STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505351	A. Building B. Wing	01/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arlington Health and Rehabilitation	620 South Hazel Street Arlington, WA 98223

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide 3 of 3 sampled residents (Resident 3, 58, and 63) with a notice of transfer/discharge which outlined their specific rights related to their transfer/discharge and failed to notify the Long-Term Care Ombudsman for 2 of 3 residents (Resident 58 and 63) for discharge from the facility as soon as reasonably able. These failures placed residents at risk of not knowing their rights and limited their access for advocacy of their rights. Findings included . <RESIDENT 3> Resident 3 discharged on 01/13/2026 from the facility. Review of Resident 3's electronic record contained no documentation to show they received a notice of transfer/discharge prior to their discharge from the facility. In an interview on 01/26/2026 at 9:16 AM Staff I, Registered Nurse, stated when a resident discharges from the facility there was a packet of information filled out and provided to them. Staff I stated the information was kept in a folder on the wall inside the nurse's station. When asked if they provided a notice of transfer/discharge to a resident at discharge, Staff I stated they had not and were not familiar with the form. <RESIDENT 58> Resident 58 was admitted to the facility on [DATE] and was transferred to the hospital on [DATE]. Record review of Resident 58's Electronic Health Record (EHR) did not show a written notice of transfer or discharge was provided to the resident and to the Ombudsman. <RESIDENT 63> Resident 63 was admitted to the facility on [DATE] and was transferred to the hospital on [DATE]. Record review of Resident 63's EHR did not show a written notice of transfer or discharge was provided to the resident or to the Ombudsman. In an interview on 01/26/2026 at 8:30 AM, Staff H, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated they had a packet that they would send with a resident when they transferred to the hospital. Staff H stated they did not know what a written notice of transfer or discharge was (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and they don't provide that to the resident when they get transferred to the hospital. Review of the documents in the transfer packet showed no copy of a written notice of transfer or discharge. In an interview on 01/26/2026 at 8:51 AM, Staff A, Administrator, stated Social Services was the primary person that filled out the written notice of transfer/discharge and that Staff A was the back up. Staff A added they don't scan the written notice in resident's EHR and a copy of the notice of transfer/discharge was kept in a binder. Staff A stated, they filled out the notice of transfer/discharge the day following the resident's discharge, in the morning meeting. Staff A, when asked was unable to provide a copy of the written notice of transfer/discharge that was given to Resident 58 and Resident 63 at discharge. In a follow up interview on 01/26/2026 at 9:30 AM Staff A provided filled out notices of transfer and discharge for Resident 58 and Resident 63 both dated 01/26/2026. Staff A stated they would be sending the notices to the Ombudsman. For Resident 58 the notice was sent 30 days after discharge and for Resident 63 the notice was sent 5 days after discharge. Refer to WAC 399-97-0120(2)(a-c) and (5)(b)(i)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or related conditions are not inappropriately placed in nursing homes for long-term care) Level I screening form for an exempted hospital discharge (residents who remained in the facility for more than 30 days) was submitted for a Level II evaluation for 3 of 6 residents (Resident 1, 6, and 18) reviewed. This failure placed the residents at risk of not receiving the appropriate care and services for their needs timely and/or lacking access to specialized services for individuals with identified mental health diagnoses or disabilities.Findings included:In a review of the facility policy titled PASRR dated 01/01/2025 documented the facility would assure review of PASRR was done at admission. No information related to exempted hospital discharge were present in the policy. <RESIDENT 1> Resident 1 was admitted on [DATE]. Resident 1 had diagnoses to include anxiety disorder. Review of Resident 1's Level 1 PASSR dated 08/07/2025 documented the physician certified the individual is likely to require fewer than 30 days of nursing facility services. It also documented: No level 2 evaluation indicated at this time due to exempted hospital discharge: Level 2 must be completed if scheduled discharge does not occur. In an interview on 01/23/2026 at 9:16 AM, Staff C, Social Services Director stated they sent Resident 1's PASRR on 10/05/2025 for the level II evaluation since the resident had stayed past the 30 days. Staff C acknowledged this was past the 30-day exemption timeline. <RESIDENT 18> Resident 18 was admitted to the facility on [DATE] with diagnoses to include depression and anxiety. Review of Resident 18's Level 1 PASRR dated 12/09/2025 documented the physician certified the individual is likely to require fewer than 30 days of nursing facility services. It also documented: No level 2 evaluation indicated at this time due to exempted hospital discharge: Level 2 must be completed if scheduled discharge does not occur. In a record review of Resident 18's electronic health record (EHR) there were no other PASRR forms and there was no documentation that the facility followed up regarding the resident's Level 1 PASSR. In an interview on 01/23/2026 at 9:16 AM Staff C acknowledged that Resident 18's PASSR was past the 30-day exemption timeline. They added that they don't document in the resident's EHR but had their own tracking system. <RESIDENT6> Resident 6 admitted to the facility on [DATE] with diagnoses to include anxiety, major depressive disorder, and social exclusion and rejection. Review of Resident 6's PASRR, Level 1, dated 08/11/2025 documented The individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	services. and No Level 2 evaluation indicated at this time due to exempted hospital discharge: Level 2 must be completed if scheduled discharge does not occur. Review of Resident 6's EHR no documentation was found to show they were referred for a Level II evaluation after remaining in the facility past 30 days. In an interview on 01/23/2026 at 9:16 AM Staff C, stated the PASRR process for the facility was to ensure there was a Level I completed prior to admission. When asked the process for when a resident admitted to the facility with a 30-day hospital discharge exemption, Staff C stated they would send the Level I to the PASRR evaluator to have a Level II completed. Staff C stated they had a tracking system, not part of the clinical record, to audit when a PASRR Level I was sent to the evaluator. When asked about Resident 6's exempted hospital discharge, Staff C stated they thought they had sent it to the evaluator on 11/1/2025, 51 days past the 30-day exemption, by email. Staff C stated they did not document in the clinical record; they maintained the information in their tracking system. Refer to WAC 388-97-1915(4)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure respiratory equipment and tubing were regularly cleaned and/or changed and dated for 3 of 3 sampled residents (Resident 2, 8, and 9) reviewed for respiratory care. This failure placed the residents at potential risk for respiratory distress, respiratory infection, and a diminished quality of life. Findings included . Review of the facility policy titled, Oxygen Administration, dated 11/15/2023, documented to change oxygen tubing weekly and to store oxygen tubing in plastic bags when not in use. <RESIDENT 8> Resident 8 admitted to the facility on [DATE] with diagnoses of emphysema (a chronic and progressive obstructive lung disease resulting in reduced oxygen intake) and COPD (Chronic Obstructive Pulmonary Disease-a progressive and irreversible lung disease that restricts airflow and makes breathing difficult). In observations on 01/20/2026 at 10:59 AM and 2:13 PM, Resident 8 was receiving oxygen by nasal canula (a thin tube inserted into a person's nose to give oxygen). The nasal cannula was not dated or initialed. Observed some whitish debris in the cannula. In an observation on 01/21/2026 at 12:46 PM, Resident 8's oxygen cannula was lying on the resident's bed and was not dated or initialed. In an observation on 01/22/2026 at 10:40 AM, with Staff K, Licensed Practical Nurse (LPN), observed Resident 8's oxygen cannula lying on the resident's bed and was not dated or initialed. Review of Resident 8's January 20th through 26th, 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR), documented oxygen at two liters per minute via nasal cannula as needed for shortness of breath. There was no order to change the oxygen cannula/tubing. Review of Resident 8's care plan, copy date 01/22/2026 at 11:35 AM, documented no interventions regarding changing of oxygen cannula/tubing related to their respiratory status. <RESIDENT 9> Resident 9 admitted to the facility on [DATE] with diagnoses of emphysema and COPD. In multiple observations on 01/20/2026 at 11:18 AM, 01/21/2026 at 9:36 AM and 01/22/2026 at 9:35 AM, Resident 9 received oxygen by nasal canula. The oxygen cannula/tubing was dated 01/06/2026. In an observation on 01/22/2026 at 10:04 AM with Staff K, observed Resident 9 received oxygen by nasal cannula and the oxygen cannula/tubing was dated 01/06/2026. Observed whitish debris on the nasal cannula. Review of Resident 9's January 20th through 26th, 2026 MAR and TAR, documented oxygen at two liters per minute via nasal cannula as needed for shortness of breath. There was no order to change the oxygen cannula/tubing. Review of Resident 9's care plan, copy date 01/21/2026 at 3:44 PM, documented no interventions regarding changing of oxygen cannula/tubing related to their respiratory status. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and record review on 01/22/2026 at 1:14 PM, Staff K stated per the facility policy, the oxygen cannula/tubing needed to be changed, dated and initialed weekly. Staff K stated there was no order to change oxygen cannul/tubing in the MAR/TAR. In an interview and record review on 01/22/2026 at 1:59 PM, Staff J, Resident Care Manager/ LPN, stated the oxygen cannula/tubing must be changed, dated and initialed weekly. Staff J stated an order must be obtained to change the oxygen cannula/tubing weekly and in the care plan. Staff J confirmed there was no order in the MAR/TAR and no documentation regarding changing of oxygen cannula/tubing in the care plan. In a joint interview on 01/23/2026 at 11:15 AM with Staff L, Nurse Consultant and Staff B, Director of Nursing Services, Staff B stated the oxygen cannula/tubing needed to be changed weekly and they expected an order to be placed in the MAR/TAR. <RESIDENT 2> Resident 2 admitted to the facility on [DATE] and recently readmitted on [DATE]. Resident 2's diagnoses included pulmonary edema (fluid in the lungs causing difficulty breathing), asthma, atelectasis (air sacs in the lungs fail to inflate properly), pleural effusion (fluid builds up in the lungs), congestive heart failure (heart muscle is weak and does not pump blood efficiently causing fluid to back up into the lungs), and pulmonary hypertension (high blood pressure in the lungs). Review of Resident 2's January 2026 MAR documented physician orders for oxygen at 2 liters per minute as needed for shortness of breath, comfort, or oxygen rates lower than 90%. In an observation on 01/21/2026 at 9:13 AM, Resident 2 had an oxygen concentrator by their bed with oxygen tubing connected. The oxygen tubing had white debris on the nasal piece, the tubing was not dated and was not stored properly in a bag. Resident 2's door did not have an oxygen in use sign posted. In an observation on 01/22/2026 at 8:59 AM, Resident 2 had an oxygen concentrator by their bed with oxygen tubing connected. The oxygen tubing had white debris on the nasal piece, the tubing was not dated and was not stored properly in a bag. Resident 2's door did not have an oxygen in use sign posted. In a review of Resident 2's care plan, dated 11/11/2025, there was a respiratory focus on the care plan but it did not include oxygen care, such as changing the tubing, in the interventions. In an interview on 01/23/2026 at 10:17 AM, Staff D, LPN, stated the policy for changing oxygen tubing was once a week with a date. Staff D confirmed that changing the oxygen tubing was not an active order for Resident 2. Reference WAC 388-97-1060 (3)(j)(vi)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received care and treatment in accordance with professional standards of practice and received the necessary care and services to attain or maintain their highest practicable level of well-being for 1 of 1 residents (Resident 15) reviewed for hospice services and 2 of 3 residents (Resident 1 and 27) reviewed for diabetic care. The facility failed to ensure Resident 15's physician orders from hospice were implemented timely and ensure diabetic monitors were in place for Resident 1 and 27. These failures placed the residents at increased risk of unmet care needs and delay in care and treatment.Findings included .In a review of the facility policy titled Diabetic Management dated 11/2017 documented it was the facility's policy to ensure they properly managed episodes of hyper/hypoglycemia (high/low blood sugar levels). <RESIDENT 15> Resident 15 was admitted to the facility on [DATE] with diagnoses to include history of falling, dementia, psychotic mood disturbance and anxiety. Review of Resident 15's Electronic Medical Record (EMR) documented they admitted to hospice services on 12/31/2025. Review of Hospice Visit Notes, timestamped 01/08/2026 at 3:56 PM as received by the facility, documented Resident 15 had an order dated 12/31/2025 for Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg), one tablet every two hours as needed for anxiety/dyspnea (shortness of breath). Review of Resident 15's Medication Administration Record (MAR) documented an order for Lorazepam 0.5 mg, one tablet every two hours as needed for anxiety/dyspnea with a start date of 01/13/2026, five days after the hospice orders were received. Review of Resident 15's EMR documented a consent signed by Power of Attorney (POA) for use of Lorazepam on 01/13/2026. No other information was documented in Resident 15's progress notes regarding the Lorazepam order prior to 01/13/2026. In an interview on 01/26/2026 at 8:55 AM Staff H, Licensed Practical Nurse(LPN)/Resident Care Manager (RCM) stated hospice faxed orders, and the facility would update the orders in Resident 15's clinical record and MAR. When asked about the receipt of orders from hospice for Resident 15 on 01/08/2026 and orders not placed in the MAR until 01/13/2026, Staff H stated they were awaiting consent from the POA. In an interview on 01/26/2026 at 8:59 AM Staff I, Registered Nurse, stated when hospice orders were received, they were processed as quickly as possible within a 24-hour period of time. Staff I stated it was the responsibility of the nurse on the cart to review, process, and clarify any hospice orders. <RESIDENT 1> Resident 1 was admitted to the facility 08/07/2026 with diagnoses to include type two diabetes (a condition that causes sugar to build up in the blood which leads to high blood sugar levels). Review of Resident 1's physician orders included Lantus (a hormone that lets sugar enter into the body's cells and lowers blood sugars) 14 units in the morning and to hold for blood sugar levels less (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	than a 100. Resident 1 had orders for glucagon 0.5 mg every 15 minutes as needed for symptoms of hypoglycemia or blood sugar less than 60. Resident 1 had orders for blood sugar checks one time a day in the morning. Physician orders did not include monitors of symptoms for diabetes management including signs and symptoms of hypo/hyperglycemia. Review of Resident 1's care plan, dated 08/07/2025, did not document a focus area related to type two diabetes. Resident 1's care plan did not include goals, interventions or monitors for type two diabetes. In an interview on 01/26/2026, at 8:32 AM, Staff K, LPN stated that for a resident with diabetes there should be a care plan related to the diabetes management, including monitoring for signs and symptoms of hypo/hyperglycemia. In an interview on 01/26/2026, at 8:54 AM, Staff B, Director of Nursing Services (DNS) stated, that they would expect a resident with a diagnosis of type two diabetes to have a care plan related to their diabetes. Staff B confirmed that Resident 1's care plan did not include a focus area for their type two diabetes. Staff B stated that monitoring for hypo/hyperglycemia should be in the care plan and Kardex (summary of a resident's daily care needs used by the nursing assistant). <RESIDENT 27> Resident 27 was admitted to the facility on [DATE] with diagnoses to include type two diabetes. Review of Resident 27's physician orders included Metformin (medicine in tablet form to control blood sugar) 500 mg twice a day. Physician orders did not include blood sugar checks and monitoring signs and symptoms for hypo/hyperglycemia. In a record review of Resident 27's care plan, diabetes was included under focus however, monitoring for signs and symptoms of hypo/hyperglycemia was not included. Record review of Resident 27's MAR for November and December 2025 and 01/01/2026 through 01/26/2026 did not have monitoring for signs and symptoms of hypo/hyperglycemia. In an interview on 01/26/2026 at 8:51 AM, Staff B, stated for residents who had diabetes, the expectation was to have monitoring for signs and symptoms of hypo/hyperglycemia as an intervention and should reflect that in the care plan. Staff B reviewed Resident 27's physician orders and care plan and stated they would update the care plan and implement monitoring. Reference WAC 388-97-1060(1)(4)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 of 2 residents (Resident 17) reviewed for Pressure Ulcers (PU), were provided recommended and physician ordered interventions they required for the prevention and treatment of a PU. This failure placed residents at risk for PU development, worsening of PU, pain and a diminished quality of life.Findings included .Resident 17 admitted to the facility on [DATE] with diagnoses to include fracture of the left upper leg, diabetes mellitus type two (disorder that disrupts the way the body uses sugar), and pressure ulcer of the sacral region and right heel.On 01/21/2026 at 9:25 AM observed Resident 17 in their room, sitting upright in their wheelchair, with a heel protector boot on their left foot only and another heel protector boot sitting on a chair across from them.In an interview on 01/21/2026 at 9:25 AM Resident 17 stated they had pressure ulcers on both of their heels, with the left side being bigger than the right.On 01/23/2026 at 10:21 AM Resident 17 was observed in the hallway with therapy, upright in their wheelchair, with no heel protectors, their feet on the wheelchair footrests. Observed Resident 17's heel protectors in their room, on a chair.On 01/23/2026 at 3:01 PM observed Resident 17 lying in their bed, their feet hanging over the foot of the bed, heels not offloaded (lifted to avoid pressure to the skin), and not wearing any heel protectors on either foot. Observed Resident 17's heel protectors sitting on a chair across from their bed.On 01/26/2026 at 8:44 AM observed Resident 17 lying in their bed, their feet hanging over the foot of the bed, heels not offloaded and not wearing their heel protectors.Review of Resident 17's care plan dated 01/07/2026 documented they had multiple skin conditions to include diabetic foot ulcers, surgical incisions, and shearing to their coccyx. Interventions included encouraging Resident 17 to utilize protective skin measures.Review of Resident 17's Kardex (resident specific guide outlining care needs) dated 01/23/2026 showed the only direction for skin care/intervention was to encourage Resident 17 to utilize protective skin measures.Review of Resident 17's wound care note dated 01/13/2026 documented they had a PUs to their coccyx, right heel and multiple PU's to their left foot. Interventions for pressure relief included: being repositioned every two hours, low air loss mattress and heel offloading boots.Review of Resident 17's Medication Administration Record for 01/01/2026 through 01/22/2026 documented an order dated 01/05/2026 to offer to offload their heels when in bed to maintain skin integrity throughout each shift every shift for impaired skin integrity.In an interview on 01/26/2026 at 9:08 AM Staff I, Registered Nurse, stated Resident 17 slid down in their bed often and the aides had to reposition them by pulling them up in bed frequently. When asked about Resident 17's heel protectors, Staff I stated they were to wear them when up in their wheelchair and their heels were floated when in bed. Staff I stated when Resident 17 was up they were to wear their heel protector boots. When asked how the aides were to know how to care for a resident, Staff I stated the aides followed the resident specific care plan and Kardex.Reference WAC 388-97-1060(3)(b)

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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 ensure safety assessment and monitoring were conducted and ensure consent and/or physician orders were completed prior to placing resident's bed against the wall for 1 of 2 residents (Resident 38) reviewed for accidents/falls. These failures placed residents at risk for injury and diminished quality of life. Findings included.According to the facility policy titled Devices/Enablers Policy and Procedure, undated, any device/enabler that is ordered for a resident . has been appropriately assessed . ensure that the resident and their responsible party had been fully informed of the risks versus benefits of the device/enabler and are in agreement with it and have signed an informed consent.use of the device/enabler will be appropriately care planned and added to resident's Kardex (resident specific guide outlining care needs).Resident 38 was admitted to the facility on [DATE] with diagnoses to include Guillain-Barre Syndrome (autoimmune disease that attacks nerves causing rapid weakness and tingling), Parkinsons Disease (brain disorder that makes it hard to control body movements) and Prostate Cancer. According to the admission Minimum Data Set (an assessment tool) dated 12/17/2025, the resident had moderate cognitive impairment.In an observation on 1/21/2026 at 9:37 AM, Resident 38's bed was positioned against the wall.Record review of Resident 38's electronic health record (EHR) showed no documentation of an order, consent or care plan regarding resident's bed placement against the wall.Review of the State reporting log showed Resident 38 had falls on 12/13/25, 12/17/25, 12/21/25, 12/23/25, 01/06/26 and 01/13/26.In a record review of the investigations for the falls noted above, bed against the wall was not documented as an intervention to prevent falls for Resident 38.In an interview on 1/22/2026 at 9:48 AM, Staff D, Licensed Practical Nurse (LPN) stated the bed against the wall was considered a restraint and prior to moving the bed against the wall, an order should be obtained from the provider and the resident or Power of Attorney (POA) would need to be notified. Staff D stated risks and benefits would need to be discussed, consent obtained, and the care plan updated.In an observation on 01/23/2026 at 8:55 AM, Resident 38's bed was no longer against the wall which allowed them access to get out of bed from either side. In an interview on 01/23/2026 at 1:33 PM, Staff D, LPN, stated Resident 38's bed was moved away from the wall because there was not an order to have it against the wall.In an interview on 01/23/2026 at 3:00 PM, Staff J, LPN/Resident Care Manager stated a bed against the wall was considered a restraint and they had to assess the need for the bed against the wall, obtain an order and consent from the resident or POA prior to moving the bed. Staff J stated, they moved Resident 38's bed away from the wall because there were no order or care planned to have their bed against the wall. Refer to WAC 388-97-0620(1)(a)(b)

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Arlington Health and Rehabilitation	620 South Hazel Street Arlington, WA 98223

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure staff provided medications at the appropriate time for 2 of 25 medication observations, creating an 8.33 % error rate. Failure to provide medications at the correct time placed residents at risk of decreased effectiveness of medication.Findings included.Review of an undated facility policy, titled, The 5 rights of Medication Administration, documented staff were to ensure the timing of medications was appropriate, such as timing with food.During an observation on 01/21/2026 at 8:14 AM, Staff D, Licensed Practical Nurse, provided morning medications to Resident 6. The provided medications included Sucralfate (a medication that coats the lining of the stomach for protection against stomach acid) and Pantoprazole (medication that decreases stomach acid production). Resident 6 had their meal tray at the bedside and stated they had finished their breakfast.Review of Resident 6's order summary report, effective date 01/20/2026, showed an order for Sucralfate 1 gram by mouth before meals and at bedtime, and an order for Pantoprazole 40 milligrams two times a day before meals.Review of Resident 6's January 2026 medication administration records showed both Sucralfate and Pantoprazole were scheduled to be given at 7:00 AM before meals.During an interview on 01/21/2026 at 8:18 AM, Staff D stated they were aware the order was to give these two medications before meals. Refer to WAC 388-97-1060 (3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to properly label and/or discard undated, opened Aplisol (solution used to test for persons with possible Tuberculosis - an infectious respiratory disease), to ensure refrigerated drugs were stored at proper temperatures, and to ensure expired medications were properly disposed of in 2 of 2 medication rooms reviewed for medication storage and labeling. The facility failed to ensure treatment carts were locked for 1 of 3 treatment carts (200 hall treatment cart). These failures placed residents at risk of receiving compromised or ineffective medications and at risk for having access to treatment supplies and medications, missing medication, and access to medication by unauthorized individuals. Findings included .<LONG TERM CARE MEDICATION ROOM>In an observation on 01/20/2026 at 11:41 AM, Staff G, Registered Nurse (RN), opened the long-term care medication room for this surveyor. Review of the medication refrigerator revealed one bottle of open Aplisol solution. The label documented that the product should be disposed of 30 days after opening but did not have an open date. Review of stocked medications showed a medication called Pure Bone Health with an expiration of 10/2025 with a resident's name written on the bottle. The medication fridge temperature log documented that temperatures should be within 36 degrees and 46 degrees and that temperatures should be checked twice daily if vaccines are present. The long-term care medication refrigerator did contain Influenza vaccines. Review of the medication fridge temperature logs documented the following: January 2026 from the 1st to the 20th, five morning temperatures and six afternoon temperatures below the accepted 36 degrees. December 2025 documented one afternoon temperature below the accepted 36 degrees and two missing afternoon temperatures. November 2025 documented 10 morning temperatures and 10 afternoon temperatures below the accepted 36 degrees and four missing morning temperatures and two missing afternoon temperatures. In an interview on 01/20/2026 at 11:41 AM, Staff G, RN confirmed no documented open date on the Aplisol solution. Staff G stated there should be an open date and to discard after 30 days per the label. Staff G stated that the expired Pure Bone Health medication was a resident's personal property and that is why it was not disposed of. In an interview on 01/20/2026 at 12:35 PM, Staff B, Director of Nursing/RN, acknowledged the out of range and missing medication room refrigerator temperatures for the months of January 2026, December 2025 and November 2025. Staff B stated their expectation is for medication room refrigerators to be checked twice daily and documented and that staff should be notifying maintenance or administration if temperatures are out of range.<REHABILITATION MEDICATION ROOM>In an observation on 01/20/2026 at 11:55 AM, Staff H, Resident Care Manager/Licensed Practical Nurse, opened the rehabilitation medication room for the surveyor. Review of stocked medications showed a Melatonin (sleeping medication) bottle with an expiration date of 12/2025.In an interview on 01/20/2026 at 11:55 AM with Staff H, confirmed expired Melatonin and removed the expired bottle for disposal. <UNLOCKED TREATM/ENT CART>In an observation 01/20/2026, at 9:45 AM, the 200-hall treatment cart was unlocked and unattended. The unlocked treatment cart contained wounds supplies (gauze, pads, dressing supplies), prescription skin creams, hemorrhoid cream, antifungal cream and Nystatin powder (prescription antifungal powder). Multiple facility staff walked by the unlocked and unattended treatment cart. In an interview at 01/20/2026 at 9:56 AM, Staff F, RN, stated they did not know why the treatment cart was left unlocked and that the expectation was for it to be locked when not in use. Staff F then locked the cart. Reference WAC 388-97-1300 (2)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure prompt dental services were provided for 1 of 2 sampled residents (Resident 12) reviewed for dental services. This failure placed residents at increased risk for continued dental problems, difficulty chewing, associated health complications, and diminished quality of life. Findings included .Review of a facility policy titled, Dental Services, documented the facility would be assessed for dental health needs upon admission and periodically as part of routine health evaluations; the facility will provide or arrange for access dental services and assisted residents in scheduling appointments as needed. <RESIDENT 12> Resident 12 was admitted to the facility on [DATE]. According to the Minimum Data Set (MDS-an assessment tool) assessment, dated 01/02/2026, the resident was cognitively intact. In an interview and observation on 01/20/2026 at 11:34 AM, Resident 12 stated they had no teeth, and they could not use either upper or lower dentures because they were too loose to wear. Resident 12 stated they could not chew certain veggies or meat without dentures. Resident 12 stated they wanted to fix their dentures, and they would eat better if the dentures worked. The resident was observed with no natural teeth. In an interview and observation on 01/23/2026 at 3:50 PM, Resident 12 stated they could not even talk with the loose dentures on. Resident 12 put on both upper and lower dentures; observed the upper dentures just dropped and could not remain at all and the lower dentures moved when the resident was talking which caused slur speech. Resident 12 stated they mentioned to some staff in the facility that they would like to have their dentures fixed since they were admitted in June 2025. Review of admission MDS dated [DATE], coded the resident had no natural teeth. In the Care Area Assessment, there was no documentation about whether the resident had/use denture or the reasons why not use dentures or any denture care. Review of a care conference form dated 07/02/2025 at 4:20 PM, under the section of the resident needs accommodation, dentures or other dental needs was checked, but it was blank in the following comments/follow up section. Review of Resident 12's care plan initiated on 09/12/2025, documented that the resident had upper and lower dentures but did not wear them. There was no documentation of the reasons why the resident did not wear them. Review of a consulting dentist report dated 10/06/2025, showed Resident 12 had loose and ill-fitting dentures and recommended reline upper and lower dentures. The form was signed noted and dated and initialed on 10/13/2025. Review of progress notes from 10/06/2025 through 01/22/2026, no documentation was found about denture fixation arrangement. In an interview on 01/21/2026 at 2:16 PM, Staff P, Nursing Assistant Certified, stated Resident 12 did not wear dentures but they did not know why. Staff P stated they were not aware of the dentures were loose or if the resident wanted to fix the dentures. In an interview on 01/22/2026 at 1:59 PM, Staff J, Resident Care Manager/ Licensed Practice Nurse, stated Resident 12 did not wear dentures and they were not aware of the dentures were loose and the resident was seen by consulting dentist on 10/06/2025. Asked if the consulting dentist had any recommendation, Staff J stated no. In a following up interview and record review on 01/23/2026 at 3:52 PM, Staff J confirmed on the consulting dentist form dated 10/06/2025, documented Resident 12's dentures were loose and ill-fitting and the recommendation was to reline upper and lower dentures. Staff J stated they were the one signed noted on the form, dated and initialed on 10/13/2025. Staff J stated the consulting dentist provided denture fixation service and the resident's name should be on the next dentist visit's list. Staff J stated the medical record staff had the dentist to see list. In an interview on 01/23/2026 at 4:07 PM, Staff O, Medical Record, stated Resident 12's name was not on the next dentist visit list. In an interview on 01/26/2026 at 10:26 AM, Staff B, Director of Nurses, stated they were not aware that Resident 12's dentures were loose or that the resident wanted to fix their dentures; and they were not aware of the recommendation of relining the resident's dentures. Staff B stated they expected staff to arrange appointments for residents if they wanted to fix their dentures. Reference WAC 388-97-1060 (3)(j)(vii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to ensure resident meals were stored in accordance with professional standards of food safety for 1 of 3 nourishment refrigerators. The failure to ensure nourishment refrigerators were free from potential contaminants left residents at risk for food contamination, food borne illnesses, and consumption of spoiled food. Findings Included .On 01/20/2026 at 1:13 PM observed the refrigerator/freezer unit in the conference room/dining room which contained the following:-the bottom left drawer of the refrigerator contained a plate covered with foil, not dated, with a name and room number. The plate had turkey (dried on the edges), potatoes, stuffing and gravy.-Rice pudding with a name and room number with an expiration date of 01/17/2026.-Plastic bag with [pizza dated 01/18/2026.A printed sign was on the door to freezer that read: items need to be labeled with date, resident name, and thrown out after 3 days. In an interview on 01/20/2026 3:19 PM Staff M, Food Preparation Worker, removed items from the refrigerator. When asked to explain the process of maintaining the refrigerator, Staff M stated checks temperatures on the thermometer and documents them on the paper taped to the side of the refrigerator for both the refrigerator and freezer. Staff M stated they removed any expired items from the refrigerator and discarded them. Staff M stated they discarded expired items from the refrigerator, sandwiches which had expired, nutritional shakes and juice (for a 14-day shelf life).On 01/20/2026 at 3:20 PM observed the bottom left drawer of the refrigerator contained a plate covered with foil, not dated, with a name and room number. The plate had turkey (dried on the edges), potatoes, stuffing and gravy.In an interview on 01/21/2026 1:54 PM Staff M entered conference room/dining room, checked temperatures and filled out the temperature log. When asked if they had found anything else to throw away, Staff M stated they had not. When Staff M was asked to look in the bottom drawers they stated they never looked in left drawer, no one is supposed to put anything in there. Staff M located the plate covered with foil, not dated, with a name and room number and discarded it in the trash. Staff M stated they would inform the dietary manager of food being placed in the left drawer.Refer to WAC 388-19-1100 (3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a system in which resident's records were complete, accurate, accessible and systematically organized for 1 of 1 resident (Resident 17) for dialysis and 1 of 2 residents (Resident 5) reviewed for unnecessary medications. These failures placed residents at risk for not having their medical records accurate and incorrect/incomplete information being considered when making medical decisions. Findings included . <RESIDENT 5> Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5 had diagnoses to include chronic pain syndrome and generalized anxiety syndrome. In a record review of Resident 5's physician orders included Methadone 5 milligrams (mg) 1 tablet by mouth every eight hours as needed for severe pain and Acetaminophen (pain medication to relieve mild to moderate pain) 325 mg two tablets every four hours as needed for pain. Resident 5 had as needed pain management non-pharmacological interventions to include reposition, rest, offer activity of choice, quiet environment, or other. In a review of Resident 5's Medication Administration Record (MAR), for January 1st - 21st, 2026 documented administration of two 325 mg Acetaminophen tablets on January 1st, 3rd, 4th, 5th, 6th, 12th, 13th, 14th, 16th, 17th, twice on 18th, 19th and 20th as needed for pain. Resident 5's as needed pain management non-pharmacological interventions had no documentation on any of the days when as need pain medication was administered. In a record review of Resident 5's physician orders included, Hydroxyzine 50mg by mouth every eight hours as needed for anxiety. Resident 5 had three active physician orders for non-pharmacological interventions to be used prior to administration of as needed psychotropic medications and a progress note required for results of interventions as needed. Non-pharmacological interventions included putting on favorite music, assist resident in calling a loved one, place resident near others to not feel alone, assess for comfort, offer snack, massage, make a quiet area, and to offer reassurance. In a review of Resident 5's MAR for January 1st-26th, 2026 Hydroxyzine 50 mg as need for anxiety was documented as administered on January 2nd, 3rd, 5th, 6th, twice on the 8th, 9th, 10th, 11th, 12th, 13th, 14th, 15th, 16th, 17th, 18th, 19th and 21st. Resident 5 had one documented as needed anxiety medication non-pharmacological interventions on January 12th. In an interview on 01/23/2026. at 9:44 AM, Resident 5 stated they had requested as needed medication for pain and anxiety. Resident 5 stated the staff had offered them some non-pharmacological interventions before administering the medication. In an interview on 01/23/2026, at 10:17 AM, Staff D, LPN stated the procedure for as needed medications included offering a non-pharmacological intervention prior to administration. Staff D was unable to locate any documentation of non-pharmacological interventions used for Resident 5. In an interview on 01/26/2026, at 12:35 PM, Staff B, Director of Nursing Services (DNS) stated Resident 5 had one documented non-pharmacological intervention on 01/12/2026 when multiple as needed pain and anxiety medications were administered from January 1 through 26, 2026. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<RESIDENT 17> Resident 17 admitted to the facility on [DATE] with diagnoses to include end stage renal disease (kidneys can longer adequately filter waste products from the blood), dependent on dialysis (process of removing toxins and water from the blood). In an interview on 01/21/2026 at 9:20 AM Resident 17 stated they had received kidney dialysis for the last five years prior to admission to the facility. Review of Resident 17's Electronic Medical Record (EMR) documented they had dialysis scheduled on Tuesdays, Thursdays and Saturdays. The dialysis communication sheets directed facility staff to complete the top portion which provided information to dialysis staff, to include resident status changes since last dialysis treatment (i.e. fever, pain, nausea, vomiting, diarrhea, surgical procedures, medication changes) and any medication given for pain and/or anxiety. The bottom portion of the dialysis communication sheet directed facility staff to document blood pressure, pulse and respirations; any bleeding at the dialysis access site, check for bruit and thrill (sound heard over an artery and palpable vibration felt over a vessel). The EMR contained Dialysis Communication Sheets for Resident 17 for the following dates: 01/06/2026 return to the facility information was not complete 01/08/2026 fully completed 01/10/2026 return to the facility was not completed, a note that read VS (vital signs) taken In an interview on 01/26/2026 at 8:47 AM Staff I, Registered Nurse, stated Resident 17 was on dialysis and they send a dialysis communication sheet with the resident, fill out the top portion which contains information on vitals, dialysis fills out the middle portion, and when they return the bottom portion was filled out by the facility nurse. When asked where the completed dialysis communication sheets were located, Staff I stated they were located at the nurse's station, in a binder, that was labeled dialysis. Review of the dialysis binder, located at the nurse's station, dialysis communication sheets were found (not in the EMR) for Resident 17 for the following dates: 1/24/2026-complete 1/22/2026-complete 1/20/2026-incomplete, return to the facility information was not complete 1/17/2026-complete 1/15/2026-complete 1/13/2026-incomplete prior to and return to the facility information was not complete (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/26/2026 at 11:08 AM Staff O, Medical Records, stated the dialysis communications are uploaded into the EMR after the nursing staff place them in their box. Staff O stated they were not aware that dialysis communication sheets were kept in a binder at the nurse's station. Reference WAC 388-97-1720(1)(a)(i)(ii)