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	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Post Acute	414 - 17th Southeast Auburn, WA 98002

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to: ensure the main entrance to the facility was safely accessible to all residents for 1 of 1 main entrances, failed to ensure sharps containers were emptied before becoming a hazard for 3 of 4 nurse carts, and failed to provide sufficient fall management for 2 of 4 (Residents 24 & 40) residents reviewed for falls. These failures placed residents at risk for injury, blood borne pathogen exposure, avoidable falls, and other negative health outcomes.Findings included .<Facility Policy>According to the facility's 10/05/2025 Fall Management policy, the facility would assess residents upon admission/readmission, quarterly, with a significant change in condition, and with any fall events for fall risk. The policy showed residents would be assessed for fall indicators upon admission, readmission, quarterly, change in condition, and with any fall. <Front Doors> Observation on 05/05/2026 at 12:21 PM showed the facility's main entrance had twin doors that opened to the outside. When the ADA (Americans with Disabilities Act) Operators (square metal, easy-to-press buttons placed by the doors to enable residents with disabilities to pass through the door safely) located on the interior side of the entrance was pressed, neither door opened. The exterior button also failed to open either door. At that time, Staff S (Receptionist) was seated at the front desk with a kiosk arrangement In an interview at that time Staff S stated the ADA Operator was broken for some weeks and that they helped residents in wheelchairs or other mobility needs pass through the door when they wanted to come in or out. Staff S stated some of the residents could squeeze themselves through the door when there was no one at the front desk. Staff S declined to answer if that was a safe arrangement and stated they believed the was a work order for the Operator repair. Observation at 05/05/2026 12:25 PM showed Resident 77 coming down the hall from the front door toward the elevator using a wheelchair. In an interview at that time Resident 77 stated the front door used to work but it no longer did. Resident 77 stated they felt cheated by the inconvenience. Observation on 05/06/2026 at 8:25 AM showed Resident 74 in a wheelchair, typing in the code to the twin doors. The doors did not open automatically, and the resident required assistance to have the door opened so they could exit the facility. In an interview at that time, Resident 74 stated they could not open the door by themselves. Review of the facility's maintenance book on 05/06/2026 at 8:28 AM showed nothing logged regarding the functionality of the ADA Operators on the front door. In an interview on 05/06/2026 at 8:30 AM, Resident 37 stated they used the facility's front door (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	independently, but it was a pain to use the door now the ADA Operators did not work. Resident 37 stated the door was heavy and a pain to use as they needed to pass through in their wheelchair. Resident 37 stated they told the facility of the issue, but it was not yet fixed. Observation on 05/06/2026 at 8:54 am showed Resident 22 sitting in a specialized wheelchair at the front door. Resident 22 entered a code in the keypad and attempted to activate the ADA Operator. The door did not open automatically. Resident 22 attempted to use a second button next to the door and the door did not open automatically. Resident 22 stated they used their wheelchair to physically push the door open, but doing so did not feel safe. Resident 22 stated the ADA Operators did not work for a couple of months. In an interview on 05/06/2026 at 1:15 PM, Staff R (Maintenance Director) stated they began working at the facility in February 2026, and the door/ADA Operators had issues going back further than that. Staff R stated there was a lot of management turnover at that time but in March/April 2026, they and Staff A (Administrator) began seeking bids for repair In an interview on 05/06/2026 at 8:36 AM, Staff A Staff A acknowledged the ADA Operators to the main entrance were not working. Staff A stated there was not dedicated staff responsible to assist residents with mobility issues through the doors while the ADA Operators were broken but either the receptionist or the security officer was in that area for all but four hours of the day. Staff A stated there was not a specific process to assure resident safety while the ADA Operators were inoperative. Staff A stated they had an estimate from a vendor to repair the ADA Operators. Staff A provided emails between the facility and the vendor. Review of the emails between the facility and a vendor discussing the need to repair the ADA Operators showed an estimate was provided on 04/03/2026. The estimate for repair was valid until 05/04/2026. In an interview on 05/06/2026 at 12:15 PM Staff A acknowledged the facility allowed the estimate to lapse to repair the ADA Operators but they discussed the situation again with the vendor that morning and were now waiting for the part(s) to arrive. Staff A stated once the parts were available, repair would be quick. <Resident 40> According to the 01/15/2026 Quarterly MDS, Resident 40's cognitive status was unable to be assessed. The MDS showed Resident 40 had diagnoses including a fracture, inability to control blood sugar levels, and stroke. The MDS showed Resident 40 had impairment to one of their upper extremities and had a fall since their prior assessment. Review of a 12/31/2025 nursing progress note showed nursing staff documented Resident 40 had a fall on 12/31/2025 at 4:00 PM. The resident was walking with their walker and another staff member witnessed Resident 40 start to fall and assisted the resident to the ground. Review of the 12/31/2025 facility's fall investigation report showed the resident was walking with their walker when they felt their feet letting go. The resident was assisted to the ground by a nurse. Resident 40 reported their walker was faulty and that the brakes were not working. The fall investigation did not include documentation showing staff reassessed Resident 40's fall risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 40's evaluations tab on 05/06/2026 showed no documentation staff reassessed Resident 40's risk for falls during the time of the fall on 12/31/2025. In an interview on 05/06/2026 at 11:32 AM, Staff D (Resident Care Manager) stated the facility process was to complete a new fall assessment with each resident fall. Staff D reviewed Resident 40's records and confirmed a fall assessment was not completed after the resident's fall on 12/31/2025. In an interview on 05/06/2026 at 1:15 PM, Staff B (Interim Director of Nursing) reviewed Resident 40's fall investigation and records and confirmed an updated fall assessment was not completed by staff but should be. <Resident 24> According to the 02/13/2026 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 24 had medical conditions including Multiple Sclerosis (a progressive, debilitating disease causing numbness, vision loss, and extreme fatigue), a brain injury with resulting muscle weakness to one side of their body, and memory impairment. The MDS showed Resident 24 had limited range of motion to both their upper and lower extremities and required substantial/maximum staff assistance with bed mobility. The MDS showed Resident 24 was under hospice (end of life) care and a significant change assessment was completed for the resident. The revised 06/18/2024 fall Care Plan (CP) showed safety devices were put in place and a 09/14/2023 intervention instructed the nursing staff to follow the facility's fall protocol. Observation and interview on 04/29/2026 at 1:45 PM showed Resident 24 had their bed against the wall; there were bilateral mobility rails in place and a blue mat was on the floor next to Resident 24's bed. Resident 24 stated they had a fall but could not recall exactly when, and that they were scared of everything around them. Review of the 03/22/2022 fall risk assessment upon Resident 24's admission showed the resident was identified to be high fall risk. The fall risk assessment log showed Resident 24's fall risk was not consistently assessed by the facility; there was no fall risk assessment observed to be completed when Resident 24 had a significant change in condition and was admitted to hospice care on 11/06/2025. Review of the 04/27/2026 investigation report after Resident 24 sustained a fall showed the facility identified the root cause of the resident's fall was from rolling out of their bed during repositioning. Review of the 04/27/2026 safety devices assessment showed the facility did not capture Resident 24's recent history of rolling out of the bed (as the identified root cause of the resident's most recent fall) to consider as a fall risk factor and ensure resident safety. In an interview on 05/05/2026 at 10:02 AM, Staff C (Resident Care Manager) stated they should have captured Resident 24's identified risk factors when completing the resident's 04/27/2026 safety device assessment to prevent reoccurrence of falls, but they did not. In an interview on 05/05/2026 at 2:02 PM, Staff B (Director of Nursing) reviewed Resident 24's fall risk assessments log and stated they were untimely and incomplete. Staff B stated they expected the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing staff to conduct fall assessments per their facility protocol to prevent falls from reoccurring and avoid negative outcomes. <Sharps Container> In an observation on 05/01/2026 at 11:13 AM a sharps container on North Long-Term Care (LTC) nurses' cart was filled past the fill line. In an observation and interview on 05/01/2026 at 11:20 AM Staff B (Director of Nursing) verified the sharps container was over-filled and stated the container should have been changed. Staff B stated the over-full sharps container presented a risk of exposure to used needles and infection control concerns. In an observation on 05/05/2026 at 11:10 AM a sharps container on South LTC nurses' cart was filled past the fill line. In an observation and interview on 05/05/2026 at 11:11 AM Staff Y (Registered Nurse) verified the sharps container was over-filled and stated that the containers are usually changed on night shift. Staff Y stated it was important to change the sharps containers for staff safety as it is important to have a safe place to dispose of used needles. In an observation on 05/05/2026 at 11:15 AM a sharps container on South LTC Nurses' cart was filled past the fill line. In an observation and interview on 05/05/2026 at 11:31 AM Staff L (Registered Nurse) verified the sharps container was over-filled and stated it should be replaced prior to being over-full so that staff can dispose of used needles safely. REFERENCE: WAC 388-97-1060(3)(g).

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all portions of the communication system were functioning and adequately equipped to allow residents to call for staff assistance to a centralized staff work area from each resident's bedside for 2 of 2 nursing units (North Unit and South Unit) and from toileting areas for 2 of 2 first floor bathrooms (Bathrooms 1 & 2) reviewed for call light system. The facility failed to ensure staff responded timely to residents' call lights and the pull cord at each bathroom was accessible to a resident lying on the floor in case of an emergency. These failures placed residents at risk for delayed care, pain or discomfort, and a decreased quality of life.Findings included.<Facility Policy>The undated facility policy titled, Call Lights: Accessibility and Timely Response, showed the facility ensured the call system alerted staff members and channeled to a centralized staff work area. The policy showed the staff would report problems with a call light or the call system immediately to the supervisor and/or maintenance director and would provide immediate or alternative solutions until the problem was remedied or resolved. The policy showed all staff members who saw or heard an activated call light were responsible for responding. The policy showed the call system must be accessible to the resident lying on the floor at each toilet and bath/shower area.<North and South Units>Observation on [DATE] at 8:36 AM showed the audible sound from the call system turned on but the call system panel at the nurse station did not have any resident room lighted up. Hallway observation showed the call light above room [ROOM NUMBER] was up; Staff GG (Registered Nurse) and Staff HH (Certified Nursing Assistant) were observed sitting at the nurse station; both staff looked at the call system panel, did not respond to the audible sound, and proceeded to do their task in the computer. At 9:18 AM, this surveyor approached the nurse station and validated room [ROOM NUMBER]'s call light that remained on for more than half an hour with Staff GG. Staff GG stated the button assigned to room [ROOM NUMBER] from the call light panel was missing and the call system was malfunctioning for months. The call light panel was observed to be missing several buttons dedicated to resident rooms for proper identification and response. Staff GG stated they would notify the maintenance department regarding room [ROOM NUMBER]'s call light that was not working.In an observation and interview on [DATE] at 9:20 AM, Resident 71, who was the resident in room [ROOM NUMBER]-1, stated they turned on their call light because their stomach was hurting. Resident 71 was observed bent over, guarding their abdomen, with facial grimacing, and was catching their breath while talking despite having supplemental oxygen on via a nasal tube. Resident 71 stated it took staff at least half an hour or longer to answer their call light.Observation on [DATE] at 9:10 AM showed the call light above room [ROOM NUMBER] was on but it did not light up or register the resident's call in the panel at the nurse station.Observation on [DATE] at 9:25 AM showed the call light above room [ROOM NUMBER] was on but it did not light up or register the resident's call in the panel at the nurse station.Review of the facility's [DATE] through [DATE] maintenance logs showed: On [DATE], the call light in room [ROOM NUMBER] was reported not working and the response written in the log showed, [Part of] a big project. On [DATE], the call light in room [ROOM NUMBER] was reported not working and the response written in the log showed, Working with vendor. On [DATE], the call light in room [ROOM NUMBER]-2 was reported not working and the response written in the log showed, Vendor. On [DATE], the call light in room [ROOM NUMBER] was reported not working and the response written in the log showed, Vendor. On [DATE], the call light in room [ROOM NUMBER] was reported not working and the response written in the log showed, Vendor. On [DATE], the call light in room [ROOM NUMBER] was reported broken and the response written in the log showed, Replaced call box. On [DATE], the call light in room [ROOM NUMBER]-1 was not working and the response written in the log showed, Vendor. There logs did not show Staff GG reported Resident 71's (room [ROOM NUMBER]-1) malfunctioning call light.Observation and interview on [DATE] at 8:37 AM showed (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 71's call light was still malfunctioning; the light above the room door was blinking faintly and it had a broken, high-pitched audible sound. The call system panel at the nurse station was observed still without a button labeled for room [ROOM NUMBER]. Staff M (Wound Nurse/Infection Preventionist) confirmed room [ROOM NUMBER]'s did not have a dedicated button in the panel and stated the call light system remained defective.In an interview on [DATE] at 8:42 AM, Resident 51 in room [ROOM NUMBER]-1 stated it took longer than 30 to 40 minutes for staff to respond to their call light and the resident referred to the North Hall as a ghost town.In an interview on [DATE] at 8:44 AM, Resident 55 in room [ROOM NUMBER]-2 stated they got used to staff not responding to their call light in a timely manner and highlighted night shift as the worst, .at night, forget it.it would take more than an hour for them [staff] to come.In an interview on [DATE] at 8:49 AM, Resident 35 in room [ROOM NUMBER]-1 stated often they saw staff walk by their room two to three times after turning on their call light, but staff would not come in to help them. Resident 35 stated, at one point, they asked their roommate in bed two to turn on the call light from their side of the room because they felt their call light was not working. Resident 35 stated it was difficult for them when staff did not respond timely especially when they were in pain, needed water for hydration, or had bladder discomfort and needed staff to check their urinary catheter.In an observation and interview on [DATE] at 8:59 AM, Staff KK (Medical Records Coordinator), who was observed at the nurse station, confirmed the panel's buttons for rooms [ROOM NUMBERS] did not light up to alert the staff. Staff KK stated the call light malfunction was not ideal and posed as a safety risk for residents.In an interview on [DATE] at 9:13 AM, Staff HH stated it was important to have a functional communication system because it helped them respond faster to residents in need especially during emergent cases such as a fall. Staff HH stated both ends of the North Hall turn around the corner and it was difficult for staff to see the light above the door of those resident rooms. Staff HH stated the audible sound produced when a call light was turned on could come from either the North or South Hall, so it was challenging when buttons on the panel assigned specifically to a resident's room were not working.In an interview on [DATE] at 10:10 AM, Staff R (Maintenance Director) stated vendor meant the call light malfunction was irreparable at their level and required a third-party vendor to fix it. Staff R stated the staff notified them of resident care-related work orders by writing the concern(s) identified in the maintenance log binder located at the South Hall nurse station. Staff R reviewed the maintenance logs and stated there was no call light work order request for room [ROOM NUMBER].In an interview on [DATE] at 10:32 AM, Staff A (Administrator) stated they were aware the facility's call system was malfunctioning and needed repair or replacement.<First Floor Bathrooms 1 & 2>Observation on [DATE] at 10:08 AM showed both bathrooms located on the first floor were locked and did not have a door handle from either the inside or outside. The call light pull cords attached to the metal plate on the wall sticking out was observed to be about half an inch long for both bathrooms.In an interview on [DATE] at 1:19 PM, Resident 47 stated staff instructed them to use the bathroom in their room because the main floor restrooms were for staff and visitors only. Resident 47 stated this negatively impacted their ability to comfortably attend meals and activities on the main floor because they were required to return to their room for bathroom use.In an interview on [DATE] at 11:20 AM, Staff G (Administrator In-Training) stated residents could not use the main floor restrooms due to non-functional call lights creating a safety risk.In an interview on [DATE] at 9:44 AM, Staff A stated the residents were allowed to use the first floor bathrooms. Staff A stated both bathrooms were kept locked since the call light system inside was malfunctioning. Staff A stated the call light pull strings observed from both bathrooms were not accessible to a resident lying on the floor as required.Refer to F584- Safe/Clean/Comfortable/Homelike Environment.REFERENCE: WAC 388-97-2280(1)(a).