

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER North Bend Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 219 Cedar Avenue South North Bend, WA 98045	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review the facility failed to submit complete and accurate direct care staffing information to the Centers for Medicare and Medicaid Services (CMS- a federal agency managing healthcare programs and health insurance standards) for Quarter 4 (Q4, October 2025, November 2025, December 2025) reviewed for Payroll Based Journal (PBJ-mandatory reporting of staffing information based on payroll data) submission. This failure affected the accuracy of Nursing Home (NH) staffing level data collected by CMS and had the potential to impact provisions of resident care and services. Findings included . Findings included .<CMS-Electronic Staffing Data Submission PBJ>Review of the June 2022, CMS Long-Term Care Facility PBJ Policy Manual, showed long term care facilities were required to electronically submit direct care staffing information based on payroll and auditable data. The data, when combined with the census information can be used to not only report on the level of staff in each nursing home, but reports staff turnover and tenure, that can impact the quality of care delivered at the facility. The policy manual showed the facility must electronically submit complete and accurate information by the required deadline to include; direct care staff, the category of work for each direct care staff member, resident census data, and direct care staff turnover and tenure. Review of the PBJ data submitted by the facility for Q4, dated October 01, 2025 through December 31, 2025 showed a reported census total of 5133, a difference of two days from the correct census of 5135. Review of the facility monthly census for October 1, 2025 through December 31, 2025 showed multiple days to include 11/04/2025, 11/16/2025, 11/17/2025, 11/25/2025, 11/26/2025 and 12/12/2025 with an inaccurate reported census.During an interview on 06/05/2026 at 10:04 am Staff A (Administrator) stated an issue was identified with the facility payroll software that did not correctly carry over certain job codes affecting the licensed nurse and certified nursing assistant total hours. Staff A stated if the codes were carried over correctly the facility would have met the 3.4 HPRD and they would expect correct and accurate census and staffing hours to be reported. REFERENCE: WAC 388-97-1090(1)(2)(3)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the appropriate transfer notifications for 1 of 4 residents (Residents 48) reviewed for hospitalization, and 1 supplemental resident (Resident 61). Failure to ensure a written notification was provided to the resident and/or representative in a language and manner the resident and/or representative understood and give a report to the receiving hospital on resident's condition placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care/preferences, and a break in communication and continuity of care. Findings included .<Facility Policy>Review of a 2025 Transfer and Discharge policy showed when the facility transferred or discharged a resident, they would document the transfer or discharge in the medical record and appropriate information would be communicated to the receiving care institution or provider. This policy showed when the transfer or discharge was initiated, the resident would receive written notice using the Resident Notice of Transfer or Discharge form.<Resident 48> According to the 01/16/2026, 02/21/2026, and 02/27/2026 Discharge Return Anticipated Minimum Data Sets (MDS - an assessment tool) Resident 48 discharged to the hospital on the corresponding dates related to a change in the resident's condition. The MDSs showed Resident 48 had medical conditions including respiratory disease and anxiety. Review of Resident 48's health records for transfers on 01/16/2026, 02/21/2026, and 02/27/2026 showed no report was communicated to the receiving hospital and no written transfer notifications were provided to Resident 48. In an interview and record review on 06/04/2026 at 10:00 AM, Staff B (Director of Nursing) stated the facility should have provided Resident 48 with written discharge notices and provided a report to the receiving hospital for each hospital transfer, but they did not. Staff B stated transfer/discharge notices were important to ensure continuity of care and inform Resident 48 of their right to appeal transfer decisions. <Resident 61> According to the 05/05/2026 Discharge Return Anticipated MDSs, Resident 61 discharged to the hospital on [DATE] related to a change in the resident's condition. The MDS showed Resident 61 had medical conditions including failure to thrive and narrowing of the spine. Record reviews showed no documentation facility staff provided Resident 61 or their representative with a written notification of the reason for transfer to the hospital as required. In an interview and record review on 06/04/2026 at 7:55 AM, Staff B stated the facility did not provide written notices for hospitalizations and they were only aware this was the requirement for planned discharges. Staff B stated the facility should have provided the written discharge notice to Resident 61, but they did not. REFERENCE: WAC 388-97-0120(1)(2)(a)-(d)(3)(a)(4)(b)(5) -0080 -0140(1)(a)-(c)(i)-(iii).		

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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 observation, interview, and record review, the facility failed to ensure Level I Preadmission Screening and Resident Reviews (PASRR - a mental health screening required prior to most nursing home admissions) screenings were accurate for 3 of 6 (Residents 48, 3, & 29) residents reviewed for PASRR. This failure placed residents at risk for inappropriate placement, unmet health needs, and other health concerns. Findings included . <Facility Policy>According to the facility's undated Resident Assessment - Coordination with PASRR Program policy, the facility would coordinate resident assessments with the PASRR program to ensure individuals with mental disorders or related conditions received services in the most integrated setting appropriate to their needs. The policy required a Level I screening prior to admission and Level II evaluation for positive screens to determine appropriate placement and specialized services.<Resident 48> According to the 10/24/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 48 admitted on [DATE] with a diagnosis of anxiety disorder (a mental disorder causing a person to overly worry or fear). The MDS showed Resident 48 took antidepressant medications. Record review showed a Level I screening was completed for Resident 48 on 01/26/2026. This screening did not indicate Resident 48's diagnosis of anxiety and did not refer the resident for a Level II evaluation. In an observation and interview on 06/05/2026 7:33 AM, Resident 48 expressed constant concern related to not being stable enough to safely return home in the future. Resident 48 stated they were unsure where they would live after leaving the facility and stated, I can't get it off my mind. In an interview and record review on 06/05/2026 at 10:30 AM, Staff H (Admissions Coordinator) stated Resident 48's Level I screening should have included their diagnosis of anxiety and indicated the need for a Level II evaluation, but it did not. Staff H stated a corrected Level I screening should have been resubmitted prior to Resident 48's admission, but it was not. Staff H stated it was important to ensure an accurate and timely Level I screening to ensure Resident 48 received any recommended mental health care and services, as needed. In an interview and record review on 06/05/2026 at 11:02 AM, Staff B (Director of Nursing Services) stated Resident 48's Level I screening should have been completed accurately and corrected prior to admission, but it was not. Staff B stated it was important to accurately assess the need for Level II evaluations to better support residents with serious mental illnesses. <Resident 3> According to the 05/08/2026 Significant Change MDS, Resident 3 had diagnoses including anxiety, depression, and Post Traumatic Stress Disorder. The MDS showed Resident 3 used an antidepressant medication. The MDS showed Resident 3 admitted to the facility on [DATE]. Observation on 06/02/2026 at 7:00 AM showed Resident 3 lying in bed awake. The light was off and (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the shades were drawn. Review of Resident 3's orders showed a 04/20/2026 order for an antidepressant medication, used to treat Resident 3's depression. Record review showed no Level I screening available in Resident 3's chart. Review of a 03/25/2026 Level II PASRR Invalidation showed Resident 3 had PTSD and anxiety diagnoses but did not capture their depression diagnosis. In an interview on 06/04/2026 10:04 AM with Staff H and Staff I (Social Services), Staff I stated it was important for Level I screenings to be accurate. Staff H provided a copy of a 03/25/2026 Level I PASRR screening. Staff I reviewed the PASRR and confirmed it did not but should have captured Resident 3's depression diagnosis. <Resident 29> According to the 03/27/2026 Quarterly MDS, Resident 29 had diagnoses including anxiety, depression, and an intellectual disability. The MDS showed Resident 29 admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 3's 10/10/2023 Level I PASSR screening showed this PASRR identified Resident 29's depression diagnosis, but not their anxiety diagnosis. In an interview on 06/04/2026 10:04 AM, Staff I stated the 10/10/2023 Level I Screening did not capture Resident 29's anxiety diagnosis. Staff I stated the Level I screening should be accurate but was not. REFERENCE: WAC 388-97-1915(1)(2)(a)-(c).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were comprehensive, resident-specific and/or implemented for 4 of 17 residents (Residents 3, 54, 6, & 58) whose CPs were reviewed. This failure placed residents at risk for unmet care needs and frustration. Findings included . <Facility Policy>According to the facility's 2025 Care Planning - Resident Participation policy, the care planning process would include assessment of the resident's strengths and needs. The policy showed the CP would incorporate the resident's personal and cultural preferences, and be person-centered.<Resident 3>According to the 05/08/2026 Significant Change Minimum Data Set, Resident 3 was cognitively intact and independent with mobility and personal care. The MDS showed Resident 3 had diagnoses including a viral blood borne disease, an ileostomy (a surgical hole to allow the passing of digestive waste bypassing the large intestine), and puncture wounds on their lower back and pelvis. The MDS showed Resident 3 was not considered by the Preadmission Screening and Resident Review (PASRR - a mental health screening process) process to have a serious mental illness.In an interview on 06/01/2026 9:10 AM Resident 3 stated they had an ileostomy. Resident 3 stated they did a lot of the care and maintenance of the ileostomy themselves. Observation at this time showed Resident 3 had an ileostomy pouch extending from their abdomen. Resident 3 stated they hoped to discharge from the facility but first needed a surgery in August 2026.Review of Resident 3's comprehensive CP showed a 04/19/2026 alteration in bowel elimination [related] to ileostomy . Care Plan (CP). This CP included a revised 05/21/2026 goal showing ostomy care will be done by nursing. The Comprehensive CP included 04/07/2026 Discharge Potential CP included an intervention showing discharge potential to lesser care discussed with resident/family/responsible other is _____. This CP intervention was incomplete and did not indicate what Resident 3's potential for discharge was.The Comprehensive CP included a 04/07/2026 PASRR Recommendations CP that included an intervention showing PASSAR is (negative/positive) and did not indicate whether the PASRR identified Resident 3 with serious mental illness.In an interview on 06/05/2026 at 9:05 AM Staff B (Director of Nursing) stated the purpose of the CP was to identify the individual resident's needs and guide the staff in the care and treatment of the resident. Staff B stated all CPs should be comprehensive, accurate, and resident-specific, and CPs should be updated periodically with reassessment, and as needed. In an interview on 06/05/2026 10:30 AM, Staff B stated the Ileostomy CP should reflect Resident 3's current care needs. <Resident 54>According to the 02/18/2026 Quarterly MDS, Resident 54 required partial/moderate assistance with rolling from their back to their side in bed. The MDS showed Resident 54 had medically complex diagnoses including a progressive blood circulation disorder that narrows the blood vessels outside the heart and brain, often affecting the legs and feet, malnutrition, and a condition making controlling blood sugar more difficult. The MDS showed Resident 54 was at risk for developing pressure injuries (bed sores - open wounds caused by pressure over bony prominences).Record review showed a 05/19/2026 order for an air mattress to manage Resident 54's risk for pressure injuries. This order directed staff to keep the mattress on the soft setting.Review of the at a high risk for pressure injury . CP showed the instruction to keep the mattress on the softest from the 05/19/2026 air mattress order was not reflected on the CP. In an interview on 06/05/2026 at 9:05 AM, Staff B stated Resident 54's CP should be comprehensive and address all their identified care needs.In an interview on 06/05/2026 at 9:18 AM, Staff B stated Resident 54's mattress should be on the soft setting. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 6>According to the 04/06/2026 Quarterly MDS, Resident 6 had diagnoses including lower body paralysis. The MDS showed Resident 6 had two pressure wounds with full thickness skin and tissue loss and exposure of bone or tendon. Review of the actual skin breakdown . CP, Resident 6's air mattress should be set at on the soft setting. The CP showed the mattress setting should be checked each shift. In an interview on 05/31/2026 at 10:43 AM Resident 6 stated they had pressure wounds and needed the air mattress because being turned too often was too much. Observation at the time showed the air mattress set three quarters of the way from the soft setting, one quarter from the firmest setting. The same air mattress setting of three quarters firm was observed on 05/31/2026 at 11:00 AM, on 06/04/2026 at 7:33 AM, and on 06/04/2026 at 8:49 AM. In an interview on 06/05/2026 9:18 AM, Staff B stated nurses should check the air mattress setting each shift. Staff B stated the mattress should be on the softest setting and that the CP should be followed. <Resident 58>According to the 03/13/2026 admission MDS, Resident 58 admitted to the facility on [DATE] and had intact cognition. The MDS showed Resident 58 was not actively planning to discharge from the facility at the time of the assessment. Review of Resident 58's comprehensive CP showed a 03/06/2026 Discharge Potential CP. This CP included an intervention showing Discharge potential to lesser care discussed with resident/family/responsible other is _____. This CP intervention was incomplete and did not indicate what Resident 3's potential for discharge was. In an interview on 06/05/2026 at 9:05 AM Staff B stated all CPs should be comprehensive and accurate. REFERENCE: WAC [PHONE NUMBER](1)(2)(a)(b).		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to conduct care conferences to ensure person-centered care for 8 of 18 residents (Residents 7, 10, 41, 43, 48, 54, 32, & 29) sample residents. These failures placed residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings included . <Facility Policy>According to the facility's 2025 Care Planning-Resident Participation policy, the facility would support the resident's right to be informed of and participate in care planning and treatment. The policy showed the facility would honor residents requests for care plan meetings, encourage resident and/or resident representatives participation in choosing care and treatment options at regular scheduled care plan conferences, upon admission, at routine intervals, and after a significant change occurred.<Resident 7> According to the 04/07/2026 Annual Minimum Data Set (MDS - an assessment tool) Resident 7 had severely impaired memory, was unable to make their own decisions, and depended on staff for mobility, hygiene, and transfers. Review of Resident 10's record showed a care conference last occurred on 09/24/2025. There was no documentation showing a care conference was conducted or offered since that time. Record review showed Resident 7 had a medical Power of Attorney (POA) who participated in previous care conferences. <Resident 10> According to the 04/03/2026 Quarterly MDS, Resident 10 admitted to the facility on [DATE] with no memory impairment. Review of Resident 10's record showed the last documented care conference occurred on 07/16/2025, with no other care conference provided or offered since. In an interview on 05/31/2026 at 1:37 PM Resident 10 stated they could not remember having a care conference or being offered one for a long time but would like to participate in one. <Resident 41> According to the 05/04/2026 Quarterly MDS, Resident 41 admitted to the facility on [DATE], had clear speech, could be understood and was able to understand others in conversation. Review of Resident 41's record showed no documentation that a care conference was conducted or offered since admission. In an interview on 06/01/2026 at 12:27 PM Resident 41 stated the facility had not conducted or offered a care conference to them since their admission. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 43> According to the 05/01/2026 Quarterly MDS, Resident 43 was admitted to the facility on [DATE]. The MDS showed Resident 43 had no memory impairment. Record review showed the last documented care conference for Resident 43 occurred on 10/23/2025 with no evidence that a care conference was conducted or offered since. In an interview on 06/01/2026 at 08:23 AM Resident 43 stated they did not participate in a care conference for almost a year, was not contacted regarding one, and would like the opportunity to discuss concerns with the Interdisciplinary Team (IDT &ndash; a multidiscipline committee of department heads overseeing resident care). In an interview and record review on 06/04/2026 at 9:26 AM, Staff N (Social Services) stated care conferences should be conducted upon admission, quarterly, with a significant change in residents care, and as needed if requested by residents or their representatives. Staff N reviewed the records for Residents 7, 10, 41 and 43 and confirmed care conferences did not occur and were not offered for the residents or their representatives since the documented care conferences in their records. <Resident 48> According to a 10/24/2025 admission MDS, Resident 48 admitted to the facility on [DATE] with clear speech, could be understood, and was able to understand others in conversation. In an interview on 06/02/2026 at 1:32 PM, Resident 48 expressed concern about not knowing the plans for their future care and did not recall having a care conference. Review of Resident 48's record showed no documentation of any care conferences since admission. In an interview and record review on 06/04/2026 at 10:00 AM, Staff B (Director of Nursing) stated care conferences should occur quarterly and be documented in a progress note in the resident's record. Staff B reported they did not see documentation showing care conferences were completed for Resident 48. Staff B stated care conferences were important so all departments and the resident were informed and could follow up on any identified concerns. <Similar Findings> <Resident 54> According to the 02/18/2025 Quarterly MDS, Resident 54 admitted to the facility on [DATE]. The MDS showed Resident 54 had intact cognition and did not refuse any care during the assessment's lookback period. Record review showed Resident 54's most recent quarterly care conference was on 08/22/2025. There were no progress notes indicating Resident 54 refused to participate in a care conference since (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that date. <Resident 32> According to the 04/06/2026 Quarterly MDS, Resident 32 had intact cognition and did not refuse any care during the assessment's lookback period. The MDS showed Resident 32 admitted to the facility on [DATE]. Record review showed Resident 32's most recent quarterly care conference was on 08/29/2025. There were no progress notes indicating Resident 32 refused to participate in a care conference since that date. <Resident 29> According to the 03/27/2026 Quarterly MDS, Resident 29 admitted to the facility on [DATE]. The MDS showed Resident 29 had intact cognition and did not refuse any care during the assessment's lookback period. Record review showed Resident 29's most recent quarterly care conference was on 07/15/2025. There were no progress notes indicating Resident 29 refused to participate in a care conference since that date. In an interview and record review on 06/04/2026 at 9:26 AM, Staff N stated care conferences should be conducted upon admission, quarterly, with a significant change in residents care, and as needed if requested by residents or their representatives. In an interview and record review on 06/04/2026 at 10:00 AM, Staff B stated care conferences should occur quarterly and be documented in a progress note in the resident's record. REFERENCE: WAC 388-97-1020(2)(e)(f)(4)(b)(d)-(f).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the facility environment was free of accident hazards. The failure to: ensure residents who smoked complied with facilities policies for 3 of 3 residents reviewed for smoking (Residents 6, 41 & 58), ensure safe hot water temperatures were maintained for 2 of 2 units (North and South Units), ensure fire exits were free of obstructions for 1 of 2 units (South Unit), and failure to ensure shower rooms did not contain unsecured hazards for 1 of 2 shower rooms (South Shower room) placed residents at risk for smoking hazards, burns, cuts, and other negative health outcomes. Findings included .<Smoking> <Facility Policy> According to the facility's revised 01/28/2025 Smoking Policy, the facility was a no-smoking facility. The policy showed effective 07/09/2024, newly admitted residents would not be permitted to smoke independently outside the facility. The policy showed residents and their representatives would be informed of the policy, and residents with a history of smoking would be assessed to see if they needed pharmacological or behavior interventions to assist them to not smoke while a resident. <Resident 6> According to the 04/06/2026 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 6 had no vision or hearing impairments, was cognitively intact, and used their wheelchair independently. The MDS showed Resident 6 had a nicotine dependence diagnosis. In an interview on 05/31/2026 at 11:02 AM, Resident 6 stated they smoked outside the facility. Resident 6 stated they kept their cigarettes on their person during the day but you can turn them into the nurse at night. Resident 6 was sitting up in bed at the time. Resident 6 stated they had cigarettes on their person but declined to show them. According to the 10/08/2024 Smoking Care Plan (CP), Resident 6's goals were to sustain no injuries from smoking and follow facility smoking rules. This CP showed all Resident 6's smoking paraphernalia would be stocked in an individualized box in the nurse's cart or nurse's med room for safety. Resident 6 would ask staff for their smoking items and must sign out when going out to smoke. The CP showed upon return to the facility, Resident 6 would sign in, immediately return smoking supplies to the staff and if Resident 6 was noncompliant with the smoking policy other steps would occur. According to the 04/23/2026 Smoking Assessment, Resident 6 had decreased sensation in arms, legs or trunk that would impair their ability to detect pain from burning embers and took a medication that could affect cognition or judgment. This assessment determined Resident 6 was safe to smoke independently. In an interview on 06/04/2026 9:04 AM, Staff B (Director of Nursing) stated Resident 6 flagged twice (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on their Smoking Assessment, but a threshold of three or more flags was required to determine that a resident was unsafe. Staff B stated they expected Resident 6 to be compliant with facility policies on smoking and to keep their cigarettes locked with the nurse when not smoking. <Resident 58> According to the 03/13/2026 admission MDS, Resident 58 admitted to the facility on [DATE], had no vision or hearing impairments, and had intact cognition. The MDS showed Resident 58 was independent with most mobility and cares. The MDS showed Resident 58 had diagnoses including tobacco use but was not currently smoking. In an interview on 06/01/2026 at 10:01 AM, Resident 58 stated they still smoked and kept their own cigarettes but smoked away from the facility. Resident 58 appeared comfortable sharing their smoking status. According to 02/25/2026 Hospital History and Physical (H & P) Resident 58 smoked approximately 2 cigarettes daily. Review of the facility's list of residents who smoked on 06/02/2026 showed Resident 58 was not identified as an active smoker. Record review showed a copy of the facility's revised 05/27/2025 smoking policy, signed by Resident 58 in their chart. This copy of the policy had language showing smoking, including the use of electronic cigarettes, is prohibited in all areas ., new admission[s] wishing to smoke will initiate immediate discharge planning from the facility. Only grandfathered residents will be allowed to smoke ., and residents with a history of smoking will be further assessed to determine whether or not. Record review showed no smoking assessment in Resident 58's chart. In an interview on 06/04/2026 8:54 AM, Staff B stated when a resident admitted who wished to smoke, the facility completed a smoking assessment. Staff B stated they discussed the expectations with the resident. Staff B stated if a resident wished to stay and was an active smoker there were tools to help them stop but they needed to go through the doctor. Staff B stated facility staff monitored residents as they came and went from the facility for compliance with the facility's smoking rules. Staff B reviewed Resident 58's record and could not find a smoking assessment. Staff B looked frustrated and stated Resident 58 was dishonest with the facility about their desire to smoke. Staff B stated they did not see anything in Resident 58's chart to indicate the facility attempted to determine if Resident 58 needed assistance with smoking cessation. <Resident 41> According to the 05/04/2026 Quarterly MDS, Resident 41 admitted to the facility on [DATE] with Chronic Obstructive Pulmonary Disease (COPD - breathing difficulty), respiratory failure, and nicotine dependence. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the 04/28/2026 Risk for Relapsing on Smoking CP showed Resident 41 was at risk for a smoking relapse due to an extensive history of smoking and had a goal of smoking cessation. In an interview on 05/31/2026 at 10:51 AM, Resident 41 stated they smoked cigarettes and they hid their cigarettes from staff. In an interview on 06/06/2026 at 08:39 AM, Staff L (Registered Nurse) stated that Resident 41 smoked cigarettes and observed smoking outside the facility. In an interview on 06/04/2026 at 08:41 AM, Staff M (Certified Nurse Assistant - CNA) stated Resident 41 was a smoker. In an interview and record review on 06/04/2026 at 11:06 AM, Staff B stated residents who smoked were assessed upon admission, the facility followed up on the resident's smoking history, physician's orders relating to smoking were obtained, and CPs were developed and implemented by staff. Staff B stated the facility also documented the resident's name on to the active smokers list for monitoring safety. Staff B reviewed Resident 41's record and stated, we do not have record on that, confirming there was no documented smoking assessment, physician's order, or smoking-related CP interventions related to the resident's ongoing smoking. <Hot Water> According to the facility's 2026 Safe Water Temperatures policy, the facility would maintain hot water temperatures between 100 Degrees Fahrenheit (F) and 120 F. The policy showed hot water tanks/boilers/thermostats would be adjusted as needed to maintain safe temperatures and water temperature logs would be kept for three years Observation on 06/05/2026 at 7:33 AM showed the water temperature in room S3 was 124.2 F. Resident 3 stated the water in the room was hot but not hot-hot. On 06/05/2026 at 7:38 AM the water temperature in room N1 was measured at 127.4 F. In an interview at that time, Staff A (Administrator) observed the reading on the thermometer and stated he would instruct the maintenance department to adjust the thermostat. Staff A stated the temperature of 127.4 F was not within the acceptable range. Observation on 06/05/2026 at 7:42 AM showed the temperature in room N6 was 126.5 F. In an interview at that time Resident 21 stated the water gets hot. Observation on 06/05/2026 at 7:48 AM showed the hot water temperature in room N 11, at the far north end of the building was 126.4 F. Observation on 06/05/2026 at 7:53 AM showed the hot water in room S12, at the far south end of the building was 115.9 F. In an interview on 06/05/2026 at 10:40 AM, Staff A stated facility staff tested water temperatures (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	throughout the facility and identified hot water exceeding 120 F in the majority of resident rooms. Staff A stated it was important to maintain hot water temperatures under 120 F for safety and the facility was monitoring water temperatures until all rooms had hot water within the safe range. <Blocked Fire Exit> Observation on 06/04/2026 at 4:18 AM showed the fire exit located next to the conference room was blocked by a mechanical lift and a large wheelchair. A sign on the wall next to the lift showed THIS CORRIDOR TO BE KEPT CLEAR AT ALL TIMES. In an interview on 06/04/2026 at 6:55 AM Staff B looked at the blocked fire exit and stated it was not appropriate to leave the equipment in a hallway that needed to remain clear and they would provide education to staff. In an interview on 06/04/2026 at 7:03 AM Staff A stated it was important to keep fire exits clear for safety in the event of an emergency. <South Unit Shower Room> Observations on 05/31/2026 at 9:38 AM and on 06/01/2026 at 10:45 AM and 1:35 PM showed the South Unit shower room door was unlocked with no staff present. Hair and body cleaning products, and disposable razors were stored in unlocked cabinets. In an observation and interview on 06/01/2026 at 1:36 PM, Staff B entered the unlocked South Unit shower room and stated it should be always locked but was not. Staff B noted that razors and cleaning products were accessible in the unlocked cabinet. Staff B stated the unlocked shower room posed a safety hazard for residents with mental illness or an altered mental status, as staff would not know if a resident entered the room and experienced a fall or injury. REFERENCE: WAC 388-97-1060(3)(g).		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure controlled medications were accurately reconciled for 2 of 2 (South Medication and Central Medication) carts reviewed for medication storage and reconciliation. Failure to ensure an accurate account of resident narcotic medications placed the residents at risk for uncontrolled pain, decreased quality of life, and possible diversion of controlled substances. Findings included. <Facility Policy> According to the facility's undated Medication Storage policy the facility would maintain controlled substance accounting in an accurate, legible, and traceable manner at all times. <Central Medication Cart> In an observation and interview on 05/31/2026 at 11:35 AM, the Central medication Cart narcotic ledger showed the following discrepancies: Resident 6 had prescriptions for two controlled substances, an antiseizure drug and a narcotic pain medication. The narcotic ledger showed there were 20 antiseizure capsules left but the pack showed 19 capsules were available. The narcotic ledger showed there were three narcotic pain pills left but the pack showed two pills were available. The narcotic ledger showed Resident 34 had four narcotic pain pills, but the pack showed only 3 pills were available. The narcotic ledger showed Resident 2 had 11 antiseizure capsules left but the pack showed only 10 capsules were available. In an interview at this time, Staff G (Licensed Practical Nurse - LPN) stated they administered the controlled medications earlier that morning to the residents. Staff G stated the morning medication pass was busy and they would sign the medications out later in the day. Staff G confirmed they should sign the narcotic medications out at the time of administration. <South Medication Cart> In an observation and interview on 05/31/2026 at 12:32 PM, the South Medication Cart narcotic ledger showed Resident 51 had four bottles of a liquid narcotic left but there were only three bottles available in the cart. The narcotic ledger showed Resident 52 had four bottles of a liquid narcotic available but there were only three bottles available in the cart. In an interview at this time, Staff E (LPN) stated the morning medication pass was very busy. Staff E confirmed they should sign the narcotics out at the time of administration. In an interview on 06/04/2026 at 7:45 AM, Staff B (Director of Nursing) stated staff not signing out narcotics at the time of administration was a safety concern. Staff B stated they expected staff to sign out narcotics at the time the narcotic was given. REFERENCE: WAC 388-97-1300(1)(b)(i-ii).		

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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 nursing services were provided within professional standards of nursing. The failure to: clarify physician's orders when required for 2 of 4 residents (Residents 32 & 6) reviewed for pain management, follow physician's orders for 3 of 18 sample residents (Residents 6, 54, & 10), and discontinue obsolete orders for 1 of 18 sample residents (Resident 29), placed residents at risk for unmet care needs, unneeded care, and other negative health outcomes. <Facility Policy>According to the facility's 2025 Weight Monitoring policy, the facility would ensure residents maintain acceptable nutritional status and body weight parameters. The facility would develop and consistently implement individualized interventions, monitor effectiveness, and revise them as necessary. The policy showed that staff would implement ongoing monitoring and document residents' weight to ensure residents maintain acceptable nutritional status. Findings included .<Clarifying Orders> <Resident 32> According to the 04/06/2026 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 32 had diagnoses including a chronic autoimmune disease of the central nervous system, disc degeneration, and migraines. The MDS showed Resident 32 had mild pain that occasionally had an effect on their sleep and day-to-day activities. Review of the physician's orders showed Resident 32 had two as-needed pain medications they could take for pain management: a 10/20/2022 order for an over-the counter pain medication to be given every four hours as needed for pain management; an 04/02/2026 order for an opioid pain medication to be given as needed for chronic pain okay to take additional 1 tab if waken due to pain at night. The as-needed opioid order did not show how long to wait between doses. Neither as-needed pain medication order included parameters to direct nurses to know which medication to be given for what level of pain. In an interview on 06/05/2026 at 9:05 AM, Staff B (Director of Nursing) stated Resident 32's as-needed opioid pain medication should indicate how frequently the medication could be given but did not. Staff B stated if a resident had more than one as-needed pain medication, the orders should include parameters for when to give which medication such as use of a zero-to-ten pain scale, but did not, so it was unclear when to give each medication. Staff B stated the orders needed clarification. <Resident 6> According to the 04/06/2026 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 6 had diagnoses including traumatic spinal cord dysfunction and received both scheduled and as needed pain medications. The MDS showed Resident 6 was assessed with frequent, severe pain that frequently affected their sleep and occasionally interfered with their day-to-day activities. The MDS showed Resident 6 had two pressure wounds (bed sores - open wounds caused by pressure over bony prominences) with full thickness skin and tissue loss and exposure of bone or tendon. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders showed two as needed pain medications: a 10/01/2024 over-the-counter pain medication, give two 325 Milligram (MG) tablets every 4 hours for pain; a 05/21/2026 order for a narcotic pain medication, give one 15 MG tablet every three hours as needed for pain. Neither as-needed pain medication order included parameters to direct nurses to know which medication to be given for what level of pain. In an interview on 06/05/2026 at 9:05 AM, Staff B stated the orders should include parameters for when to give which medication but did not. Staff B stated the orders needed clarification. Staff B stated nurses were responsible for clarifying unclear or incomplete with the physician. <Following Orders> <Resident 6> Record review showed a 02/07/2025 order for an air mattress for treatment of pressure wounds. The order showed Resident 6's mattress should be kept on the soft setting. In an interview on 05/31/2026 at 10:43 AM, Resident 6 stated when they were in the hospital, staff there would turn them at regular intervals, which they found to be too much. Resident 6 stated the air mattress helped as an alternative. Observation at the time showed the air mattress set three quarters of the way from the soft setting, one quarter from the firmest setting. Observation at the time showed the air mattress set three quarters of the way from the soft setting, one quarter from the firmest setting. The same air mattress setting of three quarters firm was observed on 05/31/2026 at 11:00 AM, on 06/04/2026 at 7:33 AM, and on 06/04/2026 at 8:49 AM. In an interview on 06/02/2026 at 9:01 AM, Resident 6 expressed concern that their air mattress was not set at the right firmness level. Observation showed the air mattress set at three quarters firm In an interview on 06/05/2026 at 9:18 AM, Staff B stated Resident 6's mattress should be kept at the setting identified in the 02/07/2025 order but was not. <Resident 54> According to the 02/18/2026 Quarterly MDS, Resident 54 required partial/moderate assistance with rolling from their back to their side in bed. The MDS showed Resident 54 had medically complex diagnoses including a progressive blood circulation disorder that narrows the blood vessels outside the heart and brain, often affecting the legs and feet, malnutrition, and a condition making controlling blood sugar more difficult. The MDS showed Resident 54 was at risk for developing pressure wounds. Record review showed a 05/19/2026 order for an air mattress needed due to Resident 54's history of wounds on their tailbone area. The order showed the air mattress should be set on the soft setting each shift. Observation on 06/01/2026 at 10:36 AM showed mattress on the firmest setting. Resident 6's (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mattress was again observed on the firmest setting on 06/03/2026 at 11:56 AM and 06/05/2026 at 7:13 AM. In an interview on 06/05/2026 at 9:18 AM, Staff B stated Resident 54's mattress should be kept at the setting identified in the 02/07/2025 order but was not. <Resident 10> Review of the revised 07/13/2025 Nutritional Risk CP showed Resident 10 had the potential for an altered nutrition status related to alcoholic liver cirrhosis, hypertension, and diuretic (water pill) use and instructed staff to monitor, record, and report to the physician any weight loss greater than five % (Percent) in one month, 7.5 % in three months, and 10 % in six months. Review of Resident 10's Order Summary showed a 04/04/2024 physician's order directing staff to obtain and document the resident's weight weekly every Wednesday. Record review showed that the last documented weight for Resident 10 was obtained on 05/13/2026. Review of April 2026 and May 2026 MARs showed weights documented on 04/22/2026, 04/13/2026 and 05/13/2026. In an interview and record review on 06/05/2026 at 10:17 AM, Staff O (Dietitian) stated the last nutritional assessment completed for Resident 10 was the quarterly assessment dated [DATE]. Staff O stated they expected nursing staff to follow physician's orders for weekly weights. Staff O reviewed Resident 10's health record and confirmed Resident 10's weights were not obtained as ordered. In an interview and record review on 06/05/2026 at 10:53 AM, Staff B stated staff were expected to follow and implement the physician's orders. Staff B reviewed Resident 10's health record and confirmed the order for weekly weights was not followed. <Obsolete Orders> <Resident 29> According to the 03/27/2026 Quarterly MDS, Resident 29 had diagnoses including high blood pressure, a history of stroke, and an enlarged heart. The MDS showed Resident 29 took an antiplatelet medication but no anticoagulant medication during the assessment period. Review of the order summary showed Resident had a 1/12/2024 order for an antiplatelet medication, and a no anticoagulant orders. The orders included a 11/04/2024 order to monitor for adverse side effects of an anticoagulant medication. In an interview on 06/05/2026 at 9:33 AM, Staff B stated Resident 29 switched from an anticoagulant medication to an antiplatelet medication. Staff B stated when the anticoagulant medication was discontinued, the anticoagulant medication adverse side effect monitoring should have been but was (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not discontinued. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADL - grooming, bathing, personal hygiene etc.) to dependent residents for 1 of 3 residents (Resident 54) reviewed for ADL. Findings included . <Facility Policies>According to the facility's 2025 ADL Policy, the facility would provide assistance with ADL including bathing consistent with the resident's assessed needs. According to the facility's 2025 Nail Care Policy, the resident's Care Plan (CP) would identify the frequency and type of nail care the resident needed. This policy showed residents' nails should be kept smooth to avoid skin injury.<Resident 54>According to the 02/18/2026 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 54 required substantial/maximum assistance with bathing and was totally dependent on staff for personal hygiene. The MDS showed Resident 54 was always incontinent of bladder and bowel.Observation on 06/01/2026 at 10:56 AM showed Resident 54 in bed. Resident 54's fingernails were observed to extend past the tips of their fingers, and were uneven/jagged with soiling visible under the nails. Observation on 06/04/2026 at 8:27 AM and 06/05/2026 at 8:59 AM again showed Resident 54 with fingernails extending past the tips of their fingers, and were uneven/jagged with soiling visible under the nails.Review of the Resident 54's bathing documentation showed no documentation of any showers or baths in May 2026. Resident 54 was documented to refuse their shower on 05/01/2026 and 05/08/2026 and was marked as inapplicable on 05/28/2026. The April 2026 bathing records showed Resident 54 received a shower on 04/03/2026 and 04/10/2026, refused on 04/17/2026, and was marked as not applicable on 04/24/2026. Review of the progress notes showed no refusals of bathing over that time period.According to the 05/26/2024 ADL CP, nursing staff should provide Resident 54 ADL care as needed. This CP showed Resident 54 should be provided bathing/showering at least two times per week . This CP showed nailcare should be offered during Resident 54's shower.In an interview on 06/05/2026 9:27 AM, Staff B (Director of Nursing) stated Resident 54 should be provided bathing per the schedule. Staff B stated Resident 54 was scheduled for bathing twice weekly, and if the resident refused a shower one day, there was still an opportunity for a second shower that week. Staff B stated there could be additional shower documentation in a shower book that was not yet added to Resident 54's record. Staff B stated Resident 54 now refused nail care from nursing staff and would only allow a family member to trim their nailsOn 06/05/2026 at 9:40 AM, Staff B reviewed the shower book and located a documentation of a shower provided on 05/29/2026 and a refusal of bathing on 05/22/2026. Staff B was not able to provide documentation showing Resident 54 was offered a shower twice weekly as per the ADL CP, or received at least one shower per week. REFERENCE: WAC 388-97-1060(2)(c).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review the facility failed to ensure appropriate ileostomy (a surgically created hole allowing waste to void into a bag, bypassing the large intestine) care was provided for 1 of 1 residents (Resident 3) reviewed for ileostomy. This failure placed residents at risk for unmet care needs and infection control concerns. Findings included . <Facility Policy>According to the facility's 2025 Ostomy (surgical hole) Policy, ostomy care would be provided by licensed nurses under the orders of the attending physician.<Resident 3>According to the 05/08/2026 Significant Change Minimum Data Set, Resident 3 was cognitively intact and independent with mobility and personal care. The MDS showed Resident 3 had diagnoses including a viral blood borne disease, an ileostomy, and puncture wounds on their low back and pelvis. In an interview on 06/01/2026 9:10 AM Resident 3 stated they had an ileostomy. Resident 3 stated they stated did a lot of the care and maintenance of the ostomy themselves. Observation at this time showed Resident 3 had an ileostomy pouch extending from their abdomen. Record review showed a 04/19/2026 alteration in bowel elimination [related] to ileostomy . Care Plan (CP). This CP included a revised 05/21/2026 goal showing ostomy care will be done by nursing. The CP showed ileostomy care would be completed as ordered. Record review showed a 04/22/2026 order to place Resident 3 on Enhanced Barrier Precautions (an infection control measure requiring nursing staff to use gowns and gloves for certain types of care) related to their ileostomy. There were no other orders in Resident 3's record describing how to care for and/or monitor Resident 3, including monitoring. In an interview on 06/05/2026 at 10:30 AM, Staff B (Director of Nursing) stated both the nurses and Resident 3 were responsible for the care of Resident 3's ileostomy. Staff B stated the site of the ileostomy needed to be checked and the wafer (a small, disc-shaped barrier placed between the ileostomy pouch and the skin for skin protection) changed as needed. Staff B reviewed Resident 3's record and confirmed there were no orders related to care and maintenance of the ileostomy in Resident 3's record. Staff B stated there should orders and the absence of ileostomy orders was a failure on the part of the facility. REFERENCE: WAC 388-97-1060(1)-(3).		

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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 physician orders, assessment and care planning were in place for 1 of 1 resident (Resident 41) reviewed for respiratory care. These failures placed the resident at risk for potential negative outcomes such as poor/under oxygenation and a decreased quality of life. <Policy>According to the facility's 2026 Oxygen Administration policy, staff were to administered oxygen to residents according to professional standards of practice, physician orders, comprehensive person-centered care plans, and resident goals and preferences. According to the 05/04/2026 Quarterly Minimum Data Set (MDS-an assessment tool), Resident 41 admitted to the facility on [DATE] with severe impaired memory, chronic obstructive pulmonary disease (COPD-breathing difficulty) and respiratory failure. Review of the 02/07/2026 COPD risk for ineffective breathing pattern care plan (CP) showed staff would administer oxygen as ordered. Review of physician progress note on 04/01/2026, 05/02/2026, and 05/19/2026 instructed staff to use supplemental oxygen as needed to maintain Resident 41's oxygen saturation at greater than 90%. Review of Resident 41's order summary on 04/2026, and 05/2026 showed there was no physician order for supplemental oxygen use. In an observation and interview on 06/02/2026 at 07:13 AM, Resident 41 was lying in bed, and a portable oxygen tank positioned beside the bed. A nasal cannula (a tubing to deliver oxygen therapy) was attached to the oxygen tank. Resident 41 appeared to be alert and oriented and stated they independently used the portable oxygen tank for oxygen therapy. Resident 41 stated, I usually use it before going for my walk outside. I get my oxygen up and then go for my walk. Resident 41 stated, I turn it on up to two for 15 minutes, and after my oxygen is up, I turn it off and go for my walk. In an interview on 06/02/2026 at 11:10 AM, Staff J (Certified Nurse Assistant), stated Resident 41 independently operated the portable oxygen tank in their room. In an interview on 06/02/2026 at 11:15 AM, Staff K (Licensed Practical Nurse) stated Resident 41 knew how to independently operate the portable oxygen tank and had used it when their oxygen was low. In an observation, interview, and record review on 06/02/2026 at 11:44 AM, Staff B (Director of Nursing), observed the portable oxygen tank in Resident 41's room. Staff B stated residents with respiratory problems were assessed upon admission, physician orders were obtained, and care plans were developed and implemented by nursing staff. Staff B stated Resident 41's record had no physician order for supplemental oxygen use, no assessment, and no care plan related to supplemental oxygen therapy but should have. Reference: WAC 388-97-1060 (3)(iv).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER North Bend Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 219 Cedar Avenue South North Bend, WA 98045	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident medical records were complete and accurate for 3 of 17 (Residents 29, 7, & 3) whose records were reviewed. The failure to ensure admission documents were added to the chart timely and ensure device assessments were documented placed residents at risk for incomplete records and undocumented care. Findings included . <Facility Policy>According to the facility's 2025 Maintenance of Electronic Clinical Records policy, electronic clinical records should contain physician orders, required assessments, and care provided. The policy showed records would be maintained in accordance with acceptable standards of practice.<Resident 29> According to the 03/27/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool) Resident 29 used a wheelchair and a had a history of falling since the last assessment. The MDS showed Resident 29 had diagnoses including a history of stroke, dementia, one-sided paralysis, and a developmental disorder. Observation on 06/01/2026 at 10:25 AM showed Resident 29 in a wheelchair with a buckled lap belt around their waist. Resident 29 demonstrated they could unbuckle the lap belt. Review of Resident 29's record showed the last documented safety assessment for the lap belt was completed on 09/12/2024. In an interview on 06/04/2026 9:08 AM, Staff B (Director of Nursing) stated it was important to assess devices like lap belts periodically for safety and to ensure they were still of benefit to the resident. Staff B stated they completed assessments of various safety devices for Resident 29 quarterly and completed one recently. Staff B reviewed the most recent safety device assessment for Resident 29 and noted it did not include an area to document assessment of Resident 29's lap belt. Staff B stated they could not demonstrate Resident 29's lap belt was assessed after 09/12/2024 as the form used since did not have a space to capture that assessment. <Resident 3> According to the 05/08/2026 Significant Change in Status MDS, Resident 3 had diagnoses including anxiety and depression. The MDS showed Resident 3 admitted to the facility on [DATE]. Record review showed a 03/25/2026 Level II Preadmission Screening and Resident Review (PASRR) Invalidation Assessment (a determination the resident did not require specialized mental health services while in the home) indicating a prior Level I PASRR Screening showed Resident 3 had potential serious mental illness indicators requiring further assessment. This Level I PASRR screening was not found in Resident 3's record. In an interview on 06/04/2026 10:04 AM, Staff H (Admissions Coordinator) stated they had Resident 3's Level I PASRR screening that was not available in the resident's record and stated it should have (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505339	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER North Bend Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 219 Cedar Avenue South North Bend, WA 98045	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been uploaded to the chart by now but was not. In an interview on 06/05/2026 at 9:05 A, Staff B stated they expected Resident 3's Level I PASRR to be uploaded into their record in a timely fashion. <Missing Documentation> <Resident 7> According to the 04/07/2026 annual MDS assessment, Resident 7 had severely impaired memory, was unable to make own decisions, and was dependent on staff for mobility, hygiene, and transfers. Review of the 04/26/2026 Risk for Falls related to arthritis, seizure disorder, unsteady gait, impulsiveness, syncope, and history of falls Care Plan (CP) showed staff were to identify and address fall risks and educate Resident 7 and their family regarding safety risks and interventions. Observation on 06/02/2026 8:12 AM showed Resident 7 lying in bed on a scoop mattress (a mattress with raised, curved sides intended to prevent falls). In an interview and record review on 06/04/2026 at 1:06 PM, Staff B stated the facility should obtain informed consent from the resident or (resident's representative), a physician's order, and complete an assessment prior to use of a scoop mattress. Staff B stated it was important to complete and document due to potential safety risks for Resident 7. Staff B reviewed Resident's 7's record and stated there was no documented informed consent, physician's order, or assessment completed by the facility related to the scoop mattress. REFERENCE: WAC 388-97 -1720(1)(a)(i)-(iv)(b).		