

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2026
NAME OF PROVIDER OR SUPPLIER Auburn Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and record review, the facility failed to ensure the kitchen environment was sanitary and the meal service followed the requirements in accordance with professional standards of food safety for 1 of 1 facility kitchen observed. The failure to ensure: (1) the kitchen ceiling was kept clean and intact; (2) cabinets had working doors and drawers; (3) garbage/trash receptacle had a lid or was covered; and (4) proper food handling practice was observed to avoid cross-contamination placed residents at risk for ingesting unsafe and/or contaminated food and the development of foodborne illness. Findings included <Facility Policy>The facility policy titled, Food Preparation and Service, revised April 2019, showed food and nutrition services staff prepared and served food in a manner that complied with safe food handling practices to prevent the spread of foodborne illness. The policy showed appropriate measures were used to prevent cross-contamination including wearing gloves when handling food directly and changing them between tasks. <Kitchen Ceiling Panel>Observation on 04/29/2026 at 8:20 AM showed the kitchen ceiling panels above the dishwasher area had dry, brown-stained water marks. A panel was observed missing which exposed mechanical drains and pipes covered with dust build-up and spider webs. There were clean/sanitized kitchen utensils in dish trays from the dishwasher below the exposed ceiling. In an interview on 04/29/2026 at 8:22 AM, Staff V (Dietary Supervisor) stated the maintenance department fixed a leaking pipe in the ceiling at one point but did not put the panel back. Staff V stated the ceiling should be covered for sanitation purposes. <Non-Closing Cabinet Drawers And Doors>Observation on 04/29/2026 at 8:44 AM showed multiple kitchen cabinets that contained clean utensils used for food preparation and service had drawers and doors that did not fully close. The drawers and doors had failed magnetic locks and worn-out drawer tracks. In an interview on 04/29/2026 at 8:47 AM, Staff V stated that they notified both administration and the maintenance department regarding the status of the kitchen cabinets. Staff V stated it was important for the kitchen cabinets to be in good working condition to ensure equipment and utensils stored inside them remained clean and free from any contamination. <Food Waste Disposal Equipment/Garbage Bins>Observation and interview on 04/29/2026 at 8:54 AM showed multiple scattered chunks of food waste/debris along the dishwashing area; two bins were half-filled with food scraps and garbage. The two bins were observed without a cover/lid. Staff X (Kitchen Cook) stated the kitchen's food waste disposal unit was not working so all food scraps were physically thrown in garbage bins. Staff X stated the bins should be covered for sanitation purposes and to avoid the risk of contaminating clean dishes/utensils. In an interview on 04/29/2026 at 9:01 AM, Staff V stated the food waste disposal unit was broken for months and the administration was aware of its condition. Staff V stated, We [kitchen staff] need to be sanitary with all our processes at all times. <Tray Line Meal Service>Observation on 05/05/2026 at 12:13 PM during lunch service showed Staff W (Kitchen Cook) sliced the chicken using (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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure and designate a qualified staff person to serve as an Infection Preventionist (IP). This failure placed residents at risk for unmet infection control issues and prevented a lack of oversight of the facility staff's infection control practices. Findings included. In an interview on 05/05/2026 at 1:07 PM, Staff M (Wound Nurse/Infection Preventionist) stated they were the current IP for the facility and had held the IP position for a week. Staff M stated the previous IP recently left the position and the facility was working to hire a permanent person. Staff M stated they did not have the required infection prevention and control certification. In an interview on 05/06/2026 at 10:00 AM, Staff B (Interim Director of Nursing) confirmed they had oversight over the IP role. Staff B confirmed Staff M did not have the required infection prevention and control certification. Refer to F880 &ndash; Infection Prevention and Control Refer to F881 &ndash; Antibiotic Stewardship Program Reference: (WAC) 388-97--1620(2)(b)(i)(ii).		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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).		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents were provided a safe, homelike environment for 2 of 2 units (North Unit and South Unit) and safe accessible use of 2 of 2 bathrooms (first floor public bathrooms 1 & 2). The failure to ensure resident rooms were free of wall scrapes, floor thresholds, broken window blinds, unpleasant stains, and safe accessible bathrooms placed residents at risk for a less than homelike environment and a diminished quality of life. Findings included .<Facility Policy>According to the facility's undated Safe and Homelike Environment policy, the facility would provide a safe, clean, comfortable, and homelike environment in good repair to maximize resident comfort and independence. <North Unit> Observation and interview on 04/29/2026 at 10:51 AM showed Resident 15's room blinds had broken slats. Resident 15 stated it had affected their sleep quality since the actual break was at their eye-level when lying in bed. In an interview on 05/06/2026 at 12:03 PM Staff R (Maintenance Director) identified the broken blinds and stated they should be replaced. <South Unit> Observation on 04/29/2026 at 10:00 AM showed a dark stain covering two ceiling tiles above Resident 6's window. In an interview at that time, Resident 6 stated they had a leak in their ceiling. Observation on 04/30/2026 at 10:30 AM showed missing flooring thresholds between the hallway and resident rooms #245 and #247. Push levers were missing from wall-mounted hand sanitizer dispensers across from the second-floor elevator and inside room [ROOM NUMBER]. Observation on 05/01/2026 at 10:17 AM showed the staining on the ceiling tiles remained. In an observation and interview on 05/06/2026 at 12:05 PM, Staff R stated they were aware of the stained ceiling tiles and stated there was a previous leak in the ceiling that was repaired. Staff R confirmed the ceiling tiles should be replaced. Staff R stated they expected staff to document daily repair needs in the maintenance log binder located at the nursing station. Staff R stated they toured the facility daily and addressed repair needs listed in each unit binder. After touring the facility, Staff R stated the missing door thresholds and broken hand sanitizer dispensers should be identified by nursing staff and entered in the maintenance log binder but were not. In an interview on 05/06/2026 at 12:35 PM Staff B (Interim Director of Nursing) stated they expected nursing staff to identify and list repair needs in the unit maintenance binder. Staff B stated this ensured timely correction of environmental concerns and maintained a safe, functional, and homelike environment for residents. <Bathrooms 1 & 2> (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of 05/01/2026 at 12:16 PM showed the emergency pull cords were missing from the wall mounted call light devices in bathrooms #1 and #2 on the main floor. In an interview on 05/04/2026 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 05/05/2026 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 05/06/2026 at 1:09 PM Staff S (Receptionist) stated leadership instructed staff that the main floor bathrooms were unavailable to residents due to excessive resident use resulting in decreased availability to staff and visitors. During an observation and interview on 05/06/2026 at 1:11 PM Staff A (Administrator) stated the main floor bathrooms were available to all residents. Call light pull cords were absent in both bathrooms. Staff A tested the call lights by activating the wall switch, which illuminated a ceiling light outside the bathroom; however, no audible alarm sounded. Call lights identified as R11 and R12 illuminated on the second-floor nurse call panel but were not clearly audible on the panel or in the bathroom area. Refer to F919- Call Lights. REFERENCE: WAC 388-97-0880.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the required discharge process for 3 of 6 residents (Residents 84, 55, & 8) reviewed for hospitalizations. The failure to inform residents of the facility's bed hold (a process by which a resident can pay a daily rate to ensure they can return to the same bed when they readmit) policy placed residents at risk for losing their right to return to their bad and frustration. Findings included .<Facility Policy>According to the facility's 04/28/2025 Bed Hold Notice policy, the facility would provide residents and/or their representative with a bed hold notice as soon as practical for emergent discharges and at the time of therapeutic leave for scheduled procedures. The policy showed residents could choose to pay a daily rate if they wished to ensure they returned to the bed they had prior.<Resident 84> In an interview on 04/29/2026 at 1:47 PM, Resident 84 stated they recently needed to go out to hospital unexpectedly but did not recall the reason why or when they went out. Resident 84 stated they did not recall if they were informed of the facility's bed hold policy at that time. According to a 02/19/2026 progress note, Resident 84 went to the hospital on [DATE]. A 02/23/2026 progress note showed Resident 84 returned to the facility on [DATE]. Record review showed no progress note or any other documentation indicating the facility discussed their bed hold policy with Resident 84 as required. In an interview on 05/06/2026 at 12:44 PM, Staff C (Resident Care Manager) stated there was an issue with bed holds at the time the resident went to the hospital and it was likely this process did not occur for Resident 84. Staff C stated they would provide any documentation showing the bed hold policy was reviewed with Resident 84. No further documentation was provided. <Resident 55> In an interview on 04/30/2026 at 9:55 AM, Resident 55 stated they were hospitalized for a surgery and did not recall being offered a bed hold. According to a 01/29/2026 Interdisciplinary progress note, Resident 55 went to the hospital on [DATE] for a surgery and was expected to return to the facility the following week. A 02/23/2026 progress note showed Resident 55 returned to the facility. Record review showed no progress note or any other documentation indicating the facility discussed their bed hold policy with Resident 55 as required. In an interview on 05/06/2026 at 12:39 PM, Staff C stated they would provide any documentation showing the bed hold policy was reviewed with Resident 55. No further documentation was provided. <Resident 8> (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 02/08/2026 Discharge Minimum Data Set (MDS &ndash; an assessment tool) showed Resident 8 discharged to a short-term general hospital. The MDS showed Resident 8 had memory problems and impaired daily decision-making. A 02/13/2026 Entry Tracker MDS showed Resident 8 was admitted back to the facility. Review of Resident 8's medical records showed the resident's family member was delegated as the Durable Power of Attorney (DPOA) for Financial/Healthcare. In an interview on 04/29/2026 at 2:23 PM, Resident 8 stated they remember being sent to the hospital from the facility but could not recall exactly when. Resident 8 stated they did not know if their DPOA was informed of the facility's bed hold policy. According to a 02/08/2026 progress note, Resident 8 was observed very weak, sluggish, and with delayed responses. The note showed the staff notified the physician and received the order to send Resident 8 to the emergency department for further evaluation. In an interview on 05/06/2026 at 1:05 PM, Staff F (Social Services) stated the nursing staff on the floor was responsible for the bed hold policy notification. Staff F stated the admissions coordinator would follow up if the bed hold notification was not done onsite such as during an emergent hospital transfer/discharge. In an interview on 05/06/2026 at 2:36 PM, Staff C (Resident Care Manager) confirmed the nurses on the floor were responsible for offering the bed hold policy to residents and/or their representative(s). Staff C stated a bed hold notification was important because it was a resident's right to be informed and it was necessary for financial decision-making. Staff C reviewed Resident 8's medical records and stated there was no documentation found to support a bed hold was offered to Resident 8 or their DPOA. REFERENCE: WAC 388-97-0140(1)(a)-(c)(i)-(iii).		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete resident assessments within the regulatory timeframes for 10 of 14 residents (Residents 15, 84, 18, 11, 2, 35, 38, 44, 55, & 6) reviewed for comprehensive assessments and timing. The failure to ensure comprehensive admission and Annual Minimum Data Set (MDS - an assessment tool) assessments were completed timely delayed the residents' care planning process necessary to provide the appropriate care and services, and placed residents at risk for unidentified care needs, delayed services, and a decreased quality of life. Findings included. <Facility Policy>The undated facility policy titled, MDS 3.0 Completion, showed residents were assessed using a comprehensive assessment process in order to identify care needs and to develop an interdisciplinary Care Plan (CP). The policy showed an admission MDS was completed within 14 days of admission, counting the day of admission as day #1. <Resident Assessment Instrument (RAI - instructional guidelines for MDS completion) Manual>The October 2023 RAI Manual outlined an Annual MDS was a comprehensive assessment for a resident and must be completed on an annual basis. The manual showed the completion date of an Annual MDS must be no later than 14 days after the Assessment Reference Date. <Resident 15>Review of Resident 15's 02/14/2026 admission MDS showed the resident admitted to the facility on [DATE]. The assessment showed the Registered Nurse (RN) Coordinator completed the assessment on 03/03/2026, nine days past the required regulatory timeframe. <Resident 84>Review of Resident 84's 02/06/2026 Annual MDS showed the RN Coordinator completed the assessment on 02/28/2026, nine days past the required regulatory timeframe. <Resident 18>Review of Resident 18's 12/20/2025 admission MDS showed the resident admitted to the facility on [DATE]. The assessment showed the RN Coordinator completed the assessment on 01/03/2026, five days past the required regulatory timeframe. <Resident 11>Review of Resident 11's 12/22/2025 admission MDS showed the resident admitted to the facility on [DATE]. The assessment showed the RN Coordinator completed the assessment on 01/06/2026, eight days past the required regulatory timeframe. <Resident 2>Review of Resident 2's 12/19/2026 Annual MDS showed the RN Coordinator completed the assessment on 01/02/2026, one day past the required regulatory timeframe. <Resident 35>Review of Resident 35's 01/10/2026 Annual MDS showed the RN Coordinator completed the assessment on 01/30/2026, seven days past the required regulatory timeframe. <Resident 38>Review of Resident 38's 01/21/2026 Annual MDS showed the RN Coordinator completed the assessment on 02/09/2026, six days past the required regulatory timeframe. <Resident 44>Review of Resident 44's 02/02/2026 admission MDS showed the resident admitted to the facility on [DATE]. The assessment showed the RN Coordinator completed the assessment on 02/22/2026, seven days past the required regulatory timeframe. <Resident 55>Review of Resident 55's 01/09/2026 Annual MDS showed the RN Coordinator completed the assessment on 01/30/2026, eight days past the required regulatory timeframe. <Resident 6>Review of Resident 6's 02/04/2026 Annual MDS showed the RN Coordinator completed the assessment on 02/22/2026, five days past the required regulatory timeframe. In an interview on 05/05/2026 at 7:50 AM, Staff O (MDS Nurse) stated they use the RAI manual as their guide in completing MDS assessments. Staff O stated it was important to ensure comprehensive resident assessments were completed timely because it was a federal regulatory requirement for Nursing Homes. Staff O stated timely MDS completion allowed the interdisciplinary team to catch significant changes in residents necessary for care planning. Staff O stated the CP derived from these (continued on next page)		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments should reflect the resident's current and actual state or condition so the nursing staff could provide safe and appropriate care. Staff O verified the comprehensive assessments of Residents' 15, 84, 18, 11, 2, 35, 38, 44, 55, & 6 and stated they were all completed late. In an interview on 05/05/2026 at 7:58 AM, Staff B (Director of Nursing) stated they expected the RN Coordinator to complete comprehensive MDS assessments timely as required. REFERENCE: WAC 388-97-1000(1)(b)(c)(ii)(d), (3)(a).		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to ensure Care Plans (CPs) were developed and implemented as required for 5 of 19 sample residents (Residents 35, 55, 15, 9, & 48) whose CPs were reviewed. The failure to ensure CPs were comprehensive, resident-specific, and implemented placed residents at risk for unmet care needs, inappropriate care, and frustration. Findings included .<Facility Policy>According to the facility's undated Comprehensive CP policy, the facility would develop and implement a comprehensive, person-centered CP for each resident to meet each resident's medical, nursing, mental, and psychosocial needs and all services needed. <Resident 35> According to the 04/10/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool) Resident 35 had diagnoses including a history of stroke, a nerve condition making bladder control more difficult, and a blockage in their urinary tract making voiding more difficult. The MDS showed Resident 35 required an indwelling urinary catheter (tubing to assist with urinary drainage). The MDS showed Resident 35 needed partial assistance with toileting. Record review showed a 04/29/2026 order to change Resident 35's catheter as needed. Observation on 04/29/2026 10:51 AM showed Resident 35 in bed with their catheter hung on their bed frame. At that time Resident 35 stated they needed more consistent catheter care, including emptying their catheter. Review of the 01/27/2026 Catheter CP showed no directions were included to assist Resident 35 to empty their catheter. Review of Resident 35's Kardex as of 04/29/2026 (care instructions for nurses' aides) showed no directions were included to Resident 35's catheter. In an interview on 05/05/2026 at 11:18 AM Staff C (Resident Care Manager) stated it was nurses' aides' responsibility to empty Resident 35's catheter. Staff C stated directions to empty the catheter bag should be on the CP and Kardex. <Resident 55> According to the 02/06/2026 Quarterly MDS, Resident 55 was dependent on staff for toileting assistance and was always incontinent of bowel. In an observation and interview on 04/30/2026 at 9:20 AM, Resident 55 stated they frequently had diarrhea. At that time, Resident 55 was observed in bed with both legs amputated and their bed raised in a high position. Record review showed Resident 55 had a 04/11/2024 physician's order for a probiotic supplement. This order indicated the probiotic should be taken twice a day for diarrhea. Review of Resident 55's CP showed no CP developed to address Resident 55's diarrhea and probiotic (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supplement use. The only mention of diarrhea in the CP was as a potential side effect of a medication used to treat a different condition. In an interview on 05/06/2026 at 2:38 PM Staff B (Director of Nursing) stated the purpose of a CP was to ensure the appropriate care was provided to residents for their wellbeing and safety. Staff B stated it was important for CPs to address all residents' treatment needs. Staff B stated they expected CPs to comprehensively address residents' care needs. <Resident 15> According to the 02/14/2026 admission MDS, Resident 15 had clear speech, intact memory, and medical conditions including the loss of bladder control and with limited range of motion to their extremities. The MDS showed Resident 15 had an indwelling urinary catheter in place during the assessment period. The MDS showed Resident 15 was assessed to require substantial/maximum assistance with their personal hygiene including shaving. The 04/29/2026 urinary catheter CP showed a privacy cover would be used to ensure Resident 15's dignity. Observation on 04/30/2026 at 9:38 AM showed Resident 15's catheter bag was hanging from the garbage can next to the bed, halfway full, and without a privacy cover as care planned. The revised 04/20/2026 Activities of Daily Living (ADL) CP showed Resident 15 had self-care performance deficits because of functional/mobility impairment, limited range of motion, and pain. The CP directed staff to provide Resident 15 one-person physical assistance with their personal hygiene and grooming needs. Observation on 04/29/2026 at 10:32 AM showed Resident 15 had matted and unruly hair; their beard and mustache were observed long and with several white debris woven in from the resident's dry, peeling facial skin. Resident 15 stated the staff did not provide them any assistance with their grooming/personal hygiene as care planned. In an interview on 05/06/2026 at 11:17 AM, Staff B stated following the CP was important because it ensured the staff understood residents' condition/status as a whole to be able to properly and safely care for them. Staff B stated they expected all staff to implement the interventions listed in the CP. <Resident 9> According to the 03/24/2026 Quarterly MDS, Resident 9 primarily spoke Vietnamese language, was rarely understood by others, and had medical conditions including weakness, joint pain, and memory impairment. The MDS showed Resident 9 was assessed to require moderate to maximum staff assistance with dressing. The revised 04/17/2026 ADL CP showed Resident 9 had self-care performance deficit because of their functional/mobility deficits and directed staff to provide the resident one-person physical (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with their dressing/undressing needs. Observations on 04/29/2026 at 1:50 PM and 04/30/2026 at 8:21 AM showed Resident 9 was wearing the same yellow t-shirt and was not provided staff assistance with dressing/changing their clothes as care planned. Observations on 04/30/2026 at 8:49 AM and 05/01/2026 at 12:26 PM showed Resident 9 was wearing the same brown, long-sleeved top and was not provided staff assistance with dressing/changing their clothes as care planned. In an interview on 05/01/2026 at 12:42 PM, Staff C stated they expected the nursing staff to implement interventions identified for residents when providing ADL care according to the CP. <Resident 48> According to a 12/19/2025 Quarterly MDS, Resident 48 admitted to the facility on [DATE] with medical conditions including a progressive brain disease with memory deficits, high blood pressure, and malnutrition. The MDS showed Resident 48 needed substantial/maximal assistance with rolling from left to right, from sitting to standing, and with transfers. The MDS showed Resident 48 was assessed to be at risk for developing pressure ulcers/injuries. Review of the revised 03/11/2026 skin CP showed Resident 48 was at risk for skin breakdown because of their fragile skin. A 11/12/2026 CP intervention instructed staff to encourage and assist Resident 48 with repositioning for comfort and pressure relief. In a continuous observation on 05/01/2026 at 7:40 AM, Resident 48 was seen sitting in their tilt-in-space wheelchair (a mobility device with the ability to recline), tilted back at an 80-degree angle in the hallway outside the resident's room. From 7:42 AM until 8:36 AM, Resident 48 was observed eating their breakfast while sitting in their wheelchair in the hallway outside their room. At 8:37 AM immediately following breakfast, Resident 48 was toured around the facility in their wheelchair by a staff; Resident 40 remained sitting at an 80-degree angle in their wheelchair. From 8:40 AM until 8:52 AM, Resident 48 sat in their tilt-in-space wheelchair in the hallway outside their room and remained in the same position. At 8:53 AM, Resident 48 was offered to go to activities and was brought to a waiting area by the facility elevator. At 9:47 AM, Resident 48 was still sitting by the elevator waiting for a staff member to take them to activities. At 9:50 AM, a staff came and brought Resident 48 to activities. From 9:50 AM until 10:10 AM, while in activities, Resident 48 kept the same position while sitting in their wheelchair. At this time, more than two hours had passed from 7:40 AM to 10:10 AM where Resident 48 remained sitting in their wheelchair in the same position and there was no staff observed encouraging or offering the resident any pressure relief intervention or repositioning assistance as care planned. In an interview on 05/01/2026 at 11:42 AM, Staff Z (Certified Nursing Assistant) stated Resident 48 should be repositioned every two hours to prevent skin breakdown. In an interview on 05/06/2026 at 10:19 AM, Staff C stated they expected the staff to follow resident (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CPs. Staff C stated Resident 48 should have been offered repositioning assistance every two hours as part of the facility's standards of care for dependent residents, but was not. In an interview on 05/06/2026 at 1:30 PM, Staff B stated it was important to encourage and offer repositioning assistance to residents who could not do it independently to provide comfort and prevent skin breakdown. Refer to F677- ADL Care Provided for Dependent Residents. Refer to F690- Bowel/Bladder Incontinence, Catheter, UTI. REFERENCE: WAC 388-97-1020(1)(2)(a)(b).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were dependent on facility staff for assistance with Activities of Daily Living (ADLs) received the assistance they were assessed to require for 3 of 5 residents (Residents 9, 15, &1) reviewed for ADLs. The failure to provide dressing assistance (Resident 9) and personal hygiene/grooming needs (Residents 15 & 1) left residents at risk for body odors, unmet care needs, diminished feeling of self-worth, and a decreased quality of life. Findings included .<Resident 9> According to the 03/24/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool), Resident 9 primarily spoke Vietnamese language, was rarely understood by others, and had medical conditions including weakness, joint pain, and memory impairment. The MDS showed Resident 9 was assessed to require moderate to maximum staff assistance with dressing. The revised 04/17/2026 ADL Care Plan (CP) showed Resident 9 had self-care performance deficits because of functional and mobility impairment. The CP directed staff to provide Resident 9 one-person physical assistance with their dressing and undressing needs. Observation on 04/29/2026 at 1:50 PM showed Resident 9 was observed in their room lying in bed and wearing a yellow t-shirt. Observation on 04/30/2026 at 8:21 AM showed Resident 9 was observed in their room sitting up in the wheelchair while eating breakfast; the resident was still wearing the same yellow t-shirt observed from the day before. At 8:49 AM, Staff J (Certified Nursing Assistant - CNA) came to the room, changed Resident 9's yellow t-shirt to a brown, long-sleeved top with black print, and wheeled the resident out of the room. Observation and interview on 05/01/2026 at 12:26 PM showed Resident 9 was touring the first floor main dining area in their wheelchair with Staff MM (CNA). Resident 9 was observed still wearing the brown, long-sleeved top with black print from the day before. Staff MM stated they were the morning shift staff assigned to Resident 9. Staff MM stated they did not change Resident 9's clothes when they got the resident up from bed. In an interview on 05/01/2026 at 12:42 PM, Staff C (Resident Care Manager) stated it was important to provide dependent residents' ADL assistance to enhance their sense of dignity and quality of life. Staff C stated they expected the nursing staff to provide Resident 9 morning and evening care, which included changing the resident's clothing, to ensure the resident felt clean and comfortable. <Resident 15> According to the 02/14/2026 admission MDS, Resident 15 had clear speech and intact memory. The MDS showed Resident 12 had medical conditions including a motor vehicle accident resulting in their inability to voluntarily move or feel the lower parts of their body. The MDS showed Resident 15 was assessed to require substantial/maximum assistance with their personal hygiene including shaving. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The revised 04/20/2026 ADL CP showed Resident 15 had self-care performance deficits because of functional/mobility impairment, limited range of motion, and pain. The CP directed staff to provide Resident 15 one-person physical assistance with their personal hygiene needs. Observation and interview on 04/29/2026 at 10:32 AM showed Resident 15 had matted and disheveled hair; their beard and mustache were observed long and with several white debris woven in from the resident's dry, peeling facial skin. Resident 15 stated, I feel like a caveman. Resident 15 stated they need staff assistance to help them shave their beard and mustache safely. Resident 15 stated they wanted a haircut badly. Observations on 04/30/2026 at 1:04 PM and 05/01/2026 at 1:05 PM showed Resident 15 remained with unkempt hair, and long beard and mustache. In an interview on 05/01/2026 at 1:30 PM, Staff HH (CNA) confirmed Resident 15 needed personal hygiene assistance with shaving their beard and mustache. Staff HH stated the facility's shower aide was responsible for shaving residents (as residents would allow) during bath days. In an interview on 05/01/2026 at 1:55 PM, Staff A (Administrator) stated the activities department was in charge of scheduling outside services for residents who wanted a haircut because they used to, but did not have salon services in-house at the moment. In an interview on 05/04/2026 at 10:31 AM, Staff C validated Resident 15's ADL care concerns and stated they expected the nursing staff to provide residents personal hygiene and grooming assistance they were assessed to require for safety. <Resident 1> According to the 04/02/2026 Quarterly MDS, Resident 1 admitted to the facility on [DATE] and had medical conditions including heart failure and history of a stroke. The MDS showed Resident 1 required substantial/maximal assistance with personal hygiene including combing their hair and shaving. Review of Resident 1's 06/27/2025 ADL CP showed the resident had self-care deficits and required one person physical assistance for personal hygiene. The CP did not show if the resident preferred to keep their hair or facial hair short or long. In an interview and observation on 04/29/2026 at 1:50 PM, Resident 1 was lying in bed in a hospital gown. Resident 1's hair was observed to be greasy, long, and unkempt and their beard extended several inches past their chin. Resident 1 stated they would like to get a haircut and did not have a haircut since their admission to the facility, nearly one year ago. Observation on 05/04/2026 at 8:35 AM showed the facility had a designated barber shop area. A clipboard hanging on the wall showed a list of residents who wished to have barber shop services. The list was dated 02/13/2026 and Resident 1's name was not listed. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/05/2026 at 9:11 AM, Staff II (CNA) stated the facility used to have a beautician, but they left a while ago. Staff II stated they were not sure what the facility's process was currently for when a resident wanted a haircut. In an interview on 05/06/2026 at 1:15 PM, Staff A stated the facility did not have a barber since 02/2026 and that the facility was working to hire someone. Staff A stated they did not have anyone in the facility providing haircuts but they should assist residents to get their haircut outside of the facility when appropriate. In an interview on 05/06/2026 at 1:22 PM, Staff JJ (Activities Supervisor) stated they were working to hire someone to perform haircuts at the facility. Staff JJ stated the facility did not have a current process for coordinating or tracking which residents wanted a haircut. Refer to F656- Develop/Implement Comprehensive Care Plan. REFERENCE: WAC 388-97-1060(2)(c).		

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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 there 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 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. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 &ndash; 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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility failed to ensure urinary catheters were maintained according to professional standards of nursing (tubing used to facilitate bladder drainage) for 2 of 3 residents (Residents 35 & 15) reviewed for urinary catheter. The failure to ensure catheter bags were placed correctly and emptied as needed placed residents at risk for infection, discomfort, and other negative health outcomes. Findings included .<Facility Policy>According to the facility's 03/03/2025 Catheter Care policy, the facility would ensure residents with indwelling catheters received appropriate catheter care. The policy showed catheter bags should be emptied when half full. The policy showed catheter bags should be kept below bladder level to prevent backflow but did not discuss if it was acceptable for the catheter bag to be placed on the floor.<Resident 35> According to the 04/10/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool) Resident 35 had diagnoses including a history of stroke, a nerve condition making bladder control more difficult, and a blockage in their urinary tract making voiding more difficult. The MDS showed Resident 35 required an indwelling urinary catheter. Recorded review showed the following physician orders related to Resident 35's catheter care: a 04/29/2026 order to change the indwelling catheter and drainage bag as needed for blockages, soiling, and dysfunction; a 01/02/2025 order to change Resident 35's catheter dressing daily and keep the tubing secured with to their leg or thigh at all times, and ensure the catheter tubing did not pull from Resident 35's body. According to the 01/27/2026 catheter Care Plan (CP) Resident 35 had goals to be free of urinary infections and catheter-related trauma. The CP showed nursing staff should check for kinks and monitor Resident 35 for pain and discomfort. The CP did not direct nursing staff to empty the catheter bag either periodically or as needed, or to ensure the catheter bag remained off the floor. Record Review showed Resident 35's Kardex (resident-specific care directions for nurses' aides) as of 04/29/2026 did not include instructions to empty the catheter or ensure it did not lie on the floor. In an interview on 04/29/2026 at 10:51 AM Resident 35 stated they had a concern with the catheter care provided by the nursing staff. Resident 35 stated their concern was the frequency the catheter bag was emptied by staff and the associated health risks. At that time Resident 35's catheter was suspended above the floor with a hook on the bedframe and was mostly empty. Observation on 05/01/2026 at 1:47 PM showed Resident 35's catheter bag was completely full with eight inches of urine visible in the tubing connected to the top of the bag. The bag was not hung on the bedframe with a hook and rested on the floor beneath the resident's bed. Observation on 05/04/2026 at 10:01 AM showed the catheter bag was resting on the floor. At 10:03 AM, a nurses aide came to assist Resident 35 in bed and did not notice the catheter bag on the floor. On 05/04/2026 11:52 AM catheter bag was still not hooked to the bed and was placed on the floor and (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was again observed on the floor at 12:36 PM. In an interview on 05/05/2026 at 7:55 AM, Resident 35 stated there could be an issue with the catheter bag as a staff member told them yesterday there was urine on the floor. Observation on 05/05/2026 at 10:41 AM showed Resident 35's catheter bag was again on the floor. In an interview on 05/2026 at 11:18 AM, Staff D (Resident Care Manager - RCM) stated Resident 35 was at risk for Urinary Tract Infection (UTI) due to their indwelling catheter status. Staff D stated catheter bags should be emptied before they became completely full and before urine backed into the tubing for infection control purposes and to minimize the risk of UTI. Staff D stated nursing aides should complete these tasks. At this time Staff C (RCM) stated directions to empty the catheter bad should be included on the Kardex and CP and stated that catheter bags should be hung and not resting on the floor. In an interview on 05/06/2026 at 2:38 PM, Staff B (Director of Nursing) stated they expected catheter bags to be kept off the floor for infection control reasons. <Resident 15> According to the 02/14/2026 admission MDS, Resident 15 had medical conditions including loss of function/mobility from their waist down to their feet, loss of bladder control, urinary retention, and recurrent Urinary Tract Infection (UTI). The MDS showed Resident 15 had an indwelling urinary catheter in place during the assessment period. The 04/29/2026 urinary catheter CP showed a privacy cover would be used to ensure Resident 15's dignity. Review of Resident 15's physician orders showed a 04/14/2026 order directing staff to empty the catheter bag every shift four times a day because the resident was at high risk for UTI. The order showed the staff must ensure Resident 15's catheter bag was emptied without exception. Observation and interview on 04/30/2026 at 9:38 AM showed Resident 15's catheter bag was hanging from the garbage can next to the bed, halfway full, and without a privacy cover. Resident 15 stated there were several instances where their catheter bag would be full and the staff did not empty it as they should. Resident 15 stated they had to call staff for their catheter bag to be emptied. Observation on 05/04/2026 at 10:13 AM showed Resident 15's catheter bag was full and sitting on the floor next to the bed, still without a privacy cover in place. In an interview on 05/04/2026 at 10:15 AM, Staff GG (Registered Nurse) verified Resident 15's catheter bag was full, sitting on the floor, and without a privacy cover. Staff GG stated nursing staff should have emptied the catheter bag, kept it off the floor, and put it inside a privacy bag but they did not. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/04/2026 at 10:22 AM, Staff C (RCM) stated they expected the nursing staff to empty Resident 15's urinary catheter bag as ordered, ensure it was not left sitting on the floor for infection control, and provide a privacy cover/bag for resident dignity. Refer to F656- Develop/Implement Comprehensive Care Plan. REFERENCE: WAC 388-97-1060(3)(c).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure narcotic logs were maintained in a manner which preserved original documentation and accurate controlled substance accounting for 1 resident (Resident 18), ensure expired medications were discarded timely and refrigerator temperatures were logged for 1 of 1 medication storage rooms (Medicare Medication Room) and 2 of 4 medication carts (Long term care south medication cart and Medicare south medication cart) reviewed for medication storage, and failed to ensure the treatment cart was secured for 1 of 1 treatment carts. This failure placed residents at risk of receiving incorrect or expired medications, ineffective treatment, and diminished quality of life. Finding included. <Facility Policy> According to the facility's undated Medication Storage policy the facility would store all drugs and biologicals in a locked compartment, ensure only authorized personnel had access to locked compartments, and store all medications according to manufacturer's recommendations. The facility would maintain controlled substance accounting in an accurate, legible, and traceable manner. This policy showed all medications requiring refrigeration were stored in the refrigerator and temperatures would be maintained within 36-46 degrees Fahrenheit. The policy showed charts would be kept on each refrigerator and temperatures would be recorded daily by the charge nurse or other designee. The policy showed all medication rooms were routinely inspected for discontinued, outdated, defective, or deteriorated medication and these medications would be destroyed. <Narcotic Log> According to the 03/22/2026 Quarterly Minimum Data Set, Resident 18 had diagnoses of chronic pain. Review of the archived January/February 2026 Narcotic Ledger for Resident 18 on page 109 showed the medication label for a liquid opioid indicated a starting quantity of 400 milliliter (mL). On 02/15/2026 at 9:00 AM, Staff E (Charge Nurse Licensed Practical Nurse - LPN) documented administration of 18 mL with 10 mL remaining. On 02/16/2026 at 7:10 AM, Staff NN (LPN) documented administration of 18 mL and wrote count corrected leaving 15 mL written directly over the original remaining quantity in darker, thicker handwriting, obscuring the initial entry rather than correcting it with a single-line strike-through. The correction signatures included Staff NN and a second signature that could not be identified from the ledger signature page. Directly below, the word discard was documented with 0 mL remaining. Review of the Disposition of Unused Medication section at the bottom of page 109 showed Staff D (Residential Care Manager) and Staff E documented disposal of 15 mL into a drug buster (a medication disposal container). Review of the February 2026 Medication Administration Record (MAR) showed Resident 18 was ordered to receive 18 mL of the narcotic daily. Staff NN documented administration on 02/16/2026 and that the resident refused the narcotic on 02/17/2026. No progress notes detailing the administration discrepancy, count correction, or refusal were documented in the medical record. In an interview on 05/05/2026 at 9:14 AM with Staff D and Staff E, Staff D stated medication bottles may arrive from the pharmacy with more medication than reflected on the labeled quantity. Staff D (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated this discrepancy was often recognized during the final doses and required reconciliation of the remaining quantity. Staff E stated the documented 10 mL remaining was inaccurate and should have been reconciled to show a remaining quantity of 15 mL but did not. Staff D stated Staff NN later clarified by telephone that 18 mL was administered to the resident and 15 mL remained. Staff D stated corrections to the narcotic ledger should be completed with a single-line strike-through to clearly show the corrections but were not. In an interview on 05/06/2026 at 12:35 PM, Staff B (Interim Director of Nursing) stated corrections to narcotic count logs should be completed with a single-line strike-through so the original entry remained visible, but it was not. Staff B stated Resident 18's MAR record for refusing the pain medication was inaccurate and staff were expected to accurately document in the residents' medical record, but they did not. <Medication Storage Room> Observation on 05/01/2026 at 1:55 PM of the medication storage room showed the medication room refrigerator had an opened bottle of Tuberculin (highly contagious respiratory disease) testing solution dated 03/25/2026. The refrigerator contained 10 influenza vaccinations with an expiration date on 03/16/2026. Observation at this time showed no log or documentation was available showing staff were monitoring and documenting the refrigerator temperatures. Observation on 05/01/2026 at 2:05 PM of a drawer in the medication room showed the drawer contained a bottle of an anticonvulsant medication with an expiration date of 12/24/2025. The drawer contained a bottle of opened glucose tablets without an expiration date. In an interview on 05/01/2026 at 2:20 PM, Staff LL (Registered Nurse) confirmed refrigerator temperatures should be recorded, and the log should be in the medication room or at the nurse's station, but they could not locate the log. Staff LL confirmed all the expired and undated medications and biologicals should be discarded. In an interview on 05/06/2026 at 12:40 PM, Staff B stated if staff could not verify the refrigerator temperatures were maintained at the appropriate temperature, items in the refrigerator needed to be disposed of. <Medicare South Medication Cart> Observation on 05/01/2026 at 1:29 PM of the Medicare South Medication Cart showed an open bottle of antibiotic eye drops dated 03/21/2026 and a bubble pack of water pills with an expiration date of 03/29/2026. In an interview at this time, Staff K (Registered Nurse) stated the eye drops were no longer in use and should be discarded. Staff K stated the expired water pills should be discarded as they were expired. <Long term Care South Medication Cart> In an observation on 05/01/2026 at 1:30 PM the south long term care medication cart was found to (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have a box of opened respiratory medication solution cartridges with no open date, an opened box of eye drops with no open date, and a bottle of prescription eye drops expired on 2/26/2026. In an interview on 05/01/2026 at 1:45 PM Staff AA (Registered Nurse) stated they were not aware of the medication open dates, or how long it would take the medications to expire once opened. Staff AA stated that expired medications should be disposed of prior to the expiration date to prevent medication errors. In an interview on 05/05/2026 at 1:32 PM Staff B stated medications should be reviewed for expiration date before being given. Staff B stated that medications should be removed from the cart and disposed of prior to the manufacturers' expiration date to prevent the risk of errors. <Facility Treatment Cart> In an observation on 05/01/2026 at 9:03 AM the facility's treatment cart was locked, though the bottom drawer was able to be accessed without use of a key. Within the drawer were medicated ointments, creams, and wound cleansing supplies, as well as various non-medicated wound treatment supplies. In an interview on 05/01/2026 at 9:04 AM Staff M (Wound Nurse/Infection Preventionist) stated the cart should be secured, and that they were able to close the bottom drawer and have it lock appropriately. In an observation on 05/01/2026 at 2:00 PM, the facility's treatment cart was locked, though the bottom drawer was able to be accessed without use of a key. In an interview on 05/01/2026 at 2:01 PM Staff A (Administrator) stated the cart should be secured and opening when locked presented a safety concern if residents were to access it due to the medicated creams, ointments, and cleansers. In an observation on 05/06/2026 at 10:08 AM, the facility's treatment cart was locked, though the bottom drawer was able to be accessed without use of a key. In an interview on 05/06/2026 at 10:10 AM Staff D stated the cart was not secured due to supplies behind the drawer preventing it from closing all the way. REFERENCE: WAC 388-97-1300(1)(b)(ii)(c)(ii-iv), -1320(2), -2340.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure 3 of 3 residents (Residents 31, 32, & 5) and 1 family member were educated and provided the facility policy regarding the use and storage of foods brought by family and visitors in the facility from outside sources including safe food handling practices. This failure placed residents at risk for foodborne illness. Findings included. <Facility Policy>The undated facility policy titled, Use and Storage of Foods Brought by Family and Visitors and Food Reheating Policy & Procedure, showed the facility would provide safe and sanitary storage and handling of foods brought in from the outside by family and visitors and would ensure staff assisted residents to access, reheat, and consume these foods. The policy showed residents and families would be given a copy of the policy and offered a handout on safe food handling practices. The policy showed food brought in from the outside would be checked by a member of the food and nutrition department or a licensed nursing staff to ensure it did not conflict with the resident's prescribed diet. The policy showed non-perishable foods would be stored in air-tight container bags to prevent staleness and pest infestations. <Resident 31>Review of Resident 31's 12/04/2025 physician order showed the resident was prescribed a regular diet with east-to-chew texture. Review of Resident 31's 03/12/2026 Nutritional Assessment showed the resident had cognitive and behavioral problems including altered mental status which affected their food intake. Observation and interview on 05/06/2026 at 10:39 AM showed Resident 31's family member (son) was observed entering the resident's room with a restaurant-bought Mexican food in a plastic bag. The nurse was standing by the medication cart parked next to Resident 31's room, saw the son enter the resident's room with the food on hand, and did not check the food brought from outside. Resident 31's son stated they had been bringing outside food for the resident for a while now and no staff had checked the food they brought in. Resident 31's son stated they did not know if the resident had dietary restrictions. Resident 31's son stated they were not provided a copy of the facility's policy. <Resident 32>Review of Resident 32's 02/12/2024 physician order showed the resident was prescribed a cardiac diet. Observation and interview on 05/06/2026 at 10:28 AM showed a half-eaten meal next to a food delivery service bag on top of Resident 32's bedside table. Resident 32 stated it was the left-over food they ordered yesterday from door dash. Resident 32 stated they were not informed of the facility's food storage practices or provided a copy of the facility's policy. <Resident 5>Review of Resident 5's 04/30/2026 physician order showed the resident was prescribed a regular diet after Resident 5 signed a risk agreement to liberalize their diet according to their preference. Observation and interview on 05/06/2026 at 10:25 AM showed Resident 5 had several snacks and canned beverages in their room; a snack bag was left open. Resident 5 stated they did not know they needed to store their opened food/snacks in air-tight bags nor did staff assist/provide them with any. Resident 5 stated they were not informed of the facility's food storage practices or provided a copy of the facility's policy. Review of the facility's admission Agreement provided to residents and their representatives showed the policy titled Use and Storage of Foods Brought by Family and Visitors and Food Reheating Policy & Procedure was not included in the packet. In an interview on 05/06/2026 at 10:43 AM, Staff V (Dietary Supervisor) stated they educated the residents regarding safe food handling and storage as they encounter the residents and their needs. Staff V stated they did not know how the residents' family members were educated on the facility's policy regarding foods brought in from outside sources. In an interview on 05/06/2026 at 11:24 AM, Staff A (Administrator) stated it was important for residents and their family members to be aware of the facility's policies and procedures when bringing outside food into the facility for safety. REFERENCE: WAC 388-97-1780(1)(2).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to adhere to Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms) for 3 of 10 residents (Resident 46, 78, & 1) reviewed for infection control, failed to ensure resident equipment was able to be hygienically cleaned for Resident 8, and failed to ensure the facility's washing machine was maintained at the proper temperature. These failures placed residents at risk for communicable diseases, poor quality of life, and adverse health outcomes. Findings included. <Following EBP> <Resident 46> Review of Resident 46's 12/21/2024 physician orders showed they were on EBP due to having a wound, requiring staff to wear a gown and gloves when providing high contact care including bathing, dressing, transfers, and handling of linens. In an observation on 04/30/2026 at 9:54 AM Staff BB (Certified Nursing Assistant- CNA) and Staff CC (CNA) entered Resident 46's room without wearing gown or gloves. Staff BB and Staff CC transferred Resident 46 back to their bed following a shower. In an interview on 04/30/2026 at 9:59 AM, Staff BB stated that they should have been wearing a gown and gloves for Resident 46's care. In an interview on 04/30/2026 at 10:03 AM, Staff CC stated that they should have been wearing a gown and gloves when providing care for Resident 46, and that it was important to protect themselves and others from potential communicable diseases. <Resident 78> Review of Resident 78's 03/17/2026 physician's orders showed they were on EBP due to having an indwelling urinary catheter (a tube that drained urine from the bladder), requiring staff to wear a gown and gloves when providing high contact care such as transfers, dressing, and emptying the catheter drainage bag. In an observation on 04/30/2026 at 9:39 AM Staff DD (Restorative Nursing Assistant) entered Resident 78's room without gown or gloves and transferred Resident 78 back to bed and emptied their urinary drainage bag. In an interview on 04/30/2026 at 9:41 AM, Staff DD stated they should have worn proper Personal Protective Equipment (PPE) to care for Resident 78, and that it was important to have a barrier to prevent the spread of diseases. In an interview on 05/05/2026 at 1:35 PM, Staff M (Wound Nurse/Infection Preventionist) stated they expected staff to wear appropriate PPE when caring for a resident that was on EBP. Staff M stated it (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was important to follow precautions to prevent the spread of potentially communicable diseases. <Resident 1> Review of Resident 1's physician orders showed a 01/28/2026 order directing staff to implement EBP due to the resident having an indwelling catheter. The order directed staff to wear appropriate PPE when providing care. Observation on 04/29/2026 at 2:01 PM showed Staff II (CNA) enter Resident 1's room, put on gloves and empty the resident's catheter bag into a urinal. Staff II did not put on a gown prior to emptying the catheter. After emptying the catheter, Staff II stated I was supposed to wear a gown and I totally forgot. <Laundry Room Washing Machine Temperatures> Observation of the facility's laundry room on 05/01/2026 at 10:47 AM showed the facility had two washing machines. One washing machine was in use and connected to low temp solid detergent solution, chlorine sanitizer, and a laundry softener. Review of the facility's temperature log showed the last temperature recorded for the washing machine was 07/2025, nearly 10 months prior. In an interview at that time, Staff KK (Medical Records Coordinator) stated they just recently took over the role as the laundry manager. Staff KK stated the temperatures should be documented at least daily and confirmed the temperatures were not monitored or documented since 07/2025. In a follow up interview on 05/01/2026 at 12:08 PM, Staff KK stated they called the service company who reported the washing machine temperature needed to reach 120 degrees Fahrenheit to dissolve the detergent. In an interview on 05/06/2026 at 12:37 PM, Staff B (Interim Director of Nursing) stated the washing machine temperature should be checked and logged daily. Staff B confirmed staff were not monitoring the washing machine temperatures but should be. <Equipment surfaces> Observation on 04/30/2026 at 8:37 AM showed Resident 8's wheelchair was parked next to the nurse's med cart in front of room [ROOM NUMBER]; both arm rest covers were torn/tattered along the edges and with exposed foam padding. In an interview on 05/05/2026 at 1:42 PM, Staff M stated if the foam was exposed, the surface was not cleanable and could pose as an infection risk. REFERENCE: WAC 388-97-1320 (1)(a), (2)(a)(c), (3).		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish an infection prevention and control program that included implementation of the Antibiotic (ABO) Stewardship Program to promote appropriate use of ABOs and reduce the risk of unnecessary ABO use for 1 of 5 residents (Resident 1) reviewed for unnecessary medications. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of ABOs. Findings included. <Policy> Review of the facility's 05/2025 Antibiotic Stewardship Program policy showed the facility would use the updated McGeer's criteria (a set of standardized definitions and criteria used to define infections and guide ABO use) to define infections and review new ABO orders for appropriateness. <Resident 1> According to the 04/02/2026 Quarterly Minimum Data Set (an assessment tool) Resident 1 admitted to the facility on [DATE] with diagnoses of high blood pressure, a respiratory infection, and a traumatic brain injury. Review of Resident 1's health record showed a 02/05/2026 ABO to be administered by staff two times a day for ten days for a bacterial skin infection affecting both legs. Review of providers notes showed Resident 1 had redness, warmth, and tenderness to the affected areas. Review of the updated McGeer's criteria showed that Resident 1's condition only met three out of four criteria used to define an infection. In an interview on 05/05/2026 at 2:22 PM, Staff M (Wound Nurse/Infection Preventionist) stated Resident 1's infection did not meet criteria, and that it should have been reported to the provider for review. Staff M stated it was important to ensure appropriate use of ABOs due to the risk of adverse side effects they may have. REFERENCE: WAC 388-97-1620(2)(b)(i)(iii).		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide informed consent and risks and benefits of treatment for 3 of 5 residents (Residents 1, 84, & 40) reviewed for unnecessary medications. This failure placed residents at risk for unwanted treatments, diminished quality of life, and adverse health outcomes. Findings included .<Facility Policy>Review of the facility's undated Use of Psychotropic Medications policy showed prior to initiating or increasing a psychotropic medication, the resident and/or resident representative must be informed of the benefits, risks, and alternatives for the psychotropic medication. The policy showed the residents and/or representatives had the right to accept or decline the medication and the facility would document the residents and/or representatives were informed in advance of the risks and benefits. This policy showed when a medication was prescribed as an alternative to a psychotropic medication rather than the original approved indication, then the medication was subject to the requirements pertaining to psychotropic medications.<Resident 1> According to the 04/02/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool) Resident 1 admitted to the facility on [DATE] with diagnoses of a traumatic brain injury, an anxiety disorder, and depression. The MDS showed Resident 1 had feelings of isolation and verbal behaviors during the assessment period. Record review of physician orders for Resident 1 showed an antianxiety medication ordered on 02/11/2026 for one tablet to be administered two times a day for treatment of their anxiety disorder. The physician's orders showed Resident 1's antianxiety medication was increased to two tabs to be administered two times a day on 03/24/2026. Review of Resident 1's health records showed that no consent for treatment was obtained for the antianxiety medication on 02/11/2026 or 03/24/2026. In an interview on 05/05/2026 at 10:55 AM Staff C (Resident Care Manager - RCM) stated Resident 1 should have had an informed consent prior to the use of psychotropic medications. Staff C stated no informed consent was completed for Resident 1's antianxiety medication. In an interview on 05/05/2026 at 11:50 AM Staff B (Director of Nursing) confirmed that Resident 1 did not have an informed consent for the antianxiety medication but should have. Staff B stated it was important to obtain informed consent for psychotropic medications to ensure residents were aware of potential adverse side effects and to honor their rights. <Resident 84> According to the 02/06/2026 Annual MDS, Resident 84 had diagnoses including Post Traumatic Stress Disorder (PTSD), an adjustment disorder, and hallucinations. The MDS showed Resident 84 sometimes refused care and took antipsychotic medications. Review of the physician's orders showed Resident 84 resumed taking an antipsychotic medication on (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/10/2026 after previously discontinuing the medication on 02/27/2025. Record review showed the facility obtained consent from Resident 84 for the antipsychotic medication on 02/25/2026, 15 days after the resident began treatment. The consent form showed the medication was intended for long-term use. In an interview on 05/06/2026 at 2:38 PM, Staff B stated they expected consent for antipsychotic medications to be obtained prior to treatment. Staff B stated consent was not obtained timely from Resident 84. <Resident 40> According to the 04/17/2026 Quarterly MDS, Resident 40 had moderate cognitive impairment and multiple diagnoses including PTSD. Review of a 10/27/2025 physician progress note showed Resident 40 stated they were experiencing flashbacks and nightmares. The note showed the physician ordered a blood pressure medication that had an off-label use for treatment of PTSD. Review of Resident 40's order history report showed the blood pressure medication was first ordered to treat the resident's PTSD on 10/27/2025. Resident 40 had taken the medication since it was ordered, for nearly six months. Review of Resident 40's Psychotropic Medication Therapy consent form, showed the facility did not obtain consent from Resident 40 for the use of the blood pressure medication treating their PTSD until 05/05/2026, over six months after the resident initially started the medication. In an interview on 05/06/2026 at 11:42 AM, Staff D (RCM) reviewed Resident 40's records and confirmed the consent was not completed prior to initiating the medication. Staff D stated staff should have completed the consent prior to the resident starting the medication. REFERENCE: WAC 388-97-0260, 1020(4)(a)(b).		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to initiate, log, and complete thorough grievance investigations for 1 of 5 residents (Residents 18) and 1 supplemental resident (Resident 39) who were reviewed for grievances. This failure to ensure thorough investigations and resolutions placed residents at risk for frustration and a diminished quality of life. Findings included .<Facility Policy>According to the facility's undated ?Resident and Family Grievances' policy, staff would receive grievances verbally or in writing, ensure grievance forms were completed with the nature and specifics of the grievance, log the grievance, identify each allegation within the grievance, analyze contributing factors, document corrective actions, and communicate outcomes to the resident. The grievance official would keep the residents informed regarding progress toward resolution.<Care in pairs><Resident 18>According to the 03/22/2026 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 18 had diagnoses including anxiety, depression, chronic pain, and muscle weakness. The MDS showed Resident 18 required a wheelchair and had limited lower body mobility. Review of a progress note dated 03/22/2026 showed Resident 18 asked Staff K (Licensed Practical Nurse) why two staff came to their room when assistance was requested. Staff K informed Resident 18 it was because they were considered a 2-person transfer. Resident 18 verbalized not being happy being placed on care in pairs. Review of the facility's March 2026 grievance log showed no grievance reported for Resident 18. In an interview on 04/29/2026 at 10:15 AM, Resident 18 stated they were unhappy with the care in pairs intervention and were not satisfied with the response regarding being a 2-person transfer. In an interview and record review on 05/05/2026 at 11:02 AM, Staff F (Social Services Director) stated Staff K should have completed a grievance form when Resident 18 verbalized their grievance with the care in pairs intervention, but they did not. In an interview on 05/06/2026 at 1:46 PM, Staff B (Interim Director of Nursing) stated they expected staff to assist residents in completing grievance forms when resident concerns could not be immediately resolved.<Pain management>Review of a grievance form completed on 02/27/2026 by Staff G (Administrator in Training) showed Resident 18 reported they were not assessed for pain upon return from an outside clinic and alleged they were left without adequate pain management resulting in extreme pain and vomiting. The facility's response to the grievance focused on outside provider requirements and did not evaluate the facility's role in ensuring continuity of care, addressing pain management needs upon return, or responding to the resident's reported physical and psychosocial distress. In an interview and record review on 05/06/2026 at 12:02 AM, Staff G stated they initiated Resident 18's grievance and understood the expectation was to address each allegation but they did not. <Prompt investigation and resolution><Resident 39>According to the 03/22/2026 Quarterly MDS, Resident 39 had medically complex conditions including depression and bipolar disorder. The MDS showed Resident 39 was able to communicate their needs. In an interview on 05/04/2026 1:19 PM, Resident 39 stated they submitted several grievances to the facility, but staff did not communicate resolutions back to them. Review of a grievance form completed on 04/09/2026 showed Resident 39 reported three concerns related to Staff Q (Certified Nursing Assistant) including a broken phone, being made to feel like a bother when asking for help and waiting for assistance at the front door. The grievance investigation and resolution sections were blank. Review of the facility's April 2026 grievance log showed no grievance reported for Resident 39. In an interview and record review on 05/05/2026 at 11:02 AM, Staff F confirmed they were the Grievance Official responsible for ensuring grievances were logged, investigated, and resolved timely. Staff F stated Resident 39's grievance (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not logged or thoroughly investigated. Staff F acknowledged the failure to investigate grievances and communicate outcomes to residents could cause frustration and feelings that concerns were ignored or unimportant. REFERENCE: WAC 388-97-0460.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) accurately reflected the status for 3 of 19 sample residents (Residents 1, 4, & 18) reviewed for accuracy of assessments. This failure placed residents at risk for unmet and/or unidentified care needs, and a diminished quality of life. Findings included. <Resident Assessment Instrument (RAI - instructional guidelines for MDS completion) Manual> According to the current RAI Manual dated October 2023, the completed MDS must accurately reflect the resident's overall status and the information collected in this assessment would be used as the basis for ensuring that residents received appropriate and quality care. The manual showed the MDS assessment was used to develop, review, and revise the resident's comprehensive care plan. <Resident 1> According to the 07/01/2025 admission MDS, Resident 1 admitted to the facility on [DATE]. The MDS showed Resident 1 was at risk for developing pressure ulcers but did not have any current pressure ulcers. Review of the 06/27/2025 hospital discharge summary showed Resident 1 had two pressure ulcers upon discharge from the hospital. Review of the 06/27/2025 Admit/Readmit Assessment showed the nurse made several attempts to complete an admission skin check for Resident 1, but the resident declined. The nurse documented has known wound to bilateral buttocks on the skin integrity section of the assessment. Observation on 04/29/2026 at 1:47 PM showed Resident 1 lying in bed on an air mattress (specialty mattress for the treatment/prevention of pressure ulcers). Resident 1 stated they had some wounds on their legs and hips. In an interview on 05/06/2026 at 10:25 AM, Staff O (MDS Nurse) reviewed Resident 1's admission MDS and records. Staff O confirmed the MDS was coded incorrectly and required modification. Staff O stated the process for assessing pressure ulcer status on an admission MDS was to review hospital documentation and included a physical assessment of the resident. <Resident 4> According to the 02/13/2026 Quarterly MDS Resident 4 had unclear speech and intact cognition. The section of the MDS dedicated to assessing Resident 4's routine and activity preferences had a resident interview section to be completed if a resident was able to be interviewed and an assessment for staff to complete if the resident was not. Both sections were empty with the resident interview answer spaces all filled with a dash mark. In an interview on 05/06/2026 at 10:26 AM, Staff O stated if a resident was able to answer for themselves, the resident interview should be completed, and if not, the staff assessment should be completed. Staff O stated if section F was dashed, it meant staff did not complete the interview before the MDS assessment was finalized. Staff O stated Section F should be completed. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 18> According to the 12/20/2025 admission MDs and 03/22/2026 Quarterly MDS, Resident 18 admitted to the facility on [DATE]. Both MDS records indicated Resident 18 had diagnoses of anxiety and depression (other than bipolar). Review of the 12/29/2025 physician progress note showed Resident 18 had bipolar disorder with current episodes of mild to moderate depression. Observation on 04/29/2026 at 10:15 AM showed Resident 18 lying in bed with multiple personal belongings, including books, paperwork, electronics snacks and beverage containers positioned around the bed and on tables within reach. Resident 18 appeared visibly distressed and stated they were upset regarding recent behavior contracts they refused to sign and a notice they would be forced to discharge to an adult family home. In an interview and record review on 05/04/2026 at 11:10 AM, Staff O confirmed Resident 18's bipolar disorder diagnosis was missing from both MDS records. Staff O stated the bipolar disorder diagnosis should have been included but it was not. Staff O stated Resident 18's MDS assessment should be modified to include their bipolar disorder diagnosis. REFERENCE: WAC 388-97-1000(1)(a)(b)(4)(a).		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR - a mental health screening required before the transfer to a nursing home) assessment was accurate to reflect the residents' mental health conditions for 1 of 7 residents (Residents 18) reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs. Findings included .<Facility Policy>According to the facility's undated Resident Assessment - Coordination with PASRR Program policy, the facility would coordinate resident assessments with the PASRR program to ensure individuals with mental disorders or related conditions received services in the most integrated setting appropriate to their needs. The policy required a Level I screening prior to admission and Level II evaluation for positive screens to determine appropriate placement and specialized services.<Resident 18>According to the 12/20/2025 admission Minimum Data Set (MDS, an assessment tool), Resident 18 had diagnoses including anxiety and depression (other than bipolar disorder). The MDS showed Resident 18 was admitted to the facility on [DATE] and the MDS showed no PASRR was initiated. Review of a progress note dated 12/26/2025 showed Staff N (Medical Director) documented Resident 18 had bipolar disorder (a mental disorder causing dramatic shifts in a person's mood or energy) with current episodes of mild to moderate depression. Review of the 01/03/2026 Care Area Assessment (CAA) Summary showed additional observation and assessment were needed to determine the relationship between pain, cognition, and behavioral symptoms. The CAA documented Resident 18 experienced delirium, described as inattention and disorganized thinking, as well as behavioral symptoms including screaming, babbling, cursing, repetitive questioning, pacing, kicking, and scratching. Review of Resident 18's medical record showed the facility implemented care in pairs (a restrictive two-to-one observation intervention) on 12/19/2026. The facility implemented two punitive behavior agreements (a written agreement outlining behavior expectations and possible consequences or interventions) on 02/19/2026 and 03/30/2026. Resident 18's record showed a 30-day notice of transfer was initiated on 03/30/2026 and submitted to the Office of Administrative Hearings (OAH) on 04/29/2026. Record review showed a Level I PASRR was completed for Resident 18 by Staff F (Social Services Director) on 03/22/2026. This PASRR listed diagnoses of depression, anxiety, history of homelessness, and polysubstance use disorder under the Serious Mental Illness (SMI) Indicators section. It did not include Resident 18's bipolar diagnoses. Review of the 03/30/2026 Nursing Home Transfer or Discharge Notice showed the facility identified the reason for discharge as the safety of other individuals in this facility is endangered due to the clinical or behavioral status of the resident. The facility stated despite repeated education on behavioral expectations and the implementation of multiple behavior contracts, the resident continues to violate these agreements through ongoing verbal and physical aggression toward staff. In an interview on 04/29/2026 at 10:15 AM, Resident 18 stated they did not want to transfer to another facility because they enjoyed their current care team. Resident 18 stated they were being forced out of the facility and feared being placed in a new facility with staff they didn't know. In an interview and record review on 05/05/2026 at 11:02 AM, Staff F stated Resident 18's Level I PASRR should have been completed adequately and prior to admission but was not. Staff F stated Resident 18's bipolar disorder diagnosis should have been included, when the PASRR was submitted late, but it was not. Staff F stated it was important to initiate an accurate and timely PASRR process to ensure residents receive the necessary mental health care services they need. In an observation and interview on (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/06/2026 at 10:55 AM, Resident 18 was observed apprehensive during the conversation; their voice was shaky, had tense hand gestures and a distressed facial expression. Resident 18 stated the facility's behavior contracts and involuntary discharge notice caused them to feel significant fear, mistrust, and negatively impacted their quality of life. REFERENCE: WAC 388-97-1915(1)(2)(a-c).		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed to provide routine care conferences for 2 of 3 residents (Resident 7 & 40) sampled for care planning. This failure placed residents at risk for unmet care needs, frustration, and diminished quality of care. Findings included .<Resident 40> According to the 10/17/2025 admission Minimum Data Set (MDS &ndash; an assessment tool), Resident 40 had clear speech, was understood and able to understand others. The MDS showed Resident 40 had moderate cognitive impairment and had diagnoses including a fracture, blood sugar disorder, poor nutrition, depression, and a psychotic disorder. This MDS showed Resident 40 had a goal to discharge back to the community and active discharge planning was occurring. Review of Resident 40's 04/27/2026 Discharge/Transfer Preference care plan showed the resident had a history of homelessness and was homeless prior to admission to the facility. This care plan showed interventions for staff to hold interdisciplinary care conferences for the resident and family to address discharge planning and directed staff to review the plan of care initially and quarterly or as needed. In an interview on 04/29/2026 at 9:12 AM, Resident 40 stated they did not have a care conference since their admission to the facility. Resident 40 stated they wanted to go home and asked when they would be able to go home. Review of Resident 40's progress notes from October 2025 to April 2026 showed no documentation Resident 40 was offered or provided a care conference until 04/20/2026, six months after their admission to the facility. Progress notes showed staff did not provide or offer a care conference on the resident's admission or during their first quarterly assessment period in 01/2026. Review of Resident 40's evaluations showed there was only one care conference assessment completed on 04/20/2026. There were no other care conference assessment documents. In an interview on 05/05/2026 at 9:23 AM, Staff F (Social Services) stated the facility was working to get caught up with care conferences. Staff F stated the facility's process was to offer residents and/or representatives a care conference upon admission and quarterly. Staff F reviewed Resident 40's records and confirmed staff did not provide a care conference on admission or during the resident's first quarter. Staff F stated care conferences were important so facility staff could address any concerns or grievances, review the resident's goals of care, and ensure the facility provided care that aligned with the resident's goals. <Resident 7> According to the 04/15/2026 Quarterly MDS, Resident 7 admitted the facility on 09/22/2023 with diagnoses of high blood pressure, stroke, and a seizure disorder. The MDS showed Resident 7 did not have memory deficits. Review of Resident 7's health records showed that care conferences were conducted annually on (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/22/2023, 03/21/2024, and on 03/31/2026. In an interview on 05/05/2026 at 8:31 AM, Resident 7 stated they first had a care conference about a month ago. Resident 7 stated it would have been nice to have had a care conference before that to be able to communicate and address their needs. In an interview on 05/06/2026 at 10:51 AM, Staff F stated care conferences should have occurred quarterly and as needed for Resident 7. Staff F stated they were new to the building, aware of the lack of care conferences for residents, and were working to make sure residents got caught up on missing care conferences. REFERENCE: WAC 388-97-1020(2)(e)(4)(b)(d)-(f).		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide care and services according to professional standards of quality and accepted standards of clinical practice for 7 of 19 residents (Residents 9, 72, 40, 1, 4, 7, & 8) whose medical records were reviewed for physician orders, medication administration, assessments, monitoring, and documentation. The facility failed to ensure residents' weight (loss or gain) was identified, monitored, and documented (Residents 9 & 72), pain and blood pressure medications were administered with and/or according to established parameters (Residents 40 & 1), skin evaluations were completed (Resident 4), respiratory care was followed as ordered (Residents 7 & 1), bowel care was followed as ordered (Resident 1), and physician orders were discontinued after completion (Resident 8). These failures placed residents at risk for malnutrition, untreated pain, medication errors, unidentified skin issues, unmet care needs, and a decreased quality of life. Findings included. <Weight Monitoring and Documentation> <Facility Policy> The undated facility policy titled, Weight Monitoring, showed the facility would ensure all residents maintained acceptable parameters of nutritional status as significant unintended changes in weight (loss or gain) could indicate a nutritional problem. The policy showed the facility utilized a systemic approach including the identification and assessment of each resident's nutritional status and risk factors, weekly weight monitoring for residents identified with weight loss, and weight analysis by comparing the newly recorded resident weight (mathematical rounding to the nearest whole number) to the previous recorded weight. The policy showed the physician was informed of a significant change in weight for appropriate nutritional interventions. <Resident 9> According to the 03/24/2026 Quarterly Minimum Data Set (MDS &ndash; an assessment tool), Resident 9 had medical conditions including memory deficits, unstable blood sugar levels, and painful finger joints that required staff assistance with eating their meals. The MDS showed Resident 9 had a significant weight loss and was not on a physician prescribed weight loss regimen during the assessment period. The revised 02/15/2025 nutrition Care Plan (CP) showed Resident 9 was at risk for nutritional problems due to their advanced age, mechanically altered diet, and memory impairment. The 04/17/2026 Activities of Daily Living (ADL) CP showed Resident 9 required one person staff supervision with eating after set-up assistance was completed. Observation on 04/29/2026 at 1:24 PM showed Resident 9 finished eating their lunch in their room and they consumed about 50 percent (%) of their meal. Observation and interview on 05/04/2026 at 1:31 PM showed Resident 9 was observed eating their lunch in their room supervised by Staff J (Certified Nursing Assistant); the resident consumed less than 50% of their meal. Staff J stated Resident 9 picked and chose what they ate and would consume about 25-50% of the meals served to them especially when the resident was very active or in a bad (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mood. Review of Resident 9's physicians orders showed a 02/27/2026 order to obtain the resident's weekly weight every Monday. Review of Resident 9's weight logs showed: On 02/16/2026, Resident 9 weighed 173.1 pounds (lbs.) and on 02/25/2026, the resident weighed 165.5 lbs. This was an eight lbs. (rounded off) weight loss in nine days. On 03/18/2026, Resident 9 weighed 164 lbs. which was a nine lbs. weight loss in one month from February 2026 to March 2026. A 03/05/2026 physician communication form showed Staff C (Resident Care Manager) identified Resident 9's significant weight loss and attributed the weight change to the resident's eating behaviors. In an interview on 05/06/2026 at 2:22 PM, Staff C (Resident Care Manager - RCM) stated if a resident lost or gained two to three lbs. over a week, the resident was re-weighed to determine if it was a true weight loss and the physician was notified as per protocol. Staff C reviewed Resident 9's medical records and stated there was no documentation found to support Resident 9 was re-weighed by staff for validation. Staff C stated the physician was not notified of the resident's significant weight loss as soon as the weight change was identified. Staff C stated immediate action was important and necessary to address significant weight loss for resident safety and to prevent serious health outcomes. In an interview on 05/06/2026 at 3:45 PM, Staff B (Director of Nursing) stated the facility's software system did not trigger or calculate Resident 9's weight change as significant weight loss. Staff B stated the nursing staff did not notify the physician regarding Resident 9's weight change because it was not ordered. <Resident 72> Review of Resident 72's physician orders showed an active 09/10/2024 order directing staff to obtain the resident's weight each week on Tuesdays. Review of Resident 72's vital signs tab showed the last weight recorded by staff was completed on 10/30/2025. There were no other weights recorded for Resident 72. Review of Resident 72's 04/2026 Treatment Administration Record showed nurses documented a checkmark, indicating the resident's weight was obtained on 04/07/2026, 04/14/2026, and 04/28/2026 but there were no weights recorded. On 04/21/2026, the nurse documented a 9 indicating a progress note was made. Review of Resident 72's 04/2026 nursing progress notes showed staff documented on 04/21/2026 that they were unable to obtain the resident's weight. The note did not indicate if Resident 72 refused to be weighed, if staff attempted to obtain the weight again, passed the information to the next shift, or if the physician was notified that Resident 72's weight was unable to be obtained. There were no (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	other progress notes regarding Resident 72 and their weights for 04/2026. In an interview on 05/06/2026 at 11:43 AM, Staff D (RCM) stated Resident 72 often refused to let staff obtain their weight. Staff D stated the process was for the nurse's aide to obtain the weight, if the resident refused, the aide would report to the nurse who would then make a progress note regarding the resident's refusal. Staff D reviewed Resident 72's progress notes and confirmed the 04/21/2026 progress note was unclear. Staff D confirmed there were no other progress notes documented regarding Resident 72's weight for 04/2026. <Medications Outside of Parameters/Without Parameters> <Facility Policy> The undated facility policy titled, Pain Management, showed the facility must ensure pain management was provided to residents who needed them that was consistent with professional standards of practice. The policy showed the resident/representative and the interdisciplinary team would collaborate to review clinical conditions that required several analgesics and/or narcotic pain-relieving medications to optimize their effectiveness and minimize adverse consequences. <Resident 40> Review of Resident 40's 04/29/2026 physician orders showed the resident had three orders for three different pain-relieving medications. A 10/12/2025 order directed staff to administer Medication A, an over-the counter pain reliever every four hours as needed. There were no pain level parameters directing staff at what pain level to administer Medication A. A 10/21/2025 order directed staff to administer Medication B, an over-the-counter pain-relieving medication every eight hours as needed with meals. There were no pain level parameters directing staff at what pain level to administer Medication B. A 04/07/2026 order directed staff to administer Medication C, a narcotic pain-relieving medication every eight hours as needed for pain. There were no pain level parameters directing staff at what pain level to administer Medication C. Review of Resident 40's April 2026 Medication Administration Record (MAR) showed staff administered Medication A on 04/18/2026 for a pain level of 6/10 on the numeric pain scale (a verbal pain scale with 0 indicating no pain at all and 10 indicating the worst pain imaginable). This MAR showed staff administered Medication C on 10 occasions during the month of April. Staff administered Medication C once for a pain level of 5/10, twice for a pain level of 6/10, six times for a pain level of 7/10, and once for a pain level of 8/10. In an interview on 05/06/2026 at 11:39 AM, Staff D stated Medication A, B, and C should have pain parameters, so staff knew which medication was appropriate to administer to Resident 40. Staff D stated Medication A was usually given for a pain level of 1-5/10 and Medication C was given for a pain level of 6-10/10. Staff D stated residents would usually request Medication A or Medication B but stated the orders should be clarified. <Resident 1> (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's 04/29/2026 physician orders showed a 04/12/2026 order directing staff to administer a blood pressure medication twice daily, with meals. The order instructed staff to hold the medication if the resident's Systolic Blood Pressure (SBP - maximum pressure the blood exerts against artery walls when the heart beats) was less than 100 millimeters of mercury or if the resident's heart rate was less than 60 beats per minute. Review of the April 2026 MAR showed the staff administered Resident 1's blood pressure medication on 04/16/2026 at 1400, 04/20/2026 at 1400, 04/21/2026 at 1400, 04/24/2026 at 1400, 04/25/2026 at 1400, 04/26/2026 at 1400, and 04/30/2026 at 1400 without checking Resident 1's SBP and heart rate parameters prior to administration as ordered. In an interview on 05/06/2026 at 1:13PM, Staff C stated the blood pressure medication parameters ordered for Resident 1 should have been followed to prevent the risk of low blood pressures but were not. <Weekly Skin Evaluation> <Facility Policy> <The facility policy titled, Pressure Injury [PI] Prevention and Management, dated 03/19/2025, showed a resident with PI was provided with the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new PI from developing. The policy showed a skin inspection/assessment should be performed weekly by a licensed nurse and after a thorough evaluation was completed, the interdisciplinary team would develop a relevant CP that included measurable goals for prevention and appropriate interventions for PI management. <Resident 4> According to the 02/13/2026 Quarterly MDS, Resident 4 was dependent on staff for all cares, and had medical conditions including a disease that caused numbness, weakness, trouble walking, and vision changes, a seizure disorder, unstable blood sugar levels in the body, and the loss of function and mobility on all four limbs. The MDS showed Resident 4 had an unhealed, full-thickness pressure ulcer/injury (deep wound caused by pressure and loss of several layers of skin tissue) during the assessment period. Observation on 04/30/2026 at 1:48 PM showed Resident 4 was sleeping in bed with a pump on the end of their bed moving air through their air mattress to offload pressure. Review of the physician's orders showed a 10/27/2025 order for the air mattress use, and a 05/24/2024 order directed the staff to complete weekly skin evaluations. According to a 01/28/2026 progress note, Resident 4's wound healed. The note showed a layer of skin now covered the opening. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's skin documentation on 04/30/2026 showed there was no weekly skin evaluations completed for the resident after 04/01/2026 In an interview on 05/06/2026 at 1:04 PM, Staff D stated the nurses should have followed the order and completed Resident 4's weekly skin evaluations as ordered but the staff did not since 04/01/2026. In an interview on 05/06/2026 at 2:38 PM, Staff B stated it was important for nurses to follow physician's orders. <Respiratory Care> <Facility Policy> <The undated facility policy titled, Oxygen Administration, showed oxygen therapy was administered to residents who needed it, consistent with professional standards of practice, the comprehensive CP, and the resident's goals and preferences. The policy showed staff should follow physician orders as to the amount of oxygen to be administered. The policy showed infection control measures were implemented including changing the oxygen tubing and mask/cannula weekly and as needed if it became soiled or contaminated. <Resident 7> Review of Resident 7's physician orders showed an 08/23/2024 order to change the oxygen tubing and humidifier (an attachment for oxygen tubing to prevent drying on the airways) weekly on Sunday nights and to date the tubing when changed. A 01/12/2026 order instructed nurses to administer oxygen to Resident 7 at two liters per minute. In an observation on 4/29/2026 at 2:06 PM, Resident 7's oxygen was observed not hooked up to the humidifier, the oxygen tubing was undated, and amount of oxygen being administered was at two and a half liters per minute. In an interview on 04/29/2026 at 2:07 PM, Resident 7 stated they could tell the humidifier was not on because the oxygen was drying out their throat causing some irritation. In an interview on 05/05/2026 at 11:45 AM, Staff B stated the staff should have changed Resident 7's oxygen tubing and administered the amount of oxygen as ordered but did not. Staff B stated it was important to follow the physicians orders for Resident 7's respiratory care to meet the resident's needs. <Resident 1> Review of Resident 1's physician orders showed a 01/31/2026 order directing staff to change the resident's oxygen tubing and supplies every week on Sunday nights. This order directed staff to date the supplies when changed. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/29/2026 at 1:58 PM showed Resident 1 was lying in bed using their oxygen. The tubing on the oxygen was dated 04/18/2026, 11 days prior. Similar observations of Resident 1's oxygen tubing dated 04/18/2026 were made on 04/30/2026 at 1:56 PM. In an interview on 05/06/2026 at 11:28 AM, Staff D stated they expected staff to change oxygen tubing as ordered. Staff D stated if a resident refused to have their oxygen tubing changed, the refusal should be documented and the resident re-approached at another time. <Bowel Care> <Resident 1> Review of Resident 1's physician orders showed active orders for as needed stool softeners to be administered to prevent and treat constipation if Resident 1 did not have a bowel for three days. Review of Resident 1's April 2026 ADL task documentation showed the resident did not have a bowel movement for five days from 04/02/2026 to 04/07/2026. Review of Resident 1's April 2026 MAR showed there was no as needed stool softeners administered to the resident as ordered. In an interview on 05/06/2026 at 1:00 PM, Staff C (RCM) stated the staff were notified when Resident 1 did not have a bowel movement for 3 or more days through a clinical alert. Staff C stated the staff should have administered the stool softeners as needed for Resident 1 but did not. <Discontinue Physician Orders> <Resident 8> According to the 03/04/2026 Annual MDS, Resident 8 was not on hospice (end of life) care services. Observation and interview on 05/04/2026 at 2:56 PM showed Resident 8 was lying in bed, eyes closed shut but responded to verbal stimuli. Resident 8 stated they did not want to get up because were very tired and just wanted to stay in bed for the rest of the day. Review of Resident 8's physician orders showed a 03/17/2026 active order for a hospice referral due to Resident 8's to failure to thrive from both functional and cognitive decline. A 03/30/2026 progress note showed the hospice staff was notified and would schedule to evaluate Resident 8. A 04/01/2026 progress note showed Resident 8 was evaluated and the resident was not appropriate for hospice care services. In an interview on 05/06/2026 at 2:04 PM, Staff D (RCM) stated it was important to ensure residents' medical records remained accurate to reflect the residents' actual condition so the staff could provide the appropriate cares and services. Staff D reviewed Resident 8's physician orders and stated the (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/17/2026 hospice referral order should have been discontinued after the determination was made but it was not. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i).		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide Restorative Nursing Programs (RNP) for 1 of 1 residents (Resident 7) reviewed for restorative services. The failure to provide restorative services placed residents at risk for decline in mobility and Range of Motion (ROM), functional status, and other negative health outcomes. Findings included. <Facility Policy> According to the facility's 05/2025 RNP policy, the facility would assess residents need for restorative services when therapy services were no longer indicated, develop a plan including the types of activities needed and the frequency at which the activities were to occur, and implement the RNP by having Certified Nursing Assistants complete and document the restorative services offered and completed. <Resident 7> According to a 04/15/2026 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 7 admitted to the facility on [DATE] with diagnoses including stroke, high blood pressure, and weakness affecting the left side of the body. The MDS showed Resident 7 received restorative services two times in the seven day look back period. Review of Resident 7's 09/2024 RNP care plan showed a 02/13/2026 intervention for restorative services three to six times a week to exercise both arms and both legs. Review of Resident 7's March 2026 restorative documentation record showed they did not receive restorative services for the month of March. Review of Resident 7's April 2026 restorative documentation record showed they received the restorative services on 04/09/2026, 04/17/2026, and on 04/23/2026, less than once a week. In an interview on 04/29/2026 at 2:05 PM Resident 7 stated they did not remember having restorative services since the beginning of the month. In an interview on 05/05/2026 at 11:48 AM Staff B (Director of Nursing) stated Resident 7 should have received restorative services as outlined in their RNP. Staff B reviewed restorative documentation in Resident 7's record and stated that this did not occur. Staff B stated it was important to provide restorative services to prevent loss of range of motion and decline in functional abilities. REFERENCE: WAC 388-97-1060(3)(d)(j)(ix).		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to ensure for 1 of 1 residents (Resident 4) that required enteral feeding (Tube Feeding - food delivered to the stomach via tubing that bypasses the esophagus) received the nutrition they required in accordance with professional standards of nursing. The failure to ensure tube feeding was provided in accordance with the physician's orders, and accurately documented with the nutrition provided, placed residents at risk for unwanted weight loss, unwanted weight gain, gastrointestinal discomfort, and other negative health outcomes. Findings included . <Facility Policy>According to the facility's 03/20/2025 Care and Treatment of Feeding Tubes policy, feeding tubes should be used according to physician's orders which typically include the type and caloric value of the formula required, volume, duration, and amount of water flushed through the tubes.<Resident 4>According to the 02/13/2026 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 4 was dependent on staff for all care, and had diagnoses including Multiple Sclerosis (MS - an autoimmune disease that can cause numbness, weakness, trouble walking, vision changes and other symptoms) a seizure disorder, Diabetes (a condition making blood sugar regulation more difficult) and quadriplegia (paralysis of all four limbs). The MDS showed Resident 4 received more than half of their daily caloric intake via their feeding tube and received 500 Cubic Centimeters (CC) of nutritional formula daily. Record review showed the following physician's orders related Resident 4's tube feeding needs: a 02/08/2024 order to hang Tube Feeding supplies, change the feeding bottle, bag, tubing, and syringe every night shift; a 04/27/2026 order to check the tube placement prior to each feeding or flush starting at 3:00 PM and ending at 09:00 AM; a 08/08/2023 order to dress and cleans the stoma (hole for the feeding tube); an 04/27/2026 order for a low-sugar feeding formula infused at at 90 CC per hour for 18 hours for total of 1620 CC and 1944 calories daily; a 04/27/2026 order to ensure all the formula was infused before ending the feeding.Observation on 04/29/2026 at 1:23 PM showed the pump not running, and 500 CC of formula remaining hung in a bag not connected to the pump and a second bag of saline for flushing. The formula bag was not dated or timestamped to demonstrate when it was hung. The bag with saline showed 04/29/2026 4:06 AM, which did not correspond with the start time of 3:00 PM/Observation on 04/30/2026 at 1:49 PM showed both the saline bag and formula bag were filled to the top and disconnected from the pump. A label on the formula bag showed it 04/30/2026, 00:00 AM. Observation on 05/04/2026 at 8:50 AM showed a label placed on the saline bag indicating 05/04/2026, 4:00 AM.Observation on 05/05/2026 at 7:50 AM showed the pump was working and 770 CC of formula remaining. A label on the formula bag showed 05/05/2026, 8:00 AM.Observation on 05/05/2026 at 10:39 AM showed bags with 500 CC of saline and formula, with the pump still on.Review of the April 2026 Medication Administration Record (MAR) showed the 02/08/2026 order to change the tube feeding supplies was scheduled at 6:00 PM, three hours after the feeding was scheduled to start. The 08/08/2023 order to clean and dress the tube site was also scheduled at 6:00 PM. The 04/27/2026 order to provide 1620 CC of formula had a row to indicate the quantity provided at 9:00 AM. For each day from 04/27/2026 through 04/30/2026, nurses charted they provided only 270 CC of formula rather than the 1620 CC ordered. Review of the May 2026 MAR showed on the 04/27/2026 order to provide 1620 CC, each day from 05/01/2026 through 05/05/2026, nurses charted they provided only 270 CC of formula rather than the 1620 CC ordered. In an interview on 05/06/2026 at 12:51 PM, Staff D (Resident Care Manager - RCM) reviewed the April 2026 MAR and stated it did not show the correct amount of nutrition was provided daily. At that time Staff C (RCM) also reviewed the April MAR and (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it did not show Resident 4 received the amount of formula orderedOn 05/06/2026 at 12:58 PM Staff C observed full bags of formula and saline hung on the pole by Resident 4's bed, unconnected to the pump. Staff C stated they thought the bags were prepared for a later feeding.In an interview on 05/06/2026 at 3:35 PM, Staff B (Director of Nursing) stated the MARs did not show Resident 4 was provided the formula they needed but stated this could be a charting error. Staff B observed the formula bag in Resident 4's room which contained 950 CC at that time. Staff B stated the bag that hung could not accommodate all 1620 CC of the required formula at one time, but they thought nurses refilled the bag during the feeding. Staff B stated there was no documentation this happened. Staff B stated they expected the feedings to be provided consistently but did not speculate whether the surveyor's observations showed inconsistent care. Staff B stated the MAR should accurately reflect the nutrition provided and show that Resident 4's assessed nutritional needs were met. Staff B stated the 270 CC documented daily could be the result of the nurse misunderstanding what they were documenting. REFERENCE: WAC 388-97-1060(3)(f).		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to assess and provide special/adaptive eating equipment and utensils to residents who needed them for 1 of 1 resident (Resident 70) observed during dining. This failure placed residents at risk of losing their ability to eat independently, feelings of frustration, and a decreased quality of life. Findings included. <Facility Policy>The undated facility policy titled, Adaptive Feeding Equipment, showed residents who required eating assistance were potential candidates for a restorative dining program or adaptive utensil use and was determined by the Occupational Therapist (OT). The policy showed any staff member could refer a resident for an evaluation. <Resident 70>Review of the 02/05/2026 Quarterly Minimum Data Set (MDS - an assessment tool) showed Resident 70 had medical conditions including a brain injury resulting with the loss of verbal communication and function/mobility on the right dominant side of their body. The MDS showed Resident 70 was Samoan, understood most conversation, preferred American Sign Language, and wanted an interpreter during communication. The MDS showed Resident 70 was independent with eating their meals. Review of Resident 70's revised 06/01/2024 Activities of Daily Living (ADL) care plan showed the resident had self-care performance deficits due to their medical conditions and limited mobility. In an observation and interview on 04/29/2026 at 12:18 PM, Resident 70 was observed struggling to cut up their meal while using a teaspoon on their left hand; some cut-up food fell off the plate as Resident 70 tried to scoop them up. Staff EE (Activity Aide) who was Samoan speaking interpreted for Resident 70 and stated the resident told them having adaptive utensils/plate would greatly help/assist them in eating their meals independently. When Staff EE asked Resident 70 if OT evaluated them for adaptive utensils to use while eating, Resident 70 shook their head indicating no. In an interview on 05/01/2026 at 11:52 AM, Staff T (Director of Rehabilitation) stated it was important for OT to assess a resident's ADL function including eating to ensure they would not lose their independence, improve their quality of life, and decrease caregiver burden. Staff T stated newly admitted residents were assessed for skilled needs upon admission and long-term residents' ADL needs /changes were identified during their monthly Interdisciplinary Team (IDT) meeting. Staff T stated IDT communication was necessary to ensure residents' who required OT evaluation were screened. Staff T reviewed Resident 70's therapy notes and stated the resident should have but was not assessed for adaptive feeding equipment use. REFERENCE: WAC 388-97-1140(2)(4).		