STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505309	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Coupeville Rehab and Nursing Center	311 Northeast 3rd Street Coupeville, WA 98239

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences (a collaborative care plan meeting where a resident's care was discussed and coordinated by a team of health care providers, family members and residents) for 1 of 3 sampled residents (Resident 1) reviewed for participation in care planning. This failure placed residents at risk of not being allowed to be involved and informed about care and services and a diminished quality of life. Findings included.Review of the facility's policy, titled, Interdisciplinary Care Conference, dated 3/2024 and revised on 12/16, documented an interdisciplinary care conference is completed upon the resident's admission to the facility, quarterly, and following a change in condition. The resident and/or the resident representative will be invited to the care conference. Resident 1 was admitted to the facility on [DATE] with a diagnosis to include dementia with anxiety. Review of Resident 1's electronic medical record (EMR) documented a care plan conference (CPC), dated 07/14/2025, was held. There were no other CPCs found in Resident 1's EMR. During a telephone interview on 02/12/2026 at 11:00 AM, Collateral Contact 1 (CC 1) stated they have only attended one CPC since Resident 1 was admitted to the facility. CC 1 stated there had been a CPC set up within the past month, and something had come up at the last minute and was not able to attend and requested for the meeting to be rescheduled. CC 1 stated they would like to be involved in Resident 1's care. In an interview on 02/26/2026 at 2:34 PM, Staff J, Social Services, stated CPCs were completed within the residents first week of admission, and quarterly CPCs were set up in accordance with the residents scheduled Minimum Data Set (MDS - an assessment tool) assessment. Staff J was asked about Resident 1 CPCs. There was one documented CPC held on 07/14/2025 at 2:00 PM located in Resident 1's medical record. Staff J searched through Resident 1's EMR and did not find any additional CPCs. Staff J stated the facility was working on scheduling a CPC with Resident 1 and CC 1. Reference WAC 388-97-0200(3)

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure resident choices/preferences regarding their bathing schedule were honored for 2 of 3 sampled residents (Residents 1 and 3) reviewed for choices. These failures placed the residents at risk for decreased cleanliness, increased risk of infection and diminished quality of life. Findings included .<RESIDENT 1>Resident 1 was admitted to the facility on [DATE] with a diagnosis to include dementia with anxiety. Review of Resident 1's Minimum Data Set (MDS - an assessment tool) assessment, dated 12/30/2025, documented the resident had severe cognitive impairment. Review of Resident 1's bathing/shower care plan, dated 07/08/2025, documented the resident frequently declined showers and required maximal assistance of one person for showering. There was no information directing staff on what to do when the resident refused a shower. Review of Resident 1's December 2025 Documentation Survey Report v2 (a report that showed the Nursing Assistant Certified documentation to specific tasks performed with a resident), documented the resident received three showers (on 12/04/2025, 12/08/2025 and 12/11/2025). Resident 1 refused a shower on 12/18/2025, 12/25/2025, 12/29/2025, and the Nursing Assistant Certified (NAC) documented NA (not applicable) on 12/20/2025 and 12/22/2025. Review of Resident 1's January 2026 Documentation Survey Report v2, documented Resident 1 was showered on 01/15/2026 (36 days after their last shower) and 01/29/2026. Resident 1 refused on 01/01/2026, 01/08/2026, and 01/22/2026. Review of Resident 1's February 1 through 25, 2026 Documentation Survey Report v2, documented Resident 1 was showered on 02/17/2026 (19 days after their last shower). The resident refused a shower for six days (on 02/02/2026, 02/05/2026, 02/12/2026, 02/16/2026, 02/19/2026, and 02/23/2026). Review of Resident 1's progress notes dated 12/01/2025 to 02/26/2026, documented the resident refused a shower on 12/29/2025 and the staff reapproached offered the resident a shower and they refused. The staff documented the resident stated she bathed in the sink with soap and water each morning and did not want a shower with someone else present. There was no other documentation regarding Resident 1's refusals of showers. Review of Resident 1's electronic medical record showed no documentation of the resident's preference of how they wished to be showered/bathed. In an interview on 02/26/2026 at 1:36 PM, Staff D, NAC, stated Resident 1 does refuse care at times. Staff D stated the resident told them they have been doing it for years and is capable to care for themselves. Staff D stated when a resident refused care, they attempted to reapproach the resident and obtain a different staff member. If the resident continued to refuse, they reported the refusal to the nurse, and the refusal was documented in Point Click Care (PCC - the facility's electronic medical record). In an interview on 02/26/2026 at 1:58 PM, Staff H, NAC/Shower NAC, stated residents were showered twice a week. Staff H stated Resident 1 did refuse showers, but when they were able to shower the resident, they communicated to them step by step what they were doing. Staff H stated when a resident refused a shower they attempted to reapproach, offer them a shower on a different day, documented the refusal and informed the nurse on shift. <RESIDENT 3>Resident 3 was admitted to the facility 10/22/2025 with diagnosis to include a stroke with left-sided hemiplegia (complete loss to control one side of the body). Review of Resident 3's Quarterly MDS assessment, dated 01/26/2026, showed the resident's Brief Interview for Mental Status (BIMS - a structured cognitive interview) score was 13 out of 15. The resident was cognitively intact. Review of Resident 3's bathing/showering care plan, revised on 11/06/2025, documented Resident 3 preferred two showers a week per the facility shower schedule and required maximal assistance of one person. Review of Resident 3's December 2025 Documentation Survey Report v2, documented the resident was showered once on 12/24/2025, refused twice (on 12/03/2025 and 12/10/2025), documented (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NA three times (on 12/06/2025, 12/08/2025, and 12/10/2025), and was not available for a shower on 12/31/2025. Review of Resident 3's January 2026 Documentation Survey Report v2, documented Resident 3 was showered/bathed on 01/10/2026 (16 days since their last shower), and 01/28/2026. The resident refused showers twice (on 01/14/2026 and 01/21/2026). Review of Resident 3's February 1 through 25, 2026 Documentation Survey Report v2, documented the resident was showered/bathed once 02/04/2026, and refused twice on 02/14/2026, and 02/18/2026. The NAC documented NA. Review of Resident 3's nursing progress notes, dated 12/01/2025 to 02/26/2026, showed no documentation of the resident's refusal to be showered. In an interview on 02/26/2026 at 1:47 PM, Staff F, NAC, stated residents were showered twice a week. When a resident refused their shower, they would attempt to offer it again before their next scheduled shower day. Staff F stated they document in PCC when they gave a resident a shower. Staff F stated if a resident refused a shower they would inform the nurse on duty. In an interview on 02/26/2026 at 1:58 PM, Staff H, NAC, stated the residents were scheduled to receive two showers a week. If a resident refused a shower, they would reapproach two times, and if they continued to refuse would document the refusal in PCC and notify the nurse. Staff H stated they would try to offer the resident a shower later in the week. Review of an email communication on 02/26/2026 at 3:59 PM, Staff C, Registered Nurse (RN)/Regional Director of Clinical Operations, documented the facility does not have a resident shower policy. Reference WAC 388-97-0180(2)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the resident's responsible party of orders for a new medication for 1 of 3 sample residents (Resident 1) reviewed for notification of changes. This failure prevented the person responsible for making healthcare decisions from being part of the care planning process and being knowledgeable about medications the resident was taking. Findings included.Resident 1 was admitted to the facility on [DATE] with a diagnosis to include dementia with anxiety. Review of Resident 1's Minimum Data Set (MDS - an assessment tool) assessment, dated 12/30/2025, documented the resident had severe cognitive impairment.During a telephone interview on 02/12/2026 at 11:00 AM, Collateral Contact 1 (CC 1), Resident 1's responsible party, stated they were not kept informed of when Resident 1 had any changes in their medications. Review of a physician order, dated 01/21/2026, documented to increase Resident 1's acetaminophen (a pain reliver) to two tablets every 12 hours and start a lidocaine external patch to their lower back daily and removed per schedule for back pain. Review of Resident 1's electronic medical record showed CC1 had not been notified of the resident's back pain or the medication change.On 02/26/2026 at 4:52 PM, Staff B, Chief Operating Officer, Staff C, Registered Nurse (RN)/Regional Director of Clinical Operations, and Staff K, RN/Corporate nurse, were asked if residents responsible party were notified when there were medication changes. Staff C stated yes. The staff were notified that CC 1 had not been notified of Resident 1's 01/21/2026 medication changes. Reference WAC 388-97-0320(1)(c)

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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 interview and record review, the facility failed to ensure 1 of 4 residents (Resident 2) reviewed for the Pre-admission Screening and Resident Review (PASSR) process received the required follow up from the Regional Developmental Disabilities Act (DDA) Intellectual Disability (ID) or Related Condition (RC) PASRR team before admission to the facility and failed to ensure they were referred for a PASRR Level 2. These failures placed Resident 2 at risk for unmet care needs and a diminished quality of life. Findings included .Review of the Level 1 PASRR document, revised 06/2025, documented if the resident had an ID or RC, the form was to be forwarded to the Regional DDA ID/RC PASRR team, and follow up by the DDA Administration was required before the resident could be admitted to a nursing facility.Resident 2 was admitted to the facility on [DATE] with diagnoses to include intellectual disabilities, and disorders of psychological development.Review of Resident 2's Level 1 PASRR, dated 02/09/2026, documented they had an ID and were required to forward the form to the Regional DDA ID/RC PASRR team before the resident could be admitted to a nursing facility.Review of Resident 2's Electronic Medical Record (EMR) showed no documentation the Regional DDA ID/RC PASRR team had been contacted prior to their admission to the facility.In an interview on 02/26/2026 at 2:33 PM, Staff J, Social Services Director (SSD) stated they were unaware the Level I PASRR was required to be forwarded to the Regional DDA ID/RC PASRR team prior to admission to the facility. Staff J stated Staff I, Admissions, were the ones who reviewed PASRR information before a resident was admitted . Staff J stated they did not see a resident's PASRR until after they had been admitted to the facility, after it was scanned into the EMR by medical records.In an interview on 02/26/2026 at 3:07 PM, Staff I, Admissions, stated they were responsible to review the Level 1 PASRR forms prior to admission to the facility and were unaware that Resident 2's PASRR was required to be forwarded to the Regional DDA ID/RC PASRR team for review and determination for admission to the facility related to their diagnosis of an intellectual disability. Reference WAC: 388-97-1915(1)(2)(a-c)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete, accurate, and accessible clinical records for 5 of 8 sampled residents (Residents 1, 2, 3, 10 and 11) reviewed for complete and accurate medical records. The failure to maintain clinical records in accordance with professional standards of practice placed residents at risk for unmet care needs and diminished quality of life. Findings included . <RESIDENT 1>Review of Resident 1 December 2025 Documentation Survey Report v2 (a report that showed the Nursing Assistant Certified documentation to specific tasks performed with a resident), showed several missing entries of Nursing Assistant Certified (NAC) documentation. Review of the intervention/tasks showed: - The task of ALL CARE PROVIDED, there was no documentation on 12/02/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/17/2025 – 12/19/2025, 12/26/2025, and 12/28/2025 (day shift), once on evening shift (12/02/2025), and three days on night shift (12/16/2025, 12/22/2025, and 12/31/2025).- The task Skin Observation, there was no documentation on 12/02/2025, 12/10/2025, 12/11/2025, 12/13/2025, 12/14/2025, 12/17/2025 – 12/19/2025, 12/26/2025, and 12/28/2025 (day shift), and three days on night shift (12/16/2025, 12/22/2025, and 12/31/2025).- Further review of the report showed missing documentation on all shift under the intervention/task section of behavioral symptoms, bowel monitoring, activities of daily living (ADL's – dressing, transfers, upper body and lower body dressing, oral hygiene, personal hygiene, toileting, bathing, bed mobility, bowel and bladder continence, walking, and eating), and food and fluid intake. Review of Resident 1's January 2026 Documentation Survey Report v2, showed no intervention/tasks documentation on ten days. No day shift documentation on 01/01/2026, 01/02/2026, 01/05/2026, 01/12/2026, 01/19/2026 and 01/26/2026), and three days on night shift (on 01/04/2026, 01/10/2026, and 01/11/2026). Review of Resident 1's February 1 through 25, 2026 Documentation Survey Report v2, showed no intervention/tasks documentation on three days on day shift (on 02/04/2026, 02/09/2026, and 02/12/2026), once on the evening shift (02/03/2026), and once on the night shift (on 02/07/2026). Review of Resident 1's Fall risk assessment, dated 02/18/2026, documented it was not locked/completed until 02/24/2026. <RESIDENT 3>Review of Resident 3 December 2025 Documentation Survey Report v2, showed no intervention/tasks documentation eight days on the day shift (on 12/05/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/17/2025, 12/19/20025, 12/20/2025, and 12/27/2025), two days on the evening shift (on 12/08/2025, 12/17/2025), and three days on the night shift (on 12/14/2025, 12/16/2025, and 12/31/2025). Review of Resident 3's January 2026 Documentation Survey Report v2, showed no intervention/tasks documentation six days on the day shift (on 01/03/2026, 01/07/2026, 01/08/2026, 01/17/2026, 01/19/2026, 01/24/2026 and 01/31/2026), two days on the evening shift (on 01/04/2026 and 01/13/2026), and two days the night shift (on 01/06/2026 and 01/31/2026 In an interview on 02/26/2026 at 1:36 PM, Staff D, NAC, and Staff E, NAC, stated all NAC documentation was documented in Point Click Care (PCC - the facility's electronic medical record). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 2>Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Electronic Medical Record (EMR) documented they had an interdisciplinary care conference on 02/17/2026, and the documentation was not completed by Staff J, Social Services Director (SSD), as of 02/26/2026. <RESIDENT 10>Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's EMR documented they had an interdisciplinary care conference on 2/17/2026, and the documentation was not completed by Staff J, SSD, until 02/22/2026. <RESIDENT 11>Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's EMR documented that they had an interdisciplinary care conference on 12/17/2025, and the documentation was not completed by Staff J, SSD, until 12/26/2025. On 02/26/2026 at 4:52 PM, an interview was conducted with Staff B, Chief Operating Officer, Staff C, Registered Nurse (RN)/Regional Director of Clinical Operations, and Staff K, RN/Corporate Nurse. Staff B stated a Care Plan Conference User-Defined Assessment (UDA) form may be initiated prior to the scheduled CPC. On the day the CPC was held the expectation was it was completed/locked within a day. When asked when the NAC should complete their documentation in PCC stated by the end of their shift. The staff were made aware of the incomplete NAC documentation found in PCC. Reference WAC 388-97-1720 (a)(i)(ii),(4)(a)