STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505326	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Extended Healthcare	1649 East 72nd Tacoma, WA 98404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement a process to maintain inventory of residents' personal belongings for 2 of 3 residents (Residents 1 and 2) reviewed for loss of personal property. This failure placed residents at risk for inability to safeguard personal property, inability to receive replacement/reimbursement for missing property, and increased the risk of theft, loss and misappropriation.Findings included. Review of a facility policy titled, Notice of Theft and Loss Control Policy, updated March 2025, showed that the facility made reasonable efforts to safeguard resident property and valuables, and that suspected theft or loss of resident property was timely and thoroughly investigated. The policy further showed that Personal Belonging Inventory was completed upon admission and updated as items were sent home and new items were brought in to the facility. Resident 1Resident 1 was admitted to the facility on [DATE] for skilled nursing and physical and occupational therapy services after surgery. Resident 1 was their own responsible party and was alert and oriented to person, place, time and situation. Resident 1 was able to make their needs known and they were able to understand others. During interview on 06/23/2026 at 12:01 PM, Resident 1 stated that they had several items that had gone missing since they admitted to the facility, to include three bottles of fragrance, eight baseball jersey-style tops that had Resident 1's name embroidered across the back, and two sweat suits that had Resident 1's name embroidered across the back. Resident 1 stated that they had the fragrance shipped to the facility since they admitted , but all the clothing they already had upon admission. Resident 1 further stated that no one completed inventory for their personal belongings, the facility ignored the grievances they filed about the missing items, saying they were not replacing anything because they could not prove it was there, and that facility staff had told Resident 1 to limits personal belongings and not have items shipped to the facility because things continued to come up missing. Review of a grievance form, dated 04/01/2026, showed that Resident 1 was missing many personal clothing items that were labeled with Resident 1's name. The written response from the facility was that a police report was filed. Review of a grievance form, dated 5/19/2026, showed that Resident 1 was still missing their clothing (jersey's and sweat suits with their name on them), and was requesting that laundry be searched and it they weren't found, that they be reimbursed for the missing clothing. The written response from the facility was that they were previously filed as a claim, the items were not on Resident 1's inventory list, and Resident 1 was informed to send their items to their fiance. Review of another grievance form, dated 05/19/2026, showed that Resident 1 reported a pair of earbuds missing. The written response from the facility was that Resident 1 was informed to not send items to the facility, and if they did, to add them to their inventory sheet. Review of another grievance form, dated 05/19/2026, showed that Resident 1 reported a corset and three bottles of cologne were missing. The written response from the facility was that Resident 1 was informed that wedding supplies were to be sent to their spouse and not the facility. During interview on 06/24/2026 at 11:35 AM, Staff C, Registered Nurse (RN), stated that when a new resident admits to the facility, a certified nursing assistant (CNA) would complete their personal belongings inventory sheet, and if new belongings were brought in, staff would add the items to the resident's inventory sheet. Staff C, RN, stated that the inventory (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505326	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Extended Healthcare	1649 East 72nd Tacoma, WA 98404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sheets were kept in a binder at the nurses' station. Review of the binder at the nurses' station showed that there was no inventory sheet for Resident 1. Review of Resident 1's electronic health record (EHR), showed no inventory sheet present and the facility was unable to provide an inventory sheet for Resident 1. Resident 2Resident 2 was admitted to the facility on [DATE]. Review of the binder at the nurses' station showed that there was no inventory sheet for Resident 2.Review of Resident 2's EHR showed no inventory sheet present and the facility was unable to provide an inventory sheet for Resident 2. During interview on 06/24/2026 at 12:30 PM, Staff A, Administrator, stated that when new residents admit, an inventory sheet should be completed, and as new items were brought in, those items should be added to the resident's inventory sheet with the assistance of facility staff. The inventory sheet should then be scanned into the resident's EHR, and every resident should have an inventory sheet on file. Staff A, Administrator, further stated that the facility had identified a weakness in this process. Reference WAC 388-97-0640 (2)(a)(3)(d).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505326	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heartwood Extended Healthcare	1649 East 72nd Tacoma, WA 98404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to conduct a thorough investigation into a resident's allegations of neglect to determine if abuse or neglect had taken place for 1 of 3 residents (Resident 3) reviewed for investigations. This failure placed residents at risk for ongoing abuse and/or neglect, feelings of insecurity in the facility, unmet care needs, psychological harm, and a diminished quality of life.Findings included. Review of the electronic health record (EHR) showed that Resident 3 admitted to the facility on [DATE] with a diagnosis of quadriplegia (paralysis affecting arms, legs and torso). Further review of the EHR showed that Resident 3 was totally dependent on staff for mobility and all care needs. Resident 3 was alert and oriented and was able to communicate their needs to the staff. Review of a grievance form, dated 06/01/2026 at 07:45 AM, showed that Resident 3 reported that the previous midnight (06/01/2026 at 12:00 AM) two male nursing assistants agreed to reposition Resident 3 every two hours through the night, but they never came back. The grievance further showed that Resident 3 reported that the same thing had happened many times before, and that not being repositioned puts them in a lot of pain. The grievance showed that the facility converted this complaint into a reportable allegation of neglect, and the facility reported it to the State Agency. Review of the facility incident investigation, initiated 06/01/2026 and concluded 06/02/2026, showed that nursing documentation and staff assignments were going to be reviewed, staff interviews were to be conducted, Resident 3's care plan would be reviewed and revised, and that Resident 3 would be assessed for any skin impairments, pain, and any other adverse outcomes. Further review of the investigation showed no staff interviews, no resident interviews, no resident assessments, and no documentation of investigation findings to determine whether neglect had taken place. Review of the EHR, on 06/24/2026, showed that Resident 3's care plan had not been updated after the allegation was made, and there were no follow-up progress notes to show that Resident 3 had been monitored for continued care concerns. During an interview on 06/23/2026 at 12:52 PM, Resident 3 stated that the facility had not done anything in response to their report about not being turned through the night. Resident 3 stated that no one had come to talk to them or ask them any questions about their concerns. Resident 3 stated that it had been an on-going issue that had not yet been resolved. During an interview on 06/24/2026 at 2:00 PM, Staff B, Director of Nursing (DNS), stated that they could not provide staff interviews and that Resident 3's care plan had not been updated post-investigation. During the same interview, Staff A, Administrator, stated that it was expected that the facility conduct a thorough investigation into allegations of abuse and neglect, and that staff should have monitored Resident 3 for on-going concerns after the allegation was made. Reference WAC 388-97-0640(6)(a)(b).