STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505344	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury House	502 29th Street Southeast Auburn, WA 98002

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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 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 was stored and prepared in accordance with professional standards of safety for 1 of 1 facility kitchens reviewed. The failure to ensure the kitchen's range vent hood and freezer were kept clean and free of dust, debris, and/or dirt build-up placed residents at risk for ingesting contaminated food and the development of foodborne illness. Findings included <Facility Policy>The facility policy titled, Sanitary Conditions: Equipment and Utensil Cleaning and Sanitization, published 01/2008, showed a potential cause of foodborne outbreaks was improper cleaning of contaminated equipment. The policy showed protecting equipment from contamination including dust and grease was indicated.The facility policy titled, Food Storage, updated 10/2017, showed the facility would ensure food storage areas/environment were kept clean, safe, and sanitary at all times. <Range Vent Hood>Observation on 01/12/2026 at 8:39 AM showed the kitchen's range vent hood had a visible buildup of dust and dirt. There were spider webs floating along the stainless vent hood baffle filter. The dirty range vent hood was situated adjacent to the food preparation area where steam tables were placed, and resident trays were prepared for meal service. In an interview on 01/12/2026 at 8:43 AM, Staff S (Dietary Supervisor) confirmed the range vent hood had an accumulation of dust and dirt built-up. Staff S stated it needed to be cleaned to ensure the food prepared and served to the residents during meal service remained free from any form of contamination. <Walk-In Freezer>Observation on 01/12/2026 at 9:09 AM showed the kitchen's walk-in freezer was dimly lit, with several boxes and packages stocked up all the way to the ceiling and almost touching the sprinkler head. The freezer's bulkhead had a notable amount of grayish-black dirt buildup which appeared in round patches and was mostly concentrated in areas of condensation (water vapor turned into a liquid form that could cause issues like molds). Review of the November 2025 and December 2025 Daily Cleaning Schedule- Landscape showed the dietary aide was responsible for cleaning the two refrigerators in the kitchen. In an interview on 01/12/2026 at 9:14 AM, Staff S confirmed the walk-in freezer's bulkhead had accumulated moist, dirt buildup and needed to be cleaned. Staff S stated they were unsure if cleaning the freezer's bulkhead was part of their daily cleaning schedule. Staff S stated it was important to ensure food was stored in sanitary conditions to prevent contamination that could result in foodborne illnesses. REFERENCE: WAC 388-97-1100 (3), -2980

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure essential equipment (a dishwasher) was kept in safe operating condition for 1 of 1 facility kitchens reviewed. These failures placed the residents at risk for infection from using improperly sanitized dishes and utensils during meals and the development of foodborne illness. Findings included.<Facility Policy>The facility policy titled, Sanitary Conditions: Equipment and Utensil Cleaning and Sanitization, published 01/2008, showed dishwashing machines were operated according to the manufacturer specifications. The policy showed, for Low Temperature Dishwashers, chemical sanitization included a wash cycle at 120 degrees Fahrenheit (F) and a final rinse with 50 parts per million (PPM) Chlorine (the chemical component used to test for proper sanitation) concentration on the dish surface.< Manufacturer's Instructions - Dishwasher> According to the 12/17/2010 Ecolab Installation and Operation manual provided by the facility, the safe operating temperature specified for this dishwasher was 120F (minimum) for both the wash and rinse cycle and the sanitizing rinse solution should be 50 PPM Chlorine (minimum). <Kitchen Dishwasher> Review of the January 2025 Kitchen Dishwashing Temperature Log showed the morning monitoring of the dishwasher was completed on 01/12/2026 and the dishwasher was within safe operating temperatures and chemical sanitation. Observation and interview on 01/12/2025 at 8:57 AM with Staff S (Dietary Supervisor) showed the dishwasher's chemical sanitation using the Chlorine test strip after a complete wash/rinse cycle did not meet the criteria of 50 PPM during testing as specified in the manufacturer's instruction manual. Staff S repeated the wash/rinse cycle, and the test strip yielded the same results. Staff S asked Staff T (Dietary Aide) to change the chemical solution bucket connected to the dishwasher and they ran the wash/rinse cycle again; the chemical testing still did not meet the criteria of 50 PPM. Staff S stated they would call the service maintenance provider to check the dishwasher immediately and would utilize the three-compartment sink (a manual dishwashing method) for the time being to ensure sanitation in washing the dishes. In an interview on 01/12/2025 at 10:37 AM, Staff S stated it was important to ensure the dishwasher was functioning according to the manufacturer's specifications, .so the residents would not get sick from eating off of dirty and unsanitized dishes and utensils. Staff S stated the monitoring of essential kitchen equipment for proper functioning was necessary for resident safety in preventing foodborne illnesses. REFERENCE: WAC 388-97-2100.

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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: (1) failed to provide the resident and/or the representative a written notice of the facility's bed hold (a process to reserve a resident's current bed when was temporarily absent) policy, at the time of transfer/discharge or within 24 hours, and document in the resident's records for 3 of 4 residents (Residents 9, 27, & 82); and (2) failed to ensure appropriate information was communicated to the receiving health care institution or provider and document in the resident's records for 2 of 4 residents (Residents 9 & 27) reviewed for hospitalizations. These failures placed residents and their representatives at risk of not being informed of their right to, or the cost of ensuring their bed was held for them while hospitalized and unsafe and ineffective transition of care. Findings included . <Policy>The facility policy titled, Bed Hold, updated 05/2025, showed the resident and/or resident representative should be informed of the facility's bed hold policy in writing upon admission, transfer, or leave of absence. The policy showed if the facility was unable to provide the bed hold policy at the time of transfer, the policy must be provided within 24 hours. The policy showed if nursing was unable to provide notification at the time of transfer or discharge, the Social Services Director or designee would contact the resident and/or their representative to notify them of the bed hold policy, obtain a decision whether or not the resident or responsible party chose to secure a bed hold, and document the notification and decision in the Bed Hold Agreement form.<Resident 9> According to the 10/19/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 9 did not have the ability to communicate words, had severely impaired cognitive ability due to a neurological developmental disability, and was dependent on their representative for decision-making. A 01/03/2026 Discharge MDS showed Resident 9 was discharged to the hospital. Review of Resident 9's progress notes from 01/03/2026 until 01/08/2026 did not show the resident's transfer/discharge to the hospital was coordinated with the receiving institution or provider for safety as required. Review of Resident 9's medical records showed there was no documentation to support a bed hold was offered to the resident's representative or that the receiving hospital was provided with all the necessary personal and health information required for a safe and effective transition of care during the transfer/discharge. The facility was asked for any documentation regarding offering Resident 9's representative a bed hold and for any hospital transfer communication, but none was provided. In an interview on 01/16/2026 at 12:52 PM, Staff B (Director of Nursing) reviewed Resident 9's medical records and confirmed there was no documentation a bed hold was offered to the resident's representative or that staff documented their coordination with the receiving hospital. Staff B stated they expected staff to offer residents and/or their representatives a bed hold when they were transferred/discharged from the facility because it was a resident's right to be informed for appropriate decision-making. Staff B stated they expected the nursing staff to complete the required hospital transfer protocol and to document what was done in the resident's medical records. <Resident 82> According to the 11/14/2025 admission MDS, Resident 82 was alert, oriented, and was their own decision-maker. A 12/19/2025 Discharge MDS showed Resident 82 was discharged to the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 82's medical records showed there was no documentation to support a bed hold was offered to the resident during or 24 hours after they were transferred/discharged to the hospital. The facility was asked for any documentation regarding offering Resident 82 a bed hold, but none was provided. In an interview on 01/16/2026 at 12:50 PM, Staff B reviewed Resident 82's medical records and stated there was no documentation found to support a bed hold was offered to the resident. <Resident 27> According to a 01/05/2026 Discharge Return Anticipated Minimum Data Set (MDS – an assessment tool), Resident 27 transferred to an acute care hospital on [DATE] with their return to facility anticipated. Review of Resident 27's medical record showed no documentation that the facility provided a medical report to the hospital, and no documentation that a bed hold was offered to Resident 27 for their 01/05/2026 transfer to the hospital. In an interview on 01/15/2026 at 10:56 AM, Staff K (RN Unit Manager) said the bed hold policy was included in pre-assembled hospital transfer packets that were sent with residents when they transferred to the hospital. Staff K said they believed Admissions staff followed up with hospitalized residents to offer the bed hold. Staff K looked for but could not find any hospital transfer packets at the nurse's station. In an interview on 01/16/2026 at 8:59 AM, Staff K said no hospital transfer packets were currently assembled. Staff K said they expected staff to document when they called a medical report to the hospital. Staff K confirmed staff did not document that a medical report was called to the hospital for Resident 27's transfer on 01/05/2026. In an interview on 01/16/2026 at 9:48 AM, Staff Z (Admissions Director) said their process when a resident transferred to the hospital was to call the patient at the hospital or their representative, offer the bed hold over the phone, and document in a progress note. Staff Z said when Resident 27 transferred to the hospital on [DATE], they called them on their cell phone and left a voicemail to offer the bed hold. Staff Z said they did not document the call but should have. In an interview on 01/16/2026 at 11:53 AM, Staff B (Director of Nursing) said when residents were transferred to the hospital, it was their expectation that staff document bed hold offered and that a medical report was called to the hospital. REFERENCE: WAC 388-97- 0120(4), -0140(1)(a)-(c)(i)-(iii). .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: physician orders were followed for 4 of 18 sampled residents (Residents 55, 1, 9, & 27), failed to notify the physician for refusals of medications for 1 of 5 residents (Resident 27) whose medication regimens were reviewed. These failures left residents at risk for unmet care needs and other negative health outcomes.Findings included .Facility PolicyAccording to the facility's 2007 Non-Controlled Medication Orders policy, staff were to administer medications in accordance with prescribers' written orders and, if necessary, staff would contact the prescriber for clarification. Staff were to document all interactions and the resulting order clarification in the nursing progress notes and elsewhere in the medical record.<Following Orders> <Resident 55> According to the 11/06/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 55 admitted on [DATE] with diagnoses including orthopedic (bone/muscle) conditions. The MDS showed Resident 55 required their nutrition to be delivered through tubing intravenously (directly to the blood). Review of the 11/10/2025 Care Area Assessment (CAA - care planning assessment using MDS data) showed Resident 58 received intravenous nutrition and staff were to care for the resident's Peripherally Inserted Central Catheter (PICC - the tubing providing Resident 55's nutrition to their blood) per the protocol. Record review showed a physician order for staff to remove liquid nutrition bag and tubing set from the infusion pump at 12:00 PM each day and discard, and an 11/22/2025 order for staff to perform a dressing change for Resident 55's PICC site every seven days on Saturdays and as needed. Record review showed nursing staff documented the dressing change on 01/10/2026 at 05:00 PM was not administered. Review of 01/10/2026 at 6:15 PM nursing progress note showed Resident 55 was out of the facility with their family. Observations on 01/12/2026 at 2:32 PM showed Resident 55's liquid nutrition bag and tubing set were connected to the infusion pump and Resident 55's PICC site, over two hours after the time the order stated to disconnect them. Resident 55's PICC site dressing was not dated, and the edges of the dressing were detaching from their skin. In an observation and interview on 01/12/2026 at 2:36 PM, Staff F (Registered Nurse - RN) stated Resident 55's PICC site dressing should be dated and changed based on its appearance but was not. Staff F stated the liquid nutrition bag and tubing should be disconnected and discarded at the ordered time but was not. In an interview on 01/16/2026 at 1:30 PM, Staff B (Director of Nursing) stated they expected staff to follow facility policy to label dressings with the date they were placed and follow physician orders. <Resident 1> According to the 12/26/2025 5-day MDS, Resident 1 had medically complex conditions including diabetes (difficulty controlling blood sugar), respiratory failure, and memory impairment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the January 2026 Medication Administration Record (MAR) showed an 01/16/2025 order for a steroid inhaler, take one inhalation every morning and at bedtime and rinse the resident's mouth out after each use to avoid oral thrush (a yeast infection in the mouth which could be caused by steroid use). Review of the January 2026 MAR showed a 12/19/2024 order for a long-acting inhaler daily to treat Resident 1's chronic respiratory condition. Observation on 01/15/2026 at 8:21 AM Staff W (Licensed Practical Nurse - LPN), administered the steroid inhaler to Resident 1. After administering the steroid inhaler, Staff W provided Resident 1 their other long-acting inhaler medication without first rinsing Resident 1's mouth after using the steroid inhaler. Staff W did not wait in between administering both inhaler medications. In an interview on 01/15/2026 at 8:32 AM, Staff W stated they should have waited between inhalers for better effectiveness and rinsed Resident 1's medication after use of the steroid inhaler but did not. In an interview on 01/16/2026 at 12:00 PM, Staff K (RN unit manager) stated the nurses should follow orders as written. Staff K stated if the order stated to swish and rinse after use, the nurses should follow written orders. Staff K stated nurses should also wait between administering two different inhalers to avoid mixing the medications for better effectiveness of the medications. <Resident 9> According to the 10/19/2025 admission MDS, Resident 9 did not have the ability to communicate words, had short-term and long-term memory deficits, and medical conditions including an early-onset, progressive neurological condition that affected their bladder function. The MDS showed during the assessment period, Resident 9 had a suprapubic indwelling urinary catheter (tubing that entered their body through the abdomen to help drain their urine). According to a 01/03/2026 Discharge MDS, Resident 9 was discharged to the hospital. According to a 01/08/2026 Entry Tracking, Resident 9 returned to the facility. Review of the 01/08/2026 hospital discharge summary showed Resident 9 was diagnosed with a systemic infection because of their indwelling urinary catheter. The summary showed the discharging physician ordered two oral antibiotics for Resident 9; one of which was a double-strength antibiotic. Review of the January 2026 MAR showed, on 01/08/2026, Resident 9 was administered a single-strength dose of the antibiotic for which they required a double dose. The MAR showed, on 01/09/2026, the physician order was changed to the double-strength dose but incorrectly listed pneumonitis (a respiratory infection due to inhalation of food and vomit) as the indication for its use, instead of a urinary infection. On 01/13/2026 at 11:47 AM, Resident 9 was observed with an indwelling urinary catheter in place; it was draining clear, yellow urine into the collection bag. Resident 9 was observed without any breathing issues or respiratory discomfort. In an interview on 01/16/2026 at 1:15 PM, Staff DD (Advanced Registered Nurse Practitioner) stated both antibiotics prescribed for Resident 9 during their hospital discharge were for the treatment of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their systemic urinary infection. In an interview on 01/16/2026 at 1:08 PM, Staff B reviewed Resident 9's January 2026 MAR and confirmed the resident was incorrectly administered a single-strength dose of antibiotic on 01/08/2026. Staff B stated they expected the nurses to follow physician orders as prescribed for resident safety. Staff B stated the nurse should have clarified the indication for Resident 9's antibiotic use to ensure the resident's medical records were accurate but did not. <Resident 27 - Oxygen> According to a 12/19/2025 Quarterly MDS, Resident 27 had multiple medically complex diagnoses including Chronic Obstructive Pulmonary Disease (COPD – a progressive lung disease that makes breathing difficult) and received oxygen therapy. Review of a 09/16/2025 physician's order showed Resident 27 was to receive oxygen through a nasal cannula (tubing with two prongs to deliver supplemental oxygen through the nose) at the rate of two Liters per Minute (L/Min) to keep oxygen saturation (oxygen sats – the level of oxygenation of the blood) between 88% - 92%. Observation on 01/13/2026 at 12:32 PM showed Resident 27 lying in their bed and received oxygen through a nasal cannula connected to an oxygen concentrator (a medical device that provides concentrated oxygen through a nasal cannula or mask). The concentrator was set to deliver oxygen at a rate of 0.5 L/Min. Resident 27 stated someone had been messing with the settings, and it should be set at least at 1 L/Min. Resident 27 said they felt they were getting enough oxygen. Resident 27 used a pulse oximeter (a device placed on a finger to measure oxygen sats) and showed his oxygen sats were currently 98%. Observations on 01/14/2026 at 08:54 AM and on 01/14/2026 at 10:08 AM showed Resident 27 received oxygen at a rate of 0.5 L/Min. In an observation and interview on 01/14/2026 at 10:26 AM, Staff L (RN) confirmed the oxygen concentrator was currently set at 0.5 L/min. Staff L said Resident 27 was to receive oxygen at 2 L/Min continuously and someone must have changed the rate. Staff L adjusted the concentrator rate to 2 L/min. Review of a January 2026 Treatment Administration Record (TAR) showed staff documented Resident 27's oxygen sats and administration of oxygen every shift (day, evening, and night) each day. For 34 shifts between 01/01/2026 and 01/14/2026, staff documented oxygen sats that ranged from 94% to 99%. No documented oxygen sats were within the oxygen parameters of 88% - 92%. Review of a December 2025 TAR showed staff documented oxygen sats for 92 shifts that ranged from 94% to 99%. No documented oxygen sats were within the oxygen parameters of 88% - 92%. Review of September 2025, October 2025, and November 2025 TARs showed similar results. All documented oxygen sats since the order date of 09/16/2025 ranged from 93% to 100%, with no results within the oxygen parameters of 88% - 92%. In an interview on 01/14/2026 at 2:06 PM, Staff K stated they thought there was an order to verify the oxygen concentrator settings, but there was not. Staff K stated they expected staff to follow (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ordered parameters to keep oxygen sats between 88% - 92% and confirmed they did not. In an interview on 01/15/2026 at 2:53 PM, Staff B said they expected staff to follow ordered parameters. <Notifying the Provider> <Resident 22> According to the 12/18/2025 Quarterly MDS, Resident 22 had multiple complex conditions including diabetes, depression, anxiety, and a chronic heart condition. Review of the revised 10/16/2025 impaired psychosocial well-being related to depression and anxiety Care Plan (CP) showed Resident 22's target behaviors included refusals of their medications. Review of the January 2026 MAR showed Resident 22 refused their oral diabetes medication daily from 01/01/2026 through 01/13/2026; refused their anxiety/depression medication daily from 01/01/2026 through 01/07/2026; refused their water pill to treat their chronic heart condition from 01/01/2026 through 01/09/2026; and refused their injectable diabetes medication on 01/01/2026, 01/02/2026, 01/03/2026, 01/06/202601/07/2026, 01/08/2026, 01/09/2026, 01/10/2026 and on 01/11/2026. Review of the January 2026 medical record did not show Resident 22's provider was notified every time Resident 22's refused their medications. In an interview on 01/15/2026 at 9:34 AM Staff W stated Resident 22 refused their medications all the time, and they should document each refusal and notified the provider about the refusals but did not. In an interview on 01/15/2026 at 8:41 AM Staff K stated they expected the nurses to notify the provider every time Resident 22 refused their medications. Staff K stated the nurses were expected to follow the directions provided, document interventions, and notify leadership and family, but did not. In an interview on 01/16/2026 at 10:56 AM Staff B stated the nurses should have reapproached the resident and determined the reason for the medication refusals and notified the provider for further instructions. <Resident 27> Review of a 07/11/2025 physician order showed staff were to administer a nasal spray (used to relieve allergy symptoms) with one spray in both nostrils each morning. Observation of a medication administration pass on 01/14/2026 at 8:54 AM showed Staff L administered multiple medications to Resident 27. Staff L did not offer or administer the ordered nasal spray. In an interview on 01/14/2026 at 10:22 AM, Staff L said they did not give the nasal spray and documented it was refused, because Resident 27 refused it every time. Staff L said Resident 27 did not want nurses to offer it anymore, so they did not offer and documented refused. Staff L said that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other nurses and the doctor were aware of the refusals. In an interview on 01/14/2026 at 10:24 AM, Resident 27 said they did not like the nasal spray because it dried up their nose. Record review of November 2025, December 2025, and January 2026 MARs showed Resident 27 accepted the nasal spray 27 times and refused 43 times since 11/01/2025. In an interview on 01/14/2026 at 2:06 PM, Staff K said Resident 27 always refused the nasal spray. Staff K said staff should notify the doctor of refusals and ask for an order to discontinue it, and possibly an order for an alternative that Resident 27 would accept. Staff K said they would check to see if that was done. In an interview on 01/16/2026 at 8:59 AM, Staff K said staff notified Resident 27's doctor in December 2025 of refusals of the nasal spray. Staff K said the doctor wanted staff to continue to try to administer, but Resident 27 continued to refuse. No requested documentation to show communication with the doctor regarding nasal spray refusals was provided. In an interview on 01/15/2026 at 2:53 PM, Staff B said they expected staff to offer the medication each time it was due until the medication was discontinued. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review the facility failed to ensure 3 of 5 residents (Residents 5, 9, & 74) reviewed for Restorative Nursing Program (RNP) services received the care and services they were assessed to require. The failure to provide hand splinting (Resident 5), Range of Motion (ROM) exercises (Resident 9), and grooming/dressing program (Resident 74) placed residents at risk for pain, contractures (the permanent or severe tightening of muscles resulting to immovable joints), decline in mobility, increased dependence on staff, and a decreased quality of life. Findings included . <Facility Policy>The facility's undated policy titled, Contracture Management, an addendum to ROM from the Restorative Nursing Aide (RNA) Training Program, showed the nursing team screened, assessed, and tracked in regular intervals changes in joint mobility in all residents with evidence of limited ROM, and plan a RNP as needed. The policy showed RNAs had an active role in screening and monitoring residents for changes in their joint mobility as they were involved with the residents' everyday living and had a better chance in observing ROM changes. The policy showed staff were expected to provide ROM programs initiated for residents and to follow a resident's splinting schedule if any. <Resident 5> According to a 11/30/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 5 had limited ROM to both arms and legs. Resident 5 required total assistance from staff with personal hygiene, bed mobility, transfers, dressing, and toileting. The MDS showed Resident 5 had no rejection of care during the assessment period. Review of Resident 5's revised 03/23/2022 Impaired Mobility related to Muscle Weakness Care Plan (CP) RNAs were to provide Resident 5 a splint to their left hand seven days a week, wash and dry their hand, and apply a palm guard six-to-eight hours per day. Observation on 01/14/2026 at 10:54 AM, showed Resident 5 with no palm guard on their left hand. Review of the December 2025 and January 2026 Treatment Administration Records (TARs) showed Resident 5 did not receive their RNP on Sundays in December 2025 and January 2026. In an observation and interview on 01/16/2026 at 11:56 AM, Staff FF (Licensed Practical Nurse, MDS) reviewed Resident 5's December 2025 and January 2026 STARs and stated the lack of staff initials meant restorative services were not completed. Staff FF stated restorative services should be provided as ordered for the resident's care and should have been provided seven days per week but were not. <Resident 9> According to the 10/19/2025 admission MDS, Resident 9 could not communicate using words, had severely impaired cognitive and functional abilities due to an early onset progressive neurological condition, and was dependent on staff for all daily cares. The MDS showed Resident 9 had limited ROM to both their arms/hands and legs. A 01/03/2026 Discharge MDS showed Resident 9 was discharged to the hospital and a 01/08/2026 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Entry Tracking showed the resident readmitted back to the facility. Review of Resident 9's 11/14/2025 Impaired Mobility CP showed the resident had decreased ROM and mobility due to their medical diagnosis of functional quadriplegia (the partial or total loss of sensation and motor function in all four limbs) resulting from their progressive neurological disorder. The CP showed a ROM program was put in place as a restorative nursing intervention. According to a 11/11/2025 Restorative Program Referral Form, the physical therapist recommended passive ROM (PROM) to Resident 9's bilateral upper and lower extremities. This referral form showed to provide all tolerated ROM and positional changes to prevent contractures and wounds/pressure injuries. Observation on 01/13/2026 at 11:58 AM showed Resident 9's wrists curled inwards; their hands and fingers were stiff and rigid. There were no purposeful movements observed on Resident 9's bilateral legs/feet. Review of the January 2026 TAR showed Resident 9 was not provided PROM from 01/04/2026 to 01/15/2026. In an interview on 01/15/2026 at 10:20 AM, Staff GG (RNA) stated Resident 9's PROM was discontinued. In an interview on 01/15/2026 at 10:43 AM, Staff FF stated they were part of the RNP staff as the licensed nurse responsible for the initiation, quarterly evaluation, and discontinuation of RNPs when they were no longer beneficial or applicable for the resident. Staff FF stated when Resident 9 discharged to the hospital, their PROM RNP was automatically discontinued from their software system. Staff FF stated, based on their assessment, Resident 9 continued to benefit from their PROM RNP which should have been re-initiated when the resident came back to the facility on [DATE] but was not. <Resident 74> According to the 12/30/2025 Quarterly MDS, Resident 74 had clear speech, intact memory and medical conditions including a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements. The MDS showed Resident 74 had limited ROM to both their arms/hands and legs; Resident 74 was assessed to be dependent on staff for dressing and required substantial/maximal assistance with their personal hygiene. Review of Resident 74's revised 10/20/2025 Impaired Mobility CP showed the resident had decreased ROM and an intervention was in place for a dressing/grooming RNP to help the resident attain and/or maintain their highest practicable function and wellbeing. The RNP was to be provided to Resident 74 two-to-four times a week. Review of Resident 74's 01/11/2026 Quarterly RNP evaluation completed by Staff FF showed the grooming program remained appropriate and beneficial for the resident at the time of the assessment. The ongoing goal for Resident 74's RNP was to maintain their current functional abilities in performing personal hygiene/grooming tasks and for their quality of life. In an observation and interview on 01/13/2026 at 8:38 AM, Resident 74 was observed in bed eating (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their breakfast with noticeable tremors to both their hands. Resident 74 stated they had limited ROM and experienced issues with raising both their arms. The resident was observed unable to fully extend their arms. Resident 74 stated they were provided RNP once in a while when the staff were able to get to it. Review of the December 2025 TAR showed Resident 74 was not consistently provided their grooming RNP as care planned: On the week of 12/07/2025 – 12/13/2025, it was provided once on 12/12/2025; and on the week of 12/14/2025 – 12/20/2025, none was provided. Review of the January 2026 TAR showed Resident 74 was not consistently provided their grooming RNP as care planned: On the week of 01/04/2026 – 01/10/2026, it was provided once on 01/09/2026. In an interview on 01/16/2026 at 10:21 AM, Staff GG stated they were one of two RNAs working in the facility and the two of them had alternate working days providing RNPs and working as a Certified Nursing Assistant (CNA) on the nursing units. Staff GG stated they had trouble meeting the RNP needs of residents, .it [RNPs] was too much for one restorative aide to provide all the RNPs for the day.[we] cannot possibly cover the RNP's recommended frequency and have not been able to do so. In an interview on 01/16/2026 at 10:43 AM, Staff FF reviewed Resident 74's grooming RNP and confirmed it was not consistently provided to the resident as care planned. Staff FF stated they were aware both restorative aides had difficulty providing RNPs to all the residents who were assessed to require them, especially if/when the restorative aide worked alone. Staff FF stated they informed Staff B (Director of Nursing) regarding this hardship. In an interview on 01/16/2026 at 11:19 AM, Staff HH (RNA) confirmed their work schedule as outlined by Staff GG. Staff HH stated they worked as a CNA at this time while Staff GG provided RNPs to residents. Staff HH stated they knew RNPs were important to provide to residents to prevent their functional decline, but it was not achievable with only one person doing it all. In an interview on 01/16/2026 at 2:35 PM, Staff B stated they expected the RNP staff to provide restorative care and services according to the resident's assessed needs/benefits and according to the resident's individualized CP. Staff B stated they expected the RNP staff to notify them if they had difficulty providing RNPs. Staff B stated it was important to provide RNPs to residents in order to maintain function and mobility, which were important aspects of a resident's quality of life. REFERENCE: WAC 388-97-1060(3)(d)(j)(ix).

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on observation, interview, and record review the facility failed to ensure effective coordination of care between the facility and hospice staff and failed to implement and develop a coordinated Care Plan (CP) for 2 of 2 residents (Resident 5 & 3) reviewed for hospice services. The failure to implement a system by which consistent communication between the facility and hospice staff occurred placed residents at risk for not receiving necessary care and services, avoidable discomfort, and other negative health outcomes. Findings included . <Facility Policy>According to the facility's updated September 2017 Hospice Provision of Care Policy, the facility would collaborate with outside providers to coordinate the provision of hospice care as directed by each residents' physician. The hospice and facility would agree upon a coordinated Care Plan (CP) to include directives and services hospice care which the facility would be responsible for. The CP was to be updated quarterly and as needed and would indicate each party's responsibilities. The unit manager would coordinate care services with the hospice team, and the hospice team would notify the facility of the care to be rendered. <Resident 5> According to a 11/30/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 5 was unable to be understood, had a traumatic brain dysfunction and received hospice (end of life) care services. Record review showed the revised 07/31/2025 Terminal Condition CP directed staff to work collaboratively with the external hospice team to ensure Resident 5's spiritual, emotional, intellectual, physical, and social needs were met to include working with the facility nursing staff to provide maximum comfort for Resident 5. The CP did not indicate what services the hospice team provided or how often services were provided to Resident 5. Record review of Resident 5's January 2026 Kardex (nursing aides' instruction sheet) showed staff were to provide a shower or bed bath twice weekly. The Kardex did not show what care services were provided by hospice services. Review of Resident 5's medical record showed documented hospice visits on 10/01/25 and 11/27/2025 and no hospice visits documented in the month of January 2026. In an interview on 01/15/2026 at 9:51 AM, Staff V (Certified Nursing Aide) stated they thought the hospice team provided showers to Resident 5 but was not sure. In an interview on 01/16/2026 at 9:04 AM Staff Y (Licensed Practical Nurse) stated hospice visit notes should be sent to the Director of Nursing (DON)after each visit and incorporated into the medical record. In an interview on 01/16/2026 10:32 AM Staff K (Registered Nurse, Unit Manager) stated hospice visit notes should be sent to the DON and then scanned into the medical record. Staff X stated they were unable to locate additional visit notes other than what was already noted in Resident 5's medical record. Staff K stated they knew the hospice nurse recently visited Resident 5 but was unsure what services were provided to coordinate care. Staff K stated hospice visit notes were important for the coordination of care and provided residents with continuity of care between the facility and hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/16/2026 at 10:53 AM Staff B (Director of Nursing) stated they expected the hospice team to provide notes when they visited to coordinate and provide continuity of care. Staff B stated they could not locate recent hospice visit notes in the medical record but they should be there. <Resident 3> According to a Modified 06/15/2025 Significant Change Assessment MDS, Resident 3 was able to be understood, had multiple diagnoses including heart conditions, respiratory conditions, wounds, and pain issues, and received hospice care services. Review of the revised 09/19/2025 hospice services CP showed staff would work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs were met, including working with nursing staff to provide maximum comfort for Resident 3. The CP did not show what services the hospice team provided or how often the service was provided to Resident 3. Observation and interview on 01/14/2026 at 8:25 AM showed Resident 3 lying in bed on their back. Resident 3 stated they had some pain. Resident 3 said they required hospice services and a hospice nurse visited them. In an interview on 01/14/2026 at 10:12 AM, the visiting hospice nurse stated they visited Resident 3 that day, and visited about once every three days for the last few months. The hospice nurse stated they monitored Resident 3's wound, provided medication management, and addressed other health and comfort issues. Review of Resident 3's medical record showed Resident 3 admitted to hospice services on 06/09/2025, and hospice visit notes were documented on 06/09/2025, 07/10/2025, 07/14/2025, 07/16/2025, 08/27/2025, and 10/02/2025. No hospice visits were documented for the month of September 2025, November 2025, December 2025 or January 2026. In an interview on 01/15/2026 at 11:28 AM, Staff K stated hospice staff were able to write visit notes to leave in Resident 3's hospice binder at the nursing station. Staff K stated normally hospice staff sent them an email for any order changes, and medical records staff would notify nursing staff, and upload orders to the EHR. Staff K was unable to locate Resident 3's hospice binder at that time and stated they would look for it. In an interview on 01/16/2026 at 8:59 AM, Staff K said they did not locate Resident 3's hospice binder. Staff K said they were unable to find any emails from hospice regarding Resident 3. Staff K stated they frequently coordinated verbally with hospice staff and stated such communication should be documented in the medical record. In an interview on 01/16/2026 at 11:53 AM, Staff B stated there should be consistent documentation of coordination of Resident 3's care with hospice staff. REFERENCE: WAC 388-97 -1620(1)(2)(b)(i)(ii), -0220.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves and gowns used to prevent exposure to infectious materials) for 1 supplemental resident (Resident 55) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms); ensure staff followed Transmission Based Precautions (TBP - a set of infection control practices used to prevent the spread of infectious agents, in addition to standard precautions) for 1 supplemental resident (Resident 88) reviewed for TBP; and ensure respiratory equipment was free from visible debris for 1 of 1 sampled residents (Resident 27) reviewed for respiratory care. These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases.Findings included .<Facility Policy>According to the facility's March 2025 TBP policy, the facility used different types of precautions to protect residents and staff from different kinds of communicable diseases. The facility would place appropriate signage at the entrance door of resident rooms to alert staff and visitors of necessary measures. The policy showed staff would use personal protective equipment (PPE) as indicated by the identified precaution.According to the facility's 03/26/2024 Cleaning and Disinfecting Environmental Surfaces policy, the facility would clean and disinfect semi-critical items, including respiratory therapy equipment, according to current CDC recommendations for disinfection of healthcare facilities.According to the facility's May 2015 Respiratory Equipment policy, updated May 2015, hand-held nebulizers (a machine that turns liquid medicine into a fine, inhalable mist for a 5-10 minute treatment, used for respiratory conditions), masks, and tubing were to be cleaned after each use and stored in a mesh bag, paper sack, or the compartment within the nebulizer machine<Precautions> <Resident 55>According to the 11/06/2025 admission Minimum data Set (MDS - an assessment tool), Resident 55 had received their nutrition intravenously (IV - through the blood). Record review of the 11/10/2025 Care Area Assessment (CAA - areas triggered by the MDS that required care planning) showed Resident 55 was at risk for infection related to their IV site. Observation on 01/14/2026 at 8:50 AM showed an EBP sign placed outside Resident 55's door, with instructions to staff to wear an isolation gown and gloves during high contact patient care activities. At this time, Staff E (Licensed Practical Nurse) was observed leaning over Resident 55 to administer an insulin injection. Staff E did not wear a gown. In an interview on 01/14/2026 at 8:54 AM, Staff E stated they did not consider insulin injections a high contact activity requiring a gown. In an interview on 01/16/2026 at 1:30 PM, Staff B (Director of Nursing) stated the administration of insulin was a high contact patient care activity. Staff B stated they expected staff to follow the facility infection control policy, but they did not. <Resident 88> Observation on 01/14/2026 at 10:35 AM showed Resident 88's door had a Contact Precaution sign posted and instructed all staff and visitors to put on a gown and gloves before entering the resident's room. Observation showed Staff G (Certified Nursing Assistant) repositioning Resident 88 in bed without wearing an isolation gown. At that time Staff C (Infection Preventionist) observed Staff G (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	providing care for Resident 88 without wearing an isolation gown. Staff C stated they expected Staff G to follow the instructions on the sign and put on a gown and gloves prior to entering Resident 88's room, but they did not. In an interview on 01/16/2026 at 1:30 PM, Staff B stated they expected staff to follow instructions on posted precaution signs and follow the facility's infection control policy. <Respiratory Equipment> <Resident 27> According to the 12/19/2025 Quarterly MDS, Resident 27 re-admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory conditions. The MDS showed Resident 27 received oxygen therapy. Review of a Hospital After Visit Summary, dated 01/08/2026, showed Resident 27 was hospitalized from [DATE] through 01/08/2026 for exacerbation of a respiratory condition. Review of Resident 27's January 2026 Medication Administration Record showed Resident 27 received respiratory medication via a nebulizer four times daily. In an interview on 01/12/2026 at 10:02 AM, Resident 27 stated they frequently got pneumonia (a lung infection), and just returned from a hospital stay due to difficulty breathing. Observation on 01/12/2026 at 10:02 AM showed a nebulizer machine on Resident 27's overbed table. The machine had yellowish debris on the upper surface near the oxygen tubing port, and the air filter port was stained brown. The connected tubing and mouthpiece (a hand-held nebulizer delivery device the resident holds in their mouth to inhale the medicated mist) was stored directly on top of the nebulizer machine. The machine's tubing storage compartment contained a bottle of saline nasal spray and numerous sugar packets. Observations on 01/13/2026 at 12:32 PM, 01/14/2026 at 8:07 AM, and 01/14/2026 at 12:25 PM showed similar findings. In an interview on 01/13/2026 at 12:32 PM, Resident 27 stated staff cleaned the tubing and mouthpiece, but they did not clean the nebulizer machine itself. In an interview on 01/14/2026 at 12:25 PM, Staff L (Registered Nurse) stated the nebulizer machine was dirty and should be cleaned. Staff L stated the mouthpiece storage compartment should be emptied of personal items. In an interview on 01/14/2026 at 2:06 PM, Staff K (Unit Manager) stated the nebulizer machine should be clean. In an interview on 01/16/2026 at 11:45 AM, Staff B stated they expected respiratory tubing and equipment to be free from visible debris for resident safety and infection control. REFERENCE: WAC 388-97-1320(1)(a)(2)(a)(b).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to implement a system to ensure 2 of 5 Certified Nursing Assistants (CNAs) reviewed for training (Staff H,CNA & Staff I, CNA), received the required in-service training of no less than 12 hours per year. This failure placed residents at risk of receiving care from unqualified staff.Findings included.In an interview on 01/14/2026 at 12:44 PM, Staff J (Licensed Practical Nurse, Minimum Data Set) said CNAs should complete 12 hours of in-service training each year by the anniversary of their date of hire.<Staff H>Review of staff listing provided on 01/12/2026 showed the facility hired Staff H on 11/07/2019.Review of the training records provided for Staff H's last completed year of employment from 11/07/2024 through 11/07/2025 showed Staff H completed 15 minutes of in-service training.<Staff I>Review of the staff listing showed the facility hired Staff I on 10/16/2024.Review of records provided for training completed since 10/16/2024 showed Staff I had 38 in-service trainings assigned to them and none were completed.In an interview on 01/14/2026 at 12:42 PM, Staff C (Infection Preventionist/Staff Development) confirmed there was no system in place to track CNA's annual in-service hours. Staff C said it was important to ensure CNAs completed the required 12 hours of in-services annually to ensure they kept up with skills and knowledge to ensure the safety and care of residents, and to meet the requirement needed to renew their CNA license.In an interview on 01/16/2026 at 10:10 AM, Staff C confirmed Staff H and Staff I did not complete 12 hours of annual in-service training as required.In an interview on 01/16/2026 at 11:53 AM, Staff B (Director of Nursing) said they expected CNAs to complete 12 hours of in-service training annually.REFERENCE: WAC 388-97-1680 (2)(a-c).

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 1) review resident rights and the grievance policy in accordance with their process and 2) initiate, investigate and document resolutions for grievances raised during 3 of 3 Resident Council (RC) meetings (11/03/2025, 12/10/2025, and 01/08/2025) reviewed. This failure placed residents at risk of increased feelings of powerlessness, frustration, and decreased quality of life.Findings included .<Facility Policy>According to the facility's January 2017 Resident Council policy, the facility was responsible for providing staff support for monthly RC meetings to gather and discuss thoughts, ideas, or issues related to the residents' care and treatment. Staff would review old and new business to ensure members had an opportunity to express their concerns. Staff would ensure resident concerns were resolved via the facility's grievance policy and provide updates on each concern by the next RC meeting.Review of the November 2016 Grievance Procedure policy showed staff would resolve grievances immediately, if possible, or complete a Grievance Form and give it to the Grievance Official within 24 hours.Review of the March 2025 Grievance Procedure Policy Posting showed the Grievance Official would give the Grievance Form to the appropriate department manager, who would review the concern, respond within five business days, and return the form to the Grievance Official. If unable to resolve the grievance in five days, the Administrator would review during the daily manager meetings until a resolution was obtained. The residents would receive a written decision regarding their grievances.<Resident Council> Review of the 11/03/2025 RC Minutes showed RC sample members (Resident 24, Resident 14, Resident 47, and Resident 60) attended. The old business section was labelled Yes and no additional information was documented. The new business section instructed staff to review resident rights and the grievance policy, but no additional information was documented. residents not knowing their shower schedule times, wanting fresh ice water at the beginning of each shift, ensuring soiled linens were removed after each resident care, and experiencing long callˆlight wait times. A Dietary concern was expressed regarding wanting taco salads returned to the menu. Review of the 12/10/2025 RC Minutes showed RC sample members attended. The old business section was labelled Yes and no additional information documented. The new business section included concerns regarding nursing staff not wearing their name tags and trash not being removed after resident care. Residents raised housekeeping concerns with bathroom cleanliness. No additional information was documented regarding staff reviewing resident rights or the grievance policy. Review of the 01/08/2026 RC Minutes showed RC sample members attended. The old business section was labelled Yes and no additional information documented. The new business section included the same housekeeping concern from the previous meeting regarding bathroom cleanliness. No additional information was documented regarding staff reviewing resident rights or the grievance policy. In an interview on 01/14/2026 at 1:19 PM, RC members stated they were unaware they had the right to receive a written response regarding their grievances and had not received a response for the issues raised during RC meetings. Resident 24 stated they were unaware of the status of concerns verbalized during the past 3 monthly RC meetings, did not think Grievance Forms were completed for each concern, and did not feel their concerns were resolved. RC members stated they did not feel they could rely on nursing staff to file Grievance Forms on their behalf and did not feel the current grievance process offered enough privacy. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/15/2026 at 12:02 PM, Staff D (Activities Director) stated they conducted all RC meetings but did not complete Grievance Forms when residents verbalized concerns during the meetings. Staff D stated they discussed the residents' concerns with Staff A (Administrator) after each RC meeting. Staff D stated they did not review resident rights and the grievance policy with residents as instructed on the RC Minutes form. In an interview and record review on 01/15/2026 at 12:36 PM, Staff A stated they expected staff to follow the facility policies and procedures when conducting RC meetings, but they did not. Staff A stated the facility should have initiated the grievance process (including starting a Grievance Form and adding the grievance to the log) to address each of the residents' concerns discussed during the 11/03/2025 and 12/10/2025 RC meetings, but they did not. Staff A stated it was important to resolve grievances timely, so the residents felt the facility was a safe and homelike environment. REFERENCE WAC 388-97-0920 (1-6)

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	505344	A. Building B. Wing	01/16/2026

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Canterbury House	502 29th Street Southeast Auburn, WA 98002

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete resident assessments within the regulatory timeframes for 2 of 12 sampled residents (Resident 2 & 5) reviewed for assessment completion and timing. The failure to ensure comprehensive admission Minimum Data Set (MDS - an assessment tool) and Quarterly MDS assessments were completed timely delayed the residents' care planning process, hindered necessary Care Plan (CP) revisions, and placed residents at risk for delayed services, unidentified status change and care needs, and a decreased quality of life. Findings included <Resident Assessment Instrument (RAI - instructional guidelines for MDS completion) Manual>The October 2023 RAI Manual outlined the admission MDS as a comprehensive assessment for a new resident and, under some circumstances, a returning resident, used to promptly assess the resident, develop their CP, and provide the appropriate care necessary to attain and/or maintain the resident's highest practicable well-being; a Quarterly MDS was a non-comprehensive assessment for a resident completed at least every 92 days to track a resident's status between comprehensive assessments that ensured critical indicators of gradual change in a resident's status were monitored. The manual showed the admission MDS must be completed by the end of day 14 of the resident's stay; with day 1 as the admission date to the facility and the Quarterly MDS must be completed no later than 14 days after the Assessment Reference Date (ARD). <Resident 2>According to the 12/08/2023 admission MDS, Resident 2 admitted to the facility on [DATE]. This MDS was dated as complete by the Registered Nurse (RN) Coordinator on 12/23/2025, eight days past the required regulatory timeframe. <Resident 5>Review of Resident 5's 11/30/2025 Quarterly MDS showed the RN Coordinator completed the assessment on 12/15/2025, one day past the required regulatory timeframe. In an interview on 01/14/2026 at 9:36 AM, Staff U (Licensed Practical Nurse, MDS) stated they referred to the RAI manual for guidance in completing MDS assessments. Staff U stated it was important to ensure MDS assessments were completed timely because it was what drove the CP, .so there would not be a delay in the resident's care planning process, and the staff would be able to provide safe and appropriate care. Staff U reviewed Resident 2 and 5's MDS assessments and stated they were both completed late. REFERENCE: WAC 388-97-1000(b)(c)(ii), (3)(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) accurately reflected the status of 3 of 16 sample residents (Residents 67, 3, & 10) reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life.Findings included . <Facility Policy>According to the facility's March 2019 updated Resident Assessment Instrument (RAI) Policy, the facility would complete MDS assessments per the RAI Manual.<Resident 67> According to the 12/27/2025 Annual Minimum Data Set (MDS – an assessment tool), Resident 67 had multiple medical conditions including anxiety and bipolar disorder (a serious mental illness causing extreme shifts in mood, energy, and activity, from intense highs characterized by mania to deep lows characterized by depression, that disrupts daily functioning, sleep, and concentration). The MDS showed Resident 67 was given antipsychotic, antianxiety, and antidepressant medications during the assessment period. The MDS showed Resident 67's was not currently considered by the state Preadmission Screening and Resident Review (PASRR) process to have serious mental illness. Review of Resident 67's medical records showed the resident was referred to the State Agency for a Level II PASSR evaluation on 03/05/2025. The initial psychiatric evaluation was completed on 09/16/2025 and the evaluator provided recommendations regarding Resident 67's mental health care. Review of Resident 67's 11/13/2025 Level II PASSR Care Plan (CP) showed the interventions put in place to care for and support the resident's mental health needs included routine monitoring of their target behaviors (behaviors requiring treatment), medication side effects, and the provision of non-pharmacological interventions such as breathing exercises and diversion activities. On 01/12/2026 at 10:12 AM, Resident 67 was observed lying in bed and watching television; their room was dark as there were no lights on and the window blinds were closed shut. Resident 67 stated they prefer their room as such because they did not want too much stimulation. Resident 67 was observed to be hesitant about responding to the questions being asked and avoided eye contact but was pleasant during the conversation. In an interview on 01/14/2026 at 9:28 AM, Staff U (Licensed Practical Nurse, MDS) stated it was important to ensure MDS assessments were completed accurately because it involved the direct care of residents, [we] want to make sure the care needs identified during the assessment was captured in the CP for resident safety. Staff U reviewed Resident 67's Annual MDS and stated the resident's Level II PASSR status should have been captured in the assessment, but was not. <Resident 3> According to the 12/11/2025 Quarterly MDS showed Resident 3 not receive hospice services. According to a 07/21/2025 physician's order, Resident 3 admitted to hospice services on 06/09/2025. In an interview on 01/14/2026 at 10:12 AM, the visiting Hospice Nurse stated they visited Resident 3 about every three days for the last few months and provided services including medication management and wound monitoring. In an interview on 01/15/2026 at 2:18 PM, Staff U confirmed the MDS was incorrect. Staff U stated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they should have coded that Resident 3 received hospice services but did not. <Resident 10> According to the 08/14/2025 admission MDS, Resident 10 had no dental issues. Review of a 07/31/2025 hospital speech therapy swallow assessment showed Resident 10 had upper and lower dentures. Observation on 01/14/2026 at 10:56 AM showed Resident 10 had one upper denture in place and no lower teeth present. At that time, Resident 10 stated plans were in place to get them new lower dentures at that time. In an interview on 01/15/2026 at 2:18 PM, Staff U stated Resident 10 had both upper and lower dentures when they assessed them. Staff U stated they should have coded Resident 10 had no natural teeth or tooth fragments, but did not. REFERENCE: WAC 388-97-1000(1)(a)(b)(4)(a). .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review the facility failed to ensure residents' Care Plans (CPs) were comprehensive and implemented for 1 of 18 (Resident 22) sample residents whose CPs were reviewed. This failure placed residents at risk for unmet care needs, frustration, and other negative health outcomes. Findings included . <Facility Policy>The facility was unable to provide a policy describing their CP development and implementation standards and expectations. <Resident 22> According to the 12/18/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 22 had multiple complex conditions including diabetes, depression, anxiety and a chronic heart condition. Review of the revised 10/16/2025 Impaired psychosocial well-being related to depression and anxiety CP showed Resident 22's target behaviors included refusing their medications. This CP included no directions to staff showing what to do when Resident 22 refused their medications. No other CP was developed to address Resident 22's needs related to refusing medications. Review of the January 2026 Medication Administration Record showed Resident 22 refused their oral diabetes medication daily from 01/01/2026 through 01/13/2026; refused their anxiety/depression medication daily from 01/01/2026 through 01/07/2026; refused their water pill to treat their chronic heart condition from 01/01/2026 through 01/09/2026; and refused injectable diabetes medication on 01/01/2026, 01/02/2026, 01/03/2026, 01/06/202601/07/2026, 01/08/2026, 01/09/2026, 01/10/2026 and on 01/11/2026. Review of the medical record did not show Resident 22's provider was notified every time Resident 22's refused their medications in January 2026. In an interview on 01/15/2026 at 9:28 AM, Resident 22 stated they did not want to talk about their refusal of medications and became frustrated. In an interview on 01/15/2026 at 9:34 AM, Staff W (Licensed Practical Nurse) stated Resident 22 refused their medications all the time and they should have documented each refusal and notified the provider about the refusals but did not. In an interview on 01/15/2026 at 8:41 AM Staff K (Registered Nurse, Unit Manager) stated they expected the nurses to notify the provider every time Resident 22 refused their medications. Staff K stated the nurses were expected to follow the directions provided, document the interventions attempted, notify behavior support services, and notify leadership and family but did not. Staff K stated refusal of medications should be addressed in Resident 22's CP with instructions for staff to follow when Resident 22 refused their medications. In an interview on 01/16/2026 at 10:56 AM Staff B (Director of Nursing) stated the nurses should have reapproached the resident and determined the reason for the medication refusals and notified the provider. Staff B stated Resident 22's CP should include interventions showing staff what to do when Resident 22 refused their medications but did not. Refer to: F658 - Services Provided Meet Professional Standards REFERENCE: WAC 388-97-1020(1), (2)(a-b).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were dependent on facility staff for assistance with Activities of Daily Living (ADLs) received the assistance they were assessed to require for 2 of 3 sampled residents (Residents 1 & 29) reviewed for ADLs. The failure to provide bathing and grooming assistance for (Residents 29) and nail care for (Resident 1) left residents at risk for body odors, unmet care needs, and a decreased self-worth and/or quality of life. Findings included <Facility Policy>The facility policy titled, Bath or Shower Assistance, updated 11/2016, showed the facility provided ADL assistance according to the resident's Care Plan (CP) and the resident's need for assistance.<Resident 1> According to the 12/26/2025 5-day Minimum Data Set (MDS - an assessment tool) Resident 1 had medically complex conditions including diabetes (a condition making it more difficult to control blood sugar), respiratory failure, and muscle weakness. The MDS showed Resident 1 required substantial assistance from staff for bathing and lower body dressing. According to the 06/23/2025 Diabetes CP, staff were to notify the nurses when Resident 1 had long toenails. The CP showed the facility nurses were to trim Resident 1's nails or refer Resident 1 to the podiatrist for foot care because of the resident's diabetes diagnosis. Review of the January 2026 caregiver task sheets and the nurses' January 2026 Treatment Administration Record (TAR) did not show toenail care scheduled for Resident 1. Observations on 01/12/2026 at 9:33 AM and on 01/14/2026 at 10:16 AM showed Resident 1 had long toenails that were half an inch past the nail bed. In an interview on 01/12/226 at 9:41 AM, Resident 1 stated they would like their toenails trimmed as they caused discomfort. In an observation and interview on 01/15/2026 at 8:37 AM, Staff W (Licensed Practical Nurse) observed Resident 1's toenails and stated Resident 1's toenails should be trimmed for comfort and to prevent curling but were not. In an interview on 01/14/2026 at 10:16 AM Staff L (Registered Nurse) stated nurses should cut diabetic resident's toenails unless the nails were too hard to cut. Staff L stated staff should check residents' toenails on bath days and report to the nurses when toenails needed to be cut. In an interview on 01/15/2026 at 8:33 AM Staff K (Unit Manager) stated the nursing aides should tell the nurses when residents' toenails needed to be cut. Staff K stated toenail care task should be on the Resident 1's TAR but was not. In an interview on 01/16/2026 at 11:03 AM Staff AA (Regional Director of Clinical Operations) stated there was a standard of care for ADLs and providing ADL assistance was important to promote healing and independence and to retain functional ability. <Resident 29> According to the 01/07/2026 admission MDS, Resident 29 had clear speech, intact memory, and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses including heart and kidney failure, unstable blood sugar levels, severe obesity, and muscle weakness and had difficulty in walking. The MDS showed Resident 29 was assessed to be dependent on two staff for assistance with their shower/bathing and toileting hygiene. Review of the revised 01/12/2026 ADL CP showed Resident 29 needed substantial/maximal assistance with showers, grooming, and hygiene, and their bathing schedule was twice a week on Mondays and Thursdays during day shift. The CP showed Resident 29 was unable to perform ADLs independently due to their limited mobility and medical conditions. In an observation and interview on 01/13/2026 at 8:49 AM, Resident 29 was observed with facial hair/stubbles and long, unkempt, matted hair; a pungent smell was noticeably coming from the resident's breath and lower body. There were white flakes covering both the shoulders and upper chest portion of the resident's gown. Resident 29 stated they did not have a shower/bath in almost two weeks since they admitted to the facility on [DATE]. Resident 29 stated a caregiver came and offered them a shower once, only to come back and tell them the facility ran out of towels so the shower/bath was not provided. Resident 29 stated they did not brush their teeth since they were admitted and pointed to a facility-provided toiletries bag sitting on top of their nightstand and stated all items inside it were still unopened. Resident 29 stated they told staff they wanted to shave their facial hair and needed help but was told they Need to walk first. Review of Resident 29's January 2025 shower log showed the resident was provided a bed bath on 01/03/2026, 01/05/2025, and 01/08/2026 by Staff N (Licensed Practical Nurse, Care Coordinator). The log showed Resident 29 was not given a shower/bath on 01/12/2026 as care planned. In an interview on 01/14/2026 at 9:15 AM, Staff BB (Certified Nursing Assistant - CNA) stated the facility did not have a delegated shower aide and the CNAs were responsible for giving residents their shower/bath. Staff BB stated they refer to the CP to determine the resident's bathing preference and what day(s) in the week to provide it. In an observation and interview on 01/14/2026 at 11:16 AM, Staff CC (CNA) stated they were the staff assigned to Resident 29 for that day. Staff CC went inside Resident 29's room, confirmed the resident needed grooming and hygiene assistance, and stated they would help the resident. Resident 29 was observed telling Staff CC they did not have a shower/bath or received assistance to brush their teeth since they admitted to the facility. Resident 29 was observed directing Staff CC to look into the bag of toiletries. Staff CC did and found all items inside the bag were sealed/unopened including the toothpaste and mouthwash; the toothbrush was still inside the intact plastic wrapper. In an interview on 01/14/2026 at 12:42 PM, Staff DD (Registered Nurse, Unit Manager) reviewed Resident 29's medical records and stated the resident should have but did not receive a shower/bath on 01/12/2026. Staff DD stated it was important to provide ADL assistance to dependent residents, especially with bathing and grooming, for their quality of life and dignity, .so [residents] feel clean, loved, and respected. REFERENCE: WAC 388-97-1060(2)(c).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain safe water temperatures for 2 of 14 resident room sinks (Rooms 215 & 301) reviewed for water temperatures; and failed to secure potentially hazardous items in 1 of 2 clean utility rooms (West Nursing Station clean utility room) reviewed for accident hazards. These failures placed residents at risk for accidents, injury, and a diminished quality of life.Findings included.<Policy>According to the facility's July 2008 Washington State Water Temperature Regulations policy, the facility must ensure the hot water system maintained water temperatures at 110 degrees Fahrenheit (F), plus or minus 10 F, for fixtures used by residents and staff.<Water temperatures> <room [ROOM NUMBER]> Observation on 01/13/2026 at 10:33 AM showed the hot water temperature of the sink in room [ROOM NUMBER]'s bathroom was 123 F. No residents were present. Observation on 01/13/2026 at 11:32 AM showed Resident 46 independently using the sink in room [ROOM NUMBER]'s bathroom. Resident 46 stated the water was hot, but they were able to adjust the temperature with cold water. In an interview on 01/14/2026 at 1:19 PM, Staff M (Maintenance Director) stated they tested and documented water temperatures in sampled resident rooms weekly. Staff M stated the highest water temperature should be 120 F for safety. Observation with Staff M on 01/14/2026 at 1:22 PM showed the hot water temperature of room [ROOM NUMBER]'s bathroom sink using a facility thermometer reached 125.1 F before settling at 120 F. Staff M stated they would document a temperature of 120 F as the result. <room [ROOM NUMBER]> Observation on 01/13/2026 at 10:21 AM showed the water temperature of the room sink in room [ROOM NUMBER] was 121.5 F. Residents 58 & 77 (the room's occupants) stated they used the sink and adjusted the water when it was too hot with the cold water. Observation with Staff M on 01/14/2026 at 1:26 PM showed the hot water temperature of room [ROOM NUMBER]'s room sink reached 122.7 F before settling at 116 F. Staff M stated they would document a temperature of 116 F as the result. In an interview on 01/14/2026 at 2:02 PM, Staff A (Administrator) stated they expected hot water temperatures in resident rooms to always be within the safe range. Staff A stated there could be a short burst of hot water coming through the lines from the hot water heater when water was first turned on and agreed it would be hazardous to residents using the sink during that time. Staff A confirmed the temperatures went above the safe range, and the facility needed to adjust the hot water temperature. <Clean Utility Room> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/12/2026 at 8:33 AM showed the clean utility room across from the [NAME] Nursing Station had a keypad lock on the door. The door opened easily without entering a code on the keypad. Observation inside the clean utility room showed supplies stored included a bin of disposable razors. In an interview on 01/12/2026, Staff E (Licensed Practical Nurse) stated the door should be locked because there were hazardous items stored in the room but was not. Observations on 01/12/2026 at 12:14 PM, 01/13/2026 at 12:29 PM, and 01/14/2026 at 11:06 AM showed the door opened easily without using the keypad. In an interview on 01/14/2026 at 11:07 AM, Staff A stated the door was supposed to be locked, but it did not latch correctly and needed to be fixed. Staff A stated the razors in the room were hazardous and should be secured for resident safety. Reference WAC 388-97-1061 (3)(g), -3320