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	07/30/2025

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 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 ensure required notices were provided to 3 of 4 residents (Residents 11, 23 and 43) reviewed for hospitalizations. Failure to provide and follow-up to ensure communication of the required notices, placed residents and their representatives at risk of being uninformed of their legal rights related to bed hold and transfer/discharge status. Findings included .<RESIDENT 23> Resident 23 admitted to the facility on [DATE] with diagnoses to include metabolic encephalopathy (alteration in consciousness that is induced by brain dysfunction), Parkinson’s disease (progressive movement disorder of the nervous system) and clostridium difficile (bacterium that causes an infection of the colon). Review of Resident 23’s progress note dated 07/23/2025 at 12:15 PM, Staff N documented the resident was hard to arouse throughout the morning and that the provider was notified and the resident was sent to the hospital. Review of Resident 23’s progress notes dated 07/23/2025 showed no documentation that the resident had been transferred to the hospital or given a facility bed hold or notice of transfer/discharge. In an interview on 07/29/2025 at 1:22 PM, Staff C, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated that when a resident required transfer out of the facility, that staff were to print off a transfer packet which included the bed hold. Staff C stated the transfer packet for Resident 23 did not have any documentation related to a bed hold and was unaware of any facility document related to notice of transfer/discharge. <RESIDENT 43> Resident 43 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) (lung disease that restricts breathing), and Chronic Heart Failure (CHF) (condition that occurs when the heart is unable to pump blood effectively) and right pelvis fracture. Review of Resident 43’s progress note dated 06/23/2025 at 8:16 PM, Staff M, LPN, documented the resident was found on the floor and expressed pain in their left hip, Provider was notified and gave an order to send the resident to the hospital. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of progress notes dated 06/23/2025 showed no documentation related to a bed hold or a notice of transfer/discharge had been provided. In an interview on 07/29/2025 at 1:22 PM, Staff C stated there was no documentation of a transfer assessment, bed hold or notice of transfer/discharge documentation for Resident 43. <RESIDENT 11> Resident 11 admitted [DATE] with diagnoses which included a history of falls and a fracture. According to the 12/03/2024 comprehensive MDS assessment, Resident 11 was alert and oriented. Review of Resident 11's medical record dated 01/08/2025, documented Resident 11 was transferred to the emergency department following a fall and was admitted to the hospital. Review of an assessment titled transfer to hospital evaluation dated 01/08/2025, documented by check box that bed hold notice/transfer notices were sent to the hospital with the resident. Further review of the record found no copies of the stated forms or documentation of follow-up to ensure the resident or their representatives were informed of their rights regarding bed hold or their transfer/discharge rights. In an interview on 07/28/2025 at 11:30 AM, Staff G, LPN, RCM, provided a blank copy of the form titled bed hold/transfer notice which Staff G stated was automatically sent with residents when they go out to the hospital. Staff G stated they do not keep any copy of the form. In an interview on 07/30/2025 at 11:18 AM, Staff B, Director of Nursing Services, stated the bed hold notice and transfer notice are a combined form and it is sent with the resident when they are transferred. Staff B stated that a copy should go to medical records and there should be follow up done immediately and a note made in the chart. Reference WAC 388-97-0120

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to incorporate the recommendations from the Level II Preadmission Screening and Resident Review (PASRR, a federally required screening of all individuals who have a serious mental illness (SMI) report into the resident's assessment, and care planning for 1 of 1 resident (Resident 8) reviewed for PASRR. Facility failure to incorporate the PASRR recommendations into the residents' assessment and care plan delayed the implementation of recommendations and left the residents at risk for unmet mental health and activity needs and a diminished quality of life. Findings included . Review of the facility policy titled, Pre-admission Screening and Resident Review (PASRR) dated 11/2016 directed the interdisciplinary team to incorporate level II recommendations into the resident's care plan. Resident 8 was re-admitted to the facility on [DATE] with diagnoses to include a history of depression and moderate dementia with anxiety. Review of the clinical record showed a Level II PASRR was completed for Resident 8 on 03/05/2025. The PASRR recommendations included environment, staff approach and training, behavioral support and activity recommendations. The activity recommendation was for staff to encourage daily activities for structure and mental stimulation and for staff to ask Resident 8's family what activities they had previously enjoyed. Review of the Level II PASRR included Resident 8's mental health history and approaches to be utilized by staff to identify triggers and mitigate the resident's extreme/rapid mood swings and many incidences of uncontrollable crying. The PASRR included Resident 8's need for a consistent routine with consistent staff who speak in gentle tones and redirect or distract them with happier thoughts. The evaluation noted Resident 8 may not do well with a roommate and monitoring was necessary if a roommate was unavoidable. Review of Resident 8's care plan, initiated on 06/24/2025, did not include the Level II PASRR recommendations. In an interview and observation on 07/25/2025 at 9:58 AM, Resident 8 was sitting in their chair positioned up against the wall of their shared room. The resident was coloring on their overbed table. Resident 8 stated someone gave them the paper to color and they felt like they were back in school, but it passed the time. In observations on 07/25/2025 at 11:40 AM and 1:38 PM, Resident 8 was in their room with no activity items present. In observations on 07/28/2025 at 10:09 AM and 11:01 AM, Resident 8 was in their room with no activity items present. In observations on 07/29/2025 at 8:30 AM, 9:50 AM, 11:40 AM and 2:20 PM, Resident 8 was in their room with no activity items present. In an interview on 07/30/2025 at 10:47 AM, Staff J, Regional Director of Clinical Services, stated the PASRR evaluations included good information that needed to go onto the care plan. Staff B, Director of Nursing Services, was informed of the PASRR issues for Resident 8. Staff B stated their expectation was the PASSR information needed to go into the care plan. In an interview on 07/30/2025 at 12:24 PM, Staff K, Social Services Director, stated that once the Level II PASRR was received, they reviewed the PASRR evaluation and send it to medical records to be scanned into the medical record. Staff K stated they had not been putting the PASRR recommendations or interventions on the care plan as they were not aware they needed to. Refer to WAC 388-97-1915 (1)(2) (a-c) .

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Preadmission Screening and Resident Review (PASRR) assessments were completed timely following a significant change in status for 2 of 5 residents (Residents 10 and 21) reviewed for possible serious mental disorders and related conditions. This failure resulted in a potential inability to receive and benefit from Level II PASRR services for Residents 10 and 21, and placed other residents at risk for unmet mental health needs and a decreased quality of life. Findings included .Review of the facility policy titled, Pre-admission Screening and Resident Review (PASRR), dated 11/2016, showed the PASRR would be reviewed and updated as indicated with significant changes in residents' physical or mental condition. The state mental health authority would be notified of the changes affecting the residents' physical or mental condition. <RESIDENT 10>Resident 10 admitted to the facility on [DATE] with diagnoses to include post-traumatic stress disorder (PTSD, a mental health condition caused by an extremely stressful or terrifying event). Review of Resident 10's admission Minimum Data Set (MDS) assessment dated [DATE] and quarterly MDS dated [DATE] documented the resident was not experiencing hallucinations (perception of having seen, heard, touched , tasted or smelled something that was not actually there) or delusions (false belief that persists despite evidence proving it is false). Review of Resident 10's quarterly MDS assessments on [DATE], [DATE] and the annual MDS on [DATE] indicated the resident was experiencing a new onset of hallucinations and delusions. Review of Resident 10's Behavior Care Area Assessment, dated [DATE], showed the resident had PTSD with behaviors, a history of night terrors and hallucinations. Review of Resident 10's Level I PASRR, dated [DATE], showed the resident had a serious mental illness indicator, however delusional disorder and psychotic disorder were not marked. The PASRR responses showed a Level II PASRR referral was indicated. The PASRR did not reflect the new onset of hallucinations and delusions, so the PASRR evaluator could properly assess the resident. Review of Resident 10's Level II PASRR, dated [DATE], showed the reason for the referral was a new anti-depressant order for nightmares and restlessness with presumed association with PTSD. The evaluation did not address the delusions or hallucinations. Review of Resident 10's physician visit note dated [DATE] at 12:00 AM, showed the chief complaint was increased hallucinations and confusion. <RESIDENT 21>Resident 21 admitted on [DATE] with diagnoses to include depression, dementia and mood disturbance. Review of Resident 21's admission MDS assessment dated [DATE] documented the resident was not experiencing hallucinations. Review of Resident 10's quarterly MDS assessment on [DATE] indicated the resident began experiencing hallucinations. Review of the clinical record showed there was no significant change PASRR referral when Resident 21 began experiencing hallucinations. Review of Resident 21's care plan initiated on [DATE] showed the resident had verbalized having very vivid hallucinations about aliens, visitors taking pictures in her room for a newspaper, little blue boys by the fire alarm, very descriptive information of people outside the window, and bubbles on their feet. In an interview on [DATE] at 10:20 AM, Resident 21 stated they had been experiencing delusions. The resident stated the facility had turned the parking lot into Sea World and there were boats and sea [NAME] there. In an interview and observation on [DATE] at 2:10 PM, Resident 21 stated a couple was in a fight and slamming doors the other night. The resident said the man in the fight had been upset because one of the baby seals that live outside on the blue awning had died. The resident pointed out the window and said the other two seals were still there and this was not a hallucination. In an interview on [DATE] at 10:48 AM, Staff B, Director of Nursing Services, was informed of the PASRR issues for Residents 10 and 21. Staff B stated their expectation was to notify the PASRR evaluator of significant changes and the PASSR information needed to go to the care plan. In an interview on [DATE] at 12:27 PM, Staff K, Social Services Director stated they did not know about referring anything other than depression or anxiety to the PASRR evaluator. Staff K stated they knew about significant changes with anxiety and depression, but they were not aware of the need to notify the PASRR evaluator about delusions or hallucinations. Reference (WAC): 388-97-1975(7) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure professional standards of practice were implemented for 1 of 5 residents (Resident 13) reviewed for medication management. Failure to obtain a doctor's order and failure to monitor residents use of their own medical equipment, placed residents at risk for injuries and potential adverse outcomes.Findings include.Resident 13 was admitted to the facility on [DATE] with diagnoses to include lower extremity cellulitis (bacterial infection of the deeper layers of the skin) and polyneuropathy (nerve damage in multiple areas of the body). According to the admission Minimum Data Set (MDS - an assessment tool) dated 07/15/2025, the resident was cognitively intact.In an observation and interview on 07/25/2025 at 9:58 AM, Resident 13 stated that the rectangular white machine that was on their table and was plugged in the electrical socket in the wall was a machine called Therma Zone (pain management device that provides heating and cooling therapy without the use of ice). Resident 13 explained that it was a hot or cold compress that they used for their shoulder, lower back or knee pain. The machine had two tubes attached and on the other end of the tubes was a fabric that had Velcro that you wrap on your back, shoulder or knee. Resident 13 demonstrated how the machine worked by showing what buttons to push, to turn on and which buttons to press for hot or cold temperature. They stated that they add distilled water in the machine and the water is what makes the compress hot or cold. Resident 13 further explained that it helped with their joint pain.In an observation on 07/28/2025 at 10:03 AM, the Therma Zone machine was on Resident 13's overbed table and was plugged into the wall. The resident was not in their room.In a record review on 07/28/2025 at 10:13 AM, there were no physician orders about the use of the Therma Zone in Resident 13's electronic chart. There was no monitoring regarding the Therma Zone in Resident 13's Treatment Administration Record (TAR). The Therma Zone was not mentioned in resident's care plan.In an interview on 07/28/2025 at 10:14 AM, Staff E, Nursing Assistant Certified, stated that on admission anything that a resident brings to the facility was listed in the resident's personal inventory list and if it's medical equipment they also inform the nurse. Staff E was not aware of the Therma Zone equipment in Resident 13's room and had not seen the resident use the device.In an interview on 07/28/2025 at 10:45 AM, Staff D, Licensed Practical Nurse (LPN), stated they were not aware of Resident 13 having medical equipment in their room aside from the CPAP machine. Staff D looked at the machine on the resident's bedside table and stated it's a hot/cold compress machine. They stated they don't have a doctor's order for the resident to use it and it's not in the resident's TAR. Staff D stated they have not seen Resident 13 use the machine.In an interview on 07/28/2025 at 11:03 AM, Staff F, Occupational Therapist, stated that they have worked with Resident 13. They stated that they had not done a hot or cold compress therapy with the resident and was not aware that resident had a Therma Zone machine in their room.In an interview on 07/28/2025 at 11:19 AM, Staff C, Resident Care Manager stated that according to their policy, aside from CPAP and pacemaker monitor machine, the facility does not allow residents to bring and use any electrical medical equipment in the facility. Staff C stated they were not aware that Resident 13 had a Therma Zone machine in their room.In an interview on 07/30/2025 at 10:19 AM, Staff B, Director of Nursing Services, stated that if a resident brings in a medical device, they will need to get an order from the doctor first, assess the resident if they were able to safely use the machine and then the maintenance department will need to inspect the device prior to the resident using it. Staff B expected the staff to check residents' rooms to ensure that if there's some equipment they don't recognize that they report it to the nurse so the nurse on the floor can verify the equipment was ordered for the resident to use. Refer to WAC 388-97-1620(2)(b)(ii)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure pharmacy services were provided to meet the needs of 2 of 3 residents (Resident 70 and 72) reviewed for Admission/Discharge planning. Failure to ensure medications were acquired and administered as ordered, and to follow facility processes for medications not available, placed residents at risk for adverse events related to missing medications. Findings included . <Resident 70>Resident 70 admitted to the facility on [DATE] with diagnoses to include hypomagnesemia (low magnesium levels in the body). Review of Resident 70’s physician orders showed an order for Magnesium with calcium (a supplement for magnesium and calcium), three times a day for a daily supplement with a start date of 05/01/2025 at 6:00 PM. Resident 70’s physician orders showed an order for Magnesium Oxide three times a day for Hypomagnesemia with a start date of 05/06/2025 at 12:00 PM. Review of Resident 70’s electronic medication administration record (EMAR) for May 2025 documented on 05/01/2025, 05/02/2025, 05/03/2025, 05/04/2025, 05/05/2025, 05/06/2025, and 05/07/2025 a “9” coded which indicated the medication was not given as ordered and to see progress notes. Review of Resident 70’s progress notes showed licensed staff documented the following:• 05/01/2025 at 9:42 PM - “Medication ordered; MD notified.”• 05/02/2025 at 8:57 AM – “Unavailable. Will reorder.”• 05/03/2025 at 8:19 AM – “On order. ”• 05/03/2025 at 4:49 PM – “On order.”• 05/04/2025 at 1:50 PM - On order.• 05/05/2025 at 9:12 AM – “Not given, on order pharmacy unable to deliver. ”• 05/05/2025 at 9:02 PM – “Call from WMHC lab to report critical low magnesium level of 0.9. Normal range is 1.2-2.3. Call placed to on-call provider. Theorder received was to administer a one time dose of 400 mg magnesium oxide from house supply and redraw BMP tomorrow 5/6. House MDalerted via note in provider notebook.”• 05/06/2025 at 7:40 AM – “not sent by pharmacy, called for update. Not in Omnicell to pull.”• 05/06/2025 at 11:53 AM – “Pharmacy has on order, awaiting shipment. Notified PCP of need for update in order or order for facility supply. Awaiting response.”• 05/07/2025 at 8:27 AM – “On hold awaiting clarification from provider, pharmacy does not carry.” There was no documentation that the resident had been notified of the omission of magnesium supplement and no documentation that the resident had been assessed for signs of hypomagnesemia related to lack of medication being administered as ordered. In an interview on 07/30/2025 at 10:34 AM, Staff C, Licensed Practical Nurse(LPN)/Resident Care Manager(RCM), stated as an RCM they confirm medications are at the facility when they admit a resident. Staff C acknowledged the EMAR was coded 9 on those dates for magnesium supplements and acknowledged the progress notes stating that the medication was not given for multiple shifts. Staff C stated they have options and there should not be a reason a resident does not get a medication. <Resident 72>Resident 72 admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD – a disease that effects the lungs causing breathing problems) and depression. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 72’s physician orders showed an order for Pramipexole Dihydrochloride (depression medication) at bedtime related to depression with a start date of 05/18/2025 at 9:00 PM. Resident 72’s physician orders showed an order for Trelegy Elipta Inhalation, to give one inhalation orally one time a day related to COPD with a start date of 05/19/2025 at 8:00 AM. Review of Resident 72’s EMAR for May 2025 documented on 05/18/2025 and 05/19/2025 a “9” coded which indicated the medications were not given as ordered and to see progress notes. Review of Resident 72’s progress notes showed licensed staff documented the following:• 05/18/2025 at 9:01 PM – “not in Omnicell – on order”• 05/19/2025 at 8:10 AM – “has not arrived from pharmacy. calling today.” There was no documentation that the resident had been notified of the omission of medications or assessed for adverse outcomes. In an interview on 07/30/2025 at 11:26 AM, Staff B, Director of Nursing Services, stated if a medication was not available and was not in the emergency kit there should be follow-up with the pharmacy about when they would get the medications, and if not available, the provider must be notified that there is a delay and to get direction. Reference WAC 388-97-1300 (1) (a) (b) (i) (ii)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure a licensed pharmacist's monthly Medication Regimen Reviews (MRRs) were reviewed and acted upon for five of six months reviewed. This failure placed residents at risk for delays in necessary medication changes, risk for adverse side effects, and receiving medications without required pharmacist oversight. Findings included .Review of the (undated) facility policy titled Timeliness of Medication Regimen Review (MRR) Reports documented that the facility would receive MRR reports within 3 days of the pharmacist review, and the provider would review and respond to reports within 14 days. The policy did not address the timeliness of the facility to note and implement the recommendations after the provider reviewed them. The policy also stated if the pharmacist identified an irregularity that needed urgent attention, they would notify the facility to ensure prompt attention from the physician. It is noted that recommendations that were labeled as urgent were, in fact, addressed. The following applied to the remainder of the monthly MRR reports and recommendations that were not identified as urgent. Review of the January 2025 MRR reports showed the pharmacist review dates varied from 01/13-01/16/2025 and were not reviewed by the provider until 02/10/2025. Review of the February 2025 MRR reports showed the pharmacist review dates varied from 02/07, 02/09, and 02/29/2025 and were not reviewed by the provider until 03/26/2025. After review by the provider, the reviewed recommendations were not noted and implemented by the facility until 04/14/2025. Review of the March 2025 MRR reports showed the pharmacist review dates varied from 03/11-03/13/2025 and were not reviewed by the provider until 04/10/2025. After review by the provider, the reviewed recommendations were not noted and implemented by the facility until 04/14/2025. Review of the May 2025 MRR reports showed the pharmacist review dates varied from 05/07-05/14 and were not reviewed and signed by the provider until 06/02/2025. After review by the provider, the reviewed recommendations were not noted and implemented by the facility staff until 06/19/2025. Review of the June 2025 MRR reports showed the pharmacist review dates varied from 06/15-06/24/2025 and were not reviewed and signed by the provider until 07/11/2025. After review by the provider, the recommendations reviewed were not noted and implemented by the facility staff until several days later, on 07/15/2025. Six reviews were not noted or implemented until 07/22/2025. In an interview on 07/30/2025 at 11:27 AM, Staff B, Director of Nursing Services, stated the facility had switched pharmacies in February and the MRR reports are sent by email to them (Staff B). Staff B stated they are printed as they arrive and given to the provider. Staff B stated they used to come at the end of the month and now they are at all different dates and stated they should be reviewed timely and implemented and the facility needed to work on the process as they have still not adjusted to the new pharmacy process and acknowledged that not all the reviews are being reviewed or addressed timely. Reference WAC 388-97-13300 (4)(c)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **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 significant medication errors for five of eight residents (3, 10, 12, 13, and 21) reviewed for medications. Failure to follow physician's orders related to medication parameters placed residents at risk for adverse outcomes including low blood pressure which can result in dizziness and fainting from receiving medications which were outside of the ordered parameters for administration.Findings included .<RESIDENT 3> Resident 3 admitted on [DATE] with diagnoses to include respiratory disease, heart failure and high blood pressure. Review of the physician medication orders showed the resident received Metoprolol (a hypertension medication) twice daily and Digoxin (a heart medication) daily. The Licensed Nurse (LN) was to hold the medications if the systolic blood pressure (SBP) was below 110, or the heart rate was below 60. Review of the July Medication Administration Record (MAR) showed Resident 3 received the 07/13/2025 PM dose of Metoprolol even though the SBP was 90. <RESIDENT 10> Resident 10 admitted on [DATE] with diagnosis to include high blood pressure. Review of the physician medication orders showed the resident received Metoprolol twice daily and Lisinopril (a hypertension medication) once daily. The Licensed Nurse (LN) was to hold the Metoprolol medication if the SBP was below 100, or the heart rate was below 60. The Lisinopril was to be held if the SBP was less than 110. Review of the May MAR showed documentation that Resident 10’s PM dose of Metoprolol was held on 05/31/2025 even though the SBP was 100. The chart code entered into the MAR was a “5” indicative of hold/see progress notes. Review of the progress notes for May did not include an entry as to why the Medication was held. Review of the June MAR showed documentation Resident 10 received the Lisinopril on 06/01/2025 when the SBP was 107 and on 06/06/2025 when the SBP was 109. Review of the July MAR showed documentation Resident 10 received the AM dose of Lisinopril on 07/04/2024 when the SBP was 104 and on 07/12/2025 when the SBP was 106. <RESIDENT 21> Resident 21 admitted on [DATE] with a diagnosis of high blood pressure. Review of the physician medication orders showed the resident received Metoprolol twice daily. The LN was to hold the Metoprolol medication if the SBP was below 110, or the heart rate was below 60. Review of the May MAR showed Resident 10 received the PM dose of Metoprolol on 05/31/2025 when the SBP was 108. (continued on next page)

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	505309	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the June MAR showed Resident 10 received the PM dose of Metoprolol on 06/02/2025 when the SBP was 104. Review of the July MAR showed Resident 10 received the PM dose of Metoprolol on 07/21/2025 when the SBP was 108 and on 07/22/2025 when the SBP was 98. Review of the facility's state reporting log did not show these medication errors had been identified. In an interview on 07/30/2025 at 10:48 AM, Staff B, Director of Nursing Services stated their expectation was for the nurses to take the vital signs and hold the medication if the blood pressure was lower than the parameters ordered. <RESIDENT 13> Resident 13 was admitted to the facility on [DATE] with diagnoses of high blood pressure. Record review of Resident 13’s physician’s order showed, Amlodipine, give 1 tablet by mouth daily for HTN and hold if SBP is less than 110, or HR of less than 60. The resident also had orders for Losartan Potassium 1 tablet by mouth twice a day for HTN, hold if SBP less than 110. Record review of Resident 13’s MAR for July 2025, with a print date of 07/24/2025, showed a documentation that on 07/22/2025 the medications Amlodipine and Losartan Potassium were administered outside the ordered parameters. <RESIDENT 12> Resident 12 was admitted to the facility with diagnoses to include HTN, autonomic nervous system disorder (dysfunction of the nerves that regulate the non-voluntary body functions such as HR, blood pressure [BP] and sweating), panic disorder and seizures. Review of Resident 12’s physician orders showed: -Propranolol, give 1 tablet by mouth twice a day for HTN, hold if SBP is less than 110 or HR less than 60. -Amlodipine Besylate,1 tablet mouth daily, hold if SBP less than 110 or HR less than 60. - Propranolol HCl, give 1 tablet every 24 hours as needed (PRN) for when severe overstimulation is anticipated and signs of Autonomic storm – atypical seizure like movements/posturing, elevated BP, HR, respirations, sweating, or hyperthermia. Check vital signs (measurement of body’s most basic functions, it includes temperature, pulse/HR, respiration rate, and blood pressure) before administration and immediately after the episode. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a record review of Resident 12’s July 2025 MAR with a print date of 07/24/2025, it was documented that the resident received Propranolol on 07/07/2025 and 07/11/2025. There was a set of vital signs documented on 07/07/2025 and another set of vital signs on 07/11/2025. It was not clear whether the vital signs were taken prior to giving the medication or after. Further review of the resident’s electronic chart did not show another set of vital signs on 07/07/2025 and 07/11/2025. In a record review of Resident 12’s MAR for May and June 2025 with a print date of 07/24/2025, it was documented that the resident received Propranolol outside the BP parameters on 05/27/2025, 05/30/2025 and 06/12/2025. In a record review of Resident 12’s May 2025 MAR with a print date of 07/24/2025, it was documented that resident received the medication Amlodipine was administered outside the BP parameters on 05/27/2025. In an interview on 07/28/2025 at 2:14 PM, Staff D, Licensed Practical Nurse (LPN) stated that a check mark on top of a nurse’s initial in the MAR meant the medication was given. They stated that with BP parameters, they should get the resident’s BP and HR prior to giving the medication and then document it in the MAR or under the vital signs tab in the resident’s electronic chart. If a medication was not given, they usually document reason in the resident’s progress note. Staff D reviewed the vital signs for the PRN propranolol, and they stated that they can’t find the other set of vital signs. They added per the provider’s order, they should take the vital signs before and then after the medication was given. In a record review on 07/28/2025 at 3:10 PM, Resident 13’s progress notes did not include any documentation regarding medications given outside the parameters and vital signs taken after the PRN propranolol was given. In an interview on 07/29/2025 at 1:28 PM, Staff C, Resident Care Manager/LPN, stated that the nursing assistant usually takes vital signs at the start of their shift and if it’s within the hour prior to giving a medication with a BP/HR parameter and they were within the parameters, the nurse usually uses that to give the medication. If it’s outside the hour and/or not within the parameters, the nurse retakes the BP/HR prior to giving the medication and if it’s outside the parameters, they expect the nurse to hold the medication. Staff C stated they don’t audit medications with parameters. Staff C reviewed Resident 12’s MAR for the PRN Propranolol and stated that the nurses seemed to not have taken the resident’s vital signs after they gave the medication as ordered. Staff C added the nurses should have taken the vital signs when they assessed the resident for the effectiveness of the medication given. In an interview on 07/30/2025 at 10:19 AM, Staff B, Director of Nursing Services stated that they expect the nurses to follow the parameters the doctors ordered and that they should not give medications outside the ordered parameters. They added that they expect the nurses to follow providers orders and if it’s stated to take vital signs after medication was given that the nurses should be taking the vital signs as ordered. Reference WAC: 388-97-1060 (3)(k)(iii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled and discarded when expired on 2 of 2 medication carts and 1 of 1 medication storage room reviewed. This failure placed residents at risk for not receiving the full benefits of the medications. Findings include .The facility provided policy was titled Storage and Expiration Dating of Medications and Biologicals, last revised 08/01/2024 showed that the facility should ensure medications or biologicals that have an expired date on the label are stored separate from other medications until destroyed or returned to the pharmacy or supplier.In an observation and interview on 07/28/2025 at 9:29 AM of the facility East medication room with Staff C showed that there were 3 sets of medical supplies with expiration dates of 12/31/2024 and one box of medical supplies with an expiration date of 04/13/2025. Staff C verified that the medical supplies were expired and should be removed.In an observation and interview on 07/28/2025 at 10:27 AM of facility medication cart #3 with Staff D showed there was over the counter bottles of cholecalciferol (Vitamin D) D3 1250 micrograms (mcg) and folic acid (supplement) 400mcg with expiration dates of 06/2025. Staff D verified the medications were expired and stated that the pharmacy staff goes through the medication carts and was unsure of the facility policy or procedure or how often this occurred.In an observation and interview on 07/28/2025 at 10:54 AM of facility medication cart #4 with Staff L, RN, showed there was an over the counter box of Nicorette gum 4mg that had an expiration date of 01/2025. Staff L verified that the gum was expired. In an interview on 07/30/2025 at 11:00 AM, Staff B stated that charge nurse does medication cart audits to make sure that expired medications are pulled out of the carts, nurses should check and the pharmacy should also review. Reference WAC: 388-97-1300 (2)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory (labs) tests were completed as ordered and to provide timely laboratory results to meet the needs of six of eight residents (Residents 4, 8, 10, 21, 70 and 72) reviewed for laboratory services. These failed practices had the potential for negative complications related to delay of obtaining and follow up of laboratory results along with a risk for medical complications, related to a lack of monitoring chronic medical conditions and delayed identification and treatment of underlying health conditions.Findings included.<RESIDENT 70> Resident 70 admitted on [DATE] with diagnoses which included sepsis (serious complication of infection causing inflammatory response throughout the entire body and can potentially lead to organ failure). Review of Resident 70’s admission orders showed several labs to be done twice weekly to monitor the status of the resident’s sepsis: CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), ESR, CRP, CK, (monitors of inflammation and infection) and Magnesium (an electrolyte). Review of the resident record showed blank entries in the resident MAR (Medication Administration record) for three of the ordered laboratory dates (05/09, 05/12 and 05/16). During this time period, Resident 70 was documented as being on alert for a critical Magnesium level dated 05/05/2025 and Magnesium was the only lab which was documented as having been repeated. Review of a progress note dated 05/08/2025 documented the lab had not called the facility regarding the continued critical Magnesium level. Labs were collected on 05/19/2025, Resident 70 was assessed by their infectious disease specialist and returned to the hospital on [DATE] related to continued fragile status and abnormal labs. <Resident 21> Resident 21 admitted on [DATE] with diagnosis to include urinary incontinence. Review of the July MAR showed a lab order dated 07/11/2025 for nursing staff to obtain a UA (urinalysis) and culture if indicated one time for 5 days. The MAR had open spots for nurses to document if they obtained the UA from 07/11/2025 to 07/16/2025. There were no entries documented. Review of a progress note dated 07/16/2025 at 7:37 AM documented Resident 21 was reminded they needed to obtain a urine sample but declined as they needed to rest. The progress note showed the resident complained in the morning it had not been obtained and the nurse assured them it would be obtained later that day. At 1:46 PM, nursing documented UA attempts were unsuccessful. Review of a progress note on 07/18/2025 at 12:58 AM showed obtaining a UA was attempted but the nurse had been unsuccessful. Review of the progress notes 07/19/2025 to 07/24/2025 did not mention the UA order or attempts to collect it. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/23/2025 at 10:23 AM, Resident 21 stated that nine days ago the doctor ordered a urine test, and it was still not done. The resident stated the nurses needed to do a urine sample and they had not been able to successfully obtain the urine, and they tried several times. In an interview on 07/24/2025 at 8:57 AM, Resident 21 stated the nurses had still not gotten their urine sample, and they asked the nurse what the procedure was when they do not follow a doctor’s order. The resident stated they were upset about this and were not sure when their doctor was getting back from vacation. The resident stated their doctor wanted their urine tested since they were having an increase in hallucinations. <RESIDENT 4> Resident 4 was a long-term care resident who had recently completed antibiotics for a urinary tract infection and had a diagnosis related to electrolyte imbalances. Review of the Resident 4’s orders showed laboratory testing for CBC and CMP were ordered to be collected with a date range of 07/18/2025 and 07/25/2025. Review of the resident record on 07/29/2025 showed the labs were documented as drawn on 07/20/2025, with no further information or laboratory results found in the record. <RESIDENT 72> Resident 72 admitted on [DATE] and discharged on 05/23/2025. Review of Resident 72’s orders showed CMP, CBC, Free T4, TSH (thyroid tests), HgbA1c (blood sugar monitor) to be drawn on 05/21 or 05/22/2025. The labs were not drawn as ordered with no explanation in the record. In an interview on 07/28/2025 at 10:20 AM, Staff M, Licensed Practical Nurse (LPN), stated the nurses drew their own labs and someone from the facility delivered them to the lab. Staff M stated the providers entered the lab orders in the system and then they showed up on the Medication Administration Record (MAR) to complete. Results came over the fax machine and then were given to the provider directly if they were here, or by phone. Staff M stated they would call the provider or on-call provider if the results needed to be addressed right away. Staff M was asked how they knew which labs were pending and Staff M stated they would expect that to be in their shift report. Once labs were completed and reviewed, they were scanned into the record in the documents section. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/28/2025 at 10:37 AM, Staff G, LPN, Resident Care Manager (RCM), stated the orders entered by the providers go to a “pending confirmation” status, and a nurse had to go in and check to make sure all the correct boxes were checked, and then the order would appear on the MAR. Staff G stated labs were usually received later the same day they were sent, or the next day, and stated they called the lab if they hadn’t received them by the next day. Staff G stated they were having trouble with the fax communication between the facility and the lab. Staff G reviewed lab orders for Resident 4 and stated it looked like it had been drawn on the 20th, and they could not locate results, stating they should have had those by now, and would have to call the lab. Staff G stated they did not know why there was no documentation of the labs ordered for Resident’s 70 and 72. Staff G stated Resident 70 had labs done and contact with the provider and stated the record likely was not accurate or lab results were not scanned in. Staff G stated resident 72's labs may have been “routine labs” that the provider orders on everyone but had no information about why they had not been drawn, and why there were no notes explaining why not. <RESIDENT 8> Resident 8 was re-admitted on [DATE] with diagnoses to include lung disease and vitamin B deficiency. Review of a physician progress note dated 07/25/2025 at 12:00 AM, documented a BMP and CBC were ordered for Resident 8. Review of the clinical record showed no indication that the BMP or CBC had been obtained or processed. <RESIDENT 10> Resident 10 admitted on [DATE] with diagnoses to include a history of prostate cancer. Review of the July Medication Administration Record (MAR) showed a lab order dated 07/17/2025 for nursing staff to obtain a UA (urinalysis) with a culture if indicated one time for 7 days. The MAR had open spots for nurses to document when they obtained the UA from 07/17/2025 to 07/24/2025. There was one entry made on 07/20/2025 at 5:10 PM that indicated “9-other/see nurses notes,”. Review of Resident 10’s progress notes showed there was no progress note completed for 07/20/2025. Review of a progress note dated 07/19/2025 at 2:30 AM documented the UA was ordered but Resident 10 was too aggressive to obtain. Review of a progress note on 07/21/2025 at 7:06 PM, documented that they were unable to get the urine sample, and Resident 10 was agreeable to provide it tomorrow. Review of a progress note on 07/22/2025 at 5:33 PM showed the Resident 10 stated they didn’t think they could provide a sample. The writer reported they would alert the oncoming nurse. Review of a progress note on 07/25/2025 at 2:44 PM showed the physician was notified they had been unsuccessful at obtaining the UA from Resident 10. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician note on 07/25/2025 at 12:00 AM, revealed the UA ordered last week was not successful for Resident 10. In an interview on 07/29/2025 at 3:49 PM, Staff I, LPN stated the lab process was that they block off the lab on the treatment administration record (TAR) so that other nurses can see if the lab had been obtained. Staff I stated that management could print a report and see if the labs had been obtained. Staff I stated if they do not obtain the ordered lab, they need to notify the doctor the lab was not obtained. In an interview on 07/30/2025 at 10:52 AM, Staff B, Director of Nursing stated the facility was working on the lab process. Staff B stated the current process is the doctor puts in the order or gives it to the nurse, a lab slip is filled out, the blood is drawn, and the lab sample is driven to the local hospital lab. Staff B stated that the nurses need to follow up if there were no results. Staff B stated they could run a report to see if there were missing labs and then follow up. Staff B stated the facility had no lab policy. There should be documentation in the notes when abnormal labs are received and communication to the providers, as well as the lab noted and scanned into the record under the laboratory section. Reference WAC 388-97-1620 (2)(b)(i)

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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 ensure a system in which resident records were complete, accurate, accessible, and that documentation was in accordance with state law for 6 residents (Residents 3, 8,10,30,32,and 43), and on one of two resident units. Failure to ensure records included accurate and timely entries and prohibit the use of stamped signatures on medical records, placed residents at risk for records that did not accurately reflect their care, and placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, General Documentation Guidelines, dated 3/2013, showed the procedure for completing and correcting clinical records was:- Every entry shall be recorded promptly as the events or observations occur. - All entries should be complete, concise, descriptive and accurate- Record pertinent observations, psychosocial and physical manifestations, incidents, unusual occurrences and abnormal behavior. -All entries shall reflect the actual date and time.-When entering late entries, document as soon as possible. The more time passes the less reliable the entry. <RESIDENT 3>Review of the Psychosocial History and Discharge Plan documented an effective date of 05/08/2025 at 8:44 AM. Included on the plan was the admission date of 05/28/2025. The assessment was documented as being completed on 07/06/2025. Review of the Interdisciplinary Care Conference documented an effective date of 06/03/2025 at 12:55 PM. The meeting time and date was recorded as 06/03/2025 at 2:00 PM. The Care Conference was documented as being completed on 07/13/2025. <RESIDENT 8>Review of the Interdisciplinary Care Conference documented an effective date of 07/09/2025 at 3:53 PM. The meeting time and date was recorded as 07/14/2025 at 2:00 PM. The Care Conference was documented as being completed on 07/20/2025. <RESIDENT 10>Review of June 2025 MAR showed weekly weights were not documented on 06/04/2025 and 06/25/2025. Review of the July 2025 MAR showed weights were not documented on 07/02/2025, 07/15/2025, 07/16/2025, 07/24/2025 and 07/29/2025. In a joint interview on 07/30/2025 at 10:54 AM, Staff A, Administrator and Staff B, Director of Nursing Services stated they were unaware of late or missed documentation concern. Staff B stated there was no current auditing in place to ensure accurate and complete medical records. Staff J, Regional Director of Clinical Services stated it was not good practice to document late. In an interview on 07/30/2025 at 12:29 PM, Staff K, Social Services Director, stated they write assessments and care plans on paper. Staff K stated they tried to use the computers for documentation but had internet issues, dead computer batteries, and could not directly focus on the tasks at hand so they documented them on paper then put care conferences and assessments into the medical record later. <RESIDENT 30>Review of Resident 30’s clinical record showed the resident had an interdisciplinary team care conference on 07/18/2025 which was not signed or documented until 07/24/2025 by Staff K. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 32>Review of Resident 32’s clinical record showed the resident had an interdisciplinary team care conference on 06/27/2025 which was not signed or documented until 07/07/2025 by Staff K. <RESIDENT 43>Review of Resident 43’s clinical record showed the resident had an interdisciplinary team care conference on 07/18/2025 which was not signed or documented until 07/24/2025 by Staff K. <Resident 12>Review of Resident 12's immunization tab for their required two-step Tuberculosis (TB - a potentially serious bacterial infections that mainly affects the lungs) testing failed to document the lot number (unique identifier assigned to specific batches of product which is necessary in the event of product recalls) and the expiration date of the product for both steps. <Resident 13>Review of Resident 13's immunization tab for their required two-step TB testing failed to document the lot number and the expiration date of the product for both steps (07/08/2025 and 07/19/2025). <Resident 11>Review of Resident 11's immunization tab for their required two-step TB testing failed to document the lot number and the expiration date of the product for step one (11/01/2024). <Resident 43>Review of Resident 43's immunization tab for their required two-step TB testing failed to document the lot number and the expiration date of the product for both steps (06/04/2025 and 06/14/2025). <Resident 32>Review of Resident 32's immunization tab for their required two-step TB testing failed to document the lot number and the expiration date of the product for step one (06/18/2025). During an interview on 07/30/2025, at 8:59 AM, Staff B, Director of Nursing Services, DNS, stated that the lot number and expiration date of the tuberculosis solution should be documented under the immunization in the clinical record for each resident. They stated if it was not documented under the immunization tab then it would not be found elsewhere. Review of Resident 32’s pharmacist consultant reviews on 07/28/2025 showed six pharmacist recommendations signed by the facility provider on 07/11/2025 that included a stamp in the lower right corner. The stamp had the word “noted” and a blank line that was filled in with the date “07/22/2025” and below the line the stamped writing included the first name of Staff G, RCM and the words “LPN/RCM.” Further review of Resident 32’s medical records showed Staff G used this stamp to indicate they had “noted” physician’s orders and other documents. In an interview on 07/28/2025 at 11:10 AM, Staff G stated they assisted with the processing of the pharmacy reviews sometimes. Staff G stated they received the pharmacy reviews or other orders and “noted” them, which indicated that the orders or recommendations had been implemented. Staff G was asked about the “noted” stamp and staff G stated that was their signature. In an interview on 07/30/2025 at 11:45 AM, Staff A, Administrator, stated stamped signatures were not allowed and they were not aware anyone was using one. Staff A stated stamped signatures were not legal in the State of [NAME]. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1720