STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505313	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Manor	32300 First Avenue South Federal Way, WA 98003

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview and record review, the facility failed to conduct a full assessment, monitor, notify the provider and take timely action for a latent injury and a significant change in pain experience for 1 of 3 residents (Resident 1) reviewed for quality of care. Resident 1 who reported a popping noise after receiving care from staff and acute pain, experienced harm with increasing pain when there was a delay in transfer to the hospital for evaluation where they were diagnosed with a right ankle fracture. Findings included .<Facility Policy>Review of the facility's revised 11/11/2025 Pain Assessment and Management policy showed, based upon a comprehensive assessment of a resident, the facility would ensure residents received the treatment and care in accordance with professional standards of practice related to pain management. The policy showed residents would be assessed for pain indicators with any changes of condition and would address and treat the underlying causes and collaborate with the attending physician/provider to manage the pain.<Resident 1>According to the 05/12/2026 Quarterly Minimum Data Set (MDS-an assessment tool), Resident 1 had a history of a stroke (sudden brain attack that blocks blood to the brain), memory impairment, partial paralysis, and muscle weakness. The MDS showed Resident 1 was dependent on staff for all mobility transfers and activities of daily living (ADL).Review of the revised 03/20/2024 At risk for alteration in comfort/pain care plan (CP) showed staff would observe, report, and evaluate changes in Resident 1's usual routine and notify the provider if a current complaint was a significant change from Resident 1's previous experience of pain.Review of a 05/23/2026 progress note showed at 10:30 AM Staff C (Registered Nurse-RN) documented they were on duty in the morning and was told by Resident 1's family member they could not take Resident 1 out for a leave of absence, due to Resident 1 reporting increased pain in their leg and they wanted to stay at the facility. Staff C noted Resident 1 told them they had pain in their right knee area and assessed Resident 1's right knee of having no swelling. There was no further documentation to show an additional assessment was made to help identify an underlying cause of Resident 1's increased pain or to determine if there was injury. There was no documentation to show an assessment of other parts of the body was made and no notes indicating the provider was made aware of the increased pain.Review of a 05/24/2026 progress note showed at 8:00PM on 05/23/2026 Staff D (Licensed Practical Nurse), assessed Resident 1 as having severe pain and assessed right ankle to be swollen, red, warm to touch and sent Resident 1 out to the hospital for an evaluation.Review of a 05/25/2025 hospital imaging result showed Resident 1 had a fracture of their right ankle. In an observation and interview, on 05/28/20256 at 4:00 PM, Resident 1 stated they had a broken ankle after care staff took care of them and they remembered hearing a pop noise and told the staff. Resident 1 reported it was the worst pain, and they experienced it for several hours until they went to the hospital to get treated.In an interview with Resident 1's family member, on 06/01/2026 at 5:02 PM, Resident 1's family member stated they told Staff C (RN) that Resident 1 had increased pain in their leg and Resident 1 stated an injury occurred to their leg while care was being provided. The family member stated Staff C came to Resident 1's room after some time and did not assess Resident 1's full leg. Resident 1's family reported at 8:00 PM that evening, they received a call that Resident 1 was being sent out due to increased pain and the right ankle being swollen and red. Resident 1's family member (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	stated Resident 1 was harmed at the facility and should not have waited all day in pain to receive proper care.In an interview, on 06/03/2026 at 4:50 PM, Staff C stated they were told by Resident 1's family Resident 1 was not wanting to leave the facility because of pain. Staff C stated they went to assess Resident 1 and asked the resident where their pain was and Resident 1 stated they had pain in their leg. Staff C stated they only looked at right knee and did not assess the full leg because Resident 1 was seated in a wheelchair and they had a history of chronic pain. Staff C stated it was important to ask residents with pain, where their pain was located, to assess for injuries and harm and to notify the provider. Staff C stated they did not do this for Resident 1 because they thought this was Resident 1's baseline of chronic pain. In an interview, on 05/28/2026 at 5:50 PM, Staff B (Director of Nursing) stated Staff C should have assessed Resident 1's full leg and may have discovered the fracture of Resident 1's ankle sooner and assessed for harm. Staff B stated Staff C should have notified the provider once they heard about the increased pain but did not and stated Resident 1 should have received treatment sooner.In an interview, on 5/28/2026 at 5:50 PM, Staff A (Administrator) stated the facility investigated the event regarding Resident 1 and was unable to determine the cause of the fracture. Staff A stated the nurse should have assessed for further injury but did not. REFERENCE: WAC 388-97-1060 (1),(2)(b),(3)(g)