STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookfield Health and Rehab of Cascadia	510 North Parkway Battle Ground, WA 98604

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, the facility failed to ensure residents who had personal fund accounts established received accrued interest in those accounts for 2 of 3 sampled residents (Residents 34 and 36) reviewed for Trust Funds interest accrued. This failure placed residents at risk not to receive, or have access to, monies owed to them.Findings included . Record review of Resident 34's Resident Fund Management Service (RFMS) .Resident Statement Landscape showed the following:01/02/2026 Interest Paid 0.00; Balance $415.0002/02/2026 Interest Paid 0.00; Balance $415.0003/02/2026 Interest Paid 0.00; Balance $395.0004/01/2026 Interest Paid 0.00; Balance $395.0005/01/2026 Interest Paid 0.00; Balance $395.0006/01/2026 Interest Paid 0.00; Balance $329.00 Record review of Resident 36's Resident Fund Management Service .Resident Statement Landscape showed the following:04/01/2026 Interest Paid 0.00; Balance $108.7405/01/2026 Interest Paid 0.00; Balance $326.2206/01/2026 Interest Paid 0.00; Balance $326.22 In an interview on 06/04/2026 at 1:53 PM, Staff J, Business Office Manager, said Resident 34 and Resident 36 had money in interest bearing accounts. When asked about Resident 34's interest accrued in the account, Staff J looked at Resident 34's Resident Statement Landscape and said the account had zero interest since January 2026. Staff J stated, I don't know why he doesn't, I've never noticed it before.interest is zero since January. When asked about Resident 36's interest accrued in the account, Staff J stated, He's not gaining any interest either, I don't know why, I'm glad you brought this up. Staff J said she needed to find out from RFMS why the accounts were not getting interest stating, I don't know if it's on our end or their end. Staff J said Resident 34 and Resident 36 should have been accruing interest in their accounts. In an interview on 06/04/2026 at 2:25 PM, Staff A, Chief Executive Officer, said she expected residents accrued interest to be in their accounts. Reference WAC 388-97-0340 (3)(a)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) test (a rating scale used to assess the severity of involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications [drugs used primarily to treat symptoms such as hallucinations and delusions]) for 1 of 5 sampled residents (Resident 51) reviewed for unnecessary medications. This failure placed residents at risk for adverse medication side-effects, medical complications, and a diminished quality of life.Findings included.Record review of facility policy, titled, Psychotropic Medications, revised 04/22/2025, documented, . 5. In addition to these triggers, the facility will conduct a formal quarterly review (in accordance with CMS [Centers for Medicare & Medicaid Services] guidance under F-758 [federal regulation] and F-756) of each resident's psychotropic regimen during the interdisciplinary team (IDT) care plan meeting. a. This review includes evaluation of: . ii. Therapeutic benefit and adverse effects.Resident 51 was admitted to the facility on [DATE] with multiple diagnosis to include Dementia (disease characterized by decline in cognitive abilities such as memory, reasoning, and communication) with other behavioral disturbances. The Quarterly Minimum Data Set, an assessment tool, dated 03/12/2026, documented Resident 51 was severely cognitively impaired.Record review of Resident 51's electronic health record (EHR) showed a physician's order, dated 12/07/2025, for Quetiapine Fumarate (an antipsychotic medication) oral tablet 25 mg (milligrams) to give 12.5 mg by mouth at bedtime. Further review of Resident 51's EHR showed that Resident 51 had been on Quetiapine Fumarate since 06/12/2025. The June 2025 to June 2026 electronic medication administration record showed Resident 51 was receiving Quetiapine Fumarate as ordered.Record review of Resident 51's EHR showed an AIMS test was first completed on 06/13/2025 and the next one on 04/01/2026, 10 months later. In an interview on 06/04/2026 at 10:06 AM, Staff B, Chief Nurse Officer/Registered Nurse, reviewed Resident 51's EHR and said last AIMS test was completed on 04/01/2026 and the one before that was completed on Resident 51's admission on [DATE] (10 months prior). Staff B said AIMS test were supposed to be completed on admission and every six months for residents on antipsychotics. Refer to 756 Reference WAC 388-97-1060 (3)(k)(i)

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NAME OF PROVIDER OR SUPPLIER Brookfield Health and Rehab of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 510 North Parkway Battle Ground, WA 98604	

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written Bed-Hold notice to residents and/or residents' representative at the time of transfer to the hospital for 2 of 2 sampled residents (Residents 39 and 3) reviewed for hospitalization. This failure placed residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . Record review of the facility policy, titled, Bed-Hold, date revised 09/09/2025, documented, Facilities are required by Federal regulation to have polices addressing holding a resident's bed during periods of absence such as hospitalization or therapeutic leave. Additionally, facilities provide this written information about these policies to residents prior to and upon transfer for such absences. The notices will be provided in writing in a manner that resident/representative [representative] understands. The second notice is provided to the resident, and if applicable the resident's advocate, at the time of transfer, or in cases of emergency transfer, within 24 hours. It is expected that facilities will document multiple attempts to reach the resident's representative in cases where the facility was unable to notify the representative. Resident 39 was admitted to the facility on [DATE]. The Modification of Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/26/2026, documented Resident 39 was cognitively intact. In an interview on 06/01/2026 at 12:02 PM, Resident 39 said he recently went to the hospital and had surgery on his left arm. Resident 39 pointed to sutures in the antecubital (the front of the arm at the bend of the elbow) area of his left arm. Resident 39 said the facility did not talk to him about holding his bed when he went to the hospital. Review of Resident 39's Electronic Health Record (EHR) showed Resident 39 was transferred to the hospital on [DATE]. Further review of Resident 39's EHR did not show documentation of a written bed-hold notice, nor was contact made to the resident and/or representative regarding bed-hold information. In an interview on 06/03/2026 at 12:44 PM, Staff H, Resident Care Manager/Licensed Practical Nurse, said when residents transferred to the hospital, they would send bed hold paperwork with the resident. Staff H said the admissions department would follow up with the resident and call them to see if they wanted a bed hold. In an interview on 06/03/2026 at 12:58 PM, Staff D, Admissions Coordinator, said they would talk about bed holds daily in their morning meeting for residents in the hospital. Staff D stated, As a team we choose one way or the other, generally we just hold it until otherwise, we try to keep as many people as we can. In an interview on 06/03/2026 at 2:30 PM, Staff B, Chief Nursing Officer/Registered Nurse, said nursing would offer a bed hold for residents. Resident 3 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], indicated Resident 3 was alert and oriented. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Brookfield Health and Rehab of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE 510 North Parkway Battle Ground, WA 98604	

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 3's eInteract transfer form, dated 04/28/2026, documented Resident 3 was transferred to an acute hospital. Record review of Resident 3's progress notes, dated 04/29/2026 at 3:41 AM, documented, Resident had emesis [vomiting] x2 [twice] this shift. Resident requested to be sent out to the hospital d/t [due to] vomiting with no relief after PRN [as needed] ondansetron [medication used to prevent nausea and vomiting]. Record review of Resident 3's EHR did not have documentation the bed-hold policy was reviewed with Resident 3 prior to or after Resident 3's transfer to an acute hospital. During an interview on 06/03/2026 at 1:54 AM, Staff B said the bed-hold agreement should be reviewed with the resident at the time of transfer or just after depending on the urgency of the transfer. While reviewing Resident 3's EHR, Staff B said she could not find a bed-hold for Resident 3. Reference WAC 388-97-0120 (4)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) was completed accurately to reflect a resident's health status and/or care needs for 1 of 5 sampled residents (Resident 46) reviewed for activities of daily living; failed to identify Hospice services for 1 of 2 sampled residents (Resident 14) reviewed for Hospice; and 1 of 5 sampled residents (Resident 52) reviewed for unnecessary medications. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life.Findings included . Resident 46 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 46 was severely cognitively impaired. Record review of Resident 46's behavior progress note, dated 03/01/2026, documented, . resident refused brief and clothing change this shift. Record review of Resident 46's behavior progress note, dated 02/28/2026, documented, On alert for monitoring behaviors, resident was verbally abusive to CNA [certified nurse assistant] when he was being asked to change his shirt, he has been wearing shirt for a week, refused showers and change of clothes and peri-care [groin area]. Re-approaching ineffective. Record review of Resident 46's behavior progress note, dated 02/26/2026, documented, On alert for monitoring behaviors, refused shower and peri-area assessment, re-approached but ineffective. Record review of Resident 46's MDS assessment, dated 03/04/2026, documented Resident 46 did not refuse care. In an interview on 06/04/2026 at 11:37 AM, Staff G, Social Services, said they coded behavior MDS assessments after they reviewed behavior monitoring documentation by the provider, nurses progress notes and CNAs documentation, looking for key words like refusal of care. Staff G said Resident 46 was coded incorrectly for rejection of care. Resident 14 was admitted to the facility on [DATE]. The quarterly MDS, dated [DATE], indicated Resident 14 was moderately cognitively impaired. Record review Resident 14's significant change MDS, dated [DATE], showed the status payer was hospice Medicaid of [NAME]. Record review of Resident 14's physician's order, dated 11/30/2025, noted Resident 14 was Admit for hospice . During an interview on 06/03/2026 at 9:41 AM, Staff E, MDS Nurse/Registered Nurse (RN) said the significant change MDS was completed on Resident 14 when she was admitted to Hospice. While reviewing the significant change and the quarterly MDSs' Staff E said she should have identified hospice services on the MDSs. During an interview on 06/03/2026 at 9:49 AM, Staff B, Chief Nursing Officer/RN, said Resident 14 was currently receiving hospice services. When asked about hospice services being identified on the MDS, Staff B any changes or services should be reflected on the MDS. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Brookfield Health and Rehab of Cascadia		STREET ADDRESS, CITY, STATE, ZIP CODE: 510 North Parkway, Battle Ground, WA 98604	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 52 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 52 was severely cognitively impaired and was taking an opioid (a prescription drug that is used to relieve pain) medication. Record review of Resident 52's physician orders, dated 02/05/2026, and discontinued 04/03/2026, showed Resident 52 was prescribed Tramadol (an opioid medication used to manage moderate to severe pain) 50 milligrams every six hours as needed for breakthrough pain. Record review of Resident 52's March 2026 Electronic Medication Administration Record showed Resident 52 did not take Tramadol during the month of March 2026. In an interview on 06/04/2026 at 10:14 AM, when asked about Resident 52's opioid medication use coded on the Quarterly MDS, dated [DATE], Staff E, looked at resident 52's Electronic Health Record and said Resident 52 was prescribed tramadol but did not take it in March 2026. Staff E said the MDS would need to be corrected. In an interview on 06/04/2026 at 10:41 AM, Staff B, said she expected the MDS was coded correctly to reflect the medications a resident was taking. Reference WAC 388-97-1000 (1)(b)

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	505331	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookfield Health and Rehab of Cascadia	510 North Parkway Battle Ground, WA 98604

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the state mental health authority coordinator of a significant change in physical condition, for 1 of 5 residents (Resident 7) reviewed for PASARR process (Preadmission Screening and Resident Review, a screening tool used to identify mental health needs). This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included.Record review of the facility policy, titled, Preadmission Screening & [and] Resident Review Process, revision date 08/29/2025, documented, .4. As part of the PASARR process, the facility is required to notify the appropriate state mental health authority or state intellectual disability [ID] authority when a Resident that triggers a Level II PASARR [an in-depth, person-centered evaluation triggered when an initial screen suspects a Serious Mental Illness [SMI] has a significant change in their physical or mental condition to ensure they continue to receive the care and services they need in the most appropriate setting. a. Referral to the SMH/ID authority should be made upon the criteria indicative of a significant change are evident.Resident 7 was admitted to the facility on [DATE] with multiple diagnosis to include depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in daily activities) and schizoaffective disorder (chronic mental health condition characterized by a combination of symptoms like delusions or hallucinations - and mood disorder symptoms, like depression). The Significant Change Minimum Data Set (MDS), an assessment tool, dated 04/13/2026, documented Resident 7 was cognitively intact.Record review of Resident 7's electronic health record documented a Significant Change MDS on 11/17/2025, 02/17/2026, 03/5/2026 and 05/29/2026. Review of Resident 7's EHR did not show a new Level I PASARR was completed with each significant change MDS. In an interview on 06/04/2026 at 11:52 AM, Staff G, Social Services, said Level I PASARR screenings were completed prior to admission. When asked if a new PASARR screening was completed when a Resident 7 had a significant change in condition, Staff G said that it was not completed. Reference WAC 388-97-1975(7)

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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 observation, interview, and record review, the facility failed to ensure resident care plans were revised to accurately reflect care needs for 1 of 2 sampled residents (Resident 7) reviewed for hospice and 1 of 1 sampled resident (Resident 39) reviewed for skin conditions. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included. Resident 7 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS), an assessment tool, dated 04/13/2026, documented Resident 7 was cognitively intact. Record review of Resident 7's medical record titled, Consent for Medicare Hospice Election Statement, dated 11/10/2025, documented Resident 7 was to begin hospice on 11/11/2025. Resident 7's care plan was updated on 11/12/2025. Record review of Resident 7's medical record titled, REVOCATION OF HOSPICE BENEFIT OR DESIGNATION OF A NEW HOSPICE, dated 02/11/2026, documented Resident 7's Medicare hospice benefit was revoked. Review of Resident 7's care plan did not show a revision indicating hospice services were discontinued on 02/11/2026. Record review of Resident 7's medical record titled, Consent for Medicare Hospice Election Statement, dated 02/26/2026, documented Resident 7 was to begin hospice on 02/26/2025. Resident 7's care plan did not document a revision indicating hospice services were restarted on 02/26/2026. Record review of Resident 7's documentation from Peace Health (PH) Hospice documented Resident 7 was discharged from hospice on 04/25/2026. Resident 7's care plan was not updated to indicate hospice was discontinued. In an interview on 06/04/2026 at 10:25 AM, Staff B, Chief Nurse Officer/Registered Nurse, said Resident 7's care plan was not updated to reflect changes to their hospice status. Resident 39 was admitted to the facility on [DATE], transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. The Modification of Quarterly MDS, dated [DATE], documented Resident 39 was cognitively intact. In an interview on 06/01/2026 at 12:02 PM, Resident 39 said he recently went to the hospital and had surgery on his left arm. Resident 39 pointed to sutures in the antecubital (the front of the arm at the bend of the elbow) area of his left arm. In an interview and observation on 06/03/2026 at 9:19 AM, Resident 39 was observed lying in his bed. Three sutures were observed in the antecubital area of his left arm. When asked about the sutures, Resident 39 said he thought he should be getting them out soon. Review of Resident 39's Electronic Health Record (EHR) admission Note, dated 05/26/2026, documented, .readmitted s/p [status post] vascular [blood vessel] intervention for dialysis access (fistula/catheter revision). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 39's EHR Health Status note, dated 06/01/2026, documented, .suture to left antecubital fossa [inner bend or crease of your left elbow] . Record review of Resident 39's care plan, Potential/actual for alteration in skin/tissue., date revised 04/28/2026, did not show a Focus, Goal, and/or Interventions/Task area related to sutures and/or a skin condition to the left antecubital area. On 06/03/2026 at 12:44 PM, Staff H, Resident Care Manager/Licensed Practical Nurse, said if a resident had a skin issue such as an incision or sutures, there would be a care plan in place regarding the skin area. When asked about Resident 39's skin care plan for sutures in his left arm, Staff H said he did not see a care plan for the sutures and there should have been. In an interview on 06/03/2026 at 2:30 PM, Staff B said she expected Resident 39's skin care plan was updated to address new skin issues such as sutures. Reference WAC 388-97-1020 (2)(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services provided met professional standards by not following physician's orders for 1 of 5 residents (Resident 51) reviewed for unnecessary medications. This failure placed residents at risk for unmet care needs, medical complications, and a diminished quality of life.Findings included.Resident 51 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 03/12/2026, documented Resident 51 was severely cognitively impaired and had a diagnosis of hypertension (elevated blood pressure). Record review of Resident 51's electronic health record (EHR) showed a physician's order, dated 11/20/2025, for amlodipine besylate (medication to help lower blood pressure) oral tablet 5 MG (milligrams) for hypertension, with parameters to not give the medication if systolic blood pressure (SBP, the top number in a blood pressure reading) was below 100 or their heart rate (HR) was below 60 beats per minute (bpm). Record review of Resident 51's EHR showed resident 51's HR was 57 bpm on 05/29/2026, 54 bpm on 05/28/2026, 59 bpm on 05/22/2026, 55 bpm on 04/17/2026, 55 bpm on 04/16/2026, 56 bpm on 04/04/2026, 58 bpm on 03/19/2026, 58 bpm on 02/27/2026, 55 bpm on 02/22/2026.Record review of Resident 51's February, March, April and May 2026 electronic medication administration record (EMAR), documented Resident 51 was administered amlodipine besylate 5mg tablet on, 5/29/2026, 05/28/2026, 05/22/2026, 04/17/2026, 04/16/2026, 04/04/2026, 03/19/2026, 02/27/2026, and on 02/22/2026, when his heart rate was less than 60 bpm.In an interview on 06/03/2026 at 1:07 PM, Staff I, Licensed Practical Nurse (LPN), said it was the expectation that if a residents SBP or HR was below physician ordered parameters, amlodipine besylate would not be administered. In an interview and record review on 06/03/2026 at 1:29 PM, Staff H, Resident Care Manager/LPN, reviewed Resident 51's HR and EMAR and said it was the expectation that the licensed nurses should have held the amlodipine besylate when Resident 51's HR was below 60 bpm. Reference WAC 388-97-1060(3)(k)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain physician and/or treatment orders for skin and/or wound care for 1 of 1 sampled resident (Resident 39) reviewed for skin conditions. This failure placed residents at risk of injury, unmet care needs, and a diminished quality of life.Findings included. Resident 39 was admitted to the facility on [DATE], transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. The Modification of Quarterly Minimum Data Set, dated [DATE], documented Resident 39 was cognitively intact. In an interview on 06/01/2026 at 12:02 PM, Resident 39 said he recently went to the hospital and had surgery on his left arm. Resident 39 pointed to sutures in the antecubital (the front of the arm at the bend of the elbow) area of his left arm. In an interview and observation on 06/03/2026 at 9:19 AM, Resident 39 was observed lying in his bed. Three sutures were observed in the antecubital area of his left arm. When asked about the sutures, Resident 39 said he thought he should be getting them out soon. Review of Resident 39's Electronic Health Record (EHR) admission Note, dated 05/26/2026, documented, .readmitted s/p [status post] vascular [blood vessel] intervention for dialysis access (fistula/catheter revision). Review of Resident 39's EHR Health Status note, dated 06/01/2026, documented, .suture to left antecubital fossa [inner bend or crease of your left elbow]. Review of Resident 39's EHR does not show physician and/or treatment orders for monitoring sutures and/or skin condition to the left antecubital area. In an interview on 06/03/2026 at 12:44 PM, Staff H, Resident Care Manager/Licensed Practical Nurse, said if a resident had a skin issue such as an incision or sutures, there would be physician orders for wound care and/or monitoring the skin area. When asked about Resident 39's sutures in his left arm, Staff H said he did not see orders for monitoring the sutures and there should have been. In an interview on 06/03/2026 at 2:30 PM, Staff B, Chief Nursing Officer/Registered Nurse, said she expected there were physician orders and treatment orders in place to monitor Resident 39's sutures. Reference WAC 388-97-1060 (1)(3)(b)

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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 obtain physician orders for oxygen and/or BiPAP (Bi-level Positive Airway Pressure, a non-invasive ventilator that delivers air and oxygen into the lungs using a mask to help people breathe more easily) use for 1 of 2 sampled residents (Resident 39) and failed to change oxygen tubing as ordered for 1 of 2 sampled residents (Residents 60) reviewed for respiratory care. This failure placed residents at risk for worsening health complications, unmet care needs, and a diminished quality of life. Findings included. Record review of the facility's policy, titled, Oxygen Administration, Safety, Storage & Maintenance, revised 10/10/2025, documented, The facility will administer, store, and maintain supplemental oxygen safely in accordance with current standards of practice and licensed practitioner orders. 6. Verify provider order prior to initiating/changes oxygen therapy. 8. Monitor oxygen parameters as needed and/or as ordered. 1. Change oxygen supplies weekly and when visibly soiled. Equipment should be dated when set up or changed out. 2. Humidifier/Aerosol bottles should be dated and replaced every 7 days regardless of H2O [water] level. Resident 39 was admitted to the facility on [DATE], transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. The Modification of Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/26/2026, documented Resident 39 was cognitively intact, was on oxygen therapy, and used a non-invasive mechanical ventilator. In an observation and interview on 06/01/2026 at 12:08 PM, a BiPAP machine was observed on Resident 39's nightstand and an oxygen concentrator was observed in Resident 39's room. Resident 39 said he used the BiPAP machine at night and sometimes used oxygen. In an observation and interview on 06/03/2026 at 9:19 AM, Resident 39 was observed lying in bed with oxygen running at 1.5 lpm (liters per minute) per nasal cannula. Resident 39 said he used the BiPAP machine last night. Record Review of Resident 39's Oxygen use care plan, revised 11/26/2025, documented Interventions/Tasks, Administer medications and treatments as ordered. BIPAP as ordered. Review of Resident 39's Electronic Health Record (EHR) showed no physician's order related to the use of oxygen and/or a BiPAP machine. In an interview on 06/03/2026 at 9:25 PM, Staff I, Licensed Practical Nurse (LPN), said for residents that used oxygen, they determined the rate of oxygen flow by the physician orders. Staff I said they had to have orders for BiPAP machine use. In an interview on 06/03/2026 at 9:36 AM, Staff H, Resident Care Manager/LPN, said they had to have orders for oxygen and BiPAP use. When asked about Resident 39's oxygen and BiPAP physician orders, Staff H looked at Resident 39's EHR and said when Resident 39 came back from the hospital the orders did not get put back in for oxygen and the BiPAP machine and they should have. In an Interview on 06/03/2026 at 2:30 PM, Staff B, Chief Nursing Officer/Registered Nurse said she (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected residents using oxygen and a BiPAP machine had physician orders for use. Resident 60 was admitted to the facility on [DATE], transferred to the hospital on [DATE] and re-admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 60 was moderately cognitively impaired, and was on oxygen therapy. In an observation and interview on 06/02/2026 at 9:38 AM, Resident 60 was observed in bed with oxygen turned on. Resident 60 reported using oxygen regularly but was unable to recall when her oxygen tubing was replaced, or oxygen concentrator was serviced. Record review of Resident 60's EHR showed physician's order, dated 01/15/2025, documented, Change Oxygen/ Nebulizer tubing and clean concentrator filter every week. Date and provide tubing bag as indicated. Record Review of Resident 60's Oxygen use care plan, revised 05/28/2026, documented, Change disposable oxygen tubing, nebulizer supplies, connecting tubing, corrugated tubing, etc [sic] weekly prn [as needed] Cleanse concentrator external filter as indicated prn. Record review of Resident 60's EHR, dated April 2026 to June 2026, showed no documentation of oxygen tubing being exchanged or concentrator filter being cleaned as ordered and care planned. In an interview on 06/03/2026 at 2:10 PM, Staff F, Infection Preventionist/ Registered Nurse said oxygen concentrator cleaning and tubing exchange were done weekly and were documented on the Medication Administration Report (MAR). Staff F was unable to find documentation of Resident 60's Oxygen concentrator being cleaned and tubing exchanged. Staff F stated, It should be on the MAR. It was left out because of the PNR order. In an interview on 06/04/2026 at 1:42 PM, Staff B said Resident 60's order was a PRN order, which was changed since. Staff B was unable to provide documentation of Resident 60's oxygen concentrator maintenance and tubing exchange. Reference WAC 388-97-1060 (1)(3)(vi)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure monthly pharmacy review recommendations were addressed as indicated for 1 of 5 residents (Resident 51) reviewed for unnecessary medications. This failure placed residents at risk of inadequately monitored medications, adverse effects, and a diminished quality of life.Findings included.Resident 51 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 03/12/2026, documented Resident 51 was severely cognitively impaired.Record review of the pharmacy recommendations, review date from 12/22/2025 to 12/24/2025, documented the facility had not conducted an AIMS test (Abnormal Involuntary Movement Scale test, which is a rating scale used to assess the severity of involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications [drugs used primarily to treat symptoms such as hallucinations and delusions]) for Resident 51 since 06/13/2025 and requested the AIMS test be updated. Review of Resident 51's electronic health record (EHR) did not show an updated AIMS test in December 2025. Record review of the pharmacy recommendations, review date from 02/07/2026 to 02/09/2026, documented a pharmacy request for an updated AIMS test for Resident 51 as last test was completed on 06/13/2025. Review of Resident 51's EHR did not show an updated AIMS test in February 2026.Record review of the pharmacy recommendations, review date from 03/09/2026 to 03/10/2026, documented, THIS IS A REPEAT RECOMMENDATION SINCE DECEMBER [December 2025]. Pharmacist documented they were unable to locate a current AIMS test in Resident 51's EHR. Pharmacy requested facility to update Resident 51's AIMS test. Review of Resident 51's EHR did not show an updated AIMS test in March 2026.Record review of the pharmacy recommendations, review date from 02/07/2026 to 02/09/2026, documented a pharmacy request for Vitamin D blood level to be drawn for Resident 51. Review of Resident 51's EHR did not show Vitamin D blood level results in February 2026.Record review of the pharmacy recommendations, review date from 03/09/2026 to 03/10/2026, documented, PROVIDER STATED TO DRAW LAB - SIGNED 2/10/2026. NO NOTED LABS DRAWN. PLEASE CLARIFY. Pharmacy requested facility to draw Vitamin D level on the next lab day. Review of Resident 51's EHR did not show Vitamin D blood level results in March 2026.Record review of pharmacy recommendations, review date from 04/13/2026 to 04/14/2026, documented pharmacy request to have Resident 51's Vitamin D blood levels drawn as was requested in February 2026. Resident 51's EHR showed Vitamin D levels were drawn on 04/21/2026, 2 months after the initial pharmacy request. In a joint interview and record review on 06/04/2026 at 10:06 AM, Staff B, Chief Nurse Officer/Registered Nurse, said AIMS test were supposed to be completed on admission and every six months for residents on antipsychotics. Staff B reviewed Resident 51's EHR and said last AIMS test was completed on 04/01/2026 and the one before that was completed on Resident 51's admission on [DATE] (10 months prior). Staff B reviewed Resident 51's pharmacy recommendations. Staff H, Resident Care Manager/Licensed Practical Nurse, said they were unable to find documentation of Resident 51 refusing his blood to be drawn.Staff B said it was the expectation that pharmacy recommendations were implemented. Staff B said it was the expectation that Resident 51's Vitamin D levels were drawn as ordered. Reference WAC 388-97-1300(4)(c)Refer to F605

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Brookfield Health and Rehab of Cascadia	510 North Parkway Battle Ground, WA 98604

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure resident's medical records were accurate and up to date for 1 of 2 sampled residents (Resident 7) reviewed for hospice and 1 of 5 sampled residents (Resident 7) reviewed for pre-admission screening and resident review (PASARR, An assessment used to identify individuals [residents] with serious mental issues, intellectual disabilities, or related conditions are not inappropriately placed in nursing facilities for long term care). This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included.Resident 7 was admitted to the facility on [DATE] with multiple diagnosis to include depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in daily activities) and schizoaffective disorder (chronic mental health condition characterized by a combination of symptoms like delusions or hallucinations -and mood disorder symptoms, like depression). The Significant Change Minimum Data Set, an assessment tool, dated 04/13/2026, documented Resident 7 was cognitively intact.HospiceRecord review of Resident 7's medical record titled, REVOCATION OF HOSPICE BENEFIT OR DESIGNATION OF A NEW HOSPICE, dated 02/11/2026, documented Resident 7'S Medicare hospice benefit was revoked. Resident 7's EHR did not have an updated physician's order discontinuing hospice services. Record review of Resident 7's medical record titled, Consent for Medicare Hospice Election Statement, dated 02/26/2026, documented Resident 7 was to begin hospice on 02/26/2025. Resident 7's EHR did not have an updated physician's order documenting hospice service were restarted on 02/26/2025.Record review of Resident 7's care plan focus documented, End of Life Care / Palliative Care [comfort care] r/t [related/to]: Parkinson's [nerve disorder that primarily affects movement] care plan, initiated on 11/12/2025, documented Resident 7's hospice care plan was resolved on 04/17/2026. Review of Resident 7's EHR did not show documentation or physician's order discontinuing hospice service. Record review of Resident 7's documentation from Peace Health (PH) Hospice documented Resident 7 was discharged from hospice on 04/25/2026. Resident 7's EHR did not have a physician's order to discontinue hospice. Further review of Resident 7's EHR showed nurses progress notes from 04/25/2026 through 05/23/2026, documenting that Resident 7 was on hospice when he was not. Record review of Resident 7's health status note, dated 05/23/2026, documented, negative lab results, called PH hospice to confirm resident's hospice status, resident off from hospice since 4/25/26.In an interview on 06/04/2026 at 10:25 AM, Staff B, Chief Nurse Officer/Registered Nurse, said the staff member who was responsible for obtaining physician orders did not update Resident 7's medical records as was the expectation. PASARR Record review of Resident 7's electronic health record showed a Level I PASARR (a preliminary screening required for anyone entering a Medicaid-certified nursing facility), dated 10/08/2025, documented Resident 7 had a SMI (serious mental illness) and triggered a Level II PASARR evaluation. Review of Resident 7's EHR did not show a completed Level II PASARR evaluation.On 06/04/2026, Staff A, Chief Executive Officer, provided a copy of the Level II PASARR evaluation/determination, date reviewed 03/05/2026. In an interview on 06/04/2026 at 2:22 PM, Staff A said, Resident 7's Level II evaluation summary was not placed in Resident 7's EHR and it should have. Refer to F676Reference WAC 388-97-1720(1)(a)(i)-(ii)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer the Covid-19 (Coronavirus disease 2019, an infectious respiratory illness caused by a virus) vaccine and/or provide education regarding risks, benefits, and potential side effects associated with the vaccine, for 1 of 5 sampled residents (Resident 52) reviewed for unnecessary medications. This failure placed residents at risk for contracting Covid-19 infections, related complications, and a diminished quality of life.Findings included. Record review of the facility's policy titled, COVID Vaccination for Residents, revised 09/25/2025, documented, In accordance with CMS [Centers for Medicare Services] regulations, the facility will continue to provide education about COVID-19 vaccines and offer vaccination to all residents within the facility.Each resident should be offered COVID immunization unless the immunization is medically contraindicated. Resident 52 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, as assessment tool, dated 03/18/2026, documented Resident 52 was severely cognitively impaired and was not up to date on the COVID-19 vaccination. Review of Resident 52's EHR did not show documentation of education provided and/or a Covid-19 vaccination offered, declined, or medically contraindicated. In an interview on 06/04/2026 at 10:00 AM, Staff F, Infection Preventionist/Registered Nurse (RN), said upon admission they would address vaccinations for residents to include influenza, pneumococcal, and Covid-19. When asked about Resident 52's Covid-19 vaccination, Staff F looked at Resident 52's EHR and said the Covid-19 vaccination was missed. Staff F said it should have been offered upon admission and it was not. In an interview on 06/04/2026 at 10:41, Staff B, Chief Nursing Officer/RN, said she expected the Covid-19 vaccination was offered upon admission. No Reference WAC

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F 0557 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide eating assistance in a manner that promoted resident respect and dignity for 1 of 9 residents (Resident 14) reviewed for dining. This failure place residents at risk for diminished self-worth, embarrassment, and a deceased quality of life. Findings included. Review of the facility's policy, titled Dignity, dated 09/12/2025, documented, Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on maintaining and enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the residents' individuality as well as honor and value their input. 2. Promoting resident independence and dignity while dining, such as avoiding. Staff standing over residents while assisting them to eat . Resident 14 was admitted to the facility on [DATE]. The quarterly Minimum Data Set, an assessment tool, dated 03/11/2026, indicated Resident 14 was dependent with eating and was moderately cognitively impaired.Record review of Resident 14's care plan, dated 04/06/2026, documented EATING: Dependent 1 staff with eating. 1:1 assistant with meals. During an observation on 06/02/2026 at 12:57 PM, Staff K, Nursing Assistant (NA), was standing next to Resident 14 on Resident 14's left side assisting Resident 14 with eating.During an observation on 06/02/2026 at 1:01 PM, Staff K walked over to pick up a slice of pizza for an unidentified male resident. Staff K stood in front of the resident and handed him the pizza using a napkin. During an observation on 06/02/2026 at 1:02 PM, Staff K went back to Resident 14 and assisted her again. Staff K was standing to the left of Resident 14.During an observation on 06/02/2026 at 1:03 PM, Staff K walked over to the unidentified male resident to pick up his pizza from his plate again.During an observation on 06/02/2026 at 1:04 PM, Staff K walked over to the sink, washed her hands and went back over to Resident 14 and started assisting her again. Staff K was standing to the left for Resident 14.During an observation on 06/02/2026 at 1:05 PM, Staff K walked over to the cart and grabbed an empty tray came back to the table, where Resident 14 was sitting, and put the plate of the resident sitting across from Resident 14 onto the tray. Staff K returned to the table and started assisting Resident 14 with her food. Staff K stood up next to Resident 14 while assisting.During an observation on 06/02/2026 at 1:07 PM, Staff K walked over to the cart and grabbed a tray. Staff K walked over to an unidentified female resident and put her plate, cup, and utensils on the tray. Staff K put the tray onto the cart. Staff K brought Resident 14 some pudding. During an observation on 06/02/2026 at 1:11 PM Staff K walked over to Resident 14 and stood on Resident 14's left side and assisted her with her food. During an interview on 06/02/2026 at 1:16 PM, Staff K said there were no stools to sit on and said she wasn't told by anyone they should sit when feeding residents. During an interview on 06/03/2026 at 8:46 AM, Staff H, Resident Care Manager/Licensed Practical Nurse, said we would want the NA to sit next to the residents when assisting the resident with their meals. The NA should try to create a homelike environment and respect residents' dignity.During an interview on 06/03/2026 at 9:41 AM, Staff B, Chief Nursing Officer/Registered Nurse, said staff assisting residents with their meals should be seated next to the resident to respect the resident's dignity.Reference WAC 388-97-0860 (1)(a)(2)

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F 0770 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a current Clinical Laboratory Improvement Amendments (CLIA Waiver- also known as a Medical Test Site Certificate of Waiver License, a license that allows the facility to legally perform certain simple, low risk medical tests like blood glucose checks and COVID-19 [Corona Virus Disease 2019, a respiratory illness] tests). This failure placed residents at risk for substandard care, delayed diagnosis and incorrect medical treatment. Findings included.Record review of the provided facility CLIA Waiver showed an expiration date of [DATE], a lapsed status of 11 months.In an observation and interview on [DATE] at 2:25 PM, Staff A, Chief Executive Officer, referred to the CLIA Waiver hanging on the wall and said it was expired, and that she would look for the current license and get it to the survey team.In an email interview on [DATE] at 12:07 PM, Staff A said she confirmed with the Business Office Manager that the renewal for the CLIA Waiver had not been completed.Reference: WAC 388-97-1620 (2)(b)(i)(ii)