STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505465	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Josephine Caring Community	9901 272nd Place Northwest Stanwood, WA 98292

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and interview the facility failed to ensure drugs and biologicals were stored in accordance with the state and federal laws appropriately for 1 of 2 (Rehab Unit) Medication Storage Rooms. The facility failed to ensure Schedule II-V (Substances with high potential for abuse which may lead to severe psychological or physical dependence) controlled medications were in separate locked, permanently affixed compartments not accessible to others. These failures left controlled substances unattended with potential of unauthorized access to drugs that should have been securely stored.Findings included . In an observation and interview on 09/10/2025 at 9:50 AM, Staff H, Registered Nurse/Case Manager opened the refrigerator in the Medication Room in the Rehab Unit, inside the refrigerator was a locked metal box not permanently affixed to the refrigerator. They took the locked box out of the refrigerator and Staff H opened it with a key. Observed in the box were 2 unopened bottles of Lorazepam (Scheduled IV medication that treats anxiety) oral liquid and 1 unopened injectable vial of Lorazepam. According to Staff H, they store controlled medications in the locked box. Staff H was not aware that the storage for Scheduled substances should be permanently affixed in the refrigerator. Refer to WAC 388-97-1300(2)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a system was in place in which residents' records were complete, accurate, accessible, and systematically organized for 5 of 11 residents (Residents 5, 8, 74, 78, and 100) reviewed for accurate and complete medical records. The facility failed to ensure the medical records reflected the physician visit documentation for 3 of 6 residents (Residents 5, 78, and 100), failed to include dialysis provider notes for 1 of 3 residents (Resident 74), failed to ensure accurate documentation for advanced directives for one of one resident (Resident 8). This failure placed residents at risk for medical complications, unmet care needs, and diminished quality of life. Findings included .Review of the facility policy titled, Medical Records, revised date 12/06/2024 stated the medical records department will maintain the records on each resident as complete, accurately documented, readily accessible and systematically organized.Review of the facility policy titled Physician Visits, revised date 12/06/2024 documented that Health Information personnel should remind the physician to write a progress note. The Physician should write or dictate a progress note for each visit.Upon entrance to facility on 09/09/2025 the facility provided Entrance Conference Worksheet, Electronic Health Record (EHR) Information dated 04/04/2025, that showed all information was located on the Electronic Health Record (EHR). <DIALYSIS> Review of Resident 74's care plan on 09/12/2025 documented they received dialysis services and were seen by their nephrologist (medical doctor specializing in kidney diseases) every three months, had labs weekly, and communication packets to/from the dialysis center (including vitals and weight) on dialysis days. Review of Resident 74's electronic medical record showed no visit notes/progress notes from their nephrologist, lab results, or communication packets. In an interview on 09/12/2025 at 9:27 AM Staff Q, RN/Nurse Manager stated the nephrologist completed their visits with Resident 74 at the dialysis center. Staff Q stated they asked for Resident 74's labs every week, they were not uploaded and placed in the paper chart. Staff Q stated they had not put any nephrology notes or labs in Resident 74's EHR but could. Staff Q stated the physicians in the facility had access to Resident 74's facility EHR, but not all had access to records from other entities. In an interview on 09/12/2025 at 10:20 AM Staff I, Health Information Manager, stated they had not been asked to upload dialysis communication forms into Resident 74's EHR and would upload them when the resident discharged . Staff I stated the facility had a hybrid system of electronic records and paper charts. When asked how records from appointments were entered into a resident's medical record, Staff I stated they would obtain the record and upload it into the EHR when they were aware an appointment had occurred. <ADVANCE DIRECTIVE> Review of Resident 8's care plan on 09/12/2025 documented they had a Power of Attorney (POA) appointed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the POA document on 09/12/2025 documented the POA would become effective when Resident 8's primary physicians determined they were unable to make their own health decisions. In a joint interview on 09/15/2025 at 8:55 AM with Staff M, Social Services and Staff P, Social Services, Staff P stated their understanding of Resident 8's decision making was that it was impaired by their severe dementia. Staff P, stated Resident 8 had conversations and would reminisce but relied on their son, who was also their POA, to assist with their decision making. When asked if there was notation by Resident 8's physician regarding their decision-making ability, Staff P deferred to the most recent physician progress note that described Resident 8 as having mild dementia. Staff M stated they would review Resident 8's medical record and provide additional information if they found it. On 09/15/2025 at 9:55 AM Staff M and Staff P provided a signed letter by Resident 8's physician, dated 1/13/2025, which indicated Resident 8 was unable to make healthcare decisions for themselves. Staff M stated the letter was found in Resident 8's paper chart. Staff M stated the letter should have been in Resident 8's EHR. <PHYSICIAN NOTES> <RESIDENT 100> Review of Resident 100's order summary on 09/15/2025 documented they had a neurology appointment on 06/02/2025. Review of Resident 100's EHR showed no documentation related to an appointment on 06/02/2025. In an interview on 09/15/2025 at 1:30 PM Staff D, LPN/Care Manager, stated Resident 100's neurology appointment scheduled for 6/02/2025 was cancelled by the clinic and rescheduled for a virtual appointment on 07/17/2025. Staff D stated they were unable to find the visit note for Resident 100 for their 07/17/2025 virtual visit. Staff D stated the process of obtaining visit notes was for medical records to request them and upload them into the residents' EHR. <RESIDENT 78> Resident 78 was re-admitted to the facility on [DATE] with diagnoses to include sepsis (body's extreme reaction to an infection that can lead to organ failure, tissue damage and death), and enterocolitis due to clostridium difficile (infection of the colon caused by bacterium Clostridium Difficile [C. Diff]). In a record review on 09/11/2025 at 2:42 PM, Resident 78's EHR did not have any progress notes from the provider since their admission on [DATE]. In an interview on 09/12/2025 at 11:50 AM, Staff H, Registered Nurse/Case Manager stated that providers come in every Monday, and any residents admitted after a Monday, the providers will see them the next Monday. Staff H stated that Medical Records prints out the provider progress notes and hands them to the Case Manager for review, then they return them to Medical Records to be scanned and placed in resident's EHR. Requested Staff H provide the provider progress note for Resident 78 after their admission on [DATE]. Staff H stated they would look for the provider progress note. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a record review on 09/15/2025 at 8:51 AM, Resident 78's chart did not have any progress notes from the provider since their admission date on 08/05/2025. In an interview on 09/15/2025 at 9:03 AM, Staff I, Health Information Manager stated that the provider usually sends their progress notes the same day of the visit or the next day. If they have not received the progress note after 4 days, they usually send a fax to the provider to remind them that they were still waiting for their progress notes from their last visit. Requested Staff I to review when the provider had seen Resident 78 and if they could get a copy of the progress note. Staff I stated that the provider was at the facility on 08/11/2025 and that would have been the date the provider had seen the resident. Requested a copy of the provider progress note for Resident 78 on 08/11/2025. Staff I could not provide a copy of the document requested. In an interview on 09/15/2025 at 10:00 AM, Staff H provided a printed copy of the provider's progress note for Resident 78 signed on 09/08/2025. The copy was not in Resident 78's EHR. Per Staff H, they were not able to provide a copy of the provider progress note for the visit on 08/11/2025. <RESIDENT 5> Review of Resident 5's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include chronic respiratory failure, diabetes and chronic pain. Review of Physician's visits documentation dated 09/15/2025 at 9:57 AM, showed Resident 5 was last visited by the physician on 09/08/2025. Review of Resident 5's EHR showed they were seen by a physician on 11/25/2024, 01/27/2025 and 06/23/2025. The EHR showed that Resident 5 was not seen by a physician in March 2025 or August 2025. The EHR did not include dictation from the 09/08/2025 visit. Reference WAC 388-97-1720(1)(a)(i-iv)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to coordinate with the preadmission screening and resident review program (PASARR) for 1 of 5 residents (Resident 8) reviewed for PASARR coordination. Resident 8 required a level II evaluation (in depth evaluation of a resident by the state designated authority) for a serious mental disorder which was not completed which placed residents at risk for unmet behavioral care needs. Findings Included.Resident 8 was admitted to the facility on [DATE], discharged to the hospital on [DATE] and was readmitted to the facility on [DATE]. Resident 8's diagnoses included Parkinson's disease, depression and dementia with psychotic features (hallucinations or delusions). Review of Resident 8's PASARR Level I (screening tool for possible serious mental illness) dated 01/10/2025 documented they required a level II evaluation. Review of Resident 8's PASARR Level II invalidation statement dated 03/06/2025 documented a level II evaluation could not be completed as they were not in the facility. Review of Resident 8's progress notes dated 04/28/2025 written by Staff P, social services director, documented a level II PASARR invalidation was received, dated of 03/06/2025. In an interview on 09/15/2025 at 8:51 AM, Staff M, Social Services, stated there was a miscommunication and the level II evaluation was not completed for Resident 8. Staff M stated there were audits in place to ensure PASARR Level I and II were completed. Staff M stated Resident 8 required a level II evaluation and it was not done. Reference WAC 388-97-1915 (4)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident care plans were updated for 1 of 1 residents (7) reviewed for Hospice services and 1 of 1 residents (100) reviewed for dental services. This failure placed residents at risk for decreased quality of care. Findings included .<DENTAL> Review of Resident 100's care plan dated 07/09/2024 documented they had no natural teeth. The goal was Resident 100 would have no signs or symptoms of improper fit of their dentures. Interventions included assisting Resident 100 with cleaning their dentures and monitor for any oral discomfort. Review of Resident 100's progress notes documented: - On 01/09/2025 Resident 100 met with social services and reported their bottom dentures did not fit properly. -On 01/30/2025 Resident 100 was placed on alert charting related to irritation on their gums. Resident 100 reported their gums were hurting. -On 03/22/2025 Resident 100 was placed on alert for an ulcer to their lower gum and complained of sore spots on their left upper side of their mouth. Resident 100 was provided with an oral/topical anesthetic. -On 05/19/2025 Resident 100, during a care conference social services would coordinate a denturist visit to have their upper and lower dentures fitted. Review of the dental hygienist notes dated 04/17/2025 documented Resident 100 was seen for their dental care. A referral was recommended for Resident 100 to see a denturist related to ill-fitting dentures and their primary care to assess their tissue under their upper denture for possible thrush. In an interview on 09/15/2025 at 9:47 PM Staff D, Licensed Practical Nurse/Resident Care Manager, stated Resident 100 had seen a denturist on 08/22/2025. Staff D stated care plans were reviewed and revised quarterly and annually. Staff D stated Resident 100's care plan should have been updated to reflect their dental needs. <HOSPICE> Resident 7 readmitted to the facility on [DATE] following hospitalization. Review of Resident 7's medical record showed they elected Hospice Services effective 08/15/2025. Review of Resident 7's medical record showed a Hospice plan of care filed in the resident's hard chart. Review of Resident 7's comprehensive care plan on 09/10/2025 showed the Hospice plan of care elements had not been incorporated into the resident's plan of care. The care plan's only mention of Hospice services was included in the care plan's smoking problem. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/10/2025 at 3:08 PM, Staff B, Director of Nursing Services (DNS) stated nursing received the Hospice plan of care and was supposed to review it and incorporate the interventions into the comprehensive care plan. Reference WAC 388-97-1020 (2)(a)(5)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure professional standards were met for 1 of 1 resident (Resident 38) reviewed for oxygen, and 1 of 3 residents (Resident 13) reviewed for diabetic (disease that affects the blood sugar levels in blood) management. The facility failed to follow physician's orders for oxygen administration and failed to ensure appropriate monitoring for diabetes was completed based on national standards. These failures placed the residents at risk for adverse outcomes, medication errors, complications, and unmet needs. Findings included . Review of the facility policy titled, Oxygen Safety, reviewed 12/09/2024, documented the licensed nurse will verify the order and adjust the oxygen flow rate as determined by the physician. Oxygen was administered by a licensed nurse under the order from the attending physician. Review of the American Diabetes Association website on 09/15/2025, documented the national standards for monitoring a hemoglobin A1c (type of blood cell that binds with glucose - standard measurement for average blood glucose levels) recommendations were the levels should be monitored every six months when the last A1c was in the goal range, or every three months if the medication had changed or out of goal range. <RESIDENT 38>Resident 38 admitted to the facility on [DATE] with diagnoses that included respiratory failure and chronic obstructive pulmonary disease (COPD - airflow disruption and damage to lungs). The Quarterly Minimum Data Set (MDS - assessment tool) dated 08/18/2025 documented the resident had no refusal of care and required the use of oxygen. Review of Resident 38's care plan focus area dated 06/02/2025, documented the resident had an alteration in their respiratory status related to their history of COPD, and respiratory failure. Interventions included that the resident was on supplemental oxygen, the resident was dependent on the staff for all tasks, and that the oxygen settings were to administer 2 liter (L)/per min continuously to keep the oxygen saturation level above 88%. Review of Resident 38's physician order dated 08/13/2025, documented to administer supplemental oxygen to resident continuously to the nasal passageway at a rate of 2 L/per minute. In an observation on 09/09/2025 at 11:37 AM, 09/10/2025 at 8:20 AM, 09/11/2025 at 8:24 AM, and 09/12/2025 at 9:34 AM, Resident 38 had oxygen tubing to their nasal passage area, and the oxygen cannister was set to 1 L/per minute. In an observation on 09/12/2025 at 12:48 PM, Resident 38 was lying in the bed, oxygen tubing applied to nasal passage. The setting on the oxygen concentrator was set to 1 L/per minute. In an interview on 09/12/2025 at 1:39 PM, Staff F, Licensed Practical Nurse (LPN) stated Resident 38 was fully dependent on staff for all cares. Staff F stated that the resident was on oxygen supplementation at the rate of 1L/per minute. Staff F was asked to verify the physician oxygen administration order. Staff F confirmed the order was for 2L/per minute. Staff F stated they thought the resident had previously been on 1L/per minute and did not verify the order. At 2:49 PM, Staff F stated they followed up on the physician order for oxygen and the resident was indeed on 2L/per minute, and stated I was following the old orders, that was my error. <RESIDENT 13>Resident 13 was admitted to the facility on [DATE] with diagnoses that included diabetes. The Quarterly MDS dated [DATE], documented the resident received insulin (premade hormone that was injected into the skin to manage blood sugars) all days of the look back period. Review of Resident 13's physician orders dated 11/11/2024, documented the resident was prescribed two oral medications to manage their diabetes, and they received a sliding scale (dose depends on the blood sugar level) injection once a day to manage their diabetes. Review of Resident 13's care plan focus area dated 11/19/2024, documented the resident had an impaired hormone function related to diabetes. Interventions were to monitor blood glucose levels, and lab work to be completed as needed. Review of Resident 13's medical record on 09/12/2025, there was no documented lab work completed for monitoring of the resident's hemoglobin A1c. In an interview on 09/15/2025 at 9:08 AM, Staff D, LPN/Case Manager stated the facility did not have a specific policy as to when to monitor residents A1c levels and stated if they noticed a resident had not had one during the quarterly review, they (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would notify the provider. Staff D confirmed there had been no A1c level check since the resident was admitted to the facility in November/2024. Staff D confirmed Resident 38's physician orders were to administer oxygen supplementation at a rate of 2L/per minute. Staff D stated their expectation was that the staff were verifying and following the physician orders. In an interview on 09/15/2025 at 9:21 AM, Staff B, Director of Nursing Services stated their expectation was that staff were verifying and administering oxygen supplementation as ordered. Staff B was unaware that Resident 38 had been receiving oxygen at a rate of 1L/per minute, which had not what had been ordered by the physician. Staff B confirmed that Resident 13 should have had a A1c lab level completed. Refer to WAC 388-97-1060(3)(vi)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and provide pain management to adequately control residents pain for 1 of 3 residents (Resident 63) reviewed for pain management. This failure put residents at risk of uncontrolled pain and a diminished quality of life. Findings included . Review of the facility policy titled, Pain Management, revised 01/22/20205 stated all resident would receive appropriate assessment and management for pain. Appropriate measures for pain control would be documented, then implemented according to a resident's plan of care. when a resident has pain, a pain assessment would be completed. Case Managers and the Minimum Data Set (MDS - an assessment tool) nurse will assess that the residents pain medication and management are effective, and update for further interventions and notifications. Resident 63 admitted to the facility on [DATE] with diagnoses to include osteoporosis, dementia, and muscle weakness. The Quarterly MDS dated [DATE] documented that the resident had severe cognitive impairment, required only supervision for transfer and walking, had no signs of pain, and was not on any medications for pain. Review of Resident 63's progress notes dated 08/28/2025 at 8:20 PM, the licensed nurse documented that the resident had complained of left side lower back pain. The note stated the resident described the pain as stabbing and spasms; resident was observed hunched over holding left side of their back. The note stated the medical provider ordered a urine analysis and started the resident on an antibiotic for five days. Resident 63 was given as needed Tylenol for back pain. Review of Resident 63's progress note dated 09/01/2025 at 8:12 PM, the licensed nurse documented that the resident continued to experience pain to their lower back, the urine analysis showed no infection, and an x-ray was ordered. Review of Resident 63's progress note dated 09/02/2025 at 7:34 PM, the licensed nurse documented the x-ray of lower back was negative. The resident continued to experience lower back pain. The medical provider assessed the resident and started the resident on ibuprofen (non-steroid anti-inflammatory medication). Review of Resident 63's progress note dated 09/02/2025 - 09/06/2025 the resident continued to have severe lower left back pain. Review of Resident 63's medical record documented the resident was seen by the medical provider a second time for severe left lower back pain with new orders for a stool softener and monitor for the pain. Review of Resident 63's progress note date 09/08/2025 at 5:44 PM, the licensed nurse documented the resident was having severe left lower back pain, refused shower due to pain, and their back was uncomfortable to touch. In an observation on 09/09/2025 at 11:46 AM, Resident 63 was observed in the memory care unit living space sitting in a chair. The resident was observed to reach to their left side and rub their lower back several times. They had a grimace look on face, then would lower their head and place their hands over their face with look of discomfort. In an observation on 09/10/2025 at 9:47 AM, Resident 63 was observed to walk back into the memory care unit with a staff member, the resident was teary and had look of discomfort on their face. In an observation on 09/10/2025 at 1:34 PM, Resident 63 was walking around the memory care unit telling staff their back was hurting, they would point to the left lower side. In an observation on 09/11/2025 at 8:26 AM, Resident 63 was observed walking around the memory care unit, they had a distressed look on their face, rubbing their back. In an observation on 09/11/2025 at 2:26 PM, Resident 63 was observed in the memory care unit living space sitting in a recliner. They had their eyes closed, they were rocking back and forth, and they were grimacing. Review of Resident 63's progress note dated 09/11/2025 at 3:27 PM, the licensed nurse documented the resident continued to have severe left lower back pain with no relief from the Tylenol or ibuprofen. The note stated the resident was having trouble sleeping due to pain. Review of Resident 63's care plan on 09/11/2025, 15 days after the severe left lower back pain started, there was no focus area for pain, no updated goal of care or interventions to treat the resident's new onset of pain. In an interview on 09/12/025 at 11:21 AM, Staff N, Nursing Assistant Certified (NAC) stated Resident 63 had been having an increase in left lower back pain. Staff N stated they had observed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them grimace and rub the area. Staff N was not aware of the source of their pain, they stated they would wander around the memory care unit. In an interview on 09/12/2025 at 11:29 AM, Staff E, Licensed Practical Nurse (LPN) stated Resident 63 had new ongoing left lower back pain. Staff E stated they had just received more orders from the medical provider to start a topical lidocaine (numbs) patch to their back. Staff E stated they were aware their urine analysis was negative and were unaware if there had been further testing to locate the source of their pain. In an interview on 09/12/2025 at 1:00 PM, Staff O, NAC stated they are educated to follow the care plan or the Kardex (shortened version of the care plan) that is located either in the electronic medical record, or they will place a copy of the Kardex in the residents' closet. Staff O stated that was how they know what level of care to provide each resident. In an interview on 09/12/2025 at 1:39 PM, Staff F, LPN stated that the Case Managers were responsible for updating the plan of care for each resident. In an interview on 09/15/2025 at 9:08 AM, Staff D, LPN/Case Manager stated that the Case Manager for the memory care unit was out. Staff D stated that the Case Manager was the primary staff member that would update the plan of care for the residents. Staff D stated they were not aware that Resident 63 had severe left lower back pain. Staff D stated that if a resident was having an acute change in condition that had not been resolved that focus area should be addressed on the plan of care. In an interview on 09/15/2025 at 9:21 AM, Staff B, Director of Nursing Services (DNS) stated the Case Managers were responsible for updating and revising the plan of care for the residents. Staff B was not aware that Resident 63 was having severe left lower back pain that had gone unresolved for 19 days. Staff B was not able to provide any further information and confirmed that problem should be addressed on the care plan. Reference WAC 388-97-1060(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to identify, assess, and address potential signs and/or symptoms of Post Traumatic Stress Disorder (PTSD) for 1 of 1 sampled resident (Resident 28), reviewed for mood and behavior. This failure placed residents at risk of re-traumatization, unmet behavioral health needs, and diminished quality of life.Findings included .According to the website www.mayoclinic.org Post Traumatic Stress Disorder (PTSD) was a mental health condition that could develop after witnessing or being part of an extremely stressful or terrifying event. Symptoms could include flashbacks (feelings that the traumatic event was occurring again), nightmares (repeated disturbing dreams), intrusive thoughts, severe anxiety, avoidance (not wanting to think or talk about a traumatic event), changes in mood or thinking and physical and emotional reactions. These symptoms last more than one month, cause major problems in social or work situations and affect how well a person gets along with others.Review of the facility policy titled, Trauma Informed Care revised 12/06/2024 documented the policy was to ensure there were sufficient staff to provide services or referrals to residents who had a history of trauma. The procedure included screening residents on admission and at any time afterward to ask questions to assess for possible experiences of trauma and to develop a care plan to assist in trauma informed care to avoid re-traumatization. Resident 28 admitted to the facility on [DATE] with diagnoses to include dementia, depression, anxiety and PTSD. Review of Resident 28's Quarterly Minimum Data Set (an assessment tool) dated 07/08/2025 showed their brief interview for mental status (a screening tool to identify cognitive condition) was three out of 15, severe cognitive impairment. Review of Resident 28's care plan on 09/10/2025 documented they had: - Impaired cognition related to PTSD and dementia and they would be able to communicate appropriately with others using yes/no questions. Interventions included staff anticipating Resident 28's needs and limiting background noise. -Refusals of personal care to include bathing and personal hygiene related to their dementia and depression. Interventions included staff to reapproach Resident 28 if they refused a shower. -Ineffective mood and behavior regulation related to their diagnoses of dementia, depression, anxiety and PTSD. Interventions included encouraging Resident 28 to participate in out-of-room group activities. Review of Resident 28's clinical record from 1/25/2025 through 9/10/2025 showed no documentation of a trauma screening, details of their PTSD diagnosis, their experiences or triggers that may impact their care or potentially cause re-traumatization. In an attempted interview on 09/10/2025 at 9:36 AM, Resident 28 was sitting in a recliner, outside of their room, in the unit hallway with a television in front of them. Resident 28, when greeted, responded slowly with a flat affect (diminished emotional response) and did not engage in conversation. In an interview on 09/10/2025 at 3:13 PM Staff P, Social Services, stated they had not discussed or gathered information about Resident 28's PTSD diagnosis or triggers with their representative or (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family. In an interview on 09/11/2025 at 9:37 AM Collateral Contact 2 (CC 2), Resident 28's family member stated they had not been interviewed by facility staff until 09/10/2025 at 5:30 PM about Resident 28's diagnosis of PTSD. CC 2 stated Resident 28 had been sexually abused as a child. Reference: (WAC) 388-97-1060(3)(e)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure timely physician visits (once every 30 days for the first 90 days after admission) were completed for 4 of 7 residents (5, 49, 79 and 84) reviewed for physician visits. This failure placed residents at risk of being denied face-to-face contact with a physician, comprehensive reviews and physician assessments of their health and well-being. Findings included .According to CMS (Centers for Medicare and Medicaid); The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. After the initial physician visit in SNFs (Skilled Nursing Facility), where States allow their use, a NPP (Nurse Practitioner) may make every other required visit. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.Review of the facility policy titled, Physician Visits reviewed and revised on 12/06/2024, showed it was the policy of the facility to ensure the physician takes an active role in the care of the residents. Health Information personnel should track due dates of physician visits and notify the resident when a physician visit was due. The resident must be seen at least once every 30 calendar days after admission and at least every 60 days thereafter with a physician delegate as appropriate by State law. The physician should review the resident's total program of care including medications and treatments at each visit.<RESIDENT 5> Review of Resident 5's medical record showed the resident was admitted to the facility on [DATE] with diagnoses to include chronic respiratory failure, diabetes and chronic pain. Review of Resident 5's electronic health record (EHR) showed they were seen by a physician on 11/25/2024, 01/27/2025 and 06/23/2025. The EHR showed that Resident 5 was not seen by a physician in March 2025 or August 2025. <RESIDENT 49> Resident 49 admitted on [DATE] with diagnoses to include hypertensive kidney disease (condition when high blood pressure damages the kidneys over time) and diabetes. Review of Resident 49's EHR showed they were last seen by a physician on 06/23/2025. The EHR showed that Resident 49 was not seen by a physician in August 2025. <RESIDENT 84> Resident 84 admitted on [DATE] with diagnoses which included dementia. Review of Resident 84's required physician's visits for 2025 showed: -02/24/2025, -06/16/2025, -09/08/2025. There was no required provider visit in April of 2025. The provider visit due in August of 2025 was not completed within the required 60 days plus the 10-day grace period. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<RESIDENT 79> Resident 79 admitted on [DATE] with diagnoses to include chronic obstructive pulmonary disorder and major depressive disorder. Review of Resident 79's EHR showed they were last seen by a physician on 06/16/2025. The EHR showed that Resident 79 was not seen by a physician in August 2025. In an interview on 09/15/2025 at 9:03 AM, Staff I, Health Information Manager stated that they audit charts to ensure residents have been seen. They update Collateral Contact (CC) 1 of the need for visits by phone or email and provide a list of residents to be seen on Mondays. Staff I stated they had notified CC 1 of missed visit documentation last week. In an interview on 09/15/2025 at 10:51 AM, Staff H, Registered Nurse/Nurse manager stated Collateral Contact (CC) 1's Residency doctor (physician in training) was supposed to complete the dictations for the 09/08/2025 visits. The visit list provided was reviewed and showed 18 residents were seen on 09/08/2025. Staff H stated they would let CC 1 know of the other missing dictations. Staff H was asked about Resident 79's medical record that showed they were last seen by their doctor on 06/16/2025 and Resident 49 had last been seen on 06/23/2025. Staff H stated they would look into that. In a joint interview on 09/15/2025 at 1:05 PM, Staff A, Administrator Staff B, Director of Nursing Services and Staff C, Licensed Practical Nurse/Assistant Director of Nursing Services were informed of missed physician visits. Staff A stated they had not been aware of missed physician visits. In an interview on 09/15/2025 at 1:47 PM, CC 1 stated they rounded on their residents on Mondays and are accompanied by 2nd and 3rd year Residency doctors. CC 1 stated the resident doctors were responsible to see their assigned residents, write the notes and they would sign off on their notes. CC 1 said they first became aware of missed visit notes last week. CC 1 stated the facility provided a list of scheduled visits that were due. CC1 stated that they tried their best to see the residents every 60 days, but it might go a week or two over that. No additional information was provided. Refer to WAC 388-97-1260(4)(c)(10)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide timely laboratory results to meet the needs of one of two residents (121) reviewed for laboratory services. This failure had the potential for negative complications related to delay of obtaining and receiving follow up of laboratory results placing residents at risk for delay in treatment and adverse outcomes.Findings included.Review of the facility policy titled Laboratory Services, (revised date 12/09/2024), documented the facility would obtain ordered laboratory testing according to provider's orders and would promptly notify providers of results that fell outside of clinical reference ranges.Resident 121 readmitted to the facility on [DATE] with diagnoses which included acute and chronic wounds with infection of the bone. Review of Resident 121's physician's orders dated 08/29/2025 showed orders for laboratory testing to be completed every week on Tuesday. Review of the resident record on 09/12/2025 showed that the resident should have had two sets of laboratory testing (on 09/02/2025 and 09/09/2025) since their readmission. Review of Resident 121's Treatment administration record showed that the ordered labs were signed as having been completed on 09/02/2025 and 09/09/2025, but further review of the record showed no results or progress notes regarding any lab results. In an interview on 09/12/2025 at 1:45 PM, Staff F, Licensed Practical Nurse, (LPN) stated hard copy results should be under the laboratory section of the resident's hard chart or scanned in to the results tab of the electronic health record. Staff F confirmed that results were not in Resident 121's record. Staff F stated the facility was not receiving results from their lab and staff were having to go into the system to print them. Staff F was not aware of any particular process or system to remind staff to follow up on pending labs. Record review on 09/15/2025 showed Resident 121's 09/02/2025 and 09/09/2025 labs were still not filed in either the hard chart or the electronic medical record. In a joint interview on 09/15/2025 at 10:40 AM, Staff G, Licensed Practical Nurse (LPN), Unit Manager, and Staff C, LPN/Assistant Director of Nursing, stated there had been a change to the lab process at the beginning of the month. Staff G reviewed the resident record and confirmed there were no laboratory results found. Staff G logged in to the laboratory portal to view the resident labs and stated the labs on 09/02/2025 showed a partial result but that the 09/09/2025 were in the system. Staff C stated they would have to contact the lab and stated the nurses should be aware of pending labs through shift report and chart documentation. Refer to WAC 388-97-1620 (2)(6)(a)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure staff adhered to infection control practices when providing care to 1 of 3 (Resident 78) residents that were on Transmission-Based Precautions. The facility failed to ensure staff used appropriate hand hygiene and personal protective equipment (PPE - equipment worn to minimize exposure to infections or diseases) when entering a room that had a sign of Contact Enteric Precaution (combination of contact precaution and enteric precautions used for infections that spread through contact with fecal matter or contaminated objects). This failure placed residents and staff at risk for potential infections.Findings included .Review of the facility policy titled Infection Control Policy/Procedure, Transmission-Based Precautions, revised date 08/28/2025 documented, Contact Enteric Precautions should don (put on) a gown and gloves prior to entry for all interactions that may involve contact with the resident or the resident's environment. Hand hygiene is performed with soap and water. Resident 78 was re-admitted to the facility on [DATE] with diagnoses to include sepsis (body's extreme reaction to an infection that can lead to organ failure, tissue damage and death), and enterocolitis due to clostridium difficile (infection of the colon caused by bacterium Clostridium Difficile [C. Diff]). In an observation on 09/09/2025 at 10:15 AM, at the side of Resident 78's door, there was a sign posted - Contact Enteric Precaution, the sign stated: prior to entering: wash or gel hands prior to entry, wear gown and gloves, use soap and water upon leaving the room. In an observation and interview on 09/09/2025 at 11:28 AM, Staff J, Nursing Assistant Certified (NAC), went in the room of Resident 78 to answer the call light. Staff J did not don any PPE. After a few minutes, Staff J left the resident's room and went directly to the clean utility room. Staff J did not perform hand hygiene after leaving the resident's room. Staff J came out of the clean utility room with a blanket and went back to Resident 78's room without any PPE. A few minutes later, Staff J came out of the room and used hand gel outside of the resident's room. Staff J was asked what the sign Contact Enteric Precaution that was posted at the side of Resident 78's door meant, Staff J stated that the only time they wear PPE was when they provided contact care to resident. In an interview on 09/09/2025 at 11:32 AM, Staff K, NAC stated that Contact Enteric Precaution meant they wear gowns and gloves when they were doing high contact care such as peri-care (washing of the genital and anal areas) or handling soiled things. They added they only wear gowns when they were doing peri-care or handling soiled things. In an interview on 09/09/2025 at 11:40 AM, Staff H, Registered Nurse (RN)/Case Manager stated that Contact Enteric Precaution sign meant to only wear PPE when they were touching the resident. When asked to clarify what was posted outside of the room with Staff H, Staff H then added that they would get back with me and would get clarification from the Infection Control nurse. At 11:53 AM, Staff H stated that what they informed me earlier was for residents who were on Enhanced Barrier Precaution (EBP -an infection control strategy that uses gloves and gowns during high-contact care activities for residents colonized or infected with specific multidrug-resistant organisms or those with wounds or indwelling devices that increase the risk of transmission) and for residents that were on Contact Enteric Precaution, anyone entering should be wearing PPE (gown and gloves). Staff H added that they had educated the other staff members on the floor about Contact Enteric Precautions. Staff H stated that the staff that went in Resident 78's room should have worn PPE prior to entering the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 09/12/2025 at 2:16 PM, Staff L, RN / Infection Preventionist stated that the staff at the facility get a lot of training regarding transmission-based precautions. Staff L stated that the notice posted by the door of a resident should explain what type of PPE the staff should use and that staff should follow what was posted. Refer to WAC 388-97-1320(1)(a)(c)