STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Americana Health and Rehabilitation	917 7th Avenue Longview, WA 98632

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure resident funds were conveyed (the act of legally transferring property from one entity to another) to the Office of Financial Recovery (OFR) within 30 days of death or discharge for 1 of 2 discharged residents (Resident 62) reviewed for trust accounts. This failure resulted in a delayed final accounting and conveyance of Resident 62's funds.Findings included . Review of the Discharge Minimum Data Set (MDS, an assessment tool), dated 02/18/2025, showed Resident 62 was transferred to the hospital on [DATE], where they subsequently passed away on the same date. Review of the facility's resident Trust- Audit Report showed Resident 62 had a trust balance of $60 from March - August 2025. A Transmittal of Resident Personal Funds form showed Resident 62's trust balance was not conveyed to the OFR until 08/27/2025. During an interview on 11/20/2025 at 1:34 PM, when asked if Resident 62's trust balance was conveyed to the OFR within 30 days of death or discharge as required Staff E, Business Office Manager, stated, No. Reference WAC 388-97-0340(4)(5).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to obtain a Safety Device Evaluation and Consent and/or physician's order for 1 of 1 sampled residents (Resident 43) reviewed for physical restraints. This failure placed the residents at risk of injury, unmet needs, and a diminished quality of life.Findings included . Record review of the facility policy, titled, Physical Restraints, revision date, January 2025, documented: 5. The resident and/or resident representative is provided risks/benefits of restraint use or enabler/device use, and consent obtained prior to implementation of the device.6. The care plan is updated for the device use with the goal for the least restrictive measures.7. The care plan is evaluated quarterly and as needed.8. The resident is evaluated using Device Evaluation on admission, re-admission, annually, and with significant change in condition. Resident 43 admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (an assessment tool), dated 09/24/2025, documented the resident was moderately cognitively impaired. In an observation on 11/19/2025 at 11:42 AM, Resident 43's right side of the bed was placed against the wall. In an interview on 11/19/2025 at 11:45 AM, Resident 43 said her bed had always been like that, and nobody discussed with her why that is. Review of Resident 43's Electronic Health Record (EHR), showed no documentation of Safety Device Evaluation, and a Consent and/or physician's order related to the bed placed against the wall. In an interview on 11/21/2025 at 01:39 PM, Staff H, Licensed Practical Nurse (LPN), said a residents' consent is required for placing a bed against a wall. Staff H was unable to find consent for Resident 43. In an interview on 11/21/2025 at 01:20 PM, Staff B, Director of Nursing Services and a Registered Nurse (RN) said with any type of potential restrains, the facility required an evaluation and a consent. Staff B was unable to provide any documentation pertaining to Resident 43's bed placement. Reference WAC 388-97-0620(1)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure admission Minimum Data Sets (MDS, an assessment tool) were completed within 14 days of admission as required, for 1 of 18 sample residents (Resident 2) reviewed for comprehensive assessments. This failure placed residents at risk for unidentified and/or unmet care needs.Findings included .Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.20.1 October 2025, showed admission assessments were required to be completed by the 14th calendar day of a resident's admission. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's admission Minimum Data Set (MDS, an assessment tool), dated 07/19/2025, showed it was not completed until 08/05/2025 20 days after admission. On 11/21/2025 at 1:47 PM, when asked if Resident 2's admission MDS was completed by the 14th calendar day after admission as required, Staff D, MDS Coordinator, stated, No. Reference WAC 388-97-1000(1)(b)(c)(ii)(d).

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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 interview and record review, the facility failed to ensure assessments accurately reflected residents' health status and care needs for 2 of 18 sample residents (Residents 6 & 2) reviewed. This failure placed residents at risk for unidentified and/ unmet care needs and decreased quality of life. Findings included . 1) Resident 6 was admitted to the facility on [DATE]. Review of the Significant Change Minimum Data Set (MDS, an assessment tool), dated 08/04/2024, showed Resident 6 had a terminal diagnosis and received hospice services. Review of the Hospice intake paperwork, dated 07/29/2024, showed due to severe chronic obstructive pulmonary disease (COPD, an umbrella term for chronic lung diseases that cause airflow obstruction and breathing difficulties), respiratory failure and hypoxia (deficiency in the amount of oxygen reaching the tissues) Resident 6 was determined to have a life expectancy of less than six months and was admitted to Hospice. Hospice documentation showed Resident 6 was repeatedly recertified for Hospice care and remained on Hospice services from 07/29/2024 - 11/21/2025. Review of the Quarterly MDSs, dated 02/04/2025, 05/07/2025 and 10/08/2025, showed Resident 6 received Hospices services but did not have a terminal prognosis (estimated life expectancy is six months or less if disease process runs its normal course). During an interview on 11/21/2025 at 1:47 PM, Staff D, MDS Coordinator, said the 02/04/2025, 05/07/2025 and 10/08/2025 Quarterly MDSs were inaccurate and should have coded Resident 6's terminal prognosis. 2) Resident 2 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed Resident 2 rejected care on 1-3 days during the assessment period. Review of the October 2025 Medication Administration Record showed Resident 2 refused their stool softener on 10/15/2025, 10/17/2025, 10/18/2025 and 10/19/2025. Additionally, review of the October 2025 meal monitor showed Resident 2 refused their alternative meal on 10/16/2025, 10/17/2025 and 10/18/2025. This showed Resident 2 rejected/refused care on five of seven days during the assessment period.On 11/21/2025 at 1:53 PM, Staff D, MDS Coordinator, said Resident 2's MDS was inaccurate and needed to be modified to reflect rejection of care on 4-6 days during the assessment. Reference WAC 388-97-1000(1)(a)(b)(4)(a).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview and record review, the facility failed to ensure resident care plans were reviewed, revised, and accurately reflected residents' care needs for 3 of 18 residents (Residents 1, 2 & 46) whose care plans were reviewed. These failures placed residents at risk for unidentified/ unmet care needs and a diminished quality of life. Findings included . 1) Resident 2 was admitted to the facility on [DATE]. Review of the electronic health record (EMR) showed an order, dated 07/21/2025, to cleanse Resident 2's anal fissure (a small tear in the thin, moist tissue that lines the anus) with normal saline or wound cleanser, pat dry, and apply zinc oxide ointment (skin protectant) twice a day and as needed. Review of the comprehensive care plan, intiated 07/17/2025, showed no care plan was developed to address Resident 2's anal fissure. During an interview on 11/21/2025 at 2:48 PM, Staff B, Director of Nursing Services (DON), said Resident 2's anal fissure should have been addressed in the comprehensive care plan, but acknowledged it was not. Review of the Quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 2 was constipated (two or fewer bowel movements during the 7-day look-back period or most bowel movements were hardand difficult for them to pass). Review of the comprehensive care plan, initiated 07/17/2025, showed a constipation care plan was not developed or implemented. During an interview on 11/21/2025 at 2:48 PM, Staff B said Resident 2's constipation should have been addressed in Resident 2's comprehensive plan of care. 2) Resident 1 was admitted to the facility on [DATE]. Review of the hospital transfer orders, dated 10/18/2025, showed Resident 1 had a peripherally inserted central catheter (PICC, a long, thin tube inserted into a vein in the arm that extends to a large vein near the heart, used for long-term IV fluids, medications, or nutrition) and an order for intravenous (IV) vancomycin (an antibiotic) once daily for septic arthritis (a serious joint infection caused by bacteria, viruses, or fungi that enter the joint through the bloodstream, an injury, or surgery) and spondylodiscitis (an infection of the vertebrae and intervertebral discs). Review of the comprehensive care plan, initiated 10/18/2025, showed no care plan was developed to address type, location, number of lumens (an individual tube or channel within a single PICC), and/or maintenance and monitoring instructions for Resident 2's PICC. During an interview on 11/21/2025 at 2:48 PM, Staff B said the type and location of Resident 2's PICC and associated maintenance and monitoring instructions should have been care planned. 3) Resident 46 was admitted to the facility on [DATE]. Review of the hospital transfer orders, dated 10/29/2025, showed Resident 46 had a PICC and an order for Sodium Thiosulfate intravenous (IV) infusions every Monday, Wednesday and Friday for calcification of muscle in the left lower extremity. Review of the comprehensive care plan, initiated 10/29/2025, showed no care plan was developed to address type, location, number of lumens and/or maintenance and monitoring instructions for Resident 46's PICC. During an interview on 11/21/2025 at 2:48 PM, Staff B said the type and location of Resident 46's PICC and associated maintenance and monitoring instructions should have been care planned. Reference WAC 388-97-1020(2)(c)(d) .

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview, and record review, the facility failed to ensure services provided met professional standards of practice for 3 of 18 residents (Residents 1, 2 & 46). Failure of nursing staff to follow and/or clarify physicians' orders when indicated, and to notify the physician of weight variances and when medications were held, placed residents at risk delayed changes in medication regimen, hypotension, falls and other adverse outcomes. Findings included .1) Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's physician's orders showed an order for daily weights, dated 10/25/2025. Review of Residnt 1's November 2025 weight record showed Resident 1 had the following 24-hour weight variances:11/08/2025 weight - 272. 6 lbs.; 11/09/2025 - 264.4 lbs. (-8.2 lbs. in 24 hours).11/11/2025 - 262.2 lbs.; 11/12/2025 - 252.2 lbs. (- 10 lbs. in 24 hours).11/14/2025 - 252.2 lbs.; 11/15/2025 - 268 lbs. (+16 lbs. in 24 hours). Review of Resident 1's electronic medical record (EMR) showed no documentation was present to show facility staff notified the provider of Resident 1's weight variances of greater than three lbs. in 24 hours. During an interview on 11/21/2025 at 2:13 PM, Staff B, Director of Nursing Services (DNS), explained if a resident was on daily weights, staff would notify the provider if there was a weight variance of greater than three lbs. in 24 hours or five lbs. in a week. When asked if there was any documentation to show staff notified the provider on the three above referenced occasions Staff B stated, No. 2) Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's electronic Medical Record (EMR) showed an order, dated 08/08/2025, for metoprolol (blood pressure medication) twice daily, hold the medication and notify the physician if the systolic blood pressure (SBP, top number in a blood pressure reading) was less than 95 or the pulse (P) was less than 60. Review of Resident 2's September 2025 Medication Administration Record (MAR) showed on the following dates/times facility nurses held Resident 2's metoprolol when their SBP and P were within the physician ordered parameters. 09/01/2025 8:00 AM dose- SBP= 98, P= 110; staff documented the medication was not administered due to vital signs outside of parameters.09/03/2025 8:00 AM dose- SBP= 98, P= 100; staff documented the medication was not administered due to vital signs outside of parameters. 09/04/2025 8:00 PM dose- SBP= 97, P= 98; staff documented the medication was not administered due to vital signs outside of parameters.09/05/2025 8:00 PM dose- SBP= 109, P= 96; staff documented the medication was not administered due to vital signs outside of parameters.09/13/2025 8:00 PM dose- SBP= 101, P= 71; staff documented the medication was not administered due to vital signs outside of parameters.09/17/2025 8:00 PM dose- SBP= 98, P= 94; staff documented the medication was not administered due to vital signs outside of parameters.During an interview on 11/21/2025 at 2:13 PM, Staff B, DNS, said according to the physicians order, on the above referenced occasions Resident 2's metoprolol should not have been held. Review of Resident 2 's physicians orders showed an order for daily weights, dated 07/18/2025, with direction to notify the physician if of weight changes greater than or equal to three pounds in two days or five pounds in a week. Review of the Resident 2's October 2025 MAR showed the following 24 hour weight variance:10/19/2025 weight - 121.4 lbs.; 10/20//2025 - 115.6 lbs. (-5.8 lbs. in 24 hours). Review of Resident 2's EMR showed no documentation that staff notified the physician as ordered. During an interview on 11/21/2025 at 2:13 PM, when asked if there was documentation to show the physician was notified of Resident 2's 5.8 lbs. weight loss in 24 hours, Staff B stated, No. 3) Resident 46 was admitted to the facility on [DATE]. Review of Resident 46's admission MDS, dated [DATE], showed the resident was cognitively intact, had a diagnosis of Left lower extremity cellulitis (skin infection), received IV medication and antibiotics during the assessment period. Review of Resident 46's EMR showed an order, dated 10/29/2025, that directed staff to flush a valved PICC with 5 milliliter (ml) normal saline (NS) before and after medication infusion and a non-valved PICC with 5 ml NS before and after medication infusion followed by 10 ml of heparin (blood thinner). Review of Resident 46's November 2025 Treatment Administration Record showed the order was transcribed without identifying if the Resident 46's PICC was valved or non-valved. Thus, it was unclear if the flushes provided by facility nurses included heparin or not. During an interview on 11/21/2025 at 2:48 PM, when asked if facility nurses were flushing with heparin Staff B agreed that you could not tell from the documentation. Staff B said facility nurses should have clarified the order but did not. Reference WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to initiate bowel interventions for 5 of 8 residents (Resident 17, 24, 27, 2 & 6) reviewed for quality of care. This failure placed residents at risk for discomfort, experiencing health complications and a diminished quality of life.Findings included . Record review of the facility policy, titled, Bowel Protocol, revision date, May 2025, documented: 1. The licensed Nurse reviews the bowel monitor daily. 2. If a resident does not have a bowel movement for three days, the nurse administers the physician ordered bowel program. 3. If the facility has no specific bowel program the nurse administers medications as ordered as follows: Administer milk of magnesia [laxative] per physician order on day four. If milk of magnesia offers no result, administer a stimulant laxative suppository or oral tablet (Bisacodyl, Senna, etc.) per physician order on the next shift, during waking hours only. If a resident continues to have no results from suppository, administer an enema on the next shift, during waking hours only. If no results from enema, notify physician. Resident 17 Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Quarterly Minimum Data Set (MDS, an assessment tool), dated 09/04/2025, documented the resident was alert and oriented. Record review Resident 17's Electronic Health Record (HER), showed Resident 17 had the following 02/01/2025 PRN (as needed) bowel care orders: a) If resident does not have a bowel movement for three days, administer milk of magnesia (MOM) on day four.b) If milk of magnesia offers no results, administer a Bisacodyl suppository rectally, the next shift (during waking hours), as needed, for constipation. c) If resident continues to have no results from suppository, administer a Fleet enema on the next shift. If no results from enema, notify the physician. Record review of Resident 17's Bowel Movement (BM) task sheet, dated November 2025, showed documentation of Resident 17's BM activity on 11/12/2025 at 1:43 PM. Resident 17's next BM was documented on 11/18/2025 at 09:32 AM, approximately 139 hours since the last BM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident 17's EHR, dated November 2025, did not show documentation of bowel interventions from 11/12/2025 to 11/18/2025. Resident 24 Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's Medicare- 5 Day MDS, dated [DATE], documented the resident was moderately cognitively impaired. Record review of the EHR, showed Resident 24 had the following 02/01/2025 PRN bowel care orders: a) If resident does not have a bowel movement for three days, administer milk of magnesia (MOM) on day four. b) If milk of magnesia offers no results, administer a Bisacodyl suppository rectally, the next shift (during waking hours), as needed, for constipation. c) If resident continues to have no results from suppository, administer a Fleet enema on the next shift. If no results from enema, notify the physician. Record review of Resident 24's BM task sheet, dated November 2025, showed documentation of Resident 24's BM activity on 11/08/2025 at 1:59 PM. Resident 24's next BM was documented on 11/18/2025 at 01:59 PM, approximately 228 hours since the last BM. Record review of Resident 24's EHR, dated November 2025, did not show documentation of bowel interventions from 11/08/2025 to 11/18/2025. Resident 27 Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's Quarterly MDS, dated [DATE], documented the resident was moderately cognitively impaired. Record review of the EHR, showed Resident 27 had the following 02/01/2025 PRN bowel care orders: a) If resident does not have a bowel movement for three days, administer milk of magnesia (MOM) on day four.b) If milk of magnesia offers no results, administer a Bisacodyl suppository rectally, the next shift (during waking hours), as needed, for constipation. c) If resident continues to have no results from suppository, administer a Fleet enema on the next shift. If no results from enema, notify the physician. Record review of Resident 27's BM task sheet, dated October 2025, showed documentation of Resident 27's BM activity on 10/23/2025 at 9:59 PM. Resident 27's next BM was documented on 10/28/2025 at 11:59 AM, approximately 110 hours since the last BM. Review of Resident 27's EMAR, dated October 2025, did not show documentation of bowel interventions from 10/23/2025 to 10/28/2025. Resident 2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Quarterly MDS 11/25/2025, showed the resident was alert and oriented. In an interview on 11/19/2025 at 08:57 AM, Resident 2 complained of constipation. They reported going days without a BM, and when they did have one the stool was hard and difficult to pass. Record review of Resident 2's HER, showed Resident 2 had the following orders, dated 07/17/2025, for PRN (as needed) bowel care orders: a) If resident does not have a bowel movement for three days, administer milk of magnesia (MOM) on day four.b) If milk of magnesia offers no results, administer a Bisacodyl suppository rectally, the next shift (during waking hours), as needed, for constipation. c) If resident continues to have no results from suppository, administer a Fleet enema on the next shift. If no results from enema, notify the physician. Record Review of Resident 2's BM task sheet, dated September 2025, showed documentation of Resident 2's BM activity on 09/03/2025. Resident 2's next BM was documented on 09/06/2025, approximately 96 hours since the last BM. Record review of Resident 2's September and November 2025 Electronic EHR, showed on both above referenced occasions, facility staff failed to administer bowel interventions on the fourth day without a BM, as ordered. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Quarterly MDS, dated [DATE], documented the resident was mildly cognitively impaired. Review of Resident 6's October 2025 bowel record showed they went from 10/07/2025- 10/13/2025 (7 days) without a BM. Review of Resident 6's October 2025 MAR showed Resident 6 was administered bisacodyl tablets twice on 10/10/2025, at 7:09 AM and 4:30 PM, with no results. The bowel monitor showed Resident 6 went three more days without a BM and staff failed to administer a bisacodyl suppository and a Fleets enema as ordered. In an interview on 11/21/2025 at 2:36 PM, when asked if staff administered PRN bowel care in accordance with Resident 6's physicians orders and the facility bowel protocol Staff C, Resident Care Manger, stated, No, not after the first dose (bisacodyl tablets and MOM were interchangeable per the facility's bowel protocol.) In an interview on 11/21/2025 at 01:39 PM, Staff I, Licensed Practical Nurse, said after three days of no BM, an alert should trigger. Staff I stated, In the morning, we see who pops up in the system for bowels. We check on them and administer what was ordered by physician. Staff I was unable to provide documentation of bowel interventions for residents 17, 24, 27, 2 & 6. In an interview on 11/21/2025 at 1:59 PM, when asked if staff administered Resident 2 MOM on their fourth day without a BM as ordered Staff B, Director of Nursing Services (DNS)/Registered Nurse, stated, No. In an interview 11/21/2025 at 02:13 PM, Staff B, said the BM protocol should have been initiated and documented per policy. Staff B stated, We fell short on bowel management and started doing an audit on Monday 11/17. Staff B was unable to provide further documentation of successful bowel interventions. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference WAC 388-97-1060(1)-(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. Building B. Wing	11/21/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 ensure 1 of 2 residents (Resident 2) reviewed for limited Range of Motion (ROM) received treatment and services to maintain and/or improve ROM. The failure to ensure residents were offered/provided Restorative Nursing Programs (RNPs) at the frequency they were assessed to require, placed residents at risk for decline in ROM, contracture formation, reduction in strength and mobility, increased dependence on staff and decreased quality of life. Findings included . Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Quarterly MDS, dated [DATE], showed Resident 2 was cognitively intact and received a passive ROM RNP on two of seven days during the assessment period. Review of Resident 2's impaired mobility related to decreased ROM care plan, revise 09/15/2025, showed Resident 2 was to receive passive ROM to both lower extremities, two sets of 15 reps (hip flexion, hip abduction, heel sliders and ankle pumps) five times a week. Review of the October and November 2025 restorative flowsheets showed from 10/01/2025 - 11/21/2025 (52 days), Resident 2's passive ROM RNP was offered/provided on eight of 36 scheduled days or 1.1 times per week. in an interview on 11/21/2025 at 2:39 PM, when asked if Resident 2's RNP was offered/provided at the frequency they were assessed to require Staff B, Director of Nursing Services, stated, No. Reference WAC 388-97-1060(3)(d)(j)(ix).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. Building B. Wing	11/21/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505361	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on observation, interview and record review, the facility failed to ensure intravenous (IV) access devices were assessed, maintained and monitored in accordance with professional standards of practice for 2 of 2 residents (Residents 1 & 46) reviewed for IV therapy. This failure placed residents at risk for unidentified complications including loss of vascular access, infection, and other potential negative health outcomes. Findings included .Review of the facility's Vascular Access Devices and Infusion Therapy Procedures policy, dated August 2021, showed upon admission or insertion staff would measure the external length of a Peripherally Inserted Central Catheter (PICC, a long, thin tube that's inserted through a vein in the arm and passed through to the larger veins near the heart), and the residents arm circumference 10 centimeter (cm) above the insertion site, to establish a baseline. The PICC external length and resident's arm circumference would then be measured weekly with PICC dressing changes. The weekly measurements would be compared to with the baseline measurements to assess for line dislodgement or migration and swelling or deep vein thrombosis (blood clot). Needleless injection caps would be changed at least every seven days and as needed. All valved vascular access devices would be flushed with 10 cubic centimeters (cc) of Normal Saline (NS) before and after infusion and a PICC insertion site would be assessed for signs and symptoms of complication at a minimum every 24 hours.1) Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's admission Minimum Data Set (MDS, an assessment tool), dated 10/22/2025, showed the Resident 1 was cognitively intact, had a diagnosis of intervertebral discitis (infection or inflammation of the intervertebral discs) and osteomyelitis (bone infection), and received IV antibiotics during the assessment period. Review of Resident 1's physicians orders, dated 10/18/2025, showed the following PICC maintenance and monitoring orders:a) Change IV administration set/ IV tubing every 24 hoursb) Change needleless injection caps on admission, after blood draws and with dressing changes as needed.c) Flush valved catheters with 5 milliliters (ml) normal saline (NS) before and after infusion. Flush non-valved catheters (clamped) with 5 ml NS before infusion, and then with 5 ml of NS, followed by 5 ml of heparin 10 units/ml after infusion. d) Change PICC dressing every seven days.The orders did not include direction to:a) Change needleless injection caps, for each lumen, weekly with dressing changes (routinely).b) Monitor PICC insertion site every 24 hours for signs and symptoms of infection.c) Measure PICC external length upon admission/insertion, and then weekly with PICC dressing changes and as needed. (.d) Measure arm circumference upon admission, weekly with PICC dressing changes and as needed. The orders failed to identify if the PICC was valved or non-valved, the number of lumens present, where it was located and directed staff to flush with 5 ml NS before and after infusions rather than 10 ml of NS as directed in the policy. Review of Resident 1's comprehensive plan of care, initiated 10/18/2025, showed a care plan was not developed/implemented to address the reason Resident 1 had a PICC, the type, location, number of lumens or the maintenance or monitoring required to care for it.Review of Resident 1's October and November 2025 Medication and Treatment Administration Records (MAR/TAR) showed staff signed daily that they flushed Resident 1's PICC but it was unclear what flush protocol was followed. The order directed staff to flush valved catheters with 5 milliliters (ml) normal saline (NS) before and after infusion. For non-valved catheters (clamped) staff were directed to flush with 5 ml NS before infusion and 5 ml of NS followed by 5 ml of heparin 10 units/ml (a blood thinner) after infusion. The order did not indicate whether Resident 1's PICC was valved or non-valved. Review of the documentation showed it was indeterminable what flush protocol each facility nurse used. Further review showed there was no documentation that staff had changed Resident 1's needleless injection cap(s) with the 10/23/2025, 10/30/2025 or 11/06 2025 weekly dressing changes or that staff were assessing the PICC insertion site daily.Review of Resident 1's electronic medical record (EMR) showed no documentation that staff obtained an initial PICC external length or an initial arm circumference measurement for Resident 1. Nor was there documentation that the external length and arm circumference measurements were obtained at any point thereafter.During an interview on 11/21/225 at 3:12 PM, Staff B, Director of Nursing Services (DNS) said Resident 1's PICC maintenance and monitoring order were incomplete and acknowledged there was no documentation to show Resident 1's insertion site, arm circumference, PICC external length had been assessed and monitored or that the needleless injection caps had been changed. Staff B confirmed Resident 1's flush orders failed to identify if the PICC was valved or non-valved, thus it was unclear what flush protocol facility nurses were following as both protocols were