STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review the facility failed to obtain and/or renew guardianship papers, and/or failed to provide assistance in the formulation of an Advanced Directive (AD - a document describing a resident's wishes for care if they became incapacitated) for 6 of 20 residents (Residents 5, 49, 9, 1, 2 & 54) reviewed for guardianship/advance directives. This failure left residents at risk for losing the right to have their preferences and choices honored during emergent and end-of-life care.Findings included .<Facility Policy>According to the facility's revised September 2022 Advanced Directives policy, the resident had the right to formulate an advanced directive (AD) and advance directives were honored in accordance with state law and facility policy. The policy showed prior to an admission, the social services director or designee would inquire about the existence of any written AD and provide written information concerning the right to formulate an AD. If the resident had an AD upon admission, the documents would be obtained and maintained in the medical record and the care plan would be updated with residents AD preferences. The interdisciplinary team would annually review the residents AD and record this in the medical record. <Resident 5> According to the 07/17/2025 Annual Minimum Data Set (MDS - an assessment tool), Resident 5 had non-Alzheimer’s dementia (a progressive impairment of memory and abstract thinking) and generalized weakness. Review of Resident 5's revised 03/19/2025 impaired cognitive function Care Plan (CP), showed Resident 5’s CP goal was to be able to communicate basic needs. Interventions showed staff were to ask yes or no questions in order to determine the residents’ needs. Advanced Directives or who to call for health concerns were not shown in the CP. In an observation on 08/22/2025 9:02 AM, Resident 5 stated their daughter was their Durable Power of Attorney (DPOA), but they were not sure if the facility had the paperwork to show this or not. Record review of a 08/04/2025 physician's note showed the DPOA was consulted. Record review showed there was no DPOA paperwork found in Resident 5’s record. <Resident 49> According to the Quarterly 05/30/2025 MDS, Resident 49 had non-Alzheimer’s dementia and other neurological conditions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the revised 05/9/2025 advance directives, full code CP, showed Resident 49’s code status was a full code. Interventions on the CP showed staff were to discuss code status and advance directives preferences with Resident 49 on a quarterly basis and to ensure the resident had an appropriate order from the attending provider regarding their advance directive preferences. Review of a DPOA acknowledgement form dated 08/15/2024 and signed by a resident representative showed a box was checked to indicate the resident representative provided a current copy of the advance directive documents or was in the process of providing a copy to the facility. Review of Resident 49’s medical record did not show an advanced directive or durable power of attorney was on file in the resident’s medical record. In an interview on 08/28/2025 at 8:47 AM Staff C (Social Services) stated ADs was completed by the admissions nurse. <Resident 9> According to a 06/16/2025 Quarterly MDS, Resident 9 had moderate memory impairment, had a life expectance of less than six months, and was on hospice (specialized care for people with a terminal illness) services. Review of Resident 9’s revised 06/27/2025 advance directive CP showed the resident’s advance directive preferences would be followed based on the resident’s preferences. Interventions showed directions to staff to discuss the advance directive preferences with the resident or the responsible party on a quarterly basis and as needed. Record review showed an 11/03/2023 hospice admission consent form which indicated Resident 9 had made a Power of Attorney (POA). No POA paperwork was found in Resident 9’s records. <Resident 1> According to a 07/13/2025 Admissions MDS, had multiple medically complex diagnoses including fractures and other multiple traumas, high blood pressure, pneumonia (an inflammation of the lungs caused by an infection, thyroid disorder, and depression. In an interview on 08/22/2025 at 9:55 AM, Resident 1 stated they had a living will and their youngest child was their POA. Review of Resident 1’s revised 06/27/2025 advance directive CP showed the resident’s advance directive preferences would be followed based on the resident’s preferences. Interventions showed directions to staff to discuss the advance directive preferences with the resident or the responsible party on a quarterly basis and as needed. Review of a 07/07/2025 Durable POA Acknowledgement form showed Resident 1 was informed of the benefits of a POA and provided a current copy of their advance directive documents or were in the process of providing them shortly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 07/09/2025 Social Service History and Initial Assessment showed staff did not mark Resident 1 had a POA and documented the resident stated their son was their, “living will.” The section on the form, asking if the financial POA, medical, and/or living will documents were on file, was left blank by staff. No POA or advance directives paperwork was found in Resident 1’s records. <Resident 2> According to a 07/27/2025 admission MDS, Resident 2 had multiple medically complex diagnoses, had moderate memory impairment, and was taking psychotropic medications during the assessment period. Review of a 07/21/2025 DPOA Acknowledgement form showed Resident 2 was informed of the benefits of a POA and provided a current copy of their advance directive documents or were in the process of providing them shortly. This form was signed by Resident 2’s son with “POA” written next to their signature. Resident 2’s son also signed other admission paperwork as well. Review of a 07/24/2025 Social Service History and Initial Assessment showed staff marked Resident 2 did not have any POA and no documents were on file. Review of Resident 2’s records showed the emergency contact information for the resident, but did not include the son, who was identified as the POA on the admission paperwork. No POA or advance directives paperwork was found in Resident 2’s records. <Resident 54> According to a 07/07/2025 admission MDS, Resident 54 had moderate memory impairment, had a life expectancy of less than six months, and was on hospice services. Review of Resident 9’s revised 07/13/2025 advance directive CP showed the resident’s advance directive preferences would be followed based on the resident’s preferences. Interventions showed directions to staff to discuss the advance directive preferences with the resident or the responsible party on a quarterly basis and as needed. Review of Resident 54’s records showed the emergency contact information for the resident included a son and was identified as the resident’s POA. No POA or advance directives paperwork was found in Resident 54’s records. Review of a 07/08/2025 Social Service History and Initial Assessment showed staff documented Resident 54’s son stated they were the POA and no paperwork was on file. There was no documentation the POA documents were requested from the family and none were located in Resident 54’s records. In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated advance directives should be readily available in the resident’s records and were important so staff would know who to contact to make decisions when a resident was unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/28/2025 at 12:30 PM, Staff C (Social Services) stated advance directives were usually done by admissions and reviewed quarterly during care conference. Staff C stated if a resident has advance directives, it was their expectation the documents be in the resident records so staff know who to contact in an emergency. In an interview on 08/28/2025 at 1:42 PM, Staff G (Admissions Liaison) stated it was the responsibility of the social worker to get the advanced directives (AD). If the AD was not in the medical record, then the facility did not have a copy of it. Staff G stated an AD acknowledgement form was contained within the admission packets and the facility asked resident’s or families to complete the forms in the packets, but they did not always provide a copy of the AD to the facility. Staff G stated staff do not provide follow up to make sure the AD or DPOA paperwork got turned in. Staff G acknowledged the facility did not have advance directives in the medical record for Resident's 1, 2, 5, 9, 49 & 54. Staff G stated AD were important and should be available because they were used to honor preferences for the resident and provide information on who to call or should be contacted regarding resident concerns. REFERENCE: WAC 388-97-0280(3)(c)(i-ii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to initiate, investigate, and resolve grievances for 1 of 1 sampled residents (Resident 49) reviewed for grievances. This failure placed residents at risk for emotional distress, unresolved frustration, and a diminished quality of life.Findings included . <Facility Policy>According to the facility's revised 10/20/2023 Resident and Family Grievance policy, the team member who received a grievance from a resident or family member would complete a grievance form or assist in completing the form. The form would be forwarded to the social services department, resident services direct, and the executive director. The policy showed the receiving team members would take steps to resolve the grievance and record the information and actions taken to resolve the grievance as quickly as possible and to notify the resident of the progress of the resolution. <Resident 49>According to the 08/20/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 49 could understand and be understood by others, had neurological conditions, and memory impairment. The MDS showed Resident 49 needed partial to moderate assistance with personal hygiene. Review of the revised 03/13/2025 activities of daily living performance deficit care plan showed Resident 49 had impaired balance and muscle weakness and needed assistance with personal care.Review of the facility's grievance reporting log did not show a grievance report completed for Resident 49. In an observation and interview on 08/22/2025 at 9:21 AM, Resident 49 stated they could not get to their clothing in the room's closet because their roommate (Resident 17) blocked the room closet with their clothes hanging on the door of the closet. Resident 49 stated they could barely wash their hands or use the bathroom because the room sink was crowded with Resident 17's hygiene products and the bathroom door was blocked with Resident 17's clothing items. Resident 49 stated Resident 17's bed was pushed over the room divider curtain towards their bed and was now taking over even more of their personal space. Observed Resident 17's bed was pushed up against the room divider curtain and pushed up against Resident 49's items, very near Resident 49's bed. Observed, the handwashing sink was cluttered with bottles of toiletries, cups and brushes that limited access to the handwashing sink. Resident 49 stated they were frustrated because they told the nursing staff on several occasions but nothing had been done about this and no one had got back to them regarding these issues. Observation on 08/25/2025 at 9:21 AM showed Resident 17's room was cluttered with clothing on the floor and clothing was hanging on the closet door and bathroom door. The room sink was overcrowded with bottles of soap, lotions, brushes, and other toiletries.Observation on 08/26/2025 at 2:15 PM showed Resident 17 was by the room handwashing sink near Resident 49's bed. Resident 17 placed more items on the counter of the sink and items into the resident drawers near sink.In an interview on 08/26/2025 at 2:17 PM Staff J (Certified Nursing Assistant) stated they were not aware there was an issue or complaint by Resident 49 about Resident 17 taking over much of the space in their room. Staff J stated they were aware that Resident 17 had a lot of items that were disorganized in the room. In an interview on 8/28/2025 at 8:47 AM Staff C (Social Services) stated they were waiting to declutter Resident 17's room when Resident 17 was better able to handle moving things in their room because they would get upset. Staff C stated they were aware of Resident 49's concerns but did not think this issue constituted completing a grievance report and they did not go back to Resident 17 to discuss a resolution. After reviewing the facility's grievance process, Staff C stated a grievance report should be completed by the staff but was not. Staff C said it was important to fill out a grievance report because it would start a grievance process so others would be aware of the issue and staff could work to resolve the problem and provide feedback to Resident 49. In an interview on 08/28/2025 at 9:30 AM Staff D (Nurse Supervisor) stated they were aware of a clutter issue in Resident 17's room, and stated it was a difficult situation to manage. Staff D stated they were not aware of a grievance by Resident 49 and did not see a grievance form completed by the staff. Staff D stated the staff should have filled out a grievance form and the staff should have documented Resident 49's issue but did not.In an interview on 08/28/2025 at 12:59 PM, Staff B (Director of Nursing) stated staff were expected to fill out a grievance form anytime a resident had a concern or complaint. Staff B stated this would allow staff to track and follow the grievance for a resolution and provide customer service such as getting back to the resident on the resolution. Staff B stated a grievance form should be completed for Resident 49 but was not. REFERENCE: WAC 388-97-0460.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 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 observation, interview, and record review the facility failed to ensure residents were free from unnecessary psychotropic medications for 3 (Residents 55, 1, & 2) of 5 residents reviewed for unnecessary medications. Staff failure to monitor residents for target behaviors, provide nonpharmacological interventions, and obtain consent for psychotropic medications placed residents at risk for receiving unnecessary medications and other negative health outcomes.Findings included .<Facility Policy>According to the facility's Psychotropic Medication Use policy, revised 02/2025, the facility would utilize behavioral and non-pharmacological approaches to minimize the need for psychotropic medications. This policy showed psychotropic medications would be considered when non-pharmacological approaches were attempted but did not relieve the resident of their medical symptoms. The policy showed prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and the physician would review non-pharmacological alternatives, rationale for the recommendation, potential risks and benefits, and the resident/representative's right to accept or decline the treatment. The policy showed staff would monitor the resident's response to treatment including a behavior flow sheet. <Resident 55> According to the 06/29/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 55 had a diagnosis of depression and received an antidepressant medication during the lookback period. Review of Resident 55’s August 2025 Medication Administration Record (MAR) showed the resident received an antidepressant medication daily. This MAR showed no orders indicating staff identified and documented target behaviors related to Resident 55’s depression and there were no orders directing nonpharmacological interventions. Review of Resident 55’s 06/23/2025 comprehensive Care Plan (CP) showed staff did not identify nonpharmacological interventions or target behaviors related to the resident’s depression. In an interview on 08/28/2025 at 9:33 AM, Staff E (Nurse Supervisor) reviewed Resident 55’s record and confirmed staff were not monitoring the resident for target behaviors or implementing nonpharmacological interventions. <Resident 1> According to the 07/13/2025 admission MDS, Resident 1 had multiple medically complex diagnoses including depression and required the use of an antidepressant medication during the assessment period. In an interview on 08/22/2025 at 9:20 AM, Resident 1 stated they struggled at times with not wanting to give up on their therapy progress and expressed feelings of frustration. An observation at this time showed Resident 1 was tearful off and on during the interview process. Review of a revised 08/22/2025 antidepressant CP directed to staff to administer the antidepressant medication as ordered and to monitor/document the side effects and effectiveness every shift. Review of Resident 1’s August 2025 MAR showed the resident was receiving an antidepressant medication daily with no behavior monitoring being documented by staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated behavior monitoring was important to justify if the medications were needed or not, and to help evaluate the effectiveness of the antidepressant medication. Staff D stated behavior monitoring should be documented on the MAR, reviewed Resident 1’s records, and confirmed there was no behavior monitoring for the use of the antidepressant medication. <Resident 2> According to a 07/27/2025 admission MDS, Resident 2 had multiple medically complex diagnoses including anxiety and required the use of antidepressant and antianxiety medications during the assessment period. Review of both revised 07/29/2025 antidepressant and antianxiety CPs showed directions to staff to administer the psychotropic medications as ordered and to monitor/document the side effects and effectiveness every shift. Review of Resident 2’s August 2025 MAR showed the resident was receiving an antidepressant daily and an antianxiety medication three times daily. No behavior monitoring was being documented by staff for either medication. Additionally, no consent for the antianxiety medication was found in Resident 2’s records. In an interview on 08/28/2025 at 10:18 AM, Staff E stated if a resident was receiving psychotropic medications, it was their expectation a consent was obtained, and staff would monitor and document behaviors. Staff E stated behavior monitoring was important to identify how often the resident experienced behaviors and/or if the medication doses need to be adjusted. Staff E reviewed Resident 2’s records and was unable to find behavior documentation for the psychotropic medications. In an interview on 08/28/2025 at 1:22 PM, Staff N Reviewed Resident 2’s records and was unable to provide the consent for the antianxiety medication. REFERENCE: WAC 388-97-0620 (2)(d), (4)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a system by which residents received required written notices at the time of transfer and/or discharge, or as soon as practicable for 3 (Residents 5, 10 & 82), offer a bed hold for 2 (Resident 10 & 82), notify the office of the Long Term Care Ombudsman (LTCO) for 1 (Resident 12), and provide discharge planning for 2 (Residents 1 & 43) of 7 residents reviewed for hospitalizations and discharges. These failures placed residents at risk of being uninformed about their discharge rights, the cost of holding the resident's bed while hospitalized , and a decreased quality of life. Findings included .<Facility Policy>The facility's October 2016, Supplement to Health Facility admission Agreement showed residents who were being discharged to a hospital or other care facility, the facility staff would ensure the resident received written notice of the reason of the transfer, an effective date of transfer, resident rights, and the name and address of the state ombudsman. The admissions agreement showed the facility would provide and document sufficient preparation and orientation made to the resident and provide it in a format the resident could understand to ensure a safe and orderly transfer. The admission agreement showed a written notice of a bed hold would be provided to the resident or their representative before they were transferred to a hospital, that specified the duration of the bed hold policy, payment and policies and permission to return to the facility. <Written Transfer Notification> <Resident 5> According to the 04/29/2025 Discharge – Return Anticipated MDS, Resident 5 discharged to the hospital on that date. Review of Resident 5's records showed a written notification of Nursing Home Transfer or Discharge Notice was given on 04/29/2025. The transfer notice was not signed by the nursing home administrator or designee and there was no signature obtained by the resident or representative to show the form was provided. During an interview on 08/28/2025 at 8:35 AM, Staff F (Charge Nurse) stated it was the responsibility of the nurse to complete the necessary paperwork for transfers to the hospital as it was important to notify the receiving facility and family of the resident’s transfer. Staff F stated they were not able to find a signed nursing home transfer form for Resident 5's discharge on [DATE]. Staff F stated nurses needed to make sure the resident or family were notified and signed the transfer forms. <Resident 10> According to the 07/14/2025 Discharge – Return Anticipated MDS, Resident 10 discharged to the hospital on that date. According to the 07/28/2025 Discharge – Return Anticipated MDS, Resident 10 discharged to the hospital on that date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's records showed a transfer/discharge notice note was filled out by the facility on 07/14/2025 and on 07/28/2025. Review of the signature line located on the transfer form showed the facility’s social worker signed the forms, Resident 10 or their representative did not sign the forms to acknowledge they received the notice. In an interview on 08/28/2025 at 8:39 AM Staff F stated the facility did not have to fill out a transfer form and obtain signatures if the resident was discharged to the hospital from the outpatient center. In an interview on 8/28/2025 at 9:08 AM Staff D (Nurse Supervisor) stated nurses completed the transfer paperwork and notify the provider regardless if the resident was sent directly from the facility or another location. Staff D stated if a resident was unable to sign the Nursing Home transfer form, then two nurses should sign to verify that the resident or representative was or was not notified. Staff D stated this was important to make sure everything was provided as required. In an interview on 08/28/2025 at 12:55 PM Staff B (Director of Nursing) stated they expected staff to complete the discharge paperwork when a resident transferred to the hospital. Staff B acknowledged a resident signed transfer discharge paperwork was not in the medical record for Resident 5 and Resident 10 but should have been signed. <Notification of LTCO and rights> <Resident 12> Review of Resident 12's 02/25/2025 Discharge MDS showed the resident was transferred to an acute care hospital on [DATE], with their return anticipated. Record review showed a 02/25/2025 transfer form was completed by staff with documentation the notice of transfer was sent with the resident. This form did not include a statement of the resident’s appeal rights and contact information for the office of the State Long-Term Care Ombudsman. In an interview on 02/28/2025 at 2:18 PM, Staff L (Social Services) stated they were unaware the notice of transfer with included appeal rights needed to be provided to a resident and/or their representative. Staff L stated it was, “not our practice” to provide the notice of transfer to the residents. <Bed Hold> <Resident 10> According to a 07/18/2025 progress note in Resident 10's medical record, showed Resident 10 was in the hospital from [DATE] through 07/18/2025. According to a 08/05/2025 progress note in Resident 10’s medical record, Resident 10 was in the hospital from [DATE] through 08/02/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's medical record showed no data to support the facility discussed and/or offered a bed hold notice to the resident or their representative for the 07/14/2025 or 07/28/2025 discharges to the hospital. In an interview on 08/28/2025 at 8:35 AM Staff F stated the nurses were to fill out a bed hold form and were responsible for notifying the resident or family of the bed hold. If there was no family and the resident was able, Staff F stated they would have the resident sign the form, otherwise the nurse had to call the family to sign the bed hold forms. Staff F was not able to locate bed hold notices for Resident 10 for the 07/14/2025 and 07/28/2025 discharges. In an interview on 08/28/2025 at 9:08 AM, Staff D stated the nurses were responsible for offering a bed hold notice to residents who were discharged to the hospital. Staff D reviewed Resident 10's record and stated there were not able to locate in the medical record, bed hold notices for Resident 10 for the 07/14/2025 and 07/28/2025 discharges. In an interview on 08/28/2025 at 10:02 AM, Staff B (Director of Nursing) stated nurses were to complete the entire discharge packet with a resident that included the transfer discharge notice and the bed hold forms. Staff B stated it may be uncomfortable for the nurses to relay the bed hold information, but was a requirement they had to do. Staff B stated staff should have offered or discussed a bed hold to the resident or their representative during Resident 10's transfer to the hospital but did not. Staff B stated they were not able to locate the bed hold forms in Resident 10's medical record for the 07/14/2025 and 07/28/2025 discharges. <Resident 82> According to the 07/21/2025 Discharge – Return Anticipated MDS, Resident 82 discharged to the hospital on that date. Review of Resident 82’s record showed no transfer notice or explanation of the facility’s bed hold policy added. In an interview on 08/28/2025 at 10:03 AM, Staff D (Nurse Supervisor) stated they did not see a transfer notice or bed hold was offered to Resident 82. Staff D stated the facility should have provided Resident 82 a transfer notice or bed hold but did not. <Discharge Planning> <Resident 1> According to a 07/13/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 1 had clear speech, was understood, and able to understand others. This MDS showed Resident 1’s overall goal was to discharge to the community and had an active discharge plan. In an interview on 08/22/2025 at 9:35 AM, Resident 1 stated they wanted to discharge and return to their house. Resident 1 stated staff did not talk to them yet about the process or their discharge goals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 07/09/2025 Social Service History and Initial Assessment showed Resident 1 did plan to return to the community and had some potential barriers to discharge. The assessment showed staff indicated Resident 1 required community services for home health upon discharge. Review of a revised 07/09/2025 discharge Care Plan (CP) showed Resident 1 wished to return home alone and identified interventions to establish a pre-discharge plan with the resident, evaluate progress, and revise plan as needed. Record review showed there was no pre-discharge planning in the record and staff were unable to find documentation when requested that a pre-discharge plan was established with Resident 1. In an interview on 08/28/2025 at 12:30 PM, Staff C (Social Services) stated if a resident had an upcoming discharge, a discharge summary would be started, and the discharge planning and status would be documented by social services in the progress notes. Staff C stated the plan for Resident 1 was to stay at the facility for another two weeks and they were working on a plan. Staff C reviewed Resident 1’s records and stated there should be, but were not any progress notes by social services documenting the discussions with the resident about discharge. <Resident 43> According to an 11/25/2024 admission MDS, Resident 43 had clear speech, was understood, and able to understand others. This MDS showed Resident 43’s overall goal was to discharge to the community and had an active discharge plan. Review of a 03/04/2025 and 05/21/2025 Quarterly MDS showed Resident 43 did not have an active discharge plan. In an interview on 08/22/2025 at 10:08 AM, Resident 43 stated they were frustrated and did not know what the plan was for discharge. Review of an 11/21/2024 Social Service History and Initial Assessment showed Resident 43 did plan to return to the community and had some potential barriers to discharge. The assessment showed staff indicated Resident 43 required community services for home health upon discharge. There was no further documentation from social services regarding Resident 43’s discharge status after the 11/21/2024 initial assessment until 08/15/2025, nine months later, at which time a quarterly social services assessment note was completed with documentation Resident 43 would like to discharge home with spouse, but needed an apartment to accommodate a wheelchair. Review of a revised 06/25/2025 discharge CP showed Resident 43 wished to return to the community when the family could find apartment placement. Staff identified the following interventions: to encourage Resident 43 to discuss feelings and concerns with impending discharge; monitor for and address episodes of anxiety, fear, and distress; and to evaluate and discuss with the resident/family/caregivers the prognosis for independent or assisted living. In an interview on 08/28/2025 at 12:30 PM, Staff C stated it was their expectation quarterly notes be made by social services and discharge planning be documented and updated in the resident’s records. REFERENCE: WAC 388-97-0120(1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS -an assessment tool) accurately reflected the status for 5 (Resident 43, 2, 5, 10, & 26) of 20 sampled residents reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs and a diminished quality of life.Findings included .<Resident 43> <Falls> According to a 05/21/2025 Quarterly MDS, Resident 43 had a functional limitation in range of motion to their upper extremity on one side and both sides to their lower extremities. This MDS showed Resident 43 had two or more non-injury falls, two or more injury falls, and one fall with major injury since the prior MDS on 03/04/2025 Review of the facility incident report log showed Resident 43 had two documented incidents, one on 03/05/2025 and one on 03/24/2025. No other incidents were documented on the log. Review of the 03/05/2025 incident report showed Resident 43 obtained a wrist fracture after having a nightmare and striking the edge of a table near their bed. No fall was indicated on the 03/05/2025 incident report. Review of the 03/24/2025 incident report showed Resident 43 had a fall from their bed and had no injuries. In an interview on 08/27/2025 at 1:00 PM, Staff I (MDS Coordinator) stated they calculate falls on the MDS by reviewing the resident’s records and adding up the falls since the previous assessment period. Staff I reviewed Resident 43’s records and stated the 03/05/2025 MDS falls section was inaccurate and needed to be modified. <Depression> According to the 05/21/2025 Quarterly MDS, Resident 43 had multiple medically complex diagnoses, did not have an active diagnosis of depression, but received an antidepressant medication during the assessment period. Review of a 04/01/2025 physician visit note showed an assessment that indicated Resident 43 had depression and was to continue on the current dose of an antidepressant. Review of Resident 43’s physician orders showed the resident was receiving an antidepressant medication for depression since their admission on [DATE]. In an interview on 08/27/2025 at 1:00 PM, Staff I reviewed Resident 43’s records and stated depression should have, but was not triggered as an active diagnosis on the 05/21/2025 assessment and needed to be modified. <Resident 2> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 07/27/2025 admission MDS, Resident 2 had multiple medically complex diagnoses, did not have an active diagnosis of depression, but received an antidepressant medication during the assessment period. Review of a revised 07/29/2025 antidepressant Care Plan (CP) gave directions to staff to administer the antidepressant medication as ordered and to monitor/document the side effects and effectiveness every shift. Review of Resident 2’s August 2025 MAR showed the resident was receiving an antidepressant for a diagnosis of depression daily since their admission to the facility. In an interview on 08/27/2025 at 1:00 PM, Staff I stated an MDS should be accurate and include the resident’s active diagnoses. <Resident 5> According to the 07/17/2025 Annual MDS, Resident 5 had cognitive impairment and depression without behaviors. No mood behaviors were noted on the MDS. Review of progress note dated 03/25/2025 showed Resident 5 was on alert for behavior issues. Review of the 05/05/2025 PASSR I form, Resident 5 had serious mental illness indicators for mood and anxiety. Review of progress note dated 05/26/2025, showed staff documented Resident 5 had confusion and hallucinations. In an interview on 8/28/2025 at 1:18 PM Staff I stated they were not aware of Resident 5’s behaviors but stated an update to the MDS should have been done. <Resident 10> According to the 08/05/2025 Quarterly MDS, Resident 10 had multiple chronic conditions. The MDS showed Resident 10 had not exhibited any behaviors. Review of a progress note dated 06/15/2025 showed Resident 10 had an attempted elopement and was found outside of the facility on the sidewalk at the bus stop and the police were notified. Review of a 08/03/2025 progress note showed Resident 10 refused a readmission skin check, used profanities toward the nurse and told the nurse to get out of their room. Review of 08/06/2025 progress note showed Resident 10 exhibited behavioral issues, including an attempted elopement from the building, verbal abuse toward staff and used inappropriate language, attempted to punch staff and discarded a portion of their prescribed medication in the trash. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/21/2025 at 1:52 PM, Resident 10 stated a staff member had to escort them whenever they left the facility because the facility was afraid they would leave. Resident 10 stated on one occasion they got out of the facility to go shop in a nearby city and the facility called the police on them. In an interview on 08/28/2025 at 12:22 PM Staff D (Nurse Supervisor) stated they were not aware that Resident 10 had any psychological issues, and thought Resident 10 acted out knowingly and on purpose and was the reason the assessment was not updated. In an interview on 8/28/2025 at 1:18 PM Staff I stated they were not aware of Resident 10’s behaviors and any unwarranted behaviors, elopement or threatening others and staff should have triggered a behavior risk alert, and this would have triggered Staff I to update the MDS. Staff I stated social services was responsible for completion of the behavior section on the MDS and an updated MDS should be done for Resident 10 but was not. <Resident 26> According to the 07/15/2025 Quarterly MDS, Resident 26 had a condition where the brain's function was impaired due to disturbances in the body's metabolism. The MDS showed Resident 26 exhibited no behaviors and Resident 26’s short- and long-term memory was ok. Review of an 07/12/2025 provider progress note showed Resident 26 had intermittent confusion. Review of 08/05/2025 social services note, showed Resident 26 had mentioned to their family on 08/01/2025 that their roommate had hallucinations about their roommate. Review of 08/08/2025 provider progress note showed if medical workup was unremarkable, the provider would consider an antipsychotic medication due to severity of delusional thought content. Review of 08/14/2025 provider progress note showed Resident 26 had a diagnosis of moderate unspecified dementia with psychotic disturbance and recent delusions. In an interview with Resident 26’s family on 08/26/2025 at 2:34 PM, the family stated the allegation about their roommate was not valid as Resident 26 was not a reliable source due to confusion. In an interview on 8/28/2025 at 1:18 PM Staff I stated they did not make any changes in the MDS due to Resident 26’s behaviors and confusion. Staff I stated if a psychological evaluation was ordered and there were changes in Resident 26’s behaviors and cognition a change in the MDS should be made but was not. In an interview on 08/28/2025 9:43 AM Staff D stated they and the MDS nurse were responsible for updating the MDS assessment. Staff D stated the MDS should be updated and revised for Resident 26's behaviors and cognition but was not. REFERENCE: WAC 388-97-1000 (1)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on observation, interview, and record review the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR) Level 2 comprehensive evaluations (a process to determine what mental health services residents required after a Level 1 PASRR determined mental health services were necessary) were obtained for 3 (Residents 5, 10 & 26) of 8 residents whose PASRRs were reviewed. This failure placed residents at risk of not receiving necessary mental health care and services. Findings included . <Facility Policy>According to the facility's admission Criteria policy, revised in March 2019, all new admissions and readmissions were screened for Mental (MD), Intellectual (ID) or Related Disorders (RD) per the PASSR process. According to the policy, if the Level I screening indicated an individual may meet the criteria for MD, ID, or RD the resident was referred to the state PASRR representative for the Level II evaluation and determination screening process. The social worker would be responsible for making referrals to the appropriate state-designated authority.<Resident 5> According to the 07/17/2025 Annual Minimum Data Set (MDS - an assessment tool), Resident 5 had cognitive impairment and depression. According to a 03/25/2025 progress note, Resident 5 was on alert for behavior issues. According to a 05/26/2025 progress note, staff documented Resident 5 had confusion and hallucinations. Review of the 05/05/2025 PASSR Level I form showed Resident 5 had serious mental illness indicators for mood and anxiety. No level II referral evaluation was indicated on the form. <Resident 10> According to the 08/05/2025 Quarterly MDS, Resident 10 had a chronic kidney condition and hepatic encephalopathy (a condition occurring when the liver was unable to rid the blood of toxins, causing changes in brain function). The MDS showed Resident 10 did not exhibit any behaviors. Review of the revised 08/13/2025 Target behavior CP showed Resident 10 had behavior problems including cursing towards staff, kicking and hitting other residents, and refusals of medications. Review of a 06/15/2025 progress note showed Resident 10 left the facility and was found at a nearby bus stop. Review of a 08/03/2025 progress note showed Resident 10 refused a skin check when readmitted , said profanities to the nurse, and told them to leave the room. Review of a 08/06/2025 progress note showed the resident exhibited behavioral issues including attempting elopement from the building, verbal abuse toward staff, inappropriate language, attempting to punch staff, and discarding a portion of their prescribed medication in the trash. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 07/19/2025 Level 1 PASSR screening showed Resident 10 had no serious mental illness indicators and did not exhibit any serious functional limitations in the past 6 months. The record did not show an updated Level 1 screening or Level II referral was made after the Level I PASSR on 07/19/2025. In an interview on 08/21/2025 at 1:52 PM Resident 10 stated facility staff person accompanied them to appointments because the facility was afraid that they would attempt to leave the facility again. Resident 10 stated a couple of months ago they went out of the facility to go shopping in a nearby city and the police were called. In an interview on 08/28/2025 at 12:22 PM Staff D (Nurse Supervisor) stated they were not aware that Resident 10 had any psychological issues, as they believed Resident 10 acted out knowingly and purposefully. In an interview on 8/28/2025 at 1:18 PM Staff C (Social Services) stated they were not aware of any behavioral issues with Resident 10 that would require a Level II PASSR referral. Staff C stated they were unsure of the PASSR Level II process for changes of condition and did not redo the PASRR process with a change of condition for Resident 10 but should have. <Resident 26> According to the 07/15/2025 Quarterly MDS, Resident 26 had a condition where their brain function was impaired due to disturbances in their metabolism. Review of the 07/17/2025 “Impaired cognitive function related to probable moderate dementia” CP showed staff were to speak in simple directive sentences. The CP did not show Resident 26 had any behavioral issues. Review of a 07/12/2025 provider progress note showed Resident 26 had intermittent confusion. Review of 08/05/2025 social services note showed Resident 26 mentioned to their family on 08/01/2025 that their roommate became pregnant by an employee and they moved to an island to have a baby. After investigation by the facility, it was determined that the allegation was unsubstantiated. Review of 08/08/2025 provider progress note showed if medically appropriate, the provider would consider an antipsychotic medication due to the severity of Resident 26’s delusional thoughts. Review of an 08/14/2025 provider progress note showed Resident 26 had a diagnosis of moderate, unspecified dementia with psychotic disturbance and recent delusions. Review of the 04/14/2025 Level 1 PASRR screening showed Resident 26 had no serious mental illness indicators or any dementia or delirium diagnosis. The Level I screening showed a Level II evaluation was not indicated. The medical record did not show an updated Level 1 PASSR screening completed or Level II PASSR referral made after the 04/14/2025 Level 1 screening. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/28/2025 at 8:48 AM, Staff C stated they reviewed PASSR forms during care conferences and after 72 hours of admission. Staff C stated PASSR evaluations were important as staff should be aware of their behavior. Staff C stated they were unsure of the requirements to rescreen residents after a change in condition and the Level II PASSR process, and unsure when they needed to be completed. Staff C stated Level 1 screenings should have been completed and Level II referrals made after identification of serious mental health indicators for Residents 5, 10 or 26 but were not. REFERENCE: WAC 388-97-1915(4).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 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 record review and interview, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR - a mental health screening required before the transfer to a nursing home) assessments were accurate, revised, or submitted for a Level II PASRR assessment after the 30 day exemption expired for 5 (Resident 1, 2, 8, 12, & 55) of 8 sample residents and 1 (Resident 43) supplemental residents whose PASRRs were reviewed. This failure left residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs.**Fix around a bit to include no referral for level 2 with SMIFindings included .<Facility Policy><Resident 1> According to a [DATE] admission Minimum Data Set (MDS – an assessment tool), Resident 1 had multiple medically complex diagnoses including depression and required the use of an antidepressant medication during the assessment period. Review of a [DATE] Level 1 PASRR showed facility staff identified Resident 1 had a Serious Mental Illness (SMI) indicator of a mood disorder, but section IV was marked no Level 2 evaluation was indicated as the resident did not show indicators of an SMI. The facility failed to refer Resident 1 for the required Level 2 PASRR evaluation related to the SMI indicator of a mood disorder identified. In an interview on [DATE] at 12:30 PM, Staff C (Social Services) reviewed Resident 1’s records, confirmed the resident had SMI indicators, and stated a Level 2 PASSR referral should have, but was not completed as required. <Resident 2> According to a [DATE] admission MDS, Resident 2 had multiple medically complex diagnoses including anxiety and required the use of antidepressant and antianxiety medications during the assessment period. Review of Resident 2’s physician orders showed Resident 2 was receiving medication for depression and anxiety since their [DATE] admission. Review of Resident 2’s [DATE] Level 1 PASRR showed the resident had no SMI indicators identified. The Level 1 PASRR did not identify Resident 2 had depression and anxiety and required the use of medications. In an interview on [DATE] at 12:30 PM, Staff C reviewed Resident 2’s records and stated the resident did have SMI indicators and should be referred for a Level 2 PASRR evaluation. <Resident 43> According to a [DATE] Quarterly MDS, Resident 43 had multiple medically complex diagnoses including anxiety. Review of Resident 43’s [DATE] Medication Administration Record (MAR) showed the resident was receiving an antidepressant medication daily for a diagnosis of depression. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed Resident 43 was admitted from the hospital with an [DATE] Level 1 PASRR that showed the resident had an SMI indicator of an anxiety disorder, but no depression diagnosis was identified. Additionally, there was no referral or evaluation completed due to Resident 43's identified SMI prior to Resident 43's admission to the facility as required. In an interview on [DATE] at 12:30 PM, Staff C stated Resident 43 did have SMI indicators and required a Level 2 PASRR evaluation. <Resident 12> According to an [DATE] admission MDS, Resident 12 had multiple medically complex diagnoses including anxiety and depression and required the use of antidepressant medication during the assessment period. Review of Resident 12’s [DATE] MAR showed the resident was receiving an antidepressant and an antianxiety medication. Record review of a [DATE] Level 1 PASRR showed staff identified Resident 12 with an SMI indicator of anxiety and a mood disorder. There was no Level 2 PASRR referral or evaluation completed due to Resident 12’s identified SMI indicators as required. In an interview on [DATE] at 12:30 PM, Staff C stated it was their expectation PASRRs be accurate and Level 2 PASRR referrals obtained as required. <Resident 55> According to the [DATE] admission Minimum Data Set (MDS – an assessment tool), Resident 55 admitted to the facility on [DATE], had a diagnosis of depression, and received an antidepressant medication during the lookback period. Review of Resident 55’s [DATE] PASRR Level 1 showed the resident had a known mood disorder. The PASRR showed the evaluator marked that a PASRR Level 2 was not indicated at the time due to an exempted hospital discharge and the resident was expected to discharge from the facility in less than 30 days. Review of Resident 55’s [DATE] Discharge MDS showed the resident discharged from the facility on [DATE], 65 days after their admission to the facility. In an interview on [DATE] at 1:24 PM, Staff C (Social Services) stated it was their process to send hospital exempted PASRRs for a Level 2 evaluation if the resident stayed past 30 days. Staff C reviewed Resident 55’s record and stated the Level 1 should be sent out but it was not. <Resident 8> According to the [DATE] admission MDS, Resident 8 admitted to the facility on [DATE] and had diagnoses including dementia (a progressive disorder affecting memory loss and the ability to make decisions), anxiety disorder, and post-traumatic stress disorder. The MDS showed Resident 8 received an antipsychotic and an antidepressant medication during the lookback period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 8’s [DATE] PASRR Level 1 showed the evaluator marked “no” indicating the resident did not have dementia. The evaluator marked a PASRR Level 2 was not indicated at the time due to an exempted hospital discharge and the resident was expected to discharge from the facility in less than 30 days. Review of the [DATE] Discharge MDS showed Resident 8 discharged from the facility on [DATE], 49 days after they admitted to the facility. In an interview on [DATE] at 12:30 PM, Staff C stated a new Level 1 PASRR needed to be submitted for residents that were not discharged and remained in the facility beyond the 30 day exempted stay. Staff C stated a new Level 1 PASRR should have, but was not completed as required for Resident 55 and Resident 8. REFERENCE WAC: 388-97-1915 (1)(2)(a-c).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review the facility failed to conduct care conferences to ensure person-centered care for 3 (Residents 43, 4, & 53) of 4 residents reviewed for care planning, and failed to ensure Care Plans (CPs) were updated and/or revised, as needed for 2 (Residents 2 & 10) of 20 sample residents whose CPs were reviewed. These failures placed residents at risk for unmet care needs, inappropriate care, and other negative health outcomes. Findings included. <Facility Policy>Review of the facility's Resident Participation - Assessment/Care Plans policy, revised 02/2025, showed the resident and/or their representative had the right to participate in the their assessments and the development of the their CP. The policy showed facility staff would support the resident's and/or resident representative's participation in the care planning process by holding meetings at a time of day when residents and/or representatives were available and when residents were functioning at their best. The policy showed staff would provide advanced notice of CP meetings and the social services director or designee was responsible for notifying the resident/representative of the CP meeting and maintaining records of notices.<Care Conferences> <Resident 43> According to a 05/21/2025 Quarterly MDS, Resident 43 had clear speech, was understood, and able to understand staff. In an interview on 08/22/2025 at 10:08 AM, Resident 43 stated they had not had a care conference and expressed frustration they did not know what the plans were for their care. Record review showed a care conference progress note from 11/21/2024 with no further documentation in Resident 43’s records regarding any care conferences until 08/14/2025, almost nine months later. The 08/14/2025 progress note showed staff documented they called Resident 43’s family to schedule a quarterly care conference. In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated care conferences should occur quarterly, and it was their expectation the care conference be documented on a progress note in the resident’s records. In an interview on 08/28/2025 at 2:18 PM, Staff L (Social Services) reviewed Resident 43’s records and stated they did not see that a care conference was done quarterly and stated, “it might have been dropped.” Staff L stated care conferences were important, so all departments and the resident knew what was going on and could follow up with any concerns identified. <Resident 4> According to the 07/08/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 4 was cognitively intact, had clear speech, could understand and be understood by others. The MDS showed Resident 4 had diagnoses including a hip fracture, malnutrition, and a blockage in their throat. The MDS showed Resident 4 had weight loss, was not on a prescribed weight loss regimen, and received more than 51 percent of their nutrition via a surgically placed tube in their stomach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/22/2025 at 11:45 AM, Resident 4 stated they did not recall having a care plan meeting since their admission to the facility on [DATE]. Review of Resident 4’s progress notes and assessments showed no information regarding a care conference for the resident. A 07/04/2025 “Social Service History & Initial Assessment” showed the social services assessed the resident’s history, advanced care planning, cognitive abilities, and the residents discharge plans. This assessment did not discuss therapy goals, activity preferences, or have input from the dietary or nursing departments. <Resident 53> According to the 07/31/2025 admission MDS, Resident 53 had clear speech, was understood, and could understand others. The MDS showed Resident 53 had diagnoses including heart disease, a major infection, wounds to their lower legs, and a disease that caused major fluid buildup to their lower legs. Review of Resident 53’s progress notes and assessments showed no information regarding a care conference for the resident. A 07/27/2025 “Social Service History & Initial Assessment” showed the social services assessed the resident’s history, advanced care planning, cognitive abilities, and the residents discharge plans. This assessment did not discuss therapy goals, activity preferences, or have input from the dietary or nursing departments. In an interview on 08/26/2025 at 11:52 AM, Staff L (Social Services) stated it was their practice to schedule care conferences for newly admitted residents within 72 hours of their admission. Staff L stated care conferences were documented on a care conference assessment form and that this form was implemented a “couple of weeks ago.” Staff L stated care conferences included resident care managers, the social worker, therapy, nursing staff, and the dietary department. Staff L reviewed Resident 4 and Resident 53’s records and confirmed there was no care conference assessment or documentation showing the residents were provided a care conference <Care Plan Revision> <Resident 2> According to a 07/27/2025 admission MDS, Resident 2 had multiple medically complex diagnoses including fractures, falls prior to admission, and required major surgery for a hip replacement. Review of a revised 08/20/2025 “actual fall” CP showed staff identified interventions including: checking the resident’s range of motion “(specify#)” times daily; and for neurological checks “x (FREQ).” Staff did not identify the number of times the range of motion checks should occur daily or the frequency of the neurological checks. In an interview on 08/27/2025 at 1:15 PM, Staff D stated CPs were important, so staff knew what kind of care to provide for a resident. Staff D stated it was their expectation staff update, and revise CPs as needed to reflect the current care needs of the residents. REFERENCE: WAC 388-97-1020(2)(c)(d), -1020 (2)(f), (4)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to ensure physician orders were clarified for 4 (Residents 4, 40, 2, & 43,), order parameters were followed for 1 (Residents 53), and staff were signing only for tasks that were completed for 2 (Residents 1 & 2) of 20 sample residents reviewed. These failures placed residents at risk for medication errors, unmet care needs, and other negative health outcomes. Findings included .<Facility Policy>According to the facility's Medication and Treatment Orders policy, revised 07/2016, medication would only be administered upon the written order for the medication. Medication orders would include the dosage staff were to administer.<Clarifying Physician Orders> <Resident 4> Review of Resident 4’s 08/2025 Medication Administration Record (MAR) showed the resident had two 07/02/2025 orders directing staff to administer an as needed; over-the-counter pain medication. The first order directed the staff to administer 10.2 milliliters (mL) of the medication every four hours as needed for pain. The second order directed staff to administer 20.3 mLs of the pain medication every four hours as needed for pain. These orders did not include parameters for Resident 4’s pain level so staff knew which order to administer. In an interview on 08/28/2025 at 10:22 AM, Staff B (Director of Nursing) reviewed the pain medication orders and stated the orders needed to be clarified to include pain level parameters so staff knew which dose to administer to Resident 4. <Resident 40> Review of Resident 40’s 08/2025 MAR showed an order directing staff to administer a suppository every 24 hours as needed if a laxative given prior to the suppository was ineffective. Further review of Resident 40’s MAR showed there was no order regarding the laxative medication. In an interview on 08/28/2025 at 9:30 AM, Staff E (Nursing Supervisor) reviewed Resident 40’s suppository order and confirmed the order required clarification. <Resident 2> Review of Resident 2’s August 2025 MAR showed an order for a blood pressure medication to be administered twice daily. This order gave directions to staff to hold the dose if Resident 2’s heart rate was less than 60. There was no documentation staff were obtaining Resident 2’s heart rate prior to administration of the dose. In an interview on 08/28/2025 at 1:33 PM, Staff B stated it was their expectation staff check a resident’s heart rate prior to administering the medication as directed by the physician and the order needed to be clarified. <Resident 43> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 43’s August 2025 MAR showed an 11/22/2024 order for a liquid supplement to be administered twice daily and a second 03/07/2025 order for another liquid supplement to be administered twice daily for weight loss. Neither of these orders gave directions to staff the amount of liquid supplement they were to administer. In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated the physician orders needed to be clarified and the amount to administer should be included in the order. <Medications Administered Outside of Parameters> <Resident 53> Review of Resident 53’s 08/2025 MAR showed a 07/25/2025 order directing staff to administer a blood pressure medication twice daily to the resident. The order directed staff to hold the blood pressure medication if the resident’s systolic blood pressure (measure of the pressure in the arteries when the heart contracts to pump blood) was less than 100 or if the resident’s heart rate was less than 60 beats per minute. This MAR showed on four occasions staff administered the blood pressure medication to Resident 53 when their heart rate was less than 60 beats per minute. In an interview on 08/28/2025 at 11:15 AM, Staff B stated they expected staff to follow parameters as stated on medication orders. <Signing For Tasks Not Completed> <Resident 1> In an interview on 08/25/2025 at 8:36 AM, Resident 1 stated after back surgery, they used to wear a chest brace, but stated they were no longer using it. Resident 1 stated it was “quite a while” since they wore it last. Observations at this time showed Resident 1 was not wearing a brace. Review of Resident 1’s August 2025 Treatment Administration Record (TAR) showed staff were documenting twice daily they were removing the resident’s chest brace immobilizer to monitor skin underneath. In an interview on 08/28/2025 at 1:33 PM, Staff B stated it was their expectation staff not sign for tasks they did not complete. <Resident 2> Review of Resident 2’s August 2025 MAR showed staff were documenting twice daily the resident was on contact precautions for an infection. The MAR included six medications that did not include the diagnosis to be treated: three medicated eyedrops, a blood thinner, a medication to treat inflammation, and a medication to treat high cholesterol or itching. Observations on 08/21/2025 at 9:05 AM and 08/22/2025 at 7:52 AM showed no contact precautions sign at Resident 2’s door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/28/2025 at 12:04 PM, Staff X (Infection Preventionist) stated Resident 2 was not on contact precautions and the order should be discontinued. Staff X stated staff should not document a task was completed, if it was not. In an interview on 08/28/2025 at 1:33 PM Staff B stated it was important for mediation orders to identify the condition being treated so staff knew why the resident needed the medication. Staff B stated medication should not be prescribed without an indication for use. REFERENCE: WAC 388-97-1620 (2)(b)(i)(ii), (6)(b)(i).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure activity programs met the needs for 5 (Residents 1, 54, 2, 9, & 20) of 7 residents reviewed for activities. The failure to provide meaningful activities left residents at risk of boredom and a diminished quality of life. Findings included.<Facility Policy>According to the facility's revised 2018 Activity Evaluation policy, an activity evaluation would be completed for each resident and the results incorporated into the resident's Care Plan (CP). This CP would facilitate the resident's participation in the activities of their choice.<Resident 1> According to the 07/13/2025 admission Minimum Data Set (MDS – an assessment tool) it was very important to Resident 1 to listen to music, be around pets, participate in group and favorite activities, and attend religious services. Review of the 07/16/2025 “somewhat dependent on staff for meeting emotional, intellectual, physical, and social needs…” CP Resident 1 had a goal to participate in activities of their choice one-to-two times a week, as able. This CP showed staff should invite Resident 1 to scheduled activities and provide the resident with materials for independent pursuits as needed. The CP identified Resident 1’s preferred activities as listening to music (country, oldies, easy listening), being around animals, socializing, watching television and movies, playing video games, spending time with friends and family, being outdoors, and religious practices. In an interview on 08/28/2025 at 10:52 AM Resident 1 stated in terms of having enough to do, “lying in bed all day doesn’t [NAME] it.” Observation on 08/25/2025 at 11:01 AM on the third floor showed activities staff helping eight residents gather in a circle for a balloon activity. Resident 1 was not among the eight residents. According to the 07/9/2025 Resident preferences Evaluation, Resident 1 enjoyed listening to music (country, oldies, easy listening), being around animals, socializing, watching television and movies, playing video games, spending time with friends and family, being outdoors, and religious participation. Review of the activities documentation showed in July 2025 the facility provided Resident 1 a one-to-one activity one occasion, and in August 2025 was again provided a one-to-one activity on one occasion only, and documented the resident participated in “independent pursuits” on two occasions. <Resident 54> According to the 07/07/2025 admission MDS, it was very important to the Resident 54 to participate in their favorite activities, going outside, and participating in religious services. According to the 07/04/2025 Activities Care Area Assessment (CAA) leisure was an important part of a resident’s wellbeing. This CAA showed staff should focus on providing Resident 54 their preferred activities and should encourage family visitation and spiritual support. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 07/07/2025 “dependent on staff and family for meeting emotional, intellectual, physical, and social needs…” CP, Resident 54 had a goal to participate in activities of their choice two-to-three times a week, as able. The CP showed staff should invite Resident 54 to scheduled activities and provide assistance to get to the activities. The CP showed staff should Review of the activities charting showed no individual or group activities provided to Resident 10 in the 30-day period from 07/29/2025 through 08/27/2025. There were no documented refusals Observation on 08/21/2025 at 11:31 AM Resident 54 was observed lying in bed, dressed. Resident 54 wanted to get up and do something. There were no individual activities available at Resident 54’s bedside. Observation on 08/22/2025 from 10:02 AM through 10:59 AM, showed Resident 54 in bed with the television off. Observation on 08/25/2025 at 11:01 AM on the third floor showed activities staff helping eight residents gather in a circle for a balloon activity. Resident 54 was not among the eight residents. <Resident 2> According to the 07/27/2025 admission MDS, Resident 2 stated it was very important to them to have reading material available, to listen to music, keep up with the news, do things in groups, participate in their favorite activities, go outside when the weather is good, and participate in religious services. In an interview on 08/22/2025 at 7:54 AM Resident 2 stated they did not attend group activities. Resident 2 stated they loved to read but their poor vision prevented them. Resident 2 stated they would like to go to “meetings” but did not while at the facility. In an interview on 08/22/2025 at 11:59 AM, Resident 2 stated they did not attend any activities that day. Resident 2 stated they hoped “there was a bridge group or something.” Resident 2 stated they did not attend activities on the third floor and asked if the activities provided on that floor were good. Observation on 08/25/2025 at 11:01 AM on the third floor showed activities staff helping eight residents gather in a circle for a balloon activity. Resident 2 was not among the eight residents. According to the 07/28/2025 “somewhat dependent on staff for meeting emotional, intellectual, physical, and social needs…” CP, Resident 2’s goal was to attend their activities of choice one-to-two times weekly. The CP showed staff should invite Resident 2 to scheduled activities and provide assistance to participate. The CP showed Resident 2 should attend a religious service on Tuesdays as available and identified the resident’s preferred activities as reading (current events), listening to music, keeping up with the news, using their phone to access internet, card games (bridge), word puzzles, being around friends and family, watching television or movies, being outdoors, and religious practices. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 07/31/2025 Health Center Activity-Life Enrichment Assessment, Resident 2 saw the benefit of activity participation, and enjoyed independent activities, card and board games, going outside, movies, music, politics, puzzles, socializing, and religious services. Review of the activities charting showed no individual or group activities provided to Resident 2 in the 30-day period from 07/29/2025 through 08/27/2025. There were no documented refusals <Resident 9> According to the 06/16/2025 Quarterly MDS, Resident 9 stated their preferred activities of reading, listening to music, being around animals, and participating in religious services were very important to them. According to the 10/10/2024 psychosocial wellbeing CAA psychosocial wellbeing was an area of concern for Resident 10 who showed little pleasure in doing things outside their room and chose to stay in their room all the time. According to Resident 9’s 10/13/2024 “dependent on staff for meeting emotional, intellectual, physical, and social needs…” CP, Resident 9’s goal was to attend activities of their choice one-to-two times a week. The CP showed Resident 9 needed staff assistance to attend activities should receive one-to-one visits in their room if unable to attend. The CP showed Resident 9 would attend a religious service on Tuesdays as needed/requested, and their preferred activities were reading, listening to music (including [NAME]), being around animals, keeping up with the news, going outside, spending time with friends and family, watching television shows and movies, cooking and baking, reminiscing, people watching, bird watching, and one-to-one visits. The CP showed staff should invite Resident 9 to scheduled activities, and provide the resident with materials to do individual activities as desired. Review of a 06/16/2025 Health Center Activity-Life Enrichment Assessment showed Resident 9 saw the benefit of and wished for more activities. The assessment showed Resident 9 needed reminders and assistance to attend activities, and sometimes enjoyed being around others. Review of the activities charting showed no individual or group activities provided to Resident 9 in the 30-day period from 07/29/2025 through 08/27/2025. There were no documented refusals Observation on 08/22/2025 at 12:35 PM, on 08/22/2025 at 1:01 PM, on 08/25/2025 at 8:31 AM and on 08/25/2025 at 2:12 PM showed Resident 9 in bed with no television, movie, or music playing. In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated the activities staff notified nursing what activities were scheduled on the calendar and communicate what assistance they needed to ensure resident were able to get to the scheduled activity. Staff D stated nurse’s aides and management helped get residents to activities. Staff D stated not many resident from the second floor made it up to the activity area on the third floor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/27/2025 at 12:36 PM Staff S (Activity Coordinator) stated the activities process started with Staff S’s doing the activities portion of the MDS assessment, and then discussing activity preferences with the resident as part of the Life Enrichment Assessment. This information was used to develop the activities CP. Staff S stated the facility’s nurse’ aides and activity assistant were responsible for helping residents get to activities. Staff S stated most scheduled activities occurred on the third floor but there was an activity cart on the second floor with recreational supplies. Staff S stated if residents liked group/social activities, they expected those residents to be invited and assisted to come as needed. Staff S stated activity participation and refusals to participate should be documented in the activities charting. Staff S stated they expected the activity CP to be updated to reflect residents’ current interests/abilities. Staff S stated there was no record of any activity participation or refusals to participate for Residents 54, 2, or 9 over the 30-day period from 07/29/2025 through 08/27/2025. Staff S stated they was no record of Resident 1 participating in groups or refusing to participate in July or August 2025 <Resident 20> According to the 08/13/2025 admission MDS, Resident 20 had adequate hearing, clear speech, was understood and could understand others. The MDS showed the resident was cognitively intact. The MDS showed it was very important for Resident 20 to have books, newspapers, and magazines to read, listen to music, be around pets, keep up with the news, and do things with groups of people. Review of Resident 20’s “… somewhat dependent on staff for meeting emotional, intellectual, physical, and social needs CP, revised 08/13/2025, showed a goal the resident would attend/participate in activities of choice two to four times per week. The care plan directed staff to invite Resident 20 to scheduled activities and showed the resident required assistance to get to facility activities. The care plan showed Resident 20’s preferred activities included reading, listening to music, being around animals, socializing, doing word searches, and being outdoors. In an observation and interview on 08/22/2025 at 9:43 AM, Resident 20 stated the facility staff did not invite them to activities and that they were not aware of what activities were occurring. Resident 20 stated they read anything the facility brought them because they were “so bored.” Resident 20 stated their son recently brought them a flyer showing the facility had dogs visit a couple times per week and stated, “I would love to pet a dog.” Resident 20 stated they received the facility’s daily newssheet occasionally but not daily. Observation on 08/26/2025 at 2:10 PM showed activities staff starting the 2:15 PM bingo activity at 2:10 PM, stating “I don’t think anyone else is coming”, five minutes before the posted time. Unidentified residents were observed getting off the elevator going to the activity, concerned that bingo started before the scheduled time. Observation and interview on 08/26/2025 at 2:14 PM showed Resident 20 in their room reading a book. Resident 20 stated staff did not invite them to the bingo activity. Review of Resident 20’s 30-day activity documentation showed the resident did not refuse to participate in any activities. The documentation showed the resident participated in one-on-one/keep in touch activities or “independent pursuits.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/28/2025 at 10:05 AM, Staff S stated they and the activity assistants notified residents of activities. Staff S stated they also relied on the nursing assistants, especially on the second floor, to invite residents and assist them to activities. Staff S stated the daily newssheet was only passed out on Saturdays, not daily. Staff S stated it was their expectation all residents were invited to activities and that activities started at the posted times. REFERENCE: WAC 388-97-0940 (1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview, and record review the facility failed to identify and provide care and services in accordance with the resident's goals and professional standards of practice in the areas of non pressure skin conditions for 3 (Resident 40, 53, 1, & 54) of 5 and 1 supplemental (Resident 54) residents reviewed, and monitor and provide notification to the provider for low blood pressure readings for 1 (Resident 10) resident. These failures placed residents at risk for decline in medical status, unmet care needs, and a decreased quality of life.<Facility Policy>According to the facility's undated Care Plan, Comprehensive Person-Centered Care policy, a comprehensive, person centered care plan would include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs and was developed and implemented for each resident. The policy showed that each resident's care plan would be consistent with resident's rights to receive the services included in the plan of care and would reflect currently recognized standards of practice for problem areas and conditions. <Monitoring Resident Skin> <Resident 40> According to the 08/03/2025 admission Minimum Data Set (MDS – an assessment tool), Resident 40 did not have cognitive impairment and had diagnoses including a fracture. The MDS showed Resident 40 did not have skin impairments. Review of a 07/28/2025 admission progress note showed Resident 40 admitted to the facility with an abrasion to their right elbow. Review of Resident 40’s physician orders showed a 07/28/2025 order directing staff to provide wound care to the resident’s right elbow abrasion and cover with a dressing daily. The order report showed the elbow treatment was discontinued on 08/11/2025. In an observation and interview on 08/22/2025 at 10:42 AM Resident 40 stated they had a bandage on their right elbow. Observation showed a dressing to their right elbow and was dated 08/16/2025.Observation on 08/25/2025 at 12:51 PM with Staff K (Licensed Practical Nurse) showed Resident 40 had the same bandage on their right elbow, dated 08/16/2025, nine days prior. Resident 40 stated they would like the dressing removed. Staff K removed the dressing showing dried skin to the resident’s elbow. Staff K reviewed Resident 40’s physician orders and confirmed there were no active orders directing staff to cover the resident’s elbow. Review of Resident 40’s Treatment Administration Record (TAR) showed a 07/31/2025 order directing licensed staff to complete a weekly skin assessment and document any skin issues. The TAR showed staff completed the skin assessment as ordered on 08/21/2025 and documented there were no skin issues for Resident 40. Review of Resident 40’s assessments showed there was no associated skin assessment with the weekly skin check documentation. In an interview on 08/28/2025 at 9:22 AM, Staff E (Nurse Supervisor) stated it was their expectation staff documented in the TAR the weekly skin check was completed and that the assessment form was completed in the assessments tab. Staff E reviewed Resident 40’s assessments and confirmed staff were not filling out the skin assessment as expected. Staff E stated they expected staff to remove the old, outdated bandage if/when it was noticed on the weekly skin check. <Resident 53> (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 07/31/2025 admission MDS, Resident 53 had clear speech, could be understood, and understand others. This MDS showed Resident 53 received a blood thinning medication during the assessment period. Review of Resident 53’s 07/26/2025 revised anticoagulant care plan showed interventions to staff to monitor, document, report as needed, adverse reactions to the anticoagulant medication including bruising. Observation on 08/26/2025 at 10:21 AM showed Resident 53 sitting in their room listening to the radio. Resident 53 had a small bruise/discoloration to their right and left cheek and bruising to the back of their right and left hands. Observation on 08/28/2025 at 8:35 AM showed Resident 53 sitting on the edge of their bed. Resident 53 had a small bruise/discoloration to their right and left cheek, bruising to the back of their right and left hands, and a bruise to their upper left arm. Resident 53 stated nobody hurt them, they just got bruises all the time but did not know why or how, stating “these things just show up.” Review of Resident 53’s August 2025 MAR showed an order directing staff to perform a skin check every week on the night shift and to notify the provider for new or worsening skin conditions. The MAR showed staff performed a skin check on the night shift of 08/26/2025 and did not note any new or worsening skin conditions. In an interview on 08/28/2025 at 10:47 AM, Staff B (Director of Nursing) stated it was their expectation staff performed full body skin checks as ordered and capture/document skin impairments. Staff B stated Resident 53’s orders required clarification so staff could document “Y” or “N” for skin issues. Staff B stated they expected staff to monitor the bruising for changes and contact the physician regarding adverse side effects to the blood thinning medication, but they did not. <Resident 1> According to the 07/13/2025 admission MDS, Resident 1 was admitted to the facility after spinal surgery, had a surgical wound, required wound care, and had no rejection of care during the assessment period. In an interview on 08/22/2025 at 9:50 AM, Resident 1 stated they had a surgical incision on their back and the area was healing. Review of a revised 08/21/2025 skin integrity care plan showed Resident 1 had an actual skin impairment related to a surgical incision and gave directions to staff to monitor/document location, size, and treatment of the skin injury. Review of Resident 1’s July 2025 Treatment Administration Records (TAR) showed orders for a weekly skin assessment to be completed by a licensed nurse. This order directed staff to document any skin issues, notify the provider, and refer for a wound consultation. Staff documented the assessments were being completed weekly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1’s records showed no skin assessments or measurements of the resident’s surgical wound until 08/04/2025, almost four weeks after the last skin assessment was completed on 07/07/2025. In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated nursing staff should be completing a skin assessment every week and documenting identified areas. Staff D stated documentation should be in the resident’s records and expected staff to document the appearance and size of any wounds. <Resident 54> According to a 07/07/2025 admission MDS, Resident 54 was at risk for developing pressure ulcers/injuries, was dependent on staff to roll from side to side in bed, had no rejection of care, and was on hospice services (specialized care for people with a terminal illness) during the assessment period. Observations on 08/21/2025 at 10:50 AM showed Resident 54 with a bandage to their left forehead. Review of Resident 54’s July and August 2025 TARs showed orders for wound care to the left face twice weekly and for a skin assessment to be completed by a licensed nurse weekly. This order directed to staff to document skin issues, notify the provider, and refer for a wound consultation. Staff documented a “-“every week for the months of July and August 2025. The TAR did not indicate what was meant by “-“. In an interview on 08/28/2025 at 10:18 AM, Staff E stated the staff completed weekly wound rounds but Resident 54 was not included in the rounds because they were receiving hospice services. Staff E stated nursing staff should be completing weekly skin assessments for Resident 54 and documenting wounds using the wound assessment form. Staff E could not provide documentation showing weekly skin assessments, wound measurements, or refusals by Resident 54. Staff E stated if there was a reason the skin assessment was not completed; the reason should be documented in resident’s records. <Blood Pressure Monitoring> <Resident 10> According to a 08/05/2025 Quarterly MDS, Resident 10 had neurological conditions, a chronic kidney condition, low Blood Pressure (BP) and received dialysis treatment (filtering of the blood treatment due to kidney failure). Review of the revised 03/19/2025 pacemaker care plan showed a goal for Resident 10 to remain free of symptoms of an altered heart output. Staff would monitor and document vital signs and notify the physician for significant abnormalities. The care plan showed staff should monitor for BP readings below the resident’s baseline BP. The care plan did not show what the baseline BP was, and did not provide instructions to staff on what to do when Resident 10’s BP was below their baseline. Review of a 01/23/2025 physician’s order showed Resident 10 took a medication to manage their low BP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the dialysis post visit notes showed on 07/03/2025, 07/08/2025, 07/14/2025, 07/15/2025, 08/15/2025 and 08/18/2025 Resident 10’s BP was low during dialysis. Review of the 07/15/2025 post dialysis note showed the dialysis center documented Resident 10’s BP was low upon arrival to the dialysis center. Review of Resident 10’s BP readings taken by the facility showed the following BP values: 98/60 on 08/23/2025, 85/53 on 08/16/2025, 85/68 on 08/15/2025, 82/50 on 08/09/2025, 85/52 on 08/07/2025, 81/50 on 08/06/2025, and 75/53 on 08/15/2025, the record did not show staff provided interventions or notified the provider of the low BP readings. In an interview on 08/26/2025 at 8:46 AM, Resident 10 stated their BP was always low, but they had a pacemaker. In an interview on 08/27/2025 at 10:54 AM Staff F (Licensed Practical Nurse) stated they knew Resident 10 had low BP, but did not know when to notify the provider when the BP readings were too low. Interview on 08/28/2025 at 9:12 AM, Staff D stated they expected staff to document and notify the provider when a resident experienced a low BP. Staff D stated the provider should be aware of low BP readings and the low BP parameters should be included in the care plan or on the MAR directing staff when to call the doctor. Staff D reviewed Resident 10’s physician’s orders, care plan, and MAR, and stated there were no low BP parameters or instructions on what to do for low BP readings. Staff D could not provide documentation that staff notified the provider or provided interventions when the Resident 10’s BP was low. In an interview on 08/28/2025 at 12:22 PM Staff B stated they expected staff to document and report low BP readings to the provider and stated there should be parameters for the nurses for both high and low BP readings, especially since Resident 10 had a history of low BP. REFERENCE: WAC 388-97-1060 (1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure 1 of 23 sample residents (Resident 54) and one supplementary resident (Resident 1) reviewed for pressure injuries (injuries to the skin and underlying tissue caused by prolonged pressure) received the necessary care and services, consistent with professional standards of practice, to prevent new ulcers from developing, identify and treat PUs. Failure to complete weekly skin assessments, implement interventions, and describe and measure wounds placed residents at risk for skin deterioration, increased discomfort, new pressure injuries, and a diminished quality of lifeFindings included.<Facility Policy>According to the facility's revised April 2018 Pressure Ulcers/Skin Breakdown. policy the facility would assess residents' risk for pressure injuries and obtain orders from the physician for wound treatment. The policy showed the physician would identify pertinent medical interventions and during wound rounds evaluate and document the progress of wound healing.<Resident 54>According to a 07/07/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 54 was at risk for developing pressure ulcers/injuries, had no open wounds, was dependent on staff to roll from side to side in bed, had no rejection of care, and received hospice services (specialized care for people with a terminal illness) during the assessment period.Observations on 08/21/2025 at 10:37 AM showed staff providing care to Resident 54. An undated dirty foam dressing was observed on the Resident 54's tailbone area.Observations on 08/28/2025 at 9:44 AM showed Resident 54 lying in bed with a pillow under their knees and their heels resting on their mattress.Review of a revised 08/01/2025 skin impairment Care Plan (CP) showed Resident 54 had an actual impairment to skin of their tailbone area. The CP directed staff to monitor and document the location and size of the skin impairment, and the treatment provided.Review of a 07/01/2025 physician's order showed directions to staff to always float (lift from a surface) Resident 54's heels while in bed for skin integrity.Observations on 08/28/2025 at 9:44 AM showed Staff N (Nurse Supervisor) providing wound care to Resident 54's tailbone area. The old dressing was removed, revealing a small opening on the surface of the skin. Staff N cleansed the area and applied a new dressing, without measuring the wound. Staff N positioned a pillow under Resident 54's knees and rested both heels directly on the mattress.According to a 08/01/2025 nursing progress note, staff noted a Stage 2 (a partial-thickness skin loss) wound to Resident 54's tailbone area which they cleaned and covered. The note showed staff repositioned the resident, notified hospice, and wound care treatment orders would be implemented and added to the Treatment Administration Records (TAR). There was no description of the appearance or measurements of Resident 54's newly identified wound.Review of an 08/01/2025 facility investigation showed staff identified a Stage 2 pressure injury on Resident 54's tailbone area and documented the nurse supervisor assessed the skin, but no wound measurements were included in the investigation.Review of an 08/04/2025 hospice progress note showed Resident 54 had a new Stage 2 pressure injury on their tailbone area that was assessed, cleaned, and dressed. There was no description of the appearance or measurements of Resident 54's newly identified wound.Review of an 08/04/2025 hospice order scanned into Resident 54's records on 08/07/2025, showed direction to cleanse, dry, and apply a foam dressing to the wound twice a week and as needed when soiled. Staff hand wrote noted on the order on 08/06/2025.Review of Resident 54's August 2025 TAR showed the wound treatment orders were not implemented until 08/11/2025, eleven days after staff identified the tailbone wound, and five days after the order was noted by staff.In an interview on 08/28/2025 at 1:33 PM, Staff B (Director of Nursing) it was their expectation skin assessments were completed on the assessment form and full measurements obtained when any open areas were identified. Staff B stated wound treatment orders and skin interventions should be implemented immediately to decrease the risk of complications. Staff B stated staff should document the assessment and measurements of Resident 54's wounds weekly and as needed. Staff B stated staff should have obtained treatment orders on 08/01/2025 when the open area was identified but did not.<Resident 1>According to a 07/13/2025 admission MDS, Resident 1 admitted to the facility after spinal surgery, had a surgical wound, and required wound care. This MDS showed Resident 1 required substantial assistance from staff to roll side to side in bed and was at risk for developing pressure ulcers.Review of a 07/18/2025 pressure ulcer/injury Care Area Assessment showed Resident 1 had a potential for impairment to skin integrity related to decreased functional bed mobility.Review of a revised 08/21/2025 potential for impairment of skin CP showed a goal that Resident 1 would maintain or develop clean and intact skin by the review date. This CP gave directions to staff for an air mattress and to monitor/document the location, size, and treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 - 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to ensure fall interventions were implemented for 1 (Resident 43) of 8 residents reviewed for accidents, and failed to ensure the potential risks of an air mattress were assessed prior to implementation for 1 supplemental resident (Resident 1). These failures placed residents at risk for falls, injury, discomfort, and frustration. Findings included. <Facility Policy>According to the facility's revised March 2018 Falls - Clinical Protocol Policy, after assessing a resident was at risk for falls, the facility would identify pertinent interventions to try to prevent future falls. <Resident 43>According to a 05/21/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 43 had multiple medically complex diagnoses and had a recent history of falls, one with major injury. This MDS showed Resident 43 had limitations in functional Range of Motion (ROM) to one of their arms and both sides of their legs, and required partial assistance from staff to roll side to side in bed.In an interview on 08/22/2025 at 10:20 AM, Resident 43 stated they have had several falls and fractured their wrist on a table next to their bed during a nightmare. Observations at this time showed an overbed table at Resident 43's bedside, a floor mat to the left side of the bed, and the resident was lying in a low bed with a raised edged mattress.Review of a revised 05/20/2025 falls Care Plan (CP) showed Resident 43 was at high risk for fall and injuries and had a history of falls related to nightmares. The established goal was that Resident 43 would not sustain serious injury through the review date. Interventions identified were: a raised edged mattress; to place floor mats on both sides of the bed during hours of sleep; the bed in lowest position. Review of a revised 05/20/2025 actual fall CP gave directions to staff to use floor mats on left side of the bed during hours of sleep.According to Resident 43's physician orders, a 03/25/2025 order showed directions for right and left side floor mats at bedtime to decrease injury from falls. There were no orders regarding the use of the floor mats during the day or for the raised edged mattress on Resident 43's bed.Record review showed no assessment or consent was found for the raised edged mattress currently in use.Review of a 03/04/2025 progress note showed Resident 43 obtained a fracture to their right wrist.According to a 03/05/2025 facility incident report, Resident 43 was having a nightmare and struck their wrist on the side of their table. Staff identified one intervention to prevent recurrence was to move all furniture two feet from the bed while sleeping. Review of Resident 43's comprehensive CP did not show staff added that injury prevention intervention on to the CP.In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated it was their expectation that fall and injury interventions be implemented to help prevent further falls or injuries and so staff are aware of what interventions should be in place. Staff D stated CPs should be updated and interventions clarified as needed. Staff D reviewed Resident 43's records and stated the physician orders and interventions needed to be updated. Staff D stated staff were only using a fall mat on the left side of the bed and that it should be in place at all times. Staff D stated all safety devices should have physician orders, be assessed for risks, and consent from the resident obtained prior to use. Staff D was unable to locate physician orders, a consent, or a safety device evaluation for Resident 43's raised edged mattress.<Resident 1>According to a 07/13/2025 admission MDS, Resident 1 had clear speech, was understood, and understands others. This MDS showed Resident 1 had a limitation in functional ROM to one of their arms and required substantial assistance from staff to roll from side to side, and had a history of falls with fracture.Observations on 08/22/2025 at 9:20 AM and 08/25/2025 at 8:36 AM showed Resident 1 lying in bed on an air mattress with their knees bent outward to the sides and their feet flat against the foot board. In interviews during the observed times, Resident 1 stated they were frustrated about their bed because it was too short and narrow for them. Resident 1 stated, I'm a tall guy and I'm afraid I could easily fall off the edge. Resident 1 stated it got worse when they changed them to an air mattress and stated they reported their concerns to staff.Review of a revised 07/10/2025 falls CP showed Resident 1 had a high potential risk for falls and injury with a goal that Resident 1 would not sustain serious injury through the review date. A revised 08/21/2025 skin integrity CP showed an intervention for a low air loss mattress was initiated for Resident 1 on 07/02/2025.Record review showed no assessment, evaluation, or consent was documented prior to the initiation of the air mattress for Resident 1.In an interview on 08/28/2025 at 10:18 AM, Staff E (Nurse Supervisor) stated an air mattress was considered to have safety risks and should have an assessment, evaluation, orders, and consent prior to implementing. Staff E reviewed Resident 1's records and was unable to locate an evaluation, assessment, or consent was obtained. Staff E stated their expectation was that a bed to be the appropriate size for the resident's comfort and safety. On 08/28/2025 at 10:47 AM, Staff E

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 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. Based on observation, interview, and record review the facility failed to ensure effective pain management was provided to residents, consistent with professional standards of practice. The failure to offer non-pharmacological interventions to residents experiencing pain or investigate causes of pain for 3 of 5 sampled residents (Residents 6, 49 & 40) reviewed for pain management, placed residents at risk for untreated pain, unnecessary discomfort, and a decreased quality of life.Findings included .<Facility Policy>Review of the facility's revised April 2025 Pain Assessment and Management policy showed procedures that helped staff identify pain in residents, helped with development of interventions consistent with the resident's goals and needs, and helped to address the underlying causes of pain. The policy shows staff were to conduct a comprehensive pain assessment whenever there was a need or significant change in condition and when there was an onset of new or worsening pain and to offer pain management interventions along with non-pharmacological intervention in conjunction with medications. The policy showed the facility would address and treat the underlying causes of the pain to the extent possible by developing and implementing both non-pharmacological and pharmacological interventions and approaches to pain management.<Resident 6> According to the 07/23/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 6 had a neurological condition, required a feeding tube to eat, and used an indwelling catheter (tube inserted in the urinary tract from the bladder) due to a urinary blockage. In an interview on 08/22/2025 at 9:49 AM, Resident 6 stated they had a suprapubic catheter (catheter surgically placed in the bladder, above the belly button) that sometimes clogged, but the staff took care of it. Resident 6 stated they were having surgery later this week to remove kidney stones. Review of the 02/25/2025 Catheter Care Plan (CP) showed staff would monitor and document fluid intake and urinary output as per facility policy and report pain/discomfort related to the catheter. The CP did not show Resident 6 had a history of kidney stones or interventions to relieve their kidney stone pain. Review of Resident 6’s physician orders showed an 08/01/2024 order for a narcotic pain medication. This order directed staff to administer 5 Milligrams (MG) every four hours as needed for “other chronic pain.” Review of the August 2025 Medication Administration Record (MAR) showed on 08/26/2025 Resident 6 received the narcotic pain medication at 2:15 AM, 7:30 AM and 1:02 PM. In an interview on 08/26/2025 at 8:59 AM, Resident 6 complained of pain and stated the nurse gave them their pain medication, but they were still in pain. In an interview on 08/26/2025 at 12:11 PM, Resident 6 stated the pain medication dulled their pain but did not really help relieve the pain, and staff did not provide or offer other interventions to help with the pain. Interview on 08/27/2025 at 10:59 AM, Resident 6 stated their pain on 08/26/2025 was caused by their catheter tubing being clogged and kinked. Resident 6 stated once the nurse was able to fix the kink, urine immediately began to flow into their catheter bag and Resident 6 felt better. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 08/28/2025 at 9:24 AM Staff D (Nurse Supervisor) stated the nurses should check the catheter for kinks in the morning and monitor for urine flow. Staff D stated there were no nonpharmacological pain interventions listed on Resident 6’s CP or medication record but there should be, so nurses knew to offer Resident 6 other options instead of medications. Staff D stated staff could have discovered the source of Resident 6’s pain earlier instead of providing additional pain medications. In an interview on 08/28/2025 at 12:48 PM Staff B (Director of Nursing) stated the nurses should have assessed Resident's 6 pain first. The nurses should have assessed how intense the pain was, the location of the pain, and offered nonpharmacological interventions. Staff B stated this should have led the nurse into resolving the kink of the catheter bag first, rather than providing more pain medications. <Resident 49> According to the 08/20/2025 Annual MDS, Resident 49 had medically complex conditions, received pain medication, and non-medication interventions for pain. Review of the revised 02/18/2025 Pain CP showed Resident 49 had a fracture to their right arm. Interventions showed pain was alleviated and relieved by rest and medication. No other non-pharmacological interventions were listed on the CP to resolve Resident 49’s pain. In an interview on 08/22/2025 at 9:35 AM, Resident 49 stated they had a fall at the facility and broke their right wrist. Resident 49 stated there was some healing, but they could not do a lot of things because of the pain. In an interview on 08/25/2025 at 12:18 PM, Resident 49 stated they always had pain, and they received a muscle relaxer but that did not help with their ongoing pain. Resident 49 stated staff did not offer other interventions to help with the pain. Review of Resident 49’s physician orders showed a 10/24/2024 order for a muscle relaxer to be administered as needed every 8 hours. The order did not specify where the resident’s pain was or what the muscle relaxer was for. Review of Resident 49’s August 2025 MAR showed staff provided the muscle relaxer medication for pain but staff did not document where or what type of muscle pain Resident 49 experienced. In an interview on 08/28/2025 at 9:41 AM, Staff D stated there were no nonpharmacological interventions listed in Resident 49’s MAR and staff were providing the muscle relaxer for Resident 49’s arm and wrist but were not documenting nonpharmacological interventions. Staff D stated the MAR should show what the medication was intended for and provide non-pharmacological interventions, but staff did not. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/28/2025 at 12:44 PM, Staff B stated nonpharmacological interventions should be provided to residents in pain as the facility's providers were working to get rid of narcotic pain medications. Staff B stated they expected for short and long term pain, the staff assessed the pain and provided non pharmacological interventions. Staff B stated these instructions should be listed on the MAR to include what interventions worked for the resident’s pain and the order should specify what the pain medication should be used for but was not for Resident 49. <Resident 40> Review of the 08/03/2025 admission MDS showed Resident 40 received scheduled and as needed pain medications during the assessment period. The MDS showed Resident 40 did not receive non-medication interventions for their pain. The MDS showed Resident 40 was experiencing a pain level of “8” out of “10” on the pain scale during the time of the assessment. Observation and interview on 08/22/2025 at 10:42 AM showed Resident 40 sitting in their wheelchair in their room. Resident 40 had a large brace on their right leg extending from their thigh down to their shin. Resident 40 stated they had a fall at home and broke their leg. Review of the 07/30/2025 revised, “…acute/chronic pain” CP showed Resident 40 had pain related to a leg fracture. The CP directed staff to report as needed side effects of pain medication, report signs and symptoms of non-verbal signs of pain, and report complaints of pain or requests for pain treatment. The care plan did not include directions to staff to offer or provide non-pharmacological interventions for pain. Review of Resident 40’s 08/2025 MAR showed the resident had a 07/28/2025 order directing staff to monitor the resident’s pain every shift, a 07/29/2025 order for an over-the-counter pain reliver to be administered three times per day, a 07/29/2025 order for a pain reliving cream to be applied three times daily, and an 08/04/2025 order for a pain patch to be applied daily. The MAR showed no orders directing staff to provide non-pharmacological interventions for Resident 40’s pain. In an interview on 08/28/2025 at 9:31 AM, Staff E (Nurse Supervisor) reviewed Resident 40’s records and confirmed there were no directions to staff to offer the resident non-pharmacological interventions for their pain but stated there should be orders for non-pharmacological interventions. REFERENCE: WAC 388-97-1060(1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to identify triggers that might prompt a recall of previous traumatic events, and develop care planned goals and interventions for a resident who was a trauma survivor for 1 of 1 residents (Resident 67) reviewed for trauma informed care (a framework for understanding and responding to the effects of trauma). This failure placed the resident at risk for re-traumatization, psychological harm and a diminished quality of life.Findings included .<Facility Policy>Review of a revised August 2022 Trauma-Informed Care policy showed an individualized Care Plan (CP) would be developed that addressed past trauma, triggers identified to decrease exposure that may re-traumatize the resident, and establish resident-care strategies.<Resident 67>According to an 08/18/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 67 had a diagnosis of depression, moderate memory impairment, and no behavioral symptoms.Review of an 08/21/2025 care conference progress note showed Resident 67 reported being punched by staff during care. Staff documented the resident would be placed on alert, and new CP interventions implemented.In an interview on 08/26/2025 at 8:59 AM, Resident 67 stated they felt safe in the facility, nobody hurt them, and had no concerns about staff.In an interview on 08/26/2025 at 9:30 AM, Staff B (Director of Nursing) stated Resident 67 had a history of trauma and they were working with the resident's family regarding the 08/21/2025 reported incident.Review of a 12/07/2024 Trauma-Informed Screening form showed staff documented Resident 67 experienced abuse when they were younger and could experience mood swings, confusion, disorientation, and depression. The assessment listed prevention strategies that could be used to prevent trauma symptoms which included: redirection; one to ones, reapproach, communication, allow participation in decision-making, and to ensure physical and/or emotional safety and security.Review of a 07/24/2025 spiritual care progress note showed recommendations for a Trauma-Informed CP to be implemented and identified specific interventions for Resident 67 to help prevent re-traumatization.Review of Resident 67's comprehensive CP showed it did not include a Trauma-Informed CP or address the resident's trauma history, identify any triggers, or prevention strategies to help prevent trauma symptoms.In an interview on 08/28/2025 at 2:08 PM, Staff B stated it was important to make sure a resident felt safe in the facility and stated it was their expectation staff develop a CP with individualized triggers and interventions to avoid re-traumatization when a resident experienced past trauma. Staff B stated staff did not but should have initiated a trauma-informed CP for Resident 67 once it was identified on the 12/07/2024 Trauma-Informed Screening form.REFERENCE: WAC 388-97-1060 (1)(3)(e).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure proper storage and labeling of medications in 1 of 1 medication storage rooms (Cascade Hall), 2 of 3 medication carts (Cascade Hall and Shoreline Hall), and ensure medications were secured for 1 of 1 residents (Resident 2) reviewed for medication storage. These failures placed residents at risk of receiving expired medications, ineffective treatment, missing medications, and a diminished quality of life.Findings included.<Facility Policy>According to the facility's Medication Labeling and Storage policy, revised 02/2023, all medications would be labeled with an expiration date. The policy showed multi-dose vials that were opened would be dated and discarded within 28 days.<Cascade Hall Medication Room>Observation on 08/21/2025 at 9:11 AM of the Cascade Hall medication storage room showed an open bottle of tuberculosis (infectious, airborne disease affecting the lungs) testing solution with an open date of 07/08/2025. The bottle was not discarded after 28 days. Observation at that time showed a box containing an open vial of tuberculosis testing solution. This vial did not have an open date to direct staff when the bottle was opened or when it needed to be discarded.In an interview on 08/21/2025 at 9:11 AM, Staff BB (Assistant Director of Nursing) confirmed the bottles of tuberculosis testing solution should be discarded.<Cascade Hall Medication Cart>Observation on 08/21/2025 at 1:24 PM of a medication cart on the Cascade Hall showed an injectable medication used to treat a blood sugar disorder with an open date of 06/14/2025. Observation at that time showed a blood sugar control solution with an open date of 11/2025. The instructions on the control solution directed the user to use the solution within three months of opening.In an interview on 08/21/2025 at 1:24 PM, Staff CC (Licensed Practical Nurse - LPN) confirmed the injectable medication should be discarded after 28 days of opening and the testing solution was expired.<Shoreline Hall Medication Cart>Observation on 08/21/2025 at 1:55 PM of a medication cart on the Shoreline Hall showed an injectable medication used to treat a blood sugar disorder with an open date of 07/07/2025. In an interview at that time, Staff K (LPN) confirmed the medication should be discarded after 28 days.In an interview on 08/28/2025 at 1:33 PM, Staff B (Director of Nursing) stated it was their expectations no medications should be opened without a date opened added to the label. Staff B confirmed the tuberculosis testing solution should be discarded after 28 days of opening and the injectable blood sugar medication should be discarded after 28 days of opening. Staff B confirmed the testing solution should be discarded after three months as specified in the manufacturer's instructions. <Medications at Bedside><Resident 2>Observations on 08/22/2025 at 11:59 AM showed one bottle of a prescription eye drop medication used to decrease the pressure in the eyes and one bottle of a prescription eye drop medication used for chronic dry eye disease caused by inflammation. The bottles were sitting on a medication tray on Resident 2's overbed table. Observations on 08/22/2025 at 12:41 PM showed the same two eye drop medication bottles still unsecured at Resident 2's bedside. In an interview at this time, Staff AA (Registered Nurse) confirmed the medications and stated they should not be left unsecured in a resident's room.REFERENCE: WAC 388-97-1300(2), -2340.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review the facility failed to ensure prompt dental services were provided for 1 (Resident 43) of 1 sample residents reviewed for dental services. This failure placed the residents at risk for unmet dental needs and a diminished quality of life.Findings included .<Resident 43> According to a 11/25/2024 admission Minimum Data Set (an assessment tool) Resident 43 had clear speech, was able to understand others, and make themselves understood. This MDS showed Resident 43 was assessed with obvious or likely tooth decay or broken teeth and had mouth or facial pain and discomfort or difficulty with chewing. In an interview on 08/22/2025 at 10:09 AM, Resident 43 stated they needed to see a dentist for their “really bad teeth.” Resident 43 stated they had some teeth that were cracked down to the gum which caused discomfort at times when eating. Resident 43 stated they had one tooth with a hole and they had to pick food out of their tooth every time they ate. Resident 43 stated they saw a dentist when they first admitted at the facility and did not hear anything afterwards. Observations at this time showed Resident 43 with broken upper and lower teeth. Review of a revised 02/27/2025 dental Care Plan (CP) showed Resident 43 had broken, natural teeth, tooth decay, occasional pain, and difficulty chewing. This CP gave directions to staff to coordinate arrangements for dental care and transportation as needed/as ordered. Review of Resident 43’s physician orders showed a 11/19/2024 order for a dental consult as needed and showed the resident could be seen and treated by a dentist. Record review showed the facility’s visiting dentist saw Resident 43 on 01/27/2025 and noted several broken and decayed teeth needing attention. A referral for x-rays, evaluation, and extraction for all Resident 43’s upper teeth was recommended. There was a handwritten note on the consultation documenting Resident 43 had an abscess (a tooth infection causing a pocket of pus to form) on one of their teeth. The note showed Resident 43 wanted extractions and a full upper denture. Record review showed a 01/31/2025 referral request form for Resident 43 requesting the x-rays, evaluation, and extractions. This form did not identify where the referral request was sent. In an interview on 08/27/2025 at 9:09 AM, Staff H (Unit Coordinator) stated they were responsible for scheduling appointments and faxing referrals to providers. Staff H stated they usually obtained a fax confirmation showing the referral was received by the provider and then added the appointment to their calendar. Staff H reviewed their records and was unable to find a fax confirmation or a dental appointment for Resident 43. In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated that timely dental follow up was important to avoid delays and stated dental issues could negatively impact a resident’s daily life. Staff D stated it was their expectation staff followed up with recommendations for dental referrals timely. Staff D confirmed there was nothing in Resident 43’s records after the request form from 01/31/2025, almost seven months earlier, to demonstrate staff scheduled the dental appointment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1060(1); (3)(j)(vii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure food was properly stored and labeled for 2 of 2 kitchens reviewed for kitchen safety. These failures left residents at risk for spoiled or contaminated foods, and food-borne illness.Findings included .<Facility Policy>According to the facility's revised 01/2025 Food Storage policy and Resident Food Services policy, all food, non-food items, and supplies used in food preparation would be stored in a manner to prevent contamination and maintain the safety and wholesomeness of the food. Food items would be labeled with a manufacturer's expiration date or the date of receipt. This policy showed staff would restrain all facial hair with a beard/hair net restraint. <Skilled Nursing kitchen >Observation of the facility's dry food storage on 08/21/2025 at 8:45 AM showed opened boxes of snacks containing nacho chips, cheese crackers, and popcorn packages. These packages did not have a label with an expiration date on the box or individual packages. Three cartons of unopened frozen orange juice were observed in the walk-in freezer and were not labeled with expiration dates.<Main Kitchen >Observation of the main kitchen on 08/21/2025 at 9:42 AM showed the following items were not labeled with an open or expiration date: two tubs of bacon jam, one container of cream cheese, uncooked eggs loosely stored in a canister, and three bags of corn tortillas. An opened package of ham lunch meat was past the labeled expiration date.Observation of the walk-in freezer on 08/21/2025 at 10:00 AM showed one bag of frozen french fries, one bag of frozen bagels, and one bag of frozen chicken quarters were not labeled with an expiration date. Observation on 08/21/2025 at 10:05 AM of small refrigerator in the main kitchen showed one container of chopped lemons that was not covered or labeled with an open or expiration date. Observed approximately a quarter of a canister containing several butter packets that were not labeled with an open or expiration date. Observation on 08/21/2025 at 10:05 AM showed the main kitchen dry storage room had a box of mayonnaise packets that did not have an expiration date on the individual packages or the box.In an interview on 08/21/2025 at 10:22 AM Staff P (Visiting Food Service Supervisor) stated all bottles should be labeled when they were opened and have an expiration date but were not.In an interview on 08/28/2025 at 10:23 AM Staff Q (Director of Nutrition Systems) stated all food should be labeled and dated. If the food came from their food supply vendor, the staff should place a sticker with the received date on the food containers. If the food was unopened, the facility would use the manufacturer's date, if the manufacturer date did not show, the food must be labeled.<Facial [NAME] Covering>Observations on 08/21/2025 and 08/26/2025 at 10:49 AM showed three kitchen cooks (Staff P, Staff R - Cook, and Staff Z - Regional Chef) had facial beards and were not wearing beard nets to cover their face while preparing food.In an interview on 08/26/2025 at 10:49 AM Staff Q acknowledged Staff P, Staff R, and Staff Z had facial beards that were not covered and stated every time staff enter the kitchen, they needed to wear a hair net or facial cover for their beard. Staff Q stated this was important as foreign objects could enter the food being prepared.REFERENCE: WAC 388-97-1100(3).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure nurses signed timely for the care provided for 1 (Resident 1) of 20 sample residents reviewed, and failed to ensure provider notes were added timely to the resident's record for 1 (Residents 9) of 1 resident reviewed for hospice and one supplemental resident (Resident 54). These failures placed residents at risk for an incomplete record of their care, unmet care needs, and delays in treatment. Findings included.<Resident 1>According to a 07/13/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 1 had multiple medically complex conditions including a thyroid (an organ that helps regulate metabolism) disorder.Review of the August 2025 Medication Administration Record (MAR) showed Resident 1 had a thyroid medication scheduled to be administered every day by staff at 6:30 AM. This MAR showed nurses left the boxes blank with no initials indicating the medications were administered as ordered on 08/20/2025 and 08/21/2025.In an interview on 08/28/2025 at 10:56 AM, Staff Y (Medical Records) stated it was important to have complete and accurate resident records. Staff T stated MARs should not be left blank.<Resident 9>According to a 06/16/2025 Quarterly MDS, Resident 9 had moderate memory impairment, a life expectancy of less than six months, and received hospice (specialized care for people with a terminal illness) services.Review of Resident 9's records on 08/27/2025 showed the last hospice note in the resident's records was from 08/04/2025, over three weeks previously. There was no record of a hospice visit after that date.In an interview on 08/27/2025 at 1:15 PM, Staff D (Nurse Supervisor) stated hospice visited Resident 9 frequently and stated their expectation was for the visit notes to be readily available in the resident's record, so they were accessible to all care staff and providers. Staff D reviewed Resident 9's records and was unable to locate any hospice notes after the 08/04/2025 visit.<Resident 54>According to a 07/07/2025 admission MDS, Resident 54 had moderate memory impairment, a life expectancy of less than six months, and received hospice services.Review of Resident 54's records on 08/27/2025 showed the last hospice note in the resident's records was from 08/04/2025, over three weeks previously. There was no record of a hospice visit after that date.In an interview on 08/28/2025 at 1:33 PM, Staff B (Director of Nursing) stated it was their expectation hospice notes were added to a resident's records timely so any orders or updates could be processed within 24 hours and any pertinent information added into the resident's care plan.REFERENCE: WAC 388-97-1720 (1)(a)(i-iv)(b).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 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 staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear, and gowns used to prevent exposure to infectious materials) for 2 of 2 residents (Resident 27 & 6) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms); ensure staff used appropriate Hand Hygiene (HH) during resident care for 4 of 4 residents (Resident 27, 6, 37 & 54) who were observed for care; ensure staff followed Transmission Based Precautions (TBP - a set of infection control practices used to prevent the spread of infectious agents, in addition to standard precautions) for 1 of 1 resident (Resident 37) reviewed for TBP; and ensure the facility was free of uncleanable surfaces for 1 of 1 residents (Resident 2). These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases. <Facility Policy>According to the facility's February 2023 Infection Prevention and Control Program policy, the facility would establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help to prevent the development and transmission of communicable diseases and infections. The policy showed staff would use standard precautions during resident care, unless the resident was on transmission-based precautions (TBP), then staff would use personal protective equipment (PPE) as indicated by the identified precaution. The policy showed for standard precautions staff would perform hand hygiene, even if gloves were used before and after contact with the resident, after contact with blood or bodily fluids, and after removing PPE. <Enhanced Barrier Precautions-EBP) <Resident 27> According to a 06/02/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 27 had history of a traumatic brain injury, had a gastrostomy (tube inserted into the stomach for feeding) and had deficiencies with their immune system. Review of 05/27/2025 tube feeding Care Plan (CP), showed Resident 27 was on EBP due to a feeding tube placement. Observation on 08/21/2025 at 1:12 PM showed a sign on Resident 27’s door that resident was on EBP and staff were to wear a gown, gloves and mask when providing personal care. Observed Staff M (Certified Nursing Assistant - CNA) provide incontinent care to Resident 27. Staff M was observed to clean Resident 27 after changing their soiled incontinent pad. Staff M did not remove soiled gloves or wash hands before putting on moisturizing ointment on Resident 27’s skin or before helping Resident 27 look through their drawers for their glasses or when using the bed remote to lower their bed. Resident 27 stated they had ongoing diarrhea and were being fed through a tube. <Resident 6> According to the 07/23/2025 quarterly MDS, Resident 6 had a neurological condition, required a feeding tube to eat, and used an indwelling catheter (tube inserted in the urinary tract from the bladder) due to urinary blockage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 08/09/2024, MRSA (Methicillin-Resistant Staphylococcus Aurea) CP, Resident 6 was on EBP due to their feeding tube and a history of multiple drug-resistant organisms that were resistant to multiple antibiotics for treatments. Observation on 08/25/2025 at 8:45 AM, Resident 6 had a sign on their door for EBP. Observed Staff O (CNA) provide care to Resident 6 after changing their soiled incontinent pad. Staff O did not wear a mask and did not change their gloves or wash their hands before putting Resident 6’s clean pants and socks on. Observed Staff O discarded their soiled gown and gloves in the trash, did not sanitize or wash their hands and then left the room to obtain assistance with resident’s care. In an interview on 08/25/2025 at 9:28 AM Staff O stated they did not wash their hands when they left Resident 6’s room but should have for infection control. In an interview on 08/28/2025 at 9:12 AM Staff D (Nurse Supervisor) stated proper hand hygiene was needed for all personal care activities and for all residents on EBP. Staff D stated staff were expected to follow instructions on the EBP form provided and staff should wear gloves, gowns, masks, when taking care of a resident on EBP. <Transmission Based Precautions – TBP> <Resident 37> Observations on 08/21/2025 at 9:05 AM showed a contact enteric precautions (a set of safety measures to prevent the spread of infections that are transmitted through the intestines and by direct or indirect contact with a person or their environment) sign posted by the door outside of room [ROOM NUMBER] with directions to staff to put on a gown and gloves when entering room and to wash with soap and water upon leaving room. Review of Resident 37’s physician orders showed an 08/21/2025 order for enteric contact isolation due to pending C-Diff (a highly contagious bacteria that causes diarrhea) results. On 08/22/2025 the facility received the lab results showing Resident 37 was positive for having a C-diff infection. Observations on 08/21/2025 at 10:34 AM showed housekeeping staff inside room [ROOM NUMBER], without a gown or gloves on, while cleaning the side of the room by the window. At this time, a staff member from the therapy department, without putting on a gown or gloves, entered the room and brought Resident 37 some water. Observations on 08/21/2025 at 12:28 PM showed staff entering Resident 37’s room carrying their lunch tray, moved items on their bedside table for the tray, and exit the room using only hand sanitizer. Staff did not put on a gown and gloves prior to entering the room and did not use soap and water for hand hygiene upon exiting. On 08/21/2025 at 12:29 PM, Staff T (Certified Nursing Assistant - CNA) entered Resident 37’s room and began assisting the resident with opening their milk container, exited the room, without performing hand hygiene, and picked up a carton of thickened liquids being kept on a beverage delivery cart to pour fluids for another resident. Staff T then went to another room, used hand sanitizer prior to entering, but had not washed their hands with soap and water after exiting Resident 37’s room, who was on a TBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505455	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Judson Park Health Center	23620 Marine View Drive South Des Moines, WA 98198

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 08/26/2025 at 12:23 PM showed Staff V (CNA) and Staff W (CNA) enter Resident 37’s room, without putting on a gown and gloves, to deliver a lunch tray and beverages to the resident. Both staff used hand sanitizer, but did not wash their hands with soap and water, upon exiting as indicated on the sign posted at the door. Observations on 08/27/2025 at 8:35 AM showed Resident 37 remained on a TBP and Staff U (Physical Therapy Assistant) entered their room, without putting on a gown and gloves, set a laptop down inside the room on a counter, and stated, “let me go get my gown on and come back.” Staff U went back into the hall and put on a gown and gloves. In an interview on 08/27/2025 at 9:01 AM, Staff U stated a gown, and gloves should be put on prior to entering a room when someone is on contact enteric precautions. In an interview on 08/28/2025 at 12:04 PM, Staff X (Infection Preventionist) stated it was their expectation staff adhere to the directions posted on the TBP signs to help prevent the spread of infections. Staff X stated for contact enteric precautions, staff should put on a gown and gloves prior to entering the room and wash their hands with soap and water upon exiting the room. <Wound Care> <Resident 54> Observations on 08/28/2025 at 9:56 AM showed Staff N (Nurse Supervisor) providing wound care to an open area on Resident 54’s backside. Staff N removed the old dressing, put cleansing solution on some gauze, and began cleaning the wound and surrounding area. With the same soiled gloves, Staff N opened and applied a skin preparation (a protective barrier to prevent damage from adhesive bandages) to the surrounding area of the wound, and covered wound with a new foam bandage. Staff N, while wearing the same soiled gloves, touched the bed remote and picked up one of Resident 54’s pillows to position under the resident’s knees. Staff N removed their gloves, did not perform hand hygiene, touched the door handle to exit the room, went into the room next door to say hello to family, exited that room, and entered a third room, all before performing hand hygiene. In an interview on 08/28/2025 at 12:04 PM, Staff X stated it was their expectation staff perform hand hygiene during wound care after removing soiled dressings and prior to applying a clean dressing. Staff X stated staff should also perform hand hygiene after removing gloves and when moving between resident rooms. <Cleanable Surfaces> <Resident 2> Observations on 08/22/2025 at 12:41 PM showed Resident 2 sitting in their wheelchair with cracked, peeling material noted to both arm rests. In an interview on 08/28/2025 at 12:04 PM, Staff X stated wheelchair armrests were not cleanable once they are cracked and peeling and should be replaced to decrease the spread of bacteria and improve the ability to sanitize the surfaces. REFERENCE: WAC 388-97-1320 (1)(a)(c),(2)(b).