

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2026
NAME OF PROVIDER OR SUPPLIER Regency Wenatchee Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1326 Red Apple Rd Wenatchee, WA 98801	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents health information remained private for 4 of 5 residents (Residents 5, 3, 23, and 41) reviewed for the resident's right to privacy. Additionally, the facility staff referred to Resident 5 by a pet name which did not respect their right to be addressed by their own name when interacting with staff. This failure placed residents at risk for embarrassment and a poor quality of life. Findings included .</p> <p>Review of the facility's policy titled, Resident Rights revised date, 11/2025, showed the facility will honor resident rights as follows:</p> <p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including state agencies and the resident's representative.</p> <p>The resident has the right to receive treatment and care with respect and dignity in a manner and in a safe, clean, and homelike environment that promotes maintenance or enhancement of his or her quality of life.</p> <p>Resident 5</p> <p>Review of the resident's medical record showed they were admitted to the facility with diagnoses which included dementia, Parkinson's disease (an ongoing disease that destroys nerve cells and effects muscle movement) and dysphagia (difficulty in swallowing).The comprehensive assessment dated [DATE] showed the resident had severe cognitive impairment and required total assistance from staff for activities such as dressing grooming toileting, mobility and bathing. The assessment also showed the resident had swallowing difficulty which required a specialized texture diet.</p> <p>During an observation on 03/09/2026 at 9:30 AM, Staff U, Nursing Assistant (NA) was standing by Resident 5's bed getting ready to assist them with their meal. Above the bed taped to the wall was an undated handwritten paper sign which had specific swallowing guidelines for Resident 5. The sign with health care information was clearly visible to anyone who entered the resident's room. The sign was titled, Swallow Strategies</p> <p>Sit upright (continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Suspension/Support</p> <p>Encourage resident to fully chew and swallow</p> <p>Single drinks no changing</p> <p>Alternate bites and sips</p> <p>Make sure mouth is clear after meal</p> <p>Continued observation of Staff U conversing with Resident 5 while assisting them to eat, showed Staff U say to Resident 5 here baby take one more bite as they coaxed the resident to eat. Staff U continued to refer to the resident as baby several more times during the interaction.</p> <p>During additional follow up observations on 03/10/2026 at 9:30 AM, 03/10/2026 at 12:09 PM, and 03/11/2026, at 9:01 AM, showed the sign titled Swallow Strategies remained above Resident 5's bed with the specific health information visible to anyone who entered the room.</p> <p>During a concurrent observation and interview on 03/11/2026 at 9:10 AM, Staff C, Interim Director of Nursing Services was shown the sign above Resident 5's bed and agreed it had health care information and stated they (Resident 5) were unable to give consent to post the sign above their bed and removed it. Staff C stated they were not sure where the sign originated or why it was above the resident's bed. Additionally, Staff C stated it was not appropriate for staff to refer to Resident 5 as baby when conversing or interacting with them.</p> <p>Resident 3</p> <p>Review of the medical record showed that Resident 3 was admitted to the facility on [DATE] with diagnoses that included stroke (when blood flow is blocked from the brain), cognitive communication deficit (trouble participating in conversations), dysphagia (difficulty swallowing), and the need for assistance with personal care. The comprehensive assessment dated [DATE] showed the resident's cognition was moderately impaired and required assistance of one staff member with eating.</p> <p>During an interview and concurrent observation on 03/09/2026 at 3:32 PM, Resident 3 stated they liked to be up for dinner to have their tuna salad. A yellow paper was observed hanging from the light fixture above the resident's bed dated 02/17/2026 that had Resident 3's diet and their diagnoses.</p> <p>During an observation on 03/10/2026 at 2:16 PM, Resident 3 was lying in bed resting. The same yellow sign was observed above the resident's bed taped to the light fixture. The yellow sign contained the resident's diet and diagnoses with a date of 02/17/2026.</p> <p>Resident 23 (continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the medical record showed Resident 23 was admitted to the facility on [DATE] with diagnoses to include heart failure, dysphagia, and diabetes (a disease in which the body does not control glucose [a type of sugar] in the blood). The comprehensive assessment dated [DATE], showed Resident 23 was independent with eating, required assistance of one staff member for transfers and their cognition was moderately impaired.</p> <p>During an interview and concurrent observation on 03/10/2026 at 11:44 AM, Resident 23 stated the food was hard to swallow because they did not like the stuff called puree (food that is blended to a silky-smooth texture). Resident 23 had a yellow paper above the bed taped to the light fixture; the paper had showed a puree diet and diagnoses of dysphagia for Resident 23.</p> <p>In an interview on 03/11/2026 at 12:38 PM, Staff M, Nursing Assistant (NA), stated the sign above the bed had been there since the resident admitted . Staff M stated they were unclear why the sign had been posted above the resident's bed. Staff M stated that there were a few residents in the facility with those types of signs up by the head of their beds.</p> <p>During an observation on 03/11/2026 at 12:41 PM, showed Resident 23 had a yellow paper taped to the light fixture above the bed with a puree diet and diagnoses of dysphagia.</p> <p>Resident 41</p> <p>Review of the medical record showed Resident 41 was admitted to the facility on [DATE] with diagnoses to include Parkinson's disease (a progressive brain disorder that causes movement problems like tremors, stiffness and slowness), dysphagia, and dysphonia (an abnormal voice). The comprehensive assessment showed Resident 41 required setup assistance of one staff member for meals, and their cognition was moderately impaired.</p> <p>During an observation and concurrent interview on 03/09/2026 at 12:20 PM, Resident 41 was lying in bed resting, they had a sign above their bed for thickened liquids. The resident was being assisted by an unidentified staff member with their meal. The unidentified staff member stated they were unsure who placed the signs above the beds but stated a lot of the residents had the signs posted in their rooms.</p> <p>During an observation on 03/11/2026 at 10:53 AM, Resident 41 was asleep in bed covered with a sheet. There was a sign above their bed that stated the resident was to have thickened liquids.</p> <p>In an interview on 03/13/2026 at 10:04 AM, Staff C Interim Director of Nursing Services acknowledged the signs above the residents' beds and stated they had removed the signs that were above the beds.</p> <p>Reference: WAC 388-97-0180 (1-4)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure notification of the notice of transfers to the representative of the Office of the State Long Term Care (LTC) Ombudsman (a person that advocates for residents in nursing homes) occurred for 2 of 5 residents (Residents 52 and 61) reviewed for discharge. This failure placed the residents at risk for diminished protection, lack of access to an advocate that could inform them of their options and rights, and to ensure the resident advocacy agency was aware of the facility practices and activities related to discharge. Findings included . Resident 52 Review of the resident's medical records showed they admitted to the facility on [DATE] with a diagnosis of sepsis (A life threatening medical emergency caused by the body's extreme dysfunctional response to an infection). Review of the 02/18/2026 discharge assessment showed Resident 52's cognition was intact. Review of Resident 52's medical record showed Resident 52 was discharged home on [DATE]. Review of the Ombudsman notification list (a formal internal record or log used by a nursing facility to track and verify that they have informed the ombudsman of every resident transfer or discharge) for February and March 2026 showed no notification of discharge to the Ombudsman for Resident 52. Resident 61 Review of the resident's medical records showed they admitted to the facility on [DATE] with a diagnosis of influenza A (A highly contagious respiratory illness). Review of the 02/11/2026 discharge assessment showed Resident 61 had moderately impaired cognition. Review of Resident 61's medical record showed Resident 61 was discharged home on [DATE]. Review of the Ombudsman notification list (a formal internal record or log used by a nursing facility to track and verify that they have informed the ombudsman of every resident transfer or discharge) for February and March 2026 showed no notification of discharge to the Ombudsman for Resident 61. During an interview on 03/11/2026 at 10:49 AM, Staff P, Admissions Manager, stated they were responsible for notifying the Ombudsman of discharges. Staff P stated they only notified the Ombudsman if a resident was transferred to the hospital. Staff P further stated they were not aware of the requirement to notify the Ombudsman of all facility discharges. During an interview on 03/12/2026 at 12:11 PM, Staff B, Administer in Training, stated the correct process was for the Ombudsman to be notified of every resident discharge. Staff B further stated Staff P did not follow the correct process. Reference WAC 388-97-0120 (5)</p>		