STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505429	A. Building B. Wing	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharon Care Center	1509 Harrison Avenue Centralia, WA 98531

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the survey result binder included the health recertification and complaint survey results for 2 of 3 years (2024 and 2025) reviewed for availability of survey reports. This failure prevented residents, resident representatives, family members, and visitors from exercising their right to review past survey results.Findings included . In an observation on 09/10/2025 at 10:30 AM, the facility's survey binder was observed in a wall mounted receptacle across from the nurse's station near the skilled nursing entrance of the facility. Record review of the survey binder labelled, [NAME] Care Center Survey Binder 3 most current years of survey reports. showed the binder contained a Federal Fire and Life Safety re-certification survey, dated 09/10/2024, and the re-inspection, dated 10/31/2024, as the most recent survey completed. Further review of the binder did not show health re-certification survey results for 2024 and/or health complaint investigation surveys for 2024 or 2025. In an interview on 09/10/2025 at 11:09 AM, Staff B, Director of Nursing/Registered Nurse, said that Staff A, Administrator, would post new survey results in the binder after each survey. Staff B said there was only one survey binder. In an interview on 09/10/2025 at 11:11 AM, Staff A said he put the survey results in the binder as soon as they came out and were approved. Staff A said the survey results were never available last year and he couldn't find them online anymore. Staff A said he was able to print the complaint investigation surveys but he did not put them in the binder, stating, I usually only put the annuals in, not the complaints. Reference WAC 388-97-0480 (1)(a)(b)(c)(4)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an AIMS (Abnormal Involuntary Movement Scale) test (a rating scale used to assess the severity of involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications [drugs used primarily to treat symptoms such as hallucinations and delusions]) for 1 of 5 sampled residents (Resident 59) reviewed for unnecessary medications. This failure placed residents at risk for adverse medication side-effects, medical complications, and a diminished quality of life. Findings included .Review of the facility's policy titled, Psychotropic Medications [drugs that affect a person's thoughts, emotions, and behaviors], updated 01/01/2023, showed, . If a resident is on antipsychotic medications when they are admitted to the facility, an AIMS test will be performed upon admit, every 6 months, and PRN [as needed].Resident 59 was admitted to the facility on [DATE] with multiple diagnosis to include dementia with agitation and delirium (a condition that causes cognitive decline with a severe state of confusion known as delirium, often manifesting as agitation, hallucinations, and/or delusions).Record review of Resident 59's BIMS (Brief Interview for Mental Status, a screening tool used to evaluate a resident's cognitive function and identify the presence and severity of cognitive impairment), dated 08/27/2025, showed Resident 59 was severely cognitively impaired.Record review of Resident 59's physician orders, dated 08/26/2025, showed Resident 59 was prescribed Olanzapine (an antipsychotic medication) 2.5 mg (milligrams) at bedtime. The August 2025 and September 2025 Electronic Medication Administration Record showed Resident 59 was receiving Olanzapine 2.5 mg at bedtime. Review of Resident 59's Electronic Health Record did not show documentation of an AIMS test completed for the administration of Olanzapine. In an interview on 09/10/2025 at 2:50 PM, Staff C, Resident Care Manager/Registered Nurse (RN), said an AIMS test should be completed for residents receiving antipsychotic medications upon admission and when a new antipsychotic medication was started. Staff C said she could not find an AIMS test completed on Resident 59, stating, It got missed upon admission, it should have been done. In an interview on 09/10/2025 at 3:09 PM Staff B, Director of Nursing/RN, said he expected an AIMS test to be completed on residents taking an antipsychotic medication upon admission and upon starting a new antipsychotic medication. Reference WAC 388-97-1060 (3)(k)(i)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident admission Minimum Data Set (MDS, an assessment tool) was completed within the required timeframe for 1 of 10 sampled residents (Resident 59) reviewed for resident admission assessments. Failure to complete the admission MDS within the required timeframe placed residents at risk for unmet care needs and a diminished quality of life.Findings included . Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (a guide to facilitate accurate and effective resident assessment practices in long-term care facilities), Version 1.19.1, effective October 1, 2024, showed the admission MDS assessment must be completed no later than the 14th calendar day of the resident's admission (admission date plus 13 calendar days). Resident 59 was admitted to the facility on [DATE]. Record review of Resident 59's Electronic Health Record, on 09/10/2025 at 2:09 PM, showed Resident 59's admission MDS was still In Progress, 16 calendar days after admission. In a joint interview on 09/10/2025 at 2:22 PM, with Staff B, Director of Nursing/Registered Nurse (RN), and Staff E, MDS Nurse/RN, Staff B said Staff E scheduled the MDS assessments. Staff E said she would schedule the admission MDS when a new resident was admitted . Staff E said the MDS ARD (assessment reference date) was usually scheduled for seven days after admission, sometimes sooner. Staff E said the MDS needed to be completed one week after the ARD. Staff E said she did not have Resident 59's MDS done yet because she went on vacation and it should have been completed 2 days ago. In an interview on 09/10/2025 at 2:29 PM, Staff B said he expected the admission MDS was completed by the 14th day of admission. Reference WAC 388-97-1000 (1)(b)(c)

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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 the Pre-admission and Resident Review (PASRR) assessment was reviewed, completed and submitted for 2 of 5 residents (Resident 16 and Resident 4) reviewed for PASRR. This failure had the potential to place residents at risk of not receiving the necessary mental health services and a diminished quality of life. Findings included… 1. Resident 16 was admitted to the facility on [DATE] with multiple diagnoses to include anxiety (a common emotional state characterized by feelings of unease) and depression (a common mental health condition characterized by persistent of low mood or sadness). The quarterly Minimum Data Set (MDS, an assessment tool), dated 06/17/2025, indicated Resident 16 was moderately cognitively impaired. Review of Resident 16's PASRR, dated 07/23/2024, indicated Resident 16 had a Mood Disorder (a mental health condition that primarily affects a person's emotional state); however, “No Level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur.” No other PASRR was completed or transmitted. During an interview on 09/10/2025 at 1:08 PM, Staff H, Social Service Director, said the exemption meant a resident did not need a PASRR evaluation unless the resident was in the facility beyond 30 days and had not discharged . While reviewing Resident 16’s PASRR, Staff H said that one was missed, it should have been reviewed. 2. Resident 4 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 4 was alert and oriented and admitted with diagnoses including major depressive disorder (a persistent mood disorder that affects how you feel, think, and handle daily activities. It is not just temporary sadness but serious mental illness that requires treatment.) Record review of Resident 4's PASRR Level 1 assessment, dated 08/04/2025, documented Resident 4 had a Serious Mental Health Indicator of a Mood Disorder: Depression. The assessment documented that Resident 4 qualified for an Exempted Hospital Discharge because the individual was likely to require fewer than 30 days of nursing facility services. The assessment also documented that a PASRR Level 2 for resident 4 must be completed if the scheduled discharge (of less than 30 days) does not occur. Record review of Resident 4’s Electronic Health Records (EHR) showed no documentation of a new PASRR Level one or Level 2 was completed. In an interview on 09/10/2025 at 1:08 PM Staff H, said she was responsible for making the referrals to the PASRR Coordinator. When asked what an Exempted Hospital Discharge meant on the PASRR Level 1 evaluation, Staff H said it meant the resident didn’t need a PASRR unless they were at the facility longer than 30 days. Staff H said she had not sent in a new the referral to the PASRR Coordinator for Resident 4 requesting a PASRR Level 2 evaluation, and that she hadn’t realized Resident 4 had been at the facility longer than 30 days. Reference WAC 388-97-1915 (1)(2)(c

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident care plans were revised to accurately reflect care needs for 1 of 3 sampled residents (Resident 3) reviewed for accidents related to falls. This failure placed residents at risk for subsequent falls, injuries, unmet care needs, and a diminished quality of life. Findings included.Resident 3 was admitted to the facility on [DATE] with multiple diagnosis to include repeated falls. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 06/16/2025, documented Resident 3 was cognitively intact.Record review of the facility's Resident Incident Log, dated August 2025, showed Resident 3 had a fall on 08/12/2025 and 08/24/2025. Record review of Resident 3's fall investigation, dated 08/12/2025, Notes documented, .The Care Plan has been updated: Cue and encourage him to use call light and wait for help.Record review of CONCLUSION FALLS: [Resident 3] 08/12/2025 0530 AM, undated, documented, .The Care Plan has been updated: Cue and encourage him to use call light and wait for help.Record review of Resident 3's fall investigation, dated 08/24/2025, showed Notes dated 08/28/2025, documented, .Care Plan has been updated: Cue and encourage to use call light and wait for help.Record review of CONCLUSION FALLS: [Resident 3] 08/24/2025 @ [at] 11:25 AM, undated, documented, .Care Plan has been updated: Cue and encourage to use call light and wait for help.Record review of Resident 3's At risk for falls related to history of falls care plan, revised 08/14/2025, showed Resident 3 had a fall on 08/12/2025. The fall care plan further showed an intervention, date initiated 08/14/2025, Cue and encourage him to use call light and wait for help.Record review of Resident 3's fall care plan, revised 08/14/2025, did not document a fall and/or a new revision or intervention for a fall on 08/24/2025.In an interview on 09/11/2025 at 11:57 AM, Staff G, Resident Care Manager/Licensed Practical Nurse, said after a resident had a fall, the nurse would do an incident report at the time of the fall. Staff G said she would follow up after the fall and form a conclusion, write a summary of the fall, and update the care plan with a new intervention. When asked about a new fall intervention in the care plan for Resident 3 after the fall on 08/24/2025, Staff G said normally she would have changed the care plan with a new intervention, stating, I must have missed it. In an interview on 09/11/2025 at 12:17 PM, Staff B, Director of Nursing/Registered Nurse, said he expected the care plan was updated to include a new intervention after a resident had a fall. Reference WAC 388-97-1020 (2)(a)(d)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain daily weights per physician's orders for 1 of 5 residents (Resident 5) reviewed for quality of care. The facility also failed to check for PICC (peripherally inserted central catheter line used for long-term intravenous (IV) access to administer medications) line blood return for 1 of 1 resident (Resident 23) reviewed for medication administration. This failure placed residents at risk of unmet care needs, potential complications and a diminished quality of life.Weights Resident 5 was admitted to the facility on [DATE] with multiple diagnoses to include congestive heart failure. The admission /Medicare - 5 Day Minimum Data Set (an assessment tool), dated 06/20/2025, documented Resident 5 was severely cognitively impaired.Record review of Resident 5's physician's order, dated 06/14/2025, documented, Daily Weights for one week and the weights once per week unless ordered otherwise by provider every day shift for Weight until 06/19/2025 18:00 AND every day shift every 7 day(s) for Weight. Record review of Resident 5's electronic health record (EHR) did not show documentation of weights on: 06/15/2025, 06/16/2025, 06/17/2025, 06/18/2025 and 06/19/2025.Record review of Resident 5's physician's order, dated 06/23/2025, documented, Daily Weights for one week and the weights once per week unless ordered otherwise by provider.Record review of Resident 5's EHR did not show documentation of weights on: 06/24/2025, 06/25/2025, 06/26/2025, 06/28/2025, 06/29/2025 and 07/01/2025.In an interview on 09/10/2025 at 1:25 PM, when asked to review Resident 5's weights based on physician's orders, Staff C, Resident Care Manager/Registered Nurse (RN), said some weights were missed. Medication AdministrationResident 23 was admitted to the facility on [DATE] with multiple diagnoses including Endocarditis (an inflammation of the inner lining of the heart caused by a bacterial or fungal infection).Record review of Resident 23's physician's order, dated 08/24/2025, documented PICC: Flush with 5ml [milliliters] Before & After each medication during your shift. Check for blood return prior to flush. If no blood return, notify MD [doctor] EBP [enhanced barrier precautions] for IV Line every shift EBP for IV terapy [sic]. During a medication administration observation on 09/10/2025 at 1:45 PM, Staff F, RN, was observed to flush Resident 23's right arm PICC line and start IV antibiotic administration. Staff F did not check the PICC line for blood return as per physician's order. When asked if it was a requirement that Resident 23's PICC line be checked for blood return, Staff F said blood return was checked the previous day during blood draws (procedure where a small amount of blood was removed from the body for laboratory testing).Reference WAC 388-97-1060 (1)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete pain assessments every shift for 1 of 5 residents (Resident 6) reviewed for pain. This failure placed residents at risk for unmet care needs and a diminished quality of life.Resident 6 was admitted to the facility on [DATE], with multiple diagnoses to include vascular dementia (a type of cognitive decline caused by damage to the blood vessels in the brain), fibromyalgia (chronic condition characterized by widespread muscle pain) and chronic pain syndrome. The Quarterly Minimum Data Set (an assessment tool), dated 05/02/2025, documented Resident 6 was severely cognitively impaired.Record review of Resident 6's Nightingale Pain Assessment: Verbal & Non-verbal, dated 08/25/2025, documented Resident 6 occasionally experienced pain and staff assessment for pain should have been conducted.Record review of Resident 6's Nightingale Pain Assessment: Verbal & Non-verbal dated 07/18/2025, documented Resident 6 was unable to verbalize if she had pain and documented indicators for pain which included non-verbal sounds, vocal complaints of pain, facial expressions and protective body movements or postures related to right heel deep tissue injury.Record review of Resident 6's care plan, initiated on 03/28/2023, documented Resident 6 had chronic pain related to fibromyalgia and interventions included to monitor, record and report complaints of pain.Record review of Resident 6's Hospice IDG [interdisciplinary group] Comprehensive Assessment and Plan of Care Update Report, dated 08/19/2025, documented G: PAIN WILL REMAIN AT OR BELOW GOAL OF 4/10 THROUGH 9/1/25. I: SN -ASSESS PT'S [patients] PAIN USING APPROPRIATE SCALE.Record review of Resident 6's nursing progress note, dated 06/27/2025 at 6:29 AM, documented, Notified by CNA [certified nurses assistant] that res [resident] has a skin issue oh R [right] heel. Upon assessment noted res R heel was black 4.7 cm [centimeters] x 5.2cm. no discharge noted. No open areas noted. Third L [left] toe 0.5 cm spot on knuckle. Res reports it is painful.09/08/2025 at 10:09 AM, Resident 6 was observed lying in bed. When asked if Resident 6 was in pain, Resident 6 said she had pain all over and the pain medication she had received earlier in the morning did not help.In an interview on 09/10/2025 at 1:00 PM, Staff C, Resident Care Manager/Registered Nurse, when asked how Resident 6's pain was assessed Staff C stated, She is supposed to be assessed for pain every shift. When asked to review Resident 6's medication administration record for pain documentation Staff C stated, Pain assessment is normally a separate order, and it should be added.In an interview on 09/11/2025 at 1:19 PM, Staff D, Nursing Assistant, was asked if Resident 6 complained or was observed to be in pain. Staff C stated, she hollers out during care. Staff C said Resident 6 sometimes verbalizes generalized discomfort when receiving care.Reference WAC 388-97-1060 (1)

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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. Based on observation and interview, the facility failed to ensure food items were labeled and dated when opened in 1 of 3 kitchen refrigerators, and in 1 of 2 nourishment refrigerators (East Hall) reviewed for food storage. The facility also failed to keep an accurate temperature log for 1 of 2 nourishment refrigerators (East Hall). These failures placed residents at risk for food borne illness, and a diminished quality of life.Findings included . During an observation on 09/08/2025 at 9:12 AM, the kitchen refrigerator on the left, was observed with the following expired, opened items: 1. Plastic Tupperware container of Parmesan Cheese- labeled with use by date of 09/02/20252. Plastic Tupperware container of Jam - labeled with ineligible use by date During an observation on 09/09/2025 at 9:23 AM, the nourishment refrigerator on East Hall, was observed with the following expired, opened items: 1. Fruit cup- labeled with use by date of 09/03/2025 2. Six undated fruit cups During an observation on 09/09/2025 at 9:25 AM, the nourishment refrigerator on East Hall was observed with the latest temperature taken on 09/04/2025. Review of the temperature log did not show documentation for the following dates:09/05/2025, 09/06/2025, 09/07/2025, 09/08/2025, and 09/10/2025. In an interview on 09/08/2025 at 9:19 AM, Staff L, Dietary Manager, said the kitchen staff were responsible for restocking, cleaning, and monitoring temperatures in the nourishment refrigerators. Staff L said the items going into the food storage areas should be labeled right away, should be kept until the use by date, and then disposed of by the third day. Staff L stated, We keep it in the fridge for three days. Staff L proceeded to throw away the expired items. In an interview on 09/10/2025 at 11:38 AM, Staff B, Director of Nursing/Registered Nurse, said he expected food items in the refrigerators to be labeled accurately and discarded by the use by date. Reference WAC 388-97-1100 (3) & 2980

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a safe, sanitary, and comfortable environment was maintained for 2 of 7 rooms (rooms [ROOM NUMBERS]) reviewed for environment, when sharps containers (a puncture-resistant, leak-proof container designed to safely collect and dispose of sharp medical instruments that can puncture or cut skin, like needles, syringes, and lancets) were observed above the full line. This failure placed residents, visitors, and staff at risk for injury, potential exposure to diseases, and a diminished quality of life. Findings Included . In an observation on 09/08/2025 at 11:07 AM, the red sharps container mounted on the wall inside of room [ROOM NUMBER], date written on container 09/16/24, showed sharps instruments inside of the container above the fill line that said, do not fill above this line. The top lid, where the sharps instruments were placed in the container for disposal, was observed to not open all the way as sharps instruments in the full container would catch on the lid and pop up and out to the opening of the lid. In an observation on 09/08/2025 at 11:21 AM, the red sharps container mounted on the wall inside of room [ROOM NUMBER] near the sink, undated, showed sharps instruments inside of the container above the fill line that said, do not fill above this line. Syringes were observed inside the sharps container obstructing the top lid, where the sharps instruments were placed in the container for disposal, from opening and closing all the way. In an interview on 09/08/2025 at 2:23 PM, Staff J, Registered Nurse (RN), said either environmental services and/or nursing staff would empty full sharps containers, just whoever noticed it needed to be done. Staff J said he considered it needed to be done when the sharps instruments inside the container were at the fill line. In a joint observation and interview on 09/08/2025 at 2:34 PM with Staff J, the sharps container in room [ROOM NUMBER] was observed over the fill line. Staff J locked the sharps container lid stating, It's high enough that it should be emptied, it is at the fill line for sure. In a continued joint observation with Staff J, the sharps container in room [ROOM NUMBER] was observed over the fill line. Staff J said it should be locked too and locked the lid on the sharps container. In an interview on 09/08/2025 at 2:36, Staff K, Environmental Services Supervisor, said if she saw a sharps container at the full line she would empty it. Staff K said it was not mandated to any specific department for checking the sharps containers. Staff K said they did not have a process for checking the sharps containers, stating, I suppose we should make it a certain department. In an interview on 09/09/2025 at 11:20 AM, Staff B, Director of Nursing and RN, said he expected staff would change the sharps containers when they reached the full line. Reference WAC 388-97-3220 (1)