STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505355	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Post Acute	414 - 17th 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 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. Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from abuse for 1 of 2 residents (Resident 10) reviewed for resident-to-resident incidents. The failure to protect Resident 10 who experienced unwanted and unconsented inappropriate touching of their breasts by another resident placed all residents at risk for the potential of sexual abuse, psychological harm, and diminished quality of life.Findings included.Review of the facility Abuse, neglect and Exploitation policy, dated 2025 showed the facility would provide protection for the health, welfare and rights of each resident by developing and implementing written abuse policies and procedures that prohibit and prevent abuse. The policy defined sexual abuse as non-consensual sexual contact of any type with a resident. The policy showed the facility would establish a safe environment to prevent sexual abuse and would make efforts to ensure all residents were protected from abuse.Findings included.<Resident 10>Review of a 01/26/2026 admission Minimum Data Set (MDS, an assessment tool) showed Resident 10 was able to make their own decisions, was cognitively intact, and had no behaviors. The MDS showed Resident 10 had diagnoses including a bone infection, diabetes, and need for assistance with personal care. The MDS showed Resident 10 required moderate staff assistance with transfers, dressing, toileting, and personal hygiene.Review of a 01/24/2026 Emotional/Trauma care plan showed Resident 10 was at risk for decreased psychosocial well-being and adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social or spiritual well-being related to a history of sexual assault, physical assault with a weapon, and an unexpected and sudden death of someone close. The care plan directed staff to help identify triggers that prompt symptoms, attempt approaches to reduce anxiety and fear with goals for Resident 10 to feel safe and secure in the environment.Review of a 02/03/2026 progress note showed Staff S (Social Services Director) documented at approximately 11:45 AM Staff S met with Resident 10 following an allegation of a resident-to-resident incident. Resident 10 reported to Staff S they were passing the snack closet by the nurse's station in route to their room when a male resident (Resident 9) positioned in the hallway made unwanted physical contact with their chest area. Resident 10 told the male resident to stop and sought staff help. Staff S documented Resident 10 reported feeling safe in the facility provided they keep Resident 9 away from them.Attempts to interview Resident 10 on 02/03/2026 were unsuccessful as they were not available. Attempts to interview Resident 10 were unsuccessful on 02/13/2026 as Resident 10 had discharged from the facility on 02/10/2026. Attempts to interview Resident 10 on the phone on 02/27/2026 were unsuccessful.<Resident 9>Review of the 12/30/2025 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 9 had clear speech, rarely made self-understood or was able to understand others, had confusion and memory loss, had a preferred language that was not English, and required an interpreter. The MDS showed Resident 9 had medically complex conditions including heart failure, Alzheimer's disease, anxiety, and depression. The MDS showed Resident 9 had physical and verbal (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors directed at others, other behavioral symptoms not directed towards others, and wandering behaviors.Review of a sexual inappropriate care plan, revised on 02/05/2026, showed Resident 9 had behaviors of grabbing private areas and hitting buttocks related to dementia and poor impulse control. The care plan directed staff to intervene as soon as the resident expressed sexually inappropriate behavior, staff were directed to guide the resident away from other residents and staff, and re-direct Resident 9 to a private area. An additional behavior care plan, revised 02/15/2025, showed Resident 9 had intrusive behaviors, would wander into other resident's spaces, and take their belongings.Review of a 02/03/2026 progress note showed staff documented the provider was notified of the incident with Resident 10. No further information was documented about the incident.Observations on 02/03/2026 at 3:00 PM showed Resident 9 sitting in their wheelchair in their room and no one on one staff member observed. Observations at 3:08 PM showed Resident 9 sitting in their room with no one on one supervision. Observations at 4:45 PM showed no one on one supervision for Resident 9, until 5:00 PM.Review of Resident 9's medical record showed three staff progress notes that documented incidents on 11/04/2025, 01/22/2026, and 01/30/2026 involving Resident 9 sexually and inappropriately slapping and grabbing other residents. The progress notes did not indicate what staff did in response to Resident 9's inappropriate behavior and what actions staff took to protect other residents at the facility.Review of the 02/03/2026 facility investigation for Resident 9 and Resident 10 showed the same investigation was completed on both residents and both concluded that abuse and neglect were ruled out as the incident was determined to be behavioral in nature rather than intentional.In a joint interview on 02/13/2026 at 11:40 AM with Staff A (Administrator) Staff B (Director of Nursing) and Staff D (Regional Market Leader), Staff B stated they completed the investigation for Resident 9 and Resident 10. When asked how the three prior documented incidents of Resident 10 inappropriately touching other residents were missed, Staff D stated the facility is now implementing a clinical stand-up meeting where a twenty-four hour or a seventy-two-hour report of progress notes would be reviewed for any concerning progress notes or incidents not reported. Staff D stated the progress note reviews should have but were not being done as expected, these incidents were not reported to management as expected, and staff did not follow abuse policies and procedures to prevent recurrence.REFERENCE: WAC 388-97-0640(1).

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident to resident altercations including alleged sexual, physical, and verbal abuse incidents the facility was aware of or witnessed was investigated, logged, and reported for 8 of 10 residents (Resident 9, 11, 16, 17, 6, 7, 4, 5) reviewed for abuse. The failure to investigate these incidents deterred the facility from preventing re-occurrence and taking appropriate corrective actions resulting in repeated abuse that placed all residents at risk for unidentified abuse and/or continued abuse, psychological harm, and diminished quality of life, and constituted an Immediate Jeopardy (IJ). On 02/13/2026 at 5:35 PM, the facility was notified of an IJ at CFR 483.12(c)(2)(4) F610 Alleged Violations-Investigate/Prevent/Correct, related to the facility's failure to identify allegations of abuse, ensure alleged abuse were reported and thoroughly investigated. The IJ was determined to begin on 11/04/2025 when Resident 9 inappropriately touched Resident 11 that staff were aware of, documented the incident, and failed to report, investigate and prevent further reoccurrences. The facility removed the immediacy on 02/15/2026 with an on-site verification from an investigator by conducting resident and staff interviews, ensuring residents with sexual behaviors were placed on one-on-one supervision. All staff were re-educated regarding abuse policies/procedures, which ensured an effective system was in place to safeguard, protect and prevent residents that were at risk for abuse.Findings included.According to the 2025 facility policy, Abuse, Neglect and Exploitation, the facility would establish policies and procedures to investigate allegations of abuse and train all new and existing staff on activities that constitute abuse, reporting procedures, and resident abuse prevention. The facility would designate an Abuse Prevention Coordinator who was responsible for reporting allegations of suspected abuse to the state survey agency in accordance with state law. The policy showed the facility would provide oversight and supervision of staff to ensure that the abuse policies are implemented as written, an immediate investigation would be warranted when suspicion of abuse or reports of abuse occurred, and staff would provide complete and thorough documentation of the investigation.In a joint interview on 02/13/2026 at 11:32 AM with Staff A (Administrator), Staff B (Director of Nursing) and Staff D (Regional Market Leader), Staff A stated they were the abuse coordinator for the facility. Staff A stated staff were educated on abuse policies and procedures upon hire, annually, and as needed.<Sexual Abuse><Resident 9>Review of the 12/30/2025 Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 9 had clear speech, rarely made self-understood or was able to understand others, had confusion and memory loss, had a preferred language that was not English, and required an interpreter. The MDS showed Resident 9 had medically complex conditions including heart failure, Alzheimer's disease, anxiety, and depression. The MDS showed Resident 9 had physical and verbal behaviors directed at others, other behavioral symptoms not directed towards others, and wandering behaviors.Review of a revised 02/05/2026, sexual inappropriate care plan, showed Resident 9 had behaviors of grabbing private areas and hitting buttocks related to dementia and poor impulse control. The care plan directed staff to intervene as soon as the resident expressed sexually inappropriate behavior, staff should guide the resident away from other residents, and re-direct Resident 9 to a private area. An additional behavior care plan, revised 02/15/2025, showed Resident 9 had intrusive behaviors, would wander into others spaces, and take their belongings.Review of a facility investigation, dated 02/03/2026, showed on 02/03/2026 a nurse overheard Resident 10 on the phone and stated another resident touched them. Facility staff interviewed Resident 10 who stated at 11:30 AM on 02/03/2026, while near the elevator on the second floor Resident 9 grabbed their breasts. Resident 10 told Resident 9 to stop and went to speak to staff. The investigation showed no staff witnessed (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the interaction, interviews with residents were conducted, revealed no resident witnesses to the incident and showed Resident 9 would wander into resident's rooms and not exit when asked. The investigation concluded that due to Resident 9's dementia, behavioral history and cognitive impairment the incident is determined to be behavioral rather than intentional abuse, and abuse was ruled out.In an interview on 02/03/2026 at 2:45 Staff A (Administrator) stated the inappropriate touching between Resident 9 and Resident 10 occurred at 11:30 AM, no staff witnessed the incident, and Resident 10 was alert, oriented, and cognitively intact. When asked what the skin assessment for Resident 10 revealed, Staff A stated because it just happened (three hours prior) they would do a skin assessment and put Resident 9 on one-on-one supervision.Observations on 02/03/2026 at 3:00 PM showed Resident 9 sitting in their wheelchair in their room and no one on one staff member observed. Observations at 3:08 PM showed Resident 9 sitting in their room with no one on one supervision. Observations at 4:45 PM showed no one on one supervision for Resident 9.In an interview on 02/03/2026 at 5:00 PM Staff Q (Certified Nurses Assistant, CNA) stated they were the one on one for Resident 9. Staff Q stated Resident 9 would grab and touch anybody, mostly females but would grab the front area and buttocks of men as well when passing by or in reaching distance. Staff Q stated they would watch themselves as they passed by Resident 9 to avoid being grabbed.Review of Resident 9's progress notes, dated 01/30/2026, four days prior to the incident with Resident 10, showed Staff E (Registered Nurse, RN) documented Resident 9 displayed behavioral issues. The note showed Staff E was informed by an aide that Resident 9 was grabbing and touching various staff and residents. The progress note did not indicate what was done to protect the other residents, prevent further abuse, what notifications were made, and if staff determined who the other residents were, if the incident was reported and/or an investigation initiated.Review of Resident 9's progress notes, dated 01/22/2026, eight days before the other two incidents. Staff E documented that Resident 9 was hitting staff and residents, touched the buttocks of another resident and grabbed onto another resident's coat as they walked by. The progress note did not indicate what was done to protect the other residents, prevent further abuse, what notifications were made, and if staff determined who the other residents were, if the incident was reported and/or an investigation initiated.Review of the January 2026 facility abuse log showed no entries logged, reported or investigated for Resident 9.<Resident 11>Review of a 10/11/2025 admission MDS showed Resident 11 was cognitively intact, able to make their own decisions and had no behaviors. The MDS showed Resident 11 was able to make themselves understood, could understand others, and had diagnoses including a fracture and abnormal gait. During record review of Resident 11's progress notes, a progress note dated 11/04/2025, showed Staff F (Licensed Practical Nurse, LPN) documented that Resident 11 reported that when they bent over to get some condiments off the coffee cart Resident 9 spanked their buttocks. Staff F stated Resident 11 found the incident strange and reported the incident to the Director of Nursing. The progress note did not indicate what was done to protect the other residents, prevent further abuse, what notifications were made, and if the incident was reported and/or an investigation initiated.In a joint interview on 02/13/2026 at 11:32 AM with Staff A (Administrator), Staff B (Director of Nursing), and Staff D (Regional Market Leader), Staff B stated they completed the investigation for Resident 9 and Resident 10, did not identify the other inappropriate touching incidents and stated those incidents should be logged, reported, investigated, and a plan put in place to prevent reoccurrence to ensure all resident's safety at the facility.During an observation and interview on 02/18/2026 at 1:20 PM Resident 11 was observed in the smoking area outside on their cell phone. Resident 11 stated Staff A talked with them after the incident with Resident 9. Resident 11 stated they were bending over, getting sugar off the coffee cart when they were swatted on the (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	buttocks by Resident 9. Resident 11 stated they thought the incident was weird and stayed clear of Resident 9 since the incident.<Physical Abuse><Resident 16>Review of the 12/01/2025 Quarterly MDS showed Resident 16 had clear speech, was able to make themselves understood, and could understand others. The MDS showed Resident 16 was able to make their own decisions, was cognitively intact, and had no behaviors. The MDS showed Resident 16 had diagnoses including debility, vascular disease, anxiety, and depression.Review of a progress note dated 12/08/2026 showed Staff G (LPN) documented Resident 16 notified them that morning they had a physical altercation with their roommate (Resident 17) that resulted with Resident 16 being scratched on their left arm, Staff G offered Resident 16 a room move, and Resident 16 declined. The note showed Resident 16 was placed on alert charting to monitor the scratches for infection and the provider was notified. The progress note did not indicate what was done to protect the resident, other residents, prevent further abuse, and if the incident was reported and/or an investigation initiated.In an interview on 02/13/2026 at 1:43 PM Resident 16 was observed in their room they shared with Resident 17. Resident 16 stated they had no concerns related to their roommate.<Resident 17>Review of the 01/19/2026 Quarterly MDS, Resident 17 had clear speech, was able to make themselves understood, and could understand others. The MDS showed Resident 17 had no behaviors and diagnoses including a history of brain bleed, anxiety, depression, bipolar disorder, schizophrenia, and post-traumatic stress disorder.Review of a 07/24/2025 Brief Interview for Mental Status (BIMS, an assessment tool) showed Resident 17 was cognitively intact and able to make their own decisions.Review of progress notes dated 12/08/2025-12/17/2025 showed no documentation of the physical altercation with their roommate on 12/08/2025 and what actions staff took in response to the physical altercation.In an interview and observation on 02/13/2026 at 1:31 PM Resident 17 stated they and their roommate (Resident 16) had arguments, fought like siblings and were over it.Review of the December 2025 facility abuse log showed no entries logged, reported or investigated for Resident 16 and Resident 17's physical altercation.During an interview on 02/13/2026 at 11:35 AM Staff A stated if a resident informed staff they had a physical altercation with another resident they would expect staff to immediately separate the two residents, complete a skin assessment, notify the provider, administrator and director of nursing. Staff A stated the police should be notified, the incident should be logged, reported and investigated, and staff should monitor and treat any wounds sustained from the altercation. At 12:15 PM Staff D stated this incident should have but was not logged, reported and investigated as they would expect staff to follow the facility abuse policies and procedures.<Verbal Abuse><Resident 6>Review of a 10/20/2025 Medicare MDS showed Resident 6 had clear speech, was able to make themselves understood, and could understand others. The MDS showed Resident 6 was cognitively intact, able to make their own decisions, and had no behaviors. The MDS showed Resident 6 had medically complex conditions including high blood pressure, anxiety and depression.Review of a 12/06/2025 progress note showed Staff J (RN) documented Resident 6 was verbally aggressive and demeaning towards their roommate (Resident 7), called Resident 7 derogatory names, told Resident 7 they stink, and it was disgusting they needed to be changed in bed. Staff J documented Resident 6 was offered and accepted a room move and had no further concerns. The progress note did not indicate who was notified if the resident-to-resident verbal abuse was reported, logged and/or an investigation initiated.<Resident 7>Review of a 11/18/2025 Quarterly MDS showed Resident 7 had clear speech, was able to make themselves understood, and could understand others. The MDS showed Resident 7 was cognitively intact, able to make their own decisions, and had no behaviors. The MDS showed Resident 7 had medically complex conditions including respiratory failure, heart failure, depression, borderline personality disorder, and post-traumatic stress disorder.Review of progress notes dated (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	12/03/2025-12/10/2025 showed no documentation on 12/06/2025 from staff on the resident-to-resident verbal incident with their roommate (Resident 6).In an observation and interview on 02/03/2026 at 3:12 PM Resident 7 was observed in bed on their phone. Resident 7 stated they recorded the verbal altercation with their roommate, at first did not say anything back to Resident 6 and eventually couldn't hold back after hours of Resident 6's rude comments. Resident 7 stated they were called a [NAME] and a fat pig all because the staff moved Resident 6's phone cord which made them upset. Resident 7 stated they felt terrible, had low self-esteem and was relieved when Staff J moved Resident 6 out of the room.Review of the December 2025 facility abuse log showed no entries logged, reported or investigated for Resident 6 and Resident 7's verbal altercation.During an interview on 02/13/2026 at 12:18 PM Staff D stated they would expect the resident-to-resident verbal altercation to be logged, reported, and investigated.<Resident 4>Review of the 12/14/2025 admission MDS showed Resident 4 had had clear speech, was able to make themselves understood, and could understand others. The MDS showed Resident 4 was cognitively intact, able to make own decisions, and had physical and verbal behaviors directed at others that put Resident 4 as significant risk for injury, interfering with the resident's care and participation in activities and social interactions. The MDS showed the behaviors significantly disrupted the living environment and Resident 4 had medically complex conditions including anxiety, depression, and schizophrenia.Review of a 12/16/2025 progress note showed Staff E documented Resident 4 was aggressive, engaged in loud arguments with staff and surrounding roommates, used foul language, and was name calling neighbors. The progress note did not indicate what staff did to protect the residents, determine which residents were involved, who was notified of the incident, and if an investigation was initiated.<Resident 5>Review of a 12/19/2025 Quarterly MDS showed Resident 5 had had clear speech, was able to make themselves understood, and could understand others. The MDS showed Resident 5 was cognitively intact, was able to make own decisions, and had no behaviors. The MDS showed Resident 5 had medically complex conditions including fractures and adult failure to thrive.Review of Resident 5's progress notes dated 12/09/2025-12/17/2025 showed no indication staff put Resident 5 (Resident 4's roommate) on alert charting, made a progress note about the verbal incident, documented who was informed of the incident, what actions staff took to protect the residents and if an investigation was initiated.During an observation and interview on 02/03/2026 at 4:45 PM, Resident 5 was observed in bed. Resident 5 stated their roommate (Resident 4) would cuss at them for anything, would go off on the staff, cuss at everybody, throw things, and staff were aware but didn't do anything. Resident 5 stated they didn't like being yelled at or called names and was happy the roommate is no longer at the facility.Review of the December 2025 facility abuse log showed no entries logged, reported or investigated for Resident 4 and Resident 5's verbal altercation.During an interview on 02/13/2026 at 12:20 PM Staff D stated they would expect the resident-to-resident verbal altercation to be logged, reported, and investigated timely. Staff D stated they reported the resident-to-resident altercation on 02/13/2026 and agreed it was not reported timely as they would expect.In a phone interview on 02/17/2026, Staff R (Interim Administrator) stated the facility made change in their administration and Staff R would be the new administrator and abuse coordinator at the facility. Staff R stated changes were made to ensure all allegations of abuse were properly reported, logged, and investigated as required. REFERENCE: WAC 388-97-0860(1)(2)(a)(4)(5)(a)(6)(a-c)

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F 0686 Level of Harm - 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 3 of 3 residents (Resident 1, 2, & 3) reviewed for Pressure Ulcers (PU-injury to the skin and underlying tissue due to prolonged pressure) received the necessary care and services, consistent with professional standards of practice to prevent new PU's from developing. Failure to implement wound prevention interventions, assess PU risk, complete and document skin and wound assessments, ensure treatments were carried out as ordered, to notify the facility dietician of new PU's, and to ensure skin was assessed thoroughly during skin assessments and during care activities. Resident 1 experienced harm when they developed avoidable full thickness (wounds that extend beyond the first two layers of skin into the fat and muscle tissue) PU's on each elbow. This failure placed residents at risk for PU development, increased pain and discomfort, and diminished quality of life.Findings included. Review of the facility policy titled, Pressure Injury Prevention and Management, revised 03/19/2025, showed the facility was committed to preventing avoidable PU's and would provide care and services to heal PU's. The policy showed a Braden Scale (a standardized tool to assess risk of PU's) would be completed on admission, weekly for four weeks, quarterly, and as needed. A skin inspection would be completed weekly by a Licensed Nurse (LN), any open areas identified or soiled, saturated or dislodged dressing would be reported to the LN by the Certified Nurses Assistants (CNA), and the LN would complete further assessment and treatment if needed. The policy showed a care plan would be developed that included measurable goals for prevention and management of PU's. Interventions would be implemented for residents who are assessed at risk of PU development, documented on the care plan, and communicated to staff. The provider would be notified of the presence of a new PU, and of complications or worsening of wounds. <Resident 1>Review of a 12/20/2025 admission Minimum Data Set (MDS- an assessment tool) showed Resident 1 had moderate cognitive impairment, able to make own decisions, and no behaviors. The MDS showed Resident 1 admitted to the facility on [DATE], had diagnoses including fractures and liver disease. The MDS showed Resident 1 had no PU's, was assessed at risk for PU's, and had surgical wounds that required care and application of dressings.Review of a 12/16/2025 care plan showed Resident 1 had self-care deficits due to fractures to the right and left humerus (long bone in upper arm, extending from shoulder to elbow) that required surgical repair and could not bear weight to both upper extremities. The care plan showed Resident 1 was totally dependent on staff for bathing, bed mobility, dressing, eating, hygiene, toileting, and transfers. Review of Resident 1's comprehensive care plan showed no skin or wound care plan or interventions implemented by facility staff.Review of a 12/16/2025 admission collection tool showed Resident 1 admitted to the facility with two surgical wounds and bruising. The admission collection tool showed Resident 1 had no PU's upon admission to the facility. Review of a 12/17/2025 Braden assessment showed Resident 1 was assessed at moderate risk for PU's. The assessment showed Resident 1 had limited sensory perception, occasionally moist skin, chairfast (walking severely limited or non-existent), very limited mobility, and a potential problem with friction and shearing of skin. No other Braden assessments were documented for Resident 1.Review of a skin and wound evaluation dated 12/25/2025 and locked on 12/29/2025 showed Resident 1 was assessed with an open lesion (tissue damage) in the middle of the left elbow that was acquired at the facility. The assessment showed staff left the exact date, who staged the wound, the actual stage of the new wound, and whether the dietician was notified blank with no documentation. Review of a skin and wound evaluation dated 12/25/2025 and locked on 12/29/2025 showed Resident 1 was assessed with a open lesion to the middle of the right elbow that was acquired in the facility. The assessment showed staff left the exact date, who staged the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound, the actual stage of the new wound, and whether the dietician was notified blank with no documentation.Review of Resident 1's progress notes dated 12/20/2025- 12/29/2025 showed no documentation from staff for the two newly acquired PU's, what was done in response to the new wounds, and if the director of nursing and/or dietician was notified.Review of the December 2025 Treatment Administration Record (TAR) showed staff implemented and documented dressing changes to Resident 1's right and left elbow that started on 12/30/2025, five days after the wounds were first documented.Review of a 12/31/2025 wound provider note showed Resident 1's left elbow wound was assessed as a Stage 3 PU (Stage 3-full thickness skin injury extending into the subcutaneous fat tissue). The assessment showed Resident 1's right elbow was assessed by the wound provider as an unstageable PU (severe, full thickness wound with base obscured and inability to determine wound depth). The wound provider recommended an evaluation of proper off-loading equipment for Resident 1.Review of a 12/31/2025 skin/wound evaluation for Resident 1's right elbow showed incomplete documentation of the wound assessment, that included no assessment of the wound bed, peri-wound, exudate, wound pain and treatment. The assessment showed two different measurements of the PU. Facility staff documented wrong wound measurements that did not match the wound providers assessment of the right elbow PU. Review of Resident 1's 12/31/2025 skin/wound evaluation for the left elbow showed similar findings with incomplete documentation of the evaluation. Review of a 01/09/2026 progress note showed Resident 1 was seen by the wound provider, their right elbow had deteriorated and bone was now exposed in the wound. The progress note showed concerns for OM (Osteomyelitis- an infection of the bone), and a bone biopsy was obtained from the right elbow. Review of a 01/13/2026 provider note showed Resident 1's right elbow PU was positive for an infection with bacteria that was resistant to most common antibiotics and caused hard to treat infections. During an observation and interview on 01/21/2026 at 2:21 PM Resident 1 was observed in bed with elbow protectors to both elbows and stated they had no wounds on their elbows when they were admitted to the facility. Resident 1 stated both elbows were sore, painful, and three days ago staff brought elbow protectors which have helped but it took a long time for staff to take care of their elbows.In an interview on 02/26/2026 at 11:12 AM Staff B (Director of Nursing) stated Resident 1 was at risk for PU's due to bi-lateral arm fractures, limited mobility and potential nutritional problems. Staff B would expect staff to assess Resident 1's PU risk using the Braden scale weekly for four weeks after admission, quarterly, as needed with new skin issues, and acknowledged only one Braden assessment was completed for Resident 1. Staff B would expect a skin/wound care plan in place to include interventions for wound prevention, updated with current wounds, and interventions implemented to promote healing of wounds. Staff B stated in response to a new facility acquired PU they would expect staff to write a progress note, initiate an investigation, notify the provider, dietician, resident representative, implement interventions and acknowledged staff did not respond as they would expect. Staff B would expect skin/wound evaluations to be thoroughly completed and match the wound providers assessment of the wound.<Resident 2>Review of a 01/14/2026 Quarterly MDS showed Resident 2 was cognitively intact, able to make own decisions, and had no behaviors. The MDS showed Resident 2 had diagnoses including history of brain bleed, diabetes, and anxiety. The MDS showed Resident 2 had no PU's, was at risk for developing PU's, and had a pressure reducing mattress on their bed. The MDS showed Resident 2 was dependent on staff for bathing, required maximum assistance with dressing, hygiene, bed mobility, and transfers.Review of a 01/05/2026 Braden assessment showed Resident 2 was assessed at high risk for PU's. The assessment showed Resident 2 had slightly limited sensory perception, was constantly moist, bedfast (confined to bed), completely immobile, and problems with friction and shearing when moving in bed.Review of a 09/25/2025 revised skin care plan showed (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 2 had a right gluteal fold shearing wound and was at high risk for skin breakdown. The care plan directed staff to avoid friction and shearing, encourage and assist with repositioning, and monitor/document the location, size, and treatment of skin injuries.Review of a 07/29/2025 progress note showed Staff E (Registered Nurse, RN) documented Resident 2 had skin breakdown to the posterior thoracic(mid-back) fold. The progress noted showed Staff E documented no change in condition, continue to monitor, apply barrier cream, and notify the provider for any changes in the wound. The note did not indicate if the provider was informed of the new wound, what type of wound, and measurements of wound. Additional notes showed Staff E documented on Resident 2's back wound on 09/06/2025, 09/07/2025, 09/08/2025, 09/12/2025, 09/17/2025, on 10/16/2025 staff E described Resident 2's back wound as open and fleshy, 10/24/2025, 10/25/2025, 10/29/2025, 10/30/2025, 11/01/2025, 11/03/2025, 11/05/2025, 11/06/2025, 11/25/2025, and 12/01/2025. The progress notes do not indicate if the provider was informed and if the wound was assessed.Review of Resident 2's skin/wound evaluations showed no evaluations completed for Resident 2's back wound.Review of a 01/05/2026 hospital transfer orders showed wound care recommendations for Resident 2's four wounds that were present on admission to the hospital on [DATE]. The four wounds included a right gluteal fold PU, left posterior leg full thickness wound, upper left back partial thickness wound, and the left labia with a partial thickness wound.Review of a 01/05/2026 nursing re-admission assessment showed Staff H (Registered Nurse, RN) did not document the skin integrity and left the skin integrity section of the re-admission assessment blank.Review of Resident 2's physician orders showed a 01/06/2026 order for treatment for the right gluteal wound. No other wound treatment orders were observed for the three other wounds.In an observation and interview on 01/21/2026 at 3:02 PM Resident 2 was observed in bed on an air mattress. Resident 2 stated they had a wound to their right buttocks, it hurt, and they had to ask staff to change the dressing and to help with turning in bed. Resident 2 stated they did not have wound care done today and staff told them their wound was healing but it was painful.During an observation and interview on 02/03/2026 at 5:05 PM with Resident 2 and Staff B present in the room. Resident 2 agreed to have their skin checked, no dressing was observed on an open area to their right gluteal fold. Staff B stated Resident 2 should have a dressing covering the wound. Resident 2 stated they informed staff that they needed a new dressing to their buttocks. Resident 2 stated the wound hurt, the brief being used was too little and made the sore worse. Resident 2 stated they used a size 5X brief and was currently in a 3X brief. Resident 2's brief was observed sitting in area of the gluteal fold where the wound was present. Resident 2's back was observed with a dressing dated 01/05/2026, twenty-nine days prior. The dressing was observed soiled, was removed, a strong odor was present, and no open areas were observed on Resident 2's back. Resident 2's left leg and labia were observed with no open wounds. Staff B stated they were not sure how staff missed the dressing on Resident 2's back if the staff were completing showers, skin checks, and assisting with the resident with upper and lower body.In an interview on 02/26/2026 at 11:15 AM Staff B when asked how shearing was being reduced if that was the cause of Resident 2's gluteal wound and Staff B stated Resident 2 was being followed by an outside wound provider, on an air mattress, using ointment to reduce shearing, using a draw sheet and staff were assisting with bed mobility to reduce shearing to Resident 2's skin. Staff B stated they could consider using an underpaid with no brief for Resident 2 to reduce shearing of the skin. Staff B stated when a new wound was found they would expect staff to inform the provider, obtain a treatment order, implement provider orders, document a thorough wound assessment to include measurements, pain, and notifications. Staff B stated they would expect staff to change dressings as ordered, to thoroughly assess the skin during skin assessments, bathing, and resident care.<Resident 3>Review of a (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	11/14/2025 Quarterly MDS showed Resident 3 was cognitively intact, had a decision maker, no behaviors, and no speech. The MDS showed Resident 3 had diagnoses including progressive neurological conditions, diabetes, depression, and schizophrenia. The MDS showed Resident 3 did not have a PU, was at risk for PU's, and had a pressure-reducing device for the bed. The MDS showed Resident 3 was dependent on staff for oral hygiene, toileting, bathing, dressing, bed mobility, and transfers.Review of a 02/09/2024 physician order directed staff to apply a thick layer of barrier cream after each incontinent episode and as needed.Review of a 10/15/2024 Braden assessment showed Resident 3 was assessed at moderate risk for PU's. The assessment showed Resident 3 had slightly limited sensory perception, was constantly moist, chairfast, limited mobility, and a potential problem with friction and shear when moved in bed. No other Braden assessments were documented in Resident 3's record after 10/15/2024.Review of a 09/18/2025 revised skin care plan showed Resident 3 had a sacral PU that was resolved and was high risk for skin breakdown. The care plan directed staff to offload and reposition the resident every 2-3 hours while in bed and follow facility policies and protocols for the prevention and treatment of skin breakdown.Review of Resident 2's weekly skin evaluations showed staff did not complete and/or document the results of the skin evaluations on 10/14/2025, 10/21/2025, 10/28/2025, 11/11/2025, 11/25/2025, 12/01/2025, 12/08/2025, 12/22/2025, 12/30/2025, 01/05/2026, and 01/12/2026.Review of a 01/14/2026 wound provider note showed Resident 3 was seen for a new Stage 4 (severe full thickness wound extending to the muscle and the bone) sacral (tailbone) PU and a new Stage 3 PU to their right buttocks.Review of Resident 3's medical record from 10/30/2025-01/13/2026 showed no progress notes on the date the two PU's were discovered, who was notified, and what staff did in response to the two new PU's. Review of Resident 3's medical record showed no skin/wound evaluations completed by staff to determine when the wound developed and was identified by facility staff.Observations on 01/21/2026 at 2:32 PM showed Resident 3 could not answer questions and was in bed on their back on an air mattress. Staff J (Registered Nurse, RN) was present in the room and at 2:33 PM stated Resident 3 had a stage 1 PU to their sacrum (tailbone area) , the resident was repositioned every few hours but it made it hard because Resident 3 received tube-feeding (nutritional formula given directly into the stomach) and the head of the bed had to be elevated to prevent choking.In an interview on 02/26/2026 at 11:22 AM Staff B stated they would expect staff to complete a Braden skin assessment quarterly, update the skin care plan with current PU, complete and document skin and wound assessments. Staff B stated Resident 3 had physician orders for barrier cream after each incontinent episode, did not know how staff did not identify the PU's to Resident 3's bottom until it was a stage 3 & stage 4 PU, and would expect the staff to be able to identify skin breakdown. Staff B stated when a new PU was identified staff should complete a progress note, an incident report, inform the provider, resident representative, obtain and implement treatment orders, and update the care plan. REFERENCE: WAC 388-97-1060(1)(b)(3)(b).

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 timely and accurately assess resident's ability to smoke safely; implement a resident specific care plan for smoking; secure smoking supplies; ensure a safe designated smoking area; and implement, and enforce the facility smoking policy for 7 of 9 residents (Residents 13, 8, 12, 14, 15, 18, & 19) reviewed for smoking. In addition, the facility failed to re-assess Resident 16's ability to smoke independently after a cigarette burn, and failed to provide supervision to 1 of 3 residents (Resident 8) who was assessed to require supervision outside of the facility, used a Wander Guard device (a device that sets off an alarm to notify staff if the resident is close to the exit door) and eloped from the facility five times. The failure to ensure residents were free from elopement and dangerous accident hazards from smoking placed all residents at risk for serious adverse outcomes with the potential for fire and an explosion and/or serious harm, serious injury, and possible death and constituted an Immediate Jeopardy (IJ). On 02/13/2026 at 5:35 PM, the facility was notified of an IJ at 42 CFR S483.25(d), F689- Free of Accident Hazards/Supervision/Devices related to the facility's failure to ensure safety when residents were smoking. The IJ was determined to begin on 12/25/2025 when Resident 8 was identified smoking inside the facility. Resident 8 continued to smoke inside the facility on 01/13/2026, 01/16/2026, and 01/31/2026. Resident 13 was smoking inside the facility on 12/26/2025, 12/29/2025 and 02/10/2026. Both Residents were assessed as not safe to smoke independently. There were no new interventions implemented by Administration when both residents continued to smoke inside and outside the facility. The facility removed the immediacy on 02/15/2026, with onsite verification from investigators, by ensuring all residents were accurately assessed to smoke, educated all smokers and staff of the revised smoking policy, provided a safe designated smoking area, and secured smoking supplies which ensured an effective system was in place to safeguard, protect, and prevent harm or injury to all residents. Findings included.<Smoking> Review of the undated Facility Smoking policy showed Smoking cigarettes, marijuana, and the use of any/all tobacco products as well as electronic cigarettes and vaping devices anywhere on the premises by residents is strictly prohibited. Residents admitted after 04/18/2024 must smoke off the facility premises under direct supervision by a non-staff responsible party. The policy directed the non-staff responsible party to store all smoking supplies off the facility premises. The policy showed staff would assess smokers for smoking safety, handling smoking materials, and use of a wheelchair or walker while outside. Smokers were expected to sign out when going out to smoke and sign in upon return. Observation and interview on 02/13/2026 at 11:39 AM showed the designated smoking area was in the back of the parking garage, the ground was littered with hundreds of cigarette butts, a fire extinguisher was lying on the ground, a smoking blanket and second fire extinguisher was secured to the wall but blocked by two large trash cans, a chair, and a bed frame making them not accessible. Staff W (Maintenance Assistant) observed the designated smoking area, stated certain residents were allowed to smoke there, identified the hundreds of cigarette butts on the ground and stated people should use the ash tray, lifted the fire extinguisher, stood it up on the pavement, and stated the fire extinguisher laying on the ground was unsafe. <Resident 13> Review of a 12/12/2025 admission Minimum Data Set (MDS, an assessment tool) showed Resident 13 was admitted to the facility on [DATE] for skilled services and had impairment to both legs requiring a wheelchair. Resident 13 was assessed to depend on staff for personal care and mobility. Review of an undated Non-Smoking Tobacco and Marijuana Free Notice and Agreement showed Resident 13 was informed of the facility policy and signed the agreement on 12/08/2025 agreed to read, understand and fully comply with (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the December 2025 and February 2026 abuse reporting log showed Resident 8's incidents of smoking inside the facility were not recorded on the incident log. In an interview on 02/13/2026 at 11: 45 AM Staff A stated smoking incidents should be reported to the administrator, written on the incident log, investigated, and interventions implemented to prevent re-occurrence. Staff A stated Resident 13's incidents of smoking inside the facility were not on the incident log or investigated. In an interview on 02/13/2026 at 12:52 PM Staff D (Regional Market Leader) stated residents were not allowed to share cigarettes and staff were to secure smoking supplies. Staff D stated they expected staff to intervene when a resident was found smoking inside the facility, secure smoking materials, report incidents to management, and to document the event. Staff D stated incidents are expected to be logged and investigated to prevent recurrence and ensure all residents' safety at the facility. <Resident 8> Review of the 11/19/2025 Annual MDS, showed Resident 8 was re-admitted to the facility on [DATE] after hospitalization, had moderate cognitive impairment, memory loss, poor judgement, and unable to make decisions. The assessment showed Resident 8 had multiple diagnoses including debility, dementia, a traumatic brain injury, and severe mental illness. Resident 8 was assessed to depend on a wheelchair for mobility and required staff assistance with care. Review of Resident 8's medical record showed no documentation that Resident 8 was informed of the Non-Smoking Tobacco and Marijuana Free Notice and Agreement as stated in the policy would be provided on admission. Review of Resident 8's medical record showed no assessment was completed for smoking safety. Review of a 12/22/2025 elopement assessment showed Resident 8 had a history of wandering, exit seeking, elopement, and was able to deactivate exit alarms. Review of Resident 8's comprehensive care plan showed a 01/21/2026 intervention that Resident 8 may be assisted by staff outside to smoke to alleviate smoking perseverance. Review of a 12/25/2025 progress note showed Resident 8 was observed smoking in their restroom. Staff confiscated the cigarette and lighter, provided education on the dangers of smoking in the facility, and monitor the resident's behavior. The progress note did not show notification of management. Review of a 01/13/2026 progress note showed Resident 8 was observed smoking in the shared bathroom with another unnamed resident. The note showed smoke had filled the room causing the non-smoking roommate discomfort. The note showed Staff A and a nurse manager addressed the incident immediately after the event, the room was searched and an ash tray was collected from the room. Review of a 01/16/2026 progress note showed an aide found Resident 8 smoking in the atrium. There was no other information in the progress note and no subsequent notes addressed the smoking event. Review of a 01/29/2026 interdisciplinary team note showed a review of Resident 8's behaviors including frequent perseverating on smoking, unsafe to smoke independently and plan to contact representative. Review of a 01/31/2026 progress note showed residents reported to staff that Resident 8 was smoking marijuana with other residents in the atrium in previous days. There was no further documentation of follow-up actions. Review of the January 2026 facility incident log showed no record of Resident 8's incidents of smoking inside the facility. <Resident 12> Review of a 01/05/2026 admission MDS showed Resident 12 was cognitively intact, able to make their own decisions, and had no behaviors. Review of Resident 12's medical record showed no assessment or care plan for smoking safety. Review of a 01/10/2026 progress note showed Resident 12 was observed at 11:12 AM on the facility camera in the garage smoking an unknown substance with a second unnamed resident. The progress note showed both residents were approached, informed of the observed behavior and that the area was under video surveillance and both residents left the area. The progress note showed the smoking incident would be reported and discussed during the next morning's staff meeting. The progress note did not show an investigation was started to collect details, no actions taken to protect residents, or interventions to prevent (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	re-occurrence. There were no further progress notes for follow up. Review of the January 2026 incident log did not show the smoking incident of Resident 12. In an interview on 02/13/2026 at 12:56 PM Staff A stated staff should have absolutely reported a resident smoking an unknown substance on facility property and enter the incident on the incident log. Staff A could not provide documents that an investigation occurred. <Resident 14> Review of a 01/21/2026 admission MDS showed Resident had mild cognitive impairment but was able to make their own decisions. Review of Resident 14's medical record showed no assessment or care plan for smoking safety. Review of a 02/11/2026 progress note showed there was a strong smell of cigarette smoke coming from Resident 14's room. The note showed ash was observed on the floor, a second staff member confirmed the smell of smoke. Resident 14 denied smoking in the room. The note showed Resident 14 was told it was a fire hazard to smoke in a room while their roommate's oxygen was in use. The note showed Staff A and Staff B (Director of Nursing) were notified of the incident. The progress note did not indicate if smoking materials were located or removed or if interventions were implemented to protect Resident's 14's roommate or prevent Resident 14 from future incidents of smoking inside. Review of the February 2026 facility incident log showed no incidents of Resident 14 smoking indoors. In an interview on 02/13/2026 at 12:56 PM Staff A stated staff should have reported any resident smoking inside their room. The incident should be placed on the incident log. Staff A could not provide documents that an investigation occurred. In an interview on 02/13/2026 at 1:03 PM Staff D stated staff were expected to log and investigate any incidents of smoking inside the facility. <Resident 15>Review of the 01/23/2026 Annual MDS showed Resident 15 was cognitively intact, able to make own decisions, and had wandering behaviors. Review of Resident 15's medical record showed no assessment or care plan for smoking safety. Review of a 06/18/2025 smoking assessment showed Resident 15 was not a smoker. Sections of the assessment for sensory perception, functional ability, medications, behaviors and nursing assessment of Resident 8 were not completed. There were no other smoking assessments in the record after 06/18/2025. Review of Resident 15's comprehensive care plan initiated on re-admission of 01/16/2025 showed no mention of Resident 15 smoking plan. Review of a 01/19/2026 provider note showed Resident 15 was observed smoking outside, was offered nicotine cessation and Resident 15 refused. The progress note did not show what staff did to assess smoking safety, implement safety interventions, report resident changes in smoking preferences. In an observation on 02/13/2026 at 12:02 PM, Resident 15 was sitting in a power wheelchair to the east of the facility across a private driveway and near a wooden fence. Resident was off the facility property. Resident 15's wheelchair had coats and bags hanging from the back and sides of the chair and Resident 15 had a blanket over their lap. Resident 15 was observed smoking a cigarette. <Residents 12, 14, 18, & 19> In an observation and interview on 02/13/2026 at 11:54 AM, Resident 12 was sitting on a walker, Residents 18 and 19 were sitting in wheelchairs in the driveway of the parking garage all smoking cigarettes. Resident 18 stated they (residents) were breaking the rules and should be off facility property to smoke because they were not allowed to smoke in the designated smoking area on the other side of the parking garage. At 11:56 AM Resident 14, with a cane, walked up to the group of residents and pulled out a cigarette and lighter and began smoking. A review of medical records for Residents 18 and 19 showed these residents had no assessments or care plans for smoking safety. In an interview and record review on 02/13/2026 at 4:08 PM with Staff A and Staff B, a list of residents who smoked was provided, 17 residents were identified by the facility as known smokers. Staff A stated residents were identified as smokers on admission; residents signed the non-smoking facility policy, and alternate treatments for smoking were offered. Staff A stated three residents were grandfathered into the prior smoking policy which allowed the residents to smoke in a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	designated smoking area in the parking garage, but other residents must go off property to smoke. Staff B stated residents that are active smokers were assessed to be independent with smoking, the assessment would be in their medical record, and they would have a smoking focused care plan. Staff B stated smoking supplies were kept on the medication cart and the residents would check out their supplies from the nurse, then sign out to go smoke outside. Staff A stated smoking inside the facility and the atrium was prohibited. Staff A stated the smoking policy was unclear and was not followed by residents or staff. Staff B reviewed the medical records for Residents 8 and 13 and stated they were assessed as not safe to smoke independently. Staff A and B stated both residents were frequently observed outside smoking and acknowledged they were listed on the list of residents who smoked. Staff B reviewed the records for Residents 8, 13, 12, 14, 15, 18 and 19. Staff B stated these residents did not have smoking assessments for smoking safety and should have been assessed if they were smokers. Staff B stated there was a breakdown in the system of residents smoking. <Resident Cigarette Burn> <Resident 16> Review of the 11/24/2025 progress note showed Resident 16 informed the shower aide they accidentally burned their leg with a cigarette when smoking outside. The progress note did not show how the burn occurred or new interventions to protect Resident 16 from future burns. Review of the state tracking and reporting system showed facility staff did not report Resident 16's burn injury when the incident occurred in November 2025. During an observation and interview on 02/18/2026 at 2:25 PM Resident 16 was sitting in their wheelchair in their room. Resident 16 stated they were one of the smoking residents that was grandfathered in when the facility became a non-smoking facility, was able to smoke independently, and facility staff updated them on the smoking policies and procedures. In a joint interview on 02/13/2026 at 12:25 PM Staff D stated a resident burn was expected to be reported, logged, and investigated. Staff B stated they would expect the nurse to assess the burn, perform first aide, notify the provider, obtain and implement treatment orders, re-assess the resident's ability to smoke independently, offer a smoking apron and a smoking cessation plan. <Elopement> <Resident 8> Review of the 11/19/2025 Annual MDS, showed Resident 8 was re-admitted to the facility on [DATE] after hospitalization, had moderate cognitive impairment, memory loss, poor judgement, and unable to make decisions. The assessment showed Resident 8 had multiple diagnoses including debility, dementia, a traumatic brain injury, and severe mental illness. Resident 8 was assessed to depend on a wheelchair for mobility and required staff assistance with care. Review of Resident 8's elopement care plan initiated on 07/13/2024 showed Resident 8 was at risk for elopement based on an elopement screening assessment. A revision of the care plan on 09/13/2024 showed Resident 8 was a wanderer, and directed staff to monitor whereabouts frequently, intervene for safety, a wander guard device was attached to the back of the wheelchair, and staff to ensure device placement and functioning. A revision of the care plan on 01/21/2026 showed Resident 8 repeatedly talked about smoking and staff should assist them outside to smoke. A 01/21/2026 care plan revision showed Resident 8 was placed on 1:1 monitoring from 6:00 AM to 10:00 PM until an alternate intervention was found. The care plan did not show any revised interventions after 09/13/2024 until 01/21/2026. A 12/19/2025 10:15 AM progress note showed Resident 8 stated they needed to go to the bank to buy two bus tickets. The note showed this was Resident 8's usual behavior. A 12/20/2025 10:21 AM progress note showed Resident 8 was agitated and was exit seeking. A 12/20/2026 6:30 PM progress note showed Resident 8 left the facility unassisted. The nurse directed two staff to follow Resident 8 who went to the store two blocks away and staff returned with Resident 8 to the facility. The progress note did not indicate if Resident 8 had the wander guard device, if the event was reported to management, or any new interventions to prevent future events of Resident 8 leaving unassisted. Review of a 12/21/2025 progress note (continued on next page)

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	505355	A. Building B. Wing	02/26/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	showed Resident 8 went to the store two blocks away with a staff member. The note showed Resident 8 disappeared from the staff member's supervision after arriving at the store, and the staff member returned to the facility without Resident 8. The note showed the administrator and local police were notified, and staff searched the area for Resident 8. Resident 8 was found by staff, returned to the facility, then placed on 1:1 supervision. Review of a 12/22/2025 progress note showed Resident 8 continued with exit-seeking behavior, with verbal aggression, pushing and banging on the exit door, redirection was provided and behavior continued. The note showed the physician was notified for advice and 1:1 supervision continued. Review of a 12/22/2025 elopement assessment showed Resident 8 was high risk for elopement due to statements of leaving the facility, behaviors of wandering and exit seeking, and prior elopements from the facility. Review of a late entry progress note, dated 12/26/2025 and created on 12/28/2025, showed Resident 8 was watching the elevator for opportunities to leave the facility without supervision. The note showed Resident 8 exited the building on 12/26/2025 without authorization and was observed by staff heading to the store. Staff assisted Resident 8 to return to the facility. The note showed Resident 8 exited a second time on 12/26/2025 without staff awareness and was later found at a store six blocks from the facility. Staff found Resident 8 and returned them to the facility. Resident 8 stated they were going to the bank. The notes did not indicate if Resident 8 was still on 1:1 supervision from the 12/21/2025 elopement. The note stated Resident 8 would be on 1:1 supervision. Review of the December 2025 accident and incident log showed no elopement events reported or investigated for Resident 8's elopements on 12/20/2025, 12/21/2025, or two separate elopements on 12/26/2025. Review of a 01/21/2026 progress note showed Resident 8's representative was notified of an elopement and investigation in process. Review of progress notes 01/01/2026 through 01/21/2026 showed no documentation of elopement. Review of the January 2026 facility accident and incident log showed Resident 8 was a missing person / Elopement on 01/20/2026 and the incident was reported to the state agency. Review of the 01/20/2026 facility investigation documents showed Resident 8 could not be located and the facility missing person policy was implemented. The investigation showed Resident 8 wanted a cigarette and was let out of the facility by another resident at 7:13 PM. Resident 8 was located at the store two blocks away unsupervised and returned to the facility at 7:49 PM. The investigation did not identify why the wander guard system did not alarm when Resident 8 left the facility. The intervention implemented by the investigation was to initiate 1:1 supervision of Resident 8. During observation and interview on 02/03/2026 at 3:02 PM, Resident 8 was self-propelling in their wheelchair on the second floor, there was no 1:1 staff supervising. Resident 8 was near the elevator, a wander guard device was observed on the wheelchair, and the wander guard system did not alarm. At 3:06 PM, Resident 8 moved closer and pushed the elevator button, then the alarm sounded. Resident 8 stated they wanted their money, had $5000 and needed to get to the bank. At 3:07 PM the alarm was still sounding; Resident 8 stated, I'm going to [the store] by myself. At 3:09 PM Staff P (Housekeeping Manager) arrived and turned off the alarm when Resident 8 self-propelled away from the elevators. No 1:1 supervision by staff was observed. Review of a binder at the nurses station contained an undated document named 1:1 supervision guideline elopement prevention plan for Resident 8. The plan directed staff to always maintain a continuous line of sight of Resident 8, stay within arm's length when near exits or high-risk areas, accompany Resident 8 during all movement throughout the facility, do not leave unattended for any reason, if relief was needed ensure proper hand off before stepping away. Staff logs in the book showed staff signing in from 6:00 AM to 2:00 PM and 2:00 PM to 10:00 PM starting on 01/23/2026. A staff member signed in on 02/03/2026 at 2:00 PM to supervise Resident 8. In an interview on 02/03/2026 at 5:25 PM, Staff B stated Resident 8 was able (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	to get on the elevator from the second floor without staff knowledge. Staff B stated Resident 8 often expressed desire to smoke which increased their risk of elopement. Staff B stated Resident 8 eloped from the facility on 01/20/2026. In an interview on 02/13/2026 at 11: 45 AM Staff A stated an elopement, or missing resident would be a resident who was not cognitively able to manage themselves outside of the facility. Staff A stated staff were expected to follow the policy for a missing resident. Staff A stated the incident should be reported to the administrator, written on the incident log, investigated, and interventions implemented to prevent re-occurrence. Staff A stated Resident 8's incidents of elopement were not on the incident log or investigated. In an interview on 02/26/2026 at 3:00 PM, Staff R (Interim Administrator) stated an administrator is responsible for the safety of residents and staff are required to report resident incidents so interventions can occur timely. Staff R stated the facility should have, and did not, implement a smoking policy that supports resident rights and safety. Staff R stated the facility had a policy for elopement and the policy was not followed by administration or staff for Resident 8. Reference: WAC 388-97-1060 (1)(3)(g); -1620(7)(b)-3220(1).

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review, the facility administration failed to efficiently and effectively manage the facility in compliance with state and federal regulatory requirements to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The failure to ensure oversight, monitoring, investigation, reporting, and implement prevention to ensure resident safety for incidents of abuse, smoking and elopement, and ensure mandatory staff training and competency, placed all residents at risk for physical, sexual and verbal abuse, resident altercations, physical, mental and psychological harm, serious injuries, unmet needs, and dissatisfaction with their quality of life. Findings included.Review of a job description signed by Staff A (Administrator) on 10/18/2025 showed the administrator is responsible for the daily operation of the facility, will utilize resources effectively and efficiently to attain and maintain the highest level of care for residents in accordance with regulatory standards. The job description showed the administrator had essential position duties, which included: ensure residents are free from abuse; ensure nursing services are planned, implemented, and evaluated to maximize resident rights, quality of life, and quality of care; ensure staff are present in number and ability to meet the highest practicable level of physical, mental and psychosocial well-being for each resident; observe, monitor, and evaluate outcomes of all facility programs, policies and procedures to ensure effectiveness.<Abuse: Investigate/Prevent/Correct Alleged Violation>In an interview on 02/13/2026 at 11:32 AM with Staff A (Administrator), Staff B (Director of Nursing) and Staff D (Regional Market Leader), Staff A stated they were the abuse coordinator for the facility. Staff A stated facility staff were educated on abuse policies and procedures upon hire, annually, and as needed.In an interview on 02/13/2026 at 11:40 AM with Staff A (Administrator) Staff B (Director of Nursing) and Staff D (Regional Market Leader), Staff D stated facility management did not, but were expected to, review progress notes written by staff on resident care every 24-72 hours to identify care concerns and incidents. Staff D stated staff were required to follow facility abuse policies and report incidents to management. Staff D stated not all incidents of abuse, smoking or elopement were identified or reported to management as expected, which led to missed investigations and missed opportunities for prevention of recurrence and protection of residents safety.< Free of Accident Hazards/Supervision/Devices>During a review of the facility's historical surveys a complaint investigation survey completed on 05/02/2024 showed the facility was cited in F689 for Free of Accident Hazards/Supervision/devices for failure to timely and accurately assess a resident's ability to safely smoke, secure smoking supplies, implement and enforce the facility smoking policy when a resident was smoking inside the facility repeatedly, which constituted an Immediate Jeopardy (IJ) on 04/18/2024.In an interview and observation on 02/13/2026 at 4:08 PM, Staff A (Administrator) provided a list of 17 known resident smokers. Staff A stated they had observed these residents outside their office window when they would go in and out of the facility to smoke. During the interview in the Administrator's office, the facility entrance walkway, sidewalk and street were observed outside the window with a clear view of any person coming in and out of the facility. Staff A stated residents who smoked were identified on admission, reviewed and signed the non-smoking facility policy, and were required to go off property to smoke. Staff B (Director of Nursing) stated residents that smoke would be assessed, have a smoking-focused care plan, and smoking supplies were kept on the nurse's medication cart to be checked in and out by the residents. During the interview Staff A stated they were aware that Resident's 8 and 13 had smoked multiple times inside the facility recently. Resident 13 was smoking in the facility on 02/10/2026, three days prior. Staff B stated they planned to do a smoking assessment but had not completed it (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	yet. Staff A stated they completed a behavior agreement with Resident 13 who was told they were not allowed to smoke indoors. Staff B reviewed the medical records of Residents 8, 12, 13, 14, 15, 18 and 19 and stated none of the residents had smoking assessments and verified all seven residents were on the identified smokers list.On 02/13/2026 at 5:35 PM, the facility was notified of an IJ at F689- Free of Accident Hazards/ Supervision/ Devices related to the facility's failure to ensure safety when residents were smoking. The IJ was determined to begin on 12/25/2025 when Resident 8 was identified smoking inside the facility. Resident 8 continued to smoke inside the facility on 01/13/2026, 01/16/2026, and 01/31/2026. Resident 13 was smoking inside the facility on 12/26/2025, 12/29/2025 and 02/10/2026. Both Residents were assessed as not safe to smoke independently.In an interview on 02/26/2026 at 3:00 PM, Staff R (Interim Administrator) stated an administrator is responsible for the safety of residents and staff are required to report resident incidents so interventions can occur timely. Staff R stated the facility should have, and did not, implement a smoking policy that supports resident rights and safety. Staff R stated the facility had a policy for elopement and the policy was not followed by staff for Resident 8.<Nurse Aide Training>In an interview on 02/26/2026 at 1:35 PM, Staff U (Staff Development Coordinator) described orientation, ongoing education, and competency evaluation for staff. When asked to provide documentation for training at hire, orientation, annual mandatory training, annual performance evaluations for competency, and training provided as stated in the facility assessment. Staff U stated they could not provide documentation for the sampled staff. Staff U stated there was not a system in place for scheduling, documenting, tracking, or monitoring staff completion of required training.In an interview on 02/26/2026 at 3:00 PM, Staff R stated an administrator is responsible for the training and competency of all staff. Staff R stated the facility should have, and did not implement a policy for training, did not document or track required training or competency of staff. Refer to F600 Free from Abuse and NeglectRefer to F610 Investigate/Prevent/Correct Alleged ViolationRefer to F689 Free of Accident Hazards/Supervision/DevicesRefer to F947 Required In-Service Training for Nurse Aides Reference: WAC 388-97-1620(1)(2)(b)(i-ii)(c)(3)(b)(d).

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review the facility failed to submit complete and accurate direct care staffing information to the Centers for Medicare and Medicaid Services (CMS- a federal agency managing healthcare programs and health insurance standards) for Quarter 2 (Q2, April 2025, May 2025 and June 2025) reviewed for Payroll Based Journal (PBJ-mandatory reporting of staffing information based on payroll data) submission. This failure effected the accuracy of Nursing Home (NH) staffing level data collected by CMS and had the potential to impact provisions of resident care and services. Findings included .<CMS-Electronic Staffing Data Submission PBJ>Review of the June 2022, CMS Long-Term Care Facility PBJ Policy Manual, showed long term care facilities were required to electronically submit direct care staffing information based on payroll and auditable data. The data, when combined with the census information can be used to not only report on the level of staff in each nursing home, but reports staff turnover and tenure, that can impact the quality of care delivered at the facility. The policy manual showed the facility must electronically submit complete and accurate information by the required deadline to include; direct care staff, the category of work for each direct care staff member, resident census data, and direct care staff turnover and tenure. Review of the PBJ data submitted by the facility for Q2, dated April 01, 2025 through June 20, 2025 showed a reported census total of 6988. Review of the facility monthly census for April 2025 showed 2266, May 2025 showed 2242, and June 2025 showed 2238 for a census total of 6746. A difference of 242 days. During an interview on 01/07/2026 at 3:10 PM Staff A (Administrator) stated PBJ submission and census reporting was completed on a corporate level. Staff A stated issues were identified with prior Minimum Data Set (MDS, an assessment tool) submission being timely and accurate. In an electronic communication (e-mail) on 01/12/2026 at 8:45 PM, Staff C (Corporate Staff) wrote the accurate census for Q2 was 6789 after reviewing all PBJ submission documents. During an interview on 01/21/2026 at 3:35 PM, Staff A stated they would expect complete and accurate PBJ information to be submitted as required. REFERENCE: WAC 388-97-1090(1)(2)(3)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. Based on observation, interview, and record review, the facility failed to implement and effectively maintain a smoking policy in accordance with applicable Federal, State, and local laws and regulations regarding smoking, smoking areas, and smoking safety for resident smokers, resident non-smokers, and staff. The failure to monitor and intervene when the smoking policy was not followed, failure to provide a safe designated smoking area, and failure to ensure resident safety while smoking, placed residents at risk for serious adverse outcomes including potential for fire, explosion, and/or serious injuries. Findings included.Review of the undated Facility Smoking policy showed Smoking cigarettes, marijuana, and the use of any/all tobacco products as well as electronic cigarettes and vaping devices anywhere on the premises by residents is strictly prohibited. Residents admitted after 04/18/2024 must smoke off the facility premises under direct supervision by a non-staff responsible party. The policy directed the non-staff responsible party to store all smoking supplies off the facility premises. The policy showed staff would assess smokers for smoking safety, handling smoking materials, and the use of a wheelchair or walker while outside. Smokers were expected to sign out when going out to smoke and sign in upon return. The policy showed an area for the residents to sign acknowledgement and compliance with the facility smoking policy. The policy did not define where the facility premises ended, a designated smoking area, smoking safety, or any rules that applied to residents admitted prior to 04/18/2024. Observation and interview on 02/13/2026 at 11:39 AM showed the designated smoking area was in the back of the parking garage, the ground was littered with hundreds of cigarette butts, a fire extinguisher was lying on the ground in the gravel, a fire blanket and second fire extinguisher was secured to the wall but blocked by two large trash cans, a chair, and a bed frame making them not accessible. Staff W (Maintenance Assistant) observed the designated smoking area, stated certain residents were allowed to smoke there, identified the hundreds of cigarette butts on the ground and stated people should use the ash tray, lifted the fire extinguisher, stood it up on the pavement, and stated the fire extinguisher laying on the ground was unsafe. In an interview and record review on 02/13/2026 at 4:08 PM with Staff A (Administrator) and Staff B (Director of Nursing), the facility smoking policy and a list of residents who smoked were provided, 17 residents were identified by the facility as known smokers. Staff A stated residents were identified as smokers on admission; residents signed the non-smoking facility policy, and alternate treatments for smoking were offered. Staff A stated three residents were grandfathered into the prior smoking policy which allowed the residents to smoke in a designated smoking area in the parking garage, but other residents must go off property to smoke. Staff B stated residents that are active smokers were assessed to be independent with smoking, the assessment would be in their medical record, and they would have a smoking focused care plan. Staff B stated smoking supplies were kept on the medication cart and the residents would check out their supplies from the nurse, then sign out to go smoke outside. Staff A stated smoking inside the facility and the atrium was prohibited. When Staff A and Staff B were asked if the smoking policy provided was being followed, Staff A stated the smoking policy was unclear and was not followed by residents or staff. Staff B stated there was a breakdown in the system of residents smoking. In an interview on 02/26/2026 at 3:00 PM, Staff R (Interim Administrator) stated an administrator is responsible for the safety of residents. Staff R stated the facility should have, and did not, implement or maintain a smoking policy that supported resident rights and resident safety. Refer to F689 Accidents/Hazards/Supervision/Devices. REFERENCE: WAC 388-97-1780(1)(2)(a)(i)(d).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 develop, implement and permanently maintain an in-service training program for nurse aides that was appropriate and effective, as determined by nurse aide performance reviews and the facility assessment for 3 of 3 nurse aide staff (Staff X, Y, & Z) reviewed for training and competency. The failure to have a system to provide a minimum of 12 hours of nurse aide training per year, conduct nurse aide performance reviews to address weaknesses for additional training, track nurse aide participation in required training with documentation of completed in-service education, and assess nurse aide demonstration of competency to meet residents' needs, placed all residents at risk for unmet needs and diminished quality of life.Findings included. Review of the revised 08/04/2025 Facility Assessment (FA) showed the facility had 96 licensed beds with an average daily census of 74 residents. The FA showed the facility staff provided care to residents with common conditions including psychiatric, mood, and substance use disorders, cognitive impairment, memory deficits, dementia, traumatic brain injury, and behaviors related to these conditions. The FA showed residents required care for skin and wound care, and activities of daily living such as bathing, dressing, oral care, eating, transfers, and ambulation. The FA showed a staffing plan which included 41 nurse aides working eight-hour shifts with assignments of 1:10 ratio of staff to residents. The FA showed staff required training in communication with residents, resident rights, abuse/neglect identification, reporting and prevention, infection control, resident-centered care, cultural competency in care delivery, activities of daily living, disaster planning, measurement of vital signs, care to residents with cognitive impairment, mental and psychosocial disorders, non-pharmacological management of resident behaviors, caring for residents with a trauma history, and care to residents with substance use disorders. An observation on 02/26/2026 at 11:28 AM showed Staff Y and Z answering call lights on the long-term side of the unit. Review of the nurse aide assignment sheet for 02/26/2026 showed Staff Y (CNA- Certified Nursing Assistant) and Staff Z (CNA) were assigned to resident care on the day shift and Staff X was assigned to the evening shift.Review of the current staff list provided by the facility on 02/26/2026 showed Staff X (CNA) was hired on 01/03/2026. Staff Y was hired on 10/30/2024. Staff Z was hired on 10/09/2024.In an interview on 02/26/2026 at 1:05 PM, Staff U (Staff Development Coordinator) stated staff received video training on a corporate portal prior to orientation which included abuse/neglect, resident rights, infection control, and dementia. Staff U stated these topics were also discussed at all staff meetings. Staff U stated there was not a tracking system to ensure staff participation on annual required training topics. Staff U stated nurse aide inservice training could be obtained through reports from an online training portal, but there was no system in place to track the 12-hour nurse aide required inservice training. Staff U stated there was no support from the Administrator to put systems in place to track staff training, assess staff competency through skills evaluation, and no communication to Staff U regarding nurse aide performance evaluation for additional training needs of nurse aide staff. Staff U stated they were not involved in nurse aide performance reviews to provide training in identified areas of weakness. Staff U was asked to provide documentation of annual mandatory training, performance evaluations, skills assessment for competency, and 12-hour in-service documentation for nurse aide Staff X, Y, and Z. No documentation was provided. In an interview on 02/26/2026 at 3:00 PM, Staff R (Interim Administrator) stated the facility should have a mandatory annual inservice schedule to provide in-service training for all staff; that the training provided should be tracked and participation should be documented. Staff R stated the facility should provide, track and document 12-hour inservice training for nurse aide staff. Staff R stated nurse aides (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have performance and competency evaluated annually. Staff R stated there were no systems in place and no documents could be provided for the training requirements identified in the FA. Refer to F835 Administration.REFERENCE: WAC 388-97-1660(1)(a), -1680(1)(2)(a-b)(i-ii)(c),-1740(4)(b),-1040(1)(c).