STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505413	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Vista Post-Acute & Rehab Center	625 Okanogan Ave Wenatchee, WA 98801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review [(PASARR)-an assessment used to identify people referred to nursing facilities with serious mental illness (SMI), intellectual disabilities (ID), and related conditions were not inappropriately placed in nursing homes for long-term care] had the required Level II referral sent when residents had a positive Level 1 PASARR and were an exempted hospital discharge (a process that allowed residents admission to a nursing facility from a hospital without undergoing the PASSAR screening when certain criteria were met) in the facility for more than 30 days for 4 of 7 residents (Resident 35, 64, 44 and 8) reviewed for PASARR. Additionally, the mental health diagnoses were not accurately documented on the PASARR Level I. These failures placed the residents at risk for inappropriate placement and not receiving timely and necessary services to meet mental health care needs. Findings included. Resident 35 Review of the medical record showed Resident 35 was admitted to the facility on [DATE] with diagnoses including a left leg fracture and anxiety. The 06/27/2025 comprehensive assessment showed Resident 35 had an intact cognition. Review of Resident 35's PASARR dated 06/20/2025, showed Resident 35 had a SMI for anxiety disorders and was an exempted hospital discharge. The PASSAR further showed a Level II must be completed if the scheduled discharge did not occur. Record review showed no PASARR Level II evaluation for Resident 35. ˆResident 64 Review of the medical record showed Resident 64 was admitted to the facility on [DATE] with diagnoses including 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), Post-Traumatic Stress Disorder [(PTSD) a mental health condition that's caused by an extremely stressful or terrifying event], and anxiety. The 07/24/2025 comprehensive assessment showed Resident 64 had an intact cognition. Review of Resident 64's PASARR dated 07/18/2025, showed Resident 64 had a diagnosis of anxiety disorders and depression and was an exempted hospital discharge. The PASSAR further showed a Level II must be completed if the scheduled discharge did not occur. (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record showed no PASARR Level II evaluation completed for Resident 64. Resident 44 Review of Resident 44's medical record showed they were admitted to the facility on [DATE] with diagnoses which included a right femur (hip) fracture, dementia (a decline in cognitive ability) and depression (a mood disorder which causes sadness). The comprehensive assessment dated [DATE], showed the resident was severely cognitively impaired.^ Review of Resident 44's PASARR Level I, showed the assessment was completed by hospital staff on 07/14/2025 prior to admission to the facility. The assessment indicated the resident had an anxiety disorder, however, did not accurately reflect the resident's diagnosis of depression. Additionally, the PASSAR showed the resident was exempt from further screening as it was expected they would be discharged from the facility in 30 days or less. It was noted as of 08/22/2025 that the resident was already five days past the 30-day exempted stay and required a Level II screening. Record review showed no PASARR Level II evaluation for Resident 44. Resident 8 Review of the medical record showed Resident 8 was admitted to the facility on [DATE] with diagnoses including cardiac disease and PTSD. The comprehensive assessment dated [DATE], showed Resident 8 was cognitively intact. Review of Resident 8's PASARR Level I dated 05/28/2025, showed they had no mental health diagnoses and a Level II PASARR was not indicated. A second PASARR Level I was completed on 06/23/2025 by facility staff stating the 05/28/2025 completed PASARR Level I was incorrect and was updated to reflect the diagnoses of a depressive mood disorder and PTSD, though the PASARR still stated that no Level II evaluation was indicated for this resident. Record review showed no PASARR Level II evaluation for Resident 8. During an interview on 08/22/2025 at 10:33 AM, Staff D, Social Services Director, stated residents admitted to the facility had their PASARR's reviewed for accuracy of mental health diagnoses and 30-day hospital exempted discharges upon admission to ensure accuracy and if additional assessments such as a PASARR Level II was required for residents. Staff D stated the process was not followed. Reference WAC 388-97-1915(1)(2)(-c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of meaningful activities for 6 of 6 residents (Resident 74, 14, 66, 57, 15, and 69) reviewed for activities. This failure placed the residents at risk for dissatisfaction with their activity choices, poor psychosocial well-being, and boredom. Findings included. Resident 74 Review of the medial record showed Resident 74 admitted to the facility on [DATE] with diagnoses including poliomyelitis (an infection that affects nerves, brain and spinal cord and can result in loss of muscle functions), diabetes (a disease that results in excess sugar in the blood), and obesity. The comprehensive assessment dated [DATE], showed Resident 74 required total assistance of one to two staff members with activities of daily living (ADLs) and was cognitively intact. Resident 14 Review of the medical record showed Resident 14 admitted to the facility on [DATE] with diagnoses including diabetes and kidney disease. The comprehensive assessment dated [DATE], showed Resident 14 required extensive assistance of one to two staff members with ADLs and was cognitively intact. Resident 66 Review of the medical record showed Resident 66 admitted to the facility on [DATE] with diagnoses including a stroke (a medical emergency that occurs when blood flow the brain is disrupted and deprives the brain of oxygen, leading to brain damage, disability or death) and diabetes. The comprehensive assessment dated [DATE], showed Resident 66 required total assistance of one to two staff members with ADLs and was cognitively intact. Resident 57 Review of the medical record showed Resident 57 admitted to the facility on [DATE] with diagnoses including kidney disease and heart disease. The comprehensive assessment dated [DATE], showed Resident 57 required extensive assistance of one to two staff members with ADLs and was cognitively intact. Resident 15 Review of the medical record showed Resident 15 admitted to the facility on [DATE] with diagnoses including cerebral palsy (a brain disorder that affects body and muscle coordination and movements) and kidney disease. The comprehensive assessment dated [DATE] showed Resident 15 required extensive assistance of one to two staff members with ADLs and was cognitively intact. Resident 69 Review of the medical record showed Resident 69 admitted to the facility on [DATE] with diagnoses including heart disease and kidney disease. The comprehensive assessment dated [DATE] showed Resident 69 required extensive assistance of one staff member for ADLs and was cognitively intact. During a Resident Council meeting (a group of residents that meet regularly to improve the quality of life and care in the nursing home) on 08/20/2025 at 10:10 AM, Resident 74 stated they were not happy with the activities that were provided by the facility anymore. Resident 74 stated in the past year since they have had a new Activities Director, they had not gone outside of the facility on any outings. They stated they used to get on the facility bus and go shopping or just out for drives but all that had stopped. Resident 74 stated they had brought it up before in Resident Council meetings, but were told they did not have anyone in the facility that could drive the bus anymore or that there was not enough help to take them out of the facility, so basically we are stuck in here unless we have family who can provide the appropriate transportation and assistance. During the same Resident Council meeting at 10:15 AM, Resident 14 stated they missed going on facility outings and when they complained about it, they had been told that there were not enough staff or volunteers to safely take them out anywhere. Resident 14 stated they did not understand that since the other Activities Director took a few different residents on outings at least once a week. This ensured everyone had a chance to go out once a month, even if they could not accommodate a large group. During the same meeting at 10:18 AM, Resident 69 stated the group used to go on outings called a Tour of Washington that were drives to interesting places, mostly within an hour of the facility. Resident 69 stated residents did not get off of the bus once they were loaded, as they did not require much care. Resident 69 stated not being able to go out and visit the world outside of the facility was depressing. During the same Resident Council meeting at 10:22 AM, Resident 15 stated (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they had a different problem about not going out of the facility on outings. Resident 15 stated they had been told their wheelchair was too large to fit in the facility bus. Resident 15 stated they used to be able to take the community bus and meet up with other residents for shopping or a meal, but that option had not been offered to them in over a year. Resident 15 stated they were told the facility bus was broken and that was why they were unable to go out of the facility unless they took the community bus. During the same meeting at 10:26 AM, Resident 57 stated they were also unhappy with the limited activities in the building and not being able to go out of the facility. Resident 57 stated they especially missed being able to go to the local apple festival and the annual [NAME]. They stated it used to be a big deal, and the residents would look forward to it and the staff would help take the residents to these events since they were close to the facility. During the same meeting at 10:30 AM, Resident 66 stated they agreed with all the other residents attending the meeting and would like to see more interesting activities both in and outside of the facility as they were frequently bored. During an interview on 08/20/2025 at 3:26 PM, Staff P, Activities Director, stated the residents had shared in past Resident Council meetings that they would like to go on facility outings again, but they had limited ability to do so since most of the residents were in wheelchairs, and it was difficult to load and unload them by themselves. Staff P stated the facility bus had been broken but was now fixed and they mainly used the facility van for appointments only. During an interview on 08/21/2025 at 9:15 AM with Staff A, Administrator and Staff K, Regional Nurse, stated they were aware the residents were requesting outside of facility outings and were working on arranging more outings with the activities department now that their bus was repaired. Reference WAC: 388-97-0940(1)(2)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure care and services were provided in a respectful and dignified manner for 2 of 5 residents (Resident 6 and 15) reviewed for dignity. This failure placed residents at risk for being treated with a lack of dignity, respect and embarrassment. Findings included . Review of the policy titled Activities of Daily Living dated 03/2021, showed residents would be provided with care, treatment, and services to ensure their ADLs were maintained and did not diminish. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently in accordance with the care plan including appropriate support with assistance with elimination (toileting), hygiene (dressing) and eating. Resident 6Review of the medical record showed the resident admitted to the facility with diagnoses including stroke (when blood stops flowing to part of your brain) and Alzheimer's Disease (a progressive brain disorder where brain cells are damaged and die, leading to a gradual decline in memory, thinking, and the ability to perform daily tasks). The 04/10/2025 comprehensive assessment showed Resident 6's cognition was severely impaired and required the assistance of two staff for ADLs including toileting hygiene and lower body dressing. During multiple observations from the hallway on 08/19/2025 at 3:18 PM, Resident 6 was visible from the hallway unclothed from the waist down lying in bed without an incontinent brief in place, there was a urine-soaked incontinent brief on the floor to the right of the bed. The resident's bottom and bed linens were soiled with bowel movement (BM), and urine saturated the bedding. A strong odor of BM was noted radiating into the hallway. At 3:27 PM, the resident was unclothed from the waist down, with BM on their bottom and linens. Four different staff members walked past the resident's doorway without providing assistance. At 3:31 PM, Staff J, Nursing assistant, NA, looked into the resident's room, observed the resident partially unclothed, and continued down the hallway without providing assistance to Resident 6. At 3:48 PM, the resident remained lying on their back, soiled with BM, attempting to pull their shirt down to cover themselves. At 3:54 PM, the resident continued to lie on the soiled mattress without a call light in use. The BM remained dried on the resident's bottom and linens. During an interview on 08/19/2025 at 3:55 PM, Staff J, stated they observed Resident 6 exposed when they looked into the resident's room. Staff J stated they did not notice the brief on the floor or the BM on both the resident and linen. Staff J stated they did not enter the room or provide the care that was needed at that time. Staff J stated they were told by other NAs to wait until it was the scheduled time to do cares on Resident 6 because he was restless. Staff J further stated they should have entered the room immediately to provide the necessary care. During an interview on 08/21/2025 at 4:02 PM, Staff A, Administrator, stated they would expect a NA to provide care immediately upon observing a resident who was exposed, and the correct process was not followed for Resident 6. Resident 15 Review of Resident 15's medical record showed the resident was admitted with diagnoses which (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included cerebral palsy (a disease due to abnormal brain development which effects movement and muscle tone), depression (a mood disorder which causes sadness) and dysphagia (difficulty swallowing). Review of the comprehensive assessment dated [DATE] showed Resident 15 was cognitively intact and was able to independently feed themselves after their meal was set up by staff. During an observation on 08/18/2025 at 11:55 AM, Resident 15 was sitting at a table in the dining room with another resident who had been served their meal and was eating. At 12:21 PM, Resident 15 stated to the Surveyor Can someone please go and find my lunch I am hungry. Resident 15 further stated This happens quite a bit. During a continued observation on 08/18/2025 at 12:25 PM, the resident sitting with Resident 15 stated to dietary staff She doesn't have a tray, and I am almost done. At 12:30 PM, Resident 15 received their tray, 30 minutes after the other resident had been served their meal and were done eating. During an additional observation on 08/20/2025 at 12:07 PM, Resident 15 was waiting for their meal after the other resident had been served and was eating. At 12:17 PM, Resident 15 was served their meal (10 minutes after the other resident). During an interview on 08/20/2025 at 12:20 PM, Staff L, NA, stated Resident 15's tray was usually sent out on the hall cart and placed in the resident's room instead of the dining room, which was why their meal was late every day. During an interview on 08/21/2025 at 10:31 AM, Staff K, Regional Nurse, stated it was an expectation that residents were served their meals at the same time to ensure their dignity was maintained. REFERENCE: WAC 388-97-0180(1-4).

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents were evaluated and assessed for safe administration of medications for 2 of 3 residents (Residents 35 and 79), reviewed for self-medication administration. The failure to complete a self-administration of medication assessment placed the residents at risk for medication errors, adverse medication interactions, and complications. Findings included. Review of the policy titled, Self-Administration of Medications, revised 02/2021, showed residents had the right to self-administer medications when the interdisciplinary team [(IDT) a group of healthcare professionals from different disciplines to help people receive the care they need] determined it was safe and appropriate through an evaluation and assessment of the residents cognitive and physical abilities. The policy showed when a resident was identified as appropriate and safe to self-administer medications, it would be documented in the resident's medical record and care plan. Resident 35Review of the medical record showed Resident 35 was admitted with diagnoses including a left leg fracture, multiple sclerosis (a disease that damages the communication between the brain and body, leading to muscle weakness, vision changes and memory issues) and fibromyalgia (a long-term health disorder of widespread body pain, tenderness, and fatigue). The 06/27/2025 comprehensive assessment showed Resident 35 required one to two staff members for activities of daily living (ADLs) and had an intact cognition. Review of Resident 35's medical record showed the resident had not been evaluated by the IDT for self-administration of medications or documented on their care plan.An observation on 08/18/2025 at 3:07 PM, Staff G, Licensed Practical Nurse, LPN, brought a medicine cup with three unknown medications, two white pills and one yellow capsule, into Resident 35's room and placed them onto the bedside table and exited the room. Staff G did not identify the medications or ensure Resident 35 took the medications. During an interview on 08/20/2025 at 9:41 AM, Staff G stated there were no residents that were allowed to have any medications in their rooms. Staff G stated Resident 35 was care planned to take their potassium and Lasix [(diuretic) increase production of urine] after their physical therapy. Staff G stated they did not need to observe residents taking their medications. Staff G further stated Resident 79 was permitted to have a pain relieving cream in their room as they were able to administer to themselves. During an interview on 08/20/2025 at 10:38 AM, Staff F, Resident Care Manager, RCM, stated there were no residents on the South Hall, where Resident's 35 and 79 resided, that were approved to self-administer their medications. Staff F further stated nurses were not allowed to leave any medications at the resident's bedside.During a concurrent observation and interview on 08/21/2025 at 2:22 PM, Resident 35 lying in their bed, with two white medications (a potassium tablet and a diuretic) in a medication cup and a box of topical pain relief cream on their bedside table. Resident 35 stated the medications were provided to them during the morning medication pass, and they held them all day and took them after their therapy in the afternoon and the pain relief cream was brought in by their family and the nurses were aware of this. Resident 79Review of the medical record showed Resident 79 was admitted with diagnoses including endocarditis (a serious infection of the heart lining), high blood pressure and diabetes (a chronic disease that results in too much sugar in the blood). The 07/24/2025 comprehensive assessment showed Resident 79 required substantial/set-up assistance of one to two staff for ADLs and had an intact cognition. Review of Resident 79's medical record showed the resident had not been evaluated by the IDT for self-administration of medications or documented on their care plan.During a concurrent observation and interview on 08/21/2025 at 3:33 PM, Resident 79 was sitting in a wheelchair in their room with a family member. On their bedside table were two types of pain relief creams, eyedrops, a topical cough suppressant and sleep supplement. Resident 79 stated their family had brought all these medications and supplements from home and they took them when they wanted. During an interview on 08/21/2025 at 2:41 PM, Staff B, Director of Nursing, stated the process for residents to administer their own medications was, the residents needed to be evaluated by the IDT to ensure the residents (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were cognitive, able to identify the medications, and use appropriately and have a physician's order. Staff B stated unless a resident had this process in place, nurses were to observe the residents taking their medications and not leave at the bedside. Reference WAC 388-97-0440

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were able to use personal possessions in their room, specifically a personal refrigerator, for 2 of 2 residents (Residents 74 and 69) reviewed for resident rights. This failed practice placed the residents at risk of feeling like their rights had been taken away and emotional distress. Findings included . Resident 74Review of the medial record showed Resident 74 admitted to the facility on [DATE] with diagnoses including poliomyelitis (an infection that affects nerves, brain and spinal cord and can result in loss of muscle functions), diabetes (a disease that results in excess sugar in the blood), and obesity. The comprehensive assessment dated [DATE], showed Resident 74 required total assistance of one to two staff members with activities of daily living (ADLs) and was cognitively intact.Resident 69Review of the medical record showed Resident 69 admitted to the facility on [DATE] with diagnoses including heart disease and kidney disease. The comprehensive assessment dated [DATE], showed Resident 69 required extensive assistance of one staff member for ADLs and was cognitively intact.During a Resident Council meeting (a group of residents that meet regularly to improve the quality of life and care in the nursing home) on 08/20/2025 at 9:50 AM, both Resident's 74 and 69 stated approximately one year ago their personal refrigerators that were in their rooms were taken away from them with no explanation other than they were not allowed to have them anymore. They stated they were told by the previous facility administrator, if they wished to own personal food and drink items that required refrigeration, the activities department would keep the items for them. They both stated they knew of other residents who had personal refrigerators and felt it was not right for some to be able to have them and others not with no explanation or facility policy explaining the reason behind their decision.During a concurrent interview on 08/20/2025 at 3:21 PM, Staff B, Director of Nursing and Staff K, Regional Nurse, stated they were looking into getting the residents who wanted their refrigerators back to them as they had no knowledge of the reasons they were taken from them last year. Staff K stated they understood it was a resident's right to have personal items in their rooms as long as they were properly maintained and would review policies to cover personal refrigerator use in the facility. Reference WAC 388-97-0560 (1)(a-c)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure adequate monitoring and indications for use was in place for psychotropic (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) medication management for 1 of 5 residents (Resident 10) reviewed for unnecessary medications. These failures placed the residents at risk for unmet care needs and adverse side effects. Findings included .Review of the policy titled, Antipsychotic Medication [used to treat mental health symptoms], dated 08/2024, showed nursing staff would observe and document information regarding the effectiveness of any antipsychotic medications. It further showed that nursing staff would review for appropriate indications for use for the drug, monitor for and report to the attending physician, side effects and adverse consequences.Resident 10Review of the medical record showed Resident 10 admitted to the facility with diagnoses including dementia (a decline in mental ability, specifically affecting thinking, memory, and reasoning), depression (a serious, long-lasting medical illness that involves persistent sadness, a loss of interest or pleasure in daily activities, and a range of emotional and physical problems), post-traumatic stress disorder (PTSD- a mental health condition that can develop after experiencing or witnessing a life-threatening or terrifying event, like war, a serious car accident, or assault) and insomnia (when you consistently have trouble falling asleep, staying asleep, or waking up too early, leading to poor-quality sleep even when you have time and opportunity for it). The 05/23/2025 comprehensive assessment showed Resident 10 had an impaired cognition and required the assistance of one staff member with activities of daily living (ADLs).Review of Resident 10's physician's order dated 07/19/2025, showed an antipsychotic medication had been ordered for insomnia, which was not an approved indication for use. Further review showed no monitoring for side effects related to antipsychotic medication. During an interview on 08/21/2025 at 12:30 PM, Staff D, Social Service Director, stated the process for any resident on psychotropic medications was to ensure the indication for use was correct, and monitoring of the medication was in place. Staff D stated they had not been notified that Resident 10 had been placed on an antipsychotic medication therefore their process for Resident 10 was not followed. During an interview on 08/21/2025 at 12:45 PM, Staff B, Director of Nursing, stated residents prescribed psychotropic medications were expected to have monitoring of side effects documented in the physician's orders and on the medication administration record. Staff B further stated social services and the Resident Case Managers were responsible for reviewing all psychotropic medications to ensure the correct indication for use and monitoring was in place. Staff B stated insomnia was not the correct diagnosis for the medication prescribed and should not have been used. Staff B Further stated they were aware they had ongoing issues with psychotropic medication practices. Reference: (WAC) 388-97-1060 (3)(k)(i)(4)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Vista Post-Acute & Rehab Center	625 Okanogan Ave Wenatchee, WA 98801

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide adequate supervision during meals consistent with resident needs for 1 of 3 residents (Resident 15) reviewed for accidents and supervision. This failure placed Resident 15 at risk for choking and adverse health outcomes. Findings included. Resident 15 ˆ Review of the resident's medical record showed they were admitted to the facility with diagnoses which included cerebral palsy (a disease due to abnormal brain development which causes disorders of movement, muscle tone and posture), and dysphagia (difficulty swallowing). Review of the comprehensive assessment dated [DATE] showed the Resident 15 was cognitively intact and dependent on staff for dressing, grooming and personal hygiene however they were able to eat independently after their meal was set up. ˆ Review of a physician order dated 08/20/2025 showed Resident 15's diet was regular texture with soft bite sized pieces served with gravy or sauce to decrease choking risk and thin liquids with straws to maintain swallowing precautions.ˆˆ ˆ Resident 15's care plan updated on 08/12/2025 showed the resident had identified choking risks related to their diagnosis of dysphagia. The intervention outlined in their care plan was to provide monitoring and supervision during meals for choking, coughing and/or holding food in their mouth without swallowing.ˆ ˆ During an observation on 08/18/2025 at 12:36 PM, showed Resident 15 was sitting at a table in the activity room with another resident eating their meals. The residents were eating alone with no staff providing any monitoring or supervision during the meal.ˆ ˆ During an interview on 08/18/2025 at 12:50 PM, Resident 15 stated they ate most of their meals with the unidentified resident in the activity room as they enjoyed each other's company and were good friends. Resident 15 stated they needed the other resident when they ate because they were afraid of choking on their food and further stated the nursing staff did not monitor them or provide them with supervision during their meals. ˆ During additional observations of Resident 15's meals showed on 08/19/2025 from 12:18 PM to 12:51 PM no staff supervision, on 08/20/2025 from 8:10 AM to 9:00 AM no staff supervision and on 08/20/2025 from 12:17 PM to 12:55 PM there was no staff in the activity room providing supervision or monitoring Resident 15 for choking during their meals. During an interview on 08/20/2025 at 12:14 PM, Staff L, Nursing Assistant, (NA), stated the nursing staff did not provide supervision for Resident 15 during meals as they were not aware they had swallowing precautions. During an interview on 08/21/2025 at 10:20 AM, Staff K, Regional Nurse, stated nursing staff should be providing supervision for Resident 15 during meals as they had dysphagia and were at risk for choking when they ate. Reference WAC388-97-1060(3)(g) ˆ ˆ ˆ ˆ ˆ

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who was continent of bowel and bladder received services and assistance to maintain their continent status for 1 of 2 residents (Resident 19) reviewed for bowel and bladder function. Failure to identify the decline in bladder and bowel continence and assess/determine causative factors, left the resident at risk for continued decline, feelings of embarrassment, and a decreased quality of life. Findings included. Resident 19 Review of the medical record showed the resident was admitted to the facility on [DATE] with diagnoses including respiratory disease, diabetes, obesity, kidney disease, and depression. Resident 19's comprehensive assessment dated [DATE], showed they required total assistance of two staff members for bed mobility and transfers with a mechanical lift and were cognitively intact. During a concurrent observation and interview with Resident 19 on 08/19/2025 at 10:40 AM, showed them lying in bed with only a gown and an incontinent brief on. Resident 19 stated they liked to use a bed pan (a shallow vessel used by bedridden persons for urination or defecation) or a bedside commode when they needed to go to the bathroom and were continent of both their bowel and bladder if they were toileted in time. They stated they put on their call light multiple times a day to either be placed on the bedpan or gotten up on a commode, but the staff rarely answered their call light timely, so they had accidents in their brief and needed to be changed. During the same interview Resident 19 stated it was embarrassing to be cleaned up after an accident, but they could only hold it for so long before they just went ahead and went in the brief. Resident 19 stated I feel like the staff ignore my call light a lot of the time, because due to my large size, it takes at least two people to turn me over and position a bed pan under me or get me out of bed, so I rarely even ask to get up anymore. Review of Resident 19's care plan for bladder incontinence dated 06/12/2024 showed, the resident has bladder incontinence related to weakness and decreased mobility with the interventions listed as, bladder: some control, wears briefs, clean peri area with each incontinence episode. Review of Resident 19's care plan for bowel incontinence dated 06/12/2024 showed, the resident has bowel incontinence with the interventions listed as, bowel: some control, provide bedpan/bedside commode, provide peri-care after each incontinent episode. Review of the nursing assistant documentation from 07/23/2025 to 08/21/2025 showed Resident 19 was continent of their bladder 19 times and 66 times of incontinence. Review of the nursing assistant documentation from 07/23/2025 to 08/21/2021 showed Resident 19 was continent of their bowel three times, 21 times of incontinence, and eight times with no bowel movement recorded. During an interview on 08/20/2025 at 9:20 AM, Resident 19 stated they had never been assessed by the nursing staff on their bowel and bladder function or placed on any type of scheduled toileting to monitor for continence when toileted on a regular basis since their admission to the facility. During an interview on 08/21/2025 at 4:07 PM, Staff M, Registered Nurse, stated Resident 19 would use their call light to use the bedpan, however by the time staff got into the room, they had already gone in their brief. Staff M stated Resident 19 rarely got out of bed anymore, even though they were asked daily if they wanted to get up. Staff M stated they did not know if Resident 19 had been evaluated for the reason of their incontinence or been trialed for a scheduled toileting program (a structured approach to help individuals with mobility or incontinence, use the bathroom at regular intervals). During an interview of 08/22/2025 at 11:45 AM, Staff K, Regional Nurse, stated Resident 19 should have been assessed for their ability to remain continent of bowel and bladder since they were known to request being toileted daily. Reference WAC 388-97-1060 (3)(c) ˆ

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Infection Prevention and Control Guidelines and standards of practices were followed; 1. During a facility COVID-19 (an infectious disease causing respiratory illness with symptoms including cough, fever, new or worsening malaise [a general feeling of discomfort/uneasiness], headache, dizziness, nausea, vomiting, diarrhea, loss of taste or smell, and in severe cases, difficulty breathing that could result in severe impairment or death) outbreak to mitigate the risk for transmission of COVID-19 on 1 of 3 halls (South Hall); 2. During a residents Peripherally Inserted Central Catheter [(PICC) a long thin tube inserted through a vein in an arm to the heart to administer fluids, medications, and blood draws] dressing change for 1 of 2 residents (Resident 79). These failures placed residents, staff and visitors at risk for exposure to cross contamination (harmful spread of diseases) and the transmission of infectious diseases. Findings included. Review of the 06/2025 Washington State Department of Health SARS-CoV2 Infection Prevention and Control in Healthcare Settings Toolkit, showed long term care facilities were to conduct unit-wide testing and continue testing all residents and staff on the affected unit who previously tested negative every three to seven days for a minimum of 14 days from the most recent positive result, or the Licensed Health Jurisdiction direction. COVID-19 Testing During an interview on 08/19/2025 at 10:47 AM, Staff C, Infection Preventionist, stated the facility had admitted a resident with COVID-19 in July 2025 to the South Hall and was placed in quarantine and placed on aerosol contact precautions. Staff C stated a resident tested positive on 07/22/2025 when they went to the hospital for an emergency visit unrelated to COVID-19. Staff C stated three additional residents tested positive on 07/23/2025, when they experienced a low-grade fever, weakness, and a sore throat. Staff C stated they notified the Department of Health (DOH) and informed them they had closed the South Hall unit to include the dining room, activities and to other residents and staff. Staff C stated on 07/25/2025 another resident tested positive for COVID-19 and a staff member after they had symptoms of a moist cough, scratchy throat and lethargy (lack of energy) and on 07/26/2025 a second staff member tested positive after working the night shift in South Hall. Staff C stated the facility did not perform COVID-19 testing for all residents and staff during the outbreak. Staff C stated the facility performed testing for symptomatic residents only. Staff C stated in total there were six residents and three staff members who were COVID-19 positive during the outbreak and the outbreak ended on 08/11/2025. During a follow-up interview on 08/20/2025 at 1:50 PM, Staff C stated they did receive the WA DOH Toolkit and did not review in its entirety, therefore did not complete the required COVID-19 testing. During an interview on 08/20/2025 at 11:43 AM, Collateral Contact, Communicable Disease Specialist from the Local Health Jurisdiction (CC), stated they had been in communication with the facility for the COVID-19 outbreak. The CC stated they provided guidance to the facility and the IP and emailed the [NAME] Department of Health Covid toolkit. The CC stated they had requested updates from the facility on the COVID-19 outbreak. The CC stated the information they were provided with showed a line listing of residents and staff when they tested positive. The information also showed on 07/24/2025, 07/28/2025, 07/29/2025, 07/30/2025, and 07/31/2025 the facility had no new COVID-19 positive residents or staff. The CC stated when they received the information showing no new positives, they believed they facility had been continuing COVID-19 testing per the guidance, and they were unaware the facility had not continued to test the residents and staff. The CC stated the facility should have conducted COVID-19 testing of all residents and staff in the affected unit to ensure there were no Covid-19 residents and staff identified. The CC stated the WA DOH Toolkit they provided did show the facility was required to continue testing of all residents and staff who previously tested negative every three to seven days for a minimum of 14 days from the most recent positive result. During an interview on 08/20/2025 at 2:02 PM, Staff K, Regional Nurse, stated they were not aware there were additional residents who tested COVID-19 positive and if they had been (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	made aware the facility should have continued COVID-19 testing per the guidelines. PICC Review of the medical record showed Resident 79 was admitted with diagnoses including endocarditis (a serious infection of the heart lining), and a PICC line for antibiotic therapy. The 07/24/2025 comprehensive assessment showed Resident 79 required substantial/set-up assistance of one to two staff for activities for daily living and had an intact cognition. During an observation and concurrent interview on 08/21/2025 at 4:27 PM, Staff H, Registered Nurse, prepared to perform a PICC dressing change on Resident 79. Staff H performed hand hygiene, donned (put on) gloves and used a disinfecting wipe and cleaned Resident 79's bedside table. Staff H disposed of the used wipe and gloves and tossed into the trash and without performing hand hygiene, opened the dressing supply package and then washed their hands. Staff H placed a surgical mask on Resident 79 and themselves and donned gloves. Staff H removed the sterile drape from the kit and placed it under Resident 79's arm with the PICC line. Staff H proceeded to remove the used dressing from Resident 79's PICC line, upon removal Staff H tossed the used dressing and their gloves into the trash can. Staff H without performing hand hygiene, donned sterile gloves, measured the length of the PICC line and the circumference of Resident 79's arm and placed their right hand into their pants pocket and removed a pen and wrote down measurements on the drape and placed pen back into their pocket. Staff H proceeded to open the antiseptic swab and clean around the PICC opening on Resident 79's arm and outward. Staff H attached a PICC line holder to Resident 79's arm and placed their right hand back into their pocket and removed the pen and placed onto bedside table. Staff H proceeded to apply a barrier adhesive and a a clear dressing with a white adhesive bordered edge covering the PICC, used the pen to write the date and their initials on the PICC dressing, put their hand back into their pocket and removed an alcohol swab and removed the old PICC cap access device and attached a new one. When completed, Staff H gathered all used supplies and tossed them into the trash can and removed their gloves and washed their hands. Staff H stated they placed their hands into their pockets during the dressing change with their sterile gloves and they should not have. Staff H stated they were unaware they did not use hand hygiene between glove changes and when they opened the dressing supply package. During an interview on 08/22/2025 at 11:25 AM, Staff B, Director of Nurses, stated Staff H had not followed the steps for the PICC line dressing change and they were going to provide re-education on the proper technique. Reference WAC: 388-97-1320(1)(c)(2)(a)(5)(b)