STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505318	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Skagit Valley	1462 West State Route 20 Sedro Woolley, WA 98284

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review the facility failed to act, respond, and resolve the organized resident group's concerns for 1 of 1 Resident Council groups. The facility's failure to provide assistance, respond to written requests from the group meetings, and maintain accurate meetings minutes, resulted in reported concerns going unidentified and uninvestigated, and placed residents at risk for unidentified, unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy, Grievance Program, dated 09/26/2025, documented the facility was responsible for ensuring that all grievances have been reviewed and addressed in a timely and appropriate manner and the residents feel that some type of resolution has been communicated, achieved, and maintained. The policy also documented maintaining a recordkeeping system of all complaints. <RESIDENT COUNCIL MEETING MINUTES> Review of the resident council minutes from April 2026 documented grievances for meal trays arriving late, shower frequency, and that chicken and pork were hard to cut. Meeting minutes documented that residents were reminded to complete blue card grievance forms when they were experiencing issues. Review of the resident council minutes from February 2026 documented grievances for shower frequency, meat was tough to cut, meal trays late, not getting condiments with meals and food requests not being followed. Meeting minutes have documented that residents were reminded to complete blue card grievance forms when they were experiencing issues. Review of the resident council minutes from January 2026 documented grievances for not receiving condiments during meals and wanting more fresh fruit options. Meeting minutes have documented that residents were reminded to complete blue card grievance forms when they were experiencing issues. Review of the facility's grievance log from January 2026 through April 2026 had no entries associated with the above resident council concerns, nor were any grievance forms completed as per the facility's grievance policy. In an interview on 05/12/2026 at 11:15 AM with Resident Council group stated that the shower concerns have not improved and the food concerns with late meal trays, tough meats, and not getting condiments had also not improved. In an interview on 05/12/2026 at 2:48 PM, Staff W, Activity Director stated that they did not do grievances for resident council as a whole. Staff W stated they did grievance cards for individuals sometimes, and other times the resident said they would do it themselves. Staff W stated they brought the resident council concerns to the following months Quality Assurance and Performance Improvement (QAPI) meeting. (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/12/2026 at 3:40 PM, Staff A, Administrator stated they had educated the Activity Director on the grievance process for Resident Council. In an interview on 05/15/2026 at 10:30 AM, Staff A stated resident council grievances had been started with the most recent month and will go back as needed and an updated grievance log was not provided. Reference WAC 388-97-0920 (5)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 5 of 5 sampled residents (11, 13, 20, 44, and 59) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) as required. The facility failed to comprehensively assess the risks, benefits and parameters of use and to ensure the least restrictive alternatives were attempted. The facility further failed to ensure consent was obtained prior to administration, and appropriate indication and monitoring of psychotropic medications. This failure placed residents at risk of experiencing unnecessary side effects such as sedation, falls, decline in physical functioning, and adverse medical events including stroke and death and placed residents at risk of experiencing an undignified life. Findings included .As referenced in the Food and Drugs/Drug (FDA) Safety Information, anti-psychotic medications have serious side effects and can be especially dangerous for elderly residents. The use of anti-psychotic medications without an adequate rationale, or for the sole purpose of limiting or controlling expressions or indications of distress without first identifying the cause, there was little chance that they would be effective, and they commonly cause complications such as movement disorders, falls with injury, stroke, and increased risk of death. The FDA Boxed Warning, which accompanied, second-generation anti-psychotics stated, Elderly patients with dementia-related psychosis treated with atypical anti-psychotic drugs are at an increased risk of death. Review of the facility policy titled, Psychotropic Medication Management, reviewed 12/02/2025 showed the facility must ensure that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. With regards to psychotropic medications, the regulations additionally require: -Giving psychotropic medications only when necessary to treat a specific diagnosed and documented condition -Implementing gradual dose reduction (GDR) and other non-pharmacologic interventions for residents who receive psychotropic medications, unless contraindicated; the resident's medical record must show documentation of adequate indications for a medication's use and the diagnosed condition for which a medication is prescribed. -When selecting medications and non-pharmacological approaches, members of the interdisciplinary team (IDT), including the resident, his or her family, and/or representative(s), participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition. -Involvement of the resident, his or her family, and/or the resident representative in the medication management process. (A consent is required for each medication)Selection of medications(s) based on assessing relative benefits and risks to the individual resident. -Evaluation of a resident's physical, behavioral, mental, and psychosocial signs and symptoms, in order to identify the underlying cause(s), including adverse consequences of medications; Selection and use of medications in doses and for duration is appropriate to each resident's clinical conditions, age, and underlying causes of symptoms and based on assessing relative benefit and risks to, and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	preferences and goals of, the individual resident. -The use of non-pharmacological approaches, unless contraindicated, to minimize the need for medications, permit use of the lowest possible dose, or allow medications to be discontinued; and the monitoring of medications for efficacy and adverse consequences. -An evaluation of the resident by the IDT helps to identify his/her needs, goals, comorbid conditions, and prognosis to determine factors (including medications and new or worsening medical conditions) that are affecting signs, symptoms, and test results. This evaluation process is important when selecting initial medications and/or non-pharmacological approaches and when deciding whether to modify or discontinue a current medication. The evaluation also clarifies: Whether other causes for the symptoms (including expressions or indications of distress that could mimic a psychiatric disorder) have been ruled out. Whether the physical, mental, behavioral, and/or psychosocial signs, symptoms, or related causes are persistent or clinically significant enough (e.g., causing functional decline) to warrant the initiation or continuation of medication therapy. Whether non-pharmacological approaches are implemented, unless clinically contraindicated for the resident or declined by the resident. Whether a particular medication is clinically indicated to manage the symptom or condition. Whether the intended or actual benefit is understood by the resident and, if appropriate, his/her family and/or representative(s) and is sufficient to justify the potential risk(s) or adverse consequences associated with the selected medication, dose, and duration. <RESIDENT 20> Resident 20 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (a progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), dementia with agitation (a decline in mental abilities), and diagnosed with major depressive disorder (MDD) on 03/02/2026. Review of Resident 20's care plan, dated 03/25/2026, documented that they use antipsychotic medications related to terminal agitation (end of life agitation). Review of Resident 20's active physician orders documented Quetiapine (a second-generation antipsychotic medication that calms the brain to treat mental health conditions like schizophrenia, bipolar disorder, and severe depression) 25 milligrams (mg) one tablet every eight hours related to MDD active as of 05/11/2026 and one 25mg tablet two times a day related to MDD active as of 05/13/2026. Resident 20 had active orders for Depakote Sprinkles (a medication primarily prescribed to treat seizure disorders, manage the manic phases of bipolar disorder, and prevent migraine headaches) 125 mg three capsules at bedtime related to MDD with an order date of 02/27/2025. Review of discontinued physician order documented Quetiapine first being ordered on 01/30/2025 through 04/05/2026 for terminal agitation. Quetiapine was ordered on 04/05/2026 through 05/11/2026 for terminal agitation. Review of Resident 20's Minimum Data Set (MDS) (a required assessment tool) dated 02/25/2025, 11/28/2025 and 02/26/2026, all documented that the resident did not experience hallucinations or delusions. The MDS's documented no physical or behavioral symptoms were exhibited. Active diagnoses for MDS's dated 02/25/2025 and 11/28/2025 included Alzheimer's and dementia but documented no to anxiety, depression, bipolar disorder, psychotic disorders, and schizophrenia. Active diagnoses for MDS dated [DATE] included Alzheimer's, dementia, and depression but documented no to anxiety, bipolar disorder, psychotic disorders, and schizophrenia. Medications (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented yes to taking antipsychotics and no to antidepressants. Review of February 2026 pharmacy recommendations for Resident 20 recommended to update diagnosis for quetiapine and Depakote from dementia with behaviors (not a Centers for Medicaid and Medicare Services (CMS) approved diagnosis) to agitation associated with dementia due to Alzheimer's disease. The pharmacy recommendations were signed by the provider on 03/09/2026 and signed as completed by the facility on 03/16/2026. In an interview on 05/14/2026 at 9:53 AM, Staff R, Certified Nursing Assistant (CNA), stated that Resident 20 does have dementia and can be combative sometimes in the evening but can be easily redirected. In an interview on 05/14/2026 at 1:26 PM, Staff L, Social Services Director (SSD) stated they were in charge of the psychotropic meeting that they have monthly. Staff L stated that pharmacy would let the facility know if they did not have a proper diagnosis for psychotropic medications. In an interview on 05/14/2026 at 2:08 PM, Staff D, Licensed Practical Nurse, Resident Care Manager, (LPN/RCM), stated that Resident 20 had been doing better than when they first admitted and that they did not have a lot of behaviors anymore. In an interview on 05/14/2026, at 3:40 PM, Staff B, Director of Nursing Services (DNS), stated that they were in charge of the pharmacy recommendations for all residents. Staff B stated Resident 20's pharmacy recommendations from February 2026 to change the diagnosis was completed but the diagnosis did not get attached to the medications. <RESIDENT 13> Resident 13 re-admitted [DATE] with diagnoses to include major depressive disorder (MDD) with psychotic symptoms and adjustment disorder with depressed mood. Review of the physician's orders showed Resident 13 received the anti-depressant Bupropion 150 MG once a day since 10/28/2022 and a second-generation antipsychotic Aripiprazole 1 MG once a day beginning 05/09/2025. Review of the psychotropic care plan initiated 02/29/2024 showed Resident 13 used Bupropion and Aripiprazole for management of MDD and directed staff to consult with pharmacy and doctor to consider dosage reduction when clinically appropriate, at least quarterly and discuss with the doctor and family the ongoing need for use of medication. Nursing staff were directed to review behaviors, interventions and alternate therapies attempted and their effectiveness as per facility policy. Review of Resident 13's quarterly MDS, dated [DATE], showed the resident did not experience signs of psychosis, such as hallucinations (perceptual experiences in the absence of real external sensory stimuli) or delusions (misconceptions or beliefs that are firmly held, contrary to reality). The resident was taking an antipsychotic medication, and a GDR had not been attempted since 05/09/2025. The physician did not document that a GDR was contraindicated. Review of a provider note on 04/15/2026 at 10:23 PM directed staff to monitor mood and behavior for any changes or signs of worsening depression and continue mental health follow-up and discuss at GDR rounds. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of progress notes beginning 05/15/2025 to 05/15/2026 showed no documentation Resident 13 exhibited psychosis (delusions or hallucinations). Review of the clinical record did not contain psychoactive medication evaluations or documentation of GDR meetings. There were no pharmacist recommendations in the past six months. <RESIDENT 44> Resident 44 admitted on [DATE] with diagnoses to include MDD, dementia unspecified severity with behavioral disturbance. The resident was not taking an antipsychotic medication on admission. Review of the current physician orders showed Resident 44 was receiving a second-generation anti-psychotic Seroquel 25 MG twice a day for dementia, unspecified severity, without behavioral disturbance, mood disturbance and anxiety since 03/20/2025. Review of the 08/30/2025 Psychotropic Care Area Assessment showed Resident 44 received an antipsychotic to manage dementia with other behavioral disturbance and to GDR per protocol and interdisciplinary team (IDT) determination. Review of a psychiatry provider note on 01/07/2026 at 9:30 AM, showed Resident 44 had a history of delusions 2 weeks ago, believing people wanted to hurt them. Currently reports resolution of these paranoid thoughts, stating I pushed them out, and has no memory of who the perceived threats were. This improvement suggests possible medication response or natural fluctuation in psychotic symptoms. The provider plan was for nursing to continue all medications as necessary, monitor for return of delusional thinking and follow-up in 2 weeks Review of the Medication Administration Record beginning January 2026 until 05/15/2026 showed there was no monitor in place for delusions. Review of the quarterly MDS dated [DATE] showed Resident 44 experienced delusions and had verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) one to three days in the 7-day lookback period. The MDS showed Resident 44 received antipsychotic medication and the last GDR was 01/18/2025 and the physician had not documented a GDR was clinically contraindicated. Review of Resident 44's care plan initiated 12/03/2024 showed the resident received antipsychotic related to dementia with psychotic disturbances. The care plan showed Resident 44 failed a GDR on 03/18/2025. Review of the clinical record did not include adequate monitoring for delusions and without adequate indications for its use and did not contain psychoactive medication evaluations or documentation of GDR meetings. There were no pharmacist recommendations in the past six months. In a joint interview on 05/14/2026 at 2:12 PM, Staff F, LPN/RCM, stated they attend psychotropic meeting if they are available and sometimes the meeting was just the provider and social services. Staff C, Assistant Director of Nursing (ADNS), stated their pharmacist provided education and made sure they had the necessary components for psychotropic medications. Staff C stated they were aware of the need for proper diagnosis for psychotropic orders. Staff C stated Resident 44 failed their GDR and there should be documentation to that. They were asked about the lack of delusion (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring and stated they would look into their behavior monitoring. In a joint interview on 05/15/2026 at 10:31 AM, Staff B, DNS, Staff N, (Regional Director of Clinical Services/RDCS), and Staff A, Administrator were informed of lack of delusion monitoring for Resident 44 and that lesser alternatives were not attempted prior to antipsychotic use for Resident 13 and 44. Staff A stated there needed to be better documentation for psychotropic use in the resident records. Staff A, B and N were asked for documentation of psychotropic GDR meetings as they were not located in the clinical records. No additional information was provided. <RESIDENT 11> Resident 11 admitted [DATE] with diagnoses which included anxiety and depression. Review of Resident 11's physician's orders on 05/12/2026 documented an order for a second-generation antipsychotic medication with an indication of hallucinations related to major depressive disorder. Review of Resident 11's behavior monitoring for the antipsychotic medication with an initiation date of November 2025, documented the target behaviors as negative statements and self-isolation. There was no monitoring for hallucinations. Review of Resident 11's care plan on 05/12/2026 documented the resident was taking an antipsychotic medication related to depression. In an interview on 05/14/2026 at 12:39 PM, Staff D, LPN/RCM stated residents on antipsychotics should have behavior monitoring and be on alert for documentation if they exhibit behaviors. Staff D stated they do not believe Resident 11 has ever exhibited hallucinations, stating this medication was one that the resident had ordered on admission. Staff D stated we should be reviewing to make sure there were monitors in place for the target behaviors. <RESIDENT 59> Resident 59 admitted to the facility on [DATE] with diagnoses that included dementia, history of mental and behavioral disorder (non-specified), and major depressive disorder. The admission MDS dated [DATE] documented the resident had severe impaired cognition, with no behaviors. Review of Resident 59's physician orders, dated 04/22/2026 documented an active order for quetiapine three times a day for agitation and dementia. Review of the administration record the resident received all doses administered. Review of Resident 59's medication informed consent form dated 05/05/2026 (14 days after the medication was started), documented the resident consented to an antipsychotic medication three times a day for dementia, severe behavioral disturbances and history of mental and behavioral disturbances. The consent was signed by the resident who has severe cognition impairment. Review of Resident 59's behavioral monitor documentation from 04/22/2026 to 05/15/2026, showed there was no behavior monitoring in place until 04/29/2026. The behaviors that were added to monitor (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every shift (three times a day) were agitation, aggression, and combativeness. There were no behaviors documented until 05/11/2026. Review of Resident 59's care plan, dated 04/23/2026 documented the resident used an antipsychotic medication related to behavior management. There were no individualized goals or interventions related to an appropriate rationale or indication for the use of psychotropic medication. In an interview on 05/14/2026 at 8:44 AM, Staff J, CNA, stated that Resident 59 has been combative with care and have severe cognition impairment. Staff J added they cannot understand basic directions like, go to bathroom, or get out of bed. In an interview on 05/14/2026 at 9:41 AM, Staff K, LPN/Infection Preventionist (was working the medication cart the week of 05/11/2026 – 05/15/2026) stated the admission nurse should review consents and ensure diagnosis were appropriate for all psychotropic medications, then the RCMs would review and verify for accuracy. Staff K stated all licensed staff were responsible for updating care plans as needed, and the RCM's review for accuracy. Staff K stated Resident 59 has had some combative behaviors, and any behaviors demonstrated should be documented in the medical record. Staff K was not aware that Resident 59 had an inappropriate indication for use of an antipsychotic, was not aware they had signed their own consent for that medication. Staff K stated Resident 59 was did not know what was going on and was not aware that the consent was dated 14 days after the medication had been started. In an interview on 05/14/2026 at 10:32 AM, Staff B, DNS stated they located another consent for Resident 59's antipsychotic medication dated 04/22/2026, that was found in the medical records office. Staff B stated they were not sure why the consent had not been included as part of Resident 59's medical record. In an interview on 05/14/2026 at 12:29 PM, Staff E, LPN/RCM stated they were the nurse manager responsible for Resident 59. Staff E stated the admission nurse would initiate a basic care plan, then the RCM would update based on assessments to ensure they were accurate. Staff E stated they reviewed consents and proper diagnosis for medications when a resident was admitted to the facility. Staff E stated they were not aware that the consent for Resident 59's antipsychotic medication was not in the medical record until 14 days after the resident was admitted . Staff E stated they were not aware the diagnosis was not appropriate indication for use of an antipsychotic and would usually try and ensure they were. In an interview on 05/14/2026 at 1:30 PM, Staff L, SSD stated they were responsible for the gradual dose reduction/psychotropic meeting that they had monthly with the pharmacist, medical director, DNS, and nurse managers. Staff L stated the pharmacist would send over a spreadsheet with all the residents in the facility on psychotropic medication. Staff L stated they did not usually review new admits in this meeting and waited a quarter cycle for documentation to be in the medical record. Staff L stated the form provided, the diagnosis, behavior monitors, and the pharmacists reviewed those for accuracy. Staff L was not sure if the pharmacist reviewed the consents. Staff L was not aware that Resident 59's diagnosis was inappropriate, that the target behaviors were for agitation, and that the consent for their antipsychotic was not loaded into the medical record timely. Staff L agreed they should review new admissions sooner rather than waiting a quarter cycle to review. In a follow up interview on 05/14/2026 at 3:14 PM, Staff B, DNS stated they were not aware that the new admissions were not reviewed for accuracy in the psychotropic meeting. Staff B stated that (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 59 had major depressive disorder, and agreed with the findings that the diagnosis, behavior monitoring and care plan did not support the reason for administering the medication. Staff B stated it was their expectation that the consents were completed prior to administering medications and were included in the medical record timely. Reference WAC 388-97-0620 (1)(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance with bathing and grooming for 6 of 7 residents (Residents 8, 13, 15, 44, 63, and 79) reviewed who were dependent on staff to carry out their ADL's (activities of daily living). Failure to provide the residents assistance with bathing and grooming, placed the residents and others at risk for poor hygiene, unmet care needs and a diminished quality of life. Findings included . <RESIDENT 8> Resident 8 was admitted to the facility on [DATE] with diagnoses to include stroke that affected their ability to speak, write, and understand language, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting right dominant side. Review of Resident 8's MDS dated [DATE] documented that they needed substantial/maximal assistance with showering. Review of Resident 8's care plan dated 05/12/2026 documented that they preferred a shower twice a week and that they required substantial assistance from one staff to provide a shower. Review of Resident 8's progress notes from 01/01/2026-05/13/2026 did not have documentation of refusals of showers. In a review of Resident 8's May 1st-13th 2026 bathing documentation showed Resident 8 preferred a shower twice a week and was only scheduled for once a week. Resident 8 received a shower on 05/04/2026, 05/11/2026 and had a shower scheduled for 05/18/2026 and 05/25/2026. In a review of Resident 8's April 2026 bathing documentation showed Resident 8 preferred a shower twice a week and was only scheduled for once a week. Resident 8 received a shower on 04/06/2026, 04/11/2026, 04/13/2026, 04/20/2026 and 04/29/2026. Resident 8 had documented as activity did not occur on 04/10/2026 and 04/27/2026. In a review of Resident 8's March 2026 bathing documentation showed Resident 8 preferred a shower twice a week and was only scheduled for once a week. Resident 8 received a shower on 03/02/2026, 03/10/2026, 03/16/2026, 03/24/2026 and 03/30/2026. Resident 8 had blank documentation for bathing on 03/09/2026 and 03/23/2026. In a review of Resident 8's February 2026 bathing documentation showed Resident 8 preferred a shower twice a week and was only scheduled for once a week. Resident 8 received a shower on 02/09/2026 and 02/16/2026. Resident 8 had blank documentation for bathing on 02/02/2026 and 02/23/2026. In a review of Resident 8's January 2026 bathing documentation showed Resident 8 preferred a shower twice a week and was only scheduled for once a week. Resident 8 received a shower on 01/12/2026 and 01/19/2026. Resident 8 had blank documentation for bathing on 01/05/2026 and 01/26/2026. In an interview on 05/13/2026 at 10:04 AM, Collateral Contact 3 stated that Resident 8 used to take a shower everyday at home and would like more showers. When asked if Resident 8 would like showers twice a week they nodded their head yes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 79> Resident 79 was admitted to the facility on [DATE] with diagnoses to include heart failure, muscle weakness, and limitation of activities due to disability. Review of Resident 79's MDS dated [DATE] documented that they needed substantial/maximal assistance with showering. Review of Resident 79's care plan dated 03/05/2026 documented that they preferred a shower twice a week and required substantial assistance for bathing. Review of Resident 79's progress notes from 01/01/2026-05/13/2026 did not have documentation of refusals to showers. In a review of Resident 79's May 1st-14th 2026 bathing documentation showed Resident 79 preferred a shower twice a week. Resident 79 received a shower on 05/07/2026 and had bathing documented as activity did not occur on 05/05/2026, 05/09/2026 and 05/12/2026. Resident 79 had blank documentation for bathing on 05/12/2026. In a review of Resident 79's April 2026 bathing documentation showed Resident 79 preferred a shower twice a week and was only scheduled for once a week. Resident 79 received a shower on 04/21/2026 and 04/18/2026 and bathing documented as activity did not occur on 04/07/2026, 04/09/2026, and 04/12/2026. Resident 79 had blank documentation for bathing on 04/14/2026 and 04/28/2026. In a review of Resident 79's March 2026 bathing documentation showed Resident 79 preferred a shower twice a week and was only scheduled for once a week. In a review of Resident 79's February 2026 bathing documentation showed Resident 79 preferred a shower twice a week and was only scheduled for once a week. Resident 79 received a shower on 02/10/2026, 02/21/2026 and 02/24/2026 and blank documentation for bathing on 02/03/2026 and 02/17/2026. In a review of Resident 79's January 2026 bathing documentation showed Resident 79 preferred a shower twice a week and was only scheduled for once a week. <RESIDENT 13> Resident 13 readmitted to the facility on [DATE] with diagnoses to include stroke with hemiplegia (paralysis on one side of body) and hemiparesis (weakness on one side of body), muscle contractures (tightening and shortening of muscles), and difficulty walking. Review of the quarterly minimum data set (MDS - a required assessment tool) assessment dated [DATE] showed the resident had no cognitive impairment, required extensive assistance for bathing and did not refuse care. Review of the Kardex (guide to show nurse aides how to care for resident) showed the resident preferred showers two times a week and to provide a sponge bath when a full bath or shower could not be tolerated. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/14/2026 at 9:28 AM, Resident 13 stated they were only getting one shower a week, and they wanted two a week. They stated they were in need of a shave. The resident denied refusing showers and stated, I never refuse, that is not true. Review of Resident 13's February bathing documentation showed they wanted two showers a week and received bathing on 02/11/2026,02/15/2026, 02/18/2026, refused on 02/25/2026 and received bathing on 02/28/2026. Review of Resident 13's March bathing documentation showed they received bathing on 03/04/2026, refused 03/11/2026, received on 03/13/2026, and 03/18/2026. Review of Resident 13's April bathing documentation showed they refused bathing on 04/01/2026, received bathing on 04/04/2026, 04/15/2026, refused 04/22/2026, received on 04/24/2026. Review of Resident 13's May bathing documentation showed they received bathing on 05/01/2026, refused 05/06/2026, received on 05/08/2026, refused on 05/10/2026 and received on 05/13/2026. In a joint interview on 05/14/2026 at 2:18 PM, Staff C, Assistant Director of Nursing (ADON) and Staff F, License Practical Nurse (LPN)/ Resident Care Manager (RCM), Staff C stated Staff B, Director of Nursing audited showers and the facility had a performance improvement plan (PIP) on showers. Staff C stated they were unsure when the PIP was developed. Staff F verified that Resident 13 wanted 2 showers a week and bathing was received on 03/04/2026, 03/13/2026 and 03/18/2026, 04/04/2026, 04/15/2026, 04/24/2026, 05/01/2026, and 05/08/2026. Staff F acknowledged there was no documentation about bed baths. Staff F stated Resident 13 was agreeable to care. <RESIDENT 15> Resident 15 admitted on [DATE] with diagnoses to include hemiplegia and hemiparesis, respiratory disease, difficulty walking and muscle weakness. Review of the quarterly MDS dated [DATE] showed the resident had mild cognitive impairment, required extensive assistance for bathing and refused care one to three days in the 7-day lookback period. In an interview on 05/11/2026 at 11:08 AM, Resident 15 stated their bath was never done yesterday and they missed three showers. They stated they were supposed to have lotions on their feet and back every week, but they don't get it. They stated they were supposed to be turned on their side and that happened only when they changed their brief twice a day. The resident stated they went weeks in a row without a shower, and they should have had one on Friday but didn't. They stated the staff say they are just busy. In an interview and observation on 05/12/2026 at 8:50 AM, Resident 15 was in bed. Their hair was greasy and body odor was present. They stated they did not get a shower yesterday. In an interview and observation on 05/13/2026 at 9:36 AM, Resident 15 was in bed. Their hair was greasy and body odor was present. They stated they had not had a bath yet. They stated they wanted a bed bath once a week, but it did not always happen. Review of the Kardex showed the resident preferred showers once a week and to provide a sponge (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should work around the resident's activity times. They stated they would try to talk them into a bed bath, if they adamantly refuse to be showered. They stated if they still refused, nurses were to document the refusal in the progress notes. They stated most residents were set up twice a week for showers. Staff Q stated there were a lot of residents who told them they did not get their showers. Staff Q stated shower aides were pulled to the floor a lot. In a joint interview on 5/15/2026 at 10:31 AM, with Staff B, DNS, Staff N, Regional Director of Clinical Services, Staff A, Administrator. Staff A stated their shower PIP continued as they were not able to have substantial compliance so then continued to 03/08/2026. Staff A stated shower aides were pulled to work the floor related to call ins and they could not staff with agency at the last minute. In an interview on 05/15/2026 at 10:46 AM, Staff V, CNA/Shower Aide, stated that they do day shift showers about three or four times a week and can do an average of nine showers a day. Staff V stated if a resident refuses a shower, they do try to reapproach and it was documented on the shower sheet, in the electronic medical record (EMR) and the nurse documented in a progress note. Staff V stated that if a scheduled shower was blank on the EMR it could mean that either someone did not document or it did not happen but do offer showers as needed. Reference: (WAC) 388-97-1060 (2) (c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure treatment and care was provided in accordance with professional standards of practice for 1 of 1 resident (Resident 17) reviewed for edema and 2 of 5 residents (Resident 44 and 59) reviewed for unnecessary medications. The facility failed to implement physician orders for edema management and daily weights and failed to implement the facility bowel protocol. These failures placed the residents at risk for decline and diminished quality of life. Findings included .Review of the facility policy titled, Bowel Protocol, reviewed 09/15/2025, documented the facility would provide effective interventions for signs and symptoms of constipation that were consistent with standards of practice. the facility would implement standing orders to address lack of bowel movement. Review of the facility policy titled, Therapeutic Compression Application, print date 05/14/2026 documented compression bandages were used to manage lower extremity edema and venous insufficiency (poor blood circulation back to heart) .educate resident on purpose and use of wraps. document application of use. <EDEMA> Resident 17 was admitted to the facility on [DATE] with diagnoses that included edema (swelling caused by excess fluid trapped in the body's tissue), and Prader-Willi syndrome (rare genetic disorder caused by the loss of function of specific genes that can cause poor muscle tone). The admission Minimum Data Set (MDS – an assessment tool) dated 04/20/2026 documented the resident had impaired cognition and was dependent on staff for dressing their lower body, mobility, and transfers. Review of Resident 17's physician orders, dated 04/28/2026 documented an order for ace wraps to be applied to both lower extremities daily in the morning and removed at night. Review of Resident 17's care plan dated 04/16/2026 documented the resident had an actual skin impairment to their skin which included lower extremity edema. The care plan did not have any individualized goals or interventions that addressed the edema to their lower extremities. In observations on 05/11/2026 at 9:19 AM, 1:18 PM, and 2:00 PM – 3:30 PM, Resident 17 was observed in their electric wheelchair. The resident's both lower extremities had severe edema; they were wearing non-skid socks that were observed to be tight and stretched to capacity. The top of the sock was observed to be slightly indented on the resident's lower legs. At 1:18 PM ace wraps were observed in pile on a chair in the residents' room. In an observation on 05/12/2026 at 8:08 AM, Resident 17 was lying in bed, had non-skid socks on and ace wraps were observed in a chair. In observations on 05/12/2026 at 10:04 AM and 12:23 PM, Resident 17 was observed in their electric wheelchair headed to the main dining room. Resident 17 had non-skid socks to bilateral lower extremities, socks appeared tight on their feet. At 12:23 PM, Resident 17 was observed in an alcove working on a puzzle in their wheelchair, wearing socks, legs observed to have severe edema, skin above the socks were discolored and red. In observations on 05/13/2026 at 8:20 AM Resident 17 was lying in bed, had non-skid socks on and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ace wraps were observed in chair. In observations on 05/13/2026 at 10:14 AM and 12:45 PM, Resident 17 was up in their electric wheelchair, wearing non-skid socks tightly on their feet. In a review of Resident 17's electronic medication/treatment administration record (MAR/TAR) 05/11/2026 – 05/13/2026 for the physician order to wear ace wraps daily in at the morning, the 11th and 13th were blank, and the 12th the license nurse documented that the resident had ace wraps on. In an interview on 05/14/2026 at 9:41 AM, Staff K, License Practical Nurse (LPN)/Infection Preventionist (IP) the assigned floor nurse for Resident 17 on day shift (6:00 AM – 2:00 PM) was asked if Resident 17 wore ace wraps to their lower extremities. Staff K reviewed the electronic physician orders and stated that yes they are to go on in the morning. Staff K was asked why they had not been applied to Resident 17's lower extremities on 05/11/2026, 05/12/2026 and 05/13/2026, Staff K did not have a reason. Staff K stated they were not aware they had documented they applied the ace wraps on 05/12/2026 in the medical record. In an interview on 05/14/2026 at 12:29 PM, Staff E, LPN/Resident Care Manager (RCM) stated they were familiar with Resident 17. Staff E stated they were not aware of any refusal of care since Resident 17 admitted . Staff E stated Resident 17 has severe edema to their lower extremities and was to wear ace wraps daily. Staff E stated they were not aware they had been observed for three days without their wraps on. Staff E stated it was the expectation that the licensed nurse was documenting physician orders correctly. In an interview on 05/14/2026 at 3:13 PM, Staff B, Director of Nursing Services (DNS) stated Resident 17 had edema to their lower extremities and that it was their expectation that the licensed staff were following physician orders, and if they refused, they needed to notify the provider. Staff B was not aware that Resident 17 had gone without ace wraps to lower extremities for three days, and that documentation was not completed accurately in the medical record. <UNNECESSARY MEDICATION REVIEW> <RESIDENT 59> Resident 59 admitted to the facility on [DATE] with diagnoses that included dementia, and cognitive communication deficit. The admission MDS dated [DATE] documented the resident had severe impaired cognition, was prescribed medication for pain management, and was frequently incontinent of bowel movements. Review of Resident 59's physician orders documented the following: - oxycodone, an opioid (strong pain medication that caused constipation) one to two tabs every four hours as needed for pain dated 04/22/2026, - milk of magnesia, given by mouth as needed if the resident does not have bowel movement for three days, - bisacodyl (stool softener), give rectally as needed for constipation if no results from the milk of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	magnesia, - fleet enema, give rectally as needed for constipation if no results from the stool softener. Review of Resident 59's bowel monitoring from 04/22/2026 – 05/14/2026 showed that the resident had no bowel movement 04/29/2026 until 2:00 PM on 05/04/2026 (5 1/2 days). Review of Resident 59's electronic medication/treatment record 04/29/2026 – 05/04/2026 showed there was no bowel medication administered to the resident for their constipation. Review of Resident 59's medical record 04/29/2026 – 05/04/2026 showed there was no documentation the resident was assessed for constipation, no notification the resident had refused treatment of constipation, or that the provider was notified that the resident had experienced constipation. In an interview on 05/14/2026 at 8:44 AM, Staff J, Certified Nursing Assistant (CNA) stated the facility had a bowel management program. Staff J stated the nurse would inform the CNAs in the morning who was on the list and were to let them know if the resident did not have a bowel movement so they could administer medication. Staff J stated Resident 59 had severe cognitive impairment and did not understand basic care directives. In an interview on 05/14/2026 at 9:41 AM, Staff K, stated they were notified on the electronic medical record system if a resident had not had a bowel movement documented in three days. The nurse would then administer milk of magnesia, if nothing happened the next day they would get a stool softener suppository, and then on day 5, if no bowel movement they would get an enema. Staff K stated the nurse should also document a bowel assessment, listen to the abdomen for bowel tones, and if they have continued constipation often notify the provider. Staff K was not aware Resident 59 had gone 5 1/2 days with no treatment for their constipation. In an interview on 05/14/2026 at 12:29 PM, Staff E, LPN/RCM stated the facility had a bowel management protocol, three days no bowel movement they get a treatment, day 4 a suppository, and by day 5 an enema. Staff E stated they got an alert in the electronic medical record and those were discussed in the morning clinical meeting. Staff E was unaware that Resident 59 had their constipation untreated for 5 1/2 days and stated there should have been an assessment of the resident, medication provided and follow up as needed. In an interview on 05/14/2026 at 10:32 AM, Staff B, DNS stated it was their expectation that all staff were following the bowel protocol and that Resident 59 should have had an assessment of their abdomen, medication provided as ordered and follow up as needed. <RESIDENT 44> Resident 44 admitted on [DATE] with aortic valve stenosis (narrowing or blockage of the heart valve), hypertension and edema. Review of Resident 44's quarterly MDS assessment dated [DATE] showed the resident did not reject care. Review of Resident 44's admission orders directed staff to obtain a daily weight for increasing edema (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services related to restorative nursing programs (RNPs) for 3 of 4 residents (Residents 15, 63 and 79) reviewed for positioning, mobility, and range of motion. This failed practice placed residents at risk for decline in function, contractures (shortening and hardening of muscles, tendons leading to deformity and rigidity of joints), pain and increased dependency on caregivers. Findings included .According to the Resident Assessment Instrument Manual (provides guidance for completion of the Minimum Data Set - MDS) the following criteria must be met for RNPs: - The program must have measurable objective goals and interventions must be documented in the care plan and in the medical record. - There needs to be evidence of periodic evaluation by the licensed nurse that must be present in the resident's medical record. - Nursing Assistants (NAs) must be trained in the techniques that promote resident involvement in the activity; and - A Registered Nurse (RN) or a Licensed Practical Nurse (LPN) must supervise the activities in an RNP. Review of the facility policy titled, Restorative Nursing, reviewed 09/18/2025, documented the facility would develop restorative nursing programs and residents would be provided the appropriate treatment and services to maintain or improve their ability to carry out activities of daily living (ADL's). <RESIDENT 15> Resident 15 was re-admitted to the facility on [DATE], with diagnoses to include repeated falls, hemiplegia and hemiparesis (weakness and paralysis on one side of the body), degenerative joint disease, arthritis, difficulty walking, muscle weakness and limitation of activities due to disability. Review of the physical therapy (PT) evaluation and plan of treatment on 09/12/2024 showed Resident 15 lived alone and their prior level of function was independent with all ADL's prior to admission. The focus of the treatment was restoration, compensation and adaptation. The assessment showed Resident 15 had functional limitations due to a hip contracture and PT would address the contracture impairment by further assessing and ordering or fabricating an orthotic device. Review of the occupational therapy (OT) Discharge summary dated [DATE] showed the resident continued to require significant assistance with self-care tasks. Review of the quarterly minimum data set assessment (MDS-a required assessment tool) on 03/20/2026 showed the resident had limited range of motion in both lower extremities and they did not receive a restorative nursing program. (continued on next page)

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Life Care Center of Skagit Valley	1462 West State Route 20 Sedro Woolley, WA 98284

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 05/11/2026 at 11:08 AM, Resident 15 stated they had limited range of motion in their ankles while demonstrating they could not dorsiflex (bending the ankle so the foot moves closer to shin). They stated they did not get exercises, or range of motion (ROM) and were not on an RNP. In an interview on 05/13/2026 at 9:36 AM, Resident 15 was in bed and stated the Hoyer lift hurt their joints, and they could really only move their ankles. In a follow up interview and observation on 05/13/2026 at 3:17 PM, Resident 15 stated they had arthritis and a history of falls. The resident again demonstrated their limited range in their bilateral ankles and inability to dorsiflex. Review of the clinical record on 05/13/2026 showed the resident did not have contracture management, or an orthotic device and was not on an RNP. In an interview on 5/13/2026 at 1:50 PM, Staff C, Assistant Director of Nursing Services (ADNS) stated Resident 15 did not have an RNP but that did not mean they did not need one. Staff C stated they would get a referral back to therapy for them. Staff C stated they currently had 15 restorative programs ordered. They stated there were issues when restorative staff were off for six weeks. Staff C stated they needed to review the policy. The RNP binder was requested but not provided. <RESIDENT 63> Resident 63 admitted on [DATE] with diagnoses to include upper spinal degeneration, bilateral artificial knee joints, muscle weakness and limitation of activities due to disability. Review of the OT Discharge summary dated [DATE] showed Resident 63's prognosis to maintain their current level of function was excellent with consistent staff support and showed an RNP was established. In an interview on 05/11/2026 at 10:12 AM, Resident 63 was up in their wheelchair and stated they only got restorative once or twice a week because that was all the time Staff U, Restorative Aide (RA) had for them. The resident stated Staff U was the only restorative aide and they were busy helping the aides on the floor. The resident stated they tried to work their exercise bands at night to avoid a decline and to get their legs stronger. Review of Resident 63's clinical record showed there were two restorative programs ordered; ROM (Range of Motion) Program #1 Provide resident with passive range of motion (PROM) to lower extremities (LE), 3 to 6 days/week. Staff were to document repetitions and minutes engaged in the activity. ROM Program #2 Encourage resident to participate in group exercise program 3-5 days a week for at least 15 minutes. Document total time in participation. Review of the February restorative documentation showed Resident 63 received Program # 1 four (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times and received Program # 2 seven times. Review of the March restorative documentation showed Resident 63 received Program # 1 six times and Program # 2 five times. Review of the April restorative documentation showed Resident 63 received Program # 1 and # 2 twice. Review of the May restorative documentation showed Resident 63 received Program # 1 six times and Program # 2 three times. Review of Resident 63's clinical record from 05/14/2025 to 05/14/2026 showed there was no evidence of any periodic evaluation of the RNP by the licensed nurse. In an interview on 05/13/2026 at 10:17 AM, Staff N, Regional Director of Clinical Services (RDCS), stated Staff C, ADON, oversaw restorative and stated they knew the facility was working on the restorative process. In an interview on 05/15/2026 at 10:02 AM, Staff Q, Registered Nurse stated the facility had been down to one restorative aide and Staff T, RA was pulled today from their RA duties to work the floor. Staff Q stated restorative was often pulled to the floor. <RESIDENT 79> Resident 79 was admitted to the facility initially on 10/24/2024 with the most recent admission of 03/19/2026 and with diagnoses to include muscle weakness, difficulty in walking, both knees joint replacement and limitation of activities due to disability. Review of Resident 79's MDS dated [DATE] documented impairment on both sides of lower extremities. Review of Resident 79's progress notes from 01/01/2026 - 05/15/2026 documented no refusals for restorative program. Review of Resident 79's restorative nursing documentation for January 2026 - May 2026 did not have restorative tasks for charting. Review of Resident 79's care plan dated 03/05/2026 documented functional goal care plan interventions as restorative active range of motion (AROM) program #2 daily and to document the time and repetitions completed with a start date of 04/28/2025. Restorative AROM program #3 upper extremity AROM daily and to document the time and repetitions completed with a start date of 04/28/2025. Both interventions were system cancelled on 03/16/2026. In a review of the restorative documentation, Resident 79 had documentation to include restorative program #2 and #3 completed twice in March and once in April. The resident was documented as out of facility five times. No further documentation was provided. In a review of the facility's daily schedule from 05/01/2026-05/15/2026 documented the RA's were pulled from their restorative duties to work the floor five times. On 05/02/2026 and 05/05/2026 no RA (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was scheduled. In an interview on 05/13/2026 at 2:43 PM, Staff C, stated they are in charge of the restorative program until the new Staff Development Coordinator had been trained and can take it over. Staff C stated that one of their two RA's were on leave, so they have been short on RA's during that time and the other RA was pulled from restorative duties due to other staff calling off. Staff C stated restorative duties cannot be picked up by other aides due to needing the restorative aide training. Staff C stated that restorative programs will be documented in the resident's care plan and then should go onto the aides tasks for them to document in the electronic medical record. Staff C stated they asked for a PIP (Performance Improvement Project) to be initiated for this to improve this process as they were frustrated there were so many pieces in place to get a functioning RNP. Staff C stated the program needed help and they needed more restorative aides to make the program successful. In an interview on 05/14/2026 at 10:41, AM Staff B, Director of Nursing Services (DNS) stated that Resident 79's restorative care plan was cancelled by the system and that they had not seen that issue before. Staff B stated they believed this may have happened due to the resident going out to the hospital in March 2026 and then readmitting to the facility. In an interview on 05/15/2026 at 9:39 AM, with Staff T, RA, stated they are both pulled from their restorative aide duties to work on the floor as a certified nursing assistant (CNA) and other times were scheduled to work the floor instead of doing restorative. In an interview on 05/15/2026 at 11:00 AM, Staff U, RA stated they were on leave and came back a week ago and did have days they were pulled from their restorative duties. In a joint interview on 05/15/2026 at 10:31 AM, with Staff B, Staff N, and Staff A, Administrator were informed of restorative concerns with Resident's 15, 63 and 79. Staff B stated they would see if Resident 15 would be agreeable to a restorative program. Staff A stated restorative and shower aides were pulled related to call ins, but they cannot get agency staff scheduled at the last minute. Reference WAC 388-97-1060 (3)(d)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to maintain residents' rights to privacy and choices for 2 of 3 residents (Residents 1 and 2) reviewed for dignity. Failure to ensure Resident 1 was provided privacy during cares and to determine preferences for Resident 2, placed the residents at risk for diminished dignity and decreased quality of life. Findings included.<RESIDENT 1>Review of Resident 1's medical record on 05/11/2026 documented severe cognitive impairment, on hospice services with anticipated decline in condition. In observations on 05/11/2026, 05/12/2026 and 05/13/2026, Resident 1's room had space for three beds, with two beds in the room. Resident 1's bed was closest to the door, and Resident 1's roommate was closest to the window. There was no bed in the center space. It was observed that the window bed and the middle space had privacy curtains hung on tracks that could extend around the end of the bed. Resident 1 did not have a privacy curtain for their bed. There were metal chains hanging from a track in the ceiling where a curtain should be attached. In an observation and interview on 05/13/2026 at 10:33 AM, Staff G, Certified Nursing Assistant (CNA) knocked on Resident 1's closed door and opened it. From the hallway, Staff H, CNA was observed inside the room next to Resident 1's bed providing care to Resident 1, who was observed lying on their bed with the side of their unclothed body observable from the hall. Staff G stated they provided privacy by always making sure the door was closed and stated they pulled the privacy curtain between the beds. Staff H then looked up at the ceiling where the privacy curtain would be, shook their head, and stated they would tell housekeeping a privacy curtain was missing. Applying the reasonable person's concept, a reasonable person would not feel treated with dignity or respect if their privacy was not ensured during personal care and they were able to be observed by passersby in the hallway.In an observation and interview on 05/13/2026 at 1:37 PM, Resident 1's privacy curtain remained missing. Staff I, Housekeeping, was observed with their cart outside Resident 1's room. Staff I stated they replaced privacy curtains when they deep cleaned, if they were visibly soiled, or when residents discharged . Staff I stated they had not been made aware of Resident 1's privacy curtain being missing and had not noticed it was missing when cleaning the resident's room. In an interview on 05/14/2026 at 12:32 PM, Staff E, Licensed Practical Nurse, Resident Care Manager, stated the managers did Angel Rounds and part of those rounds included looking for maintenance issues. Staff E stated the missing curtain should have been caught and the CNAs should be pulling privacy curtains around the bed when providing care. <RESIDENT 2>Record review on 05/12/2026 documented Resident 2 had severe cognitive impairment and was totally dependent on staff for activities of daily living such as transferring in and out of bed, and mobility.In an observation on 05/11/2026 at 11:22 AM, window installers were working on replacement of Resident 2's window. A large plastic sheet was removed to expose the window opening to the outside. Resident 2 was observed in their bed which was located next to the window. There were two men speaking loudly, laughing and playing music while working on the window. One man was observed stepping into the resident's room through the window opening several times as the workers prepped for the new window. The outdoor temperature was 55 degrees Fahrenheit, and a moderate wind was blowing into the room. Resident 2 was in bed with a light sheet and blanket and had their eyes closed. The bed and the window were less than three feet apart. There was an (undated) paper noted lying on the resident's bedside table that read: you are receiving this notice because your room windows will be replaced within the next 2 weeks.you have the option to remain in your room while the window replacement crew works, or to pass the time in another area of the building. Please report concerns to a staff member as soon as possible.In a continued observation, at 12:00 PM, Resident 2's window remained open with wind coming in. Resident 2 remained in bed. A resident in a nearby room was overheard to state it's cold in here. Staff M, Registered Nurse, brought Resident 2 an extra blanket only after having it brought to their attention to consider that the resident might be cold. There were (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequent loud banging sounds from the workers using nail guns right next to the resident's bed.In an interview on 05/12/2026 at 2:48 PM, Collateral Contact 1(CC1), Power of Attorney (POA), for Resident 2, stated they had not been notified that the windows were going to be replaced, and stated Resident 2 would not have been able to read or comprehend that paper notification. CC1 stated Resident 2 had recently moved to this room, and they were not notified until after the move had already occurred. CC1 stated Resident 2 had been sleeping a lot but could be easily irritated by noise and commotion. Applying the reasonable person concept, since the resident was not able to advocate for themselves, one would have expected the facility to have notified the resident's POA to determine if the resident would have preferred to have been moved from the area while window replacement occurred. Reference WAC 388-97-0180 (1)-(4)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviewed, the facility failed to ensure notification to the Office of the State Long-Term Care Ombudsman (LTCO - resident advocates) occurred for 2 of 4 sampled residents (Residents 9 and 12) reviewed for hospitalization. The failure to notify the LTCO and ensure written notification was provided to the resident/resident representative, in a language and manner they understood, placed residents at risk for lack of advocacy, to have the opportunity to make informed decisions about their transfer/discharge rights and possible unidentified or unmet care needs. Findings included .<RESIDENT 9> Resident 9 initially admitted to the facility on [DATE]. Resident 9 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. Review of Resident 9's progress notes documented on 04/18/2026 at 3:01 PM, by Staff S, Licensed Practical Nurse (LPN), Resident 9 was transferred emergently to the hospital. Review of Resident 9's electronic medical record (EMR) had no documentation of a notice of transfer and discharge (NOTD) form or Ombudsman notification related to the hospital discharge. <RESIDENT 12> Resident 12 initially admitted to the facility on [DATE]. Resident 12 was transferred to the hospital on [DATE] and had not returned to the facility. Review of Resident 12's progress notes documented on 05/07/2026 at 5:16 PM, by Staff S, LPN, Resident 12 was emergently transferred to the hospital. Review of Resident 12's EMR had no documentation of an NOTD form or Ombudsman notification related to the hospital discharge. In an interview on 05/14/2026 at 9:38 AM, Staff S, LPN stated when a resident was transferred to the hospital they are expected to do a bed hold form. Staff S was unaware of what an NOTD form was and assumed the Resident Care Manager (RCM) would know and be the one to do it. In an interview on 05/14/2026 at 2:05 PM, Staff Y, Social Services Assistant stated they did the NOTD for planned discharges and notified the Ombudsman via email and that was scanned into the resident's EMR. Staff Y stated they believed the RCMs would do the NOTD for emergency discharges such as to the hospital. In an interview on 05/14/2026 at 2:10 PM, Staff B, Director of Nursing Services, stated they were unaware they had to complete the NOTD and Ombudsman notification for residents transferred to the hospital. In an interview on 05/14/2026 at 2:17 PM, Staff D, LPN/RCM, Staff F, LPN/RCM, and Staff C, Assistant Director Of Nursing (ADON) were asked about the process of residents being transferred to the hospital regarding the NOTD and Ombudsman notification and Staff D and Staff F were unaware of the process. Staff C stated they would be doing education with the nurses about the process and (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would try to find Resident 9's and Resident 12's NOTD documentation for their hospital transfers. Reference WAC 388-97-0120(2)(a-d)(5)(b)(i), -0140

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (Resident 1) reviewed for activities received an ongoing program of activities to meet the individual resident's physical and mental needs. Based on the reasonable person concept, not having adequate recreation and/or sensory stimulation placed the resident at risk for social isolation, lack of stimulation and diminished quality of life. Findings included .Resident 1 was admitted to the facility on [DATE]. According to the quarterly Minimum Data Set (MDS)(an assessment tool) dated 04/02/2026, Activity preferences that were documented as very important to Resident 1 included: books, newspapers, magazine, music, news, doing things with groups of people and going outside. The MDS assessed the resident with severely impaired cognition.Record review of Resident 1's activities care plan on 05/13/2026 documented none of Resident 1's preferred activities were included. During observations on 05/11/2026, 05/12/2026, 05/13/2026 and 05/14/2026, Resident 1 was observed in their room with no TV, no music available, no books, magazines, no forms of stimulation observed to be provided in the room. In an interview on 05/14/2026 at 10:58 AM, Collateral Contact 2 (CC2) stated that Resident 1 had a TV, but it was never turned on for them when they visited. CC2 stated they visited about once a week. CC2 also stated Resident 1 liked music. In an interview on 05/14/2026 at 9:51 AM, Staff W, Activity Director, stated they conducted the activities interview for the MDS and tried to communicate with family to gather information for residents who were not interviewable and the care plans were based on those responses. Staff W stated that for residents who were not able to attend groups they provided one to one visits. Staff W stated they also had radios and other items available. Staff W stated they would visit Resident 1 in their room and would talk with them. Resident 1 was bedbound. Staff W stated they had not provided any music or other activity items to Resident 1. Staff W did not know why none of Resident 1's stated preferred activities had been implemented. Reference WAC 388-97-0940(1)(2)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 2 of 5 residents (Residents 13 and 63) were free from significant medication errors. The residents' medication orders were not followed per physicians' orders. Failure to properly hold and/or administer medications placed the residents at risk for complications including increased low blood pressure, low pulse, adverse health events and a potential decline in their condition. Findings included . Review of the facility's policy titled, Administration of Medications, revised 05/06/2020, showed medications were to be administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. <RESIDENT 13> Resident 13 re-admitted on [DATE] with diagnoses to include heart disease and high blood pressure. Review of the current physician's orders documented the resident was to receive Amlodipine 5 milligrams (mg) and Lisinopril 10 mg once a day for high blood pressure beginning 08/16/2024. There were hold parameters for the Lisinopril if the systolic blood pressure (SBP, top number) was less than 110 and/or the heart rate was less than 60. Another order was in place for Hydralazine 25 mg once a day for high blood pressure beginning 08/20/2025. The order directed nurses to hold the medication for SBP less than 140 or pulse less than 60. Review of the Medication Administration Records (MARS) beginning 03/01/2026 showed Amlodipine and Lisinopril doses were not held as the physician ordered on: -03/16/2026 Pulse 57, -03/23/2026 Pulse 52. Lisinopril was administered on 04/23/2026 when the SBP was below 110. Hydralazine was held on 03/02/2026 when the blood pressure (BP) was 142/60 and pulse 60. Hydralazine was administered 03/06/2026 when the blood SBP was below 140. Review of the April and March 2026 MARs showed there was no location to document vital signs (VS) prior to the evening doses of Hydralazine. Hydralazine was administered 10 evening shifts in April and two evening shifts in May. In addition, Resident 13 received Tylenol 650 MG on 03/14/2026 and 03/27/2026 when the resident had already received 3,000 mg of Tylenol with a parameter not to exceed order of 3,000 mg per day. <RESIDENT 44> Resident 44 was admitted to the facility on [DATE] with multiple cardiac diagnoses including high blood pressure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current physician's orders showed the resident was to receive Losartan Potassium twice a day for high blood pressure beginning 01/02/2026. The medication was to be held for SBP less than 100 or pulse less than 50. Review of the MARS beginning 03/01/2026 showed Losartan Potassium doses were not held as the physician ordered on: -03/18/2026 Pulse 49, -03/22/2026 Pulse 48, -04/12/2026 Pulse 49, -04/22/2026 Pulse 49, -04/29/2026 Pulse 45, -05/10/2026 Pulse 49, -05/11/2026 Pulse 45. In a joint interview on 05/14/2026 at 2:18 PM, Staff C, Assistant Director of Nursing and Staff F, Licensed Practical Nurse (LPN/RCM, stated they were unaware of any parameter issues. Staff F stated they did not audit MAR's. In an interview on 05/15/2026 at 10:02 AM, Staff Q, Registered Nurse stated if the residents blood pressure or pulse was low, they would hold the medication per doctors' orders. They stated they would then review their vital sign history and notify the doctor if there was a pattern. In an interview on 05/15/2026 at 10:31 AM, Staff B, Director of Nursing Services, stated they did periodic MAR audits and reviewed blood pressures in clinical meeting. Staff B stated they needed to re-educate the nurses on parameters. They stated they had completed an audit recently after they became aware there were issues with medication parameters. Reference WAC 388-97-1060 (3)(k)(iii)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 2 of 3 residents (Residents 57 and 92) reviewed for transmission-based precautions (TBP), 1 of 2 staff (Staff O, Certified Nursing Assistant - CNA) reviewed for environmental disinfection of equipment. The facility failed to ensure the staff were wearing appropriate personal protective equipment (PPE) in accordance with recommended national standards and failed to ensure staff were compliant with appropriately disinfecting reusable resident equipment. These failures placed all residents and staff at risk of potential infection. Findings included .Review of Center for Disease and Control (CDC) guidance titled, Viral Respiratory Pathogens Toolkit for Nursing Homes, revised 03/30/2026, documented to apply appropriate TBP based on suspected cause of the infection and the use of Droplet precautions (facemask/respirator, gowns, gloves, and eye protection). Review of the facility policy titled, Enhanced Barrier Precautions, revised 08/19/2025 documented the facility should use enhanced barrier precautions (EBP) as an additional strategy for residents that meet certain criteria during high contact resident care activities.residents with indwelling devices such as urinary catheters, and feeding tubes. high contact resident care activities required the use of gown and gloves while transferring, dressing, providing hygiene, and changing linens. Review of the facility policy titled, Cleaning and disinfection of non-critical patient care equipment, revised 07/15/2025 documented non-critical reusable equipment will be cleaned daily and before and after every use. Review of the facility policy titled, Transmission Based Precautions and Isolation Procedures, revised 12/23/2025 documented the facility must utilize TBP when a resident arrived at a nursing home with a confirmed infection.The facility should refer to the CDC for guidance on isolation precautions.use of droplet precautions applied when respiratory droplets contain pathogens such as respiratory viruses. In a continuous observation on 05/12/2026 at 11:57 AM, resident room [ROOM NUMBER] was observed to have a Contact Isolation Precautions (which requires all that enter to wear gown and gloves) sign outside the door, there was a cart with PPE supplies next to the door entry. The door to the room was open, there were two staff members observed in the room with gowns and gloves on, they were assisting a resident into the bed. Around 12:30 PM, there was a sign on the door that stated it was the room of Resident 57, according to the electronic medical records the resident was sent to the hospital on [DATE] and had now readmitted to the facility with a diagnosis of Respiratory Syncytial Virus (RSV - required droplet precautions). Observations continued until 2:00 PM of room [ROOM NUMBER], the residents call request light was observed to go on several times, with multiple staff responding. All the staff that entered the room were observed to wear gowns and gloves, at no time was the staff observed wearing face masks or face shields. In a continuous observation and interview at 05/12/2026 at 1:10 PM, Staff P, Certified Nursing Assistant (CNA) and Staff O, CNA, were observed to enter room [ROOM NUMBER], for Resident 92. Outside the door of room [ROOM NUMBER] was a sign for EBP isolation precautions. Staff P and Staff O were observed to enter the room without any PPE, with the mechanical lift machine, they were overheard telling Resident 92 they were going to transfer them back into the bed from the wheelchair. At 1:16 PM, Staff O exited the room and pushed the mechanical lift down to another room and entered the room and shut the door. Staff P exited the room and was asked what the protocol was for EBP. Staff P stated that Resident 92 was on EBP as they had a catheter and a feeding tube. Staff P stated if they would have provided peri care (cleaning of the genitals, groin, and anal area) then they would have worn a gown and gloves. Staff P was then asked to review the EBP sign that stated all staff were to wear a gown and gloves for high-risk care activities that included transferring. Staff P stated they agreed with what the guidance stated and stated they would go ask and come back. At 1:18 PM, Staff P returned and stated, I was apparently wrong, and yes we should have been wearing gowns and gloves. At 1:28 pm, Staff O exited the room (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505318	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the mechanical lift and parked it in the hallway. Staff O was asked what education they had received at the facility regarding disinfection of reusable equipment. Staff O stated they were told they were to disinfect the mechanical lift if someone had an infectious disease, other than that they do not have to disinfect after each use. In an observation on 05/13/2026 at 10:47 AM, room [ROOM NUMBER] for Resident 57 was observed to now have a Droplet Isolation Precautions sign outside the door. In an interview on 05/13/2026 at 12:30 PM, Staff K, Licensed Practical Nurse (LPN)/Infection Preventionist (IP) was asked why the isolation had changed for Resident 57. Staff K stated they were busy working the floor as a cart nurse yesterday and had not had time to review the precautions for Resident 57 until sometime after 3:00 PM. Staff K stated Resident 57 had RSV and that required droplet precautions not contact. In an interview on 05/14/2026 at 2:37 PM, Staff K stated they were the full-time IP for the facility. Staff K stated they had to work on the floor as a cart nurse on day shift (6:00 AM - 2:00 PM) the week of 05/11/2026 - 05/15/2026. Staff K was asked who supported them when they were sick or pulled to work on the floor, they stated the Director of Nursing Services (DNS) was also certified and would assist. Staff K stated that the expectation for all staff was to follow any isolation signs that are placed outside of the room. Staff K stated they were informed that staff had not been following the EBP guidance and would follow up on that. Staff K stated that regarding Resident 57's isolation, they had mistakenly thought it was contact precautions, but later double checked once they were not working the floor and corrected the problem. Staff K stated they were aware several staff had been in the room for several hours working closely with Resident 57 without the proper PPE (mask and face shield) and stated they made a mistake. Staff K stated the facility expectation was staff were disinfecting the reusable equipment such as mechanical lifts after every use regardless of an infection or not. In an interview on 05/14/2026 at 3:14 PM, Staff B, DNS, stated the expectation was staff were following the correct isolation guidance that was recommended by the CDC, and equipment was disinfected after every use. Reference WAC 388-97-1320(1)(a)(2)(b)(5)(c)