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	03/30/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to identify fall trends, evaluate the effectiveness of previous fall prevention interventions and to implement progressive resident centered interventions for 1 of 2 sampled residents (Resident 66) reviewed for falls. Resident 66, who had six falls in 10 weeks (two unwitnessed non-injury and four unwitnessed with injury), experienced harm when they fell, sustained a fracture of their right distal clavicle (collar bone) that required transfer to the emergency department for evaluation and treatment. This failure placed residents at risk of repeated falls and injuries. Findings included.Review of the electronic health record (EHR) showed Resident 66 admitted to the facility on [DATE] with diagnoses that included repeated falls, diabetes (too much sugar in blood), and dementia (decline in mental ability severe enough to interfere with daily life). Resident 66 was able to make needs known. Review of the minimum data set (MDS, an assessment tool), dated 01/19/2026, showed Resident 66 had a BIMS (a brief cognitive screening tool. 0-7 indicates severe cognitive impairment) score of 00 and required partial/moderate assistance with chair and toilet transfers. Review of the incident log from January 2026-March 2026 showed Resident 66 had unwitnessed non-injury falls 01/26/2026 and 02/11/2026. Resident 66 had unwitnessed falls with injury on 01/02/2026, 01/18/2026, 03/03/2026 and 03/14/2026. Review of Resident 66's Care Plan (CP) initiated 10/20/2025 showed the following interventions: Encourage call light use, initiated 10/20/2025. Do not put bed in lowest position, initiated 10/28/2025. Toilet Use: Max one person assist with toilet hygiene, initiated 11/06/2025. Encourage resident to call for assistance, initiated 11/06/2025. Frequent checks related to falls, initiated 11/11/2025. Encourage to attend social and recreational activities, initiated 12/31/2025. Offer assistance with toileting every two hours, initiated 12/03/2025. Review of the facility incident report, dated 01/02/2026, showed the incident report concluded the fall was Resident 66 was trying to pick up the remote. Resident 66 was transfered to the hospital and treated for a bruise on their face. No new interventions or corrective measures were documented. Review of the facility incident report, dated 01/18/2026, showed the facility concluded the fall was related to Resident 66's impulsiveness and continued to ambulate and self-transfer without using call light for assistance. Resident 66 sustained a skin tear of their left eyebrow where a previous fall bump was located. No new interventions or corrective measures were documented. Review of the facility incident report, dated 01/26/2026, showed the facility concluded the fall was the related to Resident 66 attempted to self-transfer to their wheelchair and fell due to the wheelchair brakes not being locked. Planned intervention to prevent recurrence was for therapy to assess their wheelchair for anti-lock brakes. Review of a document titled Fall Screening, dated 02/03/2026, showed a recommendation for patient to use anti-rollback device on wheelchair to prevent fall, notified staff. The document was signed by Staff K, Director of Rehabilitation (DOR). Review of the facility incident report, dated 02/11/2026, showed the facility concluded the fall was the related to Resident 66 attempted to go to the bathroom and slid from the wheelchair onto the floor. Planned interventions to prevent recurrence were continuing to encourage call light use, offer assistance to the bathroom and encourage to attend activities; interventions that were previously initiated on the (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 0689 Level of Harm - Actual harm Residents Affected - Few	CP. Review of a document titled Fall Screening, dated 02/12/2026, showed a recommendation for Patient has anti-rollback device on wheelchair to help with safety when standing. Maintenance placed on wheelchair today. Review of a document titled Fall Screening, dated 02/26/2026, showed Patient at baseline, continue nursing supervision and plan of care. Review of the facility incident report, dated 03/03/2026, showed the incident report concluded the fall was the related to Resident 66 attempting to transfer from their wheelchair to the bed. Resident 66 was transfered to the hospital and treated for a hematoma (pooling of blood outside of blood vessels) on their head. Planned interventions to prevent recurrence was to assess for safety upon return from the hospital. Review of Resident 66's Occupational Discharge summary, dated [DATE], showed a recommendation for a Left side brake handle extension, unable to locate. Review of the facility incident report, dated 03/14/2026, showed Resident 66 was found on the floor in the bathroom and unable to state what happened. The incident report concluded the fall was related to Resident 66's preference to not use their call light for assistance and self-transfer to the toilet. A staff witness statement noted Resident 66's bed was locked and in the lowest position. Resident 66 was taken to the hospital and treated for a fracture of their distal clavicle. During an observation and interview on 03/27/2026 at 11:28 AM, Staff J, Occupation Therapist (OT), observed Resident 66 attempted to roll their wheelchair backwards, but they were unable to. Staff J stated the anti-rollback device was not safe or appropriate due to Resident 66's impulse to stand when they could not roll backwards. Staff J stated their recommendation was for a brake handle extension as Resident 66 had a weak left side and was unable to unlock the left side wheelchair brake. Staff J stated nursing was responsible for ordering devices when a resident was not on therapy services. Observation and interview at 03/30/2026 at 9:31 AM, Staff K, Director of Rehabilitation, stated Resident 66 was discharged from therapy in January 2026 but should have been evaluated for therapy after the 01/18/2026, 01/26/2026 and 02/11/2026 falls. Staff K stated Resident 66 was in and out of the hospital and they were unaware of where ball was dropped. Staff K stated Resident 66 was not assessed in the wheelchair after the anti-rollback device was installed on the wheelchair for safety and to determine if the device was appropriate but should have been. During an interview on 03/27/2026 at 2:11 PM, Staff B, Director of Nursing Services (DNS), stated they were unaware of the recommendation for the brake extender; however, they did not believe that contributed to Resident 66's injury. Reference WAC 388-97-1060 (3)(g)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the facility's menus were prepared in advance, followed, and reflected input received from the residents and resident group for 3 of 3 sampled days (03/25/2026, 03/26/2026, and 03/27/2026) when reviewed for kitchen. This failure placed residents at risk of dissatisfaction with kitchen services, reduction in food consumed, avoidable weight loss, a decline in clinical condition, and a diminished quality of life. Findings included.Observation and record review on 03/26/2026 at 11:23 AM showed the facility menu for the week with entries for breakfast, lunch, and dinner daily hung in the facility's cafeteria. Review showed beef tip au jus, rice, seasoned peas, wheat roll, margarine, and frosted marble cake were scheduled to be served for lunch on 03/26/2026. Observation showed a sticky note was placed over the lunch menu entry for 03/26/2026 with carrots written by hand. Observation showed similar sticky notes placed over the lunch for 03/25/2026 with No apples, change to pineapple and peaches over the 03/25/2026 lunch entry and Diced potatoes not mashed over the dinner menu for 03/25/2026. Observation on 03/26/2026 at 12:52 PM showed residents were served beef tip au jus, rice, carrots, a piece of bread, and yellow cake for lunch (seasoned peas, wheat roll, and marble cake were not provided per menu). Review of the lunch menu for 03/27/2026 showed chicken fried rice, broccoli, egg roll, and tropical fruit. Observation on 03/27/2026 at 12:06 PM showed apricot was served in lieu of tropical fruit. During an interview on 03/27/2026 at 12:07 PM, Staff JJ, Dietary Manager, stated any substitutions to the menu were reviewed by the facility's registered dietician to ensure nutritional needs were still met and recorded on a substitution log. During an interview on 03/27/2026 at 12:31 PM, Staff JJ, Dietary Manager, stated the facility offered an alternative meal to the posted menu for the day. Staff JJ stated this alternative meal was not posted for residents to view and was based on what extra food was available in the kitchen. Review of the Menu Substitution Record showed on 03/26/2026 carrots were substituted for peas but did not show the substitutions of piece of bread for wheat roll or yellow cake for marble cake. Review showed on 03/25/2026 peaches and pineapple were substituted for baked apples but did not show diced potatoes were substituted for mashed potatoes. Review showed 10 substitutions were recorded for the month of March 2026 and 9 of 10 were due to a lack of product. During an interview on 03/30/2026 at 10:00 AM, Staff JJ, Dietary Manager, stated when a substitute needed to occur, they would have it reviewed by the registered dietician, record it in the Menu Substitution Record, and a sticky note would be put on the menu posted in the facility's cafeteria. Staff JJ stated residents were not informed of substitutions except by this sticky note. Staff JJ stated the alternative meal was not posted for residents, and residents would receive the alternative if the main menu contained items recorded as Dislikes on their tray card. Staff JJ stated the alternative menu was decided by whatever we have in stock and decided on the day it would be served. Staff JJ stated there was no system for residents to choose between the main or alternate meal. During an interview on 03/30/2026 at 10:38 AM, Staff A, Administrator, stated residents should be informed of substitutions to the menu and residents should be able to choose between the main course and the alternative menu item. Staff A stated the facility's menu system did not meet expectations. Reference WAC 388-97-1160(1)(a)(b), -1120(3)(c)(4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation interview and record review, the facility failed to implement an infection control program that ensured the surveillance of possible communicable diseases was completed for 1 of 3 months (January 2026) and to ensure the proper handling and processing of soiled linens for 1 of 1 laundry rooms when reviewed for infection control. These failures placed the residents at risk for infections, poor clinical outcomes and a decreased quality of life. Findings included.TrackingReview of the infection control logs for the month of January 2026 showed no infectious organisms were identified and included on the log. Further review showed an entry for Resident 110 dated 01/30/2026 which showed it was not a multidrug resistant organism (MDRO) and did not require special infection control precautions. Review of Resident 110's electronic health record (EHR) showed a laboratory test dated 01/20/2026 which identified Escherichia coli ESBL positive organism [an MDRO] confirmed, contact precautions should be observed with this patient. During an interview on 03/27/2026 at 1:37 PM, Staff E, Infection Preventionist/Registered Nurse (IP/RN), stated the month of January did not include the identified organisms and should have. Staff E stated they did not have access to hospital records and did not know which organisms were present for Resident 110. LaundryDuring an interview on 03/27/2026 at 10:10 AM, Resident 5 stated when they had missing clothing the facility let them go into the laundry room and look for them. Observation and interview on 03/27/2026 at 12:05 PM showed boxes of supplies being stored in the soiled linen sorting room with an open box of gauze bandages. There was one soiled linen barrel present. Staff V, Laundry, stated the soiled laundry room was currently being used for central supply and they sorted the soiled linens in the laundry room. Review of the temperature logs on 03/27/2026 for the month of March 2026 showed the last entry was on 03/24/2026. Staff V stated it should be monitored/logged every shift. During an interview on 03/27/2026 at 12:07 PM, Staff X, Central Supply, stated residents had come into the laundry room and looked through the non-labeled clothes for missing items. During an interview on 03/27/2026 at 12:07 PM, Staff B, Director of Nursing Services, stated soiled linens should be sorted in a separate area from the washing and the temperatures should be monitored daily. During an interview on 03/27/2026 at 1:37 PM, Staff E, RN/IP, stated it was their expectation that soiled linens be sorted separately from the clean linens and the temperature monitoring be completed daily. Staff E stated residents should not have been going through the laundry themselves. During an interview on 03/30/2026 at 11:12 AM, Staff A, Administrator, stated soiled linens being sorted in the washing area, temperature monitoring not being completed, and residents going through the laundry themselves did not meet expectations. Staff A stated it was their expectation that the infection preventionist reviewed all infectious disease labs results to ensure appropriate antibiotics and precautions were in place. Reference WAC 388-97-1320(2)(a)(3)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safety devices did not restrict residents' ability to move and the resident or resident representative consented to the use of restrictive safety devices for 3 of 4 sampled residents (Residents 66, 105 and 51) reviewed for physical restraints. This failure placed the residents at risk of being unnecessarily restrained and a diminished quality of life. Findings included.Resident 51 Review of the electronic health record (EHR) showed Resident 51 was admitted to the facility on [DATE] with diagnoses to include hospice (end of life care), depression, anxiety and vascular dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain). Resident 51 was not able to communicate their needs. Review of the quarterly minimum data set (MDS, a required assessment), dated 02/24/2026, showed Resident 51 was dependent on staff for completing activities of daily leaving (ADL). Review of the EHR showed Resident 51 last weight was 75.4 pounds on 01/07/2025. Observation on 03/23/2026 at 10:25 AM, showed Resident 51 laid in bed in a fetal position with a fragile, small body frame, with half side rails (metal device approximately three feet long and one foot and a half tall) on both sides of the bed. Resident 51 was surrounded by the side rails in bed. Observation on 03/25/2026 at 8:53 AM showed Resident 51 laid in bed with curled up feet and half size side rails up in the bed. Observation on 03/26/2026 at 11:48 AM showed Resident 51 watching TV in bed with half side rails up in bed. Observation on 03/27/2026 at 9:23 AM showed Resident 51 was assisted by staff to eat breakfast and the side rails were up in bed. Review of a Device and Bed Rail/Bed Enabler Evaluation and consent dated 09/05/2025 showed Resident 51 had Grab/Assist/Mobility Bars/Bed Canes – Bilat (canes are metal device that are the same height as the rails and are 10-12 inches or one foot in length). Review of the care plan problem for falls revised on 10/27/2025 showed Resident 51 had intervention for bilateral grab bars to aid with bed mobility initiated 09/05/2025. During an interview on 03/26/2026 at 1:12 PM, Staff R, Registered Nurse/Unit Manager, stated the process for restraints and devises was to have therapy evaluate residents first and if appropriate the nurses would follow up with consent and assessment. Staff R could not find documentation to explain half side rails use for Resident 51. During an interview on 03/27/2026 at 1:35 PM, Staff B, Director of Nursing Services (DNS), stated any device that could be a potential restraint should have assessment, consent and be periodically reassessed. Staff B stated the use of half side rails without accurate assessment did not meet their expectations. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 66 Review of the EHR showed Resident 66 admitted to the facility on [DATE] with diagnoses that included repeated falls, diabetes and dementia (decline in mental ability severe enough to interfere with daily life). Resident 66 was able to make needs known. Review of the 01/19/2026 5-day MDS showed Resident 66 was able to independently wheel 150 feet once seated in a wheelchair/scooter, and the ability to wheel at least 150 feet in a corridor or similar space. Observation on 03/23/2026 at 11:23 AM showed Resident 66 sat in their manual wheelchair which had an anti-rollback device (a safety mechanism, commonly used on wheelchairs, designed to prevent the chair from moving backward unintentionally) attached to both wheels. Resident 66 expressed frustration of not able to self-propel backwards. Review of Resident 66's EHR showed no order or consent for the use of the anti-rollback device. During an observation and interview on 03/27/2026 at 11:28 AM, Staff J, Occupation Therapist (OT), stated they had no knowledge of a referral for the anti-rollback device. Staff J observed Resident 66 attempted to roll their wheelchair backwards, but they were unable to. Staff J stated the anti-rollback device was not safe or appropriate due to Resident 66's impulse to stand when they could not roll backwards. Resident 66 informed Staff J that they did not like the wheelchair because they could not move backwards. During an interview and observation on 03/27/2026 at 12:43 PM, Staff M, Certified Nursing Assistant, stated the anti-rollback device was installed on the wheelchair after Resident 66 had a fall. Staff M stated Resident 66 was unable to self-propel backwards and would instead attempt to stand to move the wheelchair. Staff M stated this was unsafe for Resident 66. During an interview and observation on 03/30/2026 at 9:31 AM, Staff K, DOR, confirmed Resident 66 was restrained from propelling backwards and should not have been. Staff K stated Resident 66 was not assessed in the wheelchair after the anti-rollback device was installed on the wheelchair for safety and to determine if the device was appropriate but should have been. During an interview on 03/27/2026 at 2:11 PM, Staff B, DNS, stated the anti-rollback device was installed incorrectly and that was the reason Resident 66 was unable to self-propel their wheelchair backwards. Resident 105 Review of the EHR showed Resident 105 admitted to the facility on [DATE] with diagnoses to include dementia (decline in mental ability severe enough to interfere with daily life), unsteadiness on feet, and cognitive communication deficit (difficulty communicating, speaking, listening, reading, or writing, because of underlying thinking problems rather than just language issues). Observation on 03/26/2026 at 1:25 PM showed Resident 105 with a wander guard wrist band (a device used to prevent from wandering or eloping by triggering an alarm when approaching an exit) securely fastened to the left wrist. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 105's EHR showed no provider orders for the use of the wander guard, no wander guard assessment or informed consent, and the quarterly minimum data set assessment (MDS) dated [DATE] showed a wander/elopement alarm was not used. During an interview and joint observation of Resident 105 on 03/26/2026 at 2:23 PM, Staff C, Registered Nurse/Unit Manager (RN/UM), stated Resident 105 had an elopement risk evaluation dated 03/11/2026 for exit seeking; however, it did not include an evaluation/assessment for a wander guard. Staff C stated they were unable to locate provider orders, an assessment, an informed consent, or function and placement monitoring for the use of a wander guard, and these should have been in place. Staff C stated Resident 105's wander guard was located on the left wrist and would be hard for the resident to remove due to being securely fastened. During an interview on 03/27/2026 at 9:53 AM, Staff B, DNS, stated they were not aware that Resident 105 did not have provider orders, an assessment, an informed consent, or documentation to showed function and placement was checked for the use of the wander guard prior to or at the time of application of the device and there should have been. Reference WAC 399-97-0620(1)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Nursing Home Transfer/Discharge Notices and bed hold notices at the time of transfer to the hospital for 4 of 4 sampled residents (Residents 5, 6, 66, and 110) reviewed for hospitalization. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital, protection of resident's rights during transfer, and diminished quality of life. Findings included. Resident 5Review of the electronic health record (EHR) showed Resident 5 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's (progressive disorder that destroys memory and thinking skills), depression, and atrial fibrillation (heart rhythm disorder where the upper chambers are out of sync with the lower chambers). Resident 5 was transferred to the hospital on [DATE] for injuries to their head. Review of the EHR showed Resident 5 did not have Nursing Home Transfer and Discharge Notice or bed hold notice for the 01/18/2026 transfer. Resident 6Review of the EHR showed Resident 6 was admitted to the facility on [DATE] with diagnoses to include dementia (brain disorder that impairs memory, thinking and interferes with activities of daily life), diabetes (high blood sugar), and high blood pressure. Resident 6 was transferred to the hospital on [DATE] for vomiting. Review of the EHR showed Resident 6 did not have Nursing Home Transfer and Discharge Notice or bed hold notice for the 12/13/2025 transfer. Resident 66Review of the EHR showed Resident 66 was admitted to the facility on [DATE] with diagnoses to include atrial fibrillation, heart failure and dementia. Resident 66 was transferred to hospital on [DATE] for hip pain. Review of the EHR showed Resident 66 did not have Nursing Home Transfer and Discharge Notice or bed hold notice for the 12/05/2025 transfer. Resident 110Review of the EHR showed Resident 110 was admitted to the facility on [DATE] with diagnoses to include diabetes, traumatic subdural hemorrhage (brain injury causing bleeding in the brain), and high blood pressure. Resident 110 was transferred to hospital on [DATE] for critical blood test results. Review of the EHR showed Resident 110 did not have Nursing Home Transfer and Discharge Notice or bed hold notice for the 01/27/2026 transfer. During an interview on 03/25/2026 at 10:36 AM, Staff D, Social Service Director, stated when a resident was transferred to the hospital, the nurses sent a copy of the transfer notice and bed hold and the next day the business office manager would follow up. Staff D presented copies of Nursing Home Transfer and Discharge Notices for Residents 110 and 5. The notices had not applicable (n/a) written on the date when the notice was given and not applicable on the space that said notice provided to. During an interview on 03/26/2026 at 8:41 AM, Staff S, Licensed Practical Nurse, stated when a resident was transferring to the hospital, the nurses made a packet that included medical record information plus Nursing Home Transfer or Discharge Notice and bed hold. Staff S stated that it was mandatory and copies were available at the station. Upon reviewing the folder of copies, only Nursing Home Transfer or Discharge Notice forms were available (there were no bed hold form). During an interview on 03/30/2026 at 10:19 AM, Staff A, Administrator, stated the nurses were to present the Nursing Home Transfer or Discharge Notice with a bed hold and then the business office manager was to follow up on completing them. Staff A stated lack of documentation and bed hold for the above four residents did not meet expectations. Reference WAC 399-97 -0120(1)(2)(a)-(d)(3)(a)(4)(b)(5), -0080 -0140(1)(a)-(c)(i)-(iii)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately code the resident assessment for 6 of 20 sampled residents (Residents 11, 32, 51, 33, 10, and 105) reviewed for accuracy of assessments. Failure to accurately code Residents 11 and 32's use of blood thinning medication, Resident 51's use of side rails, Resident 33's use of a breathing device, Resident 10's dental status, and Resident 105's use of a safety device placed residents at risk of unmet care needs, inaccurate information in the electronic health record, and diminished quality of life. Findings included.Resident 11 Review of the electronic heath record (EHR) showed Resident 11 was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis following cerebral infarction (paralysis or weakness on one side of the body due to tissue death in the brain), dementia (decline in thinking skills caused by conditions that block or reduce blood flow to the brain), high blood pressure and depression. Resident 11 was not able to communicate their needs. Review of the quarterly minimum data set assessment (MDS) dated [DATE] showed Resident 11 was coded for using an anticoagulant (medication that interferes with blood clotting process). Review of the December 2025 and January 2026 medication administration records (MAR) showed Resident 11 was not administered anticoagulant medication. Resident 32 Review of the EHR showed Resident 32 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (final stage of kidney disease), anemia (lack of red blood cells), heart failure and substance abuse disorder. Resident 32 was able to communicate their needs. Review of the admission MDS dated [DATE] showed Resident 32 was coded for using an anticoagulant medication. Review of February 2026 MAR showed no anticoagulant been administered. During an interview on 03/30/2026 at 10:51 AM, Staff O, Registered Nurse (RN)/MDS, stated Residents 11 and 32 had coding errors. During an interview on 03/27/2026 at 1:40 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was for MDS to be coded accurately. Resident 51 Review of the EHR showed Resident 51 was admitted to the facility on [DATE] with diagnoses to include hospice (end of life care), depression, anxiety, and vascular dementia. Resident 51 was not able to communicate their needs. Review of the quarterly MDS, dated [DATE], showed Resident 51 was dependent on staff for completing activities of daily leaving (ADL). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/23/2026 at 10:25 AM showed Resident 51 lying in bed in a fetal position with a fragile, small body frame, with half side rails (metal device approximately three feet long and one foot and a half tall) on both sides of the bed. Resident 51 was surrounded by the side rails in bed. Observation on 03/25/2026 at 8:53 AM showed Resident 51 lying in bed with curled up feet and half sized side rails up in the bed. Observation on 03/26/2026 at 11:48 AM showed Resident 51 watching TV in bed with half side rails up in bed. Observation on 03/27/2026 at 9:23 AM showed Resident 51 been assisted by staff to eat breakfast and the side rails were up in bed. Review of the care plan problem for falls revised on 10/27/2025 showed Resident 51 had intervention for bilateral grab bars to aid with bed mobility initiated 09/05/2025 and revised on 10/27/2025. Review of the quarterly MDS dated [DATE] showed Resident 51 was not marked as using bedrails in section P and not marked as having six months or less to live in section J. During an interview on 03/26/2026 at 1:27 PM, Staff O, RN/MDS, stated the coding for Resident 51 's J section was not correct, and section P was unclear to when the side rails were initiated. Staff T stated the half side rails/device should have been on the MDS. Resident 33 Review of the EHR showed Resident 33 admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD, a lung disease that makes it hard to breath) and congestive heart failure (CHF). The resident was able to make needs known. Observation and interview on 03/24/2026 at 11:56 AM showed Resident 33 in bed, there was a bilevel positive airway pressure (BIPAP, a non-invasive form of ventilation) machine at the resident's bedside. Resident 33 stated they wore it when sleeping. Review of the EHR showed a provider's order for BIPAP machine to be worn while sleeping with a start date of 04/14/2025. Review of the administration record for January 2026 showed the resident was wearing the BIPAP daily. Review of the quarterly MDS dated [DATE] showed the resident was not using the BIPAP machine. During an interview on 03/26/2026 at 9:56 AM, Staff O, RN/MDS, stated the MDS was inaccurate and Resident 33 should have been marked for yes for non-invasive ventilator/BIPAP. During an interview on 03/26/2026 at 10:12 AM, Staff B, DNS, stated it was their expectation that the MDS be coded accurately to reflect the resident's care needs. Resident 10 Review of the EHR showed Resident 10 admitted to the facility on [DATE] with diagnoses to include quadriplegia with incomplete damage to the neck (spinal cord damaged causing partial (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paralysis/partial or complete loss of muscle function and/or feeling to all four limbs and torso/trunk of the body), high blood pressure, and depression. Resident 10 was able to make needs known. During an interview on 03/24/2026, Resident 10 stated they had a dental exam two or more months ago and were told they had broken upper teeth that needed to be pulled. Resident 10 stated it took longer to chew their food because of it. Resident 10 stated they were still waiting for staff to set up a dental appointment for them. Review of the dental visit form dated 08/11/2025 showed Resident 10 had broken teeth or root tips and missing upper and lower teeth and red/irritated gum tissue. It showed handwritten on the form that tooth #4 caused pain and Resident 10 would like tooth extraction/removed. Review of a significant change MDS dated [DATE] that was coded No, for obvious or likely cavity or broken natural teeth and No, for mouth or facial pain, discomfort or difficulty with chewing. Review of the quarterly MDS dated [DATE] showed Resident 10 was coded No for mouth or facial pain, discomfort or difficulty with chewing. During an interview on 03/30/2026 at 2:30 PM, after reviewing Resident 10's EHR, Staff B, DNS, stated the MDS should have been coded for broken and missing teeth. Resident 105 Review of the EHR showed Resident 105 admitted to the facility on [DATE] with diagnoses to include dementia, unsteadiness on feet, and cognitive communication deficit (difficulty communicating, speaking, listening, reading, or writing, because of underlying thinking problems rather than language issues). Observation on 03/26/2026 at 1:25 PM showed Resident 105 with a wander guard wrist band (a device used to prevent from wandering or eloping by triggering an alarm when approaching an exit) securely fastened to the left wrist. During an interview on 03/26/2026 at 2:23 PM, Staff O, RN/MDS, stated Resident 105's care plan had an intervention for a wander guard that was initiated on 03/13/2026. Staff O stated Resident 105's quarterly MDS dated [DATE] was not coded accurately and should have been coded Used daily, for wander/elopement alarm. Staff O stated the MDS needed to be modified. During an interview on 03/27/2026 at 9:53 AM, Staff B, DNS, stated they were not aware that Resident 105's quarterly MDS dated [DATE] was coded Not used for wander/elopement alarm and should have been coded Used daily. Reference WAC 399-97- 1000(1)(a)(b)(4)(a)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and provide written information on the formulation of advanced directives for 2 of 3 sampled residents (Residents 99 and 15) reviewed for advanced directives. This failure placed the residents at risk of unmet needs and lack of knowledge of their rights to formulate an advanced directive. Findings included.Resident 99Review of the electronic health record (EHR) showed Resident 99 admitted to the facility on [DATE] with diagnoses of diabetes (when the body doesn't process sugars effectively) and foot wounds. The resident was able to make needs known. Review of Resident 99's EHR showed no documentation that the resident was provided with written information on or assistance with completing advanced directives (a legal form appointing a decision maker if the resident is no longer able to make decisions). Resident 15Review of the EHR showed Resident 15 admitted to the facility on [DATE] with diagnoses of end stage kidney disease and was receiving dialysis (a procedure that filters waste from the blood). The resident was able to make needs known. Review of Resident 15's EHR showed no documentation that the resident was provided with written information on or assistance with completing advanced directives. During an interview on 03/27/2026 at 10:20 AM, Staff D, Social Services Director, stated Residents 99 and 15 should have been offered assistance with formulating advanced directives when they were admitted but had not. During an interview on 03/30/2026 at 11:12 AM, Staff A, Administrator, stated it was their expectation that residents be reviewed for advanced directives and offered assistance with obtaining one if needed. Reference WAC 388-97 -0280(3)(c)(i)(ii), -0300(1)(b)(3)(a)-(c)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure personal property was protected for 1 of 1 sampled resident (Resident 9) when reviewed for personal property. This failure placed residents at risk loss of property, compromised dignity, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 9 admitted to the facility on [DATE] with diagnoses that included polyneuropathy (disease that effects multiple nerves in the body), diabetes (too much sugar in the blood) and dysphagia (difficulty swallowing). Resident 9 was able to make needs known. During an interview on 03/23/2026 at 11:29 PM, Resident 9 stated they were missing two pairs of jeans that were only worn once. Observation on 03/26/2026 at 10:36 AM showed Resident 9 reported to Staff H, Registered Nurse, the missing jeans. During an interview on 03/27/2026 at 11:56 AM, Resident 9 stated they had not been contacted regarding the missing jeans. Resident 9 stated the clothes they were wearing were from the facility's donation closet. During a Resident Council meeting held on 03/26/2026 at 10:00 AM, Council members stated when they sent their clothes to the laundry sometimes, they did not get them back. Council members stated the issues with laundry had been ongoing. Review of the grievance logs from October 2025 through March 2026 showed a total of 27 grievances related to missing clothing. During an interview on 03/30/2026 at 10:59 AM, Staff A, Administrator, stated the expectation was when residents had missing clothing a grievance should be completed by the staff it was reported to so it could be investigated or the resident could receive reimbursement. Reference WAC 388-97-0880(2)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate, investigate, and resolve a grievance for 1 of 1 sampled resident (Residents 9) reviewed for personal property and grievances. This failure placed the residents at risk for emotional distress and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 9 admitted to the facility on [DATE] with diagnoses that included polyneuropathy (disease that effects multiple nerves in the body), diabetes (too much sugar in the blood) and dysphagia (difficulty swallowing). Resident 9 was able to make needs known. During an interview on 03/23/2026 at 11:29 PM, Resident 9 stated they were missing two pairs of jeans that were only worn once. Resident 9 stated they had not reported the missing clothing to any members of staff. Observation on 03/26/2026 at 10:36 AM showed Resident 9 reported to Staff H, Registered Nurse (RN), the missing jeans. Review of the EHR showed no documentation related to Resident 9's concern. During an interview on 03/27/2026 at 11:23 AM, Staff D, Social Services Director, stated they had not received any grievances related to Resident 9's missing clothing concern. During an interview on 03/27/2026 at 11:56 AM, Resident 9 stated they had not been contacted regarding the missing jeans. Resident 9 stated the clothes they were wearing were from the facility's donation closet. During an interview on 03/30/2026 at 10:59 AM, Staff H, RN, confirmed Resident 9 reported missing clothing and stated they did not complete a grievance. During an interview on 03/30/2026 at 11:36 AM, Staff A, Administrator, stated the expectation was when residents had missing clothing a grievance should be completed by the staff it was reported to so it could be investigated or the resident could receive reimbursement. Reference WAC 388-97-0460

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure injuries of unknown sources were reported to the State Hotline for 1 of 2 sampled residents (Resident 5) when reviewed for accident hazards. This failure placed residents at risk for potential abuse/neglect and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 5 admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (loss of cognitive function), congestive heart failure (when the heart is unable to pump blood efficiently) and depression. Resident 5 was unable to make needs known. Review of the January 2026 accident and incident log showed an entry dated 01/19/2026 for a fall related to Resident 5 on 01/18/2026. The fall was logged as unwitnessed with Small bruises occurring in places generally vulnerable to trauma. The fall was said to be Reasonably related to the resident's condition. The action taken was medical treatment and was not reported to the State Agency according to the incident log. Review of the facility investigation dated 01/18/2026 showed, Floor nurse reported to CNA [Certified Nursing Assistant] that resident had bruising to the right side of the forehead. [Resident 5] had an unwitnessed fall potentially hit their head on the bottom of the overbed table. No pain or concerns noted. Power of Attorney (POA) notified and requested side rails to be put back on resident's bed for safety. Further review showed the facility concluded that the incident was reasonably related to Resident 5's Alzheimer's diagnosis with behavioral disturbances. Abuse and neglect were ruled out. Review of a progress note within the investigation dated 01/18/2026 showed Resident 5 was sent to the hospital due to a black and blue bruise observed on the right side of Resident 5's forehead. Review of a document titled Post-fall Huddle dated 01/18/2026 showed Resident 5 was found with bruising to forehead while sitting in their wheelchair in their room. Resident 5 was unable to recall what happened. The box for unwitnessed fall was checked. During an interview on 03/30/2026 at 10:20 AM, Staff B, Director of Nursing Services (DNS), stated after contacting the staff who worked on the day of the incident it was confirmed that Resident 5 did not have a fall. Staff B stated the incident was an injury of unknown origin and should have been documented on the incident log correctly and reported to the State Hotline. Reference WAC 388-97-0640(5)(a)

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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 thoroughly investigate the potential for abuse and/or neglect for 1 of 2 sample residents (Resident 9) reviewed for abuse and neglect. This failure placed Resident 9 at risk for psychosocial harm and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 9 admitted to the facility on [DATE] with diagnoses that included polyneuropathy (a neurological condition occurring when multiple nerves are damaged), diabetes (too much sugar in the blood), and dysphagia (difficulty swallowing). Resident 9 was able to make needs known. During an interview on 03/23/2026 at 11:24 AM, Resident 9 stated they pressed their call light and after 15 minutes Collateral Contact went to the nurse's station to request assistance which took an additional 30 minutes. During an interview on 03/23/2026 at 11:28 AM, Collateral Contact (CC), stated they were unhappy with the care Resident 9 was receiving. CC stated they worked in long term care and Resident 9's long wait time for a brief change was neglect. Allegation was reported to Staff A, Administrator, on 03/24/2026 at 10:30 AM. Review of the EHR on 03/24/2026 at 3:00 PM, 03/25/2026 at 12:47 PM and 03/26/2026 at 10:40 PM showed no alert charting or documentation related to the allegation neglect. During a joint interview on 03/27/2026 at 11:22 AM, Staff B, Director of Nursing Services (DNS), and Staff A, Administrator, stated Resident 9 was not put on alert for psychosocial well-being to monitor for psychosocial harm but should have been. Staff A, Administrator, stated this did not meet their expectations. Reference WAC 388-97-0640 (6)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop comprehensive care plans for 2 of 20 sampled residents (Residents 10 and 1) reviewed for care plans. Failure to develop care plans that accurately reflected resident care needs related to dental issues placed residents at risk for not receiving needed care and services, negative outcomes, and a diminished quality of life. Findings included.Resident 10 Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses to include quadriplegia with incomplete damage to the neck (spinal cord damaged causing partial paralysis/partial or complete loss of muscle function and/or feeling to all four limbs and torso/trunk of the body), high blood pressure, and depression. Resident 10 was able to make needs known. During an interview on 03/24/2026 at 9:17 AM, Resident 10 stated they had a dental exam two or more months ago and were told they had broken upper teeth that needed to be pulled. Resident 10 stated it took longer to chew their food because of it. Review of the dental visit form dated 08/11/2025 showed Resident 10 had broken teeth or root tips and missing upper and lower teeth and red/irritated gum tissue. It showed handwritten on the form that tooth #4 caused pain and Resident 10 would like tooth extraction/removed. Review of the current provider order dated 06/20/2025 showed Resident 10 was prescribed a regular diet with regular texture and thin liquids. Review of Resident 10's care plan initiated on 11/14/2024 showed no care plan that identified/reflected current dental status or interventions related to broken and missing teeth. During an interview on 03/30/2026 at 2:30 PM, Staff B, Director of Nursing Services (DNS) stated they were unable to locate Resident 10's dental issues related to broken and missing teeth and need for needed tooth extraction documented in their care plan. Staff B stated the resident's dental status/issues should have been care planned. Resident 1 Review of the EHR showed Resident 1 admitted to the facility on [DATE] with diagnoses that included cholecystitis (inflammation of the gallbladder), chronic kidney disease and rectal cancer (cancer of the anus). Resident 1 was able to make needs known. Observation and interview on 03/24/2026 at 9:59 AM showed Resident 1 had missing and broken upper teeth. Resident 1 stated they had tooth pain and it was starting to effect their ability to eat. Review of the admission MDS dated [DATE] showed Resident 1 was assessed to have Obvious likely cavity or broken natural teeth. Review of Resident 1's care plan initiated 01/08/2026 showed no interventions related to oral care or dental concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/30/2026 at 9:54 AM, Staff B, DNS, stated the expectation was upon assessment Resident 1's oral needs should have been care planned with clear goals and interventions. Reference WAC 388-97-1020(1), (2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and/or conduct quarterly care conferences in a timely manner to include the residents and/or their representative for 2 of 3 sampled residents (Residents 87 and 99) when reviewed for care planning. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included.Resident 87Review of the electronic health record (EHR) showed Resident 87 readmitted to the facility on [DATE] with diagnoses to include dependence on renal dialysis (the process of filtering blood to remove waste and excess fluids due to kidney failure), high blood pressure, and encephalopathy (the brain does not work properly, often causing confusion, altered mental state, or personality changes). Resident 87 was able to make needs known. During an interview on 03/24/2026 at 11:52 AM, Resident 87 stated they did not remember going to a care conference. Review of Resident 87's EHR showed a care conference document dated 11/17/2025 that Resident 87 had attended and participated in the conference; however, there were no other documented care conferences located in the EHR. During an interview on 03/27/2026 at 1:18 PM, Staff D, Social Services Director (SSD), stated Resident 87 had a care conference on 11/17/2025 and should have had a quarterly care conference in February 2026; however, they were unable to locate documentation that another care conference had occurred. During an interview on 03/20/2026 at 9:30 AM, Staff A, Administrator, stated care conferences were to be held upon admission, quarterly, as needed with a significant change in condition, and per resident and/or responsible party request. Staff A stated they were not aware Resident 87 did not have a quarterly care conference conducted and this did not meet their expectations. Resident 99Review of the EHR showed Resident 99 admitted to the facility on [DATE] with diagnoses to include diabetes (high blood sugar), chronic obstructive pulmonary disease (COPD, a lung disease making it difficult to breathe), and peripheral vascular disease (a circulation disorder, blood vessels outside the heart and brain become narrowed, blocked, or damaged). Resident 99 was able to make needs known. During an interview on 03/25/2026 at 9:43 AM, Resident 99 stated they did not remember going to a care conference. During an interview on 03/27/2026 at 1:26 PM, Staff D, SSD, stated Resident 99 admitted to the facility on [DATE] and should have had a care conference upon admission; however, they saw no documentation that one had occurred. Staff D stated a care conference needed to be scheduled and conducted for Resident 99. During an interview on 03/30/2026 at 9:34 PM, Staff A, Administrator, stated they were not aware that Resident 99 had not had a care conference upon admission and this did not meet their expectations. Reference WAC 388-97-1020(2)(e)(f)(4)(b)(d)-(f)

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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 providers orders were followed for 2 of 2 sampled residents (Residents 66 and 71) when reviewed for pain and edema. This failure placed residents at risk of increased pain and a decreased quality of life.Findings included.Resident 71 Review of the electronic health record (EHR) showed Resident 71 was admitted to the facility on [DATE] with diagnoses to include heart failure, diabetes (high blood sugar), anxiety and traumatic brain injury. Resident 71 was able to communicate their needs. Observation on 03/24/2026 at 11:40 AM showed Resident 71 laid in bed with their feet severely swollen. Resident 71 stated their legs were swollen and they may have a wound on the back of their leg. Review of the EHR showed Resident 71 had an order for TED hose (constrictive socks used to promote blood flow) to both lower legs to be on for 12 hours, dated 11/28/2025. During an interview on 03/26/2026 at 11:43 AM, Resident 71 stated nobody had talked to them about TED hose. During an interview on 03/26/2026 at 1:09 PM, Staff R, Registered Nurse/Unit Manager (RN/UM), stated the process for TED hose was to have order and care plan and the nurses would document in the administration record. Staff R stated Resident 71 had severe edema and the order for TED hose should have been discontinued. During an interview on 03/27/2026 at 1:47 PM, Staff B, Director of Nursing Services (DNS), stated the TED hose order should have been discontinued and it did not meet expectations. Resident 66 Review of the EHR showed Resident 66 admitted to the facility on [DATE] with diagnoses that included repeated falls, diabetes (too much sugar in the blood) and dementia (decline in mental ability severe enough to interfere with daily life). Resident 66 was able to make needs known. Review of the EHR showed a 01/09/2026 provider's order for lidocaine external patch to be applied to the right hip topically two times a day for pain related to moisture associated skin damage/fungal infection right thigh abscess. Review of the March 2026 Medication Administration Record showed the Lidocaine Patch was being applied at 8 AM and removed at 8 PM. There was no documentation that the patch was being applied two times per day as directed. During an interview on 03/26/2026 at 11:34 PM, Staff C, RN/UM, stated staff were applying the patch once daily and the provider's order of two times a day was written as such to allow an apply time and removal time on the MAR. During an interview on 03/26/2026 at 11:51 AM, Staff P, Advanced Registered Nurse Practitioner (continued on next page)

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	505326	A. Building B. Wing	03/30/2026

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(ARNP), stated the Lidocaine Patch was to be applied once daily and removed after 12 hours. Staff P stated the facility requested the order be written two times a day for documentation purposes. During an interview on 03/26/2026 at 12:42 PM, Staff B, DNS, stated the lack of communication to obtain the correct administration did not meet their expectations. Reference WAC 388-97-1620 (2)(d)(i)(ii),(6)(b)(i)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the necessary care and services to ensure that residents received their showers as scheduled and incontinent briefs for 2 of 3 sampled residents (Residents 9 and 1) reviewed for activities of daily living (ADLs). This failure placed the residents at risk for compromised dignity, unmet needs, and a diminished quality of life. Findings include. Resident 9Review of the electronic health record (EHR) showed Resident 9 admitted to the facility on [DATE] with diagnoses that included polyneuropathy (disease that effects multiple nerves in the body), diabetes (too much sugar in the blood) and dysphagia (difficulty swallowing). Resident 9 was able to make needs known. During an interview on 03/23/2026 at 11:46 AM, Resident 9 stated they were not receiving their showers consistently because there was only one shower aid. Review of the shower EHR showed Resident 9 received four showers in the past 30 days. During an interview on 03/25/20206 at 2:41 PM, Staff L, Certified Nursing Assistant, stated they were responsible for all showers in the building and did not always get to every resident but would try to offer on an alternate day. Staff L stated they did not always have time to turn in their shower sheets or did not always enter showers in the EHR due to internet issues. During an interview on 03/30/2026 at 10:32 AM, Staff B, Director of Nursing Services (DNS), stated the facility was in the process of hiring another shower aid and revising the shower schedule to accommodate resident needs. Staff B, DNS stated the expectation was that showers were offered to residents on their shower days or offered a make a shower if there were no staff to provide the shower on the scheduled day. Resident 1Review of the EHR showed Resident 1 admitted to the facility on [DATE] with diagnoses that included cholecystitis (inflammation of the gallbladder), chronic kidney disease and rectal cancer (cancer of the anus). Resident 1 was able to make needs known. During an interview on 03/24/2026 at 10:08 AM, Resident 1 pointed to a package of drugstore-brand briefs on their chair and stated they had requested incontinence briefs from the staff but never received any. During an interview on 03/30/2026 at 12:17 PM, Staff G, Central Supply, stated the facility did not have a formal process for residents to request briefs. Staff G stated staff would verbally inform them if a resident needed briefs. Staff G stated they did not keep documentation on if a resident received incontinent briefs and was not aware of when and if Resident 1 had received any. Staff G stated the facility was low on briefs in the last month due to the supplier. During an interview on 03/30/2026 at 12:32 PM, Staff B, DNS, stated Resident 1 not receiving incontinent briefs did not meet their expectations. Staff B stated briefs were always available for residents who needed them. Reference WAC 388-97-1060 (2)(a)(ii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 meal service for 1 of 3 sampled residents (Resident 8) reviewed for position and mobility. This failure placed the resident at risk for weight loss, malnutrition, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 8 was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis following cerebral infarction (paralysis or weakness on one side of the body due to tissue death in the brain), parkinsonism (disorder characterized by tremors, slowness and rigidity), asthma and epilepsy (condition of recurrent, unprovoked seizures caused by abnormal electrical activity in the brain). Resident 8 was able to communicate their needs. Review of the quarterly minimum data set (MDS, a required assessment) dated 01/01/2026 showed Resident 8 was dependent on staff for eating, oral care, hygiene, toileting, dressing and moving in and out of bed or chair. Observation on 03/23/2026 at 9:33 AM, showed Resident 8 was in bed with fan on. Resident 8 had a contracture (permanent tightening of muscle, tendon or skin tissue) to their right hand and the left hand was under the blanket. Resident 8 stated they were unable to move their extremities. Observation on 03/27/2026 at 9:24 AM showed Resident 8 was lying in their bed and the breakfast tray was placed on the table next to them. During an interview on 03/27/2026 at 9:25 AM, Resident 8 stated they were waiting for staff to come and help them eat. Roommate of Resident 8 stated breakfast arrived about 10-15 minutes ago. During an interview on 03/27/2026 at 9:43 AM, Staff U, Registered Nurse, was called to Resident 8's room and Staff U stated they would find out what was going on. Review of facility mealtime schedule on 03/27/2026 showed Resident 8's meal tray for breakfast was scheduled for delivery at 8:45 AM. During an interview on 03/27/2026 at 1:42 PM, Staff B, Director of Nursing Services, stated residents dependent on staff for assistance with meals should be assisted timely, and Resident 8's delay of breakfast did not meet expectation. Reference WAC 399-97- 1060(2)(c)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide prompt services to maintain vision for 1 of 3 sampled residents (Resident 10) reviewed for communication sensory. This failure placed the resident at risk of unmet vision needs, continued visual impairment, decreased mood, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses to include quadriplegia with incomplete damage to the neck (spinal cord damaged causing partial paralysis/partial or complete loss of muscle function and/or feeling to all four limbs and torso/trunk of the body), high blood pressure, and depression. Resident 10 was able to make needs known. During an interview on 03/24/2026 at 9:01 AM, Resident 10 stated their vision had become blurry quite a while ago and the last time they saw an eye doctor was about six months ago and were told they needed glasses. Resident 10 stated staff were aware they needed glasses; however, they never received any. Review of the focus care plan initiated on 05/15/2025 showed Resident 10 had moderate impaired visual function related to age related decline. It further had an intervention dated 05/15/2025 that showed, Arrange consultation with eye care practitioner as required. Review of the eye exam form titled, Summary Ocular Progress Notes, dated 05/15/2025 showed Resident 10's chief complaint was Blurred Vision. It showed Resident 10 was prescribed a new prescription for glasses. It further showed, Deliver glasses prescribed today 2 weeks from receipt of payment. This document was signed by the Examining Doctor. This form showed, Noted 5/29/25, and an initial, handwritten on the right lower corner of the form. During an interview on 03/30/2026 at 11:54 AM, Staff F, Scheduling/Transportation, stated Resident 10 had an eye exam document dated 05/15/2025 that showed a prescription for glasses and that they would be delivered in two weeks upon payment receipt; however, they should have gotten their glasses mailed to them by now. Staff F stated they were not aware that Resident 10 had not received their glasses and they needed to be followed up on. Staff F stated this did not meet their expectations. During an interview on 03/30/2026 at 2:18 PM, Staff B, Director of Nursing Services (DNS), stated they were not aware that Resident 10 had a prescription for glasses dated 05/15/2025 and that glasses had not been provided to the resident. Staff B stated that Resident 10 should have been provided with glasses prior to now and this did not meet their expectations. Reference WAC 388-97-1060 (3)(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure restorative nursing programs were provided, thoroughly evaluated for effectiveness, carried out, and accurately documented for 1 of 4 sampled residents (Resident 10) reviewed for rehabilitation and restorative services, and/or position and mobility. This failure placed the resident at risk for worsening mobility, developing contractures (permanent tightening of muscle, tendons and skin, leading to deformity), and diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses to include quadriplegia with incomplete damage to the neck (spinal cord damaged causing partial paralysis/partial or complete loss of muscle function and/or feeling to all four limbs and torso/trunk of the body), high blood pressure, and depression. Resident 10 was able to make needs known. Observations on 03/24/2026 at 9:27 AM, 03/25/2026 at 9:01 AM, 03/26/2026 at 10:04 AM, and 03/27/2026 at 9:17 AM showed Resident 10 did not have any braces and/or splints applied to any body part. Observation and interview on 03/26/2026 at 10:04 AM showed Staff Q, Restorative Aide, providing passive range of motion (PROM, the movement of a joint through the range of motion with no effort from the resident) to Resident 10's bilateral upper extremity (BUE, shoulders, elbows, wrists, and hands) and bilateral/both lower extremities (BLE, hips, knees, ankles, and feet). Staff Q stated they provided range of motion (ROM, full movement potential of a joint) from head to toe for Resident 10. Observation showed no splints/braces or Prafos boots (used to suspend/off load the heel and for the management/treatment of contractures) were applied. Resident 10 stated that Staff Q provided PROM at the same time every day. No other restorative programs were observed or mentioned as being provided by Resident 10 or Staff Q. During an interview and observation on 03/27/2026 at 9:17 AM, Resident 10 stated they used to wear boots on their feet; however, they got a sore on both their heels and now used a pillow to float their heels. Resident 10 had a pillow placed at the foot of the bed and both heels were floated. Resident 10 stated they did not wear any splints or braces, and they had no wounds or skin issues. Review of the Risk Versus Benefit Form, with an effective date of 10/31/2025, showed Resident 10 was explained risks vs benefits for refusing care/services as recommended and/or ordered by the physician or care team for the management of contractures that included, After PROM apply splint to BLE. Keep splint on for up to 4hrs [four hours] or to toleration. Check skin for red areas when removing splint. Prafos boots for 4 hours. It showed Risks included skin breakdown and Benefits included, Provides support, pain relief, alignment of fingers/body parts. Boots off load pressure from LE [lower extremities]. Review of the Therapy to Restorative Nursing Communication Form, dated 11/16/2024 showed program recommendations included: PROM all joints upper / lower **AS TOLERATED.** Review of the Therapy to Restorative Nursing Communication Form, dated 03/05/2025 showed program recommendations included: PROM + AAROM [active assisted ROM, the resident to perform the exercise but requires some help/physical support from the staff] BLE in all planes 2 X 10 reps [two sets of 10 repetitions]. Review of the Therapy to Restorative Nursing Communication Form, dated 05/30/2025 showed program recommendations included:- Continue ROM to BUE with emphasis on AAROM of B [bilateral/both] shoulder/elbow.- Fine motor tasks to improve functional use of hands. Examples: peg board/ring stacking/dominoes **AS TOLERATED.** Review of Resident 10's EHR showed a focused care plan for [Resident 10] benefits from restorative program due to Self-care deficit, initiated on 05/19/2025, included interventions for the following nursing restorative programs:-AAROM Program Bilateral shoulders and elbows for 15 minutes a day 3-6 days a week, initiated on 01/31/2026.-Fine motor tasks to improve functional use of hands examples are: peg board, ring stacking, dominoes for 15 minutes a day 3-6 days a week, initiated on 01/31/2026-Splint/Brace Program. Prafos boots for 4 hours. Risk/benefits completed for resident (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wanting boots on all night and for significant other to put them on/off, initiated on 05/19/2025. Review of Resident 10's restorative program documentation from 02/26/2026 - 03/27/2026 for Splint/Brace Prafos boots on in AM for 4 hours, then doff. Showed every day was documented Activity did not occur It showed PROM BLE/BUE all joints, all planes. Program to run 15 min per day, 3-6x per week as tolerated and was documented as completed and no other programs were noted as being provided. Review of Resident 10's current provider orders showed no order for a splint/brace or Prafos boots. Review of the Restorative Programs overview progress note dated 03/26/2026 showed the interdisciplinary (IDT) restorative meeting was held on 03/26/2026 with overview of participation of programs PROM BUE/BLE, B [bilateral] PRAFOS boots (4hrs), fine motor tasks. It showed, Progress towards goal(s): upon look back participation with programs noted. Changes to program(s): no changes at this time and would continue with IDT Intervals of evaluations for participation. This review was inaccurate due to Resident 10 had not had Prafos boots applied to BLE and no fine motor tasks were documented as provided and/or completed. During an interview and observation on 03/27/2026 at 12:42 PM, Staff Q, Restorative Aide, stated that they provided PROM to all joints of Resident 10's BUE and BLE and was able to show documentation in the computer system. Staff Q stated Resident 10 had not been applied splint/brace Parfos boots and documentation showed, Activity did not occur, Staff Q stated the splint brace program should have been discontinued because the resident refused to have them put on. Staff Q stated those were the programs being provided and documented on. During an interview on 03/30/2026 at 2:44 PM, Staff B, Director of Nursing Services, stated Resident 10 did not have an order for splints/braces or Prafos; however, it was care planned. Staff B stated Resident 10's restorative programs should have been documented and reviewed appropriately because the resident was not getting the Parfos/boots applied and restorative documentation showed activity did not occur. Staff B stated the IDT restorative meetings should have thoroughly reviewed Resident 10's nursing restorative programs and addressed these issues and that did not happen. Staff B stated this did not meet their expectations. Reference WAC 388-97-1060 (3)(d)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care and services were provided according to professional standards of practice for 2 of 4 sampled residents (Residents 106 and 12) when reviewed for respiratory care. Failure to provide oxygen (O2) per provider's order, notify provider when O2 saturation (Sats, measuring the percentage amount of O2 in the blood) were not within ordered parameters, clarify unclear O2 orders, and/or O2 use care planned placed residents at risk for negative outcomes, discomfort, unmet needs and a diminished quality of life. Findings included.Resident 106 Review of the electronic health record (EHR) showed Resident 106 admitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis (the process of filtering blood to remove waste and excess fluids due to kidney failure), anxiety disorder, and dorsalgia (a group of conditions that produce moderate to intense pain in the muscles, nerves, bones, joints, or other structures associated with the spinal column/back bone of the body). Resident 106 was able to make needs known. Observation on 03/23/2026 did not show Resident 106 receiving O2 therapy. Review of Resident 106's modification of quarterly minimum data set assessment (MDS) dated [DATE] showed the resident received O2 therapy. Review of the EHR on 03/24/2026 showed the following active provider orders: -Order dated 11/03/2025 for O2 at 3 liters per minute (L/min), delivery: (cannula/ a flexible tube with two prongs used to provide O2 through the nose, mask/face mask to provide O2) every shift for O2. (This order did not show indication for use). -Order dated 11/10/2025 showed wean (the process of coming off O2) O2 as tolerated to greater than > 90% O2 sats. -Order dated 11/28/2025 for Sleep study for hypoxia [low levels of O2 in the body tissues] during night requiring new oxygen requirements. (This order did not explain what the sleep study consisted of or show what the new O2 requirements were.) Review of Resident 106's March 2026 treatment administration records (TAR) from 03/01/2026 – 03/23/2026 showed the order for O2 at 3L/min was documented 0 L/min every shift except for blanks/no documentation on seven out of 69 opportunities for documentation. (Provider orders were not followed). It showed the order for the sleep study for hypoxia and order to wean O2 at tolerated to >90% had an X documented every day. Review of Resident 106's O2 sats documented in the vital signs tab in the EHR from 02/04/2026 - 3/22/2026 showed inconsistent documentation of O2 Sats being documented every shift, nine times the O2 sats were below the ordered parameters ranging from 85% to 90%, and documentation showed the provider was notified one time out of nine. During an interview on 03/30/2026 at 12:41 PM, Staff C, Registered Nurse/Unit Manager (RN/UM), stated Resident 106's order dated 11/03/2025 for O2 at 3 L/minute did not have an indication for use (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and should have, was documented 0 in the March 2026 TAR and not per provider orders, had seven blanks/holes in the documentation and should have had liters of O2 provided and documented as ordered. Staff C stated Resident 106's order dated 11/20/2025 to wean O2 as tolerated to greater than 90% was missing supplemental documentation area for nurses to document the O2 liters per minute every shift for monitoring/documenting titration per O2 parameters and instead showed X's documented in the March 2026 TAR. In continued interview on 03/30/2026 at 12:41 PM, Staff C stated Resident 106's order dated 11/28/2025 for sleep study for hypoxia during the night requiring new O2 requirements did not include the new requirements, and the order needed to be clarified with the provider, and the March 2026 TAR had Xs documented every day for the order. Staff C stated Resident 106's O2 sats were not consistently being documented every shift and should have been, and each time O2 sats were outside of ordered parameters the provider should have been notified. Staff C stated they did not see O2 therapy care planned for Resident 106 and since there were O2 orders in place it should have been care planned. Staff C stated these issues did not meet expectations. During an interview on 03/30/2026 at 2:01 PM, after reviewing O2 orders, March 2026 TAR, and O2 Sats documented in the EHR, Staff B, Director of Nursing Services, stated Resident 106's respiratory care and services did not meet their expectations. Resident 12 Review of the EHR showed Resident 12 admitted to the facility on [DATE] with diagnoses that included sleep apnea (condition that makes one stop breathing while sleeping), chronic respiratory failure (inability of lungs to provide adequate oxygen) and diabetes (too much sugar in the blood). Resident 12 was able to make needs known. Review of Resident 12's admission minimum data set assessment (MDS) dated [DATE] showed the resident received O2 therapy. Observations on 03/23/2026 at 9:36 AM, 03/25/2026 at 10:48 AM and 03/26/2026 at 2:46 PM showed Resident 12 received O2 set to 3.5 L/min via a nasal canula. Observations on 03/27/2026 at 9:31 AM showed Resident 12 received O2 set to 3 liters L/min via a nasal canula. Review of a 08/25/2025 provider's order showed Oxygen 4 L/min via nasal canula. Review of Resident 12's care plan initiated 08/25/2025 showed an intervention for oxygen settings at 4 L continuously. During an interview and observation on 03/27/2026 at 9:32 AM, Staff N, Licensed Practical Nurse (LPN), observed Resident 12's O2 and stated it was set at 3 L but should have been on 4 L. Staff N stated staff were to check the O2 setting on every shift. During an interview on 03/27/2026 at 1:28 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was that staff follow the providers order and check the O2 settings every shift. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pain management that met professional standard for 1 of 8 sampled residents (Resident 106) when reviewed for unnecessary medications and/or pain management. Failure to thoroughly complete pain assessments/evaluations and to address any need for non-pharmacological interventions (NPI, health interventions/approaches used instead of medication) with Resident 106, placed the resident at risk of having unmet pain needs, and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 106 initially admitted to the facility on [DATE] with diagnoses that included dependence on renal dialysis (the process of filtering blood to remove waste and excess fluids due to kidney failure), anxiety disorder, and dorsalgia (a group of condition that produce moderate to intense pain in the muscles, nerves, bones, joints, or other structures associated with the spinal column/back bone of the body). Resident 106 was able to make needs known. Review of the provider order dated 12/31/2025 showed Resident 106 was prescribed oxycodone HCl (narcotic medication used to relieve severe pain) 5 milligrams (mg) 1 tablet by mouth every four hours as needed (PRN) for pain. Review of Resident 106's March 2026 medication administration records (MAR) from 03/01/2026 - 03/23/2026 showed oxycodone was provided one to four times a day with pain levels ranging from 4 - 10 (0 = no pain and 10 = worst pain imaginable); however, usually the pain level was 7 or higher. Review of Resident 106's focused care plan for identified pain related to disease process initiated on 11/05/2025 showed an intervention for non-pharmaceutical (treatment without drug use) pain interventions which was to Report verbal or physical signs of pain, initiated on 11/05/2025. There were no NPI documented on Resident's 106's care plan for pain management. During an interview on 03/25/2026 at 1:19 PM, Staff C, Registered Nurse/Unit Manager (RN/UM), stated a resident's care plan was built from the admission assessment. Staff C stated there was a section on the assessment that addressed NPIs and if a resident had a NPI preference, it would be care planned and offered/provided prior to giving a PRN pain medication. Staff C stated if a resident had no NPI preference then they would be provided the pain medication as ordered. Staff C stated licensed nurses were to review a resident's care plan prior to giving PRN pain medications. Staff C stated resident pain assessments were conducted quarterly and PRN. Continued interview on 03/25/2026 at 1:19 PM, Staff C stated Resident 106's admission nursing evaluation, effective date of 11/03/2025, showed not all areas of the Pain Evaluation on the form were filled in, including the question Are there any non-medication interventions that improve your pain? was left blank and should have been documented yes or no. Staff C stated this did not meet their expectations. Review of the pain interview evaluation dated 11/05/2025 showed Resident 106's pain numeric rating was 8 out of 10. It further showed the form had blanks/areas not filled out completely. Review of the pain interview evaluation dated 02/09/2026 showed Resident 106's pain numeric rating was 9 out of 10. Review showed four answered questions revealed four areas had increase in pain frequency. It further showed the form had blanks/areas not filled out completely. During an interview on 03/27/2026 at 10:36 AM, Staff B, Director of Nursing Services, stated pain and NPIs were to be asked about as part of the admission assessment process and then care planned. Staff B stated pain was assessed quarterly and as needed. Staff B stated Resident 106's admission assessment dated [DATE] had several blank areas, was incomplete, and did not address NPIs. Staff B stated Resident 106's 11/05/2025 pain interview assessment was incompletely filled out. Staff B stated the pain interview assessment dated [DATE] showed Resident 106's pain had increased and the form was not completely filled out and should have been. Staff B stated they needed to do a better job with assessments and pain management documentation, and this did not meet their expectations. Reference WAC 388-97-1060(1), -1620(2)(b)(i)(ii)

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	03/30/2026

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure medication and treatments were securely stored for 1 of 1 sampled resident (Resident 96) and 2 of 2 sampled treatment carts (Rose and Emerald Wings). These failures placed residents at risk for access to restricted medications and treatments, avoidable injury, and a diminished quality of life. Findings included.Medications at Bedside Observation and interview on 03/24/2026 at 9:49 AM showed Resident 96 sitting in their bed in the room, and next to them on the table was a saline laxative enema (water-based procedure that injects liquid directly into anus to induce bowel movements), two medicated inhalers, and a nasal spray. Resident 96 stated they were feeling constipated and would be using the enema that the facility had provided for them. During an interview on 03/27/2026 at 2:11 PM, Resident 96 stated they had not used the enema yet, but had it on standby. During an interview on 03/27/2026 at 2:34 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was for no medications at bedside, and Resident 96 having medications in their room did not meet expectations. Unsecured Treatment Carts Observation on 03/27/2026 at 1:42 PM showed the [NAME] Wing treatment cart left unlocked/unsecured while unattended at the [NAME] Wing nurses station. A resident had walked by the treatment cart to go into a room behind the nurses' station. During an interview and observation on 03/27/2026 at 1:46 PM, Staff Y, Registered Nurse (RN) Supervisor, stated that the key to the treatment cart was missing and they should be getting a new key today. Staff Y stated they placed the treatment cart by the nurses' station thinking that a nurse would be around the nurses' station to ensure it was safe. The treatment cart had five drawers that were easily opened (treatment carts contain medicated creams, ointments, wound cleansers, and treatment supplies such as various types of dressings). Staff Y stated the treatment cart should not have been unlocked while unattended. Observation and interview on 03/27/2026 at 1:57 P, showed Staff B, DNS, telling Staff Y, RN Supervisor, to place the treatments and supplies from the [NAME] Wing treatment cart in the medication storage room which was secured. Staff B stated they were informed this morning that the key was missing and that pharmacy was notified. Staff B stated they assumed it would have been delivered by now. Staff B stated that the treatment cart should have been secured. Staff B stated they had two treatment carts and the other was on the Emerald Wing. Joint observation and interview on 03/27/2026 at 2:08 PM with Staff B, DNS, showed the Emerald Wing treatment cart left unlocked/unsecured while unattended at the Emerald Wing nurse's station. The treatment cart had five drawers and Staff B immediately locked the cart and stated it had similar treatment and supplies to the other treatment cart. Staff B stated it should have been secured and that they would follow up on the issue. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1300(2), -2340

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide routine dental services for 2 of 2 sampled residents (Residents 1 and 10) reviewed for dental services. This failure placed the residents at risk for unmet dental needs and a diminished quality of life. Findings included .Resident 10 Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses to include quadriplegia with incomplete damage to the neck (spinal cord damaged causing partial paralysis/partial or complete loss of muscle function and/or feeling to all four limbs and torso/trunk of the body), high blood pressure, and depression. Resident 10 was able to make needs known. During an interview on 03/24/2026, Resident 10 stated they had a dental exam two or more months ago and were told they had broken upper teeth that needed to be pulled. Resident 10 stated it took longer to chew their food because of it. Review of the dental visit form dated 08/11/2025 showed Resident 10 had broken teeth or root tips and missing upper and lower teeth and red/irritated gum tissue with referral for x-rays, evaluation, and extraction (removal of tooth) of teeth #4 and #12. It showed handwritten on the form that tooth #4 caused pain and Resident 10 would like tooth extraction. Review of Resident 10's care plan initiated on 11/14/2024 showed no care plan that identified/reflected current dental status or interventions related to broken and missing teeth. During an interview on 03/30/2026 at 11:40 AM, Staff F, Scheduling/Transportation, stated they had been trying to get a referral and locate a place for Resident 10's extractions but had not been able to, and had not documented their attempts. Staff F stated Resident 10's dental issues should have been addressed sooner. During an interview on 03/30/2026 at 2:30 PM, Staff B, Director of Nursing Services (DNS), stated Resident 10 should have been seen for dental issues prior to now and the resident's dental status/issues should have been care planned. Staff B stated this did not meet their expectations. Resident 1 Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses that included cholecystitis (inflammation of the gallbladder), chronic kidney disease and rectal cancer (cancer of the anus). Resident 1 was able to make needs known. Observation and interview on 03/24/2026 at 9:59 AM showed Resident 1 had missing and broken upper teeth. Resident 1 stated they had tooth pain and it was starting to affect their ability to eat. Review of the admission minimum data assessment (MDS) dated [DATE] showed Resident 1 was assessed to have Obvious likely cavity or broken natural teeth. During an interview on 03/30/2026 at 9:32 AM, Staff F, Scheduling/Transportation, stated residents were referred for dental appointments by nursing. Staff F stated the dental provider was at the (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility for appointments monthly for the past three months. Staff F stated they were unable to locate any referrals for Resident 1. During an interview on 03/30/2026 at 9:54 AM, Staff B, Director of Nursing Services, stated the expectation was that upon assessment Resident 1 should have been referred for dental services and oral needs care planned. Reference WAC 388-97-1060(2)(c), (3)(j)(vii)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the daily nurse staffing data in a prominent place to include actual hours worked for 6 of 6 observed days during the survey period (03/23/2026 - 03/30/2026) reviewed for nurse staff posting. This failed practice prevented residents, family members and visitors from knowing the facility's actual number of available nursing staff. Findings included.Observations on 03/23/2026 at 10:00 AM showed the front entrance, receptionist desk, and lobby areas with no daily nurse staffing data posted. Observations on 03/24/2026 at 9:30 AM, 03/25/2026 at 8:50 AM, 03/26/2026 at 10:41 AM, 03/27/2026 at 9:07 AM, and 03/30/2026 at 8:33 AM showed the daily nurse staff data postings with no actual nursing staff hours documented, located on a window to the right of the staffing scheduler's office door, after walking through the front entrance and then taking a right towards the [NAME] Wing nurses' station. If a person were to take a left towards the Emerald Wing nurses' station, they would not have been able to view the daily nurse staff data. During an interview on 03/30/2026 at 10:42 AM, Staff KK, Staffing Coordinator, stated they were responsible for posting the daily nurse staff data; however, they did not post the actual hours even though they were being monitored and tracked. Staff KK stated postings were not updated the day they were posted but could be revised the next day. Staff KK stated people would not be able to see the daily nurse postings unless they took a right after entering the facility and went by their office window because it was the only location they were posted. During an interview on 03/30/2026 at 10:56 AM, Staff B, Administrator, stated nurse staffing postings would not be visible unless one went to the east side of the facility. Staff B stated the daily nursing staff postings should have been posted in a location for all to see. Staff B stated that daily nurse data should be updated every shift to reflect the actual hours worked and any needed changes and they were not aware they were not being posted/updated, and this did not meet their expectations. Reference WAC 388-97-1620(2)(b)(i)