STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505350	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center at Monroe	1355 West Main Street Monroe, WA 98272

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent physical abuse for 1 of 2 residents (Resident 1) reviewed for abuse. This failure placed residents at risk of injury and emotional distress.Findings included.Review of a facility policy, titled, Abuse/Neglect/Misappropriation/Exploitation, revised date 10/2022, documented physical abuse included hitting and slapping.Resident 1 had moderately impaired cognition according to the Minimum Data Set (MDS, an assessment tool) dated 03/04/2026.Resident 2 had severely impaired cognition and rarely understood others according to the MDS dated [DATE].Review of a progress note, dated 05/21/2026, documented Resident 1 had been hit on the side of the head by another resident.Review of a progress note, dated 05/21/2026, documented Resident 2 had struck another resident on the head. The note documented Resident 2 was attempting to push another resident in their wheelchair. Other residents that were present told Resident 2 to stop pushing the wheelchair which caused Resident 2 to become agitated and struck the other resident in the head.During an observation and interview on 06/03/2026 at 8:44 AM, Resident 2 was ambulating in the hallway. Resident 2 did not respond verbally to questions.During an interview on 06/03/2026 at 11:49 AM, Staff A, Registered Nurse (RN)/Resident Care Manager (RCM), reported they had not witnessed the interaction between Resident 1 and Resident 2 but had spoken with the other residents that were in the day room when it occurred. Staff A reported the residents had relayed that Resident 2 came up behind Resident 1 and started to push their wheelchair. Resident 1 told Resident 2 to stop, and the other residents present also told Resident 2 to stop. Resident 2 then struck Resident 1 on the side of the head. Staff B stated the residents that witnessed the incident were cognitively intact.During a phone interview on 06/03/2026 at 12:04 PM, Staff B, RN/RCM, stated they heard loud voices coming from the day room and entered as Resident 2 was leaving the room. Staff B reported the other residents in the room reported Resident 2 hit Resident 1. Staff B stated they observed Resident 1 sitting in the wheelchair with their hands folded in their lap and stated, I don't know why that just happened. Staff B stated Resident 1 did not report pain at that time.During an interview on 06/03/2026 at 12:20 PM, Resident 3 reported they were a witness to the interaction between Resident 1 and Resident 2. Resident 3 stated Resident 2 started to push the wheelchair of Resident 1 who told them to stop. Resident 3 reported they told Resident 2 to stop as well. Resident 3 reported Resident 2 hit Resident 1 with a flat hand on their head.During an interview on 06/03/2026 at 12:29 PM, Resident 4 reported they were a witness to the interaction between Resident 1 and Resident 2. Resident 4 reported Resident 2 came up behind Resident 1and hit them on the head.During an interview on 06/03/2026 at 12:50 PM, Resident 5 reported they were in the day room when there was an interaction between Resident 1 and Resident 2. Resident 5 reported they were in their wheelchair and had their back to the incident but could hear Resident 1 telling Resident 2 to stop and then Resident 3 also told Resident 2 to stop. Resident 5 stated they heard a slap but not able to see Resident 1's reaction, but then Resident 2 left the day room.During an interview on 06/03/2026 at 12:40 PM, Resident 1 stated they had not had any issues with any of the other residents on the unit. Refer to WAC 388-97-0640(1)

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