STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505325	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bainbridge Island Health & Rehab Center	835 Madison Avenue North Bainbridge Island, WA 98110

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to accurately identify and/or monitor target behaviors that psychotropic medications (medications that alter mood and behavior used to treat mental health conditions) were initiated to treat, and to evaluate and individualize behavior interventions for 2 of 5 residents (Residents 32 & 7) reviewed for unnecessary medications. These failures detracted from staff's ability to assess the effectiveness and need for ongoing use of psychotropic medications, and placed residents at risk of receiving unnecessary medication, experiencing associated adverse side effects, unwanted effects on mood and behavior and a diminished quality of life Findings included. 1) Resident 32 was admitted on [DATE] with diagnoses of anxiety disorder and dementia. Resident 32's Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 32 had moderate cognitive impairment. On 09/23/2025 at 11:01 AM, Resident 32 was observed to have difficulty answering a question, their face appeared worried, and they muttered I don't know what to do multiple times. On 09/25/2025 at 10:08 AM, Resident 32 was observed sitting up in bed, with breakfast tray on table. Resident 32 continually asked what activity was scheduled and was unable to participate in conversation due to perseveration on the activity schedule even after the schedule was verbalized. Resident 32's anti-anxiety medication care plan, initiated 04/08/2025 and updated 09/15/2025, showed Resident 32 received Buspirone (medication to treat anxiety) and had a goal of decreased episodes of s/sx [signs and symptoms] of anxiety. The care plan showed non-pharmacological (non-medicine) interventions: back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, and provide reassurance. Resident 32's antidepressant medication care plan r/t [related to] GAD [generalized anxiety disorder], dated 04/08/2025, showed Resident 32 received escitalopram (medication to treat depression and anxiety) and had non-pharmacological interventions: one on one, activity, adjust room temperature, back rub, change position, give fluids, give food, re-direct, remove resident from environment, return to room and toilet. Resident 32's Behavior/Psychoactive Medication IDT [intradisciplinary team) Review, dated 04/16/2025, showed Resident 32 had a history of generalized anxiety disorder, frequently became fixated on ideas, had a difficult time altering their thoughts, perseverated on their previous provider and health concerns. The IDT Review showed Resident 32 was receiving an antidepressant (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication for anxiety and an anti-anxiety medication for anxiety. The review showed the target behavior of restlessness with interventions; one on one, activity, adjust room temperature, back rub, change position, give fluids, give food, re-direct, remove resident from environment, return to room and toilet. The review showed the target behavior of tearfulness with interventions; back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, and provide reassurance. The review showed that IDT conclusion was the target behavior for both medications was perseverating on medical conditions. The IDT recommended continuing the current medications as ordered and update the target behaviors and interventions to be specific for the resident. Resident 32's Medication Administration (MAR), dated 08/01/2025 through 08/30/2025), showed staff were to document non-pharmacological interventions done: back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, and provide reassurance and one on one, activity, adjust room temperature, back rub, change position, give fluids, give food, re-direct, remove resident from environment, return to room and toilet as needed. The MAR had no documentation of interventions done. Resident 32's progress note dated 09/08/2025, showed Resident 32 was seen by the medical provider with ongoing issues with severe anxiety at times, perseveration on various tasks or worries about their health status to the point of becoming red in the face and having difficulty speaking. The note showed the medications were reviewed and orders received to increase the Buspar (medication for anxiety). Resident 32's Behavior/Psychoactive Medication IDT Review, dated 09/10/2025, showed Resident 32 received an antidepressant for anxiety and an anxiolytic (medication used to treat anxiety disorders) for anxiety. The Review showed Resident 32 continued to perseverate on health concerns, was difficult to redirect or distract from constant worry over what they should be doing and had 35+ episodes on the day shift in August. The Review showed the target behavior was perseverating on medical conditions. The Review showed the current interventions: one on one, activity, adjust room temperature, back rub, change position, give fluids, give food, re-direct, remove resident from environment, return to room and toilet and the interventions were effective at times. The Review showed the IDT recommended continuing current medications as ordered and psych [psychological] referral. Resident 32's Psych follow up provider note, dated 09/11/2025, showed Resident 32 was seen for a routine psychiatric follow up. The note showed that Resident 32's medication for anxiety had been increased due to anxiety symptoms. The note showed a heading of behavioral interventions with no documentation. Resident 32's Medication Administration (MAR), dated 09/01/2025 through 09/27/2025), showed Resident 32 had 275+ episodes on day shift of the target behavior, perseverating on medical conditions. The MAR showed staff were to document non-pharmacological interventions done: back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks/fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, and provide reassurance and one on one, activity, adjust room temperature, back rub, change position, give fluids, give food, re-direct, remove resident from environment, return to room and toilet as needed. The MAR had no documentation of interventions done. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/29/2025 at 10:08 AM, Staff B, Director of Nursing, said the IDT Behavior review was for reviewing medications and analyzing the target behaviors and interventions. Staff B said Resident 32's anxiety medication was increased on 09/08/2025 due to an increase in anxiety. When asked if the staff had changed the care planned behavioral interventions and/or individualized them to Resident 32's specific needs since admission, Staff B said it did not appear they did but would review the medical record. On 09/29/2025 at 2:02 PM, Staff B said they reviewed Resident 32's medical record and confirmed there had been no changes in the behavioral interventions, they are pretty standard. 2) Resident 7 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact, had diagnoses of anxiety disorder and bipolar disorder (mental health condition that causes extreme mood swings that include emotional highs, also known as mania, and lows, also known as depression), had a PHQ-9 score of four (0-4=None to minimal depression), demonstrated no behaviors, and received antidepressant medication during the assessment period. Review of the electronic medical record showed Resident 7 had a 08/30/2025 order for escitalopram (an antidepressant medication) daily for depression. A Behavior/Psychoactive Medication IDT Review, dated 08/20/2025, documented Resident 7 had shown signs of being easily agitated, had diagnoses of bipolar disorder and anxiety disorder, and received escitalopram with the target behavior identified as social isolation. The review showed Resident 7's son spoke with IDT member(s) and reported the best indicator that Resident 7 was experiencing anxiety was the resident's verbalization of it. The IDT documented Resident 7's target behavior for the use of escitalopram would be changed from social isolation to verbalization of anxiety. An antidepressant medication use related to bipolar and anxiety disorders care plan, initiated 08/06/2025, directed staff to monitor for episodes of depression as evidenced by verbalizing anxiety, to attempt non-pharmacological interventions to include conversing with children, reminiscing with others, offering snacks, and to offer to take to the Elder Grow Garden. Review of the September 2025 MAR showed the behavior monitor for the use of escitalopram directed staff to monitor for the target behavior Tearfulness. This was inconsistent with the identified target behavior of verbalization of anxiety as identified on Resident 7's care plan, as documented by the Behavior/Psychoactive Medication IDT review, and as reported by Resident 7's son. The nonpharmacological interventions/behavioral interventions identified on the MAR were one on one, activity, adjust room temperature, back rub, change position, give fluids, give food, redirect, refer to nurses' notes, remove environment, return to room, toilet, and other as needed. These behavioral interventions were not consistent with those identified on Resident 7's care plan. On 09/29/2025 at 9:37 AM, Staff B, DNS, confirmed staff were monitoring for the target behavior Tearfulness for the use of escitalopram. When asked if tearfulness was the target behavior identified for the use of escitalopram by the psychotropic IDT review , identified on the resident's care plan or identified by the resident's son Staff B said no. Staff B also acknowledged the nonpharmacological/behavioral interventions as identified on the residents care plan were inconsistent with the interventions staff were directed to [NAME] on the MAR. Staff B said the interventions should match. Reference WAC 388-97-0620 (1)(a).

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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 services provided met professional standards of practice for 2 of 14 sample residents (Residents 3 & 26) reviewed. Facility nurses' failure to follow and clarify Physician's orders when indicated, and to only sign for tasks that were completed, placed residents at risk for medication errors, skin breakdown and unmet care needs. Findings included . 1) Resident 3 readmitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 08/26/2025, showed the resident was cognitively intact, at risk of developing pressure injuries and required pressure redistribution devices for their bed and wheelchair. Review of the electronic health record (EHR) showed a 06/21/2025 order for a low air loss mattress with bolster cover and direction to facility nurses to check the mattress every shift for placement and function. An at risk for pressure ulcers care plan, with a target date of 12/31/2025, also documented Resident 3 utilized a low air loss mattress with a bolster cover and directed licensed nurses to ensure proper functioning every shift. Observations on 09/23/2025 at 11:16 AM, 09/26/2025 at 10:16 AM and 09/29/2025 at 06:39 AM, showed Resident 3 did not have a low air loss mattress in place. Review of the September 2025 Treatment Administration Record (TAR) showed from 09/23/2025 - 09/29/2025 facility nurses signed that they validated the placement and function of Resident 3's low air loss mattress on 12 of 13 shifts (one shift was left blank). On 09/29/2025 at 9:33 AM, Staff B, Director of Nursing Services (DNS), confirmed Resident 3t had a foam mattress with bolsters not a low air loss mattress as ordered. When asked why facility nurses signed on 12 of 13 shifts (during the survey) they validated the placement and function of a low air loss mattress that was not there Staff B, DNS, indicated the nurses had erroneously signed for a task they had not completed. 2) Resident 26 was admitted on [DATE] with a diagnosis of heart disease. Resident 26's physician orders, dated 06/26/2025, showed staff were to administer Midodrine (medication to treat low blood pressure) every 12 hours as needed for hypotension (low blood pressure) if SB [systolic blood pressure] is less than 100. Resident 26's Medication Administration Record (MAR), dated 09-01-2025 through 09-30-2025, showed blood pressure readings of 86/57 on 09/18/2025 and 89/60 on 09/20/2025. The MAR showed no documentation Midodrine was administered. On 09/29/2025 at 9:30 AM, Staff B, Director of Nursing, confirmed after a review of Resident 26's electronic medical record, the staff did not administer the Midodrine on 09/18/2025 and 09/20/2025 per the physician orders. Reference WAC 388-97--1620(2)(b)(i)(ii),(6)(b)(i) .

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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 provide activity programming designed for and to support cognitively impaired residents in their preferred activities for 2 of 5 residents (Residents 26 & 53) reviewed for activities. This failure placed residents at risk of boredom, restlessness, and a decreased quality of life.Findings included. Review of the facility's Activities policy, revised May 2016, showed the facility would provide for an ongoing program of activities designed to meet, in accordance with their comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Activities meaningful to the resident would be provided at various times throughout every day and evening based on the needs and preferences of each resident. 1) Resident 26 was admitted on [DATE] with diagnosis of severe dementia. The Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 26 had severe cognitive impairment and required staff assistance with activities of daily living. Resident 26's activity care plan, dated 02/11/2025, showed Resident 26 had a potential alteration in diversional activities and benefits from 1:1 activity visit, sensory stimulation programming and small group settings. The care plan showed the goal: use Resident 26's activity interests and strengths to enhance their sense of well – being and/or improve quality of life daily over the next 90 days as evidence by activity logs/progress notes/assessments. Care plan interventions showed: Resident 26 would benefit from all activities and encourage participation in all activities, especially small group activities, invite to and encourage activities with a low stimulation environment when available, assist outside for fresh air and provide 1:1 program to support in-room activities with supplies, conversation and comfort. Resident 26's psychiatric follow up provider notes, dated 08/25/2025, showed Resident 26 had ongoing dementia with cognitive impairment and staff were to encourage structured activities to support orientation and reduce agitation. On 09/22/2025 at 11:36 AM, Resident 26 was observed sitting in the hallway in front of the nursing station. Resident 26 was staring down the hallway. Resident 26 had no food/fluids and/or activity materials available to them. On 09/22/2025 at 12:05 PM, Resident 26 was observed attempting to stand when Staff G, Housekeeper, came over and asked Resident 26 to have a seat. Resident 26 had no food/fluids and/or activity materials available to them. On 09/22/2025 at 12:08 PM, Resident 26 was observed attempting to stand at the nursing station counter and Staff G pushed Resident 26 in their wheelchair over against the wall. Resident 26 was observed with no food/fluid and/or activity materials available to them. On 09/22/2025 at 12:41 PM, Resident 26 was observed attempting to stand. Staff D, Activity Director, was observed to ask Resident 26 to sit down and offered the resident something to drink. Resident 26 had no food and/or activity materials available to them. On 09/22/25 at 12:53 PM, Resident 26 was observed attempting to stand, a staff member was (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed asking Resident 26 to sit down. Resident 26 had no food/fluids and/or activity materials available to them. On 09/24/2025 at 9:00 AM, Resident 26 was observed in the hallway in front of the nursing station in their wheelchair with a magazine. On 09/24/2025 at 9:21 AM, Resident 26 was observed in the hallway in front of the nursing station in their wheelchair pushing the tray table away from them and attempting to stand. A staff member was observed asking Resident 26 to sit down. On 09/24/2025 at 9:26 AM, Resident 26 was observed in the hallway in front of the nursing station in their wheelchair attempting to stand, a staff member came over and told Resident 26 to sit back and tilted the wheelchair back and asked them to write in their notebook. On 09/25/2025 at 12:29 PM, Staff D, Activity Director, said they were responsible for the activity programming, and they provided programming that included physical, social, emotional, interactive and spiritual activities. Staff D said they provided activities based on the residents' assessment and care plans. Staff D said they communicated daily activities in the activity calendar and the daily chronicle, but they changed daily. When asked about what activities on the calendar were small groups with low stimulation, Staff D said those activities are not listed on the calendar. Staff D said they do 1:1 activity with residents that need that type of activity and/or when they see a small group of residents that are bored, they put together an activity, for example balloon toss and/or darts. Staff D said they had a great program for residents with cognitive impairment, they do 1:1 activities and occasional activities when they see the residents are bored and the evening activity assistant did the same. When asked what activities they planned and/or provided for Resident 26 for 09/22/2025 through 09/25/2025 during the hours of 8:00 AM to 4:00 PM, staff D said they talked to the resident and had offered them darts that morning. Resident 26's Activity Task documentation, dated 09/01/2025 through 09/22/2025, showed documentation of two creative activities, three mental activities, two social activities, one religious activity and no entertainment and/or 1:1 activity. The Task documentation showed an average of four times per week of independent activity of walking/wheeling and one episode of reading and one episode of TV. The documentation showed no resident refusals. On 09/25/2025 at 2:37 PM, Staff D, Activity Director, was observed passing out papers to residents sitting in the hallway in front of the nursing station. The noise in the area was loud and there were multiple staff members congregating around the area and in the nursing station. Visitors were observed walking through the residents to access the staff at the nursing station to ask questions. Staff D was observed handing Resident 26 a piece of paper and asked Resident 26 if they could find an apple on the paper and then proceeded down the hallway to deliver papers to the residents. Resident 26 was attempting to stand and self-propelling their wheelchair forward with the paper in their hand. Staff D returned at 2:49 PM and asked Resident 26 if they found the apples, the area continued to have multiple staff members in the vicinity, talking to each other and residents creating a noisy atmosphere. On 09/29/2025 at 9:15 AM, Staff D, Activity Director, said they knew as a facility they could improve their programming for cognitively impaired residents, and they had added an evening assistant and reached out to a consultant to assist them in improving their program. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident 53 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively impaired, dependent on staff for most activities of daily living, and had the following activity preferences: listening to music, having access to newspapers, books and magazine, and going outside for fresh air when the weather was nice were identified as Somewhat important, and being around pets/animals was Very important.Review of the Activity care area assessment (CAA) showed the resident was at risk for reduced activity participation due to cognition, depression and anxiety, and staff would proceed to care plan. Review of the comprehensive care plan showed the Activity care plan had not been developed (note: the comprehensive care plan was not required to be completed yet.) Resident 53's Initial Care Plan, dated 09/18/2025, showed direction to staff to Engage in simple, structured activities that avoid overly demanding tasks. Prefers: (SPECIFY ACTIVITY). Resident 53's preferred activities were not identified. Review of Resident 53's Activity - admission Evaluation, showed it was opened on 09/24/2025, six days after admission but was not performed. On 09/25/2025 at 2:37 PM, Resident 53 was sitting in their wheelchair, which was positioned in the hallway in front of the nurse's station with several other residents. The environment was noisy, with multiple staff congregating at and around the nurses' station and visitors attempting to navigate through the residents/staff. Staff D, Activity Director, was observed passing out papers to the residents in the area including Resident 53 and then proceeded down the hallway. Resident 53 did not appear to understand what the piece of paper was or why it was provided, so they sat there holding in their hand. At 2:42 PM Resident 53 was still grasping the piece of paper. No further interaction with facility staff had occurred. At 2:44 PM Resident 53 asked a nearby staff member why they were there. The staff member responded for rehabilitation. At 2:49 PM Staff D returned and asked some residents positioned close to Resident 53 if they could find the apples on the paper but did not directly interact with Resident 53. Visitors, staff and other residents continued to navigate through/around the residents positioned in front of the nurse's station. At 2:51 PM Resident 53 was asked if they wanted to lie down. Review of Activity documentation showed staff documented Resident 53 actively participated in a word/card game on 09/25/2025. Further review showed from 09/18/2025 -/09/25/2025 no social, religious, trips, or one on one activities were provided. The only other activity documentation present was for a reading activity on 09/22/2025 and for participation in the independent activity of passively watching television on 09/21/2025, 09/22/2025, 09/23/2025 and 09/25/2025. On 09/29/2025 at 10:47 AM, Staff D, Activity Director, said when a new resident admitted they would perform an activity evaluation to identify their preferred activities, cognition etc. When asked what was done with the information Staff D stated an activity program was set up as soon as possible and would be further personalized with completion of their MDS. Review of Resident 53's Activities admission evaluation on 09/29/2025 at 10:52 AM, showed it remained incomplete, 11 days after the resident admission, as did then resident's preferred activities on the initial care plan. Reference WAC 388-97-0940 (1)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. .Based on observation, interview and record review, the facility failed to ensure food was prepared in a manner that conserved nutritive value and palatability for 3 of 3 residents (Residents 53, 6, & 19) who required pureed meals. The failure to follow written recipes in th preparation of pureed food placed residents at risk of receiving food with decreased nutritive value and decreased satisfaction with meals. Findings included .On 09/25/2025 at 6:44 AM, Staff E, Cook, was observed preparing pureed sausage links. Staff E used a utensil to push approximately 16 link sausages off a pan into a metal tin. The metal tin was thin dumped into a food processor and pulsed x 3. The contents were then dumped into a pitcher. Staff E took the pitcher over to the beverage machine and added an unmeasured amount of hot water. Staff E then returned to the food processor and emptied the contents of the pitcher into it and blended the mixture for 1 minute. Once stopped the mixture was observed to be thin and soupy. Staff E removed the lid from a container of thickener and tapped it on the edge of food processor dumping an unmeasured amount of thickener with each tap. The mixture was then blended for 30 seconds but still appeared thin and soupy. Staff E poured the mixture into a new container and began mixing it by hand. Staff E again grabbed the thickener and tapped it three times on the edge of the container again delivering an unmeasured amount of thickener with each tap. After mixing it by hand Staff E indicated it was still a little too thin and added more thickener by tapping against the edge of the container twice delivering an unmeasured amount of thickener with each tap. Staff E proceeded to mix it by hand then stated, It is good, you want to see and presented the mixture. On 09/25/2025 at 6:58 AM, when asked if there was a recipe for the pureed sausage Staff E said there was but indicated they had been a cook for so long that they were able to prepare the correct texture by looking at it. Review of the pureed sausage recipe showed to make 25 servings/portions, 25 sausage links would be mixed with three and one quarter cups of water or broth and two tablespoons of thickener. The recipe showed that if there were varying sizes of single portion food items dietary staff were to adjust the recipe accordingly to ensure recipe integrity and serving amount.On 09/25/2025 at 11:17 AM, when asked if the cook should follow the pureed recipes when preparing pureed food to ensure nutritive value, palatability and appropriate texture was maintained Staff F stated, Yes, they should.Reference WAC 388-97-1100(1),(2).