STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505430	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Harmony House Rehab & Nursing	100 River Plaza Brewster, WA 98812

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect 1 of 3 residents (Resident 2) reviewed for drug diversion (transfer of medication from the resident it was prescribed for to another person for unlawful use), from misappropriation of controlled medications (a drug or chemical that is regulated due to its potential for abuse or dependence). This failure placed residents at risk for unmet care needs, on-going misappropriation of medication, and a diminished quality of life.Review of a facility incident report dated 07/11/2025 showed that on 07/11/2025 Staff C, RN, reported to Staff A, Administrator, that on 06/14/2025 during shift exchange, Staff D, RN, and Staff C, RN were counting controlled medications when Staff C noticed a clear, 30 milliliter (about two tablespoons), medication cup containing some liquid in the top medication cart drawer. Staff C reported they picked up the medication cup to dispose of it when Staff D, took the medication cup, with the liquid, from them, stating No. That's mine. Just leave it alone. Staff D then continued to draw the small amount up into an orange oral syringe and placed it in a medication crush sleeve (a small envelope made of clear plastic used to crush solid medications). [They] then opened up the narcotics drawer, dropped it in and said something to the effect of, 'that's for later. That's for that one,' as [they]nodded towards the resident in room [ROOM NUMBER] (Resident 3). [They] then continued to say, 'don't worry, all your numbers are right. I made sure of it.'Further record review of the facility investigation found that when Staff A, Administrator and RN, and Staff B, Director of Nursing, examined the controlled medications they found one open bottle of liquid lorazepam (a controlled medication prescribed for temporary relief of symptoms of anxiety), prescribed for Resident 2, with a pink tinged liquid in the bottle. Both RN's knew liquid lorazepam was colorless, they then removed the bottle from circulation and took photos of the bottle. They then confirmed with Staff E, Pharmacy Quality Assurance RN, that liquid lorazepam was indeed colorless and that the bottle had been tampered with. Review of Resident 2's medical record showed that they were nearing the end of their life and were on comfort care (a medical approach that focuses on relieving symptoms and improving quality of life for residents with serious illnesses, rather than treating the underlying conditions). Review of their medication administration record (MAR) showed that they had a physician order for liquid lorazepam to be administered, as needed, every four hours, for generalized anxiety disorder. Review of the Resident's MAR for June and July of 2025 showed that they were administered the liquid lorazepam six times between 06/14/2025 and 07/11/2025, in addition to other comfort focused medications. No indication was found in record review or interview that the resident did not experience relief from symptoms associated with the order for the liquid lorazepam.During an interview on 07/30/2025 at 3:10 PM, Staff A confirmed that they had found the bottle of pink tinged liquid lorazepam, prescribed for Resident 2, on 07/11/2025 when they had begun their investigation into Staff C's report. They further stated that they had immediately removed the bottle from circulation and confirmed with the facility pharmacy that the bottle had been tampered with. Reference: WAC 388-97-0640(2)(a), (3)(c)(d)See F 605 dated 07/30/2025.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. (continued on next page)

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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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of chemical restraints for 2 of 3 residents (Resident 1 and 3) reviewed for unnecessary medications. This deficient practice placed residents at risk of experiencing unnecessary side effects such as sedation, decline in physical functioning, and placed residents at risk of experiencing an undignified life.Review of a facility incident report dated 07/11/2025 showed that on 07/11/2025 Staff C, Registered Nurse (RN), reported to Staff A, Administrator, that on 06/14/2025 while counting controlled medications (a drug or chemical that is regulated due to its potential for abuse or dependence) and making sure everything was in order in the nurse medication cart, Staff C had found a clear, plastic, medication cup in the top drawer of the nurse medication cart with a small amount of clear liquid in the cup. Staff C then went to dispose of the unmarked medication cup when Staff D, RN, intervened, took the medication cup from them, drew up the clear liquid into an orange oral syringe, placed the oral syringe in a small clear plastic sleeve (used for crushing and then holding solid medications for residents who cannot swallow medication in pill form) and then placed the oral syringe in the locked narcotic box of the medication cart, stating, that's for later. That's for that one,' as [they]nodded towards the resident in room [ROOM NUMBER] (Resident 3).The same facility incident report stated that Staff C was unsure of what to do but thought the medication in the clear, plastic cup was lorazepam (a controlled medication prescribed for temporary relief of symptoms of anxiety) prescribed for Resident 2. The incident report went on to detail that on 06/29/2025, Staff C had asked Staff D did you secretly Ativan (a brand name for generic lorazepam) any residents last night to survive? Staff D then replied that they had given the controlled medication to Resident 1 and 3 and told them the dose that was given. During an interview on 07/30/2025 at 1:10 PM, Staff C reiterated their statement from the facility incident report dated 07/11/2025 and added that they thought that Staff D had given several residents, including Resident 1 and 3, the liquid lorazepam prescribed for Resident 2, on several occasions related to those residents' evening/nighttime wandering and behaviors. They further stated that they could not remember if they had noticed any side effects from the sedating medication allegedly given by Staff D to Resident 1 and 3 but that they would have charted it if they had noticed anything.<Resident1>Record review for Resident 1 showed that they were admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive brain disorder which slowly destroys memory, thinking skills and eventually the ability to carry out even simple tasks) and dementia with severe mood disturbance (a collection of symptoms affecting memory, language and cognitive function with behaviors manifesting as agitation, anxiety and mood changes).Review of nursing progress notes found that on 06/14/2025 at 2:27 AM Staff D, wrote, Resident was verbally aggressive during shift and hard to keep calm. Resident was exit seeking most of the shift, looking for dog/car.Review of Resident 1's sleep chart (a visual representation of sleep patterns over a specific period of time) for June 2024 showed that on 06/14/2025 Staff C charted Resident 1 slept for 10 hours on day shift (7:00 AM to 7:00 PM). Review of the resident's sleep chart showed this was unusual behavior and that they generally napped for one to two hours during the day.Further review of nursing progress notes found that Staff C had written on 06/14/2025 at 2:27 PM that the Resident had a difficult time getting out of bed this AM and spent most of the morning laying down.Observation and interview of Resident 1, on 07/30/2025 between 2 to 3 PM, showed a cognitively impaired individual who was self-propelling their wheelchair throughout the facility while interacting in a positive manner with staff, other residents and their visitors. They were very active during the observation, attempted to exit out the front door and were easily redirected by facility staff. <Resident 3>Record review of Resident 3's medical record showed they were not cognitively intact and had been discharged home on [DATE]. Further record review did not find a sleep chart for this resident or other supporting evidence to show side effects of the alleged administration of liquid lorazepam were identified. The facility investigation, dated 07/11/2025, showed that the residents' representative did not report any concerns for changes in this resident's behavior related to the possible use of a chemical restraint.During an interview with Staff A, on 07/30/2025 at 3:10 PM, they stated that on 07/11/2025, at the beginning of their investigation into the report from Staff C, they had found an opened bottle of liquid lorazepam, prescribed for Resident 2, with the lorazepam in the bottle tinged a pink color. They stated that liquid lorazepam is clear, and that they had then confirmed with Staff E, Pharmacy RN, that the bottle had been tampered with and it was removed from circulation and later destroyed. They further