STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505401	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside Care	308 West Emma Union Gap, WA 98903

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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 identify hazards and risks to ensure the Resident's environment remained free of accident hazards and the Resident received adequate supervision 1 of 3 residents (37) reviewed for falls. Resident 37, who had severely impaired cognition, required maximum assistance for Activities of Daily Living (ADLs) and identified as a high fall risk, experienced harm when four of 14 falls occurred in the facility within a timeframe of less than a month; two of the falls resulted in injury that required hospital intervention. Findings included. Based on observation, interview, and record review, the facility failed to identify hazards and risks to ensure the resident's environment remained free of accident hazards and the resident received adequate supervision 1 of 3 residents (37) reviewed for falls. Resident 37, who had severely impaired cognition, required maximum assistance for Activities of Daily Living (ADLs) and identified as a high fall risk, experienced harm when four of 14 falls occurred in the facility within a timeframe of less than a month; two of the falls resulted in injury that required hospital intervention.Findings included.Review of a 01/30/2023 policy titled Fall/Injury Management-Post Fall or Injury, showed the facility would revise the resident's care plans or the facility practices to reduce the likelihood of another fall, and that it was necessary to provide consistent interventions to prevent further falls. The policy showed the Interdisciplinary Team would .identify trends or potential for new risk factors.communicate interventions to the nursing staff.Review of Resident 37's medical records showed they admitted to the facility on [DATE] with diagnoses of a broken bone to their right lower arm, dementia (the loss of cognitive functioning, thinking, remembering, and reasoning, to such an extent that it interferes with a person's daily life and activities), and had a history of falling. The 01/29/2026 comprehensive assessment showed Resident 37's cognition was severely impaired, they used a wheelchair (w/c) and required substantial to maximum assistance from staff for all activities of daily living. The assessment showed Resident 37 had experienced a fall prior to admission and had experienced one non-injury fall since admission.Review of Resident 37's Fall risk assessments showed on 02/06/2026 their fall risk score was 55 (anything greater than a score of 45 was considered a High Fall Risk). On 02/09/2026 Resident 37's fall risk score was 105.During a telephone interview on 03/17/2026 at 3:59 PM, the Resident Representative (RR) for Resident 37 stated they had been contacted by facility staff (later identified as Staff Z, Unit Manager and Staff D, Social Service Director) and was told the resident required one-on-one assistance in order to keep them safe from falling, and the facility did not provide that type of care, and the RR needed to send family to sit with the resident. The RR stated they had a full-time job and lived out of town, two and a half hours away, and did not have anyone that they could send to sit with the resident. The RR stated when they came to town, they would pick the resident up and take them overnight to visit with them. The RR stated they would walk with the resident and take them to the restroom, and they did not have issues with them falling.During an observation on 03/17/2026 at 4:48 PM, Resident 37 sat in a w/c in the dining room at a table at the back of the room, in front of the fireplace, with three other residents. Resident 37 had a wander guard (an alarm that is used for protecting residents at risk of wandering) attached to the back of their w/c, (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 0689 Level of Harm - Actual harm Residents Affected - Few	they were sitting sideways in the w/c, leaning towards their right side, with the footrests in place, and a black brace to their lower right arm.During an interview on 03/18/2026 at 2:38 PM, Staff D stated Staff Z and themselves placed a call to the RR to inform them Resident 37 needed one-on-one care because they kept falling. Staff D stated they informed the RR the facility did not provide that type of care at the facility and gave them contact information for other facilities.An observation and concurrent interview on 03/19/2026 at 11:31 AM, Staff EE, Contracted NA, stated this was their first day working in this facility and had not been given information regarding Resident 37's falls or care. Staff EE stated they would watch Resident 37 and when they appeared restless or anxious, or propel in and out of their room, or point, it would indicate to them they needed something. Staff EE then asked Resident 37 if they needed to use the restroom and they stated yes. Staff EE then assisted Resident 37 to the restroom.During an observation on 03/20/2026 at 10:11 AM, Resident 37 was sitting in their w/c, with the footrests on, and they were attempting to independently ambulate. Resident 37 was holding on to the brake handle of the w/c, that was located below the left side of the seat of the w/c, with their left hand, grasping onto the right-side arm rest with the right hand, to push themselves up. Resident 37 was attempting to step over the front of the footrests on the w/c to reach the floor. Just as Resident 37 was about to stand, Staff AA, Nursing Assistant (NA), exited another resident's room, seen Resident 37, and asked them if they had to use the bathroom, Resident 37 responded with yes and was assisted to their room to use the bathroom.During an observation on 03/23/2026 at 9:45 AM, Resident 37 was in their w/c, outside of their room, and the footrests were on. Resident 37 attempted to self-propel themselves with their feet by placing one foot on the floor behind the footrest and the other on the floor in front of the other footrest.Review of the 01/01/2026 through 03/17/2026 incident log showed Resident 37 had experienced 14 falls starting 01/29/2026 with the most recent fall on 02/22/2026.Review of Resident 37's 01/29/2026 through 02/22/2026 fall investigation reports showed. 12 of the 14 falls Resident 37 experienced were unwitnessed falls even after an intervention on 02/06/2026 and 02/09/2026 to keep the resident in the hall next to the nurse to prevent self-transfers during the day, on 02/11/2026 the resident was to be kept within visual sight of staff, and 02/16/2026 a one-on-one staff was called in for the remainder of the night shift after the fall (three interventions in 14 falls). Six of the falls (02/06/2025 at 7:15 PM, a bump to the left side of their head and pain to the left hip area, 02/14/2026 at 12:00 PM, golf sized bump to the back of the head, 02/15/2026 at 4:45 PM, Hematoma to the back of the head and a torn off finger nail, 02/16/2025 at 12:01 AM, pain and redness to the back of the head, 02/18/2026 at 3:15 PM, pain to their right arm fracture repair, and 02/22/2026 at 7:08 AM, a laceration to the left side of their head) Resident 37 received an injury. Three of the falls (01/29/2026 at 12:45 AM, 02/06/2026 at 4:50 AM, and 02/14/2026 at 12:00 PM) showed the resident needed to use the bathroom or had a fall while in the bathroom. There were no interventions to attempt a toileting program for the resident, nor did they have scheduled assistance with toileting. Two of the falls (02/18/2026 at 3:15 PM and 02/22/2026 at 7:08 AM) required hospital intervention for Resident 37's injuries.Lastly, the reports showed Resident 37 had signs and symptoms of a urine infection and a urine test was pending provider assessment starting 02/06/2026, to the results were pending as of 02/11/2026, to 02/18/2026 when the lab was called for results and they were lost. The urine test was completed at the hospital on [DATE] after the third fall of the day that resulted in an injury. Review of the hospital records showed on 02/18/2026 at 5:30 PM, Resident 37 arrived at the hospital after falling and landing face-down on the ground. The record showed the resident had four falls that occurred today and complained of pain to their right eyebrow, the right side of their head, and both sides of their neck. The records showed a Computed Tomography (CT, a diagnostic imaging exam that uses X-ray technology to produce images of the inside of the body) scan was completed and was negative for injuries. The records showed the resident would benefit from a higher level of care with more frequent monitoring.Review of the hospital records showed on 02/22/2026 at 7:58 AM, Resident 37 arrived at the hospital after a fall, when they had a brief loss of consciousness, and sustained a head injury. The record showed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 37 complained of new back pain and left hip pain from the fall. The records showed there was a large scalp laceration [traumatic injuries that involve rips or tears in your body's tissues] to the left side of the back of the head that was four centimeters (cm, a unit of measure) in length and required five staples to close the wound. The records showed Resident 37 could not lift their left leg up off the bed during examination due to increased pain and had a contusion (an injury resulting from blunt force trauma that damages underlying tissue without breaking the skin's surface) to their left hip and thigh.Review of Resident 37's 01/30/2026 Care Plan (CP), showed a focus for trauma related to [Resident 37] falling, with an intervention that showed it worried me because I had to drag myself on the floor.I couldn't get up and it was dark and I couldn't see. The CP showed on 01/24/2026 (the day of admission) a behavior monitor was initiated for the resident crawling out of bed and an ADL intervention for having the bed up against the wall for a sense of safety and security and extensive assistance by staff for toileting. The 01/24/2026 fall CP showed the resident would regularly crawl out of their bed or their w/c and sit on the floor and an intervention for a fall mat at the bedside while the resident was in bed to mitigate serious injury. Review of an updated fall risk CP on 02/23/2026 showed episodes of crawling out of bed and sitting on the floor and frequent falls are inevitable. The CP showed no additional interventions for toileting, to keep the resident within visual sight to keep them safe, to remove the footrests when the resident experienced increased independent ambulation activity, or the injuries they sustained during the falls.Review of Resident 37's February 2026 Medication Administration Records, showed an order on 02/11/2026 for Resident 37 w/c footrests to be removed while they were in the w/c related to fall risk. The order was then discontinued on 02/12/2026.An observation and concurrent interview on 03/23/2026 at 9:48 AM, Staff AA stated they had not been given any additional directions or interventions regarding Resident 37 with their fall precautions. Staff AA stated they were not given any direction to keep the resident in their line of sight or to watch them closely. Staff AA stated they did not know if the footrests being on would cause the resident to fall more frequently or easier. Resident 37 was self-propelling by us during the interview with one foot in front of the footrest on the floor and the other foot behind the footrest on the floor. Staff AA stated Resident 37 had just had another fall this morning (fall number 15). Staff AA stated they did not have a schedule for toileting Resident 37 and that they waited for the resident to let them know, maybe every three hours. Staff AA continued to enter another resident's room. During an observation on 03/23/2026 at 9:53 AM, Resident 37 was sitting in their w/c at the back door of the facility, with their footrests on. Resident 37 had their right foot on the right footrest and the left foot behind the left footrest on the floor and used the arm rests to push themselves up. Staff C, Director of Clinical Operations, was walking down the hallway and intercepted, assisting the resident to sit in the w/c, and took the resident with them to the front of the facility.During an interview on 03/23/2026 at 9:55 AM, Staff E, Licensed Practical Nurse (LPN), stated Resident 37 was very impulsive and not sleeping well. Staff E stated there was no one that was watching or sitting with the resident to prevent them from falling. Staff E stated the NA staff should have toilet the resident per protocol, at least every two hours. Staff E stated Resident 37 would benefit from one-on-one supervision for their safety and had not seen that happen, I am not sure if we have the staff for that. Staff E stated they believed the footrests on the residents' w/c could be the cause of some of their falls because they try to stand or bend down to get something off the floor. Staff E stated Resident 37 did not required assistance with self-propelling in their w/c, they propel on their own.During an interview on 03/23/2026 at 10:01 AM, Staff F, NA, stated they were to attempt to keep Resident 37 in sight, but when they had to go into another room or got busy, that was not possible.During an interview on 03/23/2026 at 10:48 AM, Staff Z stated Resident 37 had been treated for a urine infection during the time frame of their falls. Staff Z stated they initiated a fall mattress at bedside but that was contraindicated because Resident 37 was too active. Staff Z stated staff were to remove the resident's footrests from their w/c when they experienced increased activity. Staff Z stated staff should have known when Resident 37 was repeatedly attempting to ambulate on their own that it was (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	time to remove the foot pedals. Staff Z stated when Resident 37 would fall, they would have staff sit with them for a little bit one-on-one, but nothing consistently. During an interview on 03/23/2026 at 10:50 AM, Staff R, Infection Preventionist/LPN, stated when they worked and Resident 37 fell, twice, they could not assign staff to sit with the resident one-on-one because the facility did not have the staff capability for a one-on-one. Staff R stated they did not provide a one-on-one on 02/16/2026 as the investigation showed. Staff R stated keeping Resident 37 within visual line of sight did not seem to work very well when the staff would have to go and take care of others.During an interview on 03/23/2026 at 11:12 AM, Staff B, Director of Nursing, along with Staff C, stated they were at a loss as to what to do for Resident 37's falls. Staff B stated Resident 37 would go home to visit and the family would walk with Resident 37, and then the resident would come back and want to walk. Staff B stated the family was able to provide the resident with one-on-one assistance at home, so they were not falling, but the facility did not have the staff to provide one-on-one assistance. Staff B stated they did not know Resident 37 had the footrests on their w/c and they thought those were being removed. Staff B stated staff were to keep Resident 37 in their line of sight, but the resident continued to fall. Staff B stated they had called the family to the facility to provide the resident with one-on-one assistance, but they could only send someone one time for 40 minutes. Staff B stated they were aware the resident had dementia, there was a high risk for falls, and that they had left their home in the middle of the night, to be found outside on the ground hours later, prior to them being admitted , and it was their responsibility to provide them with safety.Reference: WAC 388-97-1060 (3)(e)(g)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, A) staff prepared, distributed and served resident food in accordance with professional standards of practice along with the maintenance of a sanitary (relating to the conditions that affect hygiene and health) kitchen environment for 1 of 1 kitchen, reviewed for food safety requirements and, B) resident foods brought in from outside sources were stored, labeled and dated with opened by and expiration dates for 1 of 1 resident refrigerator located in the kitchen, review for food safety. This failure placed residents at an increased risk for cross contamination (the harmful spread of diseases) of food borne illnesses.Findings included. Review of the facility's policy titled, Food: Safe Handling for Foods from Visitors/Residents, revised August 2025, showed resident would be assisted in properly storing and safely consuming foods brought into the facility by residents and/or visitors. The policy showed that food item would be stored in a sealed container to prevent cross contamination and labeled with the resident name/date. Additionally, uneaten resident foods brought in would be discarded after 72 hours. Observations of the initial kitchen visit and concurrent interviews with facility staff on 03/17/2026 from 9:15 AM to 10:27 AM showed: The kitchen's entrance way had an ice machine, resident refrigerator, a sink and cabinets. The walls of the entrance way had multiple old, dried splashes of red, brown, and tan colored liquids/food particles scattered across them, where post meal food trays/carts were stacked up against, along with a current white, wet liquid that had made a puddle on the entrance ways floor. The ice machine display panel showed off and noted a melted ice block at the bottom of the machine ice storage container. Staff M, Dietary Manager, stated the ice machine was broken, was not currently being used for ice, needed to be fixed and stopped working about one to two days ago. Staff M stated they were currently utilizing bags of ice that were stored in a deep freezer. The refrigerator had storage of specific resident foods brought in by family, visitors or purchased by the resident. Inside were more than 30 residents' two ounce (oz, a unit of measure) pudding cups and apple sauce cups prepared by the facility. The pudding/apple sauce were labeled for expiration on 03/12/2026, 03/15/2026, and 03/16/2026. Staff M stated the food should have been discarded before the expiration date and not stored in the same refrigerator as resident food from outside sources. The juice machine dispenser nozzle with masking tape (a thin tape that is easy to tear with a paper backing, used during painting) over some of the buttons on the nozzle. The tape was soiled (dirty or unclean) discolored and worn. Staff M stated they did not have a record of when the nozzle was last cleaned, and the tape needed to be changed. On top of the dishwasher was a thick layer of dust and food particles. Below the dishwashing machine was a black substance caked around the pipes and on the floor and walls. The built-up grime and grease was wet and a discolored brown liquid was noted. The walls under the dishwasher table/machine had a hole where piping, from the machine, was coming thorough and caked in the same black greasy grime with unknown debris. The light green painted walls were noted to be peeling off behind the dishwasher. After observing the black, grim/greasy build-up caked on the walls and pipes under the dishwasher, Staff M and Staff T, Regional Registered Dietician, stated that below the dishwasher was a safety concern and not sanitary. Staff M stated, it could be mold. The kitchen stove top burners had a half an inch (a unit of measurement) of grime (a combination of dirt, oils, and dust) and food particles built-up on each burner. The burners had multiple areas where food had been spilled and not cleaned. The backsplash of the stovetop had multiple splashes and food particles scattered on it. Staff M stated the stove top should have a deep or thorough clean weekly and then daily if there were splashes or spills. After observing the stove top, Staff M stated that it had not been cleaned weekly nor daily due to the buildup noted on the burners, very heavy dirt and grime. Staff M observed opening the grease traps on the stove and noted it was not cleaned, with multiple layers of buildup, from multiple cooking (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	sessions noted. Staff M stated the routine and deep cleaning of the stove top was not being done and the stove was not sanitary. Shelves above the food preparation tables were dusty with a buildup of grease noted. Staff M and Staff T stated they could not show records that routine or deep cleaning was being performed during the beginning of February 2026, and Staff M showed records of incomplete routine/deep cleaning from 02/25/2026 through 02/28/2026. Under the two food preparation counters against the back wall of the kitchen and oven was a thick layer of dust, grime, and food particles with a fork/cup along with trash. An upside-down mouse [NAME] p was noted under one of the food preparation counter tops and when moved by staff an imprint of the box was outlined in a thick layer of dust/grime.During an interview on 03/17/2026 at 2:55 PM, Staff M and Staff FF, Cook, stated they did not know the last time the stove top and oven had been deep cleaned. Staff M stated they had taken pictures of the kitchen environment, under the dishwasher, counters/sinks, holes in the wall with the debris/grease, grime and showed them to the Administrator. Staff FF and Staff M stated the stove top, burners and grease trap should have been clean regularly and the correct process was not followed.Observations of the kitchen during cooking and serving out with concurrent interviews of facility staff on 03/17/2026 from 3:43 PM to 4:33 PM showed: Staff FF in the kitchen cooking. Staff FF was noted preparing a spinach, broccoli and cheese salad. Staff FF doffed (to take off) their gloves and opened a refrigerator door then proceeded to the dried food storage area to grab items without performing hand washing. Staff FF then, without donning (to put on) new gloves or hand washing, proceeded to flip a hamburger patty that was cooking on the stove top with a utensil, opened the oven, pulled back the tin foil from the roast beef in the oven and placed the thermometer into the roast beef without performing hand washing or donning new gloves. Staff FF had just pulled a baking sheet of Tator Tots out of the oven and with ungloved bare hands grabbed the thermometer probe device and while holding a Tator Tot, from the baking sheet, with their bare hands, stuck the thermometer device into the Tator Tot. After reading the temperature Staff FF washed their hands and donned a new pair of gloves then proceeded to place the same soiled Tator Tot back onto the baking sheet with the rest of them. The sound of someone whacking at ice was overheard and observed Staff FF hitting the melting ice block within the ice machines storage container, with ungloved hands. Staff FF stated they were going to use the ice to put on top of the resident juices, milk and ice cream. Staff FF stated the ice machine had been turning off/on recently, and that it was still okay to use. After placing ice from the ice machine within a bin around and on top of resident drinks/ice cream, Staff GG, Dietary Aide, stated the ice was used to keep resident drinks cold and the drinks included cups of cranberry juice, orange juice, and milk along with ice cream cups. The ice cream was in Styrofoam (a specific type of material) cups that had a paper pull-off lid that was sunken down into the cup from the top, with melted ice sitting on top of the ice cream. The juice cups had a precut cross notch in the lid, where a straw would be placed and melted ice noted on top of the juices. Additionally, the ice machine display screen still showed the machine was off. On the other side of the kitchen, Staff M stated the ice within the ice machine was not to be used, and the machine needed to be fixed. Staff M stated they did not want a staff member to have to use a device to break up the ice, since it had already been melting into a block, and risk introducing bacteria, so ice bags were to be used. Staff M stated they were verbally informing staff of not using the ice machine but had not placed a sign on the ice machine's storage lid yet. While serving out drinks to residents, it was noted that the same contaminated ice, from Staff FF breaking it up with bare hands, had been melting on top of the plastic drink lids which had a precut opening(a cut made in a plastic lid so a straw can be inserted) on all the resident juices/mil k. The ice was also melting on top of the paper ice cream lids, and both the ice cream and drinks were served out to numerous residents in the dining room.During an interview on 03/17/2026 at 5:25 PM, Staff DD, Maintenance Director, stated the facility had one ice machine in the kitchen that was turned off sometime Sunday (03/15/2026) and they had not turned the machine back on since then. Staff DD stated that it was not being used for ice and since it was off the ice had been melting. Observation of the kitchen on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	03/18/2026 at 3:01 PM showed the main ceiling ventilation cover, in the middle of the kitchen, had been covered in a thick layer of dust. The kitchen windows over the food preparation area were opened and the screens were caked in a black and brown dust/soot.During a concurrent observation and interview on 03/18/2026 at 3:13 PM showed Staff M and Staff T going through food items within the resident refrigerator. The items included: Homemade pasta in a Tupperware container with no date on it. Half of a peanut butter and jelly sandwich, not labeled or dated. A 32 oz plastic crate of shriveling (a shrinking or withering away) strawberries, with no labeled resident or received by date. A second 32 oz plastic crate of strawberries that was noted with fuzzy growing mold covering the strawberries and did not have a received by date or expiration date. A 12 oz Pepsi soda can, which had been opened and was half empty, with no date. A bag of Mozzarella cheese with no open or use by date. Staff M and Staff T both stated that food items needed to be in a container, labeled and dated with the resident's name, room number, date that the item was brought into the facility and the date it was to be used by or discarded. Both staff stated the correct process for the storage, labeling/dating of resident food items for consumption, in regard to food safety, was not followed. During a continued interview on 03/18/2026 at 3:54 PM, Staff M and Staff T stated the kitchen staff should not have been using the ice, for resident drinks, from the ice machine storage bin since it had been broken/turned off. Staff M stated the drinks and ice cream should not have been served to the residents with the potential for contamination from the melting ice. Both staff stated the facility did not follow the correct process regarding maintaining a clean, safe/sanitary kitchen environment or storage, labeling of resident foods and the correct process was not followed. During an interview on 03/20/2026 at 5:10 PM, Staff B, Director of Nursing, and Staff C, Director of Clinical Operations, stated the kitchen should have routine and deep cleaning to keep a sanitary environment for the storage, preparation and serve out of resident foods. Both staff stated the right process had not been followed regarding the kitchen environment and potential cross-contamination of resident drinks from the potentially contaminated ice utilized by dietary staff.Reference: WAC 388-97-1100(3)This is a repeat citation from the Statement of Deficiencies dated 02/07/2025.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide meal services in a dignified manner for 4 of 4 residents (23, 31,33 and 18) reviewed for dignity related to Residents (23, 31,33 and 18) waited an hour for lunch to be served. This failure placed the residents frustrated and embarrassed. Findings included . During an observation on 03/17/2026 at 11:45 AM, Residents (23, 31, 33 and 18) were seated at their tables and required assistance with meals in the main dining room. There were two tables that residents required extensive assistance and cueing. Other residents that sat in the main dining room were either setup assistance or independent with eating their meals. The lunch meal was served to residents on trays from the steam table located in the main dining room at 12:45 PM,ˆ(one hour after lunch trays were served to rooms in the 100 hall). The dining room was served their meals after hall 100 which was delayed. During an interview on 03/17/2026 at 12:18 PM, Staff T, Regional Registered Dietician, who had observed the lunch meal serve out stated the facility dietary department brought the food from the kitchen to the main dining room steam table and served the 100 hall first then the main dining room.ˆStaff T stated it was not dignified to make residents in the main dining room wait to be served their meal. Staff T stated it would make sense to serve the dining room first since some of the residents required assistance. Resident 23ˆ Review of the medical record showed the resident was admitted on [DATE] with diagnoses of progressive Multiple Sclerosis (an autoimmune disease that attacks the insulation covering of nerve cells leading to muscle weakness and coordination issues) and Dementia (a group of symptoms that affect cognitive functioning, thinking and reasoning). During an observation on 03/17/2026 at 11:45 AM, Resident 23 was seated at the Progressive Self Feeding Program (PSFP) where residents are assessed by nursing who are in need of one-on-one directions and cueing for drinking fluids or eating their meals. Nursing initiates a care plan to assist residents on a specified those specific instructions such as swallowing precautions, sufficient chewing of their foods, and cues to each one bite at a time during meals. This is usually done with a Restorative Aide (RA) who is trained to carry out the PSFP care plan. Resident 23's 10/31/2024 care plan identified memory loss and swallowing issues. Resident 23 required assistance with meals with instruction to slow down and to take small bites due to difficulty swallowing. During an observation and concurrent interview on 03/17/2026 at 12:55 PM, Staff Q, RA was standing and instructed Resident 23 to use their spoon and take a bite of food. Staff Q then went to the other residents at the table standing to instruct residents to eat. Staff Q stated they did not have time to sit with residents who need assistance because they had to pass other residents' lunch trays. During an interview on 03/17/2026 at 1:10 PM, Staff Q, RA, stated that Resident 23 had issues with eating which included shaking when using their adaptive spoon and spilling food. Resident 31 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of dyskinesia (significant tremors), kidney disease, insulin dependent diabetes (a group of diseases that effects how the body uses blood sugar and insulin (a hormone). Review of the 03/12/2026 nursing comprehensive assessment showed the tremors (involuntary shaking movements) interfered with the resident's ability to eat independently without staff assistance. Additionally, Resident 31 had problems with swallowing their food. An observation and concurrent interview on 03/17/2026 at 1:00 PM showed Resident 31 was using (continued on next page)

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Parkside Care	308 West Emma Union Gap, WA 98903

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their adaptive spoon made so the resident could scoop food off their divided lipped plate. Resident 31's right hand was shaking holding the spoon and spilling food on their chest and lap. No available staff were present until Resident 31's shaking became worse. At 1:00 PM Resident 31 asked for assistance so they could be wheeled back to their room. Resident 31 stated they were embarrassed and were tearful and wanted to return to their room as they needed to be fed due to the inability to assist themselves without shaking. The tremors interfered with Resident 31's eating and required assistance with meals with instruction to slow down and to take small bites due to difficulty swallowing. During an observation and concurrent interview on 03/19/2026 at 12:01 PM, Resident 31 was seated at the PSFP assist table holding their sippy cup (a cup with a lid and straw with handles on each side of the cup), an adaptive spoon and a divided plate. On 03/19/2026 at 12:05 PM, Resident 31 had picked up their spoon, had tremors and dropped food on themselves, became frustrated (dropped the spoon and asked to leave the dining room) and did not want to eat anymore.ˆStaff P, RA, was sitting at the table and began to assist Resident 31, who started coughing. Staff P then wheeled the resident out of the main dining room to the resident's room.ˆStaff P stated they did not have enough time to assist residents fully with their meals. Additionally, during an observation on 03/19/2026 from 12:00 PM to 12:20 PM of the lunch meal in the main dining room showed Staff P continued to move from one side of the residents at the PSFP table to the resident assisted table (separate table) and did not sit with the residents fully assisting with the residents' meals. Resident 33Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of dementia and diabetes. Review of the 03/12/2026 nursing comprehensive assessment showed the resident was impaired cognitively and needed assistance from the staff with eating their meal. During an observation on 03/17/2026 at12:07 PM, Resident 33 was first seated at the PSFP table then moved to the assistance table. Coffee was served to the resident with a lid and straw over the coffee up. The resident sat in their wheelchair at the dining table without supervision. Resident 33 took their clothing protector off and wrapped it around their coffee cup. During an observation on 03/17/2026 at12:45 PM, Resident 33 had their tray served uncovered for 15 minutes until 1:00 PM.ˆResident 33 started touching the rim of their lunch plate then started to touch their food with their fingers. Staff were not available until 1:10 PM to assist the resident with their meal. Resident 18A review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to include dementia with behavioral disturbances and hard of hearing. The 01/16/2026 quarterly nursing assessment showed Resident 18 was dependent on staff for all Activities of Daily Living (ADL) with exception of meals which required set up and clean up only. During an observation on 03/17/2026 at 1:06 PM, Resident 18 was seated at their table for lunch in the main dining room. The resident 's table was at upper chest level and made it difficult for the resident to independently pick up their fork or spoon when their lunch was served to their table. Resident 18 was at their table alone, observed eating with their fingers, utensils on table, not used, resident observed attempting to eat pudding with fingers and scraping corn bread off table. The corned beef was thinly sliced, and potatoes were in bite sized pieces. No staff came to assist the resident. During an observation on 03/18/2026 at 12:50 PM, Resident 18 sat at their table with two other residents. Resident 18 was served and was unable to pick up their utensils. The dining table was too high for the resident as they reached for their drink that was covered with a lid and straw. While (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 18 reached small plastic cup they dropped it on the table. Residents at the table assisted Resident 18 to pick up the cup. Additionally, the resident could not cut their breaded chicken to eat it. Staff F, Nursing Assistant, (NA), stated they usually set up Resident 18's meal and must cut up the meat into small pieces. During an interview on 03/19/2026 at 2:00 PM, Staff B, Director of Nursing, (DON), stated there were issues at mealtimes in the dining room and there are more people wanting to eat there. It was a lack of dignity and led to weight loss. Reference: WAC 388-97-0180 (1-4)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADL's) related to shower/bathing for 5 of 6 residents (Residents 6, 44, 24, 31, and 18) reviewed for ADL care. This failure placed the residents at an increased risk for poor hygiene, skin breakdown, an undignified existence, infection, and pain. ˆ Findings included . Residentˆ6ˆ Review of the resident's medical records showed they admitted with diagnoses toˆinclude Multiple Sclerosis (a disease that disrupts the communication between the brain and the rest of the body that leads to fatigue, vision problems, and muscle weakness) and diabetes (increased sugar in the blood). Theˆ12/08/2025 comprehensive assessment showed Resident 6's cognition was intact and was dependent on staffˆassistanceˆfor their showering and bathing needs.ˆ During an interview on 03/18/2026 at 8:42 AM, Resident 6ˆstatedˆthe facility only had one staff person that did showers. Resident 6ˆstatedˆthey were scheduled for two showers a week and would only get one shower a week,ˆif even that. Resident 6 stated when the floor Nursing Assistants (NAs) did not show up for their scheduled shift, the shower NAs would be taken from theirˆshowerˆdutiesˆto cover the floor and then nobody would get a shower. Resident 6ˆstatedˆit had been months since they received their shower on Tuesday.ˆResident 6ˆstatedˆthey returned from the hospital on [DATE] and really wanted a shower but did not get one until 03/15/2026ˆbecause there was no one available.ˆ Review of Resident 6's shower tasks for 02/01/2026 through 03/21/2026 showed Resident 6 was scheduled to receive showers on Tuesdays and Saturdays. The tasks showed Residentˆ6ˆreceived a shower on 02/10/2026, 02/14/2026, 02/17/2026, 02/28/2026,ˆ03/14/2026, and 03/21/2026. The tasks showed Resident 6 received six out of the 14 showers that were scheduled.ˆˆ ˆ Residentˆ44ˆ Review of the resident's medical records showed they admitted with diagnoses to includeˆdiabetes and anxietyˆ(a feeling of worry, nervousness, or unease about something with an uncertain outcome). The 03/11/2026 comprehensive assessment showed Resident 44's cognition was intact andˆrequiredˆsubstantial to maximumˆassistanceˆfrom staff for bathing and showers.ˆ During an interview onˆ03/19/2026 at 1:54 PM, Resident 44ˆstatedˆtheyˆhad gone as long as two weeks without a shower and more recently, ten days. Resident 44ˆstatedˆthey had reported this to the StaffˆD, Social Services Director,ˆand they would get better for a little bit but then go back toˆmissing them again.ˆ Review of aˆ03/13/2026 bathing schedule showed Resident 44 received showers onˆTuesdays and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fridays.ˆ Review of an 11/04/2025 customer concern showed Resident 44 reported theyˆhad not received their showers andˆwanted the two showers a week they were scheduled to have. The concern showedˆan attached shower scheduleˆthat showed Resident 44 had not received three of their showers. The concern showed two of the showers missed were becauseˆfloorˆNAs had called in [did not report for their scheduled shift]ˆand the shower NAs were pulled to work theˆfloor,ˆand the third one because Resident 44 was not in the facility.ˆThe plan was to hireˆadditionalˆshower NAs or floor NAs for better coverage.ˆ Review ofˆa 11/14/2025ˆcustomer concernˆ(ten days from the last shower concern reported)ˆshowed Resident 44 reported they had not had a shower in ten daysˆI do pay for two a week.ˆThe concern showed on 11/15/2025 the facilityˆhad a NA stay over so they could complete Resident 44's shower. The concern showed the planˆwas to hire two NAs to replace theˆshower NA that had beenˆterminated.ˆ During an interview on 03/21/2026 at 11:21 AM, Staff B, Director of Nursing Services, along with Staff C, Director of Clinical Operations,ˆstatedˆthey had recentlyˆterminatedˆa showerˆNA,ˆand another one had been out on family medical leave. Staff BˆstatedˆthŠey had not been able to have the staff toˆreplace the shower aids because they were needed for care on the floor. Staff BˆstatedˆtheyˆhŠad staff available to complete showers for the past few daysˆwhoˆwere able to complete showers, but they were not on theˆresident'sˆscheduled days. Staff BˆstatedˆtheyˆhŠad recently obtainedˆaccess to Contracted NAs toˆassistˆwith filling in those gaps.ˆ Resident 24ˆ Review of the medical record showed Resident 24 was admitted to the facilityˆon 02/27/2026ˆwith diagnoses including left kneeˆbacterialˆarthritis (aˆseriousˆcondition that causes inflammation,ˆpainˆand limited mobility), malnutrition,ˆandˆspondylolisthesis (a condition of the backbone that causes pain and stiffness). The 03/05/2026 comprehensive assessment showed Resident 24ˆrequiredˆone to two staff members for dependent/moderateˆassistanceˆfor ADLs, including showers.ˆThe assessment also showed Resident 24 had an intact cognition.ˆ ˆ Review of Resident 24's bathing record showed they were scheduled for bathing/showers on Mondays and Thursdays. Review of the record showed on a 30-day look backˆthat began on 03/18/2026, Resident 24 wasˆprovided withˆone shower on 03/05/2026. Review of the bathing record showed no documented refusals for bathing. The record showed four missed opportunities for showers. ˆˆ During an interview on 03/18/2026ˆat 9:21 AM, Resident 24's Representative (RR),ˆstatedˆResident 24 was scheduled for showers on Mondays and Thursdaysˆand they had only received one shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	since they had arrived at the facility. RRˆstatedˆthe facility had not offered bed baths either.ˆ The RR stated they called their mom on Monday, and they stated they did not get their shower and their bottom was hurting, and looked red, cracking, and peeling. During an interview on 03/18/2026 at 1:05 PM, Staff B, Director of Nursing,ˆstatedˆthe process forˆshowering residentsˆwasˆthe nursing assistants (NA) were to document in theˆNA tasks section of theˆresidents'ˆcharts when a shower was completed or refused.ˆStaff BˆstatedˆResident 24 was scheduled to have two showers per weekˆand they were not performed. Staff BˆstatedˆthE facility had recentlyˆterminatedˆa shower aide.ˆˆ Resident 31 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of dyskinesia (significant tremors), kidney disease, insulin dependent diabetes (a group of diseases that effects how the body uses blood sugar and insulin (a hormone).ˆ Review of the 03/12/2026 nursing comprehensive assessment showed the tremors (involuntary shaking movements) interfered with Resident 31's independence and depended on staff to provide transfers and showers/bathing. Resident 31 was alert, oriented and able to make their needs known. ˆ During an interview and concurrent observation on 03/18/2026 at 10:16 AM, Resident 31 complained about not getting baths/showers. The resident stated they had complained about not receiving a shower on 03/04/2026 and had not received two showers out of seven scheduled due to staff call outs and no replacement staff.ˆ Staff 31's hair was greasy and skin to face was flakey. ˆ During an interview on 03/18/2026 at 11:00 AM, Staff O, Nurse Assistant, (NA), stated that they had a bath team to do showers twice a week but that was taken away.ˆ So, we don't have help doing showers and baths and do not do them or bed baths. Resident 31's 02/12/2026 care plan showed the resident needed assistance with bathing and was scheduled twice a week. ˆ Review of the bath task documentation for bathing showed the resident was to receive showers twice a week on Monday and Friday.ˆ The task sheet showed four showers from 02/20/2026, 02/23/2026, 02/27/2026 and 03/06/2026. As of 03/20/2026 the resident had not received a shower from the last date of 03/06/2026. ˆ Resident 18 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to include dementia (a group of symptoms that affect cognitive functioning, thinking and reasoning) with behavioral disturbances and hard of hearing.ˆ The 01/16/2026 quarterly nursing assessment showed Resident 18 was dependent on staff for all ADLs to include showers/baths. Review of Resident 18 's 02/16/2026 care plan showed the resident was dependent on staff for bathing and would have showers two times a week. During an observation and concurrent interview on 03/18/2026 at 1:20 PM, Resident 18 sat in their wheelchair at the dining table with fingernails that had brown substances under fingernails. Asked the resident if they got enough baths/showers.ˆ Resident 18 stated they did not get showers at the facility and was unaware when they had a bath but stated they would be available for a bath. Review of the shower/bath task documentation for bathing showed the resident was to receive showers twice a week on Thursday and Sunday.ˆ The task sheet showed five showers from 02/22/2026, 03/08/2026, 03/12/2026, 03/18/2026 and 03/19/2026. The total number should have been 10 total baths. During an interview on 03/19/2026 at 1:45 PM, Staff B, Director of Nursing, (DON), stated they have not had consistent bathing/showers of residents because they have had to pull NAs from bathing tasks to work on the floor with assignment of residents due to the fact they had been short of staff.ˆ Staff B stated that there were not enough staff who were assigned to residents' cares to do baths/showers. Reference WAC 388-97-1060(2)(c)

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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 monitor and address nutritional needs for 4 of 5 residents (Residents 5, 10, 18 and 33) reviewed for nutrition. This failure placed the residents at risk for medical complications, nutritional weight loss, and a diminished quality of life.^ Findings included . Resident 5 Review of the medical record showed the resident readmitted to the facility on [DATE] with diagnoses that include end stage kidney disease with dialysis (a treatment that filters fluid and waste from your blood when your kidney are failing), dental caries (cavities), missing teeth, diabetes type 2 (a chronic condition where the body does not use insulin effectively), malnutrition (poor nutrition due poor diet intake) and heart disease. Review of Resident 5's 02/17/2026 comprehensive assessment showed the resident required setup only with their meals. Resident 5 had some cognitive and hearing loss but was able to make their needs known. Resident 5's 03/05/2026 care plan showed the resident attended dialysis three times a week from 5:00 AM to 8:00 AM. During an observation and concurrent interview on 03/17/2026 at 1:12 PM, Resident 5 had a few missing on the top and bottom. Resident 5 stated they had a problem with swallowing foods. Resident 5 stated they could not eat the puree foods (smooth, creamy food) at the facility as it was too sweet. Resident 5 signed a deviation of care from a puree diet to regular diet with soft foods. Resident 5 had asked resident representatives to bring soft foods like beans and rice and vegetables. Additionally, the resident stated that there was too much sugar in some food like mash potatoes and liked fresh vegetables, wraps and soft tortillas, no bread, soups such as potato soup and asparagus or broccoli soups or vegetables. The resident stated they like Paella, which consists of rice, saffron, seafoods or meat, stuffed peppers with meat and rice. Resident 5 also stated the small glass of supplement they gave them was too sugary and did not drink it and had refused to take it. Review of the 02/10/2026 Food Preference Record showed Resident 5 was able to make food selections and did not have special food request for meals and no snacks requested. Dislikes were orange juice, bananas and mashed potatoes. The resident did request a Hispanic Diet (which was not defined). No other preferences/ dislikes were identified by dietary staff. Review of the 02/11/2026 nutrition at risk evaluation showed Resident 5 had weight loss and added four ounces of supplement to lunch and dinner. Resident 5 received insulin (hormone) daily. Resident 5 was at risk for weight loss and malnutrition. Resident 5's weights from 02/07/2026 was 142.4 pounds and on 03/17/2026 was 123.1 pounds. Resident 5 had a 13.55% weight loss. Review of Resident 5's 02/10/2026 laboratory report showed a Comprehensive Metabolic Panel that measured proteins, minerals and electrolytes in the body that measured the balance of these substances in the body, in which results were low. The protein goal was 4.0 mg/dl (milligrams per deciliter which is a unit of measure) but measured 2.2 mg/dl, phosphorous goal was 3.0 to 5.5 mg/dl but measured 2.1mg/dl. During an observation on 03/17/2026 at 1:05 PM, Resident 5 was in bed eating food that the Resident Representative (RR) brought into the facility including rice, salad and a small bowl of refried beans. The resident had eaten a small amount of lunch. During an observation on 03/18/2026 at 12:00 PM the resident was served cornbread, meat and cooked mixed vegetables that had yellow and red bell pepper with onions. The resident stated that this was what they liked to eat. Resident 5 did not eat the cornbread and meat and did not accept the supplement drink. During an observation on 03/19/2026 at 11:45 AM, the resident chose not to eat but a small amount of their lunch meal. During an interview on 03/19/2026 at 2:15 PM, Staff T, Regional Dietician, (RD), stated that the previous facility RD did not confer with the dialysis dietician with the low laboratory results and it could affect Resident 5's nutritional wellbeing. Staff T also stated that with dialysis and fluid weight gain and loss was a factor and the resident could benefit from some renal (kidney) vitamin supplementation for low laboratory results. Resident 5 did not have steady weights and easily lost weight. Additionally, Staff T stated the dietary manager should have had a detailed list of what Resident 5's food preferences. Resident 10 Review of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medical record showed the resident was admitted on [DATE] with aftercare of bowel surgery, dementia (a group of symptoms that affect cognitive functioning, thinking and reasoning) and malnutrition. The 01/29/2026 nursing comprehensive assessment showed the resident was confused but able to make needs known, and an elopement risk which required assistance from staff. Resident 10 required supervision and setting up of meals. A review of the 01/30/2026 care plan showed the resident was to have setup assistance and had a regular texture diet. Other interventions included offering finger foods if resident had difficulty using meal utensils. Additionally, the resident was assessed to have difficulty with solid foods and to offer milk shake supplements. Review of the 01/09/2026 nutrition at risk assessment showed the resident was to maintain their body weight of 148.6 pounds. During an observation on 03/17/2026 at 12:45 PM, Resident 10 was seated at a table in the dining room and served the lunch meal which consisted of corn beef, cabbage and a dessert. The resident picked up their fork and picked at their food and tasted it. Observation of Resident 10's meal plate showed they did not eat the rest of their meal. During an interview on 03/17/2026 at 1:22 PM, Resident 10 sat at their table and served their lunch meal. The resident was unable to use their utensils to pick up their turkey with gravy opened faced sandwich and spilled it on their lap. Resident 10 wheeled themselves out of the dining room and did not finish their meal. During an interview on 03/19/2026 at 1:30 PM, Resident 10 stated they had enough food and were not hungry. Resident 10 went to their room and transferred themselves to their bed. Review of Resident 10's weights from 01/08/2026 where the resident weighed 148.6 pounds and 03/13/2026 the resident weighed 135.2 pounds. This was a 9.02% weight loss. Resident 18 A review of the medical record showed the resident admitted to the facility on [DATE] with diagnoses to include dementia with behavioral disturbances and hard of hearing. The 01/16/2026 quarterly nursing assessment showed Resident 18 had some cognitive impairment but able to make needs known, dependent on staff for meals which required set up and clean up only. The nursing assessment further showed Resident 18's weight to be 112 pounds. During an observation on 03/17/2026 at 1:06 PM, Resident 18 was seated at their table for lunch in the main dining room. The resident ?s table was at upper chest level and made it difficult for the resident to pick up their fork or spoon when their lunch was served to their table. Resident 18 was observed eating with their fingers, utensils on table, not used, resident observed attempting to eat pudding with fingers and scraping corn bread off table. No staff came to assist the resident. During an observation on 03/18/2026 at 12:50 PM, Resident 18 sat at their table and was served breaded chicken and was unable to pick up their utensils to cut their chicken. The dining table was too high for the resident as they reached for their drink that was covered with a lid and straw. There was no staff assistance for some time to set up Resident 18's meal and cut the resident's chicken. Review of the 01/30/2026 nutritional risk assessment showed Resident 18's was on a low salt regular textured diet. The assessment showed the resident ate 25-50 % of meals and refused nutritional supplements. Additionally, the resident's weight goal was to be over 105 pounds. Review of Resident 18's weight from 12/26/2025 was 112 pounds and 03/16/2026 showed 101.8 pounds. This loss was 9.1 % of the resident's body weight. During an interview on 03/19/2026 at 2:16 PM, Staff T stated they had not reviewed Resident 18 yet and were not aware of their weight loss. Staff T stated they had just recently arrived at the facility to assist them. Resident 33 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses of dementia and diabetes. Review of the 03/12/2026 nursing comprehensive assessment showed the resident was impaired cognitively and needed assistance from the staff with eating their meal. During an observation on 03/17/2026 at12:07 PM, was first seated at the Progressive Self Feeding Program (PSFP) where residents are assessed by nursing who are in need of one-on-one directions and cueing for drinking fluids or eating their meals. Nursing initiates a care plan to assist residents on a specified those specific instructions such as swallowing precautions, sufficient chewing of their foods, and cues to each one bite at a time during meals. table then moved to the assistance table. Coffee was served to the resident with a lid and straw over the coffee cup. Resident 33 removed their clothing (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protector and had wrapped it around the coffee cup. Staff P, Restorative Aide, then observed Resident 33 wheeling themselves towards the hallway and returned the resident to their table. During an observation on 03/17/2026 at 12:45 PM, Resident 33 had their tray served uncovered for 15 minutes until 1:00 PM.^ Resident 33 started touching the rim of their lunch plate then started to touch their food with their fingers. At 1:00 PM Staff O, Nursing Assistant (NA), readjusted Resident 33's clothing protector and gave the resident a spoon and instructed the resident to eat their food. Resident 33 took a few bites and started to wheel themselves away from their table. Review of the 02/12/2026 care plan showed the resident was on a restorative plan for eating and swallowing issues with verbal cues with instruction from staff to take liquids after two to three bites of food throughout the meal. Staff were to report any weight loss. Resident 33's weight on 01/21/2026 was 162 pounds and their weight measurement on 03/16/2026 was 154.4 pounds. Resident 31 weight loss was 4.69% of their weight. Review of the nutrition at risk book from12/01/2025 though 03/01/2026 contained notes of meetings for residents with risk for weight loss and actual weight loss but no actual recent notes for named Residents 5, 10, 18 and 33. During an interview 03/18/2026 at 11:45 AM, Staff G, Licensed Practical Nurse, (LPN) stated that there were no residents on a restorative nursing eating program and the Restorative Aide (RA) were to assist residents in the dining room that needed assistance. During an interview with Staff B, Director of Nursing, stated they had many changes in staff and were not surprised there were residents with some weight loss. Reference WAC 388-97-1060(3)(h)

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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 observation, interview, and record review, the facility failed to ensure there were enough competent nursing staff to provide care and services forˆ6 ofˆ9ˆresidents (Residents 37,ˆ6, 24, 31, 18, and 44) as evidenced by failures related to Activities of Daily Living (ADLs) and prevention of accidents. This failureˆplaced residents at risk of not having their needs met andˆpotential/actualˆnegative outcomesˆto their physical and mental health. Findings included.ˆ Review of the 02/25/2026 document titled Facility Assessment showed the facility had an average census of 48 residents. The assessment showed the facilities staffing plan was eight Nursing Assistants (NA) for day shift, seven NAs for evening shift, and four NAs for night shift per their census, and the resident population and their care needs and would be adjusted as needed. Review of the 02/15/2026 through 03/17/2026 (31 days), Staffing Pattern (a document that showed actual nursing staff on duty), completed by the facility, showed 29 of the 31-day shifts had four NAs scheduled. The staffing document showed 21 of the 31 evening shifts had four NAs scheduled, and one evening that had three and a half NAs scheduled. Review of the 02/15/2026 through 03/17/2026 daily census sheets showed 29 of the 31 days reviewed on the Staffing Pattern showed the facility had a census of over 50. F689 Accidents The facility failed to provide adequate supervision to prevent further falls and injuries. Resident 37 experienced harm when they fell and required hospital intervention twice. Review of Resident 37's fall from 01/29/2026 through 02/22/2026 showed they had 14 falls, in which 12 of them were unwitnessed. The review showed Resident 37 sustained some kind of injury during six of the falls, and two of the six falls, required hospital intervention. During an interview on 03/23/2026 at 9:55 AM, Staff E, Licensed Practical Nurse (LPN), stated they felt Resident 37 required one-on-one supervision to keep them safe from falling but they did not have enough staff to provide that care. During an interview on 03/23/2026 at 10:50 AM, Staff R, Infection Preventionist/LPN, stated Resident 37 they could not assign additional staff to keep Resident 37 safe because the facility did not have the staff capability to do that. During an interview on 03/23/2026 at 11:12 AM, Staff B, Director of Nursing Services, stated they did not have enough staff to provide Resident 37 the supervision they required to keep them safe from falling. F677 ADLs The facility failed to provide residents that required assistance with routine and consistent bathing or shower care. Resident 6 During an interview on 03/18/2026 at 8:42 AM, Resident 6 stated the facility did not have enough staff to provide them with their two scheduled showers a week. Resident 6 stated they would receive only one shower a week, if even that. Resident 24 During an interview on 03/18/2026 at 9:21 AM, Resident 24's Representative stated the resident had only received one shower since they admitted to the facility on [DATE] but were scheduled to have them twice a week. Resident 31 During an interview and concurrent observation on 03/18/2026 at 10:16 AM, Resident 31 stated they had not received two of their seven scheduled showers due to staff not showing up for their scheduled shifts and there were no staff to replace them. Resident 18 During an interview and concurrent observation on 03/18/2026 at 1:20 PM, Resident 18 had brown substances underneath their fingernails. Resident 18 stated they did not prefer showers and did not know when they last had a bath. Resident 44 During an interview on 03/19/2026 at 1:54 PM, Resident 44 stated they were scheduled for two showers a week but were but were often missed. The Resident stated they were told there were not enough shower NAs, or the floor NAs would not show up for their scheduled shift, and the shower NAs would need to take their place. Resident 44 stated they went for ten days and up to two weeks without a shower. Review of two customer concerns on 11/04/2025 and again on 11/14/2025 showed Resident 44 complained they were not receiving their two scheduled showers a week. Both concerns showed it was because the facility did not have enough staff to provide showers. Staff Interviews On 03/17/2026 at 9:26 AM, Staff A, Administrator, along with Staff B, Director of Nursing Services, when asked about any (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staffing needs stated during their entrance conference interview that the facility needed to hire five to six NAs. On 03/18/2026 at 11:00 AM, Staff O, NA, stated they had their bath team taken away and no one else was put in their place to help. Staff O stated they did not have the time to give bed baths or showers during their shifts because they were too busy. On 03/18/2026 at 4:06 PM, Staff JJ, NA, stated they normally had two shower aides but were unaware one had recently left. Staff JJ stated they did not offer bed baths to their residents when they worked their shifts and neither did the other NAs. On 03/20/2026 at 9:56 AM, Staff AA, NA, stated they did not have a shower aide scheduled for that day. Staff AA stated they were trying to call and see if they could find someone to come in during the evening. On 03/21/2026 at 11:21 AM, Staff B, Director of Nursing Services, stated they had recently lost a shower aide, and another one had been on medical leave, and they were unable to pull any of the floor NAs because they needed them to provide care on the floors. Reference: WAC: 388-97-1080 (1), 1090 (1) Cross reference: F677, F689, and F692

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to complete a thorough grievance process for 1 of 3 residents (Resident 3) reviewed for grievances. This failed practice placed residents at risk for unmet care needs. Findings included. Review of the 01/27/2023 policy titled Grievances, showed to read the grievance immediately when received and determine if the grievance is an allegation of .misappropriation of resident property, and exploitation., and if so, to take immediate action to prevent further potential violations. The policy showed the Grievance Officer/Executive Director/Designee Responsibilities would follow up with the Resident or the RR to ensure satisfaction with the outcome of the investigation. Review of the Resident's medical records showed they admitted with diagnoses to include a right leg, below the knee amputation (the surgical removal of all or part of a limb), diabetes (when the sugar in the blood is too high), and asthma (a lung condition that makes it difficult to breathe). The 12/28/2025 and the 02/06/2026 comprehensive assessments showed Resident 3's cognition was intact. During an interview on 03/17/2026 at 1:21 PM, Resident 3 stated they had reported to the facility (later identified as Staff D, Social Service Director) that they had $40.00 missing from their room. Resident 3 stated they had tucked two $20.00 bills, into their iPad case about a month ago and it came up missing. Resident 3 stated about a week ago they also had $8.00 in silver coins they used for the pop machine came up missing, that they had in their drawer. Resident 3 stated the facility did not replace their missing money nor did they hear anything about their missing money after they reported it. I guess I am just out $40.00, and the resident felt no need to report the missing $8.00. Review of a 02/01/2026 grievance showed Resident 3 claims they had $40 missing from their room. The grievance showed the Resident last saw the money on Friday (01/30/2026) and neither of their Resident Representatives had taken or removed the money from their room. The grievance showed on 02/02/2026, Resident 3's RR was called and the RR stated the Resident did not have any cash on them and the RR had their wallet. The RR stated a family member had left money with the facility to be added to their trust account for things the Resident might need, but the money was not given to the Resident. The grievance showed no follow up had been completed with Resident 3 regarding their missing money and had been reviewed as completed by Staff A, Administrator, on 02/03/2026. During a telephone interview on 03/20/2026 at 9:12 AM, Resident 3's RR stated the facility called them to ask them if they had Resident 3's wallet and money. The RR stated they told them they had the wallet and his money, but the facility did not relay to them why they were asking. The RR stated they just assumed they asked because it was no longer there. The RR stated they found out about the missing money when they visited and Resident 3 told the RR, and at that time had found out the Resident had another family member visit, and they had given the Resident two $20.00 bills. The RR stated they confirmed with the family member and did not think they needed to report that to the facility, since Resident 3 already had. During an interview on 03/20/2026 at 9:49 AM, Staff A, along with Staff B, Director of Nursing, and Staff C, Director of Clinical Operations, stated they did not do a follow-up with the resident because they thought the resident was okay with the outcome and because they were not the one who had completed the investigation. Staff A identified Staff D as the one who completed the interview. Staff B stated the RR was probably called, even though the Resident's cognition was fully intact, because with the resident's hospitalizations and stuff [other medical issues], there were times they were not fully cognitive. During an interview on 03/20/2026 at 11:08 AM, Staff D stated they called the RR because they had previously asked the facility not to leave money with the resident. Staff D stated there were a few times Resident 3 had returned from the hospital where they were not alert and oriented and did not know if this incident was one of those times even though the resident was cognitive at the time of the report and reported the RRs did not take or remove their money. Staff D stated the last time they were at the hospital was well over a month ago. Staff D stated they did not know if Resident 3 was alert or oriented when reporting the (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern. Staff D stated they did not follow up with Resident 3 upon completion of the grievance and were not sure if that was their responsibility. Staff D stated they were the Grievance Officer and were not aware of the missing $8.00 in silver. Review of Resident 3's admission dates, showed they last returned from a hospital stay on 12/22/2025. Review of the 12/28/2025 comprehensive assessment showed Resident 3's cognition was intact. During an interview on 03/23/2026 at 3:20 PM, Staff B along with Staff C, stated the process for missing money would be to start an investigation, make a report if needed, and follow up with the Resident. Staff C stated the report of missing money should have been elevated to an investigation into financial exploitation. Reference: WAC 388-97-0460 (1)(2)(3)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 protect a resident's right to be free from verbal abuse for 1 of 3 resident's (Resident 64) reviewed for abuse/neglect. This failure placed residents at risk of experiencing fear, intimidation and mental anguish.Findings included.Review of a policy titled, Abuse Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown source, and Misappropriation of Resident Property, revised 08/2025, showed verbal abuse/mental abuse included the use of oral, written, or gestured communication or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability that would demean or humiliate. Examples of verbal abuse included threatening residents, depriving a resident of care or withholding a resident from contact with family and friends. Review of the medical record showed Resident 64 was admitted on [DATE] with diagnoses including right foot/ankle osteomyelitis (a serious bone infection), multiple sclerosis (a disease that damages the communication between the brain and body, leading to muscle weakness, vision changes and memory issues), and anxiety. Review of a 03/11/2026 nursing admission progress notes showed Resident 62 was independent for activities of daily living and was able to make their needs known. During an interview on 03/17/2026 at 11:20 AM, Resident 64 stated during their admission to the facility they were approached by Staff K, Business Office Manager, and told after 21 days they would be required to apply for Medicaid and would owe 20% of the bill and if they would be holding any of their money at the facility. Resident 64 stated they needed more understanding and explanation of the financial responsibilities, and the interaction was confusing and off-putting (unpleasant, uncomfortable). Resident 64 stated the interaction with Staff K was overwhelming. Resident 64 stated Staff K had no finesse, empathy, or kindness, and should not have been aggressive, regarding their financials. During an interview on 03/19/2026 at 8:56 AM, Resident 64 stated they had another negative interaction with Staff K the day before on 03/18/2026. Resident 64 stated they when they were leaving the facility, Staff K approached them by their ear and stated they could only be gone four hours from the facility, because if the state looked at the sign out book, they would think they did not need to be at the facility. Resident 64 stated that interaction from Staff K scared them and they did not want to speak with Staff K again. Resident 64 stated they did not appreciate the interactions they had with Staff K. Resident 64 stated first they were going to be required to pay 20% and second, they were going to be kicked out of the facility for visiting with a friend. Resident 64 stated they felt they were targeted, by Staff K. During an interview on 03/19/2026 at 11:41 AM, Staff K stated they provided Resident 64 with an application for Medicaid. Staff K stated Resident 64 said if they did not get approved for Medicaid, they would not be able to pay for the facility. Staff K stated they told residents when Medicaid was approved, the residents would be able to keep a small amount of money after Medicaid paid for the facility. Staff K stated Resident 64 was on Social Security Disability for their income and told Resident 64 they would lose their Social Security Disability payments and only receive the remaining amount from Medicaid, $108.00. Staff K stated they did see Resident 64 leaving the facility a second time on the same day and they did tell them since they were at the facility on Medicare, they were only allowed four hours per day to leave the facility. Staff K stated they stated that to Resident 64 because Medicare would think the resident did not need to be at the facility. During an interview on 03/19/2026 at 4:08 PM, Staff A, Administrator, stated when they were informed of the allegations of verbal abuse, Staff A suspended Staff K to protect the resident pending an investigation. During an interview on 03/20/2026 at 5:00 PM, Staff B, Director of Nursing, stated the process when there was an allegation of abuse was to suspend the identified staff and continue investigating the allegations. Reference WAC: 388-97-0640(1)(3)(a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse/neglect prohibition policy for identification of verbal abuse for 1 of 1 resident (Resident 64) reviewed for abuse. This failure placed residents at risk of unidentified abuse/neglect, potential for continued exposure to abuse and psychological harm. Findings included. Review of the policy titled, Abuse Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown source, and Misappropriation of Resident Property, revised 08/2025, showed residents had the right to be free from abuse/neglect and staff were prohibited from using verbal abuse. The facility would provide immediate safety for a resident upon identification of potential abuse/neglect by staff and protect from retaliation. Resident 64 Review of the medical record showed Resident 64 was admitted on [DATE] with diagnoses including right foot/ankle osteomyelitis (a serious bone infection), multiple sclerosis (a disease that damages the communication between the brain and body, leading to muscle weakness, vision changes and memory issues), and anxiety. Review of a 03/11/2026 nursing admission progress note showed Resident 62 was independent for activities of daily living and was able to make their needs known. Review of the facility's investigation received on 03/24/2026, showed the facility identified opportunities for improvement for customer service, timeliness of reporting, and recognizing and responding to alleged abuse allegations. The facility would be educating the interdisciplinary department team [IDT) a group of healthcare professionals from different disciplines to help people receive the care they need] on the grievance process. Additionally, Staff A, Administrator, and Staff K, Business Office Manager, received disciplinary action. During an interview on 03/17/2026 at 11:20 AM, Resident 64 stated during communications with Staff K they felt the interactions were confusing, overwhelming and off-putting. Resident 64 stated Staff K lacked empathy and kindness and had been aggressive regarding their financial situation. During an interview on 03/19/2026 at 8:56 AM, Resident 64 stated they had another encounter with Staff K when they were leaving the facility with a friend when Staff K told them they were not allowed to leave the facility for more than four hours or they would lose their medical coverage. Resident 64 stated they felt scared and targeted and was concerned they would be kicked out of the facility. During an interview on 03/19/2026 at 9:29 AM, Staff Y, Licensed Practical Nurse, stated Resident 64 stated they felt that Staff K did not like them and they were offended and affected when Staff K told them they could not be gone from the facility for more than four hours. Staff Y apologized to Resident 64 on how they were made to feel. Staff Y stated they would be informing Staff A of Resident 64's concerns. During an interview on 03/19/2026 at 1:00 PM, Staff A stated they were informed by Staff Y that Resident 64 was upset about how Staff K spoke with them. Staff A stated they did not proceed to speak with Resident 64; they went and spoke with other management staff about what they heard about the four-hour Medicare requirement of being out of the facility. Staff A stated they spoke to Staff K, and they were told the conversation with Resident 64 was fine. During an interview on 03/18/2026 at 3:08 PM, Resident 64 stated Staff A came to see them around 1:30 PM and wanted to know what happened with Staff K. Resident 64 stated they told Staff A what was said by Staff K and the response they received was huh? and Staff A explained they had worked with Staff K for years and they did not mean what Resident 64 had heard. Resident 64 stated Staff A asked them, what do you want to happen? Resident 64 stated retraining, at the least. Resident 64 stated Staff A told them the rules had always been that residents could not leave the facility for more than four hours. Resident 64 stated they told Staff A they did not understand their concerns and their interactions with Staff K had been too much for them and that should be Staff A's concern. Resident 64 continued to state Staff K was abrupt and unkind and should be held accountable for their actions. Resident 64 stated they had two interactions with Staff K and made them feel they would be homeless and they were bullied and should not have to feel defensive. Resident 64 stated Staff A immediately took Staff K's side, despite Resident 64's allegations of (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	verbal abuse. During an interview on 03/19/2026 at 4:08 PM, Staff A stated they had spoken to Resident 64. Staff A stated Resident 64 stated Staff K was unprofessional and needed education and Resident 64 seemed fine. Staff A stated they provided customer service education to Staff K. Staff A stated they told Staff K that when they needed to have any further conversations with Resident 64, they were to take a second staff member with them. During a follow-up interview the same day at 4:35 PM, Staff A was informed by this surveyor that Resident 64 reported feeling targeted, bullied, and scared by Staff K. Staff A stated they were unaware of the allegations. Staff A stated they had known Staff K for a long time, and they were stunned as that was not how Staff K was. During an interview on 03/20/2026 at 11:25 AM, Staff Y stated Resident 64 stated they felt intimidated, talked down to, scared, and terrified by Staff K. Staff Y stated Resident 64 stated they felt Staff K was out to get them. Staff Y stated they informed Staff A of these allegations from Resident 64 on 03/19/2026. During an interview on 03/20/2026 at 4:52 PM, Staff A stated when they spoke to Resident 64, they stated that Staff K was rude. Staff A stated they told Resident 64 that it was not the intention of Staff K and they had worked with them for a long time. Staff A stated there had been a lot going on for the last few days and did not remember the exact conversation with Staff Y. Staff A stated they provided Resident 64 with a grievance form to report their concerns. Reference WAC: 388-97-0640(1)(3)(a) Refer to F600

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Parkside Care	308 West Emma Union Gap, WA 98903

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to develop a patient-centered discharge plan by the interdisciplinary team for 1 of 2 residents (Resident 37) reviewed for discharge planning. This failure placed residents at risk for unmet discharge care needs. Finding included. Resident 37 Review of the resident's medical records showed the resident admitted with diagnoses to include a surgical repair of their right ulna (long bone in the forearm that runs from the elbow to the wrist), had a history of falling, and dementia (a group of symptoms that cause a loss of cognitive functioning). The 01/29/2026 comprehensive admission assessment showed Resident 37's cognition was severely impaired and used a wheelchair (w/c) for mobility. The assessment showed the Resident required substantial to maximum staff assistance for all their activities of daily living. During a telephone interview on 03/17/2026 at 3:59 PM, Resident 37's Representative (RR) stated they were in the process of looking for another facility that would accept Resident 37. The RR stated they were continuously called by facility staff who was thought to be the Social Worker and told they had to find another facility that would accept Resident 37 due to their dementia and requiring one-on-one care, they don't offer that kind of care there. The RR stated they were offered a phone number for another facility and the number of a senior support service navigator but offered no other assistance in finding alternative placement for Resident 37. The RR stated Resident 37 liked to walk and the facility did not want to walk them very often and so Resident 37 had become very weak and started to fall. The RR stated the facility would consistently call them to come and sit with Resident 37 one-on-one, but they lived two and a half hours out of town and had a full-time job themselves and could not do that. The RR stated they had reached out by telephone and visited the recommended facility to see if they could take Resident 37, but they did not have any beds available for the Resident's pay status so they would have to pay privately. During the same interview, the RR stated they called the senior navigator contact number, but they charged and the RR stated they could not afford to do either of those things, so they were going to take Resident 37 home. The RR stated Resident 37 was only allotted 400 hours a month to have an in-house caregiver come in and that would leave night-time hours without a caregiver. The RR stated they relayed that information to the facility when they called them and informed them that they would have to take Resident 37 home against medical advice [AMA, a resident's decision to leave a healthcare facility or refuse treatment despite a physician's recommendation to continue care] because the resident required 24-hour care and the provider would not approve of that plan. The RR stated they had communicated to the facility that they had no placement or any other alternative so I am at a loss of what I am supposed to do and would have no other choice. The RR stated they felt like they would have to take Resident 37 home AMA because they did not feel Resident 37 was wanted at the facility any longer and were worried Resident 37 would not continue to receive the care they needed (the Social Worker was later identified as Staff Z, Unit Manager, and Staff D, Social Services Director). During a telephone interview on 03/18/2026 at 12:11 PM, the RR called the Surveyor to inform that Staff Z had just called the RR and told them they had four days to come and get my [Resident 37] because their time was up and after 03/21/2026 they would start charging them $475 a day because they had not completed the paperwork for Medicaid (a federal and state health care program that provides coverage to low-income individuals). The RR stated they informed Staff Z the Resident did have Medicaid and Staff Z told the RR We do not specialize in dementia patients so [Resident 37] cannot stay here. The RR stated they told Staff Z they did not know what they were going to be able to do with four days' notice and Staff Z told them they were actually giving them an extra two days' notice because they were only required to give them two days' notice. During an interview on 03/18/2026 at 2:38 PM, Staff D stated their process for discharge planning was to begin working on discharge planning within the first week of admission. Staff D stated the RR for Resident 37 has not done anything that was needed and we have (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called them multiple times. Staff D stated Staff Z and themselves, as a witness to the conversation, had called to inform the RR that Resident 37 required a higher level of care because we were not a one-on-one facility because they were falling. Staff D stated they had called several facilities and the Resident had been denied. When Staff D was asked for information on the facilities they had contacted, Staff D could not provide that information. Staff D stated the RR was given the contact information to a local facility and the RR did nothing with that information. Staff D stated they had also given the RR information for a senior navigator that could assist them. Staff D stated normal process would be to help the family or the resident if finding alternative placement was needed. Staff Z was asked to attend the interview, Staff Z stated they had offered the RR the contact information about another facility and someone who could help them and the RR stated they would call the facility. Staff Z stated the RR wanted to take the resident home, but they would not have a caregiver for at night so they were told they would have to take the Resident home AMA because Resident 37 required 24-hour care. Staff Z stated the resident could not continue to stay in the facility beyond 03/21/2026 unless they paid the daily rate ($475 a day) because the Resident's Medicare (a federal health insurance program that provides coverage for people aged 65 and older) benefits ended on 03/21/2026 and the RR had not done anything to complete the Medicaid application. Staff Z stated they did not know if Resident 37 already had Medicaid prior to admission. During an interview on 03/18/2026 at 3:01 PM, Staff K, Business Office Manager, stated they discussed discharges weekly in their Interdisciplinary Team (IDT) meetings. Staff K stated they checked all residents' Medicaid status upon admission so they would know if they needed to start the Medicaid application process sooner than later. Staff K stated they checked Resident 37 and they already had Medicaid with long term coverage prior to admission so there was nothing else needed. Staff K stated at the 03/17/2026 IDT meeting there was nothing mentioned about Resident 37 discharging or that they needed to complete a Medicaid application, or they would have informed them of their existing coverage. Staff K looked at their notes from the meeting and the notes showed Resident 37's last covered Medicare day was 03/21/026 and would transition right over to Medicaid on 03/22/2026. Staff K stated the Unit Managers would not always make it to the weekly meeting so probably had no idea what Resident 37's coverage was. During an interview on 03/18/2026 at 3:56 PM, Staff B, Director of Nursing Services, stated they were unaware of the discharge plan for Resident 37 until recently. Staff B stated the facility accepted dementia patients and they knew on admission Resident 37 had dementia, a history of falling, and left their home in the middle of the night to later be found outside after a fall but then continued to accept the Resident. Staff B stated Resident 37 was going to reside in the facility until the family found caregivers or until they decided if they wanted to leave the Resident long term in the facility. Staff B stated Staff Z was newer in the position and there was confusion with the Residents medical coverage. Staff B stated there needed to be better communication between the Business Office and the Unit Managers, so everyone knew what coverage the resident had or needed. Staff B stated Resident 37 had an uptake in falls during a urine infection and required one-on-one care and thought a higher level of care was needed. Reference: WAC 388-97-0120 (1)(b-f),(2)(a-e),(3)(a-b)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility) for 1 of 3 residents (Resident 6), or provide a written notice of a hospital transfer or discharge to the Office of the State Long-Term Care Ombudsman (a representative who helps residents in long-term care facilities, such as nursing homes and assisted living, understand and exercise their rights) for 2 of 3 residents (Residents 6 and 62) reviewed for hospitalization and discharge. This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed and any monetary charges associated with the bed hold and lack of discharge needs. Findings included. Review of a 04/2025 policy titled Bed-Hold showed the facility was required to provide a written notice of their bed-hold rights and the policy would be given to the Resident or the Resident's Representative (RR) upon transferring to the hospital or for a therapeutic leave. Review of a 04/2025 policy titled Notice of Transfer showed the written notice of transfer or discharge would be given to the RR or the Resident before or at the time of discharge. the policy showed the facility would send a copy of the notice of discharge/transfer to the LTC Ombudsman. Hospitalization Resident 6Review of the resident's medical records showed they admitted with diagnoses to include Multiple Sclerosis (MS, a chronic disease where the immune system mistakenly attacks the protective covering of nerve fibers in the brain and spinal cord, leading to communication problems between the brain and the rest of the body) and diabetes (the sugar in the blood is too high). The 12/08/2025 comprehensive assessment showed Resident 6's cognition was intact and was dependent on staff for their activities of daily living. Review of Resident 6's 03/11/2026 discharge hospital records showed Resident 6 was admitted for treatment of a urine infection on 03/07/2026 through 03/11/2026. Additional review of Resident 6's medical records showed the facility did not issue a written bed hold policy or a hospital transfer/discharge notice to Resident 6 nor did they notify the LTC Ombudsman of the discharge. Discharge Resident 62Review of the resident's medical records showed they admitted with diagnoses to include respiratory and heart failure. The 02/27/2026 comprehensive assessment showed Resident 62's cognition was intact. Review of Resident 62's progress notes, showed on 02/27/2026 at 3:34 PM Resident 62 discharged to home Against Medical Advice (AMA, a resident's decision to leave a healthcare facility or refuse treatment despite a physician's recommendation to continue care). The note showed education was provided to the resident regarding the need to stay and receive the care they needed. The note showed the Resident continued to want to discharge and signed the appropriate paperwork. Review of Resident 62's discharge documents showed no notification of discharge had been sent to the LTC Ombudsman. During an interview on 03/23/2027 at 2:27 PM, Staff C, Director of Clinical Operations, stated they had rechecked Resident 6 and 62's records and were unable to find that a bed hold had been completed or an appropriate transfer/discharge notification had been completed for Resident 6 and notification to the LTC Ombudsman had not been done for Resident 6 or Resident 62, and they should have. Reference: WAC 388-97-0120 (4)(5)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Preadmission Screening and Resident Review (PASRR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or Related Conditions [RC] are not inappropriately placed in nursing homes for long-term care) Level I form was completed after a 30-day exempt hospital discharge (EHD-an expected stay to be less than 30 days at a nursing home) for 2 of 5 residents (Residents 1 and 10) reviewed for PASRR. This failure placed residents at risk for inappropriate nursing home placement, and/or not receiving necessary services for mental health needs.Findings included. Review of policy titled, PASRR Requirements, dated 04/2023, showed the facility would review all PASRR's for accuracy and would immediately complete a new PASRR Level I form and notify the PASRR evaluators. Additionally, when a resident was admitted on an EHD, the facility would notify the PASRR evaluators prior to exceeding the 30 days. Resident 1 Review of the medical record showed Resident 1 was admitted on [DATE] with diagnoses including schizophrenia (severe mental disorder that affects how a person thinks, feels and behaves), malnutrition, and heart failure. The 02/25/2026 comprehensive assessment showed Resident 1 required substantial/set-up assistance with activities of daily living (ADLs) and was cognitively intact. Review of Resident 1's PASRR assessment dated [DATE], showed they were admitted with a 30-day EHD. Further review of the assessment showed a Level II PASRR form must be completed when a scheduled discharge does not occur. Resident 10 Review of the medical record showed Resident 10 was admitted on [DATE] with diagnoses including Alzheimer's (a progressive brain disorder that destroys memory and thinking skills), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity level, and concentration), major depressive disorder (MDD -a mood disorder of persistent feelings of sadness, loss of interest, changes in sleep affecting how a person feels, thinks and behaves) and anxiety. The 01/29/2026 comprehensive assessment showed Resident 10 required substantial/set-up assistance of one to two staff for ADLs and had severe impaired cognition. Review of Resident 10's PASRR assessment dated [DATE], showed they were admitted with a 30-day EHD. Further review of Resident 10 record showed no updated PASRR. During an interview on 03/20/2026, Staff D, Social Services Director, stated they were unsure of the requirements for 30-EHD PASRR's. Staff D stated they recently found Resident 10's PASRR when reviewing Resident 10's chart, as Resident 10 had behaviors and completed a new PASRR. Staff D stated they did not review the PASRR's in a timely manner as they were unsure of what the 30-EHD meant. During a concurrent interview on 03/23/2026 at 3:26 PM, Staff B, Director of Nursing, stated the process for PASRR was when a resident was to be admitted to the facility, corporate central admissions obtained the residents records, including a PASRR and placed them in the resident's charts. Staff B stated when a resident was admitted for a 30-day EHD, the facility was to submit a new PASRR for review prior to the end of the 30 days when they were not expected to be discharged . Staff C, Director of Clinical Operations, stated they needed to identify the reason PASRR's were incorrect and training would be provided for facility staff. Reference WAC: 388-97-1975(1)(2)(5)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the nature/terms of entering into a binding arbitration agreement (an alternative means of settling disputes without a jury by trial) were explained to residents in a form and manner in which they could understand for 1 of 4 residents (Resident 64) reviewed for arbitration. This failure placed the residents at risk for a lack of understanding concerning the legal contract that had been signed/entered into and being fully informed regarding the resident's choice in the event of a dispute with the facility.Findings included.Review of the medical record showed they were admitted to the facility on [DATE] with diagnosis including a right foot/ankle bone infection, Multiple Sclerosis (MS, a chronic disease where an individual's own immune system attacks the protective covering of the brain and spinal cord nerve fibers which can lead to communication issues between the brain and the rest of the body). The 03/11/2026 admission assessment showed the resident was cognitively intact and able to make their needs known. Record review of Resident 64's arbitration agreement showed they had electronically signed the legal contract themselves on 03/13/2026 at 11:45 AM. Staff K, Business Office Manager (BOM), signed the arbitration agreement on 03/13/2026 at 11:24 AM, as a witness (prior to Resident 64 signature).During an interview on 03/18/2026 at 1:58 PM, Staff K stated the facility's process was to review/explain the facility arbitration agreement with residents and/or the residents' representatives (RR) on admission to the facility and the document was part of the admission packet paperwork. Staff K stated they usually reviewed a specific situation that would involve a loss of money or something of value to explain what arbitration was to resident and/or the RR. Staff K stated they would explain the arbitration document in their office or electronically over the phone and send the admission packet documents via email. Staff K stated they explained to the residents/RR that the binding arbitration agreement was voluntary, did not have to sign the document to be admitted and had 30-days to revoke the agreement if the resident/RR changed their mind. During an interview on 03/19/2025 at 9:20 AM, Resident 64, stated they did not know what arbitration was nor that they had signed the binding arbitration agreement with the facility, I don't know what that is and I just signed things. The resident stated that Staff K did not go over the arbitration agreement within the admission paperwork, did not explain that the arbitration agreement was voluntary, that they did not have to sign the arbitration agreement nor that the resident had 30-day to revoke their signature on the agreement. The resident stated that Staff K had emailed all the admission paperwork documents and that it was really hard to read on my cellphone screen, and that admitting into the facility was very overwhelming at the beginning. Resident 64 stated they had signed all the documents because they thought that was what was required to show they had received the documents and to be admitted . Additionally, Resident stated that after understanding what arbitration was and that it was signed in agreement, they would want to revoke the binding arbitration agreement.During an interview on 03/19/2026 at 1:33 PM, Staff K stated they had emailed the arbitration form with all the admission paperwork to Resident 64 and offered to go over the paperwork if the resident had questions. Saff K stated that Resident 64 did not have questions. Staff K stated they used to have an electronic iPad/tablet with a bigger screen to show/review admission documents with residents but had not been using them recently. Staff K stated they could understand how it would have been hard for Resident 64 to read all the admission paperwork on a small phone screen. Staff K stated they did not offer another format to explain or review the documents, including arbitration for Resident 64, nor did the staff member personally go over the arbitration document or assess if the resident understood what arbitration was.During an interview on 03/20/2026 at 5:10 PM, Staff B, Director of Nursing, and Staff C, Director of Clinical Operations, stated that staff were to go over/explain arbitration agreement page by page with resident in a form and manner the resident can understand. Staff C stated that emailing the (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	arbitration agreement with the admission paperwork for a resident to review on a small cellphone screen would not be explaining the documents in a manner they could understand. Both staff stated the correct process was not being followed regarding the facility's arbitration agreements.Reference: WAC 388-97-1620(2)(b)(i)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a Compliance and Ethics Program. Based on interview and record review, the facility failed to implement, maintain, and enforce an effective compliance/ethics program that utilized monitoring/auditing systems designed to be effective in preventing/detecting criminal, civil, and administrative violations of the Social Security Act S 1819 (Title 42 United States Code 1395i-3, a set of laws that identifies the requirements for and assuring the quality of care in skilled nursing facilities) to promote residents quality of care for 2 of 2 staff (Staff A and Staff W) reviewed for compliance and ethics. This failure placed residents at an increased risk of negative outcomes related to care and services provided by the facility.Findings included .Review of the facility's policy titled, Abuse Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, revised August 2025, showed residents had the right to be free from abuse/neglect, and facility staff were prohibited from using verbal/mental abuse. Verbal/mental abuse included threatening a resident, depriving a resident of care or humiliation. The policy showed that facility staff would provide immediate safety/protection for a resident upon identification of potential or alleged abuse/neglect. Additionally, the policy showed all potential employees would have a criminal background check completed, during the hiring process, to screen for potential history of abuse, neglect, or mistreatment of residents. Review of the facility's policy titled, General Compliance, revised date 09/2024, showed the policy was to provided clear direction to facility staff for compliance procedures in accordance with relevant laws/regulations and reference the facility's employee handbook. The policy showed a criminal background check for all employees was conducted when an offer of employment had been extended and the employment of the potential staff member was conditional upon a successful completion of a background check/verification of credentials. Review of the facility's policy titled, Compliance Reporting, showed the facility staff were to report activity or conduct suspected of not being consistent with the compliance program and federal, state or local laws/regulations. Additionally, the policy showed the report could be made via telephone or the staff member might seek advice from their supervisor, Chief Nursing Officer, Compliance officer to determine if something should be reported. Review of a Staff M's, Dietary Manager, personnel records showed they were hired on 02/18/2026 and a background inquiry (BGI, a criminal history review which screens individuals for a potential account of abuse, neglect, or mistreatment that would disqualify them from working with vulnerable adults) document was submitted by the facility for review on 02/17/2026, but was not completed. During an interview on 03/20/2026 at 11:15 AM, Staff M stated their BGI was still in process and not resulted yet. Staff M stated the Administrator was aware and approved them to work without a background check completion. Staff M stated they had been working since they were hired.During an interview on 03/20/2026 at 3:33 PM, Staff A, Administrator, stated that Staff M did not have a current background check completed and was currently working in the facility. Staff A stated they hired Staff M on 02/18/2026 and on 03/20/2026 Staff M's BGI was still pending. Staff A stated that a previous background check was completed, during the previous employment of the staff member, but could not remember the date or how long Staff M had worked for the facility before leaving employment back in 2024. During an interview on 03/20/2026 at 3:49 PM, Staff W, Human Resources Director, stated that a background check had been completed on 02/06/2024 when Staff M was first employed, to which the staff member may have worked one to three weeks, but Staff W did not know for sure. Staff W stated the current BGI for Staff M had not come back yet and was still pending. Staff W stated the normal process was to have a background check completed before a new staff member was hired and if the BGI was still pending that staff would not be allowed to work on the floor with unsupervised access to the vulnerable residents. Staff W stated that Staff M had been working on the floor with vulnerable residents, unsupervised, since the staff member started working on 02/18/2026, this is not the normal process. Staff W stated Staff A made the decision to let Staff M work with the vulnerable residents without (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completing their background check. Staff W stated they had questioned the process and asked Staff A if they wanted Staff M to be supervised while working in the facility with vulnerable residents, but Staff A did not think it was needed. Staff W stated they did have a compliance and ethics hotline number they could call, that was not on my radar. Additionally, Staff W stated another potential hire was also pending a background check and had not been hired or worked in the facility. During an interview on 03/20/2026 at 4:18 PM, Staff A stated they did not feel it was necessary to have another staff member supervise the Dietary Manager when working with vulnerable residents. Staff A stated they personally knew Staff M, I trust (Staff M), and (Staff M) is a good person, so Staff A did not attempt to implement an intervention, such as supervision of the staff member when with residents, even though Staff M had not completed a background check. Staff A stated, the facility's process for abuse screening was not being followed, but I am confident the background will come back with the same thing (regarding Staff M background check). Staff A stated the decision not to have a completed background check for Staff M was not unethical.During an interview on 03/20/2026 at 5:01 PM, Staff B, Director of Nursing, and Staff C, Director of Clinical Operations, stated that new potential staff were not even brought in to go over onboarding information and should not be working with vulnerable resident until a background check was completed, which was in line with the facility's policy. Neither Staff B nor Staff C were aware of Staff M being approved by the administrator to work unsupervised with the staff members BGI in process and not completed yet. Staff C stated Staff A should not have approved Staff M to work without a validated background check completion, that is not ethical and not the correct process. Reference: WAC 388-97-1620(2)(b)(ii), -1800(1)(2)(a)Cross Reference: F607

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview the facility failed to provide a safe, functional and sanitary (relating to the conditions that affect hygiene and health) Laundry room environment for 1 of 2 washing machines (WM1) and 1 of 1 drainage system (DS1), reviewed for environmental conditions. This failure placed residents and staff at an increased risk of cross-contamination (the harmful spread of diseases).Findings included.Observations of the Laundry room on 03/18/2026 at 5:11 PM showed: The facility had two washing machines and WM1 had a one foot (ft, a unit of measure) by one ft puddle of water underneath the back end of WM1, on the concrete floor, which was in the process of drying. The water was coming from a pipe supplying water to WM1 and was slowly dripping down the back left side of WM1's metal plate, which was wet to the touch. The water had been dripping down to the bottom of the washing machine and then to the ground. The ground beneath the washing machine had a white soap-like substance that had formed a white dried up two ft by three ft ring, which extended underneath WM1's left side. Both sides of the bottom of WM1 had three big metal nuts/bolts securing a metal plate that was attached to the machine to the concrete floor on. The nuts/bolts on the right side were clean, noted shiny silver metal, and had no signs of rust on the bolts or the black plate securing WM1 to the floor. The nuts/bolts and black metal plate on the left side of WM1 were caked and covered in a white dried soap-like substance and a dark reddish brown rust color was noted underneath. The white caked soap substance extended out from the left side of the WM1 and connected to the dried-up soap like substance ring from the back of the machine. The laundry room had a concrete one and a half ft wide commercial grade deep channel drainage trough (a heavy duty system used to drain large amounts of soiled waste water from machines like washing machines) with stagnate water (liquid that is not flowing or circulating for extended periods of time and often found in places like ponds, puddles, clogged drains and water tanks). The stagnant water had a thick layer of grayish sludge floating on top, three to five inches (a unit of measure) from being full and a strong foul odor was noted. During an interview on 03/18/2026 at 5:25 PM, Staff BB, Laundry Director, in the laundry room with the surveyor, stated they were not sure how long WM1 had been leaking and noted the white substance that was caked onto the bottom left side of WM1, that is soap and it shouldn't be there. Staff BB observed touching the back of WM1, their hand was visibly wet after touching the back of the machine. Staff BB stated the leak was coming from a hose that was supplying WM1 with water and they were not sure how long the machine had been leaking. Staff BB stated the caked-up soap around the rusted blots and previous puddle that was drying up should have been cleaned and was not. Staff BB stated the leak, it needs to be fixed.During a concurrent interview and observations on 03/19/2026 at 7:33 AM, Staff CC, Laundry Aide, stated that WM1 had a lot of build-up of the white soap-like substance on the bolts/ground around the base of WM1 and that the machine had been leaking for over a week. Surveyor observed the deep channel drainage trough water as the same level with the same thick layer of grayish sludge floating on top. Staff CC stated, I have never seen it empty all the way, and I have been here eight years.During an interview on 03/19/2026 at 7:45 AM, in the laundry room, Staff DD, Maintenance Director, stated they were not aware of WM1 leaking. Staff DD stated the leak needed to be fixed and the residue (a small amount of something that remains after the main part has been taken away or used) of the soap/water leak from WM1 needed to be cleaned. Staff DD observed the deep channel drainage trough system and stated that it was not sanitary with the water not fully draining and that it was not working properly.Reference: WAC 388-97-3220(1)