STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505296	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 observation, interview, and record review, the facility failed to provide the necessary care and services related to restorative nursing programs (RNPs) for 3 of 5 residents (Resident 47, 65, and 67) reviewed for positioning, mobility, and range of motion. The failed practice placed residents at risk for a decline in function, contractures (shortening and hardening of muscles, tendons leading to deformity and rigidity of joints), pain and increased dependency on caregivers.Findings included . Review of the facility policy titled Restorative Nursing Programs dated June 2018 documented the facility provides services, care and equipment to assure that a resident maintains and/or improves his/her level of range of motion and mobility unless a reduction is clinically unavoidable. The facility guidelines showed residents would be routinely assessed for the need of a formalized RNP. Care and assistance will be provided, consistent with the resident's goals and preferences, for devices. According to the Resident Assessment Instrument Manual (provides guidance for completion of the Minimum Data Set - MDS) the following criteria must be met for RNPs: - The program must have measurable objective goals and interventions must be documented in the care plan and in the medical record. - There needs to be evidence of periodic evaluation by the licensed nurse that must be present in the resident's medical record. - Nursing Assistants (NAs) must be trained in the techniques that promote resident involvement in the activity; and - A Registered Nurse (RN) or a Licensed Practical Nurse (LPN) must supervise the activities in an RNP. <RESIDENT 47> Resident 47 was admitted to the facility on [DATE], with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness on one side) following cerebral infarction affecting the left non-dominant side, weakness and impaired physical mobility. Review of the quarterly MDS assessment, dated 11/11/2025, showed Resident 47 utilized a wheelchair and had limited range of motion in one side of upper and lower extremities. The resident received splint or brace assistance, active and passive range of motion (AROM) on two days of the seven-day lookback period, and they did not reject care. (continued on next page)

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

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 47's current care plan directed staff to provide a RNP to maintain ROM and maintain functional mobility secondary to decreased mobility related to stroke. The nursing staff were to provide ROM to left hand, including fingers and wrist, provide hygiene and gentle stretching to left hand prior to donning palm protector to their left hand as tolerated for 15 minutes. Nursing staff were to provide gentle prolonged stretch and passive ROM to their hips/knee/ankle. The staff were to provide passive ROM to bilateral upper extremities (shoulder, elbow, and wrist) for 5-10 reps at each joint, for 15-20 minutes or as tolerated with morning and bedtime cares. The goal was to maintain range of motion and have no change in joint mobility. The care plan did not specify how many days the program was to occur. Review of the clinical record showed the last evaluation of the RNP was completed on 01/10/2025. The note showed physical therapy (PT) demonstrated the resident's new arm straightener a metal piece with three Velcro straps that was to be worn ideally for 4 to 6 hours daily. The note did not include an assessment of the resident's current function, participation, tolerance to orthotic devices or range of motion. There were no further evaluations documented. Review of the occupational therapy (OT) evaluation and plan of treatment on 11/11/2025 documented Resident 47 had impaired ROM to their left wrist, hand, thumb, index finger, middle finger, ring finger and little finger. Staff H, OT documented that while a therapist provided general orthotic recommendations based on current presentation, Resident 47 would benefit from further assessment by a specialist with advanced orthotic fabrication skills to determine most appropriate splint design and fit. Splint/orthotic options were: - Functional position splint indicated for chronic flexion synergy, no active wrist extension, -Elbow extension orthosis indicated for elbow flexion contracture, -Combo of 1 and 2 options using functional splint during the day and elbow extension at night. Review of the physician's orders directed staff to apply a left elbow extension splint on for 6-8 hours during the day, complete daily skin check/hygiene, wash sleeve in the sink when soiled and hang to dry every day shift for contracture of Resident 47's left arm beginning 02/05/2025. Review of a physician's order directed the nurse to apply Resident 47's splint program. This included moisturizing hand, massaging lotion completely, and gentle stretches to hand then apply a resting hand splint to the left hand at bedtime and as tolerated daily. Nurses were to complete a skin check after removal in the morning and monitor for signs of increased redness, pain or edema in the morning after removal of the device beginning 11/12/2025. In an observation on 12/01/2025 at 11:59 AM, Resident 47 was resting in bed. Their 3rd, 4th and fifth digits were fixed with their fingertips up to the palm of their hand. The resident was unable to move their left fingers from their position. The resident stated they had worn a splint in the past, but it had been missing and must be on vacation in Hawaii. The resident stated the contractures began with their stroke. There was no splint, palm protector or elbow extender in place. In similar observations at 1:53 PM, there was no palm protector, splint or elbow extender in place. In observations on 12/02/2025 at 9:00 AM, 11:20 AM, 1:12 PM, 2:27 PM and 3:02 PM, the resident did not have the palm protector, splint, elbow extender on their left upper extremity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In observations on 12/03/2025 at 8:39 AM and 10:19 AM, Resident 47 was up in their wheelchair without any orthotics on their left upper extremity. They stated maybe their splint was in their closet. At 1:17 PM, the left hand splint was on for the first observation but there was no palm protector or elbow extender in place. In observations on 12/04/2025 at 8:16 AM, 10:11 AM, and 11:57 AM, Resident 47 did not have their palm protector, splint or elbow extender on. The splint was located on their nightstand. At 1:14 PM, 2:34 PM and 4:21 PM, they were observed with no devices on. In observations on 12/05/2025 at 9:02 AM, 10:00 AM, 11:09 AM and 12:38 PM, Resident 47 was observed without devices on, and the splint was observed on their nightstand. Observations on all dates of the survey (12/01/2025, 12/02/2025, 12/03/2025, 12/04/2025, and 12/05/2025), showed Resident 47 was not observed to receive RNP services. Review of Resident 47's clinical record showed the resident did not receive their RNP as care planned. In an interview on 12/04/2025 at 10:22 AM, Staff C, Registered Nurse (RN)/Resident Care Manager, stated Resident 47 wore a left hand splint for their left hand contracture. In an interview on 12/04/2025 at 1:29 PM, Staff F, RN stated Resident 47 was supposed to have a left arm splint on in the morning and off at night. Staff F stated nurses were expected to check to make sure the splint was on, but the aides were to put the splint on. In an interview on 12/04/2025 at 2:34 PM, Staff E. Licensed Practical Nurse/MDS nurse stated they were responsible for oversight of the restorative program. Staff E stated the programs were being completed by the NAC's on the floor as part of their duties. Staff E stated they were to review the RNP quarterly and annually. They stated Staff G, restorative aide, had been pulled to the floor since September. In an interview on 12/05/2025 at 8:48 AM, Staff G, Nursing Assistant Certified (NAC) stated they were no longer the restorative aide related to staffing. Staff G stated the responsibility lies with the floor aides to incorporate the RNP with their care. Staff G stated they did work with Resident 47 in the past and their left hand was contracted and was tight. Staff G stated Resident 47 was agreeable to ROM, the palm protector and a resting splint at night. Staff G stated Resident 47 did not refuse care or splint placement. In an interview on 12/05/2025 at 10:48 AM, Staff H, OT was asked about their recommendations for Resident 47 on 11/11/2025. Staff H stated they did an evaluation on the resident and they recommended special orthotic devices for the resident and for them to see an actual specialist. Staff H was asked what steps were taken after they made the recommendations on 11/11/2025. Staff H stated they just document it in their note and do not do anything past that. Staff H stated they did not discuss the recommendations with the Director of Rehabilitation (DOR), RCM, or any other nursing staff. In an interview on 12/05/2025 at 10:54 AM, Staff I, DOR stated that they had read the 11/11/2025 note and then sent an email to nursing. Staff I stated there had been conversations about the recommendation and the OT that evaluated the resident was not a hand specialist. Staff I stated they (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had another OT coming in tomorrow that has made specialized hand splints, and they were going to ask that OT to look at the resident. Staff I stated that there was no documentation in resident 47's medical record as to the plan and discussions with the interdisciplinary team. In an interview on 12/05/2025 at 12:55 PM, Staff A, Administrator and Staff B, Director of Nursing Services, stated the company did not have a restorative position or program and the expectation was the NACs were to provide the RNP's. <RESIDENT 67> Resident 67 admitted [DATE] following a stroke with residual right sided hemiparesis (weakness on one side of the body). The resident was also diabetic. According to the admission Minimum Data Set (MDS, a required assessment tool) assessment dated [DATE], the resident required extensive assistance or was totally dependent for activities of daily living such as bed mobility, transfers, and toileting. The MDS further showed Resident 67 had impaired range of motion impacting one side of the upper extremities and both sides of the lower extremities. In a joint interview on 12/04/2025 at 1:00 PM, with Resident 67 and CC1 (spouse of Resident 67), Resident 67 stated they were no longer getting therapy because the insurance ended. CC1 stated Resident 67 was not getting exercises other than going to the dining room to a group program. CC1 verbalized frustration that Resident 67 will never get strong enough to come home if they are not doing any exercise. Resident 67 stated they could not recall the last time they had done any exercises other than in the dining room. Review of Resident 67's therapy Discharge summary dated [DATE], showed they were discharged from both skilled physical and occupational therapy services on 08/27/2025 with recommendations for the following RNP: ACTIVE Range of motion (ROM Program): Lower extremities: Sitting exercises (see handout) 3-6x/week to maintain [NAME] strength, 1) Bilateral Knee Flexion sitting with red Thera-band 2 sets x15-20 reps, 2) Bilateral Hip Flexion sitting with 3# ankle weight 2 sets x15-20 reps each leg, 3) Bilateral Knee Extension sitting with 3# ankle weight 2 sets of 15-20 reps each leg. PASSIVE ROM (PROM) Program: Gentle PROM Right Upper Extremity (UE): all joints/all planes x10 reps each 3-6x/week to improve, contractures and ROM of affected UE, Document #minutes they are actively engaged in the program. NURSING RESTORATIVE: Active ROM Supported Standing Frame with Harness: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2-3 minute duration, 2-3 reps- increase as tolerated) to maintain static standing balance, maintain weight bearing through bilateral [NAME]. 3-6x/week, Document # of minutes they were actively engaged in the program. Review of Resident 67's medical record on 12/04/2025, showed the RNP programs were included on the resident's care plan and in the nursing assistant task documentation. Review of the documentation showed no documentation the programs were being completed. In observations on 12/02/2025 and 12/03/2025 between 11:00 AM and 11:30 AM, Resident 67 was observed sitting up in their wheelchair in the main dining room in a group setting with a TV showing seated exercises for residents to follow along. Resident 67 was observed to follow the TV instructions and participated as able which included active movement of their left upper and lower extremity. In an interview on 12/04/2025 at 2:57 PM, Staff C, Registered Nurse, Unit Manager, stated Resident 67 met their goals for therapy and was doing RNP programs and attended the group exercise program. Staff C reviewed the documentation and confirmed there was no documentation of the programs. In an interview on 12/05/2025 at 10:01 AM, Staff B, Director of Nursing Services (DNS), stated Resident 67 had an RNP program in the tasks and was supposed to be in the point of care (POC) for the nursing assistants to document. Staff B clarified that there was no dedicated RNP staff, and the dining room program did not provide passive range of motion or dedicated one on one assistance. Staff B stated it was discovered for Resident 67 that the RNP programs had been created as needed rather than routine and therefore have not been documented. <RESIDENT 65> Resident 65 admitted to the facility on [DATE] with diagnoses to include Parkinson's Disease (progressive neurological disorder affecting the nervous system). Review of Resident 65's care plan dated 08/27/2024 documented they had a restorative program to maintain function related to risks for decline in range in motion due to their Parkinson's Disease. Interventions included a set of exercises and stretches three to six times a week as tolerated. Review of Resident 65's progress notes documented no information regarding their restorative program. In an interview on 12/04/2025 at 2:12 PM Staff C, Registered Nurse/Unit Manager stated Resident 65 was not on a restorative program. Reference: (WAC) 388-97-1060 (3)(d)(j)(ix)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from unnecessary psychotropic medications for 1 of 5 residents (Resident 5) sampled for medication review. This failure placed residents at risk for unrecognized adverse effects of psychotropic medications.Findings included.Resident 5 admitted on [DATE] with diagnoses which included pneumonia and newly diagnosed metastatic (distant spread) cancer.On 10/21/2025, Resident 5's medical record documented an order for a new antidepressant medication related to a new diagnosis of depression. Review of Resident 5's care plan showed the care plan was not updated to include a problem, goals or interventions until 11/20/2025. The depression care plan instructed staff to identify and monitor for target behaviors of depression every shift. Resident 5's care plan further identified potential adverse effects of the medication with instruction for staff to monitor and document in the record every shift. Review of Resident 5's medical record on 12/04/2025 showed no documentation of the care planned interventions having been implemented. There were no identified target behaviors for the resident's depression, no behavior monitors and no adverse side effect monitors for the antidepressant medication found in Resident 5's record.In an interview on 12/04/2025 at 2:51 PM, Staff C, Registered Nurse, Unit Manager, stated all residents with psychotropic medications should have monitors set up at the time the orders were received and the residents were reviewed monthly at the facility psychotropic meeting. In an interview on 12/05/2025 at 9:55 AM, Staff B, Director of Nursing, stated there was supposed to be a process to review new orders and review for all the pieces such as an appropriate order, consent, target behaviors and monitors were in place and confirmed that pieces of the process were missed for Resident 5. Refer to WAC [PHONE NUMBER] (3)(i)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the baseline care plan included the minimum healthcare information necessary to properly care for the residents for 2 of 5 residents (Residents 5 and 77) reviewed for baseline care plan. These failures placed residents at risk for clinical complications, not receiving person centered care and being at risk of unmet care needs. Findings included .Review of the facility policy titled baseline care plan, with a revision date of 11/2017, documented the baseline care plan was developed within 48 hours of admission and should include a minimum health information necessary to care for the resident which included but were not limited to: initial goals based on admission orders, dietary orders, therapy services, social services, and PASSR recommendations, if applicable. <RESIDENT 77> Resident 77 admitted to the facility on [DATE] with diagnoses to include quadriplegia (partial or total loss of function in all four limbs and the torso). In an interview and observation on 12/01/2025 at 10:00 AM, Resident 77 was observed to have swollen left and right hands. Resident 77 stated they had compression gloves (snug fitting gloves which provide pressure to improve blood flow and reduce swelling) to wear for the swelling but had the staff remove them earlier. Review of Resident 77's admission Evaluation competed 11/24/2025 documented they had no edema (fluid retention/swelling). Review of Resident 77's Treatment Administration Record for November 2025 documented an order for compression gloves to both hands for edema management. Review of Resident 77's baseline care plan dated 11/25/2025 had no documentation regarding the need for compression gloves to manage their edema. In an interview on 12/01/2025 at 3:36 PM Staff D, Resident Care Manager/ Registered Nurse stated baseline care plans were developed with the use of the admission Evaluation. Staff D stated the baseline care plan was used to communicate care a resident required. Staff D stated the baseline care plan should include a head-to-toe assessment to include edema management. Staff D stated they were in the process of reviewing Resident 77's care plan for edema. <RESIDENT 5> Resident 5 admitted on [DATE] and was a current smoker. Review of the resident's admission smoking screen, dated 07/25/2025, Resident 5 smoked greater than 10 cigarettes per day, morning, afternoon and evening. The remainder of the smoking screen was marked N/A, this is a non-smoking facility. Review of Resident 5's level 1 PASSR stated the resident had a substance abuse history and listed smoking. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident 5's physician's orders dated 07/25/2025, showed the resident had orders for a smoking cessation patch and nicotine gum as needed. Review of Resident's 5's baseline care plan revealed that the resident's risk to smoke, smoking history, goals and interventions were not included in the baseline care plan. In an interview on 12/04/2025 at 3:28 PM, Staff C, Registered Nurse, Unit Coordinator, stated the assessments should auto-populate to the care plans and did not know why the smoking information was not on Resident 5's care plan. Staff C stated the care plans should be reviewed to ensure that they are complete. Reference WAC 388-97-1020(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow physician's orders to obtain monthly weights for 1 of 2 residents (Resident 11) reviewed for nutrition. This failed practice placed residents at risk of not receiving adequate care and services and a decline in health and/or mobility.Findings included .Resident 11 admitted to the facility on [DATE] with diagnoses to include obesity and high blood pressure. Review of Resident 11's Medication Administration Record documented a physician's order for a monthly weight. Review of Resident 11's care plan dated 10/24/2024 documented the goal was for them not to have significant weight loss of more than five percent in 30 days or ten percent in 180 days. Review of Resident 11's electronic health record contained no documentation regarding their weight from September, October or November 2025. In an interview on 12/03/2025 at 12:50 PM Staff L, Registered Dietician, stated Resident 11 was triggered for review as they had not had a documented weight since August 2025. In an interview on 12/03/2025 at 3:02 PM Staff K, Licensed Practical Nurse stated they had just obtained Resident 11's weight. Staff R stated weights were typically done around the first of the month and reported to them by the nursing assistants. In an interview on 12/03/2025 at 3:04 PM Staff C, Registered Nurse/Unit Manager stated Resident 11 was missing weights for September, October and November of 2025. Staff C stated Resident 11 has a history of refusals and was unable to locate any documentation that they had refused their weight being taken in September, October, November of 2025. In an interview on 12/03/2025 at 3:17 PM Staff B, Director of Nursing Services, stated they were made aware of Resident 11 not having weights done for September, October, November of 2025. Reference: (WAC) 388-97-1060(1)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure interventions to prevent pressure ulcers were implemented for one of one residents (Resident 67) reviewed for house acquired pressure ulcers. Failure to ensure preventative measures were implemented resulted in Resident 67 developing a stage 2 pressure injury and placed the resident at risk for delay in healing or additional pressure ulcers.Findings included. Review of the facility policy titled: Skin Integrity (dated 08/2018) documented a resident identified as at risk of developing Pressure ulcers and/or injuries (PU/PI) will have individualized interventions implemented to attempt to prevent PU/PI from developing. Interventions will be monitored for effectiveness. The resident's care plan will reflect the interventions. Repositioning or relieving constant pressure is an effective intervention for treatment or prevention of PU/PIs. Repositioning plans will be addressed in the resident's comprehensive care plan. Resident 67 admitted [DATE] following a stroke with residual right sided hemiparesis (weakness on one side of the body). The resident was also diabetic. According to the admission Minimum Data Set (MDS, a required assessment tool) assessment dated [DATE], the resident admitted with no skin impairments and the resident was assessed as at risk for pressure ulcers/injuries. Review of Resident 67's care plan dated 03/18/2025 instructed staff to utilize pressure relieving/reducing mattress, pillows to protect the skin while in bed. Resident 67's medical record showed a stage 2 (partial skin loss involving the outer layer of the skin) measuring 2 centimeters (cm) x 1cm was identified on the left outer ankle area on 10/23/2025. The care plan was updated on 10/24/2025 to include: elevate BLE (bilateral lower extremities) with pillows or wear foam boots for additional pressure relief and to document acceptance or refusals. Review of Resident 67's record on 12/04/2025 showed no documentation of implementation of the care planned interventions or documentation that indicated acceptance or refusals. In an observation on 12/01/2025 at 11:39 AM, Resident 67 was observed lying in bed with their feet/ankles directly on the mattress. There were a pair of green foam boots observed sitting on the seat of the resident's wheelchair. In an observation on 12/02/2025 at 1:00 PM, Resident 67 was lying in bed with their feet observed flat on the mattress and green foam boots were again observed on the wheelchair and not in place on the resident's feet. In an observation on 12/03/2025 at 1:33 PM, Resident 67 was observed in bed asleep with their legs flat on the mattress. In an interview on 12/03/2025 at 2:04 PM, Resident 67 stated they had a sore on their ankle and did not know how it got there or how long it had been there. Resident 67 stated they had a band aid on the wound that gets changed but they were unsure how often. Resident 67 stated they did not know why they did not have the foam boots on but stated they sometimes did. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/03/2025 at 2:11 PM, Staff O, Nursing Assistant-Certified, stated they worked evenings and knew the resident well. Staff O stated Resident 67 was cooperative and would 'go with what happens', Staff O stated if you put the boots on they will wear the boots. Resident 67 did not refuse care.and would agree, so staff just had to put them on. Staff O stated the resident was not able to take the boots off themselves and needed extensive assistance for mobility and positioning. In an interview and observation of wound care with Staff P, Registered Nurse (RN) on 12/04/2025 at 12:54 PM, Resident 67 was observed to have a foam bandage over their left outer ankle which was removed to reveal a small open area over the bony aspect of the left outer ankle approximately the size of a pencil eraser. The wound appeared superficial and pale in color. There was no drainage on the old dressing. Staff P stated the dressing was changed every Tuesday, Thursday and Saturday, and the foam was protective. Staff P stated the resident should have their heels and feet offloaded when they were in bed. In an interview on 12/04/2025 at 2:50 PM, Staff C, RN, Unit Manager, stated Resident 67 had a wound on their ankle, was at risk for further skin breakdown and should have the foam boots or pillows placed when they were in bed. Refer to WAC 388-97-1060 (3)(b)

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	505296	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Healthcare Bellingham	3121 Squalicum Parkway Bellingham, WA 98225

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent accidents for one of one residents (Resident 5) reviewed for smoking. Failure to comprehensively assess and care plan the resident's smoking history and behaviors placed Resident 5 at risk for burns or injury related to unsupervised smoking and placed other residents at risk for injury related to unsecured smoking materials in the facility. Findings included.Review of the facility policy titled smoke free facility with a revised date of 03/2019, stated residents, visitors, contractors and staff were not permitted to smoke on the property at any time. The policy stated former smokers would be offered smoking cessation. Resident 5 admitted on [DATE] and was a current smoker. Resident 5 was alert and oriented with mild short term memory loss. Review of the resident's admission smoking screen, dated 07/25/2025, documented that Resident 5 smoked greater than 10 cigarettes per day, morning, afternoon and night. The remainder of the smoking screen was marked N/A, this is a non-smoking facility. A second smoking screen dated 11/05/2025 was blank. Review of Resident 5's level 1 PASSR stated the resident had a substance abuse history and listed smoking. Review of the Resident 5's physician's orders dated 07/25/2025, showed the resident had orders for a smoking cessation patch and nicotine gum as needed. The record showed these medications were discontinued in October 2025. Review of Resident's 5's care plan dated 07/25/2025 did not address the resident's current or former smoking aside from the mention that it contributed to the resident's respiratory disease. Review of Resident 5's medical record revealed progress notes dated 11/08/2025 showing the resident had smelled of cigarettes, admitted to going outside and smoking and possessed smoking materials. The progress notes stated the resident stated I know when reminded that the facility property was non-smoking, and the resident declined resumption of smoking cessation. The resident's smoking materials were willingly given to the staff. An updated smoking screen was completed on 11/19/2025 which identified the resident smoking and included goals and interventions, which included: Instruct resident about smoking risks and hazards and about smoking cessation aids that are available. Instruct resident about the facility policy on smoking: locations, times, safety concerns. Notify charge nurse immediately if it is suspected the resident has violated facility smoking policy. Observe clothing and skin for signs of cigarette burns. Notify nurse immediately if present. The facilities smoking policy was reviewed and accepted by the resident and /or resident family. Review of Resident 5's care plan revealed the care plan had not been updated or revised to include the 11/19/2025 smoking screen interventions. In an interview and observation on 12/01/2025 at 1:27 PM, Resident 5 was somewhat evasive, and initially reluctant to discuss their smoking status, and stated they had cut down. Resident 5 stated they still smoke here and there but denied possessing any smoking materials. Resident 5 stated they only smoked when family took them out of the facility now and family provided the smoking materials at the time. Resident 5 stated they used to use the patches but did not want to use them because you are not supposed to smoke if you are using them, and they still wanted to be able to smoke when they wanted to. Resident 5 was observed to be able to self propel in their wheelchair, using their feet to pull themselves along. In an interview on 12/04/2025 at 3:28 PM, Staff C, Registered Nurse, Unit Coordinator, stated the assessments should auto-populate to the care plans and did not know why the smoking information was not on Resident 5's care plan. Staff C stated the care plans should be reviewed to ensure that they are complete.In an interview on 12/05/2025 at 9:50 AM, Staff B, Director of Nursing Services stated when Resident 5 admitted they had agreed to the non-smoking policy and were on a smoking cessation patch. Staff B stated the resident had several months with no issue until family brought them in a pack of cigarettes and a lighter. Staff B stated there should have been an update when the resident was identified as having smoked, and stated the updated smoking screen interventions (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have automatically updated to the care plan, but for some reason it did not. Refer to WAC 388-97-1060 (3)(g)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that two (44 and 49) of three residents reviewed for respiratory care, were provided care consistent with professional standards of practice. Failure of the facility to maintain respiratory equipment, including Continuous Positive Airway Pressure (CPAP), placed residents at risk for unmet needs and potential negative outcomes for sleep deprivation, respiratory distress, discomfort or skin breakdown of the ears/nostrils/face. Findings included .According to the facility policy Respiratory Care Policy dated July 2018, a resident with Obstructive Sleep Apnea (OSA-collapse of the upper airway during sleep) would have on-going assessments of the resident's respiratory status and response to therapy documented in the medical record. The Physician would provide orders, indication of use, equipment settings, when to use the equipment and the care plan would reflect the Physicians' orders. Additionally, the facility would implement infection control measures during care, handling, cleaning, storage and disposal of respiratory equipment. <RESIDENT 44>According to the 09/03/2025 Annual MDS (Minimum Data Set-an assessment tool) revealed Resident 44 was admitted on [DATE] and was assessed as cognitively intact.Review of Resident 44's physician orders directed staff to apply CPAP when sleeping, wash CPAP tubing with warm water and baby shampoo, rinse well and dry. Verify CPAP was off in the morning. At bedtime, empty humidifier chamber, dry and refill with distilled water and assemble the unit for obstructive sleep apnea.In an interview on 12/01/2025 at 10:37 AM, Resident 44 stated they had never had their CPAP cleaned in the entire year they had been here. The resident stated they had not had any new tubing, head gear or nasal pillows since admission. The CPAP was on the nightstand, and the back filter was fluffy and grey. The resident stated they were unaware there was a filter there and that it needed to be changed every 2 weeks. In a follow up interview on 12/03/2025 at 2:00 PM, Resident 44 stated their CPAP had still not been cleaned and they inquired if there was follow up and the cleaning would get done. Review of Resident 44's care plan initiated on 12/03/2024, showed the resident used a CPAP at prescribed pressure setting via full face mask when sleeping. Staff were directed to bleed in oxygen at 2 liters a minute when they were utilizing the CPAP. Review of the care plan did not address the residents' CPAP supply vendor, contact information, brand of CPAP, manufacturers guidelines and when the equipment was required to be replaced. The care plan did not address cleaning the humidifier chamber. <RESIDENT 49>According to the 11/12/2025 Quarterly MDS revealed Resident 49 was admitted on [DATE] and was assessed with moderate cognitive impairment.In an interview on 12/01/2025 at 1:30 PM, Resident 49 was in bed and stated they slept with their CPAP machine. A black Phillip's brand CPAP was at the foot of the bed with visible dust on it. The resident stated they had taken out the filter and would like new tubing and a new face mask. The resident stated they replaced the hose six months ago due to a break in the tubing. The resident stated they had not had a new face mask since admission. They stated they had repeatedly asked staff and they hoped maybe their wife can get them one. In an interview and observation on 12/04/2025 at 11:10 AM, Resident 49 stated they had not had their CPAP cleaned in a long time. In an observation on 12/05/2025 at 11:25 AM, Resident 49 was in bed asleep, CPAP was off of them. The unit had dust on it.In an interview on 12/04/2025 at 4:14 PM, Staff J, Licensed Practical Nurse stated they usually clean Resident 44 and 49's CPAP and fill the water at night. Staff J was unaware of the replacement schedule and when or if the masks, tubing and headgear had been replaced. Staff J stated the cleaning and equipment replacement should be on the physician's order, Treatment Administration Record (TAR) and on the care plan.In an interview on 12/05/2025 at 9:28 AM, Staff C, Registered Nurse (RN)/Resident Care Manager stated they knew they had two residents on their unit with CPAP's (Resident 44 and 49) Staff C stated they knew the nurses filled the reservoir with distilled water. Staff C stated Resident 44's was to be cleaned on Sunday night shift. Staff C was informed of the dirty filter and stated the filter should be cleaned every Sunday. Staff C stated they (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were unsure who their CPAP vendor was or if the head gear, mask, tubing and reservoir had been replaced for Resident 44 and 49. In a follow up interview on 12/05/2025 at 11:28 AM, Staff C, RN stated they did not have manufacturer's guidelines for the CPAP's. Staff C stated they thought Resident 49's CPAP model had a recall on it and they were trying to find out about it. Staff C stated they used AI (artificial intelligence) to learn about it as they did not have the information on it. At 11:40 AM, Staff C provided the correct user manual they had just printed off. Staff C stated they were not sure if there was a recall on it but that if there was the manufacturer should notify the resident.In a joint interview on 12/05/2025 at 12:55 PM, Staff A, Administrator and Staff B, Director of Nursing, were informed of the interviews and observations with Resident 44 and 49. Staff A and B confirmed the cleaning, equipment changes should occur per the manufacturer's recommendations and instructions should be on the orders, care plan and TAR's. Reference: WAC 388-97-1060 (3)(j)(vi)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all drugs and biologicals were labeled in accordance with professional standards for 1 of 2 medication carts (Cart 2 B-wing) reviewed for medication storage. The failure to remove expired items from the medication carts placed residents at risk to receive expired or ineffective medications and a decreased quality of life.Findings included .In an observation on [DATE] at 1:32 PM, a review of medication cart #2 on B wing was completed and Narcan (medication to reverse life-threatening opioid overdose) nasal spray was found with an expiration date of 08/2024. In an interview on [DATE] at 1:41 PM, Staff N, Licensed Practical Nurse (LPN) confirmed the Narcan had an expiration date of 08/2024. In an interview on [DATE] at 1:23 PM, Staff B, Director of Nursing Services (DNS) stated the pharmacy had just completed medication cart audits in [DATE] and staff nurses were asked to audit the carts on [DATE] and they were unsure how the expired medication got missed. Reference WAC: 388-97-1300(1)(b)(ii)(2)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure influenza and pneumococcal immunizations were offered, up to date and risks and benefits of the immunizations were provided to 3 of 6 residents (Resident 67, 54 and 80) reviewed for immunization and infection control. This failure placed the residents at risk for illness, lack of knowledge to make medical decisions, and spread of communicable diseases.Findings included.Review of the facility policy titled, Infection Prevention and Control, Influenza and Pneumococcal Immunizations, dated 02/2025 showed the facility will provide influenza and pneumococcal immunizations.residents and/ representatives will receive information related to the risk and benefits of immunizations. the medical record will reflect the provision of education and administration or refusal of the immunization.residents who have previously been offered or given a pneumococcal will be offered necessary follow up immunizations according to national guidelines (Center for Disease and Control – CDC). <RESIDENT 80>Resident 80 was admitted to the facility on [DATE] with diagnoses that included respiratory failure, and anoxic (lack of oxygen) brain damage. The Minimum Data Set (MDS – an assessment tool) dated 11/28/2025 documented the resident had moderate cognitive impairment. Review of Resident 80's medical record documentation, with an upload date of 11/21/2025 the resident had two individuals listed for them as a durable power of attorney in the event the resident could not make their own decisions about their health care. Review of Resident 80's immunization record, print date 12/04/2025, documentation showed the resident had refused influenza and pneumococcal vaccinations. Review of Resident 80's electronic immunization consent evaluation, dated 11/21/2025 showed Resident 80 had declined the influenza and pneumococcal immunizations. The consent section titled, C. Acknowledgement and Informed Consent was left blank under all three sections:- I have received and read the vaccine information for the risk and benefits, - I am unaware of any allergies, - I am aware the provider may order based on vaccine recommendations. The evaluation asked, If unable to obtain signed consent, was verbal consent received? and was answered no. The section for the residents or representatives to sign had Resident 80's name electronically printed in the box. <RESIDENT 54> Resident 54 admitted [DATE]. Review of Resident 54's immunization consent information on admission documented refusal of the influenza vaccination with the reason stated as already received. There was no documentation of the resident's prior immunization history dates. <RESIDENT 67> Resident 67 admitted on [DATE]. Review of Resident 67's immunization consent information dated 09/18/2025 showed the resident consented to receive the seasonal influenza vaccination. The consent did not address the resident's pneumococcal vaccine status. The immunization tab on admission stated only refused with no (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	corresponding immunization historical data related to the resident's pneumococcal vaccine status. In an interview on 12/05/2025 at 9:39 AM, Staff B, Director of Nursing Services, stated the facility is able to utilize the state immunization portal, the hospital documentation or request records from the resident's provider to determine immunization history and determine if residents are up to date. Staff B reviewed Resident 54's records and stated the hospital documentation was included and showed the last influenza vaccine was in 2022. Staff B stated they would need to look further to determine whether Resident 67 was up to date on their pneumococcal vaccine. Reference WAC 388-97-1340(1)(2)(3)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure COVID-19 (a viral illness that caused fever, difficulty breathing or possibly death) immunizations were offered, up to date and risks and benefits of the immunizations were provided to 2 of 6 residents (Resident 54 and 80) reviewed for immunization and infection control. This failure placed the residents at risk for illness, lack of knowledge to make medical decisions, and spread of communicable diseases. Findings included.Review of the facility policy titled, Infection Prevention and Control, COVID-19 Immunization, dated 12/07/2023 documentation showed the facility will offer COVID-19 vaccinations to residents.prior to offering the facility will educate resident and/or representative on benefits, risk and potential side effects of the vaccine.education will be provided prior to requesting consent for administration.documentation in the medical record will include provision of education and offer of vaccine, date of education and offering, who received the education, name of representative who is authorized to make decisions for resident, and if they will accept or refuse. <RESIDENT 80> Resident 80 was admitted to the facility on [DATE] with diagnoses that included respiratory failure, and anoxic (lack of oxygen) brain damage. The Minimum Data Set (MDS – an assessment tool) dated 11/28/2025 documented the resident had moderate cognitive impairment. Review of Resident 80's medical record documentation, with an upload date of 11/21/2025 the resident had two individuals listed for them as a durable power of attorney in the event the resident could not make their own decisions about their health care. Review of Resident 80's immunization record, print date 12/04/2025, documentation showed the resident had refused COVID-19 vaccinations. Review of Resident 80's electronic immunization consent evaluation, dated 11/21/2025 documentation showed Resident 80 had declined the COVID-19 immunizations. The consent section titled, C. Acknowledgement and Informed Consent was left blank under all three sections: - I have received and read the vaccine information for the risk and benefits, - I am unaware of any allergies, - I am aware the provider may order based on vaccine recommendations. The evaluation asked, If unable to obtain signed consent, was verbal consent received? and was answered no. The section for the residents or representatives to sign had Resident 80's name electronically printed in the box. <RESIDENT 54> Resident 54 admitted [DATE]. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 54's immunization consent information on admission documented refusal of the COVID-19 vaccination with the reason stated as already received. There was no documentation of the resident's prior immunization history dates. In an interview on 12/05/2025 at 9:39 AM, Staff B, Director of Nursing Services, stated the facility is able to utilize the state immunization portal, the hospital documentation or request records from the resident's provider to determine immunization history and determine if residents are up to date. Staff B reviewed Resident 54's records and stated the hospital documentation was included and did not show information related to Resident 54's Covid vaccination status. Reference WAC 388-97-1620(2)(b)(i)(ii)