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	04/20/2026

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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review the facility failed to protect residents right to be free from physical abuse for 2 of 3 sampled residents (Residents 4 and 5) reviewed for resident-to-resident altercations. Additionally, the facility failed to consistently supervise, accurately assess, and care plan 1 of 1 sampled resident (Resident 5) who had a known history of verbal and physical outbursts towards others, reviewed for 1:1 monitoring. Resident 5 caused an unsafe environment for Resident 6 when they blocked them from leaving a public area. This failure placed residents at risk for potential physical or mental abuse, feeling safe, experiencing fear, intimidation, and a decreased quality of life. Findings included. Review of the facility policy titled, Abuse/Neglect/Misappropriation/Exploitation, revised on 10/2022, documented it is the policy of the facility to protect residents from mistreatment, neglect, and abuse. The facility defined abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment resulting in physical harm, pain or mental anguish. Physical abuse included, but not limited to hitting, slapping, pinching, choking, striking with an object, kicking, shoving, and prodding. <RESIDENT TO RESIDENT PHYSICAL ALTERCATION>RESIDENT 4Resident 4 admitted to the facility in May 2024 with diagnoses to include a stroke, bipolar (a serious mental illness characterized by extreme mood swings) disorder, post-traumatic stress disorder (PTSD - a psychiatric disorder that may occur in people who have experienced or witness a traumatic event) and had a developmental disability. Review of a quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 02/13/2026, documented the resident was cognitively intact and independent with their wheelchair (w/c) mobility. Review of Resident 4's impaired cognitive function care and/or impaired thought process care plan, revised on 04/02/2026, documented the resident's goal was to communicate their daily basic needs. The care plan documented Resident 4 received services through the Developmental Disability Association. Interventions included keeping their routine as consistent as possible. Review of a progress note, dated 03/16/2026 at 5:10 PM, documented Resident 4 observed Resident 5 in their w/c pointing and coming towards Staff J, Registered Nurse (RN), and punched Staff J with a closed fist in their right arm and flank. Staff J stepped away from Resident 5, observed Resident 4 coming towards them, pushed a tray off the table, grabbed Resident 5's sweatshirt and began yelling at Resident 5. Staff J then observed Resident 5 yelling at Resident 4 and they began hitting one another with closed fists. The residents were separated and Resident 4 was having a hard time calming down and was taken to their room. In an interview and observation on 04/14/2026 at 11:55 AM, Resident 4 was in their w/c sitting in their room with a visitor. Resident 4 stated yes when asked if they had any concerns with any other residents in the facility. Resident 4 stated one evening in the dining room they observed Resident 5 running their w/c into a nurse. Resident 4 stated I guess my protective instincts kicked in and went over to Resident 5 and grabbed their sweatshirt to pull them away from the nurse. When asked if they had struck Resident 5, they stated no. The resident stated, I just avoid [Resident 5], when asked if they have had any further interaction with Resident 5. RESIDENT 5Resident 5 admitted to the facility 02/09/2026 with diagnoses to include disorder of psychological development and intellectual disability. Review of the admission MDS assessment, dated 02/13/2026, documented (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5 had severe cognitive impairment, required setup assistance with w/c mobility, speech clarity was unclear, and sometimes understands what was being communicated to them. Review of Resident 5's risk for decrease in activity involvement, dated 02/25/2026, documented the resident was at risk related to their acute condition, limited attention span, communication deficit, history of self-injurious behaviors, and history of resident-to-resident conflicts. The staff were directed to provide activities that empowered the resident to make choices, encourage self-expression, and responsibility. Review of Resident 5's impaired cognitive function and/or impaired thought process care plan, created on 02/09/2026, documented the resident was developmentally delayed and had a diagnosis of Autism (a neurodevelopmental condition affecting how individuals communicate, interact, and perceive the world). The care plan directed staff to keep Resident 5's caregivers consistent as much as possible to help decrease their confusion and required assistance with decision making. Review of Resident 5's progress note, dated 03/26/2026 at 7:49 PM, Staff J documented upon entering the East dining room the resident was observed in their w/c, yelling, putting their arms up, and stated something about the television remote control. Staff J approached Resident 5 to calm them down, when Resident 4 was observed to propel their w/c over to them, yelled and grabbed Resident 5's sweater. Resident 4 and Resident 5 were observed hitting each other with closed fists. The residents were separated, and staff stayed with Resident 5 in the dining room and distracted them as much as possible until a 1:1 caregiver could arrive at the facility. In an observation and interview on 04/20/206 at 11:05 AM, Resident 5 was observed in the hallway in their w/c with their 1:1 caregiver. The resident was smiling and said hello to this surveyor. Resident 5 stated they were doing fine today. When asked if they were on their way for lunch, the resident made a sound and wanted to go into the East dining room. No further questions were asked. RESIDENT TO RESIDENT INCIDENT INVESTIGATIONReview of a facility incident investigation, dated 03/26/2026 at 5:10 PM, documented a physical altercation was observed between Resident 4 and Resident 5. In the East dining room, Resident 4 was observed in their w/c to rush past the licensed nurse (LN), moved a table out of the way, knocked a leftover dinner tray from the table onto the floor, and grabbed Resident 5's sweater. The LN intervened immediately and thought the situation between the two residents had de-escalated, when Resident 4 wheeled past the LN towards Resident 5 and began to strike Resident 5. Resident 5 struck Resident 4 back and they began to exchange closed-fist strikes. Resident 5 was escorted to the LN station and placed on 1:1 observation until they calmed down. The investigation documented Resident 4's response was triggered by Resident 5's behaviors related to their history of PTSD which had contributed to their emotional reaction when Resident 4 perceived the LN was at risk. The investigator documented Resident 4's actions were impulsive, were intended to assist the staff, and resulted in a brief physical altercation. Abuse and neglect were ruled out related to this physical altercation had occurred during an acute resident behavioral issue. Staff were attempting to de-escalate Resident 4 and Resident 5's behaviors and their care plans were followed. The investigation documented Resident 4's actions were reactive and not premeditated or malicious in intent. During an interview on 04/20/2026 at 2:45 PM, Staff D, RN/Regional Director of Clinical Services, was asked the rational how physical abuse was ruled out regarding the resident-to-resident physical altercation between Resident 4 and Resident 5. Staff D stated Resident 4 was protecting Staff J from Resident 5. Staff D stated Resident 4 was not acting malicious and was sorry for what occurred. <ONE TO ONE MONITORING>Review of a facility undated form titled, the facility's 1:1 Monitor, documented the purpose of the monitor was to validate the safety residents and to prevention behaviors from negatively affecting others. Staff were directed to document every hour on the form describing the residents' activities and what interventions were provided for the resident. Staff were directed when the resident was found awake and wandering staff must designate an individual to support the resident, and if the resident was sleeping the staff would document this on the form. This form would help create a resident's care plan and the potential removal of the 1:1 monitoring. Review of Resident 5's progress note, dated 03/26/2026 at 7:49 PM, documented the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was observed in a physical altercation with another resident (Resident 4). The resident was placed on 1:1 staffing after the altercation. Review of a progress note dated 03/29/2026 at 1:18 PM, the LN documented Resident 5 continued to reach out towards peers and staff, and hits themselves, walls and staff when frustrated. Review of a progress note dated 03/31/2026 at 9:44 AM, the LN documented Resident 5 does raise their fist towards other people and hits themselves at times per [their] baseline behaviors. Review of an Interdisciplinary Team (IDT) progress note dated 04/02/2026 at 9:20 AM, documented Resident 5's 1:1 monitoring had been gradually increasing distance between the resident and the staff member to allow Resident 5 space, staff were to observe their behaviors and be able to intervene when necessary. The IDT note documented a trial of decreasing the 1:1 monitoring during the day shift starting 04/02/2026, and the resident will remain on 1:1 monitoring on the night shift. The IDT would reevaluate the need for 1:1 monitoring on Monday 04/06/2026. Review of a progress note dated 04/02/2026 at 10:28 AM, Staff E, RN/Patient Care Coordinator, documented they discussed the 1:1 monitoring with Resident 5 who expressed frustration with the 1:1 monitoring. Staff E documented trial discontinuation of 1:1 staring now. Review of Resident 5's progress notes, dated 04/02/2026 to 04/07/2026, documented the following:- On 04/03/2026 at 1:13 PM, documented the resident continued to yell out at staff, not easily redirected, and hits themselves. There was no documentation if the resident was on any 1:1 monitoring.- On 04/04/2026 at 1:36 PM, there was no documentation regarding the decrease in 1:1 monitoring.- There was no documentation regarding Resident 5's behaviors or 1:1 monitoring on 04/05/2026 or 04/06/2026.- There was no IDT note reevaluating the resident's need for 1:1 monitoring on 04/06/2026 per the IDT note on 04/02/2026.- On 04/07/2026 at 1:58 PM, Staff K, Licensed Practical Nurse (LPN)/Resident Care Coordinator, documented Resident 5 was now on 1:1 monitoring and required staff redirection due to their behaviors towards others. There was no further documentation indicating why this decision was made. Review of Resident 5's 1:1 Monitoring forms, dated 04/02/2026 to 04/07/2026 at noon, documented the following:- On 04/02/2026, 1:1 documentation stopped at 11:00 AM.- On 04/03/2026, 1:1 documentation was completed at 10:00 PM and 11:00 PM, there was no other 1:1 documentation on the form.- On 04/04/2026 and 04/05/2026, 1:1 documentation was completed from midnight to 6:00 AM, at 10:00 PM, and at 11:00 PM. The staff documented at 1:00 AM and at 2:00 AM the resident was upset at the nurse's station related to not being able to log into a television network. There was no documentation on the form between the hours of 7:00 AM to 9:00 PM.- On 04/06/2026, 1:1 documentation was completed from midnight to 6:00 AM. There was no further 1:1 documentation on the form.- On 04/07/2026, 1:1 documentation was completed from noon to midnight. Review of a grievance form dated 04/06/2026 at 6:00 PM, Resident 6's family member documented Resident 4 came into the lobby area where Resident 6 and their family member were visiting. Resident 4 propelled their w/c up to Resident 6 and blocked them and their daughter from exiting the room. When Resident 6 and their family member attempted again to leave the lobby area, Resident 4 came straight towards Resident 6 in their w/c. It was not safe. Staff A, Administer in Training, interviewed Resident 6's family member who stated they felt Resident 6 was being targeted by Resident 4 and this was not a safe situation. Staff A documented Resident 5's 1:1 monitoring was reinstated after the facility had received the grievance. Review of Resident 5's impaired cognitive function and/or impaired thought process care plan, revised on 04/15/2026, documented an intervention was created and implemented on 04/13/2026 that the resident had a history of sudden outbursts and was currently on 1:1 supervision related to this behavior. There was no other documentation on the resident's care plan indicating the resident had been on 1:1 monitoring prior to 4/13/2026. On 04/14/2026 at 9:41 AM, Resident 5 was observed in the main dining room doing an activity. There was an unidentified staff member next to the resident. In an interview and observation on 04/14/2026 at 9:47 AM, Staff F, Nursing Assistant Certified (NAC), was observed in the main dining area with Resident 5 who was doing an activity. Staff F stated they were Resident 5's assigned 1:1 staff member. Staff F stated the resident was on 1:1 monitoring related to their behaviors. Staff F stated they were the resident's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caregiver when they were on shift. When they went on a break, they obtained another staff member to monitor Resident 5. During the interview, Resident 5 was observed to look back at Staff F and call out to them (Resident 5's speech was not clear). Staff F would reassure the resident they would be right there. In an interview on 04/14/2026 at 10:12 AM, Staff L, NAC, stated Resident 5 was on 1:1 monitoring related to their behavior towards others. In an interview on 04/14/2026 at 10:22 AM, Staff F, NAC, stated Resident 5 was on 1:1 monitoring related to their behaviors. Staff F stated the resident would get fixate on some of the staff and would target them (seek them out when they were working). In an interview on 04/14/2026 at 11:55 AM, Staff G, Licensed Practical Nurse (LPN), stated Resident 5 currently received 1:1 staffing. When asked why they were on 1:1 staffing, Staff G stated the resident had outbursts, yelled, and would hit the staff. Staff G stated there was a special binder located at the nurse's station that directed staff on how to interact and handle Resident 5's behaviors. On 04/14/2026 at 12:43 PM, Resident 5 was observed in their w/c on the phone at the East nurse's station. Resident 5 handed the phone to Staff F who spoke to the person on the phone. Resident 5 was observed to become agitated, was motioning for the phone back, was pointing at Staff F, and repeated it is mine repeatedly. Staff F handed the phone back to Resident 5 who then calmed down. On 04/14/2026 at 12:59 PM, Resident 5 was observed in their room sitting with the 1:1 caregiver and watching television. On 04/16/2026 at 9:22 AM, Resident 5 was observed sitting in their w/c in their room, watching television and continuously moving their w/c back and forth. In an interview on 04/16/2026 at 3:02 PM, Staff M, NAC, stated Resident 5 was on 1:1 monitoring related to their behaviors. Staff M stated the 1:1 caregiver care for all of Resident 5's needs and they only cover the assigned staff member when they go on a break. In an interview on 04/16/2026 at 3:30 PM, Staff H, Social Service Director, was interviewed at the East nurse's station. Staff H was asked who was in the room with Resident 5. Staff H stated this was a person provided by an outside agency to visit with the resident two days a week for a couple of hours. At that time, Resident 5 was observed to call out (unintelligibly) to Staff H, raising their fists. Staff H stated to Resident 5 they would come and visit them in a minute. Staff H stepped back out of Resident 5's direct line of sight and Resident 5 was observed to calm down. Staff H stated the resident fixated on them at times. On 04/20/2026 at 11:05 AM, Resident 5 was observed in their w/c on the East hallway with a 1:1 caregiver. In an interview on 04/20/2026 at 2:09 PM, Staff E stated staff were to document on Resident 5's 1:1 monitors every hour what the resident was doing, the resident's behaviors, and what they did to de-escalate the resident. Staff E stated on 04/02/2026 the resident's 1:1 monitoring was decreased related to Resident 5 was exhibiting signs of frustration due to the 1:1 monitoring. Staff E was asked if there was any further information directing the staff what decreased 1:1 monitoring meant, what staff expectations were, if this had been assessed, documented, and care planned. Staff E could not provide any additional information. On 04/20/2026 at 3:15 PM, an interview with Staff B, RN/Interim Director of Nursing Services, Staff C LPN/Assistant Director of Nursing, and Staff D was conducted. The staff were asked regarding Resident 5's decreased 1:1 monitoring. Staff C reviewed the resident's record and stated Resident 5 was placed on decreased 1:1 monitoring on 04/02/2026 related to Resident 5 was becoming agitated and the facility was honoring their rights. Staff C stated the IDT was to reassess Resident 5's decreased 1:1 monitoring on 04/06/2026. Staff C could not locate an IDT note reassessing Resident 5's decreased 1:1 monitoring. The staff were asked for documentation in Resident 5's medical record assessing what decrease monitoring meant, what were the expectations of the staff, were the staff directed to document to the resident's behaviors and whereabouts during this trial period, and if the 1:1 was care planned. Staff C and Staff D could not locate any additional information in Resident 5's chart. The staff were asked regarding the grievance dated 04/06/2026 filled out by Resident 6's family member and how Resident 5 made them feel unsafe in the lobby area, the staff confirmed the 1:1 monitoring was reinstated after this incident had occurred. Reference WAC 388-97-0640(1)