STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505349	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willapa Harbor Care	1100 Jackson Street Raymond, WA 98577

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a thorough investigation was conducted for 1 of 2 sampled residents (Resident 1) reviewed for accident and incident investigations. This failure placed residents at risk for abuse and neglect, inappropriate corrective actions, and a diminished quality of life. Findings included . Record review of the facility policy, titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, dated 08/2022, documented, Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Review and investigate all allegations of abuse, neglect, exploitation, mistreatment, injuries of an unknown source, and misappropriations of resident property using the Risk Management electronic incident report in Point Click Care [electronic medical record system] and components of a thorough investigation to include resident interview, resident observation, staff interviews, other resident interviews etc. Resident 1 admitted to the facility on [DATE]. Review of Resident 1's 5-day Minimum Data Set, an assessment tool, dated 07/16/2025, documented Resident 1 was cognitively intact. Record review of a reported complaint received on 07/29/2025 at 6:36 PM, showed it was alleged Resident 1 threatened staff and another resident (Resident 2) with a butterknife. Record review of the facility's Accident and Injury log failed to document the encounter. A review of Resident 1's progress note, dated 07/28/2025, documented, [Resident 1] was having some heightened behaviors. Refusing Meds, throwing things, trying to pull the fire alarm, verbal threats to everyone around him and some physical contact with Aides. This writer came to the facility and sat with him until about 2230 [10:30 PM]. We just talked until he got tired. He agreed to take his meds and went to sleep. When this writer arrived at the building 23-2 [Resident 1] had calmed down. 23-1 [Resident 2] had been moved to room [ROOM NUMBER] to keep him out of the activity. No harm to 23-1. The following day I asked 23-1 (now 11) if he had any issues from the night before. He wasn't able to recall anything and was in a very good mood. In an interview on 08/21/2025 at 10:27 AM, Staff A, Administrator, said there was an incident with Resident 1 late 07/28/2025 going in to 07/29/2025 where he was watching news about wildfires and believed he was going to burn. Resident 1 started pulling fire alarms and was going after the staff and his roommate, Resident 2. Staff A said Resident 2 was separated from Resident 1 at this time. Staff A said Resident 1 had a butterknife he took from his meal tray and hit the window with the butterknife. Staff A said Resident 1 had made threats about cutting people and Resident 2 was there when the threats were made. Staff A said an incident report was not filed regarding this incident. Staff A said verbal abuse would be considered a reportable incident, but did not believe Resident 2 had been verbally abused. In an interview on 08/21/2025 at 11:25 AM, Staff A said she had asked staff members to write witness statements regarding the 07/28/2025 incident. Staff A said she did not ask any residents to write witness statements. Staff A said monitoring Resident 2 for possible harm did not occur. Staff A said while she talked to Resident 2 the next day, a documented evaluation to determine if Resident 2 felt safe in the facility did not occur. Staff A said she did not do what she would consider to be a full investigation. Reference WAC 388-97 -0640 (6)(a)(b).