STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505387	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodard Creek Health & Rehabilitation	3333 Ensign Road Northeast Olympia, WA 98506

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify, report and thoroughly investigate allegation of abuse/neglect for 5 of 8 sample residents (Resident 78, 37, 94, 100, & 131) reviewed for abuse and 20 supplemental residents (Resident 25, 53, 143, 4, 144, 150, 31, 45, 86, 80, 148, 149, 112, 99, 110, 69, 116, 10, 44, & 38) whose reported allegations of potential abuse and neglect were identified upon review of the facility's grievance log. The allegations identified included verbal abuse, rough handling, residents being fearful of staff, lack of incontinence care, not responding to call lights for multiple hours or turning call lights off and leaving without providing the requested care, and failure to provide help with bathing and hygiene for up to a week. Although the facility was aware of these alleged issues, they were not identified, reported, or investigated as potential allegations of abuse or neglect. Instead, they were identified as care and call light concerns and considered grievances. The failure to identify and thoroughly investigate the allegations of potential abuse and neglect allowed the alleged perpetrator(s) to have continued access to residents prior to determining if abuse or neglect occurred. This failure placed residents at serious risk for unidentified abuse and/or neglect and a diminished quality of life and constituted an Immediate Jeopardy (IJ). On 05/22/2026 at 2:28 PM, Staff A, Administrator was notified of an Immediate Jeopardy at CFR 483.12(2)-(4) F610, Alleged Violations-Investigate/Prevent/Correct, related to the facility's failure to identify allegations of abuse and neglect, ensure alleged abuse and neglect were reported, thoroughly investigated and residents were kept safe during the investigations. The facility removed the immediacy on 05/27/2026 with an onsite verification from investigators by conducting resident interviews, reporting and investigating allegations of abuse or neglect, suspending staff pending investigation conclusions, placing residents on monitoring for psychosocial harm, implementing daily manager rounds where managers visit their assigned residents, reading grievances out loud and reviewing call light times in the daily stand-up meeting, educating all staff regarding abuse policies/procedures and thorough investigations, and having the call light vendor come onsite to validate function. These actions ensured an effective system was in place to safeguard, protect and prevent residents that were at risk for abuse/neglect.Findings included . The facility policy titled, Abuse, revised 10/20/2022, showed under the section titled Identification, staff were encouraged to identify, correct, and intervene in situations which abuse, neglect and/or misappropriation of resident property was more likely to occur. Immediately following ensuring the resident's safety, staff were to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member. Under the section titled Investigation, designated staff would immediately review and investigate all allegations or observations of abuse. Under the section titled Reporting, the organization would immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, mistreatment and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator or his or her designee. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident 131 Resident 131 was admitted to the facility on [DATE]. According to the 5-Day Minimum Data Set (MDS, an assessment tool), dated 05/18/2026, Resident 131 was cognitively intact, frequently incontinent of both bowel and bladder, was dependent on staff for toileting hygiene and required continuous oxygen delivery. Resident 131 had a provider order, dated 05/14/2026, for continuous oxygen to maintain SpO2 (Peripheral capillary oxygen saturation, an estimate of the amount of oxygen in the blood) greater than 92% every shift. On 05/17/2026 at 1:57 PM, Resident 131 said they had sat in their diaper over a couple of hours that day, that they had been wet (with urine) and had had a bowel movement as well. Resident 131 said they alerted staff with their call light and it took over an hour to have their call light answered, and they called their sister (Collateral Contact 8) to let her know they needed help. Resident 131's sister then said they had been concerned Resident 131's call light was not working so they had called the reception desk and spoke with a staff member who said they would get someone right away to assist Resident 131. Resident 131 said they knew they had waited two hours for assistance because they hit their call light around 9 AM and called their sister for help at 10:51 AM, this was confirmed by Resident 131's sister's cellular phone call history. On 05/17/2026 at 2:53 PM, Staff A, Administrator, was made aware of the above allegations. Staff A said they would start an investigation and with the alleged two hour wait for care, most likely would report the allegation to the State office and place staff on leave. On 05/20/2026 at 2:36 PM, Resident 131 said they were not doing very good, needed oxygen, had hit their call light, and was feeling shaky (Resident 131s hand were observed to be shaking and they were not receiving supplemental oxygen). Observation showed the call light was not on in the hallway. Resident 131 was observed to hit their call light button, and the call light was still not visible in the hallway. On 05/20/2026 at 7:53 AM, Staff S, Licensed Practical Nurse, was alerted Resident 131 was requesting oxygen and had reported feeling shaky. Staff S went to Resident 131's room and applied oxygen via nasal cannula. Staff S reported Resident 131's SpO2 had been at 80% when he entered the room and checked it. Staff S was asked to press Resident 131's call light button, was observed to adjust the call light cord on the wall and then push the button which then was observed to have triggered the light in the hallway. Resident 131 said they were sure they had pushed the call light button that morning when they had started feeling funny. On 05/20/2026 at 10:45 AM, Staff S, when asked about Resident 131's call light not functioning, said he had observed that it had been disconnected and that was why he had adjusted it before pushing the call light button. Staff S said the call light unplugs from the wall and when the connection is broken the light on the wall comes on and the light in the hall goes on, but this had not happened when Resident 131's call light was disconnected. On 05/20/2026 at 10:49 AM, Resident 131 said sometimes their call light worked and sometimes it did not. On 05/21/2026 at 8:17 AM, the facility provided the facility investigation with supporting documentation as it pertained to Resident 131's alleged two hours wait for care. The investigation documentation showed the facility call light report (a record of call light wait times) had been (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	reviewed by the facility and did not show Resident 131 had used the call light during the time in question. In the investigation documentation Staff F, Certified Nursing Assistant (CNA), had reported that when he was made aware Resident 131 needed care he had attempted to locate a second staff member before providing care, sometime mid-morning. Under the section titled conclusion, it was documented the allegation was not supported by objective evidence sufficient to verify a two-hour delay in care, that it remained unclear how long the resident waited before the CNA informed the resident he would locate a second staff member, and this was because Resident 131 had not activated the call light. Review of the investigation did not show the call light had been inspected to ensure it was functioning properly or that Resident 131 had been interviewed. Under incident description of the investigation it was documented it was Resident 131's daughter who had called the front desk to request help in their room, not their sister. On 05/21/2026 at 9:39 AM, Staff AA, Director of Maintenance, was asked how the facility would know if a call light had become disconnected from the wall. Staff AA said the light in the hallway would come on if it was disconnected. Staff AA explained when the call light cord became disconnected it would come apart a little bit, and the Resident would then push the call light button and the call light would not work. Staff AA, said if the call light was disconnected and the light went off in the hallway, staff would come and turn off the call light in the room and then leave the room and then the resident would be left with a call light that would not work due to the disconnection not being identified. Staff AA said staff may not know to check the connection of the call light cord. On 05/21/2026 at 10:23 AM, Staff AA, regarding the call light disconnecting and staff responding and turning the light off but not checking the cord connection, said this was a known issue. Staff AA said they would get work orders regarding the call light getting disconnected once a month or something like that. When asked if they had educated staff regarding the potential issue with call lights becoming disconnected, Staff AA said once a month they would verbally provide education to CNAs and nursing staff but sometimes the staff were busy. Staff AA said he would verbally provide education but not written education, and he did not keep track of who he had educated. Staff AA said facility staff would come and go (indicating staff turnover), so he did not educate everyone. On 05/22/2026 at 1:29 PM, Staff A, Administrator, Regarding Staff AA reporting call light cords becoming disconnected was a known issue and being reported at least once a month, Staff A was asked if the call light was inspected as part of the investigation into Resident 131's reported two hours wait for care after reporting she had used her call light button. Staff A said the call light had not been inspected as part of the investigation and should have been, especially, having been a known issue. Regarding Resident 131's incident where they could not reach staff when requiring oxygen due to the call bell not functioning, Staff A said education had started after the incident. When asked if Resident 131 had been interviewed as part of their investigation, Staff A said he did not have a statement for Resident 131 and he would expect the Resident to have been interviewed as part of the investigation and for there to be a statement documenting the interview. On 05/29/2026 at 10:09 AM, Resident 131 was asked if it was their sister that called the facility to request help for them in their room or was it their daughter as the investigation indicated. Resident 131 said it was their sister who had called the facility to request help for them, and said, I don't have a daughter. On 05/29/2026 at 10:18 AM, Staff L, Interim Director of Nursing Services, said the investigation documentation indicating it was Resident 131's daughter who had called the facility to request assistance rather than their sister did not meet her expectations. When asked if a resident reported (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	an allegation of abuse or neglect should the resident be interviewed as part of an investigation, Staff L said, yes, it was the expectation to interview the resident. The following grievances were reviewed with Staff A, Administrator, on 05/21/2026 at 10:39 AM. Staff A confirmed each of the following grievances were an allegation of abuse/neglect or acknowledged the facility's failure to obtain further information about the reported events precluded the facility from ruling abuse and neglect out. (e.g. failure to follow up with a resident who alleged poor call light response to determine how long it was before staff responded, what was the resident's need, and determining what, if any, outcome/affect it had for the resident.) Resident 25 In a grievance, dated 04/05/2026, Resident 25 reported that care was not consistently provided over the weekend. The resident reported that during evening shift they requested assistance with being changed, were told staff would return, and staff did not return to provide the requested care. Resident 25 also reported that a scheduled shower was not provided despite repeated reminders to staff. Resident 53 In a grievance, dated 04/05/2026, Resident 53 reported that care over the weekend was not the best and that there were long call light wait times and incontinent care was not provided frequently enough. In a grievance, dated 04/07/2026, Resident 53 reported they had requested a brief change and were told by the aide they would come back to do it because they had left someone on the floor. Resident 53 said the aide never returned to change her. Resident 143 In a grievance, dated 4/07/2026, Resident 143 reported waiting more than 30 minutes for assistance to the bathroom after activating the call light, and experienced urinary incontinence while waiting. Resident 143 made it clear that she was not usually incontinent Resident 4 In a grievance, dated 4/06/2026, Resident 4 reported requesting a bed bath due to feeling weak and being told staff would return to provide care. The resident reported the bed bath was not provided, the resident's brief was not changed, and the resident remained in a wet brief while waiting for assistance. The resident further reported feeling ignored by staff and expressed significant concerns regarding interactions with a specific nursing assistant. In a grievance, dated 04/16/2026, Resident 4 reported a nurse came to administer medications, but the resident requested the nurse return later after eating. Resident 4 reported the nurse never returned and the medications were not administered. Resident 144 In a grievance, dated 04/09/2026, Resident 144 reported that a walker had been placed out of reach and that it took a long time to obtain assistance. The resident also reported concerns regarding a recent surgical incision, pain management concerns, and reported not feeling safe. In a separate grievance, dated 04/09/2026, Resident 144 reported experiencing long call light wait times when (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident 99 In a grievance, dated 04/24/2026, Resident 99 reported not receiving scheduled showers during the week of 04/20/2026 through 04/24/2026. The resident reported staff stated they would return to provide the showers but never returned. Resident 110 In a grievance, dated 04/29/2026, Resident 110 reported long call light response times. After reviewing the above grievances on 05/21/2026 at 10:55 AM, Staff A, Administrator, indicated it was not necessary to review further grievances as he could see the pattern (of failure to identify allegations of abuse and neglect and/or obtain enough information to rule abuse and neglect out.) In an interview on 05/21/2026 at 2:42 PM, Staff A, Administrator, confirmed the following grievances were also allegations of abuse and neglect and/or the facility failed to rule abuse and neglect out. Resident 69 In a grievance, dated 05/06/2026, Resident 69's wife reported the resident had not received a shower since admission on [DATE]. Resident 116 In a grievance, dated 05/11/2026, Resident 116 reported not receiving bathing or hygiene care since admission on [DATE]. Resident 10 In a grievance, dated 05/10/2026, a resident's husband reported concerns regarding a nurse being rude and disrespectful toward the resident and family members. The grievance alleged the interaction caused emotional distress to the resident for several hours. Resident 44 In a grievance, dated 05/11/2026, Resident 44 reported being left unattended in a mechanical lift for more than 30 minutes while staff sought assistance from another staff member. Resident 38 In a grievance, dated 05/19/2026, Resident 38 reported remaining in the same clothing for seven days without being changed. On 05/22/2026 at 12:13 PM, Staff A, Administrator, stated the facility had dropped the ball related to the facility's grievance process and identification of abuse/neglect allegations and had reached out to his boss to come help work on the investigations and to educate him and the facility managers on conducting investigations. Resident 78 (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident 78 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact. On 05/17/2026 at 2:15 PM, Resident 78 reported that approximately three to four nights earlier, at about 2:00 AM., an unfamiliar female CNA changed her roommate and then approached her bed and abruptly pulled back her covers and instructed her to get up and go to the bathroom. The resident said she pointed to the dry erase board (which had care instructions written on it) and informed the aide she was a check and change, but reports the aide just laughed and told her she could change herself and directed her to go into the bathroom. Resident 78 said she went into the bathroom and changed herself but couldn't adequately clean herself and lacked the dexterity to fastened the side tabs on the brief. The resident said she ultimately put on a pull-up she believed to belonged to her roommate. Resident 78 said throughout the process the aide stood in the doorway to the room with the door open and the bathroom door open. Resident 78 indicated she felt like she was nothing and didn't deserve to have assistance. Resident 78 said she reported to staff the next morning but no on had followed up with her about the incident. On 05/17/2026 at 2:57 PM, Resident 11, Resident 78's roommate, corroborated the incident. Resident 11 stated, I heard it. The way the aide spoke to (Resident 78) was like a sergeant in the Army. Resident 11 confirmed the CNA made Resident 78 get up and go to the bathroom and change herself like a drill sergeant. Review of the electronic health record showed there was no documentation of the incident present. Review of the facility grievance log showed a grievance was entered on 05/17/2026 by Staff B, Director of Nursing Services, on behalf of Resident 78, with an incident date of 05/13/2026. Review of the grievance record on 05/21/2026 at 10:39 PM showed the grievance details stated, 05/13/2026 day shift CNA was rude, used tone and approach that was perceived as disrespectful. The sections titled Summary of Investigation, Summary of Findings, and Summary of Actions Taken were blank. When asked if anyone had interviewed Resident 78, Staff A, Administrator, said no. Staff A was then provided with the initial interview with Resident 78 so they could follow up. On 05/22/2026 at 2:51 PM, a copy of the facility's new investigation into Resident 78's allegation was provided. The investigation included the information this writer provided to Staff A, Administrator, but no interviews conducted by the facility with Resident 78, her roommate, other residents, or staff members who may have had knowledge of the event. The investigation also did not identify the alleged perpetrator or any attempts the facility made to identify the alleged perpetrator. On 05/22/2026 at 5:13 PM, when asked if the facility had interviewed Resident 78 or Resident 11 (Resident 78's roommate) who was present at the time of the event, Staff A stated, No. When asked if an investigation can be thorough if the alleged victim and a witness who had stated they overheard what occurred were never interviewed, Staff A stated, No. Resident 37 Resident 37 was admitted to the facility on [DATE], and recently had been hospitalized for a joint replacement surgery from 05/01/2026 to 05/05/2026. The Quarterly MDS, dated [DATE], showed during the assessment period Resident 37 was cognitively intact, and was always continent of bowel, occasionally incontinent of urine (less than 7 episodes of incontinence). (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident 37's urine records, from 05/06/2026 to 05/18/2026, showed only one to two urinations a day charted by staff, of incontinent episodes. Review of Resident 37's bowel records, from 05/06/2026 to 05/18/2026, showed Resident 37 was now incontinent of bowel. During an interview on 05/17/2026 at 2:14 PM, Resident 37 reported they were only changed two times a day, could wait hours and thought they should be changed more. Resident 37 said that morning they thought they had waited about two to three hours to get changed, and during the day it could take longer than that. On 05/17/2026 at 5:16 PM, Staff A, Administrator, was notified of the allegation of neglect by surveyor. Review of Resident 37's continence care plan, showed an intervention initiated 06/09/2025 for female nursing staff to provide personal cares per resident request. Review of Resident 37's allegation of neglect investigation on 05/17/2026, showed the investigation had no details listed of Resident 37's level of consciousness (left blank), mobility (left blank), and no mental status (no selected boxes). Staff statements showed Staff Z, CNA, said they had traded rooms as Resident 37 said they needed to have a female staff come and change their brief, so they traded with Staff Y, CNA. This statement did not have any more details, such what time Resident 37's brief was first identified as soiled and needing to be changed, or how long it took before Staff Y replaced them. Staff Y's statement, said they had been notified by Staff Z about Resident 37's brief needing to be changed at around 10:00 AM, it did take an extended amount of time, and changed Resident 37 around 11:30 AM with another CNA. No other staff interviews were completed. For like residents interviewed, six were listed on the forms but only four interviews were completed. None of the other residents were asked about delays in cares or about incontinent care. During the interview with Resident 37, they expressed the facility would benefit from an extra care staff member working as a float and included a statement of, I know that sometimes the facility does have care staff floating, but sometimes they have to be reassigned to cover additional staffing concerns. Further review of this investigation, showed a summary of findings, date 05/19/2026, was added that documented they could not confirm the exact length of time Resident 37 waited as two to three hours, the call light report confirmed multiple activations with varying response intervals but did not establish a single continuous two to three hour unanswered request for care (the allegation was not about the call light being on for two to three hours, but that it took that long to receive care from staff). It also documented Resident 37 understood their care may take longer due to needing a two person assist. This investigation did not explain what steps were being taken to improve delays related to Resident 37 being a two person assist currently, or that the care plan had shown Resident 37 required a female CNA assignment for brief changes. The investigation had the conclusion, dated 05/19/2026, that the allegation was unsubstantiated. During an interview on 05/20/2026 at 11:32 AM, Resident 37 was asked about their call light. Resident 37 said that made them nervous, they were not sure it was lighting up outside. Resident 37 was seen with a grey and round soft touch call light, reporting it was for their arthritis. Resident 37 attempted to turn the light on, the light outside of the room was not lit up. Resident 37 attempted again, and the light turned on. Resident 37 stated, Shoot, I thought it was on all the time. That could be why some of my response times are long. It's hard to press because of my arthritis. I have this call light specifically for my arthritis and expressed the call light response times might be represented incorrectly, they sometimes wait 45 minutes and squeeze it again. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 05/22/2026 at 12:33 PM, Staff X, Administrator in Residency, was interviewed with Staff A, Administrator present. Staff X said for allegations, they would notify the administrator in the facility and would assist them in determining if it was an allegation; if it was an allegation, they would report to it to the state. Staff X said the very first step was to remove the staff from the situation, so the resident could not be abused or neglected, and then to get all the facts of what happened, obtain like resident interviews, and educate staff if necessary. Staff X said neglect was the failure to act, to prevent harm, discomfort, or pain to a resident. When asked if a resident needed to feel neglected to have be neglected, Staff X said no. During this interview, Staff X was asked their process for interviewing other residents. Staff X said they would typically look at the particulars of the allegation, if it was based on a specific need, then residents with a similar need. If the allegation was based on staff, Staff X said then like residents were based on other residents the staff interacted with. Staff X said they probably would do an audit trail, it depended on the situation. Regarding Resident 37, Staff X said the other like residents were chosen because they were on the same assignment as the Certified Nursing Assistant (CNA) that was suspended, and this was based only on location of the residents (not care needs). When asked why they did not intentionally select residents based on incontinence needs (which could have been on same hall), Staff X said the reason they chose the like residents they did, was because the allegation was that the CNA had done this thing, and they wanted to see if there was a pattern of the CNA providing the same substandard care. When asked about two of the like residents having no recorded responses, Staff X said the residents were unavailable, they thought they had decided not to reattempt to interview those residents, and they felt they had sufficient data based on the other residents interviewed. Regarding the questions asked to residents, not asking about delays in care, and asked how they were identifying delays in care without asking, Staff X said they were identifying delays in care, they were covering the possibility with delays in care with updated training on not turning call lights off until the need was met. During this interview, Staff X and A were asked if Resident 37 had directly been asked about the two to three hour wait that morning for their brief to be changed. Staff A acknowledged the statement in the investigation did not indicate it was asked directly. When asked if Resident 37 was asked if they had any issues with their call light, Staff A said based on the investigation they were reading, no. Staff X said through recent training and vigilance, they were aware there were long call light times, were trying to look at it systemically to create an environment without call light issues, and the call light was to stay on until the need was met. When asked if the investigation looked at Resident 37's medical history, their cognition, and documented this, both Staff A and X said no. When asked if the investigation looked at Resident 37 being continent before their recent surgery, and if this was a risk factor or an area for improvement, Staff X said they looked at it as an area of improvement, they were looking at call light response times. During this interview, Staff X and A were asked about the assigned CNA's statement, Staff Y, which documented, it did take us an extended time, but we did get in there to get her taken care of and said the wait was from 10:00 AM to 11:30 AM. Staff X confirmed the resident was documented to have waited one and one half hour. When asked what steps had been taken to determine the root cause of why it took 1.5 hours to change Resident 37, Staff X said they believed, based on their investigation, the staff had answered the call light, went to find a second staff to assist, probably got pulled away, then Resident 37 restarted their call light. When asked if this investigation looked at staffing, Staff X said they did not look at staffing based on this investigation. They had observed a lot of staff on the floor, and based on their observation, they did not think this was the issue. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During this interview, Staff X and A were asked about follow up with the male CNA, Staff Z, who had to trade assignments, so Resident 37 could have a female CNA. When asked if there was any follow up with Staff Z on how long Resident 37 was needing their brief changed before he was able to find the female CNA, Staff Y, to trade rooms with him, Staff A said they had interviewed Staff Z, it was near shift change, and they should have added that to their statement. Staff A stated, I should have put it was right at the beginning of shift. When asked what time Staff Z's shift started, Staff A said 6:30 AM. When asked if that meant Resident 37 needed assistance starting approximately around 6:30 AM, Staff A said they would need to reach back out to the male CNA and get a further statement on that. During this interview, Staff A and X were asked about if they had interviewed other staff on general delay in care questions. Staff A said they usually interviewed only the involved CNA, each investigation it depended. Staff A said they did not interview the assigned nurse in this investigation. When asked how the facility was ensuring the CNAs had all the tools needed to care for the residents, Staff A said that without interviewing them, they

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure necessary treatment and services were provided to prevent the development of avoidable pressure ulcers (PU), and to promote wound healing and prevent further decline of existing PUs for 2 of 3 residents (Residents 11 and 14) reviewed for pressure injuries. Specifically, the facility failed to thoroughly assess resident specific risk factors, develop and implement preventative measures, and timely identify, assess, monitor, treat, and notify the provider of newly developed PUs that direct care staff had knowledge of. These failures placed residents at risk for unidentified wound development and/or deterioration, delayed treatment, and intervention. Resident 11 experienced harm when they developed an unstageable PU (full thickness skin loss, where the true depth is obscured by necrotic/dead tissue in the wound bed) to the right ear, resulting in pain and bleeding. Findings included . Resident 11 Resident 11 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS, an assessment tool), dated 04/06/2026, showed the resident was cognitively intact, was at risk for PU development, and did not have a PU during the assessment period. Review of a Braden Scale assessment, dated 04/16/2026, showed the resident scored 17, indicating risk for PU development. During observation and interview on 05/17/2026 at 3:02 PM, Resident 11 reported her right ear hurt because there was an open area that developed under the oxygen tubing. Observation of the right ear showed there was a moist reddish-brown crust present to the top middle aspect of the right ear. The open area could not be visualized due to the crust/scabbing and the large amount of an unknown semi-transparent ointment that had been applied. Resident 11 reported the area had been present for approximately 30 days and was provided by her aides (Certified Nursing Assistants) at her request. During an interview on 05/17/2026 at 3:07 PM, when asked if the nurse was aware of the area, Resident 11 said she didn't think so, because no one had had come to look/assess it. During observation and interview on 05/18/2026 at 11:12 PM, observation of Resident 11's right ear showed the scab now encompassed the oxygen tubing. The resident's hair above the ear was now coated with a mixture of ointment and red crusted debris. While discussing with Resident 11 she lifted her oxygen tubing off the right ear and said Ouch and repeated that the area was sore. Observation of the oxygen tubing showed a reddish-brown scab was still attached to it after it was removed from the right ear. During an interview on 05/18/2026 at 11:18 PM, when asked if the nurse(s) identified the area while performing her weekly skin checks, Resident 11 said staff did not perform weekly skin checks on her. When asked what she would say if documentation indicated weekly head-to-toe skin assessments had been completed, Resident 11 stated, That would be a blatant lie. During observation and interview on 05/19/2026 at 3:17 PM, the ointment and crusted debris previously observed in the resident's hair were no longer present. Resident 11 reported staff had washed her hair the previous evening. When asked whether a nurse had seen the area, Resident 11 stated no. Review of the electronic health record (EHR) showed no documentation identifying the pressure (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	injury, no physician notification, no wound assessment, no monitoring, and no treatment orders related to the right ear wound. Review of the May 2026 Treatment Administration Record (TAR) showed no treatment orders or monitoring related to the area. Review of weekly skin assessment documentation dated 04/24/2026, 05/01/2026, 05/08/2026, and 05/15/2026 showed no alteration in skin integrity was identified. During observation and interview on 05/20/2026 at 4:37 PM, Staff A, Administrator, and Staff B, Director of Nursing Services, accompanied the surveyor to Resident 11's room. Staff A confirmed the presence of an open area with scabbing on the resident's right ear. Staff H, Licensed Practical Nurse/Unit Manager, assessed the area and identified a 0.5 centimeter (cm) x (by) 0.5 cm x 0.1 cm unstageable PU with light drainage and a wound bed that was 100 percent slough (wound debris - byproduct of inflammation). Following assessment of the wound, the following 05/20/2026 wound orders were obtained: Cleanse the right ear PU with wound cleanser, pat dry, apply Medi Honey and cover with a dry dressing daily and as needed. Place pressure-relieving foam on the resident's oxygen tubing to relieve pressure. Monitor skin integrity each shift. Refer to contracted wound care specialist for evaluation and treatment. During an interview on 05/20/2026 at 4:40 PM, Staff A and Staff B confirmed no skin issues had been identified during the previous weekly skin assessments, including the assessment completed on 05/15/2026. When asked whether staff awareness of the area should have resulted in nursing awareness, assessment, interventions, physician notification and treatment orders, Staff A stated, yes and Staff B nodded affirmatively. Additionally, Staff B confirmed Certified Nursing Assistants were not permitted to provide ointments to residents and was unable to identify the type of ointment that was provided/applied. Staff A and Staff B further confirmed that if staff had observed the area, applied ointment, cleaned the area, and/or washed ointment and blood from the resident's hair, nursing staff should have been notified, and the condition should have been documented and addressed. Both confirmed this had not occurred. A wound care note, dated 05/27/2026, documented Resident 11 had a 0.8 cm x 0.4 cm x 0.2 cm Stage 3 (characterized by full-thickness skin loss, exposing subcutaneous fat) medical device-related PU to the back of the right ear. The wound bed was assessed to be 100% granulation tissue (new tissue) with moderate drainage and treatment orders were revised. Resident 14 Resident 14 was admitted to the facility on [DATE]. The Significant change in status MDS, dated [DATE] documented Resident 14 was moderately cognitively impaired and had 1 unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar (dead tissue). A review of the EHR showed and an order, dated 04/02/2026, for wound care to coccyx pressure ulcer (skin and tissue damage over the tailbone caused by prolonged pressure, friction, or shear) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	every day shift and there was a discontinue date of 04/15/2026. In addition to providing wound care the order said to monitor signs and symptoms of infection or worsening and to notify the provider. A review of the April 2026 TAR showed blank boxes with no documentation on 04/09/2026, 04/13/2026, 04/14/2026, and 04/15/2026. A review of the EHR showed an order, dated 04/16/2026, for wound care to coccyx pressure ulcer every day shift. In addition to providing wound care the order said to monitor signs and symptoms of infection or worsening and to notify the provider. A review of the April 2026 TAR showed blank boxes with no documentation on 04/16/2026, 04/20/2026, 04/23/2026, and 04/26/2026. A review of the May 2026 TAR showed blank boxes with no documentation on 05/04/2026, 05/06/2026, and 05/14/2026. On 05/21/2026 at 11:28 AM, Staff H, Licensed Practical Nurse/Unit Manager said the blanks on the TAR mean the orders were not charted on. When asked if the care was provided, Staff H said she would have to reach out to the nurses to see if the wound care was provided but looking at the TAR, she could not tell if it was provided or not. Staff H said she would expect the nurses to complete the order and chart it as completed. On 05/21/2026 at 1:59 PM, Staff B, DNS, said she saw the blank boxes on the TAR and said she would expect the nursing staff to document if the resident refused care and/or document if the wound care was provided. Reference WAC 388-97-1060(3)(b)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 4 of 8 residents (Resident 78, 131, 94 & 37) reviewed for abuse and neglect were free from verbal abuse or neglect. The facility failed to ensure there was adequate supervision and sufficient staff to meet the care needs of the residents. The facility's investigations substantiated verbal abuse involving Resident 78 and substantiated neglect involving Residents 131, 94, and 37. These failures subjected Resident 78 to potential psychosocial harm and resulted in delayed provision of necessary care and services for Residents 131, 94, and 37. Findings included . Review of the facility's policy titled, Abuse, undated, showed the facility was to recognize and respect that each resident had the right to be free from abuse and neglect. Neglect was defined as the failure of the facility, its employees or service providers, to provide goods and services to a resident that was necessary to avoid physical harm, pain, mental anguish, or emotional distress. Resident 94 Resident 94 was admitted to the facility on [DATE]. The Medicare 5 Day Minimum Data Set (MDS, an assessment tool), dated 05/11/2026, showed Resident 94 was cognitively intact. They were on the 200's hallway. An investigation for Resident 94 was opened on 05/18/2026. Per the investigation, Resident 94 and their family had reported Resident 94 accidently wet their pants while waiting for staff. Resident 94 had told the interviewer that staff had gone into the room and informed them they were caring for another resident at that time. On 05/28/2026, the facility created an addendum to their previous report and substantiated the allegation of neglect. They acknowledged the delays that occurred were related to staffing. During an interview on 05/28/2026 at 9:13 AM, Staff L, Interim Director of Nursing Services/Infection Preventionist (DNS/IP), confirmed that neglect was substantiated for Resident 94. Resident 37 Resident 37 was admitted to the facility on [DATE], and recently had been hospitalized for a joint replacement surgery from 05/01/2026 to 05/05/2026. The Quarterly MDS, dated [DATE], showed during the assessment period Resident 37 was cognitively intact, and was always continent of bowel, occasionally incontinent of urine (less than 7 episodes of incontinence). They were on the 200's hallway. An investigation for Resident 37 was opened on 05/17/2026. Per the investigation, Resident 94 reported they had gone 2-3 hours without their brief changed on 05/17/2026. During an interview on 05/28/2026 at 10:49 AM, Staff L, Interim Director of Nursing Services/ Infection Preventionist (DNS/IP), confirmed that neglect was substantiated for Resident 37. Resident 78 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 78 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact. On 05/17/2026 at 2:15 PM, Resident 78 reported that approximately three to four nights earlier, at about 2:00 AM, an unfamiliar female Certified Nursing Assistant (CNA) changed her roommate and then approached her bed. Resident 78 stated the CNA abruptly pulled back her covers and instructed her to get up and go to the bathroom. Resident 78 stated she informed the CNA that she was a check and change resident and pointed to the dry-erase board identifying her care needs. Resident 78 reported the CNA laughed, refused to provide assistance, told her she could change herself, and ordered her to go into the bathroom. Resident 78 stated she attempted to change herself but was unable to adequately cleanse herself because she could not reach all necessary areas and lacked the dexterity to fasten the tabs on her brief. Resident 78 stated she ultimately used a pair of pull-up briefs belonging to her roommate. Resident 78 reported the CNA remained in the doorway with both the room door and bathroom door open and provided no assistance. When asked how the incident made her feel, Resident 78 stated, Like I'm nothing, like I didn't deserve the assistance. Resident 78 stated she reported the incident to a female staff member but could not recall the staff member's name. Resident 78 further stated no one had followed up with her regarding the allegation. On 05/17/2026 at 2:57 PM, Resident 11, Resident 78's roommate, corroborated the incident. Resident 11 stated, I heard it. The way she spoke to Resident 78 was like a sergeant in the Army. Resident 11 stated the CNA made Resident 78 get up and go to the bathroom and change herself like a drill sergeant and stated, She treated Resident 78 like she was nothing. Review of Resident 78's clinical record showed no documentation regarding the alleged incident and no indication the resident had been assessed or monitored for psychosocial impact. Review of the facility's unusual occurrence, incident, and accident log revealed no entry related to the allegation. Review of the facility grievance log showed a grievance was entered on 05/17/2026 by Staff B, Director of Nursing Services, on behalf of Resident 78, with an incident date of 05/13/2026. The grievance was categorized as a customer service interaction. Review of the grievance record on 05/21/2026 at 10:39 PM showed the grievance details stated, 05/13/2026 day shift CNA was rude, used tone and approach that was perceived as disrespectful. The sections titled Summary of Investigation, Summary of Findings, and Summary of Actions Taken remained blank. In an interview on 05/21/2026 at 10:39 AM, Staff A, Administrator, acknowledged no interviews had been conducted and no one had followed up with Resident 78 regarding the allegation. Staff A acknowledged the allegation should have been treated as an allegation of abuse and that an investigation should have been initiated, reported, and logged. Review of the facility's investigation and root cause analysis showed the facility ultimately (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substantiated verbal abuse. The facility documented immediate interventions and suspended a suspected CNA pending investigation. However, the CNA suspended by the facility did not match Resident 78's description of the alleged perpetrator. As of survey, the alleged perpetrator had not been identified. Resident 78 confirmed it was the first time she had seen the aide and that she had not seen the aide again following the incident. Resident 131 Resident 131 was admitted to the facility on [DATE]. The Medicare 5-Day MDS, dated [DATE], showed Resident 131 was cognitively intact, was frequently incontinent of both bowel and bladder and was dependent on staff for toileting hygiene. An investigation for Resident 131 was opened on 05/17/2026. Per the investigation, Resident 131 stated they had an incontinent episode of both bowel and bladder and it took two hours for the Certified Nursing Assistant (CNA) to come answer their call light. The facility investigation found the allegation was not supported by objective evidence to verify a two-hour delay in care due to the call light record not showing a call during the time period in question. The investigation documented the CNA had reported they believed delays in providing care may have occurred while assisting another resident and while trying to locate a second staff member for a two person assist. On 05/27/2026, the facility provided an investigation addendum, showing the initial allegation of neglect was substantiated, concluding abrupt staffing changes created delays in patient care delivery. On 04/26/2026 at 10:05 AM, Staff X, Administrator in Residency, confirmed Resident 131's neglect had been substantiated. Reference F690, F610, F725 Reference WAC 388-97-0640(1)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR, a federally mandated program requiring all individuals to be screened for mental illness or intellectual disabilities before being admitted to a nursing facility) assessments were accurately completed upon or during admission to the facility for 3 of 6 residents (11, 40 & 130) reviewed for PASRR. This failure had the potential to place residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs.Findings included .Resident 11Resident 11 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set, (MDS, an assessment tool), dated 01/04/2026, showed the resident was cognitively intact, had diagnosis of depression, and received antidepressant medication during the assessment period. A Level I PASRR, dated 12/31/2026, showed the resident had suspected indicators of serious mental illness of mood disorder and anxiety disorder. Resident 11 admitted to the facility on an exempted hospital discharge with physician certification that they would likely require fewer than 30 day of nursing facility services. No Level II evaluation was indicated at that time due to the exempted hospital discharge. The PASRR showed that a Level II evaluation must be completed if the scheduled discharge (in fewer than 30 days) did not occur. As of 05/27/2026, Resident 40 had been in the facility for 148 days, well beyond the 30-day hospital exemption. Record review showed the Level I PASRR had not been updated to reflect the resident's current active diagnoses and there was no documentation to show they were referred for a Level II evaluation as required. During an interview on 05/28/2026 at 3:48 PM, Staff I, Social Services Director (SSD), acknowledged Resident 11's Level I PASRR should have been updated to reflect their current active diagnoses. When asked if a referral for a Level II evaluation was made when the resident did not discharge within 30 days as required Staff I stated, No. Resident 40Resident 40 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively intact, had diagnoses including depression and anxiety disorder, and received antidepressant medication during the assessment period. A Level I PASRR, dated 12/26/2026, showed the resident had suspected indicator of serious mental illness of anxiety disorder. Resident 40 admitted to the facility on an exempted hospital discharge with physician certification that they would likely require fewer than 30 days of nursing facility services. No Level II evaluation was indicated at that time due to the exempted hospital discharge. The PASRR showed that a Level II evaluation must be completed if the scheduled discharge (in fewer than 30 days) did not occur. As of 05/27/2026, Resident 40 had been in the facility for 151 days, well beyond the 30-day hospital exemption. Record review showed the Level I PASRR had not been updated to reflect the residents current active diagnoses and there was no documentation to show they were referred for a Level II evaluation as required. During an interview on 05/28/2026 at 3:48 PM, Staff I, SSD, acknowledged Resident 40's Level I PASRR should have been updated to reflect their current active diagnoses. When asked if a referral for a Level II evaluation was made when the resident did not discharge within 30 days as required Staff I stated, No. Resident 130 Resident 130 was admitted to the facility on [DATE] with a diagnosis of generalized anxiety disorder. Review of Resident 130's PASRR, dated 05/14/2026, did not list Resident 130 had an anxiety disorder and documented no level II evaluation was indicated. On 05/20/2026 at 12:43 PM, Staff I, SSD, said when a PASRR was received at admission for a resident they were supposed to make sure to check to see if it followed the diagnosis list, such as (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	depression, anxiety, mood disturbance, schizophrenia and checking those and comparing to what the hospital had sent. Staff I said when the hospital sends the PASRR, they would make sure the PASRR was correct and if not immediately update it. During this interview Staff I said they reviewed the PASRR on admission when a resident was first coming in, and if a resident came in on the weekend it would be reviewed the first day back, on a Monday. Regarding Resident 130's PASRR not indicating anxiety disorder and asked if she had done a new one, Staff I said she had not and it should have been done by now. Staff I looked in the electronic health record and confirmed that the PASRR did not indicate anxiety for Resident 130 and confirmed Resident 130 had an anxiety disorder diagnosis and said a new one needed to be done. Staff I said this should have been caught that Monday. WAC 388-97 -1915 (1)(2)(a-c)

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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 failed to develop and implement comprehensive person-centered care plans for 8 of 24 sampled residents (Residents 10, 11, 78, 24, 7, 1, 2 & 100) reviewed. Failure to develop and implement care plans that were individualized and accurately reflected resident care needs related to activities of daily living, advanced directives, vision, self-medication/medications at bedside, oxygen services/respiratory care, and fluid restrictions, placed residents at risk of unmet care needs and potential negative health outcomes.Findings Included . Resident 10Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's comprehensive care plan, initiated 11/08/2025, showed there was no direction to staff to assist the resident with nail care, or identification of who was responsible to provide it. The care plan also failed to identify the resident required podiatry services. Resident 11Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's comprehensive care plan, initiated 01/01/2026, showed there was no direction to staff to assist the resident with nail care or identification of who was responsible to provide it. The care plan also failed to identify the resident required podiatry services. During an interview 05/28/2026 at 12:36 PM, when asked if resident nail care should be care planned and the staff responsible identified (discipline e.g. certified nursing assistant, licensed nurse etc.) Staff H, Licensed Practical Nurse/Unit Manager, said yes, because nursing assistants do not perform nail care on diabetic residents. When asked if nail care was addressed in Resident 10's or Resident 11's care plan, Staff H stated, No. Resident 78Resident 78 was admitted to the facility on [DATE]. Review of the admission minimum data set (MDS, an assessment tool), dated 01/08/2026, showed the resident had adequate vision with the use of corrective lenses. An impaired vision care plan, initiated 01/02/2026, directed staff to ensure Resident 78's glasses were clean and worn as resident tolerates. On 05/17/2026 at 2:20 PM, Resident 78 said her prescription glasses came up missing from her bedside table in March or early April 2026, right before she moved rooms. She said it was reported to staff but had not heard anything since. On 05/29/2026 at 5:21 PM, Staff L, Interim Director of Nursing Services, acknowledged that if staff had implemented the care plan (ensure glasses are clean and worn) staff would have identified Resident 78's glasses were missing. Resident 24 Resident 24 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 24 was cognitively intact. On 05/17/2026 at 3:21 PM, Resident 24 was observed with medications on their bedside table, which included eye drops, inhalers, and topical ointments. On 05/19/2026 at 2:20 PM, Staff EE, Licensed Practical Nurse (LPN) walked into Resident 24's room and acknowledged there were medications on Resident 24's table. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/19/2026 at 3:11 PM, Staff H, LPN/Unit Manager said it should be care planned and after looking at Resident 24's chart Staff H said it was not documented in Residents 24's care plan that they had medications on their bedside table. On 05/20/2026 at 1:46 PM, Staff B, Director of Nursing Services, said if Resident 24 had medications at the bedside it should have been care planned. Resident 7 Resident 7 was admitted to the facility on [DATE]. The Annual MDS, dated [DATE], documented a diagnosis of retention of urine. A review of Resident 7's orders showed an order for foley catheter care every shift for diagnosis of urine retention dated 04/28/2026. On 05/19/2026 at 6:26 AM, Resident 7 was observed with a foley catheter and dignity bag. A review of the Resident 7's care plan showed CONTINENCE: [Resident7] is incontinent of bowel and bladder and requires x2 staff dependent assistance with toileting hygiene. The care plan was initiated and revised on 10/30/2025. On 05/21/2026 at 11:26 AM, Staff H, LPN/Unit Manager said Resident 7 did have a foley catheter and it should have been care planned. When Staff H looked at the care plan for Resident 7, they said the care plan for Resident 7's catheter was resolved and not active. Staff H said, I will start it right now. On 05/21/2026 at 2:05 PM Staff B, Director of Nursing Services, said she saw an order for Resident 7's foley catheter in the chart and would expect it to be care planned depending on the facility's protocol. Resident 1 Resident 1 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood) and interstitial pulmonary disease (inflammation and/or scarring of the lung tissue) and chronic obstructive pulmonary disease (COPD, lung disease that causes airflow obstruction making it difficult to breathe). The Medicare 5-Day MDS, dated [DATE], indicated Resident 1 was cognitively intact and received oxygen therapy, intermittently (on and off). Resident 1 had an order, dated 04/28/2026, for oxygen as needed via nasal cannula at 1-3 liters per minute to maintain oxygen saturation (amount of oxygen in the blood) above 92% as needed related to interstitial pulmonary disease. Review of Resident 1's care plan, initiated on 04/28/2026, showed the goal was for the resident to be free from respiratory complications through the review period, with one of the interventions listed as administer oxygen as ordered. The care plan did not indicate the problem/need for the oxygen, the parameters for Resident 1's oxygen saturation, the flow rate, delivery device and frequency for the oxygen, or what staff should be monitoring for such as signs or symptoms of low oxygenation. On 05/26/2026 at 10:29 AM, Staff K, LPN/Unit Manager, said the expectation for a resident receiving (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen was for there to be a care plan for this which included maintenance of nasal cannula, levels of oxygen to be used, whether or not the oxygen was to be titrated down, skin integrity around the ears and nose, and to monitor oxygen concentration every shift. When asked to review Resident 1's care plan, Staff K said, it just said administer oxygen as ordered. When asked if this met expectations for a comprehensive person-centered care plan, Staff K said no, it should have shown how many liters Resident 1 was on, if it was as needed or continuous and whether staff were to titrate the oxygen down or not. Resident 2 Resident 2 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and end stage renal disease (kidney failure, requiring the blood to be filtered through a process called dialysis). The Medicare 5 Day MDS Assessment, dated 03/24/2026, showed Resident 2 had moderate cognitive impairment. Review of Resident 2's opioid care plan, initiated 02/16/2026 and pain care plan, initiated 02/17/2026, did not list non-pharmacological interventions. Review of Resident 2's fluid restriction care plan, initiated 02/17/2026, showed it was not discontinued, which indicated Resident 2 was on an 1800 milliliter (ml)/ day restriction, not 1500 ml/day. Resident 2 also had a second fluid restriction care plan, initiated 05/07/2026, that did say the resident was on 1500 ml/day fluid restriction (there were 2 different care plans for Resident 2's fluid restriction). Review of Resident 2's dialysis care plan, initiated 02/16/2026, had listed the 1800 ml/day fluid restriction, and was not up to date with Resident 2's current date/times of dialysis treatments, still indicating Resident 2 was going to dialysis on Tuesday/Thursday/Saturday and not Monday/ Wednesday/Friday. This plan did not list a goal dry weight (target body weight for a dialysis resident when all excess fluid has been removed, which helps maintain normal blood pressure and prevent complications) from dialysis, and did not mention they required a sitter to attend dialysis with them. Review of Resident 2's communication care plan, initiated 02/27/2026, did not have any mention that a translator tablet was being used for communication. Review of Resident 2's care plans on 05/20/2026, showed the care plans had not been updated to include information after returning from the hospital. There was no mention of loss of vision chronically and needing a ophthalmology appointment, and their anticoagulant care plan, which only indicated a history of deep vein thrombosis (blood clot), was not updated to mention the resident had current blood clots with the locations of where. During an interview on 05/20/2026 at 1:32 PM, Staff K, LPN/Unit Manager, reviewed Resident 2's pain care plans and said Resident 2 was taking an opioid and had risk for pain, but it did not list what interventions worked/did not work for them. Staff K also acknowledged they did not list non-pharmacological interventions on the care plans. During an interview on 05/26/2026 at 11:08 AM, Staff O, Certified Nursing Assistant, was unable to find any posted information in Resident 2's room of translator information. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 100's fall care plan, Staff K said that if Resident 100 has a history of falls, the care plan can be changed. Staff K confirmed that Resident 100 did not have a mobility bar care plan or a dementia care plan, and they needed to be care planned. During an interview on 05/26/2026 at 3:04 PM, Staff K read Resident 100's nutrition care plan, acknowledged it did not mention their significant weight loss and that it should. During an interview on 05/27/2026 at 3:58 PM, Staff K acknowledged Resident 100 did not get an incontinence care plan and interventions were not added until 05/26/2026, in a skin impairment care plan, which did not meet expectations. Regarding Resident 100's rehabilitation care plan, Staff K said it had not been updated since 04/29/2026, they no longer needed a Hoyer, occupational therapy/physical therapy was no longer occurring, and their care plan was not up to date. Reference F692, F690, F744, F689 Reference WAC 388-97- 1020(1), (2)(a)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure incontinent (episodes of uncontrolled urination or bowel movements) residents were reviewed to evaluate if they were candidates for bowel or bladder retraining for continence, and/or provided appropriate incontinent care for 3 of 3 residents (Resident 37, 94, & 100) reviewed for bowel and bladder incontinence. This failure placed residents at risk for neglect, lack of dignity, skin impairment, and a diminished quality of life. Findings included .Review of the facility's policy titled, Bowel & Bladder Management Program, undated, showed the facility was to review residents for incontinence (no or insufficient voluntary control over urine or stool) on admission, readmission, annually, quarterly, or if a change occurred in the resident's status. For residents with identified incontinence, they were to initiate a care plan for incontinence and the interdisciplinary team would determine if the resident was appropriate for bowel and/or bladder re-training. If the resident was appropriate for retraining, the team would determine the type and cause of incontinence (stress, overflow, or urge/mixed/neurological) to determine the treatment plan. Resident 37Resident 37 was admitted to the facility on [DATE], and recently had been hospitalized for a joint replacement surgery from 05/01/2026 to 05/05/2026. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/22/2026, showed during the assessment period Resident 37 was cognitively intact, and was always continent of bowel, occasionally incontinent of urine (less than 7 episodes of incontinence).Review of Resident 37's urine records, from 05/06/2026 to 05/18/2026, showed only 1-2 urinations a day charted by staff, of incontinent episodes. Review of Resident 37's bowel records, from 05/06/2026 to 05/18/2026, showed Resident 37 was now incontinent of bowel. During an interview on 05/17/2026 at 2:14 PM, Resident 37 reported they were only changed two times a day, could wait hours and thought they should be changed more. Resident 37 said that morning they thought they had waited about 2-3 hours to get changed, and during the day it could take longer than that.During an interview on 05/20/2026 at 11:32 AM, Resident 37 when asked about their continence before going to the hospital for their recent surgery, said they had been continent and had been able to use the bathroom.During an interview on 05/26/2026 at 1:48 PM, Staff K, Licensed Practical Nurse (LPN)/Unit Manager, said residents should void at a minimum, in 24 hours, 3 times. Staff K confirmed Resident 37's record had days of only one void. When asked what this indicated, Staff K said that staff was probably not offering brief and toileting as often as needed, and it most likely was not due to the resident being dehydrated. Staff K said they were unsure staff were documenting these correctly, and they needed more education of charting with the certified nursing assistants. During an interview on 05/28/2026 at 9:13 AM, Staff L, Interim Director of Nursing Services (DNS)/ Infection Preventionist (IP), said it did not meet expectations, that Resident 37 had not been evaluated for the bowel and bladder management program on readmission from the hospital. When asked about the documentation of only 1-2 voids, and Resident 37 reporting only being changed twice a day, Staff L said it did not meet expectations with that information. Resident 94Resident 94 was admitted to the facility on [DATE]. The Medicare 5 Day MDS, dated [DATE], showed Resident 94 was cognitively intact.Review of Resident 94's urine record, from 05/07/2026 to 05/19/2026, showed they had both continent and incontinent episodes. Review of Resident 94's bowel record, from 05/07/2026 to 05/19/2026, showed they had both continent and incontinent episodes.Review of Resident 94's orders, showed they had an order, dated 05/06/2026, for a diuretic (removes excess fluid from the body through urine) twice a day. During multiple interviews on 05/18/2026 starting at 12:53 PM, four friends, one family member, and one Power of Attorney (POA) were interviewed regarding Resident 94. CC1, Resident 94's friend, said they and CC2, Resident 94's friend, had come the day prior, and the commode had not been emptied/was full of stool. CC1 said they had to get Resident 94 up themselves after they called and no staff came, and that Resident 94 was in a lot of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents maintained acceptable parameters of nutritional status by following orders for weights, closely monitoring resident's with weight loss identified prior to admission/accurately identifying weight loss, accurately documenting meal monitors and supplemental shake intake, and/or following consistent implementation of required meal assistance for 2 of 3 residents (Residents 100 & 94) reviewed for nutrition. This failure placed residents at risk for continued significant weight loss, malnutrition, impaired skin integrity, unidentified/unmonitored care needs, and a diminished quality of life.Findings included.Review of the facility's policy titled, Weight Assessment and Intervention, undated, showed the interdisciplinary team would strive to prevent, monitor, and intervene for undesirable weight loss for the residents. Resident weights were to be taken on admission. If an inaccurate weight was suspected, the resident would be reweighed. Any weight change of 5% or more, would be retaken to confirm. Once verified, nursing would immediately notify the physician/practitioner and dietary team. The physician/practitioner, resident, and resident representative would be informed of significant weight change. If the weight change is desirable, this would be documented. This policy included the following: Significant Unplanned and Undesired Weight Change will be based on the following criteria [where percentage of body weight loss = (usual weight – actual weight) / (usual weight) x 100]: ˆ 1 month – 5% weight change is significant; greater than 5% is severe. ˆ 3 months – 7.5% weight change is significant; greater than 7.5% is severe. ˆ 6 months – 10% weight change is significant; greater than 10% is severe. Review of the facility's policy titled, Activities of Daily Living (ADLs), undated, showed the facility was to maintain good nutrition for residents that were unable to carry out activities of daily living independently. For dining, residents who required assistance with eating or drinking would be provided assistance as instructed in the resident's care plan. Resident 100 Resident 100 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition (not getting enough protein and calories for body needs), neurocognitive disorder with Lewy bodies (dementia, causes a decline in cognitive abilities which can interfere with daily life), and weakness. The Medicare 5 Day Minimum Data Set assessment (MDS), dated [DATE], showed Resident 100 was severely cognitively impaired, and they were not assessed as having significant weight loss >5% over the past 30 days or > 10 % in the last six months. Resident 100 was listed with a weight of 159 pounds (lbs). Review of Resident 100's hospitalization notes, showed on admission to the hospital on [DATE], they weighed 170 lbs. On 03/12/2026, Resident 100 weighed 159 lbs and 6.3 oz at discharge from the hospital. Review of Resident 100's hospitalization Registered Dietician notes, dated 03/11/2026, in which they mentioned Resident 100 had been having improved oral intake since starting mirtazapine (an appetite (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 100's nutritional/hydration care plan, dated 03/24/2026, showed Resident 100 was to have 1:1 assistance with meals for supervision, encouragement to eat, their meal intake % documented, weights as ordered, and dietary preferences reviewed with them as needed. This care plan did not mention Resident 100's significant weight loss. Review of a nutrition/dietary note, dated 03/25/2026, showed Staff C, Dietary Manager, had documented that per family request, staff should do a 1:1 for oral intake due to not eating enough. Review of Resident 100's Speech Therapy Evaluation on 04/06/2026, showed they evaluated the resident as they ate lunch. While Resident 100 was upright in the dining room in a wheelchair, they demonstrated difficulty removing the lid from a coffee cup and required assistance. Resident 100 was observed stirring coffee with a spoon for approximately four minutes without trying to consume the coffee. After a verbal reminder, Resident 100 attempted to drink the coffee, but loaded the spoon with coffee rather than drinking directly from the cup. When cued to drink from the cup without the spoon, Resident 100 patient perseverated (persisted on the action) on using the spoon. The speech therapist removed the coffee and presented a plate of food. After approximately two minutes of prompting, the patient loaded a spoon with food but demonstrated mild difficulty clearing the food from the utensil, the evaluated believed it may have been due to a reduced labial (muscles of the lips) control. The evaluator provided Resident 100 a fork, and the patient was able to clear the food without difficulty. Due to continued perseveration on spoon use, as well as inconsistent food size and ongoing difficulty with food clearance, the spoon was removed. Resident 100 self-fed 10 bites of soft and bite-sized solids using a fork. The evaluator listed, Compensatory Strategies/Positions: 1:1 assist (needs help loading fork, wait until alert to feed); Upright with meals; increased oral care. Review of Resident 100's meal monitor from 05/08/2026- 05/25/2026, showed eight days the following documentation had greater than/less than three meals recorded a day: 05/08/2026: two lunches recorded, one 76-100% eaten at 12:30 PM, the other 51-75% eaten at 2:29 PM 05/09/2026: two lunches recorded, both 51-75% eaten at 12:30 PM and 2:29 PM 05/13/2026: no documentation for breakfast/lunch 05/14/2026: no documentation for lunch 05/17/2026: no documentation for dinner 05/20/2026: no documentation for breakfast or lunch 05/24/2026: no documentation for dinner 05/25/2026: no documentation for dinner Further review, showed five days with three meals listed, but with one time outside of the traditional mealtimes: 05/11/2026: 2:21 PM and 2:22 PM, both 51-75% eaten each entry 05/12/2026: 2:13 PM and 2:13 PM, 76-100% eaten each entry (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/18/2026- no weight recorded 05/23/2026- no weight recorded 05/25/2026- no weight recorded Record review of Resident 94's EHR did not document any adjustment to meal plan, communication with dietitian, alert charting, weigh loss being addressed by an Interdisciplinary Team (IDT), or an updated care plan. In an observation on 05/27/2026 at 1:35 PM, Resident 94 was asleep when her lunch tray was brought in. Resident 94 stated, I will probably try to eat a few bites. Resident 94 proceeded to fall back asleep, without eating any food. Record review of Resident 94's meal monitor tracker for lunch on 05/27/2026, documented Resident 94, ate 51-75% of their meal as of 2:07 PM. In an observation on 5/27/2026 at 2:46 PM, Resident 94 was observed asleep in her bed, with the same lunch tray, sitting in front of her, untouched. In an interview and observation on 05/27/2026 at 2:59 PM, Staff MM, Certified Nursing Assistant (CNA) was asked to observe Resident 94's lunch tray and report of how much of it was eaten. Staff MM viewed their lunch, and stated the plate was full. Staff MM said Resident 94's meal tracker lunch entry for lunch on 05/27/2026 was marked incorrectly, and stated, CNAs are supposed to report to the nurse if residents haven't eaten. Staff MM was unable to confirm whether that had been done. In an interview on 05/28/2026 at 10:46 AM, K, Unit Manager/ Licensed Practical Nurse said the meal tracker monitor should be charted once complete and does not constitute good practice. Staff K said Resident 94 weigh loss should be addressed per facility policy. In an interview on 05/28/2026 at 1:32 PM, Staff L, Interim DNS/ Registered Nurse said it is the expectation for weights to be taken as ordered, and any weight loss addressed. Staff L was unable to produce additional documentation of Resident 94's nutritional plan. Reference F641, F690, F656, F610 Reference WAC 388-97-1060 (3)(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary respiratory care and services for 3 of 3 residents (Residents 11, 131 & 1) reviewed for oxygen therapy when facility staff failed to ensure oxygen-related treatments and services were implemented in accordance with physician orders and resident needs. This failure placed residents at risk for dry nares, nose bleeds, scabbing and/or decreased oxygen saturation levels and a diminished quality of life. Findings included . Resident 11 Resident 11 was admitted to the facility on [DATE]. Review of the quarterly Minimum Data Set (MDS, an assessment tool), dated 04/06/2026, indicated the resident was cognitively intact, had diagnoses including asthma and chronic respiratory failure, and required oxygen therapy during the assessment period. On 05/17/2026 at 3:17 PM, Resident 11 was observed lying in bed receiving oxygen at 4 liters per minute (LPM) via nasal cannula. An empty refillable humidifier bottle was attached to the oxygen concentrator. A piece of tape affixed to the bottle was dated 04/06/2026. Resident 11 stated the bottle had been empty for a while and reported the lack of humidification caused her nose to become dry and scabbed. When informed of the 04/06/2026 date on the bottle, Resident 11 stated, Yep, that sounds about right. On 05/18/2026 at 11:12 AM, Resident 11 was again observed receiving oxygen at 4 LPM via nasal cannula. Dried red flakes were observed around the resident's left nare. Resident 11 reported experiencing a nosebleed earlier that morning and stated the nasal scabbing had become so severe that it interfered with her ability to breathe. Resident 11 stated, I don't like feeling like I can't breathe. The humidifier bottle remained empty and continued to display tape dated 04/06/2026. Resident 11 further stated, I just think no one knows how to manage the humidifier. When asked why, the resident stated, Each time they look at it, they don't know how to fill it up. They are just not knowledgeable on the concentrator. On 05/19/2026 at 3:35 PM, Resident 11 was again observed receiving oxygen at 4 LPM via nasal cannula. The humidifier bottle remained empty; however, the tape displaying the date, 04/06/2026, had been removed. Resident 11 reported continued problems with nasal scabbing and stated, It gets filled up with so many scabs I can't breathe. Then you try to clear it or pick it out of the way and it bleeds. On 05/20/2026 at 2:12 PM, Resident 11 was again observed receiving oxygen at 4 LPM via nasal cannula. The humidifier bottle was observed to be approximately one-third full with a clear liquid. Resident 11 stated staff had filled the bottle the previous evening after survey observations. Review of the electronic health record identified the following physician orders: 03/20/2026: Oxygen at 1 to 3 LPM continuously via nasal cannula, titrate to maintain oxygen saturation between 90% and 95%, and notify the physician if oxygen exceeds 3 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/22/2026: Change oxygen tubing, humidification bottle (if used), and clean the concentrator filter weekly. Label supplies with name and date. The order did not indicate what nurses were to use to refill the the humidifier bottle (e.g., distilled water.) 02/01/2026: Check oxygen saturation twice daily on day and evening shifts Review of April and May 2026 medication administration records showed nursing staff signed weekly on 04/05/2026, 04/12/2026, 04/19/2026, 04/26/2026, 05/03/2026, 05/10/2026, and 05/17/2026 indicating oxygen tubing had been changed and dated, the humidification bottle had been changed and/or filled and dated, and the filter had been cleaned as ordered. Review of medication administration records further showed nursing staff signed three times daily from 05/17/2026 through 05/20/2026 indicating oxygen was administered at the ordered rate of 1 to 3 LPM. However, the medication administration record did not provide a location for staff to document the actual oxygen flow rate administered. On 05/20/2026 at 4:37 PM, Staff A, Administrator, and Staff B, Director of Nursing Services (DNS), accompanied the surveyor to Resident 11's room. Staff A confirmed Resident 11 was receiving oxygen at 4 LPM via nasal cannula and confirmed the humidifier bottle was approximately one-third full but had not been dated. Resident 11 informed Staff A and Staff B that the humidifier bottle had been empty for an extended period despite requests that staff refill it. Resident 11 further stated the resulting nasal dryness and scabbing made it difficult to breathe and had resulted in nosebleeds. In an interview on 05/20/2026 at 4:39 PM, Staff B, DNS, stated nurses should document the oxygen flow rate actually administered and acknowledged the medication administration record did not provide a location for staff to do so. Staff B further acknowledged the humidifier order should have specified what solution was to be used and stated the order should have been clarified. Staff B stated nursing staff were expected to administer oxygen within physician-ordered parameters and should only sign documentation indicating oxygen was administered at 1 to 3 LPM if that was the actual flow rate provided. Staff B acknowledged Resident 11 had been receiving oxygen at 4 LPM, which exceeded the physician-ordered range. When asked whether documentation existed showing physician notification when oxygen exceeded 3 LPM as required by the physician order, Staff B stated no. Resident 131 Resident 131 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe), obstructive sleep apnea (airway repeatedly becomes partially or completely blocked during sleep, causing breathing to stop or become very shallow for brief periods), chronic respiratory failure with hypoxia (respiratory system cannot adequately oxygenate the blood, resulting in persistently low oxygen levels), severe obesity with alveolar hypoventilation (overweight leading to impaired breathing and low oxygen levels). According to the 5-Day Minimum Data Set (MDS, an assessment tool), dated 05/18/2026, Resident 131 was cognitively intact and required continuous oxygen delivery. Resident 131 had an order, dated 05/14/2026, for continuous oxygen to maintain SpO2 (Peripheral capillary oxygen saturation, an estimate of the amount of oxygen in the blood) greater than 92% every shift. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A second order, dated 05/19/2026, was for continuous positive airway pressure (CPAP, device that delivers a constant flow of air through a mask, can have oxygen attached to it), use at night and as needed, must have oxygen attach at 4 liters per minute at bedtime for sleep apnea. On 05/20/2026 at 7:51 AM, Resident 131 said they were not doing good, they needed oxygen, had hit their call light and was feeling shaky and had been given new insulin that morning. Observation showed Resident 131 was pale, their hands were shaking, they did not have oxygen being delivered, and the call light was not on in the hallway. Resident 131 hit their call light again, and observation showed it did not light up the call light in the hallway. On 05/20/2026 at 7:53 AM, Staff S, Licensed Practical Nurse, was alerted that Resident 131 was reporting she needed oxygen and was shaky. Staff S then entered Resident 131's room and applied oxygen via nasal cannula. Staff S had applied an oximeter (device to measure the amount of oxygen in the blood) to Resident 131's finger and reported their SpO2 was at 80%. Staff S then asked Resident 131 if staff had applied their oxygen when they removed their CPAP, and Resident 131 said, no. Staff S said, we will make sure we don't do that again. Staff BB, Certified Nursing Assistant (CNA), entered the room. Staff S asked Staff BB who had removed Resident 131's CPAP device, to which Staff BB said it had been Staff CC, CNA who had removed it. Staff S said, we have to put [Resident 131's] oxygen on when the CPAP comes off. Resident 131's SPO2 returned to normal shortly after oxygen was reapplied. On 05/20/2026 at 8:03 AM, Resident 131 said they were feeling better, and that the situation had been scary. On 05/20/2026 at 9:46 AM, when asked about removing CPAP machines from resident's, Staff CC laughed and said this is because I didn't know. Staff CC said, they would shut it (CPAP) off and unhook it and if attached to oxygen make sure the oxygen line goes on the resident and the concentrator is still running. Staff CC said they had forgotten to do this that morning for Resident 131. When asked their role, Staff CC said in regard to CPAP devices, they would put them on and would take them off for however long the resident needed to wear them. Staff CC said the Medication Administration Record or the care plan would indicate how long the resident would need it for. When asked if she could remove a CPAP that was delivering oxygen to a resident, Staff CC said they thought they could and said she was not sure of the answer. Staff CC said they had always been told they could do this, they knew they were not to remove oxygen lines or adjust the oxygen settings, but as long as they were not adjusting the oxygen setting or flow of oxygen, they could remove CPAP devices. When asked if she knew Resident 131 required a nasal cannula with oxygen after the CPAP removal, staff CC said she didn't or she would have put it on Resident 131. Staff CC said, I know I messed up; it was pointed out to me. Going back, I would have double checked. When asked what time the CPAP was removed, Staff CC said between 7:00 AM and 7:15 AM most likely, adding it was hectic. On 05/26/2026 at 10:34 AM, Staff K, Licensed Practical Nurse/Unit Manager, when asked his expectation of staff when a resident is taken off of a CPAP that is delivering oxygen said, the nurse should be following and the CNA should report to the nurse and the nurse should follow through with that to make sure oxygen was in place. Staff K said the CNA should check with the nurse to make sure if the resident did or did not require supplemental oxygen. Staff K said CNA's could not change any oxygen settings. When asked who was responsible for removing a CPAP that had been delivering oxygen and then reapplying oxygen, Staff K said, nurses were to do that. Regarding the incident of Staff CC removing Resident 131's CPAP which was delivering oxygen and the ordered oxygen having (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not been reapplied resulting in Resident 131's oxygen level dropping to 80%, Staff K said this did not meet their expectations. Staff K said the CNA should have reported to the nurse to make sure the nurse followed up. Staff K said Resident 131 had asked for the CPAP to be removed so they could eat breakfast, and the CNA was allowed to remove it but should have alerted the nurse to make sure it was followed up on. Resident 1 Resident 1 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood) and interstitial pulmonary disease (inflammation and/or scarring of the lung tissue) and chronic obstructive pulmonary disease (COPD, lung disease that causes airflow obstruction making it difficult to breathe). The Medicare 5-Day Minimum Data Set, (MDS, an assessment tool), dated 04/30/2026, indicated Resident 1 was cognitively intact and received oxygen therapy, intermittently (on and off). Resident 1 had an order, dated 04/28/2026, to change and date oxygen tubing on night shift on every Sunday for oxygen maintenance. On 05/17/2026 at 1:15 PM, Resident 1 was observed with oxygen being delivered by nasal cannula (oxygen tubing) and also had a humidifier (device that delivers moisture) attached to the oxygen concentrator, neither the humidifier nor the oxygen tubing was dated. On 05/26/2026 at 10:29 AM, Staff K, Licensed Practical Nurse/Unit Manager, said his expectation was for every Sunday on night shift the nasal cannula was to be dated and initialed and the humidifier was to be dated as soon as it was placed. Regarding observation of Resident 1 not having oxygen tubing or humidifier dated, Staff K said this did not meet his expectations. Reference F610 Reference WAC 388-97-1060 (3)(j)(vi)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient nursing staff were available to meet residents' needs and provide care and services in a timely manner for residents residing on 4 of 4 units reviewed for sufficient staffing. Evidence of insufficient staffing included resident and family reports of excessive wait times for assistance and care, staff reports of insufficient time to complete assigned duties, facility records demonstrating prolonged response times to resident requests for assistance, and a pattern of resident grievances, including allegations of neglect related to delayed or unmet care needs. These failures resulted in delays in care and services and placed residents at risk for unmet needs, complications of medical conditions, and diminished quality of life. Findings included .Staffing Data Report (SDR, identifies areas of concern that require follow-up during survey)Review of the SDR showed the facility was triggered for the following staffing issues: A one-star staffing rating. Excessively low weekend staffing Resident Interviews Resident 30On 05/18/2026 at 1:32 PM, Resident 30 reported the facility did not have enough staff. The resident said the previous day they waited two hours for their call light to be answered. When staff finally responded to it, they entered the room, turned the call light off, and said they would be back, but never returned. Resident 6On 05/18/2026 12:09 PM, Resident 6 indicated the facility did not have enough staff. The resident reported when they hit their call light, it consistently took 45-60 minutes for someone to respond. Resident 6 said what bothered them the most was staff would come in, turn off the call light and say they would be right back, but never returned. Resident 11On 05/17/2026 at 2:55 PM, Resident 11 reported the facility did not have enough staff. Resident 11 stated, The nighttime is bad. The resident said the front office knows, they can see how long peoples call lights were. They came down to ask me why my call light was on so long. I told them because no one came to change my brief. Resident 4On 05/17/2026 at 1:33 PM, Resident 4 said it sometimes takes 30 - 60 minutes for staff to respond to call lights when they are short staffed. Resident 24 On 05/17/2026 at 2:28 PM, Resident 24 stated that staffing was a problem, because there wasn't enough. The resident said they had laid there in bed for 30 minutes and up to three hours. Resident 24 indicated it was hard to get staff to answer call lights on the weekend. Resident 25On 05/18/2026 at 8:43 AM, Resident 25 said call light wait times can be long, depending on if agency staff were scheduled, they don't show up, the resident said it didn't seem like they cared. Resident 25 said their scheduled shower days were Sundays and Thursdays but were not provided because staff did not show up. Resident 31On 05/18/2026 at 9:20 AM, Resident 31 indicated that the facility did not have enough staff. The resident said agency staff were ill-prepared to provide care and needed training. Resident 31 reported that there was no supervision of the nursing assistants when Staff H, Licensed Practical Nure/Unit Manager was not there. Resident 31 said the medication nurses were too busy to supervise the aides and the aides don't work unless they are supervised. Resident 80On 05/17/2026 at 2:53 PM, Resident 80 reported on day shift they wait 30 - 60 minutes for staff to respond, on the weekends it could take up to an hour and a half. Resident 14On 05/17/2026 at 1:19 AM, Resident 4 indicated the facility did not have enough staff and said it took a long time for call lights to be answered, frequently 30 - 60 minutes, and it doesn't matter what time of day or the day of the week it was. Resident 119On 05/18/2026 at 8:29 AM, Resident 119 said the facility had staffing issues, which resulted in long call light response times especially when agency staff were on duty. Resident 37On 05/17/2026 at 2:14 PM, Resident 37 reported the facility did not have enough staff. The resident said sometimes they must wait 2-3 hours after activating the call light. Resident 37 said they are only changed twice a day because they require two staff members and they must wait hours. Resident reported that it didn't matter what time of day or what the need was, you could be waiting hours. Resident 94On 05/18/2026 at 1:40 PM, Resident 94 reported concerns that call lights were not responded to for 1-3 hours. Resident 134On (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/18/2026 at 10:00 AM, Resident 134 expressed concern about call light response time and indicated they must wait 30-45 minutes. On one occasion they were waiting for incontinent care, and it took about 45 minutes for staff to respond. Resident 133On 05/18/2026 at 8:25 AM, Resident 133 said they were irritated because they had made three separate requests for a pain pill and nobody came. Resident 130On 05/17/2026 at 11:30 AM, Resident 130 said staff were so busy they cannot respond quickly. I can push the button and wait forever. Resident 130 then clarified response to the call light could take minutes or an hour. Resident 131On 05/17/2026 at 1:57 PM, Resident 131 reported concerns about not being able to access staff. The resident indicated they were incontinent and needed assistance to be changed but reported it could take hours for assistance. Resident 131 said they knew they waited two hours that morning because they were looking at the clock on the wall. They first called around 9:00 AM. At 10:51 AM Resident 131 said they called their sister because they still had not been assisted. Family InterviewsResident 66On 05/17/2026 at 1:26 PM, Resident 66's wife reported it usually took about an hour to get a response because the facility didn't have enough staff. Resident 66's wife said the staff were good, but there just wasn't enough of them. She reported on weekends the facility had no staff. Weekends were lean and it was difficult to find someone to help. Resident 7On 05/17/2026 at 3:08 PM, Resident 7's daughter reported that there was not enough staff and indicated they came every day because her mother was not being taken care of properly. Resident 7's daughter said staff were not repositioning the resident, not performing range of motion on her fingers which were getting tight, and were not ensuring her mother's head was up at 45 degrees, which was affecting her tube-feeding. Resident 7's daughter reported earlier in the day Resident 7 needed to be cleaned up and it took an hour to get someone to change her. GrievancesReview of the Grievance log from 03/30/2026 - 05/19/2026 (50 days) showed the following number of grievances were filed: Care Concern - missed care, poor hygiene etc.: 37 resident grievances were filed. Staff Responsiveness / Call Bell Delays: Eight resident grievances were filed. Customer service/Interaction: 20 grievances were filed. Medication Administration issues: 5 resident grievances filed. A sample of the grievances were selected and reviewed with Staff A, Administrator, on 05/21/2026 at 10:39 AM. Staff A confirmed the 20 grievances reviewed contained an allegation of abuse/neglect and acknowledged the facility's failure to obtain further information about the reported incidents precluded the facility from ruling abuse and neglect out for grievances filed by Residents 25, 53, 143, 4, 144, 150, 31, 45, 86, 80, 148, 149, 112, 99, 110, 69, 116, 10, 44, & 38 between 03/30/2026 - 05/19/2026. Resident Council (RC) Minutes The March 2026 RC minutes showed: Residents voiced concerns about there not being enough Certified Nursing Assistants (CNAs) on the floor. April 2026 RC minutes showed: Residents voiced concerns about CNAs being disrespectful to and argumentative with residents regarding their care. Staff enter rooms, turning off call lights and leaving without providing care. CNAs using one residents wipe on their roommate, concern over infection control. CNA saying they will be right back and never returning.Call Light Response DataReview of facility call light/bed alarm response data for the three days immediately preceding survey entrance identified the following: On 05/14/2026 resident call lights were activated for greater than 30 minutes (without being reset) 30 times, with the longest being 141 minutes. On 05/15/2026 resident call lights were activated for greater than 30 minutes (without being reset) 27 times, with the longest being 79 minutes. On 05/16/2026 resident call lights were activated for greater than 30 minutes (without being reset) 60 times, with the longest being 77 minutes.The call light response time data, provided by the Facility demonstrated a pattern of prolonged response times affecting multiple residents, units, and shifts. Staff InterviewsOn 05/29/2026 at 1:12 PM, Staff G, CNA explained that the facility did not have shower aides. The floor aides perform the showers for their assigned residents. Staff G used their Friday shower assignments as an example. On Friday their assigned showers were Room- 204 A & B, and room [ROOM NUMBER] A& B. Staff G said if they were lucky each room would only have one resident and you may be able to provide those two showers, but if both rooms had two residents and you had to provide four, you can't do them. You tell the nurse you can't make it. In addition to the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers Staff G indicated they have two meals to serve (breakfast and lunch) and may have two residents who require one-to-one assistance with meals. When that's the case you have to decide which (tasks) you are going to complete. The nurse may find someone to help but that's not guaranteed. On 05/29/2026 at 1:04 PM, Staff F, CNA said they could finish their assigned tasks on days where the facility was fully staffed, but on average one to two days a week they were not fully staffed. Staff F indicated that was when it was a challenge to get morning showers done. Staff F explained that day shift aides had two meals to serve and assist resident with, appointments, care conferences, visits from family or other health professionals that residents needed to be dressed for and assisted to and potentially, new admissions and/or resident discharges. Staff F explained that those factors took away from and greatly diminished the window of time available for providing resident showers. On 05/29/2026 at 12:16 PM, Staff NN, CNA said they were able to complete their assigned tasks each day. Staff NN said they usually skip their breaks and lunches to get everything done and sometimes needed to stay late 30 - 40 minutes to complete a shower. On 05/29/2026 at 12:16 PM, when asked if there were barriers to the facility hiring/maintaining/scheduling staff in sufficient numbers to meet the needs of the residents, Staff L, Interim Director of Nursing Services/ Infection Preventionist, said when the building was sold many senior staff chose to transfer and stay with the previous company where they could maintain their seniority etc. which left many positions open. Staff L also explained that the facility nurses and CNAs were unionized. They had been negotiating a new union contract, which was just completed, and included wage increases for nurses and CNAs to make them more competitive, which would help with recruiting and retention.Reference F585, F600, F677, F686, F687 and F689. Reference WAC 388-97-1080(1), 1090(1)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents received non-pharmacological interventions (NPI) for pain management prior to receiving as needed pain medications for 6 of 24 sampled residents (Resident 24, 138, 2, 37, 100, and 11) reviewed for pain. This failure placed residents at risk for potential side effects, increased pain, and medication reliance. Findings included. A review of the facility policy, Pain Management, undated, documented Specific Procedures/Guidance for 9. Various strategies and modalities may be utilized to assist the resident in achieving optimal comfort. Such strategies and modalities may include, but are not limited to: a. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: i. Environmental – adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.; ii. Physical – ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; iii. Exercise – range of motion exercises to prevent muscle stiffness and contractures; iv. Cognitive or Behavioral – relaxation, music, diversions, activities, etc. b. Pharmacological interventions (i.e., analgesics) may be prescribed to manage pain, however they do not usually address the cause of pain and can have adverse effects on the resident (e.g., drowsiness, increased risk of falling; loss of appetite). Resident 24 Resident 24 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS-an assessment tool), dated 02/13/2026, documented Resident 24 was cognitively intact and received scheduled pain medications, as needed pain medications, and non- medication interventions for pain. A review of the electronic health record (EHR) for Resident 24 showed orders for: - Oxycodone oral tablet 5mg (milligram-metric unit commonly used to measure very small quantities, such as the dosage of medications) Give 1 tablet by mouth every 4 hours as needed for moderate pain order dated 08/05/2025 - Oxycodone oral tablet 5mg Give 2 tablets by mouth every 4 hours as needed for severe pain order dated 08/05/2025 -Pain Reliever Plus Tablet 250-250-65 MG (Aspirin-Acetaminophen-Caffeine) Give 2 tablets by mouth every 4 hours as needed for pain order dated 04/01/2026 - Diclofenac Sodium external Gel 1 % Apply 2g (gram- a metric unit) to bilateral shoulders topically three times a day for shoulder pain order dated 11/12/2025 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Non-Pharmacological Intervention(s) document Record Non-Pharm intervention in Supplementary Documentation. Document Effectiveness. If having pain follow providers direction which may include pain medication. Code for non-pharm intervention: 0 no pain 1 Reposition 2 massage 3 apply cold 4 apply heat 5 Ambulate/movement 6. limit movement 7 promote relaxation/calm environment 14 other -add to PN the description, order date 09/29/2025. A review of Resident 24's April and May 2026 medications administration record (MAR) did not show where NPI's were being documented for as needed pain medications given. On 05/26/2026 at 2:46 PM, Staff H, Licensed Practical Nurse (LPN)/Unit Manager said there was an order for NPIs, but it was not scheduled. Staff H said they would expect the staff to document pain level and NPIs when giving PRN (as needed) pain medications. Staff H said I just fixed that order and scheduled it so the staff can document on it. On 05/26/2026 at 3:37 PM, Staff L, Interim Director of Nursing Services, said they would expect the staff to reposition, provide hot pads or cold packs, and provide imagery all before giving a narcotic to a resident for PRN pain management. Staff L said the NPIs should be scheduled and offered before giving pain medications. Resident 138 Resident 138 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 138 was cognitively intact. On 05/19/2026 at 11:08 AM, an observation was made of Resident 138's medication administration for PRN acetaminophen and no NPIs were observed given by Staff II, LPN. A review of Resident 138's EHR showed an order for: - Acetaminophen Oral Tablet 325 MG Give 650 mg by mouth every 6 hours as needed for pain or elevated temp greater than 100.0 not to exceed 3 grams in 24 hours from all Sources, Start Date 05/13/2026 A review of Resident 138's May 2026 MAR showed PRN acetaminophen was given on 05/19/2026 at 11:36am. 3 was documented as the pain level (Numerical value 0 through 10, 0 indicating no pain and 10 the worst pain) and no NPIs were documented as given. On 05/19/2026 at 3:33 PM, Staff II, LPN, said there was not an order to document NPIs. Staff II was asked if they provided Resident 138 with NPIs prior to giving the PRN acetaminophen and they said I did not and they would give NPIs only depending on if the pain was severe. On 05/20/2026 at 12:20 PM, Staff K, LPN/ Unit Manager, said Resident 138 should have had an order for NPIs and the order should have been entered on admission. Staff K said they would expect the nurse to send a secure message to the provider to get an order for NPIs for PRN pain medications and place the order. On 05/20/2026 at 1:46 PM, Staff B, Director of Nursing Services said they would expect the nursing staff to provide NPIs prior to giving pain medications and the nursing staff should have documented NPIs in a progress note. Staff B said they would look up the facility policy and follow up on providing (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and documenting NPIs. Staff B never followed up on NPIs. Resident 2 Resident 2 was admitted to the facility on [DATE]. The Medicare 5 day MDS, dated [DATE], showed Resident 2 at the time of assessment was receiving scheduled pain medications, but no as needed pain medications or non-pharmacological pain interventions. Resident 2 was assessed to have frequent pain, that frequently made it hard to sleep at night. Review of Resident 2's MAR for May 2026, showed Resident 2 had an order for acetaminophen (Tylenol, a mild pain reliever), without parameters for when to give the medication for pain. It was given on 05/15/2026 for 6/10 pain (moderate pain). Resident 2 had an order for oxycodone-acetaminophen (given for moderate to severe pain), without parameters of when to give the medication for pain. It was given on 05/17/2025 for a pain score of 3/10 pain (mild pain). No order/documentation was found in this MAR for non-pharmacological pain interventions. During an interview on 05/20/2026 at 1:32 PM, Staff K, LPN/Unit Manager, acknowledged Resident 2's as needed acetaminophen order and as needed oxycodone-acetaminophen orders should have had pain scores and did not. Staff K said for a 3/10 pain, that staff usually have parameters to give the acetaminophen instead of the oxycodone-acetaminophen. Staff K was unable to find an order or documentation of non-pharmacological interventions for the as needed pain medications given. During an interview on 05/28/2026 at 9:13 AM, Staff L, Interim Director of Nursing Services /Infection Preventionist (DNS/IP), said there should be non-pharmacological pain interventions documented for Resident 2's oxycodone-acetaminophen administrations. Staff L said their expectation was for parameters to be listed for all pain medications so they could accurately manage the resident's pain. Resident 37 Resident 37 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 37 during the assessment period had received as needed pain medication and had not had any non-pharmacological pain interventions. Resident 37 was assessed to have almost constant pain. Review of Resident 37's May 2026 MAR for 05/01/2026 to 05/18/2026, showed they received as needed acetaminophen for 7/10 pain on 05/19/2026, and their order did not list pain parameters. Resident 37 had an order for as needed oxycodone, 2.5 milligrams (mg) for pain of 3-6/10, with an administration out of parameters on 05/08/2026 for 9/10 pain. Resident 37 had an order, discontinued on 05/07/2025, for 2.5 mg for a pain score of 1-3/10, with an administration out of parameters for 7/10 pain on 05/06/2026. The MAR showed Resident 37 had an order for as needed oxycodone, 5 mg, for pain of 7-10/10 pain, with administrations out of parameter on 05/07/2026 for 5/10 pain, 05/08/2025 for 6/10 pain, 05/11/2026 for 6/10 pain, 05/13/2026 for 5/10 pain,4/10 pain, and 6/10 pain, 05/14/2026 for 6/10 pain and 4/10 pain, and 05/15/2026 for 5/10 pain and 6/10 pain. Resident 37 had a as needed tramadol (pain medication for moderate to moderately severe pain) order, without any pain score ordered. No order/documentation was found in this MAR for non-pharmacological pain interventions. During an interview on 05/26/2026 at 1:48 PM, Staff K, LPN/Unit Manager, confirmed the oxycodone was given out of parameters for Resident 37's May MAR, the acetaminophen and tramadol orders did not have pain parameters ordered, and no non-pharmacological interventions were ordered. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/28/2026 at 9:13 AM, Staff L, Interim DNS/IP, acknowledged Resident 37's pain medications did not meet expectations, regarding the oxycodone and acetaminophen administrations, the lack of pain scales listed, and no non-pharmacological interventions ordered. Resident 100 Resident 100 was admitted to the facility on [DATE]. The Medicare 5 Day MDS, dated [DATE], showed Resident 100 during the assessment period had been receiving schedule pain medication, as needed pain medication, and did not receive any non-pharmacological pain interventions. Review of Resident 100's May 2026 MAR, showed they had a scheduled lidocaine patch (topical pain reliever), without a listed location. Resident 100 had an as needed order for acetaminophen, without a pain scale listed for administration. During an interview on 05/28/2026 at 9:13 AM, Staff L, Interim DNS/IP, said lidocaine patches should have locations listed, and Resident 100's order would need to be fixed. Staff L was unable to find a pain scale attached to Resident 100's order for acetaminophen. Residents 11Residents 11 was admitted to the facility on [DATE]. Review of the physicians' orders showed an order, dated 01/07/2026, for oxycodone five milligrams (5 mg) every four hours as needed, with direction to administer one half tablet for a pain level of 4-6 out of 10, and one tablet for a pain level of 7-10 on a scale to 10. Review of the March 2026 MAR showed Resident 11 was administered as needed oxycodone on 03/08/2026 at 7:07 AM, 03/06/2026 at 1:29 AM and 9:15 AM and on 03/08/2026 at 8:56 AM. Further review showed no non-pharmacological interventions were identified or attempted by facility nurses prior to the administration of the as needed oxycodone. During an interview on 05/29/2026 at 4:46 PM, when asked if there was documentation to show facility nurses attempted non-pharmacological interventions prior to administering Resident 11 oxycodone on 3/08/2026 at 7:07 AM, 03/06/2026 at 1:29 AM and 9:15 AM and on 03/08/2026 at 8:56 AM Staff H, Licensed Practical Nurse/Unit Manager, said no. Reference WAC 388-97 -1060 (3)(k)(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 1 resident (Resident 2) reviewed for dialysis. This failure placed residents at risk of medical complications, risk for falls, discomfort, and a diminished quality of life.Findings included.Resident 2 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and end stage renal disease (kidney failure, requiring the blood to be filtered through a process called dialysis). The Medicare 5 Day Minimum Data Set Assessment, dated 03/24/2026, showed Resident 2 had moderate cognitive impairment. Review of Resident 2's April 2026 medication administration record, showed they had an as needed hydralazine (medication to lower blood pressure) order, from 04/04/2026 through 04/25/2026, for when systolic blood pressure (SBP, top number of blood pressure reading) was over 160, which could be given every 8 hours. This record showed it had only been given 3 times.Review of Resident 2's blood pressure record from 04/04/2026 through 04/25/2026, showed their SBP was regularly over 160. Resident 2's blood pressure on 04/11/2026 showed the following blood pressures (no as needed hydralazine was given per the administration record):04/11/2026 8:24 PM 170 / 86 mmHg 04/11/2026 7:38 PM 170 / 86 mmHg 04/11/2026 1:48 PM 202 / 98 mmHg 04/11/2026 12:55 PM 202 / 98 mmHg 04/11/2026 06:48 AM 164 / 82 mmHgOn 05/29/2026 at 8:45 AM, Staff M, Interim Administrator, said they were doing a medication error investigation into the timeframe when Resident 2's parameter was only for systolic blood pressure (04/04/2026 through 04/25/2026). On 05/29/2026 at 2:15 PM, Staff M, provided the following confirmation from their investigation of how many times the as needed hydralazine order was not followed (19 times):04/04/2026- 6:22 AM04/04/2026- 9:18 PM04/05/2026- 7:17 AM04/06/2026- 5:28 PM04/06/2026- 9:27 PM04/08/2026- 1:24 PM04/09/2026- 8:01 PM04/09/2026- 9:48 PM04/10/2026- 8:43 AM04/11/2026- 6:48 AM04/11/2026- 12:55 PM04/11/2026- 7:38 PM04/12/2026- 6:57 AM04/12/2026- 10:45 AM04/12/2026- 20:19 PM04/16/2026- 6:23 AM04/16/2026- 4:43 AM04/17/2026- 6:42 AM04/18/2026- 3:56 PM Reference F658, F689Reference WAC 388-97-1060 (3)(k)(iii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent cross contamination during meal preparation services for 1 of 1 kitchen, reviewed for food service safety. The failure to prevent cross contamination placed residents at risk of foodborne illness (caused by the ingestion of contaminated food or beverages), unsanitary conditions, and diminished quality of life.Findings included . On 05/19/2026 at 11:59 AM, Staff D, Dietary Aide, started dishing lunch meal plates. Staff D started plating, using utensils to pick up food and plate. On 05/19/2026 at 12:01 PM, Staff D touched the garlic bread and greens beans, to cut them up with gloved hands. Staff D continued to plate lunch meals, plating 12 more plates. On 05/19/2026 at 12:09 PM, Staff D touched the garlic bread, to cut it up, with gloved hands. Staff D continued to plate lunch meals, plating 7 more plates. On 05/19/2026 at 12:15 PM, Staff D touched the garlic bread and green beans, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 8 more plates. On 05/19/2026 at 12:23 PM, Staff D touched the grilled cheese sandwich to cut it in half. Staff D continued to plate lunch meals, plating 2 [NAME] plates. On 05/19/2026 at 12:23 PM, Staff D touched the garlic bread and green beans, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 4 more plates. On 05/19/2026 at 12:28 PM, Staff D touched the green beans and garlic bread, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 1 more plate. On 05/19/2026 at 12:30 PM, Staff D touched the spaghetti noodles with gloved hand. Staff D continued to plate lunch meals, plating 1 more plate. On 05/19/2026 at 12:32 PM, Staff D touched the green beans and garlic bread, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 2 more plates. On 05/19/2026 at 12:35 PM, Staff D touched the green beans and garlic bread, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 1 more plate. On 05/19/2026 at 12:36 PM, Staff D grabbed Whey Powder Protein container and mixed it with gravy in a cup. Staff D continued to plate lunch meals, plating 2 more plates. Staff D did not change their gloves. On 05/19/2026 at 12:38 PM, Staff D touched the garlic bread and green beans, to cut them up, with gloved hands. On 05/19/2026 at 12:40 PM, Staff D touched the spatula to flip grilled cheese sandwich. Staff D did not change their gloves. Staff D continued to plate lunch meals, plating 2 more plates. On 05/19/2026 at 12:43 PM, Staff D touched the spatula to flip grilled cheese sandwich, then returned to plating lunch meals, plating 2 more lunch plates. Staff D then touched the spatula again, flipping grilled cheese sandwich and then returned to plating lunch meals, plating 2 more plates. Staff D then touched both grilled cheese sandwiches, to cut them in half with gloved hands. Staff D continued to plate lunch meals, plating 3 [NAME] plates. Staff D did not change their gloves. On 05/19/2026 at 12:46 PM, Staff D touched the garlic bread, to cut it up, with gloved hands. Then touched grilled cheese sandwich and continuted to plate. On 05/19/2026 at 12:49 PM, Staff D touched the grilled cheese sandwich and green beans, to cut them up, with gloved hands. On 05/19/2026 at 12:51 PM, Staff D doffed (take off) gloves, completed hand hygiene and donned (put on) new gloves. Staff D continued to plate lunch meals, plating 6 more plates. On 05/19/2026 at 12:59 PM, Staff D touched the green beans, garlic bread and meatballs, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 1 more plate. On 05/19/2026 at 1:01 PM, Staff D touched the garlic bread and green beans, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 6 more plates. On 05/19/2026 at 1:06 PM, Staff D touched the garlic bread, green beans and hamburger patty, to cut them up, with gloved hands. Staff D continued to plate lunch meals, plating 1 more plate. On 05/19/2026 at 1:09 PM, Staff D grabbed the food thermometer and obtained food holding temperatures of all foods on the steam table. Staff D did not change their gloves after touching thermometer. On 05/19/2026 at 1:17 PM, Staff D touched the green beans and garlic bread, to cut them up, with gloved hands. Staff D touched toasted bread, to cut it up, with gloved hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff D then touched a hamburger patty with gloved hands, plating two different plates at the same time. Staff D continued to plate lunch meals, plating 2 more plates. On 05/19/2026 at 1:21 PM Staff D touched the spatula, flipping grilled cheese sandwich and continued to plate lunch meals, plating 1 more plate. Staff D did not change their gloves. On 05/19/2026 at 1:21 PM, Staff D touched grilled cheese sandwich, to cut it in half and continued to plate lunch meals, plating 11 more plates. On 05/19/2026 at 1:28 PM, Staff D touched the bread roll and green beans, to cut them up, with gloved hands and continued to plate lunch meals, plating 5 [NAME] plates. On 05/19/2026 at 1:33 PM, Staff D touched the spatula, flipping a grilled cheese sandwich and continued to plate lunch meals, plating 1 more plate. On 05/19/2026 at 1:35 PM, Staff D touched the spatula, flipping a grilled cheese sandwich. Staff D touched the grilled cheese sandwich, to cut it up, with gloved hands. Staff D did not change their gloves. On 05/19/2026 at 1:40 PM, tray line plating ended. On 05/19/2026 at 2:08 PM, when asked about expectations for touching food, Staff C, Dietary Manager, said their expectation was that staff do not touch the food when serving, staff should be wearing gloves and using utensils. When observations were explained about staff touching the food and then touching environmental surfaces (including containers, spatula and thermometer) without changing gloves, Staff C said it did not meet expectation, and staff should have changed their gloves after touching the environmental surfaces. Reference WAC 388-97 -1100 (3), 2980

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and record review, the Administration failed to provide oversight and monitoring of facility personnel, systems and practices related to Abuse/Neglect and failed to ensure compliance for identifying, reporting, protecting and thoroughly investigating allegations of abuse/neglect. These failures resulted in residents experiencing verbal abuse and neglect and placed other residents at risk of unidentified abuse/neglect and resulted in an Immediate Jeopardy (IJ) situation related to CFR 483.12(2)-(4) F610, alleged violations-Investigate/Prevent/Correct.Findings included .The facility policy titled, Abuse, revised 10/20/2022, showed under the section titled Identification, staff were encouraged to identify, correct, and intervene in situations which abuse, neglect and/or misappropriation of resident property was more likely to occur. Immediately following ensuring the resident's safety, staff were to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member. Under the section titled Investigation, designated staff would immediately review and investigate all allegations or observations of abuse. Under the section titled Reporting, the organization would immediately report all alleged violations involving neglect, abuse, including injuries of unknown source, mistreatment and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator or his or her designee.Review of the facilities Job Summary for Administrator, revised 06/23, showed the administrator duties included ensuring resident concerns/complaints were responded to with tact and urgency. The administrator duties also included reporting of allegations or resident abuse, neglect and/or misappropriation of resident property.A review of the Annual and Complaint surveys for the facility over the previous 22 months showed a pattern of failure to report and thoroughly investigate allegations of abuse and neglect. The facility was cited for F609 Reporting of Alleged Violations on 09/03/2024, 06/24/2025, 09/24/2025 and 01/07/2026. The facility was cited for F610 Alleged Violations-Investigate/prevent/Correct on 11/08/2024, 06/24/2025 and 09/24/2025.Grievances filed between 04/05/2026 and 05/19/2026, by Residents 25, 53, 143, 4, 144, 150, 31, 45, 86, 80, 148, 149, 112, 99, 110, 69, 116, 10, 44, & 38 were reviewed with Staff A, Administrator, on 05/21/2026 at 10:39 AM. Staff A confirmed each of the reviewed grievances were allegations of abuse/neglect or acknowledged the facility's failure to obtain further information about the reported incidents precluded the facility from ruling out abuse and neglect out.On 05/22/2026 at 12:13 PM, Staff A, Administrator, said regarding grievances they did see that they had dropped the ball. Staff A indicated they had reviewed the grievances from 04/05/2026 through 05/19/2026 as potential allegations of abuse/neglect and they were in the process of following up on abuse and neglect. Staff A said they had called their boss to assist them with the process and to provide them with education. Staff A said they had provided education to managerial staff on conducting investigations and reporting requirements and had a discussion with their team on where they had dropped the ball. On 05/26/2026 at 9:08 AM, Staff M, Interim Administrator, said call lights at the facility were an issue and the sense of urgency and culture around care needed to be worked on. Staff M said they had pulled the call light records and it had been eye opening for them to look at, they could see long call light wait times and all of these could be neglect allegations. Staff M said when reviewing grievances, many were around long call light times, and the facility was opening investigations. Staff M said it was a culture problem and needed to be addressed around urgency of call lights. Staff M said they had reviewed grievances beginning from 03/01/2026 and saw things they would have chosen to report.On 05/29/2026 at 3:47 PM, Staff M, said Staff A had made them aware of concerns with the handling of allegations related to abuse/neglect that week (after concerns were brought to Staff A's attention). Staff M reported the previous week they had toured the building and had reviewed random grievances but did not see the level of grievances that had been since identified. Staff M indicated facility staff did not understand the gravity of what residents had reported, which led to that happening more frequently and it then became culturally accepted. When (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	asked if actions, inactions, or decisions made by the previous administrator, Staff A, had contributed to not identifying alleged abuse and/or neglect, Staff M said yes.Reference F610, F600, F695, F585, F690, F725, F692Reference WAC 388-97-0640 (6)(a)(b)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ask residents if they had an Advanced Directives (AD) and attempt to obtain a copy or failed to notify residents of their right to formulate one for 1 of 3 residents (Resident 11) reviewed for ADs. This failure detracted from the resident's ability to make an informed decision regarding formulation of an AD and placed residents at risk for losing the right to have their medical preferences and choices honored regarding emergent and end-of-life care. Findings included .Resident 11 was admitted to the facility on [DATE]. Review of the electronic health record showed no documentation that the resident was asked if they had an AD or that they were informed of their right to formulate one.On 05/18/2026 at 3:44 PM, documentation that Resident 11 was asked if they had an AD and/or were informed of their right to formulate one was requested from Staff A, Administrator, via email.On 05/18/2026 at 4:27 PM, Staff A, Administrator, responded in a email, I do not see any AD's or documentation that it was discussed.Reference WAC 388-97-0280 (1)(3)(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to initiate grievances for 1 of 1 month, April 2026, that included sampled residents (Resident 139, 47, 25 & 80) reviewed for grievances. This failure placed the residents at risk of unmet needs, personal loss and a diminished quality of life. Findings included. Review of April 2026 Resident Council Meeting Minutes, on 05/18/2026, documented the following concerns: Resident 139 reported, that the CNAs are disrespectful, don't listen argue with the residents in regard to their care, they don't want to do their jobs, and the do it the way they want and not to the resident's needs. Resident 47 reported, CNAs keep taking her packages of wipes using them on her roommate. This brings up an infection control issue. Resident 25 reported, agency staff wearing ear buds, either listening to music or talking on their phone while on the floor and providing care for residents. Concerns with the morning shift coming in and being very loud first thing in the morning and having conversations right outside of residents' doors. On 05/20/2026 at 12:02 PM, Staff I, Social Services Director (SSD) with Staff J, (SS) present, said their process for reporting reported concerns in Resident council was to write down the resident's concerns, word for word, depending on the type of concern either a grievance form would be completed or allegations would be reported to the Administrator. If it was a grievance, staff either completed a grievance form or used the new electronic system, that included resident name, the concern, who the concern was reported to and who the concern would be assigned too. Staff J said she completed April 2026's Resident Council grievances and entered them on the log. Staff J said there were no care concerns from residents, only facility concerns like the new van for transportation. Staff J was asked to review April 2026's Resident Council Meeting Minutes. Staff J read Resident 139's documented concerns aloud. When asked if Resident 139's concerns were care concerns, Staff J said yes. Staff J was asked if the concern was documented on the Grievance Log, Staff J said no. When asked if it should have been documented on the Grievance Log, Staff J said yes. Staff J read Resident 47's documented concerns aloud. When asked if Resident 47's concerns were care concerns, Staff J said yes. Staff J was asked if the concern was documented on the Grievance Log, Staff J said no. When asked if it should have been documented on the Grievance Log, Staff J said yes. Staff J read Resident 25's documented concerns aloud. When asked if Resident 25's concerns were care concerns, Staff J said yes. Staff J was asked if the concern was documented on the Grievance Log, Staff J said no. When asked if it should have been documented on the Grievance Log, Staff J said yes. On 05/20/2026 at 12:30 PM, Staff A, Administrator, said depending on the type of concern either an allegation or a grievance it would determine what would happen with the concern. If it was a grievance concern, staff would fill out the paper version or the electronic version of the Grievance form. Staff A was asked to review April 2026's Resident Council Meeting Minutes. Staff A read (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 139's documented concerns aloud. When asked if Resident 139's concerns were care concerns, Staff A said yes. Staff A was asked if the concern was documented on the Grievance Log, Staff A said no. When asked if it should have been documented on the Grievance Log, Staff A said yes. Staff A read Resident 47's documented concerns aloud. When asked if Resident 47's concerns were care concerns, Staff A said yes. Staff A was asked if the concern was documented on the Grievance Log, Staff A said no. When asked if it should have been documented on the Grievance Log, Staff A said yes. Staff A read Resident 25's documented concerns aloud. When asked if Resident 25's concerns were care concerns, Staff A said yes. Staff A was asked if the concern was documented on the Grievance Log, Staff A said no. When asked if it should have been documented on the Grievance Log, Staff A said yes. Resident 80 Resident 80 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment, dated 04/17/2026, documented Resident 80 was cognitively intact. On 05/17/2026 at 3:27 PM, Resident 80 said they had concerns about their previous roommate and had filled out a grievance and Staff A, Administrator and the top nurse came and talked to them. On 05/18/2026 at 4:28 PM, a review of the grievance log did not show Resident 80's concerns and a request was emailed to Staff A, Administrator for the grievance associated with Resident 80's roommate concerns. On 05/18/2026 at 7:01 PM, Staff A, Administrator said I am not seeing a grievance for [Resident 80] related to the roommate concerns. I do know, however, that when it was brought up, [Resident 80] had agreed to transfer rooms and that room transfer happened. I will continue to look to see if there was a paper grievance. On 05/26/2026 at 8:36 AM, Resident 80 said they filled out a grievance when they had concerns about their previous roommate and gave it to the staff who said they would give it to the Administrator. A Nursing Progress Note, dated 04/24/2026 at 3:32 PM, completed by Staff FF, Licensed Practical Nurse, documented [Resident 80] stated to this nurse that roommate had woken [them] up at night by being loud, [they] stated that roommate keeps [them] up late at night talking about family members in the past and wanted to have [their] room changed. I notified nurse manager about the resident's request to be moved and to speak to the social worker. On 05/27/2026 at 9:24 AM, Staff L, Interim Director of Nursing Services said she did not see a grievance for Resident 80's roommate concerns. When asked if grievances were kept after a resident filled them out, Staff L said, I do not see a grievance. When asked if she would expect to see a grievance for Resident 80's roommate concerns Staff L said, I would expect a grievance to be done if they could not take care of it in the moment and for it to be tracked. 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 interview and record review the facility failed to accurately assess 4 of 24 residents' Minimum Data Sets (MDS, an assessment tool) reviewed. Failure to ensure accurate assessments for Preadmission Screening and Resident Review (PASRR, a federally mandated program requiring all individuals to be screened for mental illness or intellectual disabilities before being admitted to a nursing facility) (Resident 4), weight loss (Resident 100), urinary incontinence (Resident 94), cognitive pattern assessments and formal pressure injury prediction tools (Resident 17) placed residents at risk for unidentified and or unmet care needs.Findings included. Resident 4 was admitted to the facility on [DATE] and had a diagnosis of Post Traumatic Stress Disorder (PTSD- A mental health condition triggered by experiencing or witnessing a terrifying, shocking, or dangerous event.), Depression (A mood disorder that causes a persistent feeling of sadness and loss of interest.) , and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation.). According to the Annual Minimum Data Set, (MDS, an assessment tool), dated 07/28/2025, Section A documented a no when asked if Resident 4 was currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. Nothing was checked for serious mental illness. A review of Resident 4's PASRR Level I, dated 04/19/2023, documented Resident 4 had serious mental illness indicators of mood disorders and anxiety disorders. A review of Resident 4's electronic health record (EHR) showed a Level II PASRR evaluation summary, dated 05/23/2023, with recommendations for the nursing facility. A review of Resident 4's care plan, dated 04/16/2025, stated PASRR: [Resident 4] is determined to need specialized services related to a PASRR level II evaluation related to PTSD, DEPRESSION, ANXIETY. On 05/21/2026 at 8:37 AM, Staff N, MDS/Registered Nurse (RN), said Resident 4's annual MDS, dated [DATE], documented the resident did not have a level 2 PASRR and the annual MDS was inaccurate. Staff N said they would change it and correct it, to say Resident 4 had a Level II PASRR. On 05/21/2026 at 1:52 PM Staff B, Director of Nursing Services (DNS), when asked her expectations for MDS documentation said she was not familiar with the MDS and PASRR and had recently had a class on it. Staff B said she would look it up and find out. At 2:12 PM, Staff B came back and said her expectation would be if a resident has a PASRR level II she would expect it to be care planned. Resident 100 Review of the Resident Assessment Instrument (RAI- manual for MDS nurses to code assessments correctly), for a new admission to assess weight loss: 1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days. 2. Consult the resident's physician, review transfer documentation, and compare with admission weight. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. If the admission weight is less than the previous weight, calculate the percentage of weight loss. 4. Complete the same process to determine and calculate weight loss comparing the admission weight to the weight 30 and 180 days ago. Resident 100 was admitted to the facility on [DATE], with diagnoses of severe protein-calorie malnutrition (not getting enough protein and calories for body needs), neurocognitive disorder with Lewy bodies (dementia, causes a decline in cognitive abilities which can interfere with daily life), and weakness. The Medicare 5 Day MDS, dated [DATE], showed Resident 100 was severely cognitively impaired, and they were not assessed as having significant weight loss >5% over the past 30 days or > 10 % in the last 6 months. Resident 100 was listed with a weight of 159 pounds (lbs.). Review of Resident 100's weights since admission, showed they did not have a weight taken until 03/19/2026, which was after the MDS assessment had been completed. Review of Resident 100's hospitalization notes, showed on admission to the hospital on [DATE], they weighed 170 pounds (lbs). On 03/12/2026, Resident 100 had weighed 159lbs and 6.3 oz. This was a 6.18% weight loss in less than 2 weeks. During an interview on 05/28/2026 at 8:12 AM, Staff N, MDS/RN, acknowledged they did not have a baseline weight for Resident 100 when they entered the facility, they had not been messaged by the traveling MDS nurse assisting with this assessment that further information was needed, and family should have been contacted to establish a baseline weight. During an interview on 05/28/2026 at 9:13 AM, Staff L, Interim DNS/Infection Preventionist (IP), after reviewing Resident 100 did not have a weight on admission for their MDS assessment, said they expected an admission weight and a baseline, to have gotten three weights back to back. After reviewing weight loss at hospital, Staff L said their expectation was for family and residents to have been interviewed related to their weight for the MDS and for the RAI manual to have been followed. Resident 94 Resident 94 was admitted to the facility on [DATE]. The Medicare 5 Day MDS, dated [DATE], showed Resident 94 was cognitively intact, and was frequently incontinent of urine (defined as 7 or more episodes of urinary incontinence, but at least one episode of continent voiding). Review of Resident 94's documented urinary episodes, showed Resident 94 only had two episodes of urinary incontinence, and was continent all other times during the assessment period. During an interview on 05/28/2026 at 8:12 AM, Staff N, MDS/RN, reviewed Resident 94's MDS from 05/11/2026 and acknowledged their urinary incontinence should have been coded as only occasionally incontinent, due to only two episodes of urinary incontinence, not frequently incontinent. Resident 17 Review of the Long-Term Care Facility RAI 3.0 User's Manual, October 2025, showed it directed MDS nurses to attempt to conduct a Brief Interview for Mental Status [BIMS] interview with all residents. Resident 17 was admitted to the facility on [DATE]. Review of the Quarterly MDS, 03/14/2026, showed for the question should a BIMS be conducted staff documented No (resident is rarely/never (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understood). However, the resident mood interview and preferences for customary routine and activities interview were completed with Resident 17. Additionally, the MDS showed a formal assessment instrument/tool (e.g. Braden scale, Norton Scale - clinical tools for predicting the risk of developing a pressure injury) was completed during the assessment period. Review of the electronic health record showed there was no documentation that a formal assessment instrument/tool, such as a Braden scale, was completed during the assessment period as coded on the MDS. A social work note dated 03/12/2026, documented Resident 17 was alert and receptive to conversation. In an interview on 05/29/2026 at 12:56 PM, Staff N, MDS/RN, confirmed a BIMS interview should have been attempted with Resident 17 and a formal assessment instrument/tool was not completed during the assessment period. When asked if the MDS was correctly coded for those two items Staff N stated, No. Reference F692 Reference WAC 388-97- 1000 (1)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 4 of 24 sampled residents (Residents 17, 10, 11, & 119) reviewed. The failure to obtain, follow and/or clarify physicians' orders when indicated, only sign for those tasks completed, and to notify the physician/pharmacy of missed doses due to unavailable medications, resulted in medication errors and placed residents at risk for adverse side effects, ineffective treatment and adverse health outcomes.Findings included . Residents 17 Residents 17 was admitted to the facility on [DATE]. Record review showed the resident had 12/20/2025 orders for: Morphine sulfate 0.25 milliliters (ml) by mouth every four hours as needed for pain level of 1-4 out of 10, or air hunger Morphine sulfate 0.50 ml by mouth every four hours as needed for pain level of 5-10 out of 10, or air hunger. Review of the April 2026 Medication Administration Record (MAR) showed on the following occasions Resident 17's morphine dose was not administered in accordance with the physician orders. 04/10/2026 at 7:24 PM: Morphine sulfate 0.25 ml was administered for a pain level of 5/10. 04/12/2026 at 7:26 AM: Morphine sulfate 0.25 ml was administered for a pain level of 6/10. During an interview on 05/29/2026 at 12:36 PM, when asked if administering Morphine sulfate 0.25 ml for pain levels of 5/10 and 6/10 was in accordance with the physician order, Staff H, Licensed Practical Nurse/Unit Manager, said no, for a pain level of 5-10 the nurse should have administered 0.5 ml of morphine. Residents 10Residents 10 was admitted to the facility on [DATE]. Record review showed a treatment order, dated 02/25/2026, directing nurses to: 1. Apply ammonium lactate lotion to both lower extremities (LEs),2. Wrap both LEs with kerlix (rolled gauze),3. Secure kerlix to both LEs in place with ace wrap (an elastic bandage commonly used in medical settings to provide compression and decrease edema/swelling). Every evening shift On 05/18/2026 at 12:36 PM, 05/19/2026 at 1:24 PM, and 05/20/2026 at 1:27 PM, Resident 10 was observed with a tan colored tubular gauze (an elastic, seamless gauze sleeve or bandage, used for wound care, compression, and limb support) in place to both LEs from ankle to knees, with no underlayment (foundational layer between tubular gauze and skin). The nurses failed to apply ammonium lactate lotion to both LEs, wrap with kerlix and secure with ace wraps as ordered. The May 2026 Treatment Administration Record (TAR) showed nurses signed on 05/17/2026, 05/18/2026, and 05/19/2026, that Resident 10's LE treatments were completed as ordered. On 05/20/2026 at 4:50 PM, Staff B, Director of Nursing Services (DNS), observed that Resident 10 had tubular gauze applied to both LEs. After reviewing Resident 10 May 2026 TAR, Staff B acknowledged facility nurses had signed that they completed Resident 10's LE treatments as ordered, when they did not. Staff B said it was the expectation that nurses only sign for treatments that were performed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents 11Residents 11 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/06/2026, indicated the resident was cognitively intact, had diagnoses including asthma and chronic respiratory failure, and required oxygen therapy during the assessment period. Record review showed an order, dated 03/20/2026, for Oxygen at 1 to 3 liters per minute (LPM) continuously via nasal cannula, titrate to maintain oxygen saturation between 90% and 95%, and notify the physician if oxygen exceeds 3 LPM. On 05/18/2026 at 11:12 AM, 05/19/2026 at 3:35 PM, and 05/20/2026 at 2:12 PM, Resident 11 was observed receiving oxygen at 4 LPM, via nasal canula. Review of the electronic health record (EHR) showed there was no documentation to show staff notified the physician that Resident 11's oxygen flow rate exceeded 3 LPM on 05/18/2026, 05/19/2026 and 05/20/2026. The May 2026 MAR showed nurses signed three times daily on 05/18/2026, 05/19/2026 and 05/20/2026, that Resident 11 was administered oxygen at 1 to 3 LPM as ordered. During an interview on 05/20/2026 at 4:39 PM, Staff B, DNS, acknowledged facility nurses failed to administer Resident 11's oxygen at the physician ordered rate(s) (1 to 3 LPM) and failed to notify the physician when Resident 11's oxygen delivery exceeded 3 LPM, as ordered. Further review of the May 2026 MAR showed nurses could initial Resident 11 received oxygen at 1 to 3 LPM via nasal cannula but did not have a place to record the actual LPM of oxygen that was delivered. During an interview on 05/20/2026 at 4:39 Staff B, DNS, confirmed nurses were unable to record how many LPM of oxygen they administered to Resident 11. Staff B said nurses were required to record what medications they administered and at what dose. Staff B said facility nurse should have identified the inability to record the dose of oxygen they administered and corrected the order input/ clarified the order but acknowledged they failed to do so. An order, dated 02/22/2026 directed nursing to change the resident's oxygen tubing, humidification bottle (if used), clean the concentrator filter weekly, and label supplies with name and date. The order failed to identify what type of fluid the humidifier bottle should be filled with (e.g., distilled water). On 05/18/2026 at 11:12 AM, and 05/19/2026 at 3:35 PM, the refillable humidifier bottle attached to Resident 11's oxygen concentrator was empty and dated 04/06/2026. During an interview on 05/20/2026 at 4:39 PM, Staff B, DNS, acknowledged the humidifier order was incomplete and failed to identify what fluid was to be used to refill the humidifier bottle. Staff B said facility nurses should have identified the order was incomplete and clarified the order with the physician. Resident 119 A review of the facility policy Medication Shortages, dated 01/23, documented The facility nurse must make every effort to ensure that a medication ordered for the resident is available to meet their (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs. Procedures. 2. Nursing staff shall, if the shortage will impact the patient's immediate need of the ordered product:a. Notify the attending physician of the situation, explain the circumstances, expected availability and optional therapy(ies) that are available.b. Obtain a new order and cancel/discontinue the order for the non-available medication.c. Notify the pharmacy of the replacement order. Resident 119 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented the resident was cognitively intact and had a diagnosis of alcoholic cirrhosis of liver without ascites (a medical diagnosis indicating advanced scarring of the liver caused by long-term, heavy alcohol use, but fluid has not yet accumulated in the abdomen). On 05/18/2026 at 10:46 AM, Resident 119 said when they run out of my antibiotics and I don't take it, I feel bad. A review of the EHR showed an order for:-Rifaximin Oral Tablet Give 1 tablet by mouth two times a day for GI health [gastrointestinal health refers to the proper functioning of the entire digestive system] dated 02/19/2026. A review of the April 2026 MAR showed a 9=Other / See Progress Notes documented for Rifaximin on 04/24/2026 and 04/28/2026 at 7:00 PM. A review of the May 2026 MAR showed 9=Other / See Progress Notes and documented that Rifaximin was not given on 05/06/2026, 05/10/2026, 05/11/2026, and 05/15/2026 at 7:00 AM and 05/02/2026, 05/09/2026, 05/10/2026, 05/18/2026 at 7:00 PM. A review of Resident 119's EHR showed the following nursing progress notes documented with the Rifaximin order/administration record: -On 05/18/2026 at 8:46 PM by Staff HH, Licensed Practical Nurse (LPN) documented awaiting from Rx PCP notified. - On 05/15/2026 at 9:09 AM by Staff FF, LPN documented not available, reordered -On 05/11/2026 at 8:57 AM by Staff FF, LPN documented pending pharmacy delivery -On 05/10/2026 at 6:31 PM by Staff II, LPN documented pending pharmacy delivery. -On 05/10/2026 at 9:50 AM by Staff II, LPN documented pending pharmacy delivery. -On 05/09/2026 at 8:05 PM by Staff II, LPN documented OOS -On 05/06/2026 1:58 PM by Staff JJ, LPN documented none available. -On 05/02/2026 at 6:59 PM by Staff II, LPN documented Pending pharmacy delivery. -On 04/24/2026 at 8:29 PM by Staff KK, Registered Nurse documented Med not available. -On 04/28/2026 at 8:22 PM by Staff FF, LPN did not document a statement after the Rifaximin order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2026 at 3:18 PM, Staff R, LPN said when a medication is not available, they would make a call to the pharmacy to send the medication STAT (immediately or without delay) and report it to the next shift to make sure the resident got it. On 05/21/2026 at 11:33 AM Staff H, LPN/Unit Manager said when a medication was not available, Staff H would expect the nurse to recheck the cart to locate the medication and recheck the Cubex (an automated dispensing system to securely track and store pharmaceuticals). If the medication was still not available notify the resident or responsible party, notify the provider, and call the pharmacy to get a refill and see if they can satellite deliver it within 4 hours. Staff H said after looking at Resident 119's MARs and progress notes they would have to talk to the specific nurses to see if all these steps were taken because the progress notes were not detailed. On 05/21/2026 at 2:01 PM, Staff B, DNS, said the steps for the nursing staff to follow when a medication was not available was to check the Cubex for the medication and inform the provider if it was still not available in the Cubex. Ask the provider if the medication can be held or if an order can be placed for another medication. Document the provider was notified and wait until the medication arrived and if it can't wait, call the pharmacy to send a STAT delivery. Reference F686, F695 Reference WAC 388-97-1629(2)(b)(i)(ii)(6)(b)(i)

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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 dependent resident's activities of daily living (ADLs) were followed related to nutrition and/or hygiene for 1 of 5 residents (Resident 100) reviewed for ADLs and 1 of 2 residents (Resident 30) reviewed for choices. These failures placed residents at risk for nutritional concerns, lack of dignity, poor hygiene, and a diminished quality of life.Findings included. Review of the facility's policy titled, Activities of Daily Living (ADLs), undated, showed the facility was to maintain good nutrition, grooming and personal and oral hygiene for residents that were unable to carry out activities of daily living independently. Resident 100 Resident 100 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition (not getting enough protein and calories for body needs), neurocognitive disorder with Lewy bodies ((dementia, causes a decline in cognitive abilities which can interfere with daily life), and weakness. The Medicare 5 Day Minimum Data Set Assessment (MDS), dated [DATE], showed Resident 100 was severely cognitively impaired, and was dependent on staff for cares. Review of Resident 100's last 30 days of showers/baths, from 04/21/2026 through 05/18/2026, showed they were scheduled for shower/baths on Tuesday and Friday evening. Resident 100 had only two recorded showers in the reviewed 30-day period, out of eight scheduled opportunities. There were four recorded refusals, and two not applicable selections. Review of Resident 100's electronic health record (EHR), showed no documentation that CC6, Resident 100's Power of Attorney, had been notified of the shower refusals. Review of Resident 100's care plan showed their care plan was not updated with the refusals and no interventions had been added to accommodate for their dementia diagnosis related to the refusals. Review of Resident 100's diet order, showed a regular diet of soft and bite sized texture was ordered since 03/17/2026, with instructions for monitoring 1:1 assist for oral intake. Resident 100 had been seen without a 1:1 meal assistance during observations on 05/18/2026 at 9:32 AM and 12:45 PM, on 05/20/2026 at 7:04 AM, and on 05/21/2026 at 12:56 PM. During an interview on 05/19/2026 at 4:40 PM, CC6, Resident 100's Power of Attorney, was asked about how Resident 100 ate and how the facility interacted with them. CC6 said that was not a good subject for them, Resident 100 was supposed to have 1:1 eating assistance and they rarely got that help. CC6 said they often found food under Resident 100's fingernails, they were not a big fan of the care at this facility. During an interview on 05/20/2026 at 12:44 PM, Staff K, Unit Manager, was asked about the process when residents refused showers. Staff K said they encourage staff to reapproach three different times, to have someone else reapproach, and they were training staff to document this in a progress note. After reviewing Resident 100's last 30 days of showers, Staff K was asked about if Resident 100's shower refusals had been care planned and if certain times had been reviewed to see if they would do better with a different time of day. Staff K acknowledged this was an issue. When asked if (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	there was documentation Resident 100 was offered showers by staff during reattempts, Staff L said no, this was a work in progress. During an interview on 05/21/2026 at 1:02 PM, CC7, Resident 100's son, when asked about there not being staff in the dining room at that moment, said Resident 100 was supposed to get 1:1 assistance by staff and they did not see that was happening. During an interview on 05/22/2026 at 2:37 PM, CC6, Resident 100's Power of Attorney, was asked if they knew Resident 100 was refusing showers. CC6 stated, No, I did not hear that. During an interview on 05/28/2026 at 9:13 AM, Staff L, Director of Nursing Services /Infection Preventionist (DNS/IP), regarding the observations of the 1:1 feeding assistance not being done, said they expected residents who need a 1:1 assist to get this every meal. Staff L said they expected residents to be in an optimal position to eat, to be upright in a chair, to set Resident 100 up for success to drink their drinks and eat their food, and that staff would stay with Resident 100 until they consumed their meal. Resident 30 Resident 30 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was cognitively intact, required substantial to maximal assistance with bathing/showering, and decisions related bathing preferences were identified as very Important. On 05/18/2026 at 1:21 PM, Resident 30 said they were supposed to be showered twice a week but explained two showers a week may not always be necessary. Resident 30 then resolutely said at least one shower a week was necessary and reported that the staff never came. Review of Resident 30's comprehensive care plan, initiated 12/18/2025, showed assistance required with bathing/showering and the resident 30's preferred frequency were not addressed. Review of Resident 30's bathing record showed they were scheduled to be showered every Tuesday and Friday after breakfast. Further review showed Resident 30 was showered on 05/12/2026 and had not been offered/provided a shower again until 05/25/2026, 13 days later. Review of the electronic health record showed there was no documentation that Resident 30 refused bathing between 05/13/2026 - 05/24/2026. On 05/28/2026 at 1:41 PM, when asked if there was any documentation to show staff offered/provided Resident 30 bathing between 05/13/2026 - 05/24/2026, Staff H, Licensed Practical Nurse/Unit Manager, stated, No. Reference F692, F744, F656 Reference WAC 388-97 -1060 (2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review, the facility failed to ensure non-pressure skin conditions were assessed, monitored and treated, in accordance with physician orders, and as needed bowel care was provided for 3 of 8 residents (Residents 17, 78 & 10) reviewed for non-pressure skin and/or bowel management. The failure to initiate bowel care in accordance with physician's orders, and to assess, monitor and implement ordered treatments for non-pressure skin conditions, placed residents at risk for pain/discomfort, delayed wound healing, and a diminished quality of life. Findings included .Bowel Management Resident 78Resident 78 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/10/2026, showed the resident was cognitively intact. On 05/17/2026 at 2:35 PM, Resident 78 said they had a lot of trouble with constipation. Review of Resident 78's physician orders showed the following as needed bowel care orders, dated 01/02/2026: Miralax as needed, administer if no bowel movement (BM) after 72 hours; if ineffective after eight hours, administer step three of the bowel protocol. Lactulose as needed for bowel protocol step three, if ineffective after eight hours, administer step four and complete an abdominal assessment. Bisacodyl, administer one tablet as needed for bowel protocol step four; if ineffective after eight hours, administer step five. Bisacodyl suppository, administer as needed for bowel protocol step five; Notify the provider if: ineffective, no BM in greater than five days, severe abdominal pain, vomiting, or obstruction/fecal impaction suspected.Resident 78's bowel record showed they had no BM from 03/03/2026- 03/06/2026 (4 days), and from0 3/14/2026- 03/17/2026 (4 days). Review of the March 2026 Medication Administration Record showed on the above referenced occasions, facility nurses failed to administer Resident 78's as needed Miralax after three days without a BM as ordered. On 05/26/2026 at 4:12 PM, when asked if, on the above referenced occasions, facility nurses provided Resident 78 bowel care in accordance with their physician orders and the facility's bowel protocol, Staff H, Licensed Practical Nurse/Unit Manager, stated, No. Non-Pressure Skin Resident 10Resident 10 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident had moderate cognitive impairment, a diagnosis of congenital lymphedema (a condition characterized by the buildup of fluid called lymph in the tissues under your skin when something blocks its normal flow. This causes swelling, most commonly in an arm or leg) and had non-surgical dressings and ointment applied to areas other than feet. On 05/18/2026 at 12:36 PM, Resident 10's husband, who reports he visits daily from 8:30 AM - 5:00 PM, complained that staff had not been applying lotion to Resident 10's lower extremities (LEs) and performing the resident's daily lymphedema wraps. Resident 10 was observed with a tan colored tubular gauze (an elastic, seamless gauze sleeve or bandage, used for wound care, compression, and limb support) in place to both LEs from ankle to knees, with no underlayment (foundational layer between tubular gauze and skin). A daily treatment order for skin care to both LEs, dated 02/25/2026, directed nurses to:1. Apply ammonium lactate lotion to both LEs,2. Wrap both LEs with kerlix (rolled gauze),3. Secure kerlix to both LEs in place with ace wrap (an elastic bandage commonly used in medical settings to provide compression and decrease edema/swelling). Every evening shift. On 05/19/2026 at 1:24 PM, Resident 10 was observed lying in bed with tan tubular gauze in place to both LEs from ankle to knee, with no underlayment in place. Resident 10's husband pulled the tubular gauze down on the resident's LEs revealing very dry, flaking skin bilaterally. Resident 10 indicated it had been three weeks to a month since the last time staff applied the lotion and kerlix and ace wrap to Resident 10's LEs. On 05/20/2026 at 1:27 PM, Resident 10 was observed lying in bed with tan tubular gauze in place to both LEs from ankle to knee, with no underlayment in place. Review of the May 2026 Treatment Administration Record (TAR) showed the evening shift nurse had signed that they applied ammonium lactate lotion, wrapped both LEs with kerlix and secured with ace wraps on 05/17/202, 05/18/2026, 05/19/2026 and 05/20/2026 as ordered. On 05/20/2026 at 4:50 PM, Staff A, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator and Staff B, Director of Nursing Services (DNS), observed Resident 10's LEs. Staff B described the resident's LE skin as dry and flaking and confirmed there was tubular gauze in place to both LEs from ankle to knee. On 05/20/2026 at 4:57 PM, after reviewing Resident 10's LEs treatment order and associated documentation on the May 2026 TAR, Staff B, DNS, confirmed the ordered treatment for Resident 10's LEs was not provided and the facility nurse had signed off they had completed a treatment they did not perform. Staff B said it was the expectation that nurses only sign for tasks they completed. Resident 17Resident 17 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident was rarely or never understood, was at risk for pressure injuries (PIs), but had no PIs or venous or arterial ulcers during the assessment period. A Skin Impairment care plan, initiated 04/16/2026, showed Resident 17 had a lesion to the right upper chest and a deep tissue injury to the buttock. Nurses were directed to observe the wounds for signs and symptoms of infection or worsening including changes in the wound bed or adjacent areas, redness and swelling at or around the site, odor and drainage changes, delay in healing and to perform weekly skin observation. Interventions included implementation of an alternating low air loss mattress, and heel protectors.A progress note, dated 03/16/2026, documented New skin condition noted this week. Open area to right ankle (outer).Review of the electronic health record showed progress notes, dated 04/16/2026, that identified Resident 17 had a new lesion to the right upper chest, a deep tissue injury, purple/black in color to the left buttock, and a wound to the right outer ankle.An order, dated 04/16/2026, directed nurses to cleanse Resident 17's right outer ankle with normal saline or wound cleanser, pat dry, and cover with a dressing daily.A weekly wound evaluation, dated 04/16/2026, documented a new 0.7 centimeter (cm) by 0.7 cm lesion to Resident 17's right upper chest, with light drainage. The evaluation documented the treatment as clean wound with wound cleanser, pat dry, and apply a hydrocolloid dressing twice a week. A weekly wound evaluation, dated 04/16/2026, documented a 5 cm by 3 cm pressure ulcer to the left buttock. The wound bed was assessed to be 100% slough (dead/devitalized tissue). The treatment was to clean the wound with wound cleanser, pat dry, and apply a hydrocolloid dressing twice a week. Review of the electronic health record showed no further documentation that Resident 17's right upper chest lesion, pressure injury to the left buttock, or open area to the left outer ankle were assessed weekly (measurements, wound bed description, drainage amount/character, response to treatment etc.) and monitored after identification. A progress note, dated 05/13/2026, documented that a weekly skin observation was completed. The documentation identified other skin concerns as left ankle wound, scab to upper chest, [and] left gluteal fold dressings CDI [clean dry and intact] with no overt S/S [signs and symptoms] of infection noted, under treatment. This note showed the areas were still present.In an interview on 05/28/2026 at 1:21 PM, when asked if there was documentation to show Resident 17's pressure injury to the left buttock, right upper chest lesion, and open area to the right outer ankle were routinely assessed and monitored to include weekly measurements, wound description and tissue type, amount and character of drainage and response to treatment Staff H, Licensed Practical Nurse/Unit Manager, stated, No. Staff H acknowledged staff should have completed weekly wound assessments, including measurements for each of Resident 17's wounds, but failed to do so. Reference WAC 388-97-1060(1)-(3)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide necessary foot care and treatment in accordance with professional standards, including provision of nail care and podiatry services for 3 of 7 (Resident 78, 11 & 10) residents reviewed for activities of daily living. Failure to provide timely toenail care placed the residents at risk for negative health outcomes. Findings included .Resident 78Resident 78 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/10/2026, indicated the resident was cognitively intact, had a diagnosis of diabetes (condition defined by persistently high levels of sugar in the blood) and was independent with most activities of daily living. On 05/17/2026 at 2:29 PM, Resident 78 said no one had assisted her with trimming her toenails since she admitted to the facility and they needed to be cut. She indicated at home she sometimes had to go to a foot doctor to get her toenails cut because of the thickness and her inability to reach them. Observation of the toenails on both feet showed the following: the first, third and fourth digits were long, thick and untrimmed with yellow discoloration, with the nails on the third and fourth digits curling around the end of the toes toward the bottom of the foot. The toenails on the first digits were 0.6 millimeters thick. A Diabetes Mellitus care plan, initiated 01/16/2026, directed licensed staff to provide diabetic foot care and checks as indicated. The care plan did not identify the frequency at which the diabetic foot care should be performed. Review of the April and May 2026 Medication and Treatment Administration Records (MAR/TAR) and Point of Care charting (charting tool and process that allows healthcare worker to document patient provided) showed there was no direction to nurses to provide diabetic foot and nail care or a place provided to document that it occurred. Review of the electronic health record (EHR) showed there was no documentation that foot/nail care had been provided. On 05/27/2026 at 5:02 PM, Staff H, Licensed Practical Nurse/Unit Manager, confirmed Resident 78's toenails, specifically the first, third and fourth digits on both feet, were long, thick and untrimmed. Staff H indicated they were too thick to be cut by facility staff and the resident would need to be referred to podiatry. Resident 11Resident 11 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], indicated the resident was cognitively intact, had functional limitations in range of motion to bilateral (both) upper and lower extremities and required partial/moderate assistance with lower body dressing. On 05/17/2026 at 2:27 PM, Resident 11 reported that her toenails needed to be trimmed because they had not been cut since she had been at the facility. Resident 11 had footwear in place, and the toenails could not be visualized at that time. Review of Resident 11's comprehensive care plan, initiated 01/01/2026, showed there was no direction to staff to assist the resident with nail care or identifying who was responsible to do so. Review of the April and May 2026 MAR/TARs and Point of Care charting showed there was no direction to staff to assist the resident with nail care or a place provided to document that it occurred. Review of the EHR showed there was no documentation that nail care had been provided since the resident admitted to the facility. On 05/27/2026 at 5:05 PM, Staff H, Licensed Practical Nurse/Unit Manager, accompanied writer to observed Resident 11's toenails and described the following: the toenails on the second third and fourth digits on the right foot and the toenails to the first , third and fifth digits on the left foot as long and untrimmed, appeared brittle, with the toenails to the other digits observed to be chipped with jagged or sharp edges. Resident 11 interjected that the toenails sometimes get caught on the bedding. Staff H said Resident 11 needed a podiatry referral. Resident 10Resident 10 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], indicated the resident was moderately cognitively impaired, had functional limitations in range of motion to bilateral lower extremities and was dependent for lower body dressing. On 05/18/2026 at 12:26 PM, Resident 10's husband reported that no one had trimmed his wife's toenails since admission. Observation showed the toenails on digits two, three, four and five on both feet were long, untrimmed with yellow (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discoloration and beginning to curl around the end of Resident 10's toes. Resident 10's husband reported he had attempted to trim the nails about a month prior but only trimmed the great toes. Review of Resident 10's comprehensive care plan, initiated 11/08/2025, showed there was no direction to staff to assist the resident with nail care or identifying who was responsible to do so. Review of the April and May 2026 MAR/TARs and Point of Care charting showed there was no direction to staff to assist the resident with nail care or a place provided to document that it occurred. Review of the EHR showed there was no documentation that nail care had been provided since the resident admitted to the facility. On 05/19/2026 a records request was made to Staff A, Administrator, via email, that included the dates of the last two times the facility podiatrist was in the building for visits, a list of the residents seen and the estimated date of the next visit. On 05/20/2026 at 5:05 PM, Staff B, Director of Nursing Services (DNS), observed Resident 10's toenails and described them as long, thick and untrimmed, with pale yellow discoloration. Staff B indicated Resident 10 needed a podiatry referral. On 05/27/2026 at 5:12 PM, Staff L, Interim DNS/Infection Preventionist, was informed that the requested dates of the last two podiatry visits, the residents who were seen and the next scheduled podiatry visit had not been provided. Staff L stated, It has been a while; we just signed a contract for podiatry services. Staff L said she didn't know how long it had been, but when asked if it was longer than six months stated, Yes. Reference WAC 388-97-1060(j)(viii)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure falls were investigated and/or investigated thoroughly for 1 of 1 resident (Resident 2) reviewed for hospitalization related to falls, or to ensure residents with mobility bars (a form of a side rail, used to assist residents with mobility while in bed) had the required components necessary to determine if they were safe and also assess to determine they were not being used as a restraint for 3 of 3 residents (Resident 100, 37, & 50) reviewed for bed rails/restraints. These failures placed residents at risk of falls, medical complications, injury, restraint, and a diminished quality of life.Findings included . FALL INVESTIGATIONSReview of the facility's policy titled, Falls Protocols, undated, showed the facility was supposed to have an investigation by the interdisciplinary team (IDT) for each fall, to identify the reason, any contributing factors, and/or the root cause of the fall. The staff would conduct a comprehensive investigation to understand the how/why the fall occurred and implement change to protect the resident. The post fall investigation would review the resident's record to determine the history and identify any potential contributing factor. Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and end stage renal disease (kidney failure, requiring the blood to be filtered through a process called dialysis). The Medicare 5 Day Minimum Data Set (MDS, an assessment), dated 03/24/2026, showed Resident 2 had moderate cognitive impairment. Review of Resident 2's April administration record, showed they had an as needed hydralazine (medication to lower blood pressure) order, from 04/04/2026 through 04/25/2026, for when systolic blood pressure (SBP, top number of blood pressure reading) was over 160, which could be given every 8 hours. This record showed it had only been given 3 times (twice on 04/08/2026 and once on 04/15/2026). Resident 2 was also on a blood thinner. Review of Resident 2's falls showed they had a fall on 04/10/2026, 04/11/2026, 04/12/2026, 04/19/2026, 04/29/2026.Review of the facility's April 2026 Accident and Incident Log, showed Resident 2's fall on 04/10/2026 was not logged or investigated. Review of Resident 2's hospital documentation on 04/10/2026, showed they had a loss of vision chronically and were able to see light only in both eyes, and they had placed a referral for ophthalmology.Review of Resident 2's last weights prior to their 04/10/2026 fall, showed they had a post dialysis weight on 04/04/2026 of 171.7 pounds (lbs.) and their next weight was on 04/09/2026 at 191.8 lbs. (a 20.1 lb. difference).Review of Resident 2's blood pressures on 04/11/2026 showed the following:04/11/2026 at 6:48 AM, 164 / 82 mmHg04/11/2026 at 12:55 PM, 202 / 98 mmHg04/11/2026 at 1:48 PM, 202 / 98 mmHg04/11/2026 at 7:38 PM, 170 / 86 mmHg04/11/2026 at 8:24 PM, 170 / 86 mmHgReview of Resident 2's fall investigation from 04/11/2026, showed the investigation did not include any information on Resident 2's clinical picture, such as their elevated blood pressures or weight gain.Review of Resident 2's blood pressures on 04/12/2026, showed the following:04/12/2026 at 6:57 AM, 189 / 73 mmHg04/12/2026 at 10:45 AM, 170 / 58 mmHg04/12/2026 at 8:19 PM, 192 / 83 mmHg04/12/2026 at 8:46 PM, 192 / 83 mmHgReview of Resident 2's fall investigation from 04/12/2026, showed they had listed this fall as the second fall in a row (not the third). This investigation did not include any information on Resident 2's clinical picture, such as their elevated blood pressures or weight gain.Review of Resident 2's fall investigation from 04/19/2026, showed it did not include any information on Resident 2's clinical picture, such as their ongoing elevated blood pressures.Review of Resident 2's fall investigation from 04/29/2026, showed it did not include any information on Resident 2's clinical picture, such as their ongoing elevated blood pressures.Review of Resident 2's progress notes, showed at dialysis Resident 2 had reported a fall the prior week. Review of the facility's May 2026 Accident and Incident log, did not show this had been logged or investigated. Review of Resident 2's electronic health record (EHR) showed they did not have a pharmacy review related to the falls done until 05/15/2026.During an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 05/28/2026 at 9:13 AM, Staff L, Interim Director of Nursing Services /Infection Preventionist (DNS/IP), Staff L said Resident 2's fall on 04/10/2026 should have been logged and it was not. When asked if a fall investigation had been done for Resident 2's 04/10/2026 fall, if their loss of vision should have come up, Staff L said yes, the investigation needed to be done. Staff L said it was possible Resident 2 was talking about their fall on 04/29/2026, but this should have still been looked into/investigated. During an interview on 05/29/2026 at 2:41 PM, Staff M, Interim Administrator, confirmed the fall on 04/10/2026 was not investigated. When asked about the fall investigations leaving sections titled, predisposing physiological factors blank which included abnormal vital signs, anticoagulant use, etc, if this should have been filled out, Staff M said if there was something that pertained to the resident then it should have been filled out. Staff M confirmed Resident 2 had significant hypertension, medication errors, received a blood thinner at the time of the falls. Staff M, in response to if staff should have/or if staff did identify the weight gain of 20 lbs., said they would look at everything for 72 hours leading up to the incident, if any changes or things were out of the normal, to include vitals, medications, missed dialysis, significant weight gain etc. When asked if there was documentation to support these now identified issues had been identified and addressed in Resident 2's fall investigations for the 04/11/2026 and 04/12/2026 falls, Staff M said the falls were not thoroughly investigated and the above concerns should have been identified and addressed. BED RAILS/MOBILITY BARSReview of the facility's policy titled, Bed Rail Risk and Safety, undated, showed the use of bed rails was an IDT' responsibility for, including nursing, rehabilitation therapy, and maintenance. Any resident being considered for using a bed with bed rail(s) was to be evaluated by the facility's IDT to determine whether the resident's functional status (resident's ability to perform tasks such as mobility) and bed mobility would have been improved through the use of bed rail(s), to have identified any bed rail that might have constituted a physical restraint, and to have identified individual characteristics that may increase the risk of entrapment by bed rails or mattress. The bed rail evaluation, including the entrapment risk component, was to be completed on admission, readmission, quarterly, and any time there was a significant change. Once determined the bed rail was appropriate, the facility would obtain consent from the resident and/or resident representative, notify the resident's representative, obtain an order for the bed rail, and the reason for the bed rails and their proper use would be integrated into the resident's care plan. For residents whose assessment indicates they may have increased risk for entrapment, the facility was to consider care planning options to reduce the risk, such as not using bed rails as a fall prevention measure but instead using mats, lower beds, alerts, etc.Resident 100Resident 100 was admitted to the facility on [DATE], with diagnoses of severe protein-calorie malnutrition (not getting enough protein and calories for body needs), neurocognitive disorder with Lewy bodies (dementia, causes a decline in cognitive abilities which can interfere with daily life), and weakness. The Medicare 5 Day MDS, dated [DATE], showed Resident 100 was severely cognitively impaired.During an observation on 05/18/2026 at 9:32 AM, Resident 100 was seen on their left side, with their upper body curled and their head pressed against their left mobility bar. At 10:13 AM, with Resident 100 in this same position, Staff W, CNA, came into the room to assist them. Review of Resident 100's EHR showed no order was found, and the assessment done did not include an evaluation the side rail was not a restraint and was safe.During an interview on 05/20/2026 at 12:44 PM, Staff K, Licensed Practical Nurse (LPN)/Unit Manager, was asked about the process for using side rails/mobility bars with residents with a diagnosis of dementia. Staff K said their process was for physical therapy to go through and evaluate the resident prior to initiating, if the resident had dementia, they would get an authorized person to consent, then maintenance would install. When asked what kind of ongoing assessment they do for residents, Staff K said typically when they did them they would have them care planned and stated, I don't have an answer for that. Staff K confirmed a care plan, order, consent, and assessment was needed to use side rails/mobility bars. Staff K confirmed Resident 100 did not have the mobility bars in their care plan, did not have an order, and did not have an (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment saying the mobility bars were safe or not a restraint. When told of Resident 100's head being observed pressed against the mobility bar, Staff K said that was definitely concerning, and they should be reassessed. Regarding ensuring safety with residents at risk of safety concerns like Resident 100, Staff K said they were going to have to improve on this end, their nurses should definitely report this if they see something like this, they needed to improve on side rails. Resident 37Resident 37 was admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], showed Resident 37 was cognitively intact.During an observation and interview on 05/17/2026 at 2:31 PM, Resident 37 was seen with bilateral mobility bars on their bed. Resident 37 did not remember the facility going over risks or benefits with them. Review of Resident 37's EHR, showed they were missing the following related to the mobility bars: an order, consent, and assessment.During an interview on 05/26/2026 at 1:48 PM, Staff K, LPN/Unit Manager, said Resident had been care planned for mobility bars since 06/09/2025, but they were unable to find an order, consent, or assessment (of the mobility bars not being a restraint and safe for Resident 37), and confirmed this was needed. Resident 50Resident 50 was admitted to the facility on [DATE]. The Medicare 5-Day MDS, dated [DATE], showed Resident 50 was moderately cognitively impaired. During an observation on 05/17/2026 at 11:29 AM, Resident 50 was seen with their bed against the wall.Review of Resident 50's EHR, showed they were missing an order, consent, and assessment. Review of Resident 50's fall care plan, showed they had their bed against the wall for fall prevention. During an interview on 05/26/2026 at 1:48 PM, Staff K, LPN/Unit Manager, said they had charted consent from the family in a progress note. When asked if they had documentation they went over risks and benefits, Staff K said no they did not have documentation. Staff K confirmed Resident 50 did not have an order, did not have any assessments, and said there should be. During an interview on 05/28/2026 at 9:13 AM, Staff L, Interim DNS/IP, said for mobility bars, they would get therapy to do an assessment, then would get an order and care plan appropriately. Regarding a bed against the wall, Staff L said this would be the same process. Regarding the observation of Resident 100's head pressed against the mobility bar, no care plan, no order, and the therapy assessment form not including assessment for safety or for if/if not the bar was a restraint for the resident, Staff L said their expectation was for there to have been an assessment ensuring the mobility bar was not a restraint, there would be an order, and it would be care planned. For Resident 37's mobility bars, no order, no consent or assessments found, Staff L said this did not meet expectations. For Resident 50's bed against the wall, no documentation of risk/benefits being reviewed with consent, no order, and no assessment of restraint/safety, Staff L said it did not meet expectations, all of the pieces should have been there. Reference F760Reference WAC 388-97-1060 (3)(g)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to coordinate and manage dialysis (a procedure that filters the blood) care for 1 of 1 (Resident 2) reviewed for dialysis. The facility failed to maintain complete dialysis records, communicate essential dialysis information between the facility and dialysis center, update dialysis related care planning to reflect the resident's current treatment needs, monitor fluid restriction compliance, and assess and respond to abnormal blood pressure trends. As a result, Resident 2 experienced ongoing fluid management concerns, including presentation to dialysis treatments above prescribe dry weight and the need for additional dialysis treatments, placing the resident at risk for fluid overload, cardiovascular complications and a diminished quality of life. Findings included .Resident 2 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and end stage renal disease (kidney failure, requiring dialysis). The Medicare 5-Day Minimum Data Assessment, dated 03/24/2026, showed Resident 2 had moderate cognitive impairment. Communication & Documentation With Dialysis CenterReview of Resident 2's electronic health record (EHR), showed an incomplete record of Resident 2's dialysis treatments. On admission, they were scheduled Tuesday, Thursday, and Saturday for treatment. Resident 2's dialysis schedule changed 05/04/2026, to Monday, Wednesday, Friday. Review of Resident 2's pre/post dialysis evaluations, showed there was a 04/30/2026 dialysis form completed, and not another form completed until 05/20/2026.Review of Resident 2's dialysis communication forms (the paper copies of communication between the facility and the dialysis center), showed there were no paper forms after 04/30/2026, until Resident 2's appointment on 05/27/2026. Further review showed no vital signs were sent to dialysis on the following dates: 04/04/2026, 04/07/2026, 04/21/2026, 05/02/2026, 05/27/2026, and one undated form. The 04/30/2026 form did not have any information from the dialysis center on it. Care planningReview of Resident 2's fluid restriction order, showed they were to get 1500 milliliters (ml) in 24 hours, that directed for 840 ml to come from the kitchen, and licensed nursing was to give 250 ml on day shift, 250 ml on evening shift, and 160 ml on night shift. Review of Resident 2's fluid restriction care plan, initiated 02/17/2026, with latest revision dated 04/01/2026 showed it was not updated and still documented Resident 2 was on an 1800 ml/ day restriction, not 1500 ml/day. Resident 2 also had a second fluid restriction care plan, initiated 05/07/2026, that did say the resident was on 1500 ml/day fluid restriction (care plan had two separate interventions regarding fluid restrictions). Review of Resident 2's dialysis care plan, initiated 02/16/2026, with latest revision dated 04/01/2026 - showed the 1800 ml/day fluid restriction, and was not up to date with Resident 2's current date/times of dialysis treatments, still indicating Resident 2 was going to dialysis on Tuesday/Thursday/Saturday and not Monday/ Wednesday/Friday. This plan did not list a goal dry weight (target body weight for a dialysis resident when all excess fluid has been removed, which helps maintain normal blood pressure and prevent complications) from dialysis, and did not mention they required a sitter to attend dialysis with them. Review of Resident 2's tasks list (where Certified Nursing Assistants (CNAs) chart), showed CNAs were not documenting any fluid intake. During an interview on 05/26/2026 at 10:45 AM, Staff P, Licensed Practical Nurse, explained that for their role with a fluid restriction order, they documented how much they gave Resident 2 with medications or between shifts, saying the resident only got 250 ml a shift. Staff P said the kitchen gave Resident 2 840 ml, and they were not responsible for documenting this part. When asked how they knew how much Resident 2 drank from the kitchen, Staff P said that would be the CNA documentation. When asked about the communication with the dialysis center, Staff P said when Resident 2 went to dialysis, they did vital signs and medications and reported any recent changes. Staff P said they had a paper they filled out, and also in the EHR they filled out a pre/post dialysis assessment. Staff P showed a large pile that they put the communication forms in, to be scanned into the medical record. When asked if there was a (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication binder, Staff P said no.During an observation on 05/26/2026 at 11:21 AM, Staff O, CNA, entered Resident 2's room and a large puddle was on their floor. They were seen with two water pitchers at bedside, one with 450 ml in it, and one (the one that spilled) had 150 ml. Blood pressure trendsReview of Resident 2's April 2026 medication administration record, showed they had an as needed hydralazine (medication to lower blood pressure) order, from 04/04/2026 through 04/25/2026, for when systolic blood pressure (SBP, top number of blood pressure reading) was over 160, which could be given if needed every 8 hours. This record showed it had only been given 3 times (twice on 04/08/2026 and once on 04/15/2026). This order was discontinued and reordered with the following update on 04/28/2026, to give for SBP greater than 160 and diastolic blood pressure (DBP, the lower blood pressure number) greater than 100. This showed the new medication order was given on the following dates, outside of parameters:05/08/2026 at 1:58 AM- 190/8605/13/2026 at 12:31 AM- 194/9205/14/2026 at 1:32 AM- 186/8105/14/2026 at 1:18 PM- 171/7205/18/2026 at 5:24 PM- 201/9105/19/2026 at 4:02 AM- no charted BP at this timeDuring an interview on 05/26/2026 at 1:48 PM, Staff K, Licensed Practical Nurse/Unit Manager, regarding dialysis communication, said they expected there to have been a transfer assessment, full set of vital signs and a face sheet to have been sent. When the resident returned, they expected staff to enter the rest of the information. Staff K said there should have been a pre/post form in the EHR. When asked if Resident 2 went to dialysis between 04/30/2026 and 05/20/2026, Staff K was unable to determine based on the EHR and said they would need to look for hard copies. Staff K said they needed to make different arrangements with Resident 2 and the dialysis center related to needing a sitter. Regarding the forms that go to and from dialysis, Staff K was unable to find the documentation in Resident 2's EHR. Staff K said they were down staff in medical records right now, and they had not been scanned in. When asked about how the facility was documenting how much of the fluid from the kitchen that Resident 2 was consuming, Staff K said they did not know the kitchen's process and were unsure how the kitchen was tracking it. Staff K said Resident 2 should not have pitchers of water at bedside. Regarding Resident 2's blood pressures, Staff K said their expectation for SBP greater than 160 was for the provider to have been notified to let them decide if they wanted to make changes with medications or plan. After reviewing Resident 2's blood pressures, Staff K was asked what conversation they had with the provider. Staff K said they did not know, they had not had any conversations with the provider at this point. During an interview on 05/29/2026 at 2:41 PM, Staff M, Interim Administrator, was asked if there was any documentation in Resident 2's record to show they were assessed after dialysis or to show what medications were administered during dialysis or of increased fluid removal needs and she said the facility lacked the documentation in their record to show staff were aware of these things and had reached out to the dialysis center to request the communication forms.On 05/29/2026 at 10:26 AM, regarding Resident 2's increased blood pressure trend, with several SBPs greater than 200, Staff M said they had spoken to the provider and dialysis center, and a new order was obtained to increase Resident 2's scheduled hydralazine on non-dialysis days to 50 mg three times a day, and to continue 25 mg on dialysis days. For Resident 2, their DBP was determined to not be an indicator for holding their hydralazine medication moving forward. Staff M said nurses would need to contact the provider for change of condition if Resident 2's blood pressure becomes greater than 180 SBP and did not respond to a scheduled dose of hydralazine.On 05/29/2026 at 8:45 AM, Staff M provided a coordination of care summary, dated 05/29/2026. The summary showed a discussion was held with the dialysis interdisciplinary team regarding ongoing concerns related to Resident 2's fluid management. Dialysis staff reported Resident 2 frequently presented to treatments 5-11 kilograms (kg) above their prescribed dry weight, which indicated continued noncompliance with fluid restrictions. The facility expressed concerns family members were routinely bringing large quantities of food and fluids to the residents, which may have contributed to excessive fluid intake and subsequent fluid overload. The dialysis team reported the resident often required max settings during treatments, with fluid removal frequently ranging from 4-6 kg per session. Due to ongoing fluid (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	overload, additional dialysis treatments had been required on multiple occasions. Dialysis staff requested increased reinforcement of fluid restrictions with both the resident and family to support adherence to the prescribed treatment plan and reduce the risk of complications associated with fluid overload.Reference F656Reference F760Reference WAC 388-97-1900 (1), (6)(a-c)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents with a diagnosis of dementia received appropriate care and services for 1 of 1 resident (Resident 100) reviewed for dementia care. This failure placed residents at risk of unmet or unidentified care needs, and a diminished quality of life. Findings included.Resident 100 was admitted to the facility on [DATE] with diagnoses of severe protein-calorie malnutrition (not getting enough protein and calories for body needs), neurocognitive disorder with Lewy bodies (dementia, causes a decline in cognitive abilities which can interfere with daily life), and weakness. The Medicare 5 Day Minimum Data Set Assessment, dated 03/17/2026, showed Resident 100 was severely cognitively impaired, and was dependent on staff for cares.Review of Resident 100's care plans on 05/18/2026, showed there was no dementia care plan, or other care plans that reviewed/assessed/planned interventions regarding the following:- Resident preferences with family involvement, including meal preferences- The time, duration, and severity of the resident's expressions or indications of distress or refusals, or interventions/preferences of family related to the refusals- Non-pharmacological approaches to care, such as when refusals occur, used to support the residentReview of Resident 100's dietary profile, dated 03/18/2026, showed only Resident 100 was interviewed on their likes and dislikes, family was not involved. No other dietary profile was found that included family involvement. Review of Resident 100's electronic health records, showed they had multiple refusals related to showering/bathing, and also refusals for immunizations. Review of Resident 100's last 30 days of showers/baths, from 04/21/2026 through 05/18/2026, showed there were four recorded refusals. Resident 100 was documented as having refused the pneumococcal and covid vaccinations, without documentation their Power of Attorney (decision maker) had been notified or documentation of reattempts. During an interview on 05/20/2026 at 12:44 PM, Staff K, Unit Manager, was unable to find a care plan specific to dementia care for Resident 100. When asked if Resident 100's daytime/nighttime routine had been care planned, Staff K said no. When asked how they were using non-pharmacological interventions, related to dementia care, to attain or maintain the resident's well-being, Staff K said the only nonpharmacological interventions they had in the care plan was for pain, none related to dementia. When asked how they monitored care plan implementation, changes in condition, and Resident 100's baseline, Staff K said they would look at Resident 100's cognition score, the nurses would be familiar with them, and they would communicate with them. When asked about how none of those interventions involved updating the care plan, Staff K said right, it was not in the care plan. For risk and benefits of interventions, Staff K said consent would be needed from the residents Power of Attorney. When asked what the facility's dementia care guidelines and protocols were, Staff K said they would need to look into that (no follow up answer or documentation was provided). Staff K was asked about if Resident 100's shower refusals had been care planned and if certain times have been reviewed to see if they do better with a different time of day. Staff K acknowledged this was an issue.During an interview on 05/22/2026 at 2:33 PM, CC6, Resident 100's Power of Attorney, said Resident 100 had never been given many choices on the meal menu, reporting they did not like pasta and they gave it to them a lot. When asked what Resident 100 likes to eat, CC6 said bacon lettuce tomato sandwiches, eggs, bacon, tuna fish, steak, baked beans, and sausage. CC6 was asked if they knew Resident 100 was refusing showers. CC6 stated, No, I did not hear that. Zero transparency. When asked if they had refused vaccines for Resident 100, CC6 stated, I want her to get vaccines. I won't refuse those. When asked if the facility had notified them of Resident 100's refusals of the vaccinations, CC6 said no and stated, They don't like to communicate to me how she is doing or what she had done and was noted to get tearful. On 05/26/2026 at 1:22 PM, CC6 provided a list they had put together of foods Resident 100 liked (approximately 40 items) and disliked (3 in total). During an (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 05/28/2026 at 9:13 AM, Staff L, Interim Director of Nursing Services /Infection Preventionist, when asked their expectation of staff regarding residents with a diagnosis of dementia, said that they ensure they were communicating in a way the resident understood, that with refusals staff reapproach and go back, different angles used like different staff, family involvement about routines, and calm approaches. Staff L said their expectation for care plans for residents with a diagnosis of dementia, was for it to have interventions for staff, for refusals and preferences, that any needs would be written out there. Staff L said they expected family involvement in this. Regarding Resident 100 not having a dementia care plan or family input on how to care for them regarding this, Staff L said this did not meet expectations. When asked if it met expectations that Resident 100 had refused showers and this was not care planned, or times were not being tracked to see what time Resident 100 was more likely to say yes to a shower, Staff L said their expectation was for staff to drill down and figure out the best time to shower, to involve family to assist the resident as they knew the resident best. When asked about Resident 100's vaccinations regarding the pneumococcal, influenza, and covid vaccinations, Staff L was unable to find documentation Resident 100 was reapproached regarding the refusals for the pneumococcal and covid vaccinations and did not see the influenza vaccine as listed. Staff L said their expectation was for family to be involved, to ensure the best interest to the resident. When asked if there was documentation of Resident 100's Power of Attorney being notified of the vaccination refusal, Staff L said they could not see any documentation of it, and it did not meet expectations. Reference F692, F677, F656Reference WAC 388-97 -1040 (1)(a-c)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure resident safety for 1 of 1 resident (Resident 24) reviewed for medications at the bedside and expired influenza vaccinations were properly disposed of for 1 of 1 medication rooms (Medication Room) reviewed for medication storage. This failure placed residents at risk of receiving compromised or ineffective medications, accidental ingestion of medication, and a diminished quality of life.Findings included .Medications at BedsideThe undated facility policy titled, Self-Administration of Medications and Treatments, documented Residents have the right to self-administer medications / treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.Resident 24 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 02/13/2026, documented Resident 24 was cognitively intact.On 05/17/2026 at 3:21 PM, Resident 24 was observed with medications on their bedside table, which included eye drops, inhalers, and topical ointments.On 05/19/2026 at 2:20 PM, Staff EE, Licensed Practical Nurse (LPN) walked into Resident 24's room and saw the medications on Resident 24's table. Staff EE was asked what was the process when a resident had medications at the bedside? And they replied I would have to talk to the unit manager.On 05/19/2026 at 3:11 PM, Staff H, LPN/Unit Manager said if the provider was ok with the resident having medications at the bedside, there would need to be an order, and a screening to evaluate if the resident could administer their own medications safely. Staff H was asked if Resident 24 has these items in their chart. Staff H said they did not see an order in the chart or an evaluation called self-administration of medications safety. Staff H said it also needed to be care planned and they did not see a care plan for self-administration of medications for Resident 24. Staff H said they would remove the medications until there was a doctor's order.On 05/20/2026 at 1:46 PM, Staff B, Director of Nursing Services, said if Resident 24 had medications at the bedside there should have been an assessment for resident safety. Staff B said there also needed to be an order for allowing the resident to administer them independently. It should also be care planned when a resident could self-administer medications and they were located at the bedside.Expired MedicationsOn 05/19/2026 at 1:07 PM, an observation was made of 2 prefilled influenza vaccine shots (pre-measured, single-dose units designed for intramuscular injection minimizing preparation time and reducing dosing errors in clinical settings) in the refrigerator located in the medication room that had expired on 05/13/2026. Staff K, LPN/Unit Manager was also observing the expired influenza vaccine prefilled shots at the same time. Staff K was asked what was the process with expired vaccines and they said the shots should not have been in the refrigerator. Staff K said they were going to put them in the return box to the pharmacy so they could be picked up the next time the pharmacy was here. Staff K said the infectious disease nurse usually monitored this, but they were out on leave at that time.On 05/20/2026 at 1:46 PM, Staff B, Director of Nursing Services, was asked what their expectation was for expired vaccines, said they would find the policy and get back with an answer. At 4:02 PM Staff B said they would send the vaccines back to the pharmacy.Reference WAC 388-97 -1300 (2),-2340, -1300 (1)(b)(ii), (c)(ii-iv)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident medical records were complete, accurate and readily accessible and that residents personal identifiable information was protected for 1 of 1 resident (Resident 17) reviewed for Hospice services, 1 of 1 resident (Resident 2) reviewed for dialysis services, and 1 of 1 resident (Resident 142) reviewed for identifiable personal health information. These failures placed residents at risk for a loss of privacy, poor/impaired communication and coordination of care with Hospice and Dialysis center staff, and unidentified and/or unmet care needs. Findings included . Findings included . Resident 17Resident 17 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/14/2026, showed the resident had a terminal diagnosis and was on Hospice services during the assessment period. Review of Resident 17's electronic health record (EHR) showed there was no Hospice documentation present for the current certification period, to include: documentation the resident was re-certified with a terminal illness, a current coordinated plan of care, documentation of what Hospice services the resident was to receive (e, g,, registered nurse, chaplain, certified nursing assistant, massage therapist), at what frequency, and no documentation of whether those disciplines had visited, if so, when, and what care was provided. On 05/26/2026 at 8:31 AM, observation of the 300 and 400 unit revealed there was a Hospice communication binder on the 400 unit. Review of the binder showed there was no Hospice paperwork in the binder for Resident 17. On 05 /26/2026 at 3:55 PM, Staff H, Licensed Practical Nurse/Unit Manager, explained that the Hospice binder used to be updated regularly and was an effective means of communication but had recently fallen off. When asked if the facility had a copy /documentation of Resident 17's current coordinated plan of care, what Hospice services were to be provided, at what frequency, and whether those disciplines had visited Resident 17, if so, when and what occurred on the visits, Staff H, stated, No. Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses of hypertension (high blood pressure) and end stage renal disease (kidney failure, requiring dialysis). The Medicare 5-Day MDS, dated [DATE], showed Resident 2 had moderate cognitive impairment. Communication & Documentation with Dialysis Review of Resident 2's EHR showed an incomplete record of Resident 2's dialysis treatments. On admission, they were scheduled Tuesday, Thursday, and Saturday for treatment. Resident 2's dialysis schedule changed 05/04/2026, to Monday, Wednesday, Friday. Review of Resident 2's pre/post dialysis evaluations, showed there was a 04/30/2026 dialysis form completed, and not another form completed until 05/20/2026. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505387	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodard Creek Health & Rehabilitation	3333 Ensign Road Northeast Olympia, WA 98506

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's dialysis communication forms (the paper copies of communication between the facility and the dialysis center), showed there were no paper forms after 04/30/2026, until Resident 2's appointment on 05/27/2026. Further review showed no vital signs were sent to dialysis on the following dates: 04/04/2026, 04/07/2026, 04/21/2026, 05/02/2026, 05/27/2026, and one undated form. The 04/30/2026 form did not have any information from the dialysis center on it. During an interview on 05/26/2026 at 1:48 PM, Staff K, Licensed Practical Nurse/Unit Manager, regarding dialysis communication, said they expected there to have been a transfer assessment, full set of vital signs and a face sheet to have been sent. When the resident returned, they expected staff to enter the rest of the information. Staff K said there should have been a pre/post form in the EHR. When asked if Resident 2 went to dialysis between 04/30/2026 and 05/20/2026, Staff K was unable to determine based on the EHR and said they would need to look for hard copies. Staff K said they needed to make different arrangements with Resident 2 and the dialysis center related to needing a sitter. Regarding the forms that go to and from dialysis, Staff K was unable to find the documentation in Resident 2's EHR. During an interview on 05/29/2026 at 2:41 PM, Staff M, Interim Administrator, was asked if there was any documentation in Resident 2's record to show they were assessed after dialysis or to show what medications were administered during dialysis or of increased fluid removal needs and she said the facility lacked the documentation in their record to show staff were aware of these things and had reached out to the dialysis center to request the communication forms. Resident 127 Resident 127 was admitted to the facility on [DATE] and discharged from the facility on 04/17/2026. The admission MDS, dated [DATE], indicated Resident 127 was cognitively intact. Resident 142 was admitted to the facility on [DATE] and discharged from the facility on 04/16/2026. The Admission/Medicare 5-Day MDS, dated [DATE], indicated Resident 142 was cognitively intact. Resident 127's family member, Collateral Contact 9 (CC9), reported that Resident 127 was discharged home with resident 142's medication. On 05/28/2026 at 11:17 AM, Staff L, Interim Director of Nursing Services/Infection Preventionist, acknowledged that the facility had sent a nurse to Resident 127's home following their discharge from the facility to retrieve Resident 142's medication. Staff L acknowledged this was violation of Resident 142's personal health information. Reference WAC 388-97-1720 (2)(a-m)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have a system in place that ensured effective communication, collaboration, and coordination of care occurred between the facility and the hospice provider for 1 of 1 residents (Resident 17) reviewed for hospice services. The facility failed to designate a member of their inter-disciplinary team (IDT) to be the liaison with hospice staff, to obtain and maintain a current copy of the coordinated hospice plan of care, and to have a system/documentation of what hospice staff had visited (e,g,, registered nurse, chaplain, certified nursing assistant, massage therapist), when they visited, and what care they provided. These failures detracted from staffs' ability to effectively collaborate, communicate and coordinate care with the Hospice provider, and placed residents at risk for not receiving necessary care and services and/or unmet care needs.Findings included .Review of the facility's Hospice contract showed under Provision of Information, it documented that Hospice shall promote open and frequent communication with the facility and shall provide sufficient information to ensure the provision of facility services under this agreement, is in accordance with the Hospice patient's plan of care, assessments, treatment planning and care coordination. At a minimum, Hospice shall provide the following for each hospice patient,The most recent coordinated Hospice plan of care.Medication information and physician orders specific to each Hospice patient.The Hospice election form and any advanced directives.Physician certifications and re-certifications of terminal illness.Names and contact information for Hospice personnel involved in providing Hospice services.Instructions on how to access Hospice's twenty-four-hour call system. Review of the facility's undated Hospice Services policy showed the facility would communicate the name and contact information of the facility-based Hospice Coordinator. Resident 17Resident 17 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/14/2026, showed the resident had a terminal diagnosis and was on Hospice services during the assessment period. Review of Resident 17's electronic health record showed there was no coordinated Hospice plan of care present. The lone Hospice document found was an Episode Summary Report, printed 12/15/2025, for the certification period 02/10/2025 - 03/09/2026, which showed the resident was to receive six Chaplin visits, four Master Social Work visits, and 14 Registered Nurse visits (during the previous certification period. No Hospice documentation for the current certification period was present, to include: documentation the resident was re-certified with a terminal illness, a current coordinated plan of care, documentation of what Hospice services the resident was to receive (e, g,, registered nurse, chaplain, certified nursing assistant, massage therapist), at what frequency, and no documentation of whether those disciplines had visited, if so, when, and what care was provided. On 05/26/2026 at 8:16 AM, Staff B, Director of Nursing Services, acknowledged there was no Hospice documentation for the current certification period in Resident 17's electronic health record, but indicated there could be a Hospice communication Binder on the 300 or 400 unit. Staff B also informed that Staff I, Social Services Director, was the facility's interdisciplinary team member that coordinated Hospice care. On 05/26/2026 at 8:31 AM, observation of the 300 and 400 unit revealed there was a Hospice communication binder on the 400 unit. Review of the binder showed there was no Hospice paperwork in the binder for Resident 17. On 05 /26/2026 at 3:55 PM, Staff H, Licensed Practical Nurse/Unit Manager, explained that the Hospice binder used to be updated regularly and was an effective means of communication but had recently fallen off. When asked if the facility had a copy /documentation of Resident 17's current coordinated plan of care, what Hospice services were to be provided, at what frequency, and whether those disciplines had visited Resident 17, if so, when and what occurred on the visits, Staff H, stated, No. During an interview on 05/28/2026, Staff I, Social Service Director, explained that her and another social worker (who was no longer employed) previously split the building, and each was responsible (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Hospice residents in their section(s). Staff I said they were just recently informed they had assumed responsibility for coordination of Hospice care for all Hospice residents in the building. Staff I said they had not yet had any meetings with the Hospice representative(s) related Resident 17 Hospice care and services.Reference WAC 388-97-1620(1)(2)(b)(i)(ii), 0220