STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505379	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Park Health and Rehabilitation	7411 North Nevada Spokane, WA 99208

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain a system of accounting for controlled drugs (substances or medications that had a high potential for abuse, misuse and addiction) in sufficient detail to enable an accurate reconciliation in 3 of 3 medication room emergency medication kits (Medication room [ROOM NUMBER] - Oak, Medication room [ROOM NUMBER] - Evergreen, and Medication room [ROOM NUMBER]- Transitional Care Unit -TCU), reviewed for medication storage. This failure created a risk of potential undetected drug diversion. Findings included.During an observation and interview on 05/04/2026 at 10:46 AM, the refrigerator in Medication room [ROOM NUMBER] - Oak unit medication room was observed with Staff D, Registered Nurse (RN). The refrigerator contained a clear plastic emergency medication kit (e-kit) that separated medications into multiple compartments. Review of the paper inventory sheet attached to the front of the kit documented the kit was to contain two vials of injectable lorazepam (a controlled medication that treated anxiety) and two 30 milliliter (ml) bottles of liquid lorazepam. Two 30 ml bottles of liquid lorazepam were observed in the kit. The pharmacy label on the back of the e-kit documented the lorazepam was delivered on 04/29/2026. The e-kit was sealed with a red tag labeled 00087. Staff D stated the e-kit red tag seal number was not tracked and the lorazepam was not logged into a narcotic tracking book (a book where two licensed nurses counted and verified controlled medications each shift). Staff D further stated all three medication rooms contained a similar refrigerated e-kit.During observation and interview on 05/04/2026 at 11:36 AM, the refrigerator in Medication room [ROOM NUMBER] - Evergreen unit medication room was observed with Staff F, Resident Care Manager, and Staff E, RN. The refrigerator contained a clear plastic e-kit, similar to Medication room [ROOM NUMBER] - Oak unit. Review of the paper inventory sheet attached to the front of the kit documented it was to contain two vials of injectable lorazepam, and two 30ml bottles of lorazepam liquid. The two bottles of lorazepam liquid were observed through the clear tote. Staff E acknowledged the e-kit contained two 30 ml bottles of lorazepam liquid but no vials. The pharmacy label on the back of the e-kit documented it was delivered on 04/29/2026. The e-kit was sealed with a white tag labeled 3739935. Staff F stated when staff accessed the e-kit, they were to unseal it, complete a white emergency box sign-out record, fax the completed record to the pharmacy, place the record into the e-kit box, and place a new tag with a new number on the e-kit to reseal it. Staff E stated the e-kit was not logged into a narcotic tracking book unless lorazepam was removed for a particular resident. Then it would be logged into a narcotic tracking book to be counted each shift as required. Both Staff F and Staff E stated they were unsure how staff accounted for the e-kit lorazepam.During an observation and interview on 05/04/2026 at 11:36 AM, the refrigerator in Medication room [ROOM NUMBER] - TCU was observed with Staff F. The refrigerator contained a clear plastic e-kit, similar to Medication room [ROOM NUMBER] - Oak and Medication room [ROOM NUMBER] - Evergreen units. The e-kit was unsealed, contained no tag number, and was easily opened by Staff F. The e-kit contained two vials of injectable lorazepam and two 30 ml bottles of (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lorazepam liquid. Staff F stated they were unsure when the e-kit was accessed and by whom, or what was removed. They acknowledged the e-kit should have been resealed with a new red tag labeled 00081 on the kit. In an interview on 05/04/2026 at 12:35 PM, with Staff B, Interim Director of Nursing, and Staff C, Regional Director of Clinical Operations, Staff C stated a nurse would typically verify the lorazepam e-kit tag number was unchanged when they monitored the temperature of the medication refrigerator. Staff C stated the lorazepam e-kit was to be sealed. Both Staff B and C stated they expected staff to maintain a system of records with sufficient detail to enable an accurate reconciliation of controlled drugs. A policy for medication storage was requested and none was provided.During an interview on 05/05/2026 at 12:54 PM, Staff A, Administrator, stated they expected staff to maintain a system of records with sufficient detail to ensure an accurate reconciliation of all controlled drugs.Reference WAC 388-97-1300(1)(b)(ii)(c)(ii)-(iv)

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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 observation, interview and record review, the facility failed to assess and implement a care plan for a positioning device (wedge to keep head raised) that was provided to 1 of 3 sampled residents (Resident 16) reviewed for positioning and mobility. This failure placed the resident at risk for unsafe conditions, risk of poor body alignment and improper positioning. The 04/06/2026 quarterly assessment documented Resident 16 had diagnoses that included dementia and difficult swallowing. Resident 16 was severely cognitively impaired and required substantial assistance for rolling to their left or right side then returning to their back when in bed.The 04/27/2023 care plan documented Resident 16 required assistance with activities of daily living, had esophageal reflux (a disease where the stomach acid flows back up into the esophagus and casues heartburn - a burning chest pain near the sternum), and was at risk for pressure ulcers and falls. Staff were instructed to wait at least one hour after meals, then lay the resident down between meals, keep the head of bed elevated, and encourage and assist with turning and repositioning. One staff member was required for bed mobility and staff were to use pillows to elevate the resident's heel off the mattress to prevent pressure ulcers. Resident 16 had no other positioning devices documented in their plan of care for use when they were in bed. On 04/27/2026 at 10:56 AM, Resident 16 was observed sleeping in bed. Signage hung on the wall above the headboard instructed Head of bed to be elevated at all times. Resident 16's bed was observed positioned flat. A foam wedge was positioned behind Resident 16's back. The wedge was as wide as the bed and went from the resident's head to their mid-back in length. Resident 16 was positioned on their back. Their head and lower part of their body leaned to the left with their head and shoulder area partially on the edge of the wedge. On 04/28/2026 at 9:19 AM, Resident 16 was observed in the same position, awake, resting in bed leaning towards the left edge of the wedge.On 04/29/2026 at 10:24 AM, Resident 16 was napping in bed on their back. Their head rolled off the positioning wedge to the left with their neck bent forward in an awkward position. The resident's eyeglasses were skewed off their nose hanging to the left side of their face. On 04/30/2026 at 10:15 AM, Resident 16 was awake, resting in bed. The resident was cued by an unidentified Nursing Assistant (NAC) to scoot back over on the wedge and was positioned back in the center of the bed and wedge. During an interview on 05/05/2026 at 1:20 PM, Staff G, Director of Therapy, stated the positioning wedge on Resident 16's bed was not something that the therapy department had implemented. Staff G stated it might have been something the nursing staff implemented. During an interview on 05/05/2026 at 1:55 PM with Staff H, NAC, and Staff I, NAC, Staff H stated the wedge on Resident 16's bed would have to be care-planned for the resident either by the Resident Care Manager or the therapy department and it was to keep Resident 16's head elevated because of risks related to swallowing. Staff I stated they had been employed at the facility for three months, and the wedge had been in place since they began working there. Staff H stated the wedge had been in place as far back as they could remember. Staff H and Staff I acknowledged Resident 16 leaned over to the left when in bed. They stated if they saw Resident 16 lean towards the edge, they were able to reposition the resident but would not be allowed to remove the wedge. On 05/05/2026 at 2:17 PM, Resident 16's bed was observed with Staff C, Regional Director of Clinical Services. Staff C stated they were not aware the positioning wedge was used for Resident 16 and was unsure how long it had been there. Staff C was unsure why the wedge was necessary as the same effect could be achieved by raising the head of the bed. Resident 16's roommate spoke up at that time and stated Resident 16's family brought it in and it had been there for months. Staff C stated, devices used for positioning were assessed to make sure they were appropriate and safe, and if so, were added to a resident's plan of care. Staff C stated they were going to have the device evaluated. Reference: WAC 388-97-1020(5)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 nail care was provided to a resident per providers orders for 1 of 5 residents (Resident 42) reviewed for Activities of Daily Living (ADL's). This failure placed residents at risk of unmet care needs. Findings included. A quarterly assessment dated [DATE], showed that Resident 42 had severely impaired cognition and diagnoses of Congested Heart Failure (CHF, a long-term condition where the heart cannot pump blood effectively) and Osteoarthritis (a degenerative joint disease.) The resident was fully dependent on facility staff for their grooming and bathing. On 04/28/2026 at 10:43 AM, Resident 42 was observed sleeping in bed with their feet visible. Their toenails were long, thickened, and curved over the end of the toes and onto the skin. There was red polish on the ends, that had grown out over a quarter of an inch. Additionally, there was a scabby, dried, greenish area next to the right big toenail. The April 2026 Treatment Administration Record (TAR) showed a physician order, started on 04/25/2025, to perform fingernail and toenail care weekly on Fridays. It was signed as completed on 04/03/2026, 04/10/2026, 04/24/2026 and refused on 04/17/2026. Review of Resident 42's care plan, updated 12/23/2025, showed they preferred a shower or bed bath one or two times a week. As of 04/29/2026 Resident 42's medical record showed no entries about toenail care, refusals for nail care, podiatrist (a provider that specialized in all aspects of footcare) notes or referrals.In an interview of 05/05/2026 at 9:29 AM, Staff N, Licensed Practical Nurse (LPN) stated that nail care was done by the shower aide on their bath days unless the resident had diabetes. Staff N confirmed that Resident 42 was not diabetic and the shower aides did their nail care. Staff N agreed to look at Resident 42's feet together once the resident was awake. During an interview on 05/05/2026 at 9:48 AM, Staff O, Shower Aide, stated that nail care was done by the aides on shower days, unless the resident was diabetic or on blood thinners. They stated that Resident 42's toenails were too thick with fungus for the shower aides to do the nail care and previously it was done with a Dremel (a battery-operated tool used to file and smooth nails) by a podiatrist. During an observation and subsequent interview on 05/05/2026 at 11:26 AM with Staff N, Resident 42's toenails were observed unchanged from 04/28/2026. Staff N asked the resident if the facility could contact a podiatrist about their toenails, and the resident immediately agreed. Staff N stated they did not know when toenail care was last done for the resident, and the care should be done by a podiatrist. They further stated that since a referral to podiatrist was already a part of the facility's standing orders, Staff N would add Resident 42 to the list of residents to be seen by podiatry. During an interview on 05/05/2026 at 3:03 PM, Staff B, Director of Nursing and Staff C, Regional Director of Clinical Operations, acknowledged that nail care for Resident 42 was not done as ordered and that a referral to the podiatrist was appropriate. 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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to consistently monitor a resident for latent injuries after numerous falls for 1 of 4 sampled residents (Resident 4), reviewed for accidents. Specifically, the facility did not complete vital signs (VS- temperature, heart rate, respiratory rate and blood pressure) and neurological checks (neuro checks, an assessment used to evaluate the residents' level of consciousness, movement, hand grasps, pupil size and reaction) after unwitnessed falls. This failed practice placed residents at risk for unidentified injuries and diminished quality of life.Findings included.Review of the facility policy titled Fall Management and Neurological Check, updated January 2025, showed that the facility implemented a fall management plan based on medical history and the resident evaluation. Review of the facility document titled Neurological Evaluation Flow Sheet, updated January 2025, showed when initiated, neuro checks and vital signs (VS) were to be completed hourly for four hours, then every four hours for 24 hours. A 04/23/2026 comprehensive assessment documented that Resident 4 had diagnoses of dementia and paralysis on one side of the body after a stroke. The resident had severe cognitive impairment and required staff assistance with transfers to and from their wheelchair. The resident had an 03/19/2026 order for Eliquis (a blood-thinner) twice a day. Review of the facility incident log showed that Resident 4 had five falls since 03/19/2026, including four unwitnessed falls on 03/24/2026.Review of the facility investigations, which included neurological evaluation flow sheets, for the four unwitnessed falls on 03/24/2026 showed the following:At 12:15 AM, the resident was found kneeling in the bathroom, attempting to get up. A scrape on their left leg was noted. Hourly neuro checks and VS were started. At 3:00 AM, the resident was found on the floor, next to their bed. The resident had a large bump on the right temple area on their head. The resident was sent to the hospital for evaluation, as they were on blood thinners. They returned to the facility at 9:30 AM, and neuro checks and VS were resumed. At 4:00 PM, the resident was found sitting in the hallway with their wheelchair in front of them. They had a new abrasion to their left arm. Neuro checks were not restarted and the next neuro check and VS check was done at 6:00 PM, two hours later.At 6:15 PM, the resident was found sitting on the floor, next to a table and their wheelchair, in the dining room. No injuries were found. A neuro check was done at 10:00 PM and no additional neuro checks were completed after that. During an interview on 05/05/2026 at 8:58 AM, Staff K, Licensed Practical Nurse (LPN) stated that if a fall was unwitnessed, the staff needed to do neuro checks at the frequency written on the flowsheet, then give the sheet to the Resident Care Manager (RCM.) If a resident had a second fall while still on neuros, staff should restart the neuro checks as a new fall. During an interview on 05/05/2026 at 12:13 PM, Staff L, RCM, stated that after a fall, the resident should be put on neuro checks if they hit their head or may have hit their head. If the resident had another fall while on neuros, they would restart the neuros if that fall was not witnessed. During an interview on 05/05/2026 at 3:03 PM, Staff B, Director of Nursing and Staff C, Regional Director of Clinical Operations, reviewed findings regarding monitoring Resident 4 following their falls. Staff C initially stated that facility policy was that neuro checks were not always required for an unwitnessed fall in certain instances. It could be based on nursing judgement. After reviewing that Resident 4 had four unwitnessed falls that day, was on blood thinners and one of the earlier falls had resulted in a lump on their head and a hospital visit, Staff C and Staff B acknowledged that the resident should have had neuro checks for the last two falls as directed on the neuro sheet.Reference: WAC 388-97-1060 (3)(g)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (Resident 2) reviewed for medication administration. Specifically, two medications for Resident 2 were not held or administered when indicated according to parameters ordered by the provider. This failure placed residents at risk for adverse health complications and diminished quality of life. Findings included.The 02/05/2026 comprehensive admission assessment documented Resident 2 had diagnoses that included Heart Failure (ineffective pumping of the heart that caused fluid build-up, swelling of limbs and difficult breathing) and low blood pressure. Resident 2 was severely cognitively impaired. Resident 2's medication orders included the following: - 02/16/2026: Metoprolol twice daily for heart failure, hold for systolic blood pressure (SBP, the top number of a blood pressure reading) less than 110, and heart rate (HR) less than 60 beats per minute.-02/27/2026: Midodrine three times daily for low blood pressure. On 03/20/2026, the order was changed and added to hold the medication for SBP greater than 130. <Metoprolol> A review of the April and May Medication Administration Records (MAR) from 04/01/2026 to 05/03/2026, showed Metoprolol was scheduled in the morning (between 6:00 AM and 10:00 AM) and evening (between 6:00 PM and 10:00 PM). There was no documentation of the BP or HR on the MAR. Review of the April and May Treatment Administration Record (TAR) from 04/01/2026 to 05/03/2026, showed that vital signs (VS, which included BP and HR readings) were done every dayshift. The TAR showed the morning SBP was less than 110 on 18 of the 33 days reviewed from 04/01/2026 to 05/03/3036. Per the April and May 2026 MAR, Metoprolol was held on four days (04/04/2026, 04/09/2026, 04/14/2026, and 04/15/2026). There was no documentation of the VS on the MAR on the evening shift. Additional vital signs were documented in the Weights and Vitals tab of the facilities charting system. When reviewed, the times the evening VS were documented for April and May 2026 did not correlate with times the metoprolol was ordered to be given. Additionally, there were no afternoon or evening VS recorded for 04/09/2026. <Midodrine>The April and May 2026 MAR from 04/01/2026 to 05/03/2026, showed Midodrine was scheduled in the morning (between 6:00 AM and 10:00 AM), afternoon (between 2:00 PM and 7:00 PM) and in the evening (between 7:00 PM and 10:00 PM). There was no documentation of the BP on the MAR when Midodrine was administered. Additional vital signs were documented in theWeights and Vitals tab of the facilities charting system. Comparison of April and May 2026 VS to the April and May 2026 MAR showed 3 times when a dose of the Midodrine should have been held, and was given (04/14/2026, 04/19/2026 and 04/28/2026). Additionally, there were 2 times when the dose of Midodrine should have been administered but was held (04/01/2026 and 04/25/2026). 28 of the 33 days reviewed had BP readings only once or twice a day.No documentation was found in the medical record that showed the provider was notified of frequent instances when the blood pressure readings were outside of ordered parameters. During an interview on 05/04/2026 at 11:13 AM, Staff J, Registered Nurse (RN) stated that the day shift nursing assistants (NA's) obtained VS daily for all residents on the unit. They stated that the NA's documented results on paper, then put them into the computer when they were able. Staff J further stated that the nurse should have checked or obtained VS before giving any medication that had orders to hold them if outside of the parameters. During an interview on 05/05/2026 at 8:58 AM, Staff K, Licensed Practical Nurse (LPN) stated that when charting a medication given in the computer, there was an optional tab for supplemental documentation the nurse could click on. Staff K showed when that tab was opened, the most recent BP results were displayed, and the nurse could click on one of them to use this or add another reading. They further stated if a BP was added in this way, the result flowed to the resident's VS tab. Additionally, when staff documented VS results in the VS tab, the first entry of the day flowed onto the TAR as well. During an interview on 05/05/2026 at 12:13 PM, Staff L, Resident Care Manager (RCM) stated that the nurse was to obtain the VS and document results before giving those medications. After reviewing (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's record, Staff L acknowledged that the VS should have been obtained and charted prior to each dose of metoprolol and midodrine. Staff L stated the documentation on the MAR, TAR and VS tab did not clearly indicate which blood pressure and heart rate readings were used to determine if medications were to be given or held. During an interview on 05/05/2026 at 3:03 PM, Staff B, Director of Nursing, and Staff C, Regional Director of Clinical Operations, acknowledged that the documentation of VS timing and frequency was not adequate to determine if metoprolol and midodrine were or were not given as ordered according to the parameters. Reference: WAC 388-97-1060(3)(k)(iii)

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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 ensure a particular type of drinking cup was consistently provided as care planned and ordered for 1 of 1 sampled residents (Resident 16) reviewed for assistive devices. This failure placed the resident at risk of swallowing difficulties and unintended health consequences.Findings included.On 02/06/2025, the physician's order noted, Resident 16 to use a sippy cup (drink aid designed to control liquid flow and promote safe swallowing with lid) for all drinks, no straws. The 04/06/2026 quarterly assessment documented Resident 16 had diagnoses that included dementia and dysphagia (difficulty swallowing). Resident 16 had severe cognitive impairments, required moderate assistance from staff for eating, and received daily eating/swallowing skill practice during the assessment look back period. The 04/27/2023 care plan documented Resident 16 had activities of daily living (ADL) self-care deficits. On 04/16/2025, the care plan was updated to show Resident 16 used 2-handled cups for assistive devices. On 04/17/2025, the care plan was updated to show Resident 16 required staff cues to wake up and take bites/drinks throughout each meal and was to use sippy cups for beverages. Resident 16 was also at nutritional risk related to difficult swallowing. The 08/06/2025 diet list included soft and bite-sized textures, and mildly thick liquid consistencies. On 09/16/2025, interventions included aspiration precautions (safety measures designed to prevent foods or liquids from entering the airway and lungs) and no straws. On 04/27/2026 at 1:10 PM, Resident 16 was observed in their room, seated in their wheelchair next to their bed. The overbed table was positioned across Resident 16's lap. Two brown plastic coffee mugs were on the table. One had remains of a drink in the bottom, the other was half full of coffee that was thickened. The cups had no lids on them, and only one handle. There were no sippy cups present. Three signs were hanging on the wall above the head of the bed. One read Head of bed elevated at all times; a second read Thicken liquids and the third read Sippy cups only. On 04/28/2026 at 9:39 AM, Resident 16 was observed resting in bed. The overbed table next to the bed had a coffee mug on it that was half full with thickened water in it. The signage that read Sippy cups only hung above the head of the bed.On 04/29/2026, the physician's order noted, Resident 16 to use a lipped up (directs the flow of liquid smoothly onto the tongue, provides a comforting resting spot for the mouth, and prevent drips running down the outer walls) for all drinks, no straws. During an interview on 05/05/2026 at 1:55 PM with Staff H, Nursing Assistant (NAC), and Staff I, NAC, Staff H stated Resident 16 ate their meals in the main dining room with Restorative Nursing staff and Staff H did not assist with that. Staff H stated Resident 16 was allowed drinks at their bedside. They stated Resident 16 had to have thickened liquids, a spouted cup, and had to be sitting up. When asked, Staff I stated Resident 16 was not allowed to have a regular coffee mug as this was a choking risk. Staff H stated a regular coffee mug should never be given to the resident.During an interview on 05/05/2026 at 2:17 PM with Staff B, Director of Nursing, and Staff C, Regional Director of Clinical Operations, they reviewed Resident 16's orders and were uncertain if a sippy cup and a lidded cup (as ordered on 04/29/2026) were the same type of cup. They acknowledged that a regular coffee mug was not the correct type of cup for Resident 16 to drink from.Reference: WAC 388-97-1140(2)(4)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to follow professional standards for food service safety regarding cleanliness, hand hygiene and facial hair being covered for 3 of 3 food preparation areas (Kitchen, Main Dining Room and Steam Table). These failures placed residents at risk for food-borne illnesses.Findings included .<Kitchen cleanliness>During the initial Kitchen tour on 04/27/2026 at 9:00 AM with Staff P, Dietary Supervisor, crumbs and food debris were observed on counters, stove, steam table and the toaster area. The stovetop had dried, crusted food debris and a large, dried, crusted spill on the stovetop. Additionally, there was dried splatter on the backsplash behind the stove and dried drips down the right side of the stove. There was a large pot of soup simmering on the stove, over the dried spill. While this surveyor was inspecting the dry storage area, Staff P returned to the kitchen, moved the soup to another burner, removed the stovetop tray with the spill, and brought it to the dishwashing area. Staff P then began to wipe off the counters. <Hand Hygiene> On 05/01/2026 at 7:24 AM, Staff Q, Cook, was observed at the tray line plating food and wearing gloves in the Kitchen. Staff Q stopped placing food on plates and went to the stove to fry an egg, touched the burner knob, the frying pan handle, and an egg. When they cracked the egg, they got raw egg on their gloves. Staff Q removed their gloves and put on new ones, then returned to plating food. Staff Q did not wash hands or use hand sanitizer with the glove change. <Facial Hair Coverings> On 04/27/2026 at 1:04 PM, the lunch meal service was observed in the Main Dining Room. Staff R, Dietary Aide, was observed wearing a beard net, that partially covered their short beard. Their mustache and sides of their beard were uncovered. Staff S, Dietary Aide wore a beard net that covered their chin. Staff S's facial hair on their cheeks, neck and mustache were not covered. Both Staff R and Staff S plated food from the Steam Table, then handed the food to other staff, who brought it to the residents. On 05/01/2026 at 6:43 AM during food preparation in the kitchen, Staff R was observed toasting and buttering the bread. They then went to the Steam Table to add covers to the plates and, placed trays in the meal carts. Staff R was wearing a beard net over their chin, that did not cover their mustache or the facial hair on their cheeks. During an interview on 05/01/2026 immediately following the morning food preparation, Staff P stated that the dietary staff was required to keep their hair covered, including all facial hair. When informed that Staff R and Staff S's facial hair was not fully covered by their beard nets, Staff P stated two beard nets could have been used to fully cover their facial hair. Staff P also acknowledged that hand hygiene was to be completed anytime gloves were changed in the kitchen. Staff P further acknowledged that food preparation surfaces were to be kept clean when food was prepared. During an interview on 05/05/2026 at 3:03 PM, Staff B, Director of Nursing and Staff C, Regional Director of Clinical Operations acknowledged that the kitchen should be maintained in a clean manner, staff should perform hand hygiene with all glove changes and facial hair should be fully covered during food preparation.Reference: WAC 388-97-1100(3)