 30 Resident 30 was admitted to the facility on [DATE]. A restorative nursing care plan, initiated 08/20/2024, showed the resident had the following restorative program(s): Restorative walking program with front wheeled walker, 50 feet, as tolerated, up to three times per week. Active ROM program to bilateral upper and lower extremities using the Omni cycle for 15 minutes as tolerated, up to three times per week. Review of the restorative documentation from 02/02/2026 - 03/02/2026 (28 days) showed Resident 30 was offered the restorative walking program six times, and the active ROM program seven times with one refusal. Resident 32 Resident 32 was admitted to the facility on [DATE]. A restorative nursing care plan, initiated 08/20/2024, showed the resident had the following restorative program(s): Active ROM program using the Nu-step for 15 minutes as tolerated, up to three times per week. Review of the restorative documentation from 02/02/2026 - 03/02/2026 (28 days) showed Resident 32 was offered the active ROM program eight times with two refusals. Resident 9 Resident 9 was admitted to the facility on [DATE]. A restorative nursing care plan, initiated 08/20/2024, showed the resident had the following restorative program(s): Active ROM program to bilateral upper and lower extremities using the Nu-step or Omni cycle for 15 minutes as tolerated, up to three times per week. Review of the restorative documentation from 02/02/2026 - 03/02/2026 (28 days) showed Resident 9 was offered the active ROM program three times with one refusal. Resident 24 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard Bremerton, WA 98310

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 24 was admitted to the facility on [DATE]. The Annual Minimum Data Set, an assessment tool, dated 01/14/2026, documented Resident 24 was moderately cognitively impaired and needed partial to moderate assist with showers and bathing, and independent with dressing and personal hygiene. Resident 24's restorative nursing care plan, revised on 10/01/2024, said they had limited physical mobility related to impaired balance, impaired mobility, weakness. The nursing rehab interventions, revised on 12/13/2024, said omnicycle for up to 15 minutes up to 3 times a week and a walking program for up to 15 minutes ambulation up to 100 feet up to 3 days a week. A 30-day review of walking up to 100 ft. up to 3 times a week from 01/28/2026 - 02/25/2026 documented Resident 24 walked for 15 minutes on 02/02/2026 02/03/2026, 02/08/2026, and 02/25/2026. It documented Resident 24 walked for 10 minutes on 02/14/2026. Resident 24 refused on 02/12/2026. A 30-day review of active ROM with Omni-cycle up to 15 min up to 3 days per week from 01/28/2026 - 02/25/2026 documented Resident 24 participated for 15 minutes on 02/12/2026, for 5 minutes on 02/14/2026, and for 3 minutes 02/21/2026. No refusals were documented. A review of the Restorative Nursing Summary, dated 09/16/2025, said continued active ROM and ambulation program to maintain strength and functional mobility. On 02/26/2026 at 9:40 AM, Staff T, Driver/ Restorative Aide said Resident 24 was scheduled for restorative therapy three times a week. Staff T said Resident 24 did not receive restorative therapy three times a week because they had other duties. Staff T said they were the facility's transportation driver for resident appointments and they would get pulled to the floor to cover direct nursing care. Staff T said Resident 24 did not refuse restorative therapy. On 02/26/2026 at 9:59 AM, Staff B, Director of Nursing Services (DNS), said Resident 24 was not receiving restorative therapy three times a week and Resident 24 was not refusing. Staff B said restorative therapy was not being offered three times a week and this was not optimal to maintain Resident 24's functions. Refer to F-725 Reference WAC 388-97-1060 (3)(d), (j)(ix)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interviews and record review, the facility failed to have sufficient staff to provide and supervise care as evidenced by information provided by 6 resident interviews (Resident 30, 44, 23, 3, 13 & 66), Staff interviews (Staff Q & T) and Resident Council interviews. Additionally, the aid from the Restorative Nursing Program (RNP) was removed from restorative duties to cover direct care staff absences and resident transportation resulting in the RNPs not being completed for residents. The shower aides were also removed from assigned duties to cover direct care staff shortages. The facility had insufficient staff to ensure residents received assistance with Activities of Daily Living (ADL) including showers, restorative services, dining services and basic resident care. These failures placed residents at risk for unmet care needs, negative outcomes and a diminished quality of life. Findings included .On 02/23/2026 at 10:52 AM, Resident 30 said their shower days were changed without notice by Staff B, Director of Nursing Services (DNS) and they were never informed about the shower changes. On 02/23/2026 at 11:32 AM, Resident 44 said they would use the call light, and no one would respond for up to 45 minutes, and on night shift sometimes no one would respond at all, they would have to get out of bed and go into the hall to get staff. Resident 44 said they have filed grievances in the past, but it did no good, because nothing had changed. Resident 44 said when staff would call out, restorative and shower aids would be pulled from their assigned duties to cover the other staff. Resident 44 said the previous weekend two aids called out from work and they did not get care until 10 AM. On 02/23/2026 at 11:38 AM, Resident 23 said sometimes they would wait up to an hour to get care. On 02/23/2026 at 12:31 PM, during a dining room observation, the meal cart had been delivered/dropped off, and no staff were observed in the Garden dining room. Resident 38's relative had begun to pass meal trays to the residents sitting in the Garden dining room. The relative was passing one to a resident, and 4 other residents already had their trays in front of them, with no staff present. Resident 38's relative said they did not want the resident's food to get cold. On 02/23/2026 at 12:45 PM, Staff Q, Central Supply Staff, said the Garden dining room was a supervised eating area. Staff Q said they had been passing trays on another hall and could not get to the dining room by the time the meal cart had arrived. Staff Q said there was usually a shower aide in the dining room to pass trays, but there was no shower aide this day. Staff Q said the relative should not have been passing meal trays to the residents. On 02/23/2026 at 2:09 PM, Resident 3 said they had had one shower since being admitted . On 02/23/2026 at 2:14 PM, Resident 3 said they had to wait up to 45 minutes to get care. On 02/24/2026 at 8:00 AM, Resident 13 said on the night shift, it would take 30-40 minutes to obtain pain medication, due to not having enough staff. On 02/24/2026 at 9:45 AM, Resident 66 said they had waited anywhere between 45 minutes to an hour for staff to provide care, mealtimes and evening shift seem to be the worst. There were not enough staff to help pass meal trays. Resident 66 said due to staffing shortage, showers aids would be pulled from their assignments to cover other staff duties. On 02/26/2026 at 9:40 AM, Staff T, Driver/ Restorative Aide said Resident 24 was scheduled for restorative therapy three times a week. Staff T said Resident 24 did not receive restorative therapy three times a week because they had other duties. Staff T said they were the facility's transportation driver for resident appointments and they would get pulled to the floor to cover direct nursing care. Grievances:On 09/17/2025 a grievances documented Resident reports concerns about his Bi-pap face mask being cleaned. On 09/26/2025 a grievances documented Resident's sister had concern about resident needing more therapy. On 10/25/2025 a grievances documented Resident and wife requesting scheduled therapy sessions. On 11/03/2025 a grievance documented Resident reports concerns about her room not getting cleaned over the weekend. On 11/04/2025 a grievance documented Resident reports missing her shower. On 01/28/2026 a grievances documented Reports concerns about need for extra clothing for residents, need to review shower schedule for new admission and customer care concerns with staff. On 01/29/2026 a (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievances documented Resident raised concerns about bathroom assistance from staff. On 01/31/2026 a grievances documented Received reports concerning resident/nurse interaction on pain meds. On 01/31/2026 a grievance documented Resident's family reports concerns about bed mobility and oral care. Resident Council Meeting Minutes:September 2026 minutes documented:- Back up plan for when the shower aid is not available.- Cold food being warmed up. October 2025 minutes documented:- When shower aids go to the floor residents would like to be notified so they are not waiting for them to come November 2025 minutes documented:- Showers- not getting showers at times especially Saturday- Restorative aid-trying to tweak the program, maybe 3 days a week with a new and improved program. December 2025 minutes documented:- Nursing/aides- meal times in dining room aides are short with several residents. On the weekend no aide comes to the dining room. Residents are reporting long call tight times and on occasion resident has gone into hallway to see aides standing. Residents state that these have been already been submitted in grievances.- Complaints of Saturday missed showers and grievance has been filed. January 2026 minutes documented:- Residents talked with the new chef last month. Dinner is scheduled for 5:15 p.m. but served at 6:00 p.m.- Concerns: food is late, servers are rude, food is cold, raw food is served, food looks sloppy, there is only one choice.- The food is getting worse and less edible, the menu shows 6 choices, there is only one choice.- Call lights are not being answered in a timely manner.- Some residents are keeping track of response times. Residents are missing their showers and are not being notified.- One resident stated that he had not had a shower in two weeks. February 2026 minutes documented:- There is too much noise coming from the kitchen! Voices are too loud, banging dishes, etc. that echoes throughout the hall.- Food issues: most attendees had food complaints saying: The food is not good.- There doesn't seem to be staff oversite. Portion sizes are inadequate, either too large or too small, presentation is not appealing. Meat is tough or undercooked. Dietary restrictions are not being followed. A resident on a soft diet is not being accommodated.- A resident talked with [Dietary Manager] saying she wanted to show him pictures of her plates, he was rude, the resident filed a complaint.- Nursing Services/Aides: Aides are not assisting residents who need help eating.- Residents were ill with no follow through from Staff.- Showers - residents do not know the day(s) or time of their showers. Can there be a consistent shower schedule? Resident Council meeting:On 02/25/2026 at 1:35 PM, during the Resident Council Meeting interview, residents reported the following concerns:-stopped filing grievances because nothing ever happens or changes.-staff have been snappy towards residents when they were mad. Residents felt like they have to walk on eggshells around certain staff.-showers aides often pulled from showers to cover other duties.-environmental noise including slamming doors and other residents yelling during the day and night.-food concerns over the past few months. Record reviewed on 02/27/2026 showed dates shower aides were pulled to cover floor/no shower aide available in February 2026: 02/01/2026: Staff R, shower aide, pulled to cover Mtn View Odd02/10/2026: No NAC on Med202/12/2026: No NAC on MedA202/15/2026: Staff R pulled to cover Mt View Odd02/20/2026: Staff S, shower aide, pulled to cover Mtn View Even02/22/2026: Staff R pulled to cover MedB102/26/2026: Staff R pulled to cover Mtn View Odd Record review on 02/27/2026 showed dates in February 2026 where Staff T, Driver/Restorative Aide completed resident transport, not able/limited time to completed restorative duties:02/02/2026 (2 appts), 02/03/2026 (3 appts), 02/04/2026 (1 appt), 02/06/2026 (1 appt), 02/09/2026 (2 appts), 02/10/2026 (2 appts), 02/11/2026 (5 appts), 02/12/2026 (1 appt), 02/13/2026 (2 appts), 02/16/2026 (1 appt), 02/17/2026 (1 appt), 02/18/2026 (3 appts), 02/20/2026 (1 appt), 02/23/2026 (1 appt), 02/24/2026 (2 appts), 02/25/2026 (1 appt) & 02/27/2026 (2 appts). Seventeen out of 20 days the Restorative aide had transportation duties. On 02/27/2026 at 10:46 AM, Staff B, DNS, said both restorative services and showers were an issue, not enough staff and the facility currently had a Performance Improvement Plan for showers. Staff B said they thought the showers had gotten better but confirmed shower aides were pulled to cover other duties on the floor. When asked about the meals being delivered to residents without staff present, Staff B said they were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	made aware of the situation, confirmed there was no shower aide available that day and said the relative should not have served residents their meal trays. Staff B said they were not aware of residents being left on the toilet for extended periods of time during meal tray pass. Reference F677, F688 & F804.Reference WAC 388-97 -1080 (1), 1090 (1)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review the facility failed to routinely complete Certified Nursing Assistant's (CNA) annual performance reviews as required for 3 of 5 sampled nursing assistants (Staff I, J, & K) reviewed for performance reviews. 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 I, CNA, was hired 12/27/2024. Staff I had no annual performance review completed from 12/2024-12/2025. Staff J, CNA, was hired 08/07/2024. Staff J had no annual performance review completed from 08/2024-08/2025. Staff K, CNA, was hired 07/29/2024. Staff K had no annual performance review completed from 07/2024-07/2025. On 02/27/2026 at10:50 AM, Staff B, Director of Nursing Services, said none of the CNA annual performance reviews were completed for their review periods and they should have been. Reference WAC 388-97-1680 (1), (2)(a-c)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of recorded food temperatures, the facility to prepare food in a manner that conserved nutritive value, palatability and that ensured meals served were appetizing and at appropriate temperatures. The facility's failure to follow written recipes for preparation of pureed food, to ensure cold beverages were maintained at or below 40 degrees, and hot food at or greater than 135 degrees during meal service, resulted in residents being served unpalatable food and beverages at unappetizing temperatures. These failures placed the residents at risk for decreased intake, weight loss and dissatisfaction with meals.Findings included . <Meal Preparation>Observation of meal preparation on 02/26/2026 at 10:59 AM, showed Staff BB, Cook, preparing pureed carrots. Staff BB grabbed a large metal container of cooked carrots and used a spatula to push an unmeasured amount into a smaller 6 x 6 metal container. Staff BB then used a handheld immersion blender to blend the carrots for 45 seconds. Staff BB then left to fill a plastic container with an unmeasured amount of water and returned to the carrots. An unmeasured amount of water was added to the carrots and Staff BB blended the mixture for another 30 seconds. Staff BB then covered the carrots and placed them on the steam table. On 02/26/2026 11:08 AM, Staff BB obtained a large metal tub of pork and used a spoon to scoop an unmeasured amount into a 6 x 6 metal bin and added an unmeasured amount of water and blended the mixture. Staff BB then observed the mixture and added more water indicating it was a little bit dry and then blended another 30 seconds, covered the bin and placed it on the steam table. On 02/26/2026 11:17 AM, Staff DD, Dietary Aide, was placing beverages and deserts on resident trays on the tray carts. <Beverage Temperatures>On 02/26/2026 12:03 PM, Staff DD was asked to check the temperature of a cup of milk that was previously placed on a resident tray in the tray cart. The milk was 56.5 degrees. Staff DD then placed the milk back on the tray in the tray cart to be delivered. During an interview on 03/02/2026 at 12:48 PM, Staff CC, Dietary Supervisor, said Staff BB, Cook, should follow a recipe when preparing pureed food to ensure consistency and palatability. When asked about dietary staff s' practice of placing resident beverages and deserts on their trays 45 minutes before tray line began Staff CC, Dietary Supervisor said they had identified that as an issue and educated the dietary staff. Staff CC motioned to signage on the outside of the beverage refrigerator that directed staff not to put any beverages on trays until 11:40 AM at the earliest. Staff CC said putting beverages out earlier is what caused the milk to be 56.5 degrees. Staff CC said the milk should have been removed and the other beverages already on the cart checked to ensure they were less than 40 degrees. Resident 30 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool) dated 01/09/2026, documented Resident 30 was cognitively intact. On 02/25/2026 at 8:15 AM, observation of Resident 30 sitting in their wheelchair with breakfast meal tray on bedside table. On 02/25/2026 at 8:37 AM, when asked how their breakfast meal was, Resident 30 said they had not eaten it yet, due to Staff W, Certified Nursing Assistant (CNA), had told them, they needed to obtain the residents' weight prior to them eating. Staff W told Resident 30 they would be right back to get (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the residents' weekly weight and never returned. Resident 30 said the breakfast meal was cold, but they were used to eating a cold breakfast, due to things like this always happening and they never got their morning coffee. On 02/25/2026 at 8:52 AM, Staff C, Licensed Practical Nurse (LPN)/Resident Care Manger was stopped in the hall and asked when staff should be obtaining resident weights. Staff C said weights were done monthly unless otherwise directed, like weekly or daily if weight loss concerns were identified. Resident 30 told Staff C the event that had taken place with the breakfast meal. Staff C immediately found Staff W, had them obtain Resident 30's weight and obtain a hot meal for Resident 30. When asked if it was acceptable to tell a resident to not eat, say they would be back and then not return for over 45 minutes, Staff C said that was not acceptable and it should have never happened. On 02/26/2026 at 2:40 PM, in a joint interview with Staff B, Director of Nursing Services and Staff C, LPN/RCM, the situation with Resident 30's breakfast meal was explained. Staff B said the expectation was a grievance should have been written, the staff member needed more training, and it was not acceptable to tell a resident not to eat or for a resident to have to wait over 45 minutes for their breakfast meal. Reference WAC 388-97-1100 (1), (2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to follow and/or implement transmission-based precautions (TBP, infection-prevention measures for known or suspected infections used in addition to Standard Precautions) for 4 of 4 residents (Residents 52, 40, 58, and 17) reviewed for transmission-based precautions. The facility did not ensure staff used appropriate personal protective equipment (PPE) and implemented TBP for symptomatic residents. This failure placed residents and staff at risk for cross-transmission with infectious pathogens. Findings included.Review of the facility policy, titled IPCP [Infection Prevention and Control Program] Standard and Transmission-Based Precautions, revised 08/2025, documented for Contact Precautions PPE use would include wearing a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Staff were to don (put on) PPE upon room entry, then doff (take off) and properly discard PPE and perform hand hygiene before exiting the patient room to contain pathogens (microorganisms that can cause disease).Additional review of this policy documented Droplet Precautions (TBP) were to be used for patients known or suspected of being infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking. The policy referenced Center for Disease Control Appendix A: Type and duration of precautions recommended for selected infections and conditions. Droplet precautions as outlined in the policy included the following:Implement source control by placing a mask on the patient.Ensure appropriate patient placement in a single room if possible. In long-term care and other residential settings, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives.Use personal protective equipment (PPE) appropriately. [NAME] mask (and eye protection if indicated) upon entry into the patient room or patient space.Limit transport and movement of patients outside of the room to medically-necessary purposes. If transport or movement outside of the room is necessary instruct patient to wear a mask and follow respiratory hygiene/cough etiquette.FAILURE TO FOLLOW TBPResident 52 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 52 had an order, dated 02/13/2026, for contact precautions and had signage outside of their door indicating they were on contact precautions.On 02/25/2026 at 9:30 AM, Staff E, Activities, was observed in Resident 52's room with no PPE on. Staff E was observed adjusting Resident 52's shirt, pushing the call light button, holding Resident 52's hand, and squatting down and leaning their arm on Resident 52's blankets.On 02/25/2026 at 9:37 AM, Staff E, was asked about observations of not wearing PPE while interacting with Resident 52. Staff E said she was supposed to have worn a gown and gloves. On 02/25/2026 at 10:23 AM, Staff D, Infection Preventionist, Registered Nurse (RN), said her expectation of staff interacting with a resident on contact precautions was for staff to follow the signage instructions for contact precautions. Regarding the observations of staff interacting with Resident 52 without wearing PPE, Staff D said this did not meet her expectations.FAILURE TO IMPLEMENT TBPResident 40Resident 40 was admitted to the facility on [DATE]. Review of a Nursing progress note, written by Staff F, Licensed Practical Nurse (LPN), dated 02/14/2026, documented Resident 40 was noted to have a moist productive cough.An Alert Charting (charting done when a resident is being monitored) progress note, written by Staff F, dated 02/15/2026, documented Resident 40 had a moist productive cough. Review of Resident 40's electronic health record (EHR) showed no documentation that Resident 40 was placed on TBP for their symptoms that could indicate a potentially transmittable infectious process. Resident 58Resident 58 was admitted to the facility on [DATE].Review of a Nursing progress note, written by Staff F, LPN, dated 02/24/2026, documented Resident 58 had a moist productive cough. An Alert Charting progress note, written by Staff F, dated 02/25/2026, documented Resident 58 continued with upper lung congestion, cleared with cough, sputum (thick mucus that is coughed up) noted to be thick, yellowish and brown in color. Review of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 58's EHR showed no documentation that Resident 58 was placed on TBP for their symptoms that could indicate a potentially transmittable infectious process.Resident 17Resident 17 was admitted to the facility on [DATE]Review of a 02/25/2026 Nursing progress note, written by Staff F, LPN, dated 02/25/2026, documented resident 17 complained of a cough and was noted to have chest congestion. An Alert Charting progress note, written by Staff G, LPN, documented Resident 17 had respiratory symptoms with mild non-productive, congested cough.Review of Resident 17's EHR showed no documentation that Resident 17 was placed on TBP for their symptoms that could indicate a potentially transmittable infectious process.On 02/27/2026 at 3:01 PM, observations of Resident 40, 58, and 17's room doors showed no signage to indicate TBP was in place.On 02/27/2026 at 3:03 PM, Resident 17 was observed in the hallway with no mask on.On 03/02/2026 at 8:31 AM, Staff D, Infection Preventionist, RN, said for residents showing symptoms of a potentially infectious process such as respiratory symptoms staff should assess the resident, notify the physician, place residents on alert monitoring (a temporary, documented observation plan used to monitor and track a resident's condition), implement standing orders such as rapid testing (tests to rule out an infectious process). When asked the expectations of when TBP would be initiated for a resident who was symptomatic with what could be a transmittable infectious process, Staff D said when there was a positive test, TBP should be initiated. Staff D said the nursing staff had been educated and encouraged to take preventative steps and she was encouraging mask use, but it was not mandatory. Regarding Resident 40 having moist productive cough with nasal drainage and placed on alert monitoring Staff D was asked if the facility had been ruling out an infectious process, Staff D said with moist wet cough, yes. When asked if TBP had been initiated, Staff D looked in the EHR and said she did not see that it had been initiated and until suspicions had been ruled out, TBP should have been initiated.Regarding Resident 58 noted in documentation to have a moist productive cough, with alert monitoring in place, Staff D said both Resident 58 and Resident 40 were COVID-19 tested every 48 hours until 3 negative tests were obtained. When asked if TBP should have been initiated while ruling out infectious process, Staff D said if suspected and until ruled out, TBP should have been initiated, and it was not.Regarding Resident 17 noted to have cough with chest congestion, and alert monitoring in place, Staff D said Resident 17 had not been placed on TBP. Staff D said it did not meet her expectations that while ruling out potentially transmissible infections residents were not placed on TBP.Reference WAC 388-97-1320(1)(a)(2)(a)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents and/or resident representatives were informed and provided consent before administering psychotropic (medications that alter moods, behaviors, thoughts or perceptions, and affects the brain) medication for 1 of 5 sampled residents (Resident 2) reviewed for right to be informed about treatment decisions. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about medications and a diminished quality of life. Findings included .Resident 2 Resident 2 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, vascular dementia (a type of cognitive impairment caused by reduced blood flow to areas of the brain), and depression (mood disorder that causes a persistent feeling of sadness or loss of interest). Resident 2's Quarterly Minimum Data Set (MDS), an assessment tool, dated 02/04/2026, indicated severe cognitive impairment with inattention and disorganized thinking was continuously present. Resident 2's care plan, initiated 10/31/2025, documented risk for impaired cognitive function and impaired thought processes related to altered mental status change. This care plan listed as an intervention, needs supervision/assistance with all decision making. Resident 2 had an order, dated 10/31/2025, for Olanzapine (an antipsychotic medication used to treat psychiatric conditions that involve disturbances in thinking, perception, mood, or behavior) to be given daily at bedtime for vascular dementia with hallucinations (sensory perceptions in which a person sees, hears, smells, tastes, or feels something that is not actually present in the environment). Review of Resident 2's EHR showed a document titled, Consent for Treatment: Use of Anti-Psychotic Medication. dated 10/31/2025, for the Olanzapine medication. The consent listed common side effects, which included sedation, constipation, blurred vision, weight gain, swelling, loss of appetite, urinary retention, irregular heart rhythm, dizziness and more with a black box warning which indicated Olanzapine was not approved to treat mental problems caused by dementia. The consent had an area for the resident's legal representative/surrogate decision-maker to consent or decline treatment; this area was left blank. The consent indicated that Resident 2 was able to understand and consent to the treatment and was signed by Resident 2. On 02/26/2026 at 12:00 PM, Staff B, DNS, when asked about Resident 2's mentation Staff B said that it was difficult to characterize Resident 2's brand of confusion, they could talk well but were confused about their capabilities, situation, ability to care for self and safety awareness. When asked what the expectation of a resident's mentation to be before signing for psychoactive (any medication that affects brain function, mood, behavior, perception, or cognition) medications, Staff B said they would like to get family, Power of Attorney and resident involved. Staff B reviewed the antipsychotic consent for Olanzapine and confirmed Resident 2 had signed it themselves. When it was pointed out that documentation indicated Resident 2 had severe cognitive impairment and required assistance with all decision making and asked if it met expectations for them to sign their own consent, Staff B said they would have expected someone else to have been contacted. Staff B looked in the EHR and said he did not see a progress note that Resident 2's family had been contacted. When asked if this met his expectations, Staff B said no. Reference WAC 388-97-0260

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	505290	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard Bremerton, WA 98310

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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 resident assessments accurately reflected the health status and/or care needs for 4 of 20 residents (Residents 43, 80, 7 & 24) whose Minimum Data Sets (MDS, an assessment tool) were reviewed. The failure to ensure active diagnoses, oral assessments, Level II Pre-admission Screening and Resident Review (PASRR) status, and restorative services accurately reflected residents' health status and care provided, placed residents at risk for unidentified and/or unmet care needs. Findings included .Resident 43Resident 43 was admitted to the facility on [DATE]. Review of the 03/23/2025 Annual and 12/02/2025 Significant Change MDS showed the resident was edentulous (no natural teeth or tooth fragments) and had no abnormal mouth tissue, ulcers, masses, or lesions. Oral Assessment Review of Resident 43's dental consultations showed the following: A dental consult, dated 09/09/2025, instructed staff to assist Resident 43 with cleaning their oral tissues and to See all previous notes related to osteonecrosis (a rare but serious condition that causes bone cells in your jawbone to die and your jawbone to poke through an opening in your gums, characterized as a lesion or exposed and necrotic bone that has been present for more than 8 weeks) to the lower right posterior jaw, which was noted previously. The consultation documented the family was aware and directed staff to schedule an oral surgery appointment if the family desired. A dental consultation, dated 02/29/2025, documented Resident 43 had exposed bone to the lower right jaw with possible osteonecrosis noted. The consultant instructed staff to See previous notes/referral to oral surgeon. A dental consultation, dated 07/12/2023, documented that lower right buccal retromolar ulcers were identified. On 03/02/2026 at 8:43 AM, Staff U, MDS Coordinator, said the 03/23/2025 Annual and 12/02/2025 Significant Change MDSs inaccurately coded Resident 43's oral status and needed to be modified. PASRR The Quarterly MDS, dated [DATE], and Significant Change MDS, dated [DATE], showed Resident 43 had an active diagnosis of anxiety disorder (characterized by feeling nervous, restless, tense or having a sense of impending danger, panic or doom.) A [NAME] I PASRR showed Resident 43 had a diagnosis of mood disorder and did not have a diagnosis of anxiety disorder. The electronic medical record (EMR) showed no documentation was present to show the resident was treated and/or monitored for anxiety disorder. On 02/27/2026 at 1:56 PM, when asked if there was documentation to support Resident 43 had a diagnosis of anxiety disorder and that documented what facility staff were doing to treat and monitor it, Staff U, MDS Coordinator, said they could not immediately find documentation to support Resident 43 had an active diagnosis of anxiety disorder but requested more time to fully review Resident 43's EMR. During an interview on 03/02/2026 at 8:43 AM, Staff U, MDS Coordinator, indicated they were unable to find documentation to support an active diagnosis of anxiety and said the 06/23/2025 Quarterly MDS, and 12/02/2025 Significant Change MDS, needed to be modified. Resident 80Resident 80 was admitted to the facility on [DATE]. Review of the hospital history and (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical, dated 11/09/2025, documented that Resident 80 was admitted to the hospital for acute hypoxemic respiratory failure (occurs when the lungs fail to adequately oxygenate the blood) in the setting of influenza A, pneumonia and concomitant (occurring at the same time) chronic obstructive pulmonary disease (COPD). Dyspnea (difficulty breathing) was further worsened by obesity and rib fractures causing poor chest excursion (refers to the expansion and contraction of the chest during breathing). The admission MDS, dated [DATE], showed respiratory failure and COPD were not coded as active diagnoses for Resident 80. In an interview on 03/02/2026 at 8:31 AM, Staff U, MDS Coordinator, said respiratory failure and COPD should have been coded as active diagnoses for Resident 80 and the MDS needed to be modified. Resident 7Resident 7 was admitted to the facility on [DATE]. Review of the admission MDSs, dated 12/08/2025 and 12/31/2025, showed the resident had a diagnosis of Autism, but was not considered by the state Level II PASRR process to have a serious mental illness, intellectual disability or related condition. Record review showed a Level II PASRR, dated 09/18/2025, which was scanned into the EMR on 03/02/2026 under the title PASRR Invalidation, which recommended specialized services for Resident 7. On 03/04/2026 at 1:37 PM, Staff U, MDS Coordinator, said the 12/08/2025 and 12/31/2025 admission MDSs were incorrect and needed to be modified. Resident 24 - Restorative Resident 24 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented Resident 24 received restorative nursing programs as follows: two days of active range of motion (ROM) and two days of transfer for at least 15 minutes a day in the previous seven calendar days. A review of the Restorative Nursing Summary, dated 09/16/2025, said continued active ROM and ambulation program were needed to maintain strength and functional mobility. On 02/26/2026 at 2:18 PM, Staff U, MDS Coordinator said the restorative nursing summary was not completed quarterly and should have been completed in December 2025. On 02/26/2026 at 2:44 PM, Staff U said she had decided to modify the MDS for January 2026 and the plan moving forward was to have the restorative nursing summary completed when entering the MDS data for residents on restorative therapy. On 02/27/2026 at 9:59 AM, Staff B, Director of Nursing and Registered Nurse, said the most recent Restorative Nursing Assessment was [DATE] and it should have been completed quarterly. Staff B said his expectation was for the Restorative Nursing Assessment to be completed around the MDS assessment. Reference WAC 388-97- 1000 (1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) was completed and/or reflected accurate mental health diagnosis for 2 of 5 sampled residents (Residents 2 and 7) reviewed for PASRR. This failure placed residents at risk of not receiving mental health services and a diminished quality of life.Findings included. Resident 2 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder (recurring intrusive thoughts or concerns), vascular dementia (a type of cognitive impairment caused by reduced blood flow to areas of the brain), and depression (mood disorder that causes a persistent feeling of sadness or loss of interest). Resident 2's Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/04/2026, indicated severe cognitive impairment with inattention and disorganized thinking continuously present. Resident 2 was admitted to the facility with a Level 1 PASRR, dated 10/20/2025, received from the transferring hospital. The Level 1 PASRR indicated Resident 2 had an anxiety disorder, requiring a Level 2 evaluation referral for serious mental illness. The Level 1 PASRR did not include Resident 2's depression diagnosis under the section for mood disorders. On 02/26/2026 at 11:43 AM, Staff P, Social Services Director, said when a resident was admitted with a PASRR it was herself and the Admissions Director who reviewed the PASRR to make sure it was accurate. Regarding Resident 2's PASRR only reflecting their anxiety disorder when Resident 2 also had a diagnosis of depression, Staff P said she believed it was one they needed to correct. When asked if a new Level 1 PASRR should have been completed that included depression, Staff P said, yes. On 02/26/2026 at 1:50 PM, Staff P confirmed that the PASRR Level 1 had not reflected Resident 2's depression diagnosis which had been present when they transferred to the facility and said a new corrected Level 1 would be sent. Resident 7Resident 7 was initially admitted to the facility on [DATE]. A Level I Pre-admission Screening and Resident Review (PASRR), dated 12/02/2024, showed the resident had an intellectual disability or related condition. The PASRR instructions indicated the PASRR should be forwarded to the regional DDA (Developmental Disabilities Administration) PASRR Coordinator, but the resident met the criteria for an exempted hospital discharge due to requiring nursing facility care for the same condition they received acute inpatient hospital care for, and the physician certified they likely require less than 30 days of nursing facility services. Thus, Resident 7 could admit to facility without a PASRR Level II. For resident with an intellectual disability, the PASRR Level I was required to be forwarded to the DDA PASRR Coordinator upon admission to the nursing facility. The level I PASRR showed no Level II PASRR was required at that time due to the exempted hospital discharge but showed that a Level II evaluation would have to be completed if scheduled discharge (within 30 days) did not occur. Record review revealed Resident 7 was not discharged from the facility until 03/14/2025. Review of the electronic medical record (EMR) showed there was no documentation that the Level I PASRR was forwarded to the DDA Coordinator upon admission as required, or that the facility referred Resident 7 for a Level II evaluation when they did not discharge within 30 days. On 02/27/2026 at 2:05 PM, when asked if they had documentation to show Resident 7's Level I PASRR was forwarded to the DDA Coordinator upon admission to the facility as required and that Resident 7 was referred for a Level II evaluation when they did not discharge from the facility within 30 days as (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required, Staff P, Social Services Director, stated, No. Reference WAC 388-97-1915 (1)(2)(a-c)

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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 observation, interview and record review, the facility failed to implement a comprehensive care plan for 5 of 20 sampled residents (36, 2, 80, 7 & 43) reviewed for care plans. The failure to establish care plans that were individualized placed residents at risk for receiving inconsistent and/or inadequate care.Findings included. Resident 36 Resident 36 was admitted to the facility on [DATE]. The admission Minimum Data Set, MDS-an assessment tool, dated 01/26/2026 documented Resident 36 was cognitively intact and on continuous oxygen therapy. On 02/23/2026 at 3:07 PM, Resident 36 was observed wearing a nasal cannula that was administering oxygen. A review of Resident 36's care plan, on 02/24/2026, did not show oxygen therapy listed as a focus, goal, or intervention/task. On 02/26/2026 at 11:32 AM, Staff X, Licensed Practical Nurse / Resident Care Manager said while looking at Resident 36's care plan that they did not have an oxygen care plan and they should. Staff X said her expectation was for oxygen to have been added to the care plan. On 02/27/2026 at 9:59 AM, Staff B, Director of Nursing Services (DNS) and Registered Nurse (RN) said there should have been something in the care plan about Resident 36's oxygen. Resident 2 Resident 2 was admitted to the facility on [DATE] with a diagnosis of vascular dementia (a type of cognitive impairment caused by reduced blood flow to areas of the brain). The Quarterly MDS, dated [DATE], documented Resident 2 required supervision or touching assistance with upper and lower body dressing. On 02/26/2026 at 10:53 AM, Resident 2 was observed to have an open zippered red sweatshirt on and was otherwise nude. As Resident 2 sat up from a laying position their body was exposed. When asked if anyone had offered to get them dressed for the day, Resident 2 said no. When asked if they usually got dressed in the morning, Resident 2 said yes. When asked if they received regular bathing, Resident 2 said they were showered on Wednesdays and everyday staff would come in and say, let's get dressed, Resident 2 added, I sort of don't care. On 02/26/2026 at 12:30 PM, Resident 2 was observed laying on bed with same red sweatshirt on, bare buttocks showing. When asked if anybody had offered to assist them with dressing, Resident 2 said, no, it didn't matter to them unless it was Wednesday shower day. When asked if it bothered them that their buttocks were observable, Resident 2 said no. On 02/26/2026 at 2:41 PM, Resident 2 was observed to have the same red sweatshirt on, now with a blanket covering their lower body. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2026 at 2:43 PM, Staff V, Certified Nursing Assistant (CNA), was asked if they had provided morning care to Resident 2 that day, Staff V said, no that Resident 2 did not allow it and added Resident 2 would often yell at staff to get out of their room. Regarding Resident 2 being in nothing but a sweatshirt all day, Staff V said Resident 2 was usually barely dressed and that was Resident 2's preference. Regarding Resident 2's body being exposed, Staff V said that was usual for most days, staff would attempt to help Resident 2 to get dressed but they often refused and she had offered that morning to get them dressed. Staff V said she would document in the electronic health record when Resident 2 refused care. Review of the electronic health record for Resident 2 did not show an area for CNA's to document morning care refusals and/or refusals to get dressed. Review of Resident 2's progress notes did not show a note about the reported morning care refusal. Resident 2 had a care plan for Activities of Daily Living performance deficit related to cognitive deficit, memory loss, confusion, decreased awareness, revised on 11/19/2025, that documented they were refusing showers. The care plan for dressing lower and upper body, initiated 10/31/2025, documented Resident 2 required 1 staff member to participate with dressing. The care plan did not address or offer interventions for Resident 2's reported frequent refusals of care or reported preference not to be fully clothed. On 02/27/2026 at 1:49 PM, Staff B, DNS, was made aware of CNA reporting that Resident 2 was refusing care on the morning of 02/26/2026, and of the observations of Resident 2 wearing nothing but an open sweatshirt with their body exposed. Staff B was informed that staff also reported Resident 2 frequently refused care and at times would yell at staff to leave and they were unable to complete care. When asked the expectation of documentation of the refusal of morning care Staff B said it should have been somewhere in the progress notes, and for a CNA the documentation would be in the tasks. Staff B said he would expect the CNA to report this to the nurse who would then put in a progress note. Staff B looked in the electronic health record and was unable to find documentation for Resident 2's refusal of morning care on 02/26/2026 and said there should have been some documentation of this. When asked if the care plan should reflect if Resident 2 frequently refused care and list interventions for staff to attempt, Staff B said yes. Staff B reviewed Resident 2's care plan and said Resident 2 did have an Activates of Daily Living care plan regarding preference not to be fully clothed. A second review of the care plan for Activities of Daily Living, showed there had been a revision, dated 02/27/2026, (after interview with Staff V) which documented Resident 2 Required 1 staff participation to dress, dressed and undressed self independently from time to time and often likes to lay in bed and sit in chair without fully clothed. On 02/27/2026 at 2:17 PM, when made aware that the care plan reviewed previously had not included Resident 2's preference to be without full clothing and asked when it had been updated, Staff B said the update may have gone in later. When asked if there was a place for CNA's to document refusals of morning care, Staff B said, not really, the expectation was for staff to get the nurse involved unless it was care planned. Resident 80Resident 80 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact and required supplemental oxygen during the assessment period. Review of the hospital history and physical, dated 11/09/2025, documented that Resident 80 was admitted to the hospital for acute hypoxemic respiratory failure (occurs when the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lungs fail to adequately oxygenate the blood) in the setting of influenza A, pneumonia and concomitant (occurring at the same time) chronic obstructive pulmonary disease (COPD). Dyspnea (difficulty breathing) was further worsened by obesity and rib fractures causing poor chest excursion (refers to the expansion and contraction of the chest during breathing.) Resident 80 had an 11/14/2025 order for oxygen 0-2 liter via nasal canula as needed to maintain oxygen saturation greater than 90%. The November 2025 Treatment Administration Record showed the resident was administered oxygen daily. A respiratory infection secondary to Influenza and pneumonia care plan, initiated 11/14/2025, directed staff to provide antibiotic therapy as ordered, encourage resident to change positions as needed, especially if in bed, and to monitor and document any changes to level of consciousness. Care plans addressing Resident 80's COPD exacerbation, acute hypoxemic respiratory failure and use of supplemental oxygen were not developed or implemented. On 03/02/2026 9:34 AM, Staff B, DNS, said comprehensive care plan should have identified and addressed Resident 80's COPD, acute hypoxemic respiratory failure and oxygen therapy and included identified goals and interventions. Resident 7Resident 7 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact, and had a diagnosis of autism, neurogenic bladder (bladder does not function normally because of a problem with the nerves) and obstructive uropathy (urine flow is blocked somewhere in the urine tract). Record review showed a Level II Pre-admission Screening and Resident Review (PASRR), dated 09/18/2025, which determined the resident had a serious mental illness, intellectual disability or related condition and would benefit from specialized services. Review of the comprehensive care plan, initiated on 09/24/2025, showed Resident 7's diagnosis of autism and status as a Level II PASRR were not identified or addressed in the resident's plan of care. On 03/04/2026 at 1:37 PM, Staff U, MDS Coordinator, said care plans addressing Resident 7's autism and Level II PASRR status should have been included in the resident's plan of care. A urinary catheter care plan, initiated 09/24/2025, identified Resident 7 had a diagnosis of neurogenic bladder, but did not address the residents obstructive uropathy. On 02/27/2026 at 12:59 PM, Staff B, DNS, said Resident 7's diagnosis of obstructive uropathy should have been addressed on their urinary catheter care plan. Resident 43Resident 43 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident had a diagnosis of dementia with behaviors, and received antipsychotic (medications primarily used to manage psychosis symptoms like hallucinations, delusions, and severe agitation in schizophrenia, bipolar disorder, and severe depression) and antidepressant medication during the assessment period. Record review showed Resident 43 had the following psychotropic (prescription drugs that alter brain chemistry to modify a person's thoughts, feelings, moods, perceptions, and behaviors) medication orders: A 12/19/2025 order for quetiapine (an antipsychotic) for vascular dementia with moderate mood disturbance. A 07/01/2025 order for fluoxetine (an antidepressant) for major depression. An antidepressant medication use related to depression and low meal intake care plan, revised 05/03/2025, identified the goal of therapy as, will be free from discomfort or adverse reactions related to antidepressant therapy. The care plan did not identify what the goal of the antidepressant therapy was (e.g. decreased self-isolation, negative self-statements etc.). Additionally, fluoxetine is not known to have appetite stimulant effects. On 02/27/2026 at 12:59 PM, Staff B, DNS, said a goal for Resident 43's antidepressant therapy should have been identified. Staff B said the antidepressant for low meal intake was related to the mirtazapine (an antidepressant frequently used as an appetite stimulant) that had been discontinued. An antipsychotic medication use care plan, initiated 11/24/2025, documented Resident 43 had a diagnosis of dementia with psychosis. Review of the electronic health record showed there was no documentation of a diagnosis of dementia with psychosis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/27/2026 at 12:59 PM, when asked if there was documentation to support Resident 43 had a diagnosis of dementia with psychosis, Staff B, DNS, said no and indicated the care plan needed to be corrected. Review of Resident 43's electronic health record showed a dental consult, dated 09/09/2025, instructed staff to assist Resident 43 with cleaning their oral tissues and to See all previous notes related to osteonecrosis (a rare but serious condition that causes bone cells in your jawbone to die and your jawbone to poke through an opening in your gums, characterized as a lesion or exposed and necrotic bone that has been present for more than 8 weeks) to the lower right posterior jaw, which was noted previously. The consultation documented the family was aware and directed staff to schedule an oral surgery appointment if the family desired. The Significant Change MDS, dated [DATE], documented Resident 43 was edentulous (had no natural teeth or tooth fragments). An oral dental health care plan, revised 05/03/2025, directed staff to monitor for pain related to exposed tooth fragment to right lower jaw. Resident 43's diagnosis of osteonecrosis to the right lower posterior jaw was not identified or addressed. On 03/02/2026 at 9:23 AM, Staff B, DNS, indicated the care plan was inaccurate and needed to be updated/revised. Reference WAC 388-97 -1020(1), (2)(a)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary care and services to ensure that residents received weekly showers for 1 of 2 residents (3) reviewed for activities of daily living (ADLs). This failure placed the residents at risk of poor hygiene and a diminished quality of life.Findings included .Resident 3 was admitted to the facility on [DATE]. The admission Minimum Data Set, an assessment tool, dated 01/26/2026, documented Resident 3 was cognitively intact and was dependent to substantial/moderate assist with ADLs. On 02/23/2026 at 2:09 PM, Resident 3 said they had one shower since they had been in the facility. Resident 3 said things keep happening that delayed the shower, like physical therapy. Resident 3 said the nurse believed they were refusing showers. Resident 3 said they were not refusing and they would like a shower. A review of Resident 3's care plan on activities of daily living self-care performance deficit related to weakness, immobility, surgery on the nervous system, spinal fusion aftercare, was revised on 02/12/2026, and had an intervention, initiated on 01/22/2026, as bathing (shower/bathe self): one person with bathing/showering one time weekly and as necessary. A review of Resident 3's 30-day bathing record for 01/26/2026 - 02/22/2026 documented a shower on 02/06/2026 and 02/07/2026, a full body bath on 02/12/2026, a sponge bath on 02/22/2026, and a resident refusal on 01/31/2026. A review of Resident 3's progress note, dated 01/31/2026 at 3:00 PM, by Staff Y, Registered Nurse (RN), documented Resident 3 declined their scheduled bath that day because they had family/visitors and requested to have it the following day instead. A review of Resident 3's progress note, dated 02/01/2026 at 9:46 AM, by Staff Y RN, documented the assigned shower aide was made aware of Resident 3's request for bed bath that day.A review of Resident 3?s progress note, dated 02/11/2026 at 11:07 PM, by Staff Z, RN, documented Resident 3 did not receive their shower on that shift due to Certified Nursing Assistant (CNA) time constraints. On 02/26/2026 at 11:22 AM, Staff X, Licensed Practical Nurse / Resident Care Manager said Resident 3 was not getting a shower once a week and they were care planned to receive a shower once weekly and as necessary. Staff X said there was a progress note on 01/31/2026 that Resident 3 declined a shower and was supposed to get one on 02/01/2026 but there was not a shower documented that day. Staff X said they were not sure what happened on 02/11/2026 to prevent a shower due to CNA time constraints. On 02/27/2026 at 9:59 AM, while looking at Resident 3's bathing record, Staff B, Director of Nursing Services, said they were not getting a shower once a week. Staff B reviewed the progress note from 01/31/2026 and said Resident 3 should have received a shower the next day as planned. Staff B said his expectation was for Resident 3 to get a shower once a week. Reference WAC 388-97-1060 (2)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505290	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belmont Terrace	560 Lebo Boulevard Bremerton, WA 98310

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the daily nurse staffing was consistently posted to include the actual nursing staff hours worked for 3 out of 6 days (02/22/2026, 02/23/2026 and 02/27/2026). This failure caused the facility's staffing information not to be readily available to residents and visitors who may wish to review it. Findings included .On 02/23/2026 at 9:53 AM, upon entrance to the facility, the daily nurse staffing was posted on the wall outside of the therapy room, it showed the dates for 02/19/2026, 02/20/2026 and 02/21/2026. No daily nurse staffing was posted for 02/22/2026 or 02/23/2026. On 02/27/2026 at 8:56 AM, the daily nurse staffing was from 02/26/2026. Staff B, Director of Nursing Services was walking past, was stopped and asked to confirm the daily nurse staffing posted on the wall. Staff B confirmed the daily nurse staff posting was dated 02/26/2026. Staff B said the daily nurse staffing should have been updated. When observation from 02/23/2026 were explained, Staff B said the daily nurse staffing should be updated daily. No Associated WAC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	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 ensure written menus were followed, planned menu items were served at the appropriate serving size, substitutions only occurred when necessary and were approved by the Registered Dietician and communicated to the facility residents, and appropriate serving sizes were provided. These failures detracted from residents' ability to determine if they wanted the main meal or the alternative meal when filling out their menus for the week, due to uncertainty if the listed meal would actually be served. This placed residents at risk of receiving food they did not request, therapeutic diet not being followed, and dissatisfaction with meals. Findings included Review of the posted menu showed on 02/26/2026 the lunch meal would be country fried steak, garlic mashed potatoes, garden blend vegetables with banana pudding. Residents on renal diets, two-gram sodium diets, or low fat/low cholesterol diets would be served a baked beef patty, garlic mashed potatoes, garden blend vegetables with banana pudding or oranges with whipped topping (diet specific). The alternative lunch meal was cheese tortellini/no sauce and spinach with garlic butter. Observation of the steam table on 02/26/2026 at 12:04 PM showed Staff BB, Cook, had prepared pureed pork and carrots, instead of pureed country style steak, beef patties and garden blend vegetables. For regular texture meals Staff BB, prepared country style steak and pork and rice. On 02/26/2026 at 12:06 AM, when asked why Pureed pork and carrots was prepared instead of pureed country fried steak/beef patties and garden blend vegetables as directed on the menu Staff CC said because pork was easier to puree. Staff CC indicated she also made pork and rice instead of beef patties because it was already cooked (left over from the sweet and sour pork the facility served for lunch on 02/25/2026). Observation of the deserts available showed there was banana pudding and instead of oranges with whipped topping for renal diets, a canned fruit cocktail made of blend of pineapple, papaya, guava, passion fruit was provided.Review of an undated facility document titled Fruits to avoid on Renal Diet listed papaya as fruit to be avoided. <Serving Sizes>Tray line was observed on 02/26/2026 from 12:06 PM- 12:37 PM and showed the following:Resident 77's tray card showed they were to receive small portions (1/2 serving size). Staff BB provided a full portion of country style steak.Resident 41's tray card showed they were to receive small portions. Staff BB provided a full portion of country style steak.Resident 30's tray card showed they were to receive large portions (1.5 serving size). Staff BB provided double portions of country style steak.Resident 51's tray card showed they were to receive large portions. Staff BB provided double portions of country style steak. On 02/26/2026 at 12:54 PM, Staff CC, Dietary Supervisor, confirmed Staff BB failed to follow the planned menu and made substitutions without approval of the Registered Dietician and without notifying the residents or posting the changes. Staff CC, Dietary Supervisor, confirmed Staff BB provided the incorrect portion size for small and large portion diets. Staff CC said Staff BB knew the residents very well and what they wanted. Staff BB reported that he trusted Staff BBs judgment.On 03/02/2026 at 7:48 AM, Staff CC, Dietary Supervisor, said Staff BB should have provided the correct portion sizes as directed by the residents' tray card. Staff CC also confirmed changes to the menu needed to be approved by the Registered Dietician and posted. Reference WAC 388-97-1160 (1)(a)(b)