STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505338	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snohomish Health and Rehabilitation of Cascadia	800 10th Street Snohomish, WA 98290

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, interview and record review the facility failed to ensure residents who engaged in smoking had adequate supervision to protect residents and/or staff from potential fire hazards for 2 of 3 residents (Resident 51 and 32) reviewed for smoking. This failure placed all residents at serious risk for injury related to unsafe smoking practices and constituted an Immediate Jeopardy (IJ).The failed practice resulted in an IJ on 04/26/2026 when the facility failed to ensure the residents' environment was safe from burns and fire. The IJ was removed on 04/28/2026 after the facility provided a safe receptacle for properly disposing of cigarette butts, reassessed and educated staff and residents of the facility's no smoking policy and confiscated residents smoking paraphernalia. Findings included.Review of a facility policy, titled Non-Smoking Campus- Smoke Free, with revised date 09/12/2025 documented:The resident or representative sign an acknowledgement that the facility is a smoke-free environment upon admission.The facility staff are responsible for enforcing the Smoke-Free Policy.Employees, contractors and visitors are expected to comply with the smoke-free policy while on facility property. Employees who choose to smoke may do so off property or within their personal vehicles. Review of a grievance, dated 3/19/2026, showed a resident had a concern about residents smoking as they did not like the smell was reported to the administrator. The action taken showed that all smoking residents were told that smoking on property was not allowed. <RESIDENT 51>Resident 51 was admitted to the facility on [DATE].Review of Resident 51's Smoking/Nicotine use evaluation, dated 01/15/2026, documented the resident did not demonstrate an understanding that smoking was not permitted while using any form of oxygen (O2) and that smoking materials were to be used in designated smoking areas. The form designated the resident as dependent/assisted for smoking. The form documented not to proceed with a care plan.Review of Resident 51's care plan, print date 04/26/2026, showed no information about smoking.Review of Resident 51's Order Summary Report for 04/26/2026 showed an order for O2 at 1-2 liters/per minute (L/PM) continuously per nasal cannula (tubing that delivers O2 into the nose).In an observation and interview on 04/26/2026 at 9:00 AM, Resident 51 was observed sitting in their wheelchair, outside on the driveway near a group of trees. (Driveway from the road comes to a T in the road due to a group of trees. Route to the left goes to the facility entrance and the route to the right is the exit from the facility parking lot.) Resident 51 was observed to be holding a cigarette. There was a portable O2 tank hanging on the back of their wheelchair, running at 2 L/PM. There were ashes observed on the ground and on Resident 51's shoes, and there was an odor of smoke. Resident 51 told the surveyor that they smoked cigarettes.On 04/26/2026 at 9:15 AM there was an odor of cigarette smoke outside Resident 51's room. At 9:21 AM, another surveyor noted an odor of cigarette smoke outside Resident 51's room.In an interview on 04/26/2026 at 9:23 AM, Staff AA, Certified Nursing Aide (CNA), reported they were not aware of any current residents that smoke, but some of the staff smoked. Staff AA stated there was a smoking area on the property, back by the shed where there was a sign posted.In an interview on 04/26/2026 at 9:25 AM, Staff W, Culinary Cook, stated there was a picnic table outside out back that staff and residents used as a smoking area. Staff W stated they believed that there (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were a few residents who smoked but did not know any names.During an observation on 04/26/2026 at 10:04 AM, on the back corner of the facility grounds, there was a grassy hill with a picnic table and a sign that read Designated smoking area.In an interview on 04/26/2026 at 9:56 AM, Staff H, Licensed Practical Nurse, stated residents that smoke kept their cigarettes and lighters with them, the nurses did not keep any of their paraphernalia in their carts.In an interview on 04/26/2026 at 10:20 AM, Staff T, CNA, stated they were aware that Resident 51 and Resident 38 smoked. Staff T stated residents go to the smoking area or smoke outside by the circle by the trees.In an interview on 04/26/2026 at 12:44 PM, Staff B, Chief Nursing Officer, stated that the facility was aware that Resident 51 was a current smoker. Staff B replied they did not know how the resident extinguished their cigarettes and since they were a non-smoking facility, they did not provide any ashtrays. Staff B replied that Resident 51 had their smoking paraphernalia with them as the facility had not searched them or their room. <RESIDENT 32>Resident 32 was admitted to the facility on [DATE].Review of the hospital orthopedic consult, dated 03/23/2026, showed Resident 32 smoked cigars and cigarettes.Review of the hospital cardiology consult, dated 03/23/2026, showed resident smoked cigars.Review of Resident 32's Smoking/Nicotine use evaluation, dated 03/31/2026, documented the resident could not safely light the cigarette and they were not able to demonstrate safe technique for disposing of ashes. The form designated the resident as dependent/assisted for smoking. The form documented not to proceed with a care plan.Review of Resident 32's care plan showed no information on smoking was documented until 04/27/2026.Review of a provider note, dated 04/01/2026, documented that Resident 32 was a current smoker.Review of Resident 32's Smoke Free Campus Acknowledgement revealed it was signed on 04/08/2026, nine days after admission to the facility.In an observation and interview on 04/26/2026 at 10:05 AM, Resident 32 was observed sitting in their wheelchair outside the facility entrance with their spouse. Resident 32 was observed smoking a cigar. Resident 32's spouse stated that other residents smoke down by the trees, but they could not get down there. Resident 32's spouse stated they were 25 feet from the front door. Resident 32 and their spouse were on the sidewalk to the left of the facility entrance but were sitting within 25 feet of the office front windows. Staff V, maintenance director, walked in the front door from the parking lot while Resident 32 was smoking the cigar. Staff V greeted Resident 32 and their spouse while walking inside but did not say anything to them about smoking on facility property.During an observation on 04/26/2026 at 11:29 AM, three cigar butts were found on the ground in the parking stalls just outside the facility's office windows. There were no cigarette receptacles observed near the facility entrance nor at the group of trees in the parking lot.During an interview on 04/26/2026 at 11:51 AM, Resident 32 reported putting out their cigar by rubbing it on the concrete in the parking lot and throwing the butt in the garbage can on their way back into the facility.During a joint observation and interview on 04/26/2026 at 12:52 PM, Staff B observed the parking spaces just outside the facility windows. Staff B observed the cigar butts on the ground and stated they did not know who smoked cigars. Staff B observed the garbage cans at the entrance to the facility. Both garbage cans were made of plastic and one of the garbage cans had 2 paper bags inside. Staff B acknowledged that a cigarette butt could potentially light the paper bags on fire. Staff B reported there were no cigarette disposal containers as they were a non-smoking facility. Refer to WAC 388-97-1060 (3)(g)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food items were stored under sanitary conditions in two of two nourishment refrigerators. Failure to ensure refrigerator temperatures were monitored and maintained placed residents at risk for food borne illness. Findings included . According to the Food and Drug Administration food code, refrigerator temperatures must be maintained below 41 degrees Fahrenheit (f). In an interview and observation on unit 2 on 04/28/2026 at 9:48 AM with Staff E, Resident Care Manager, the unit 2 nourishment refrigerator temperature read 47 degrees (f). There was no temperature log observed. The refrigerator was observed to contain individual yogurts, applesauce, one carton of thickened lemon drink, one carton of fortified shake, and half sandwiches wrapped in plastic. Staff E stated the kitchen staff stocked the fridge and monitored the temperatures. In an interview and observation on unit 1 on 04/28/2026 at 10:03 AM with Staff Z, Certified Nursing Assistant stated the kitchen took care of the refrigerators. The unit 1 refrigerator temperature was observed to read 46 degrees (f). The unit 1 refrigerator was observed to include yogurts, sandwiches, applesauce and cartons of juices and shakes. There was no temperature log observed. In an interview on 04/28/2026 at 10:40 AM, Staff X, Dietary Services Manager, stated the nursing staff were responsible for monitoring of the nourishment refrigerators on the units. Staff X was made aware of the observations and interviews on the units and stated they would go check those refrigerators, remove food items and ensure there were temperature logs. Staff X stated the kitchen would resume the monitoring. Refer to WAC 388-97-1100(3)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the facility assessment addressed the physical environment, equipment, services, and other physical plant considerations that are necessary to care for its identified resident smoking population. Failure to thoroughly assess all factors associated with resident smoking placed residents at risk for adverse events related to smoking safety.Findings included.Review of a facility policy, titled Non-Smoking Campus- Smoke Free, with revised date 09/12/2025 documented:The resident or representative sign an acknowledgement that the facility is a smoke-free environment upon admission.The facility staff are responsible for enforcing the Smoke-Free Policy.Employees, contractors and visitors are expected to comply with the smoke-free policy while on facility property. Employees who choose to smoke may do so off property or within their personal vehicles.In an observation and interview on 04/26/2026 at 9:00 AM, Resident 51 was observed sitting in their wheelchair, outside on the driveway near a group of trees. Resident 51 was observed to be holding a cigarette. There was a portable O2 tank hanging on the back of their wheelchair, running at 2 L/PM. There were ashes observed on the ground and on Resident 51's shoes, and there was an odor of smoke. Resident 51 told the surveyor that they smoked cigarettes and kept their smoking supplies in their room or on their person.In an observation and interview on 04/26/2026 at 10:05 AM, Resident 32 was observed sitting in their wheelchair outside the facility entrance with their spouse. Resident 32 was observed smoking a cigar. Resident 32's spouse stated that other residents smoke down by the trees, but they could not get down there. Resident 32's spouse stated they were 25 feet from the front door. Resident 32 and their spouse were on the sidewalk to the left of the facility entrance but were sitting within 25 feet of the office front windows. Staff V, maintenance director, walked in the front door from the parking lot while Resident 32 was smoking the cigar. Staff V greeted Resident 32 and their spouse while walking inside but did not say anything to them about smoking on facility property.On 04/26/2026 at 11:29 AM three cigar butts were observed on the ground in the parking stalls just outside the facility's office windows. There was no cigarette receptacles observed near the facility entrance nor at the group of trees in the parking lot.In an interview on 04/26/2026 at 12:44 PM, Staff B, Chief Nursing Officer, stated that the facility was aware that Resident 51 was a current smoker. Staff B replied they did not know how the resident extinguished their cigarettes and since they were a non-smoking facility, they did not provide any ashtrays. Staff B replied that Resident 51 had their smoking paraphernalia with them as the facility had not searched them or their room.Review of the Facility assessment dated [DATE] documented the resident population included 9 residents identified with tobacco use. Further review of the Facility Assessment revealed no further documentation regarding physical environment, equipment or services necessary related to the identified resident smoking population. In an interview on 05/01/2026 Staff B stated they assisted in filling out portions of the facility assessment and was reviewed annually. Staff B stated were aware of issues regarding residents following the facility smoking policy and it was addressed on different levels such as all staff. Staff B stated they were unaware of specifics related to residents who smoked in the facility assessment.No associated WAC reference

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to provide a response to concerns voiced by 1 of 1 resident groups (Resident Council) that had concerns. The failure to respond to Resident Council about their concerns left the issues unresolved and resulted in the Resident Council process being ineffective at improving resident quality of life.Findings included.Review of Resident Council Minutes for December 2025 documented there were concerns for beverages arriving early before meals, nursing assistants not providing care properly and not getting residents up when they preferred, nursing assistants complaining about their employment, televisions not working properly with no service in some rooms, and medications not given on time by nurses. The section, on the Resident Council Minutes, titled, Recommendations/Follow-up was blank.Review of the Grievance Resolution Log for December 2025 showed no documentation or resolution to the noted concerns from Resident Council from December 2025.Review of the Resident Council Minutes for January 2026 documented there were concerns about nursing assistants choosing bedtimes for the residents and staff not answering the doorbell after 6 pm to allow visitors to come into the facility. The section, on the Resident Council Minutes, titled, Recommendations/Follow-up was blank.Review of the Grievance Resolution Log for January 2026 showed no documentation or resolution to the noted concerns from Resident Council from January 2026. There were two logged entries titled Resident Council dated 01/02/2026 for flies and snack rotation.Review of the Resident Council Minutes for February 2026 documented concerns of call light wait times were too long, more variety in the food was needed, availability of snacks, and the laundry detergent smelled funny. The section, on the Resident Council Minutes, titled, Recommendations/Follow-up was blank.Review of the Grievance Resolution Log for February 2026 showed no documentation or resolution to the noted concerns from Resident Council of February 2026.Review of the Resident Council Minutes for March 2026 documented their concerns included they did not believe their grievances were taken seriously and felt ignored, call lights wait times were too long, and cold food was being placed on the warm plates leaving the intended cold food warm. The section, on the Resident Council Minutes, titled, Recommendations/Follow-up was blank.Review of the Grievance Resolution Log for March 2026 showed no documentation or resolution to the noted concerns from Resident Council of March 2026.Review of the Resident Council Minutes dated 04/03/2026 documented concerns of mislabeled and watered down juice, missing activities due to showers, therapy visits, and vitals, smoking remained a problem and there was smoke smell in the facility and rules not being followed, and the language barrier between staff and residents had grown.Review of the Grievance Resolution Log for April 2026 showed no documentation or resolution to the noted concerns from Resident Council from April 2026.In an interview on 04/27/2026 at 1:06 PM Resident 49, Resident Council President, stated smoking in the facility had been an issue and the facility was starting to smell like smoke. Resident 49 stated call light wait times varied and it could take up to an hour for a call light to be answered and care received. They stated the juice was less watered down and the televisions worked at times and other times not; there were not enough boxes for all the rooms. They stated sometimes Staff A, Administrator, will come and talk with them about concerns, but they feel they should speak with Staff KK, Activities Director, too because their memory was not always reliable.In an interview on 04/27/2026 at 2:17 PM Staff KK, stated if residents had a grievance and they were able to complete it themselves they would, but more times than not they ask them to write it out for them. Staff KK stated when they complete a grievance, they take a copy and provide the original to Staff A. When asked about the resident council concerns, they stated they were the go between the residents and staff, the form used to document the minutes were provided by corporate, and during the resident council meetings they asked if the concern required documentation on the grievance form.In an interview on 04/30/2026 at 3:17 PM Staff A, Administrator stated grievance forms are located throughout the building, and anyone can pick them up and fill them out. Staff A stated they review the resident council minutes and talk to the resident (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	council president about the concerns. Staff A stated that sometimes the concern is placed on a grievance and other times it is not as it is hard to tell whether they need to be on a grievance.Reference WAC 388-97-0920

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on interview and record review, the facility failed to periodically inform residents of their rights after residents were admitted to the facility for 7 of 7 sampled residents (Residents 7, 20, 35, 40, 49, 67 and 75) when reviewed for resident rights. This failure placed residents at risk of not being informed of their rights and a diminished quality of life.Findings included .Findings included .On 04/28/2026 at 2:07 PM during resident council, Residents 7, 20, 35, 40, 49, 67, and 75 all stated they the staff did not talk about or review the rights of the residents in the facility. When asked if resident rights were reviewed at resident council meetings, they all stated they were not.Review of the resident council meeting minutes for November 2025 through April 2026 showed no documentation/confirmation that resident rights were reviewed.In an interview on 04/30/2026 at 3:17 PM Staff A, Administrator, stated they did not know if resident rights were routinely reviewed with residents in resident council or otherwise.Reference: WAC 388-97-0300(1)(a)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure complete and updated Notification of Medicare Non-Coverage (NOMNC - a document informing Medicare beneficiaries that their covered services will be terminated and providing information on their appeal rights) for 4 of 4 sampled residents (Resident 15, 91, 90 and 63) reviewed for liability notice. The facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF ABN-a form to inform their responsibilities for the services cost when Medicare discontinues) for 2 of 4 sampled residents (Resident 15 and 63) reviewed for Beneficiary Notices. The facility failed to utilize the current CMS-approved forms and failed to ensure proper complete the forms as the facility staff signed in the place of the resident and/or representatives; the facility failed to document an explanation of appeal rights and provide copies to residents and/or representatives. This failure placed residents and/or their representatives at risk for not fully understanding their Medicare benefits, appeal rights and financial liability. Findings included .Review of Center for Medicare and Medicaid Services (CMS) electronic web site (CMS.gov), shows the NOMNC form (CMS-10123) was last updated January 2025, and the ABN form was last updated in 2024. <RESIDENT 15>Resident 15 admitted to the facility on [DATE]. Resident 15's Medicare service was discontinued on 02/16/2026, and the resident remained in the facility.Review of the NOMNC form dated 02/13/2026, documented that Resident 15 could not sign due to dementia (progressive disease affecting memory and ability to make decisions) and the form was served to the son via a phone call. In the area labeled Signature of Patient or Representative was signed by facility Staff C, Social Services. There was no signature from the resident's representative.Review of Resident 15's electronic health record (EHR), showed there was no documentation that Resident 15's representative was provided an explanation of the NOMNC, including appeal process, phone number, or deadline, or if the representative understood the process. There was no documentation verifying the representative received a copy of the NOMNC. The form utilized was a version approved by CMS in 2011, which was not the current version.Review of Resident 15's ABN form dated 02/13/2026, showed the Signature of Patient or Authorized Representative was signed by Staff C. The EHR contained no documentation that an explanation of the ABN was provided or that a copy was sent to the representative. The ABN utilized was a 2018 version, which was not the current version. <RESIDENT 63>Resident 63 was admitted to the facility on [DATE]. Resident 63's Medicare was discontinued on 04/13/2026 and the resident remained in the facility.Review of the NOMNC dated 04/10/2026 showed the resident signed the form.Review of Resident 63's EHR showed no documentation that an explanation of appeal rights was provided or that a copy was given to the resident. The form utilized was the outdated 2011 version.Review of Resident 63's ABN dated 04/10/2026 showed the resident signed the form.Review of Resident 63's EHR, showed no documentation of an explanation of the ABN form or confirmation that a copy was received. The form utilized was the outdated 2018 version. <RESIDENT 91>Resident 91 was admitted on [DATE] and discharged on 02/19/2026.Review of the NOMNC form dated 02/16/2026 documented the notice was served to the resident's daughter. The Signature of Patient or Representative section was signed by Staff C, rather than the representative.Review of Resident 91's EHR showed no documentation that an explanation of the NOMNC or the appeal process was provided, nor was there confirmation that the daughter received a copy of the form. The form utilized was the outdated 2011 version. <RESIDENT 90>Resident 90 was admitted to the facility on [DATE] and discharged on 02/25/2026. According to the discharge Minimum Data Set (MDS-an assessment tool) assessment, dated 02/25/2026, the resident had severe cognitive impairment.Review of the NOMNC form, dated 02/20/2026, documented the NOMNC signed by the resident. Review of Resident 90's EHR showed no documentation that an explanation of the appeal process was provided to the resident or their representative, nor was there confirmation that a copy was provided. The form utilized was the (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	outdated 2011 version. In an interview on 04/29/2026 at 10:09 AM, Staff C stated they were responsible for the issueance and explain the NOMNC and ABN forms. Staff C stated they served the forms via phone to the representatives if the residents were cognitively impaired. Staff C confirmed they signed under Signature of Patient or Representative line because they were the representative of the facility serving the form. Staff C confirmed there was no documentation in the medical record or the EHR that explanations were provided. Staff C stated they were not aware of the current CMS versions of the forms.In a phone interview on 04/29/2026 at 1:59 PM, Staff PP, Assistant Business Office Manager, stated they were responsible for providing the NOMNC and ABN forms to the social services. Staff PP stated they were unaware that the form was outdated and acknowledged that the outdated forms were still being utilized in the facility currently.In an interview on 04/30/2026 at 3:54 PM, Staff C stated they would give the representative a physical copy or email them an electronic copy, but there was no documentation if they gave or emailed copies to Resident 15 and Resident 91's representatives.In a joint interview and record review on 04/30/2026 at 2:49 PM with Staff QQ, Director of clinical service, and Staff A, Administrator, Staff A confirmed the outdated forms were the incorrect version and should not have been used. Staff A stated the expectation was for the facility to utilize the most current CMS-approved forms to ensure residents and/or representatives were properly notified of their financial rights and liabilities. Staff A and Staff QQ stated the facility staff was not the Patient or Representative and was not supposed to sign for residents or representatives.In an interview on 05/01/2026 at 10:14 AM, Staff B, Chief Nursing Officer, stated they expected staff to document the explanation of appeal process in the EHR. Reference WAC 388-97-0300(1)(e)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 3 of 5 residents (4,6 and 34) selected for medication review were free from unnecessary medications. This failure placed residents at risk for adverse side effects and decreased quality of life.Findings included.Review of the facility policy Psychotropic Drugs dated 04/22/2025 stated Psychotropic medications and those used to manage behavioral symptoms must be clinically justified, individualized, and aligned with the resident's assessed needs, goals of care, and accepted standards of practice. The facility prohibits the unnecessary use of psychotropic drugs including any medication prescribed in excessive dose, excessive duration, without clear indication, or without adequate monitoring. <RESIDENT 4> Resident 4 admitted [DATE]. Review of Resident 4's physician's orders with a print date 04/27/2026 showed an order for an antianxiety medication ordered on 04/16/2026 and available every four hours as needed for anxiety. Review of Resident 4's Medication Administration Record (MAR) print date 04/27/2026 documented the antianxiety medication had been administered six doses since it was ordered. The MAR did not document target behaviors for the antianxiety medication, or document what behaviors consistent with anxiety had occurred prior to administration. The MAR included non-pharmacological interventions to attempt prior to administration; however, none were documented as attempted. In an interview on 04/27/2026 at 1:42 PM, Staff E, Resident Care Manager (RCM), stated medication orders were reviewed when they were ordered to check for consents and diagnosis. There should be target behaviors and non-pharmacological interventions on the MAR. Staff E stated there was a psychotropic meeting every month and they did a double check at that meeting. Staff E stated Resident 4 had orders for as needed medication for anxiety but was not aware that the orders did not include target behaviors or documentation of non-pharmacological interventions attempted. <RESIDENT 34> Resident 34 admitted to the facility on [DATE]. Review of Resident 34's Order Summary with a print date of 04/26/2026 documented an order for an antidepressant medication and an antipsychotic medication. (medication to manage delusions, hallucinations and paranoia). Review of Resident 34's MAR/ Treatment Administration Record (TAR) for 03/23/2026 through 04/26/2026 showed no adverse side effects (ASE) monitors in place. In an interview on 05/01/2026 at 8:54 AM, Staff B, Chief Nursing Officer, stated ASE monitors should be initiated as medications were prescribed and at admission. <RESIDENT 6> (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snohomish Health and Rehabilitation of Cascadia	800 10th Street Snohomish, WA 98290

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 6 was re-admitted to the facility on [DATE]. Record review of Resident 6's Order Summary with a print date of 04/27/2026 documented three antidepressants were ordered. Record review of Resident 6's MAR and TAR for March and April 2026 did not show documentation of ASE monitoring. In an interview on 04/29/2026 at 12:06 PM Staff DD, Licensed Practical Nurse stated that residents taking antidepressants were monitored for possible ASE and they document the monitoring every shift. Staff DD reviewed current MAR/TAR and was not able to show any documentation of ASE monitoring. In an interview on 04/29/2026 at 2:51 PM, Staff BB, RCM stated residents who were taking antidepressants were monitored for possible ASE. Documentation for the monitoring should be in the MAR and progress notes if they observed any ASE. Staff BB was unable to provide any documentation showing Resident 6 was being monitored for ASE. They stated that Resident 6 was recently readmitted and most likely it was not added when they returned to the facility. Refer to WAC 388-97-1060(3)(k)(i), 0620(1)(a)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 6 of 8 residents (Residents 4, 6, 9, 34, 42, and 51), reviewed for pre-admission screening and resident review (PASRR - a federal requirement which identifies individual with Serious Mental Illness (SMI) or intellectual or developmental disabilities to provide appropriate services), received the required screening for necessary services. This failure placed the resident at risk for unidentified mental health needs.Findings included .Review of a facility policy, titled, Pre-admission Screening & Resident Review (PASRR) Process, revised date 08/29/2025, documented a positive Level 1 screen necessitated an in-depth evaluation of the individual by the state designated authority, known as PASRR Level 2. If a resident was admitted with an exemption and the stay was going to last more than 30 days, then the state designated authority must conduct a Level 2 review within 40 calendar days. <RESIDENT 9> Resident 9 admitted to the facility with diagnoses to include schizoaffective disorder (mental health condition where a person has symptoms of a mood disorder and psychosis) and mild cognitive impairment. Review of Resident 9's PASRR dated 06/16/2025 documented they were exempted from a level two evaluation as their stay in the facility was anticipated to be less than 30 days. Review of Resident 9'sElectronic Health Record (EHR) showed no documentation related to the 30-day exempted PASRR or that a level two evaluation was sought after the 30 days. In an interview on 04/29/2026 Staff C, Social Services, stated they have tried to keep up on the PASRR accuracy by reviewing them quarterly, keeping a list and they were not up to date. <RESIDENT 34> Resident 34 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's disease (progressive disease characterized by cognitive decline, memory loss and behavioral changes), dementia with other behavioral disturbance and history of stroke. Review of Resident 34's PASRR dated 03/20/2026 documented they were exempted from a level two evaluation as their stay in the facility was anticipated to be less than 30 days. Review of Resident 34's EHR showed no documentation related to the 30-day exempted PASRR or that a level two evaluation was sought after the 30 days. <RESIDENT 42> Resident 42 was admitted on [DATE] with diagnoses to include depression and anxiety. In a record review on 04/29/2026, Resident 42 had a PASRR dated 02/12/2026 documented they were exempted from a level two evaluation as their stay in the facility was anticipated to be less than 30 days. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 42's EHR showed no documentation related to the 30-day exempted PASRR or that a level two evaluation was sought after the 30 days. In an interview on 04/29/2026 10:30 AM Staff C, stated the PASRR was not faxed to the PASRR evaluator after 30 days and should have been. In an interview on 05/01/2026 at 8:54 AM Staff B, Chief Nursing Officer, stated they had reviewed and audited PASRR's several times and had forwarded the results to social services to review and follow up. <RESIDENT 6> Resident 6 was admitted to the facility on [DATE] with depression and anxiety. In a record review of Resident 6's PASRR dated 01/01/2026 documented a level two referral was required on admission. There was no Level 2 evaluation or invalidation found in Resident 6's EHR. In an interview on 04/29/2026 at 10:08 AM, Staff C stated they reviewed PASRR's prior to resident's admission to check for accuracy. If a resident was admitted and the level two was not provided, they followed up with the PASRR Coordinator via email. Any communication with the PASRR Coordinator should be in the resident's progress note. Staff C could not provide any documentation regarding the level two evaluation for Resident 6. <RESIDENT 4> Resident 4 admitted [DATE] and had diagnoses which included dementia, anxiety and developmental delay. Review of Resident 4's level one PASSR dated 12/15/2025, documented level two evaluation was indicated based on indicators of SMI. Review of the Resident Record on 04/28/2026 showed no evidence of referral for level two evaluation and no level two evaluation or invalidation was found. In an interview on 4/29/2026 at 10:09 AM, Staff C, stated PASSRs were reviewed on admission and daily at the facility standup meeting. Staff C stated PASSR statuses were tracked and reviewed quarterly. Staff C stated Resident 4's level two PASSR was required on admission and should have been followed up on. Staff C confirmed there was no documentation that there had been a referral for Resident 4 for level two evaluation since their admission on [DATE]. <RESIDENT 51> Resident 51 was admitted to the facility on [DATE]. Review of Resident 51's PASRR level one form dated 01/13/2026, revealed a level two evaluation was required prior to admission as resident showed indicators of a SMI. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 51's EHR, no PASRR level two evaluation was found. During a phone interview on 04/28/2026 at 10:33 AM, Staff R, admissions, stated if a resident had a positive level one PASRR form, then there would need to be a notice of determination or an invalidation prior to the resident admitting to the facility. During an interview and record review on 04/28/2026 at 10:39 AM, Staff S, Medical records, stated they did not see a notice of determination or invalidation for Resident 51. On 04/28/2026 at 11:43 AM, Staff S provided a level two PASRR invalidation that was dated 04/28/2026. The comment section of the level two invalidation documented that Resident 51 was admitted to the facility without the level two determination being done. Refer to WAC 388-97-1915 (2)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food services met the dietary needs and preferences for residents on 2 of 2 resident units, 1 of 1 resident group and 1 of 2 residents (Resident 77) reviewed for food. Failure to ensure snacks were available, preferences were honored and alternates of similar nutritional value were provided during meals placed residents at risk for decreased quality of life. Findings included .<RESIDENT COUNCIL/SNACK AVAILABILITY> Review of Resident Council Minutes dated 02/06/2026, documented snacks were never available, and the nursing assistants didn't know where they were located. Review of Resident Council Minutes dated 03/06/2026, documented food that was meant to be cold was placed on warm plates during meals. In an interview 04/27/2026 at 1:06 PM, Residents 44 and 49 stated snacks were not available, at times they might not have any, or only peanut butter and jelly sandwiches were offered. In an interview on 04/28/2026 at 2:12 PM, Resident 20 stated the only snacks available yesterday were teddy graham cookies. Resident 20 stated the chips went fast and thought they should limit how many bags someone could have. In an interview and observation of unit 2's pantry on 04/28/2026 at 9:48 AM with Staff E, Resident Care Manager, the unit 2 pantry refrigerator was observed to contain five individual yogurts, four applesauce cups, one carton of thickened lemon drink, one carton of fortified shake, and five and a half sandwiches wrapped in plastic. The cupboards and drawers contained only one partial box of six dried oatmeal packages and condiments. Staff E stated, it is very empty. Staff E stated the pantries were only stocked once a day in the evening. In an interview and observation of unit 1's clean utility room on 04/28/2026 at 10:03 AM with Staff Z, Certified Nursing Assistant, the cupboards and shelves contained resident care supplies and no food items. The refrigerator contained three yogurts, four sandwiches dated 04/26/2026, eight applesauce cups, one carton of thickened juice and one carton of nutrition shake. There was a small tray on the counter with condiments and one silver bin with some packages of Teddy [NAME] graham cracker snacks. Staff Z stated this utility room was the only place they kept snacks on unit 1. In an interview on 04/28/2026 at 10:36 AM, Staff CC, Culinary Cook, stated day shift kitchen staff did not stock snacks on the units, the night shift re-stocked. They were supposed to stock enough to last until the next night when they came back. There was supposed to be a certain amount on the units, and they tried not to stock too much so they didn't have to throw things out. Staff CC stated there should be a variety of items like fruit snacks, chips, crackers and cheeses, puddings, etc. In an interview on 04/28/2026 at 10:40 AM, Staff X stated the kitchen was responsible for re-stocking the snacks. Staff X stated they used to stock snacks before dinner, but when they did that, all the snacks would be gone by dinner, so now they did it later. Staff X was not aware that snacks did not last throughout the day until the next restock or of any resident complaints about lack of snacks available. Staff X stated they had not been to a Resident Council meeting in a long time. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a follow-up interview and observation on 04/29/2026 at 11:14 AM, Staff X stated there had been a lack of snacks the last couple of days because they were out. It was observed that a delivery had just arrived and the back shelf of the dry storage area now included boxes of chips, cookies, pretzels, cheese 'n' crackers etc. that were not observed on prior visits to the kitchen. <ALTERNATE MEAL ITEMS> Review of a grievance dated 04/24/2026, written by Resident 44, documented oat milk was not available on 04/17/2026 through 04/22/2026 and they had not received extra protein with their meals, especially at breakfast. In an interview on 04/27/2026 at 10:43, AM Resident 44 stated they were gluten free, dairy free, and on a diabetic diet. Resident 44 stated they were only able to select a minimal number of meals from the menu due to their diet restrictions. Resident 44 stated there was limited number of snacks provided by the facility that met their diet restrictions and as a result they had to purchase their own snacks to meet their diet needs. In an interview and observation on 04/27/2026 at 8:54 AM, Resident 77 stated they disliked white bread, but would like brown bread. Resident 77 stated this had never been corrected and they never get any type of bread. An observation of the resident's meal ticket stated they disliked bread. In an interview on 04/28/2026 at 10:48 AM, Staff X, Dietary Manager, stated the menu showed five alternates per day, and residents could choose the main meal or choose one of the five alternates. They could also choose which specific items they wanted or didn't want and could mix and match items from the alternate choices. The meal tickets included allergies, special diets, and likes/dislikes. In an observation of lunch meal service on 04/29/2026 at 11:52 AM, the meal listed on the menu was creamy herbed chicken, wild rice, and broccoli. Staff Y, Culinary Cook, explained the items on the tray line which included the main meal items as well as other items such as mashed potato, soup, mechanically altered items and gravies. There were five alternate meal choices listed as everyday options on the menu which included: Chicken Caesar salad/dinner roll, Chef's choice deli sandwich/side salad, Hotdog/chips, Cottage cheese and fruit plate/dinner roll, French toast sticks/sausage/fruit. Staff Y was observed reading resident meal tickets and adding food items to residents' plates. A meal ticket was observed to include the words no rice at the top of the ticket. Staff Y was observed to read the ticket and then plate only chicken and broccoli and pass the plate to the dietary aid, who placed the plate on the tray and into the meal cart. Staff Y was asked why there had been no alternate starch or similar item such as the mashed potato added to the resident's plate, and Staff Y stated, we don't do that. Staff Y stated that if the ticket showed a resident did not like something, or to avoid something, they just didn't add that item to the plate, but generally don't add something else. In a continued observation, a meal ticket was observed to read that a resident disliked broccoli. Staff Y was observed to omit the broccoli and plate only chicken and rice, not adding a similar alternate vegetable or other item to the plate. Staff Y was asked again why there wouldn't be a substitute vegetable item to replace the broccoli, and Staff Y stated, I don't think anyone complains, we could, but we generally don't do that. In an interview on 04/29/2026 at 12:30 PM, Staff X was not aware that some food items or disliked items were not being replaced with similar items during meal service and stated they would review that process. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 77> Resident 77 was admitted to the facility on [DATE]. In an interview on 04/27/2026 at 8:54 AM, Resident 77 stated that the facility did not follow what was listed on their dietary slip. Resident 77 stated that there was a list of food that they could not eat because it caused them stomach upset or constipation. The resident's diet slip documented that they disliked bread, Mexican food and beef. In an observation and interview on 04/27/2026 at 1:16 PM, Resident 77 was eating lunch. The meal tray was observed to include two meatballs. The meatballs were untouched. Resident 77 stated that the meatball was made of beef and they did not eat beef. In an interview on 04/27/2026 at 1:27 PM, Staff X stated that the meatballs were made of beef. Staff X stated that the cook and the dietary aid reviewed the diet slip prior to putting the food tray together would read and review to ensure residents preferences and allergies were followed. Staff X reviewed Resident 77's diet slip with beef listed as a dislike. Staff X stated Resident 77 occasionally ate beef but could not provide documentation that the resident had requested meat balls and stated the resident did not fill out the menu for the week. Refer to WAC 388-97-1100(1),1120(3)(a),1140(6)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 a system in which resident's records were accurate, complete and readily accessible for 1 of 4 residents (Resident 2) reviewed for closed record, 1 of 2 residents (Resident 9) reviewed for Advance Directive, and 1 of 1 residents (Resident 4) reviewed for Hospice Services. This failure placed the residents at risk of a delay in care or services after discharge, unmet care needs, and diminished quality of life. Findings included .Review of the facility policy titled, Resident Medical Record, revised dated [DATE], documented medical records were maintained on each resident were to be complete, accurately documented, readily accessible and systematically organized. <RESIDENT 9> Resident 9 was admitted to the facility on [DATE] with a guardian in place. Resident 9's electronic medical record showed letters of guardianship with expiration dates of [DATE]. In an interview on [DATE] at 11:00 AM, Staff C, Social Services stated they were unaware that Resident 9's letters of guardianship had expired. In an interview on [DATE] at 11:15 AM, Staff S, medical records, stated there was no process that they were aware of to ensure letters of guardianship were updated after expiration. Staff S stated when they were given documents and they uploaded it into the medical record of the resident. <RESIDENT 4> Resident 4 admitted [DATE] on Hospice services. Review of Resident 4's record on [DATE], the Hospice Certification and plan of care start date was the day of admit ([DATE]), and the certification period ended [DATE]. The Hospice plan of care planned for Licensed Nursing (LN) visits weekly, Home Health Aide (HHA) visits twice a week, Social Worker visits monthly, Chaplain visits monthly, and a onetime Occupational Therapist (OT) visit. Further review of the record showed no updated Hospice Certification beyond [DATE]. Review of Resident 4's progress notes and scanned documents on [DATE] revealed only four notes since admission from the Social Worker and Hospice Chaplain. There were no LN, HHA or OT visit notes or summaries found in the record since admission. In an interview on [DATE] at 1:42 PM, Staff E, Resident Care Manager (RCM), stated Hospice faxed visit notes over, the nurses reviewed them and they got scanned by medical records. Staff E stated they did not know that Resident 4 did not have a current Hospice Certification and Plan of Care in the chart or what the process was to ensure visit notes were received. In an interview on [DATE] at 2:00 PM, Staff S stated they did not have any documentation pending to scan for Resident 4. In a follow-up interview on [DATE] at 10:52 AM, Staff S stated there was no standard process for full chart audits. Staff S stated when visit notes or after visit summaries were received, they were scanned and uploaded within two days. Staff S stated they did not know if it (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be medical records or nursing to audit for missing notes or visit summaries from outside providers. Staff S stated they did not know they should be looking for those. <RESIDENT 2> Resident 2 was admitted to the facility on [DATE] and discharged on [DATE]. Review of the discharge Minimum Data Set (MDS-an assessment tool) assessment, dated [DATE], showed the resident had an unplanned discharge to a hospital. Review of a progress note dated [DATE] at 10:04 PM, documented Resident 2 was transferred to the Emergency Department (ED). Review of a Discharge-Anticipated/Planned evaluation, dated [DATE] at 1:54 PM, documented the date of discharge/transfer was [DATE], and Resident 2 was discharged to an Adult Family Home (AFH) with home health services. The evaluation was signed by Staff II, RCM. Review of a Nursing Home Transfer or Discharge Notice form indicated Discharge, and Resident 2 was discharged to AFH. The form was signed by Staff C, Social Services, dated [DATE]. Review of a second Nursing Home Transfer or Discharge Notice form indicated Transfer, and Resident 2 was transferred to the hospital. The form was signed by Staff II, dated [DATE]. In an interview on [DATE] at 10:09 AM, Staff C stated they were not sure where Resident 2 was discharged . Staff C stated it was very confusing since there was documentation showing Resident 2 was discharged to both the hospital and an AFH. In an interview on [DATE] at 10:45 AM, Staff II stated Resident 2 was transferred to the hospital on [DATE]. Staff II stated the Discharge-Anticipated/Planned evaluation dated [DATE] was incomplete and the resident did not discharge to AFH. Staff II stated the Nursing Home Transfer or Discharge Notice form which indicated Discharge should be removed from Resident 2's medical record. In an interview on [DATE] at 2:27 PM, Staff B, Chief Nursing Officer, stated Resident 2 was transferred to the hospital on [DATE]; the discharge notice on [DATE] indicated Resident 2 went to AFH was predated and not supposed to be a part of Resident 2's medical record. Staff B stated the expectation was for the medical record to be accurate, complete, and not predated. Reference WAC 388-97-1720 (1)(a)(i-iv)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to allow residents to make choices about daily routines for 1 of 3 residents (Resident 51) reviewed for choices. The facility's failure to accommodate resident choice placed residents at risk for a diminished quality of life.Findings included.Resident 51 was admitted to the facility on [DATE]. According to the quarterly minimum data set assessment (an assessment of care needs), dated 04/22/2026, the resident was cognitively intact.During an interview on 04/26/2026 at 10:05 AM, Resident 51 reported they were awakened at least three times a night for medications and to have their blood pressure and heart rate checked. Resident 51 reported that they had a difficult time getting back to sleep after they had been awakened. Resident 51 stated they had spoken with the medication nurse about not wanting to be awakened at night, but the staff did not adjust their schedule.Review of Resident 51's Medication Administration sheets from 04/01/2026- 04/28/2026 showed an order for albuterol (medication for breathing difficulty) scheduled at 6AM, 12 PM, 6PM and 12 AM (midnight). There was also an order for Resident 51 to have their vital signs (blood pressure, heart rate, amount of oxygen percentage in the blood, and temperature) every shift, scheduled on day shift, evening shift and on the night shift.During an interview on 04/29/2026 at 9:48 AM, Staff P, Licensed Practical Nurse, stated that Resident 51 had mentioned on several occasions that they did not like to be awakened at night. Staff P reported they had not adjusted Resident 51's schedule nor had they reported the residents' concern to the Resident Care Manager (RCM).On 04/29/2026 at 9:54 AM, Staff D, RCM, reported if a resident's preference was not to be awakened at night, they would look at the care needs and try to rearrange the schedule for the resident. Staff D stated they were not aware that Resident 51 did not want to be awakened at night.On 04/29/2026 at 9:58 AM, Staff B, Chief Nursing Officer, reported they expected the care staff to report to the RCM when a resident did not want to be awakened at night so the RCM could adjust the schedule.Reference WAC 388-97-0900 (1)

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Snohomish Health and Rehabilitation of Cascadia	800 10th Street Snohomish, WA 98290

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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 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 PASRR (Pre-admission Screening and Resident Review-an assessment used to identify people [resident] referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities [ID], or related conditions are not inappropriately placed in nursing facility for long term care) Coordinator after a significant change in mental condition for 1 of 5 residents (Resident 37), reviewed for PASRR. This failure placed the resident at risk for unmet mental health services necessary to obtain the resident's highest level of psychosocial well-being and diminished quality of life.Finding included .Resident 37 admitted to the facility 01/04/2024 with diagnoses to include Parkinson's disease (progressive movement disorder of the nervous system), major depressive disorder, and anxiety.Review of Resident 37's PASRR dated 01/04/2024 documented they had indicators of serious mental illness but did not require a level two evaluation due to their stability on medications of venlafaxine (an antidepressant medication) and busbar (an antianxiety medication).Review of Resident 37's psychiatric provider note dated 04/29/2025 documented venlafaxine may be contributing to their anxiety and recommended to change of antidepressant.Review of Resident 37's progress notes dated 05/05/2025 documented they were given a one-time dose of hydroxyzine (an antianxiety medication) for an acute episode of anxiety.Review of Resident 37's provider progress note dated 06/25/2025 documented they were prescribed hydroxyzine on 06/16/2026 as needed for 14 days related to increased anxiety.Review of Resident 37's progress note dated 07/05/2025 documented they came to the nurse's station with complaints of anxiety and panic. An order for Hydroxyzine was provided to Resident 37 for three days.Review of Resident 37's provider progress note dated 07/23/2025 documented an order to cross [NAME] Venlafaxine with Zoloft and discontinue Venlafaxine on 07/30/2025.Review of Resident 37's progress notes from 05/01/2025 through 04/26/2026 showed no documentation that a new PASRR was completed and a level two requested for significant changes in their mental status.In an interview on 04/29/2026 at 10:30 AM Staff C, Social Services, stated they were reviewing residents PASRR's quarterly for accuracy. Staff C stated they would not complete a new PASRR or seek a level two evaluation for a resident who had changes in their psychotropic medications, only if a new diagnosis was added.Reference WAC 388-97-1975

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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 professional standards were met for 2 of 5 residents (Resident 6 and Resident 52) reviewed for unnecessary medication review; 1 of 2 residents (Resident 29) for blood glucose monitoring; and 1 of 2 residents (Resident 6) for skin observation and treatment. The facility failed to ensure physician-ordered parameters were followed for blood pressure medication administration, failed to perform blood glucose (test to check sugar level in the blood) checks prior to meals, and failed to provide treatments for a wound. These failures placed the residents at risk for adverse outcomes, medication errors, infections, clinical complications, and unmet needs.Findings included .According to the facility policy titled Skin Integrity & Wound Prevention with revision date of 09/14/2025, new areas of concern identified are documented in the medical record, provider notified with treatment orders obtained and care plan updated. <WOUND> <RESIDENT 6> Resident 6 was re-admitted to the facility on [DATE]. According to the admission Minimum Data Set (MDS – an assessment tool) dated 03/14/2026, the resident had cognitive impairment and had no pressure ulcers but was at risk for pressure ulcers/injuries. In an interview on 04/27/2026 at 8:23 AM, Resident 6 stated that they had an open area on their buttocks. Review of Resident 6's skin inspection evaluation dated 04/22/2026 documented a small open area to the left of their buttock. Review of Resident 6's April 2026's Treatment Administration Record (TAR) did not show any treatments or documentation regarding the small open area on their buttock. There were no orders in Resident 6's electronic chart for the treatment of the open area on their buttocks. In an interview on 04/30/2026 at 8:09 AM, Staff DD, Licensed Practical Nurse (LPN) stated that Resident 6 did not have any open areas on their buttocks. In an interview on 04/30/2026 at 9:30 AM, Staff BB, Resident Care Manager (RCM) stated that Resident 6 did not have any open areas on their buttocks. In an observation and interview on 04/30/2026 at 9:41 AM, with Staff EE, Certified Nursing Assistant (CNA) there was a small open area consistent with a Stage 2 (a shallow, painful open wound caused by prolonged pressure, resulting in top layer of skin is broken) observed on Resident 6's left buttock. There was no bandage or ointment applied to the wound. Staff EE stated the nurse was aware of the open area and that they would let them know that the bandage was off. In an interview on 04/30/2026 at 9:56 AM, Staff DD, LPN observe the open area and stated that it was the first time they had seen it. Staff DD added that it was just red and blanchable previously. In an interview on 04/30/2026 at 10:13 AM, Resident 6 stated that they knew about their open area on their buttocks when they went to their doctor's appointment about four-five days ago. They stated that it was painful when they sat on their wheelchair. Resident 6 stated that some staff knew about (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their open area but were not aware of their names. In a record review of Resident 6's progress note showed that the doctor's appointment was on 04/22/2026, which was the same day that a nurse documented the small open area on the resident's buttocks. <MEDICATION PARAMETERS> <RESIDENT 6> Review of Resident 6's order summary dated 04/27/2026 documented a blood pressure medication to be given two times a day with a parameter to hold if the systolic blood pressure (SBP – the top number that measures the pressure in the arteries when the heart beats) less than 100 or heart rate (HR) less than 60. Record review of March 2026 Medication Administration Record (MAR) documented that on March 1, 26 and 30, the blood pressure medication was given outside the ordered parameters. Record review of April 2026 MAR documented that on April 8, 25, 27 and 28, blood pressure medication was given outside the ordered parameters. In an interview and record review on 04/29/2026 at 3:30 PM, Staff BB, confirmed that the check marks in the MAR meant the medications were given. Staff BB reviewed Resident 6's MAR and confirmed that that the nurses gave the medication outside the ordered parameters and that the nurses should have held the medication. <RESIDENT 52> Resident 52 was admitted to the facility on [DATE] with diagnoses to include high blood pressure. Review of Resident 52's 04/01/2026 - 04/28/2026 MAR, showed an order for a blood pressure medication to be given twice a day. The order directed nurses to hold the medication for a heart rate below 60 beats per minute (bpm). However, the medication was administered when the resident's heart rate was below 60 bpm on the mornings of 04/03/2026,04/09/2026, and 04/21/2026, and the evening of 04/09/2026. In a record review and interview on 04/29/2026 at 3:23 PM, Staff H, LPN, stated nurses needed to check the parameter if the order had specific instructions and follow the provider's order to hold the medication if the parameter was out of range. Staff H stated the medication was supposed to be held and it was very upsetting that the nurses gave the medication when the resident's heart rate was out of parameter. In a record review and interview on 04/29/2026 at 3:56 PM, Staff BB, stated all nurses needed to follow the order and check the parameter prior to administering blood pressure medications. Staff BB stated the blood pressure medications should have been held on those days with out-of-range parameters. In an interview on 04/30/2026 at 2:27 PM, Staff B, Chief Nursing Officer, stated the expectation was to follow the provider's order, to read the parameter, and to hold the medication if the parameter was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of range. <BLOOD SUGAR> During an observation on 04/27/2026 at 7:52 AM, a staff member was observed removing the breakfast tray from Resident 29's bedside. Staff O, LPN, then proceeded to check Resident 29's blood sugar. Staff O reported they did not have time to check all blood sugars before breakfast. During an interview on 05/01/2026 at 8:45 AM, Staff B, reported that blood sugars needed to be checked before the meal and that they expected the staff to check the blood sugar before the resident had eaten. Refer to WAC 388-97-1620 (2)(b)(i-ii)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that 1 of 1 resident (Resident 34) who had been continent of bladder prior to admission to the facility, received appropriate treatment and services to restore continence to the extent possible. This failure placed residents at an increased risk of urinary tract infections, discomfort, loss of dignity, and decreased quality of life.Findings included . In a review of the facility policy titled Urinary Assessment & Toileting Program revised 09/15/2025 documented the facility would ensure residents were evaluated for bladder function and continence upon admission and as needed. Residents who were incontinent of bladder would receive appropriate care and services to prevent infection and restore bladder function as possible.Resident 34 admitted to the facility on [DATE] with diagnoses to include falls with concussion, Alzheimer's disease (progressive disease characterized by cognitive decline, memory loss and behavioral changes) and history of stroke.In an interview on 04/26/2026 at 2:55 PM Collateral Contact 1 (CC 1) stated Resident 34 had been continent when residing at home, did not utilize a brief and now they were wearing a brief at the facility. CC 1 stated Resident 34 was independent prior to their fall and hospitalization, and the facility was more cautious with them, utilizing a brief, because of their fall risk. CC 1 stated Resident 34 should be allowed to utilize the bathroom with supervision.Review of Resident 34's hospital Discharge summary dated [DATE] documented they had an order for Flomax (medication used to treat difficulty in urinating). There was no notation regarding Resident 34's continence status.Review of Resident 34's clinical evaluation summary note dated 03/23/2026 documented resident was incontinent with bowel and bladder.Review of Resident 34's bladder status evaluation dated 03/31/2026 documented they were incontinent prior to admission to the facility, no voiding pattern had been completed, and they were not able to communicate their toileting needs or follow direction to participate in a training program.Review of Resident 34's admission Minimum Data Set (MDS-an assessment tool) dated 03/26/2026 documented they were frequently incontinent and a toileting program had not been attempted.Review of Resident 34's Care Area Assessment (CAA-care planning worksheet) dated 03/28/2026 documented no input from the resident or family. The CAA documented Resident 34 was dependent on staff for toileting hygiene and transfers, they were frequently incontinent of bladder, and staff were to continue to assist them with toileting needs and report to the nurse if any issues arose. The CAA lacked details of Resident 34 bladder incontinence, use of briefs, and overall goal related to their toileting needs.Review of Resident 34's care plan dated 03/23/2023 documented that they were at risk for urinary complications related to impaired mobility and cognition. The goal was for Resident 34 to remain free from skin breakdown due to incontinence and brief use. Interventions included prompted voiding (asking them if they were wet or dry and prompt to use the toilet) and routine toileting (toilet with AM and PM care, before meals and as needed).Review of Resident 34's occupational therapy (OT) evaluation dated 03/24/2026 documented their prior level of function for self-care was independent, they required substantial/maximal assistance for toileting with a goal of performing toileting tasks with max cues to return to prior level of function. Review of Resident 34's subsequent OT notes documented the following:-04/21/2026 education was provided to their spouse regarding toileting routine, with no specific details.-04/15/2026 facilitated resident participation in toileting schedule after lunch to increase opportunities to use the bathroom, with no specific details of the schedule.-04/09/2026 toileting tasks were focused on cues to facilitate performance.Review of Resident 34's task response, dated 03/31/2026 through 04/29/2026 for urinary continence documented they were continent 14 times out of 87 documented opportunities. The task did not capture whether Resident 34's instances of continence/incontinence was during a time of prompted/scheduled toileting.In an observation on 04/28/2026 at 9:33 AM Staff LL, Registered Nurse (RN), asked Resident 34 if they were in pain, the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	location of their pain, and level of their pain. Staff LL provided Resident 34 with medication for their pain and then asked if they needed to use the bathroom. Resident 34 indicated they needed to use the bathroom and Staff LL assisted them to their room.In a continuous observation on 04/29/2026 starting at 1:49 PM and ending at 3:57 PM Resident 34 was outside the nurse's station. At 2:35 PM Staff OO, Nursing Assistant Certified (NAC), pushed Resident 34 around the facility and played music for them on a speaker and returned them to the nurse's station at 2:58 PM. Resident 34 remained at the nurse's station until they started to self-propel down the hall at 3:32 PM and engaged in conversation with Staff GG, Assistant Director of Nursing, at 3:34 PM. At 3:44 PM Staff MM, NAC, pushed Resident 34 outside and returned to the nurse's station at 3:57 PM. During the observation Resident 34 was not toileted.In an interview on 04/29/2026 at 2:38 PM Staff NN, NAC, stated they were assigned to care for Resident 34 for the day. Staff NN stated Resident 34 was incontinent at night and during the day they toilet them. Staff NN stated they get Resident 34 up for the day which includes changing their brief, getting dressed, and up in their wheelchair. Staff NN stated Resident 34 then hangs out at the nurse's station. Staff NN stated they changed Resident 34 around 10-10:30 AM and they were incontinent. Staff NN stated Resident 34 had their lunch in the dining room and then they were changed again between 12:30-1:00 PM and was incontinent. Staff NN stated Resident 34 was a one person assist with a walker and they toileted them on the toilet.In an interview on 04/29/2026 at 3:58 PM Staff E, Resident Care Manager (RCM), when asked what prompted toileting consisted of, stated nursing assistants helped residents for toileting as possible. Staff E stated they assisted with toileting too, for residents who required one person assistance, and answered call lights as well. Staff E stated Resident 34's was a fall risk, and care was over seen by Staff BB, RCM.In an interview on 04/29/2026 at 4:00 PM Staff DD, Licensed Practical Nurse, stated Resident 34 showed indicators of needing to use the toilet and they would say things such as I need to powder my nose, become fidgety, or tried to get up. Staff DD stated Resident 34 was prompted to use the toilet when they showed indicators. Staff DD stated scheduled toileting included toileting before and after meals.In an interview on 04/30/2026 at 1:50 PM Staff BB, RCM, stated Resident 34's incontinence was identified in the hospital and when they arrived at the facility their brief was full of urine. Staff BB stated a bladder evaluation was completed. When asked about whether a voiding pattern was conducted after admission for Resident 34, Staff BB stated one was not completed as they had cognitive challenges and it was determined they were not at a level where they could understand and follow directions, contradictory to the observation on 04/28/2026. Staff BB stated Resident 34's spouse had provided information about their incontinence stating they were more continent when at home.In an interview on 05/01/2026 at 8:54 AM Staff B, Director of Nursing Services, stated the process for determining bladder incontinence and interventions was gathering information from the hospital, completing an initial assessment with the resident/family to determine needed supplies and bowel and bladder evaluation within 24 hours of admission. Reference WAC 388-97-1060(3)(c)

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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 2 of 4 residents (Residents 37 and 42) reviewed for respiratory care and services were provided care consistent with professional standards of practice. The facility failed to ensure the oxygen concentrator (a medical device that filters air to deliver concentrated medical-grade oxygen) was set to the ordered rate and failed to ensure oxygen supplies were appropriately maintained, changed regularly and dated. This failure placed residents at risk for receiving care and services that were not physician ordered, unmet care needs and potential for complications of the respiratory system.Findings included .Review of a facility policy titled, Oxygen Administration, Safety, Storage and Maintenance with revised date 08/04/2023 documented:monitor oxygen parameters as needed and/or as ordered,change oxygen supplies weekly,equipment should be dated when set up or changed out,Humidifier (container of sterile water to add moisture to oxygen) should be dated and replaced every seven days regardless of water level.<RESIDENT 42> Resident 42 was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD- a group of lung diseases that make it hard to breathe and get worse over time). In an observation on 04/26/2026 at 11:34 AM, Resident 42 was in bed with an oxygen concentrator set to three liters per minute (lpm), there was an empty oxygen humidifier container attached to the concentrator with no date. The nasal cannula (a flexible tube, with two prongs placed in the nostril to deliver oxygen) connected to the concentrator was not dated. Review of Resident 42's order summary documented oxygen at 1-3 lpm per nasal cannula via oxygen concentrator every four hours as needed for oxygen desaturation (decreased oxygen level in blood) or resident distress. There was also an order to monitor oxygen saturation to keep oxygen saturation greater than 88% and to titrate oxygen per protocol. Both orders were dated 02/13/2026. There were no orders for oxygen humidifier, the oxygen order for as needed and not for continuous use of oxygen, and the monitoring of saturation did not include if the oxygen saturation was on room air or with oxygen. In an observation and interview on 04/29/2026 at 7:53 AM, Resident 42 was using oxygen set at three and a half lpm. The humidifier was empty. The oxygen tubing was not dated. Resident 42 stated they were on oxygen all the time. Observed a nebulizer machine (a medical device that turns liquid medicine into mist to breathe in) with tubing and face mask attached that were not dated and was laying directly on the resident's bedside table. In an interview and observation on 04/29/2026 at 12:15 PM, Staff DD, Licensed Practical Nurse, stated Resident 42 was on continuous oxygen at two lpm. Staff DD stated that if a resident required a humidifier with oxygen, there must be a doctor's order. Staff DD reviewed Resident 42's orders and they stated that the oxygen order was only PRN (as needed) and it should be changed to continuously since the resident was using oxygen all the time. Staff DD also confirmed that Resident 42 did not have a humidifier ordered. Staff DD confirmed that the humidifier was empty and the oxygen was at three and a half lpm. Staff DD reported the oxygen tubing was to be changed once a month or if dirty. In an interview on 04/29/2026 at 3:30 PM, Staff BB, Resident Care Manager, stated that for residents requiring oxygen, they must have a doctor's order and an order for the maintenance of the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator and the tubing. Staff BB stated that the staff should be dating their tubing and storing them in a plastic bag if not being used. Staff BB stated they were to change the tubing once a week or as needed if they were dirty. For residents on PRN oxygen, the nurses should be checking the residents' oxygen saturations and administering oxygen as ordered. Staff BB stated that the nurses should be documenting oxygen saturations and amount of oxygen in the Medication Administration Record (MAR). Staff BB stated that Resident 42 was on oxygen continuously and not PRN and the order was incorrect. Staff BB stated that humidifiers were only applied for residents needing four or more lpm of oxygen and they must have a doctor's order. Staff BB was not sure why Resident 42 had an empty humidifier attached to their oxygen concentrator. <RESIDENT 37> Resident 37 admitted to the facility on [DATE] with diagnoses to include COPD. Review of Resident 37's April 2026 MAR documented an order for oxygen at two lpm. In an interview on 04/26/2026 at 11:23 AM Resident 37 stated they used their oxygen continuously. Resident 37 stated their settings were at two and half lpm. In an observation on 04/26/2026 at 11:32 AM Resident 37's oxygen concentrator was set to three lpm. In an observation on 04/27/2026 at 2:13 PM Resident 37's oxygen concentrator was set to three lpm. In an interview on 04/30/2026 at 2:26 PM Staff U, Registered Nurse, stated they knew the settings for residents on oxygen by reviewing the MAR/orders. Staff U stated the settings were checked on the concentrator at the beginning of the shift. Staff U stated Resident 37's order was for two lpm. Staff U checked Resident 37's oxygen concentrator and provided education to Resident 37 about their physician orders. Staff U stated they should have checked Resident 37's oxygen setting on the concentrator. Refer to WAC 388-97-1060(3)(j)(vi)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 3 of 5 residents reviewed for unnecessary medications (Residents 4,6 and 52) and 1 of 3 residents reviewed for pain management (Resident 20). Failure to follow providers orders for pain medication parameters and provide non-pharmacological interventions for pain placed residents at risk for adverse effects of unnecessary medication and decreased quality of life. Findings included . <RESIDENT 4> Resident 4 admitted [DATE] and had diagnoses to include dementia and chronic pain. Review of Resident 4's physician's orders with a print date 04/27/2026 documented an order for pain medications: Acetaminophen (non-narcotic pain medication) every four hours as needed for pain rating between 1-5, Oxycodone (narcotic pain medication) every four hours as needed for pain. Review of Resident 4's routine pain monitor from April 1-27, 2026, documented their pain rating as 0 on 24 days, 2 on one day, and 1 on two days. Review of the Medication Administration Record (MAR) from April 1-27, 2026, documented Resident 4 received zero doses of Acetaminophen but was documented as having received three doses of oxycodone. The oxycodone was given on 04/09/2026, when the resident's pain was documented as 0, 04/14/2026, when the resident's pain was documented as 5, and on 04/16/2026, when the resident's pain was documented as 3. Resident 4 had non-pharmacological interventions (treatments not involving drugs, such as repositioning or heat/cold packs) listed to attempt prior to administering pain medications, and none were documented as having been attempted. The side effect monitors directed staff to monitor for adverse side effects of narcotic pain medication such as lethargy and constipation. The side effect monitor documented no side effects. Review of the MAR from April 1-27, 2026, documented the resident required four doses of medications that stimulates bowel movement related to constipation. In an interview on 04/28/2026 at 2:16 PM, Staff E, Resident Care Manager (RCM), stated the pain medication orders were given by Hospice and Hospice wanted Resident 4 to have more of the oxycodone. Staff E stated the resident got mad and could be hard to get up or give medications to and staff equated that to non-verbal signs of pain. Staff E acknowledged the documentation did not capture the resident's pain and the documentation of their pain level at 0-5 would indicate that the Acetaminophen would be attempted per the orders prior to the oxycodone. Staff E stated the orders needed to be clarified and documentation improved. <RESIDENT 20> (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the National Institutes of Health (nih.gov) the maximum standard dose of Acetaminophen for healthy adults is 4,000 milligrams (mg) from all sources in a 24-hour period, and 2-3,000mg for those in high-risk groups such those with liver problems, due to risk of liver toxicity. Resident 20 admitted on [DATE] with diagnoses which included a history of stroke, history of fractures and chronic pain. Review of Resident 20's physician's orders for pain medications on 04/27/2026 documented the resident had orders for: Acetaminophen 650 mg two per day routinely. This order began 06/16/2024 and was discontinued on 04/20/2026. The order gave the resident 1100 mg of Acetaminophen in a 24-hour period. Resident 20 had an additional order for a 7-day period 04/14/2026 through 04/20/2026 for Acetaminophen 1000 mg every 8 hours routinely and gave the resident an additional 3000mg of Acetaminophen in a 24-hour period (total 4100 mg.) The order did not address the Acetaminophen maximum allowable dosage guidelines. Following the discontinuation of the 7-day order, a new order was entered on 04/20/2026 for Acetaminophen 650 mg every four hours as needed. This order allowed for 3900 mg of Acetaminophen in a 24-hour period if the resident used all available doses. In addition to the routine Acetaminophen, the resident now had orders which amounted to a potential of 5,000 mg of Acetaminophen in 24 hours. The orders did not address the Acetaminophen maximum allowable dosage guidelines. In an interview on 04/30/2026 at 1:58 PM, Staff B, Chief Nursing Officer (CNO) stated normally the pharmacist would review orders and would catch if a parameter, duplication or other instruction were missing, Staff B stated the April pharmacy reviews were in progress but stated there should have been follow-up. The nurses that were entering in orders and the nurse managers that reviewed orders should be looking for that. <RESIDENT 6> Resident 6 was re-admitted to the facility on [DATE] with diagnoses to include repair of a right hip fracture, non-displaced proximal humerus fracture on the left (a break near the shoulder where the bone pieces remain in anatomical position, typically treated without surgery using sling) and type 2 Diabetes Mellitus (a chronic disease in which the body does not use insulin properly which results in consistently high blood sugar) . According to the admission Minimum Data Set (MDS – an assessment tool) dated 03/14/2026, the resident had moderate cognitive impairment, received routine and as needed (PRN) pain medications and received non-pharmacological intervention for pain. Review of Resident 6's order summary documented oxycodone oral tablet 5 mg be given every 6 hours PRN for moderate right hip pain (pain level 4 to 6 out of 10) and 10 mg be given every 6 hours PRN for severe right hip pain (pain level 7 to 10 out of 10). The orders were dated 03/31/2026. There were no non-pharmacological interventions ordered prior to giving the PRN pain medications. Review of Resident 6's care plan with a print date of 04/27/2026 documented interventions for pain included providing reassurance to the resident that pain was time limited and to encourage attempts at different non-pharmacological pain-relieving methods. The care plan did not list what specific (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	non-pharmacological interventions should be offered to the resident. Review of Resident 6's March 2026 MAR documented oxycodone 10 mg were given on March 14, 17, 18, 22 and 30 with pain level of 6 which was outside the ordered parameters. Oxycodone 5 mg was given on March 12, 14 and 17 with pain level of 7 which was outside the ordered parameters. Review of Resident 6's April 2026 MAR, dated 1-27th, documented oxycodone was given daily. On April 17, oxycodone 10 mg was given with a pain level of 6 which was outside the ordered parameter. On April 10 and 14, oxycodone 5 mg was given with a pain level of 8 and 7 respectively which were outside the ordered parameters. Review of Resident 6's MAR and Treatment Administration Record (TAR) for March and April 2026 did not have any non-pharmacological interventions for pain listed. Review of Resident 6's progress notes from 03/11/2026 to 04/28/2026 did not have any documentation that staff offered any non-pharmacological interventions prior to giving PRN oxycodone. In an interview on 04/29/2026 at 12:06 PM, Staff DD, Licensed Practical Nurse, stated Resident 6 had pain in their right hip and left shoulder. Staff DD stated prior to giving PRN pain medications, they offer non-pharmacological interventions, and they document that in the MAR and assess if it's effective or not and if the non-pharmacological interventions were not effective, then they give the PRN pain medications. Staff DD stated the non-pharmacological interventions they provided to Resident 6, were icing, repositioning, ensuring the sling was on properly and monitoring the resident's wound. Staff DD could not show where they documented non-pharmacological interventions for Resident 6. In an interview on 04/29/2026 at 3:30 PM, Staff BB, RCM stated prior to giving PRN pain medications, non-pharmacological interventions should be offered to the residents. When asked where the nurses would document the non-pharmacological interventions Staff BB stated, in the MAR. Staff BB stated Resident 6's non-pharmacological interventions were repositioning, distractions, and offering snacks (contradictory to Staff DD's descriptions of non-pharmacological interventions). Staff BB stated they would review Resident 6's care plan for pain management and update it. Staff BB reviewed Resident 6's medical record and stated there were no documentation of non-pharmacological interventions for pain offered. <RESIDENT 52> Resident 52 was admitted to the facility on [DATE]. Review of Resident 52's MAR from 04/01/2026 to 04/28/2026, showed an order with a start date of 05/25/2025 that instructed to encourage nonpharmacological interventions prior to administering pain medications, if the resident reported pain or had sign and symptoms of pain. The MAR documented Resident 52 experienced verbal and non-verbal pain on multiple days; however, there were no documentation that non-pharmacological interventions were provided. Further review of the MAR showed Resident 52 had an order with a start date of 05/24/2025 for acetaminophen, two tablets every six hours as needed for pain. Documentation showed Resident 52 received acetaminophen on 04/13/2026 and 04/22/2026; however, no nonpharmacological (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions were documented as having been provided prior to the administration of the medication. Review of Resident 52's progress notes from 04/01/2026 to 04/28/2026, showed no documentation of non-pharmacological interventions were attempted or provided. In a record review and interview on 04/29/2026 at 3:56 PM, Staff BB stated the nurses were supposed to offer, provide, and document nonpharmacological interventions prior to giving PRN pain medication. Staff BB reviewed Resident 52's record and stated there was no documentation of nonpharmacological interventions provided on 04/13/2026 and 04/22/2026, but they should have been documented. In an interview on 04/30/2026 at 2:27 PM, Staff B stated the expectation was the nurses provide nonpharmacological interventions before giving PRN pain medications and document the interventions in the MAR. Refer to WAC 388-97-1060(3)(k)(i)

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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 store medications securely for 2 of 2 residents (Resident 37 and 49) reviewed for medications stored in their room and failed to ensure 1 of 4 medication carts and 1 of 2 treatment carts were locked when left unsupervised by staff. These failures placed residents at risk for receiving compromised or ineffective medications and for having unintended access to drugs that should have been securely stored.Findings included . On 04/26/2026 at 9:39 AM observed the treatment cart located outside of nursing station two, unlocked. The treatment cart contained scissors, zinc oxide ointment (medicated ointment), hydrocortisone cream (medicated cream), Vaseline, iodine antiseptic pads (medicated pads), silicone cream, and medicated wound dressings.In an interview on 04/26/2026 at 9:39 AM Staff B, Director of Nursing Services, stated treatment carts were expected to be locked when not in use and secured by staff.In an observation on 04/26/2026 at 12:15 PM observed the medication cart on the second hall unlocked outside of nursing station two. Observed Staff DD, Licensed Practical Nurse, the assigned nurse to the medication cart, sitting behind the nurse's station. When asked Staff DD about the medication cart being unlocked, the came to the cart and immediately locked it and stated the cart should always be locked when unattended.In an observation on 04/28/2026 at 4:05 PM observed Resident 49 to have a can of topical pain relief, in an aerosol can, sitting on the windowsill.In an observation on 04/28/2028 at 4:05 PM observed Resident 37's overbed table to have a red inhaler sitting on top of it. In a brief interview Resident 37 stated the inhaler was their rescue inhaler and they needed it in case of a sudden attack.In an interview on 04/29/2026 at 3:50 PM Staff E, Resident Care Manager, stated residents required to have an order for medication to be kept in their room, lockbox for any medication in their room, and an evaluation to ensure they could administer the medication safely. Staff E stated Resident 37 had been educated regarding maintaining medication in their room and would follow up with them. Staff E stated some other residents had ordered other items, such as topical pain medication, shipped to them without the facility's knowledge.In an interview on 05/01/2026 at 8:54 AM Staff B, stated medications were not allowed at a resident's bedside without an evaluation to ensure the medications could be used safely.Reference WAC 388-97-1300 (2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 2 of 4 residents (Resident's 11 and 79) reviewed for Enhanced Barrier Precaution (EBP- personal protective equipment (PPE) required for staff during high contact care activities), 1 of 1 observation of pericare (washing of the genitalia and buttocks), 1 random observation of medical equipment sanitation and 1 of 4 nurses (Staff U) reviewed for medication administration. The facility failed to ensure the staff to wear appropriate PPE in accordance with recommended national standards; failed to ensure staff were compliant with hand hygiene during pericare; failed to ensure appropriately disinfecting reusable medical equipment; and failed to ensure proper barriers were used for medication items. These failures placed all residents and staff at risk of potential infection. Findings included .According to the facility policy titled, Enhanced Barrier Precaution dated 09/20/2025, documented examples of high-contact resident care activities requiring gown and glove use included transferring and toileting.According to the facility policy titled, Environmental Cleaning and Disinfecting revised date 10/08/2025, documented reusable resident care items were cleaned and disinfected between each use. <ENHANCED BARRIER PRECAUTION> <RESIDENT 11> Resident 11 was admitted to the facility on [DATE]. In an observation and record review on 04/26/2026 at 10:35 AM, EBP signage was posted at the entrance of Resident 11's room. The signage documented that gloves and gowns were required for high-contact resident care activities, which included transferring. Review of a physician's order, with a start date of 02/26/2026, documented Resident 11 was to be on Enhanced Barrier Precautions. Review of the care plan, initiated on 11/26/2025, documented Resident 11 required EBP. The care plan specified that gowns and gloves were required for high-contact resident care, which included toileting. In an observation and interview on 04/28/2026 at 3:02 PM, Staff Z, Certified Nursing Assistant (CNA), was observed pushing Resident 11 in a wheelchair to the resident's in-room toilet without wearing a gown. Staff Z stated they were assisting Resident 11 with toileting. Staff Z confirmed Resident 11 was on EBP and required a gown for toileting care and transferring. Staff Z stated they forgot and should have put on a gown prior to the activity. In a joint interview on 04/30/2026 at 10:55 AM, Staff GG, Infection Control Nurse and Staff B, Chief Nursing Officer, stated they expected staff to follow the instructions from the precaution signage posted by the resident's room door and the interventions in the care plan. Staff B stated the expectation was for staff to apply PPE for high-contact activities, which included transferring and assisting with toileting. <RESIDENT 79> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 79 was admitted to the facility on [DATE]. Review of Resident 79's orders showed an order for EBP dated 04/03/2026. Review of Resident 79's care plan with a print date of 04/27/2026 showed EBP to be used. In an observation on 04/26/2026 at 9:40 AM, Staff EE, CNA and Staff FF, CNA transferred Resident 79 from their wheelchair to their bed. Both staff were wearing gloves, but they were not wearing gowns. In a joint interview on 04/26/2026 at 9:48 AM with Staff EE and Staff FF, Staff FF stated that the EBP was a sign to wear gloves and gown when changing resident's briefs. Staff EE stated that we were supposed to wear gowns and gloves when they were touching bodily fluids for example, during brief change but if the resident was dressed then they don't need to wear gowns during care. After reviewing the EBP sign, Staff EE stated that they should have worn gowns before they transferred the resident to their bed. In an interview on 04/30/2026 at 10:55 AM, Staff GG, stated that it was an expectation for staff to follow the precaution signs that were posted by the residents' doors. The staff were expected to know who was on precaution by checking the residents' care plan. <HAND HYGIENE> Resident 6 was readmitted to the facility on [DATE]. In an observation on 04/30/2026 at 9:41 AM, Staff HH, CNA cleansed Resident 6's groin and genitalia and then cleansed resident's buttocks area. With the same gloves, Staff HH placed the clean sheets and brief under the resident, removed the dirty sheets and fastened the brief. In an interview on 04/30/2026 at 10:09 AM, Staff HH stated they did not perform hand hygiene and did not change their gloves after they performed peri care to Resident 6. Staff HH stated that after doing peri care they were supposed to take their dirty gloves off and wash their hands and put on new gloves before touching the clean sheets and brief. <MEDICAL EQUIPMENT SANITATION> In an observation on 04/30/2026 at 9:41 AM, Staff EE, took a resident's weight using a mechanical lift. Staff EE was observed pushing the mechanical lift into the hallway and left it there without sanitizing it. In an interview on 04/30/2026 at 10:14 AM, Staff EE stated that after using the mechanical lift, they placed it in the hallway for the next staff to use. When asked the process for cleaning the mechanical lift after use, Staff EE stated, we don't do that. In an interview on 04/30/2026 at 10:55 AM, Staff B stated that it was an expectation that staff were to clean the mechanical lift using the disinfectant wipes after each use. <MEDICATION PASS> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/27/2026 at 7:42 AM, Staff U, Registered Nurse, brought an inhaler (device to deliver medication when a person takes a breath) and bottle of eye drops into the room for Resident 39. Staff U placed the items on the resident's meal tray without a barrier. When Staff U was finished with administering medications, they picked up the eye drop bottle and the inhaler and brought them out of the room and placed them on top of the medication cart without using a barrier. During an interview on 04/27/2026 at 7:46 AM, Staff U stated they were not aware they should have used a barrier when bringing resident medication devices in and out of the resident's room. Staff U stated they were aware that items brought into a room are considered contaminated but had not thought of that for resident specific medication devices that were kept in the medication cart. Refer to WAC 388-97-1320(1)(a,c)(5)(c) <MEDICATION PASS> During an observation on 04/27/2026 at 7:42 AM, Staff U, Registered Nurse, brought an inhaler (device to deliver medication when person takes a breath) and bottle of eye drops into the room for Resident 39. Staff U placed the items on the resident's meal tray without a barrier. When Staff U was finished with administering medications, they picked up the eye drop bottle and the inhaler and brought them out of the room and placed them on top of the medication cart without using a barrier. During an interview on 04/27/2026 at 7:46 AM, Staff U stated they were not aware they should have used a barrier when bringing resident medication devices in and out of the resident's room. Staff U stated they were aware that items brought into a room are considered contaminated but had not thought of that for resident specific medication devices that were kept in the medication cart. Refer to WAC 388-97-1320(1)(a,c)(5)(c)

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to implement policies and procedures for screening of potential staff to ensure the protection of residents against abuse, neglect, exploitation, or misappropriation by requesting reference checks and/or reviewing information from former employers for 4 of 4 staff (Staff F,G,H, and I) reviewed for hiring practices. Failure to obtain references or obtain information from former employers placed residents at risk of potential abuse.Findings included.Review of a facility policy titled, Preventing Abuse, revised date 08/01/2023, documented the facility would complete at least two reference checks to obtain information from previous/current employers upon hire as part of the screening process.On 04/27/2026 at 5:56 AM, the facility was sent an email requesting documentation of screening prior to hire which included evidence of reference checks for Staff F, G, H, and I.On 04/27/2026 at 9:37 AM, surveyor received an email with the requested documents, but no reference checks were received for the four staff members.On 04/27/2026 at 2:15 PM, Staff Q, Human Resources/payroll coordinator, reported that the identified staff did not have reference checks in their files. Staff Q stated the facility no longer did reference checks as previous facilities would not give any information when they were called. On 04/28/2026 at 10:22 AM, Staff B, Chief Nursing Officer, stated Staff Q oversaw the hiring process. Staff B reported Staff Q would be the person in charge of obtaining reference checks and if they did not have them, there would not be anyone else to speak with.On 04/29/2026 at 1:36 PM - Staff A, Chief Executive Officer, reported they were not aware of the facility policy that staff should have two reference checks prior to being hired. Reference WAC 388-97-0640 (2)(a)