STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505347	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Oaks at Lakewood	11411 Bridgeport Way Tacoma, WA 98499

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure substantial injuries/injuries of unknown sources were reported to the State Agency Reporting Hotline for 2 of 3 sampled residents (Residents 7 and 9) when reviewed for abuse. This failure placed residents at risk for potential abuse/neglect and a diminished quality of life. Findings included .Resident 7 Review of the electronic health record (EHR) showed Resident 7 was re-admitted to the facility on [DATE] with diagnoses to include dementia (a decline in mental abilities such as memory, thinking, and reasoning), diabetes (too much sugar in the blood), and muscle weakness. Resident 7 was sometimes able to make needs known. Review of Resident 7's EHR showed a Change of Condition form completed on 09/25/2025 related to Resident 7's complaint of pain/discomfort in the right upper shoulder with slight swelling noted. Review of the September 2025 accident and incident log showed an entry dated 09/29/2025 related to Resident 7's 09/25/2025 incident of Other. The log entry indicated the incident was not reported to the State Agency Reporting Hotline. Review of Resident 7's progress note dated 09/25/2025 showed X-ray results received and reviewed with the provider who recommended to send the resident to the emergency room (ER) for further evaluation. Resident 7 was transported to the ER via ambulance. Review of the radiology report dated 09/25/2025 of Resident 7's x-ray results showed, Acute impacted right humeral neck fracture, (a fresh, sudden break in the top part of the right arm bone near the shoulder, where the broken pieces of bone have been jammed together). Review of the facility investigation dated 09/25/2025 showed Resident 7's fracture of the right arm/shoulder area was reasonably related to a previous fall of which the resident had refused to get an X-ray at that time and was assessed, treated for pain, monitored, and family and provider notified. Review showed the facility had ruled out any abuse/neglect; however, it did not show the incident was reported to the State Agency Reporting Hotline. During an interview on 01/29/2026 at 9:11 AM, Staff B, Director of Nursing Services (DNS), stated injuries of unknown sources should be reported to the State Agency Reporting Hotline within two hours. The DNS stated Resident 7's 09/25/2025 injury of unknown source/fracture was not reported and should have been. During an interview on 01/29/2026 at 9:40 AM, after reviewing Resident 7's investigation dated (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/25/2025, Staff A, Administrator, stated Resident 7 had an injury of unknown source that was not reported to the State Agency Reporting Hotline. Staff A stated injuries of unknown source should be reported within two hours. Resident 9 Review of the EHR showed Resident 9 admitted to the facility on [DATE] with diagnoses to include dementia, congestive heart failure (when the heart is unable to pump blood efficiently) and muscle weakness. Resident 9 was able to make needs known. Review of Resident 9's EHR showed a Change of Condition form completed on 11/05/2025. related to an abrasion in the right groin area. An additional Change of Condition form was completed on 11/09/2025 related to an abrasion in the left lateral groin area. Review of the November 2025 accident and incident log showed an entry dated 11/13/2025 related to Resident 9's 11/09/2025 abrasion. The log entry indicated the incident was not reported to the State Agency Reporting Hotline. There was no entry logged related to Resident 9's 11/05/2025 abrasion. Review of the facility investigation dated 11/05/2025 showed Resident 9 was noted with a scratch on the right inner thigh. Resident 9 was unable to recall how the scratch occurred due to poor cognition. Review of the facility investigation dated 11/09/2025 showed Resident 9 was noted with a scratch to the left groin area during personal care. During an interview on 01/28/2026 at 2:36 PM, Staff G, Resident Care Manager (RCM), stated they completed the investigations and concluded the 11/05/2025 and 11/09/2025 abrasions were reasonably related to a fungal infection. Staff G stated during the process of investigation they determined the incidents were not reportable. During an interview on 01/28/2026 at 2:52 PM, Staff B, DNS, stated Resident 9 had cognitive impairment and could not reliably report how the injuries occurred. Staff B stated both incidents were an injury of unknown origin and should have been documented on the incident log and reported to the State Agency Reporting Hotline. Reference WAC 388-97-0640(5)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected the status for 2 of 18 sampled residents (Residents 11 and 5) when reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care and a diminished quality of life. Findings included.Resident 11 Review of the electronic health record (EHR) showed Resident 11 readmitted to the facility on [DATE] with diagnoses of depression and schizophrenia (disorder that disrupts how a person thinks, feels, and behaves, causing them to interpret reality abnormally). Resident 11 was able to make needs known. Review showed Resident 11 had a pre-admission screening and resident review (PASSAR, a mental health assessment) level II evaluation completed on 03/24/2022 and a behavior health (BH) PASSAR notice of determination completed on 10/03/2024. Review of Resident 11's annual minimum data set assessment (MDS), dated [DATE], showed section A1500 was coded No for being considered by the State level II PASSAR process to have serious mental illness and/or intellectual disability or a related condition. During an interview on 01/28/2026 at 10:02 AM, Staff D, Minimum Data Set/Licensed Practical Nurse (MDS/LPN), stated Resident 11's section A1500 of their annual MDS dated [DATE] was coded No and should have been coded Yes because the resident had a PASSAR level II evaluation and a PASSAR notice of determination. During an interview on 01/28/2026 at 10:26 AM, Staff B, Director of Nursing (DNS), stated Resident 11's annual MDS dated [DATE] was not coded accurately for having a level II PASSAR and this did not meet their expectations. Resident 5 Resident 5 admitted to the facility on [DATE] with diagnoses to include stroke, diabetes (excessive blood sugar) and dementia (loss of cognitive functioning). Resident 5 was able to make needs known. Review of the annual MDS dated [DATE] and quarterly MDS dated [DATE] showed Resident 5 had a decline in bed mobility and toilet transfers. The 10/06/2025 MDS showed Resident 5 was assessed as independent, and the 01/05/2026 MDS showed Resident 5 was assessed to require substantial/maximal assistance. During an interview on 01/29/2026 at 8:28 AM, Staff F, Restorative Nursing Assistant, stated Resident 5 consistently participated in restorative services a minimum of three times per week. Staff F stated Resident 5 was able to transfer and ambulate in their room without the assistance of staff. Review of Resident 5's 10/24/2025 care plan showed an intervention Ambulate resident using FWW [front wheel walker] supervision touching assist with w/c [wheelchair] follow 50-80 ft or as tolerated. three-six times/week. Review showed Resident 5 participated in restorative three times per week during the month of January 2026. During an interview on 01/29/2026 at 8:37 AM, Staff D, MDS/LPN, stated Resident 5's MDS was inaccurate and did not meet expectation. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1000(1)(a)(b)(4)(a)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the required nursing staff posting accurately reflected the actual staff numbers and actual hours worked for 5 of 7 sampled days (01/22/2026, 01/23/2026, 01/24/2026, 01/25/2026 and 01/26/2026) when reviewed for sufficient staffing. This failure caused the facility's staffing information to not be readily available to residents, and prevented the residents, family members and visitors from knowing the facility's actual number of available nursing staff.Findings included. Observation on 01/26/2026 at 9:13 AM showed the Licensed and Unlicensed Daily Staff document posted was dated 01/22/2026. The scheduled staff and scheduled staff hours were completed; however, the actual staff and actual staff hours were blank. During an interview on 01/27/2026 at 8:54 AM, Staff E, Staffing Coordinator, provided the Licensed and Unlicensed Daily Staff documents dated 01/23/2026, 01/24/2026 and 01/25/2026. Review of these three days showed the actual staff and actual staff hours were blank. Staff D stated the form should have been completed daily to accurately reflect the actual number of staff and hours worked. During an interview on 01/28/2026 at 2:30 PM, Staff A, Administrator, stated the expectation was the Licensed and Unlicensed Daily Staff posting was completed thoroughly each day. Reference WAC 388-97-1620(2)(b)(i)