STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

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

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their abuse prohibition policy for 2 of 2 residents (Residents 2 & 3) reviewed for abuse and/or neglect. The facility failed to completely and thoroughly investigate Resident 2's unexpected death and failed to conduct through investigations to identify the root cause(s) and contributing factors related to Resident 2 & 3's falls. Failure to conduct a thorough investigation placed residents at risk for further injuries, potential abuse/neglect, and other negative health outcomes. Findings included .Review of the facility Abuse, Neglect and Exploitation Policy revised 05/01/2025, showed Neglect means the failure of the facility, its employees, or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. According to the policy the facility would investigate suspicion and/or reports of abuse, neglect, identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. In addition, all alleged violation would be reported as required. RESIDENT 2FALL INVESTIGATIONDuring an interview on 09/18/2025 at 3:20 PM a collateral contact stated Resident 2 fell on [DATE], hit their head, broke their arm and hip and had to have surgery the following day.According to 07/31/2025 5-day scheduled Minimum Data Set (MDS - an assessment tool) Resident 2 had a fall in the facility which resulted in a major injury.Review of the 07/31/2025 1:30 PM incident report and investigation showed that a student told Staff D, Resident Care Manager (RCM), that Resident 2 had fallen. Upon entering the room, the resident was found in a prone position (flat on their stomach) on the floor with their right arm extended to their side. Visible blood was observed on the floor and an open area to the resident's right wrist. Resident 2 complained of severe discomfort to their right shoulder and wrist. Right wrist observed with swelling and suspected hematoma (localized collection of blood in tissue), possible deviation or dislocation. The investigative root cause analysis was that Resident 2 stated they were attempting to self-transfer to the wheelchair to use the restroom. Call light was not on at the time of the fall. Resident was impulsive and non-compliant with asking for assistance. Resident recommended to not self-transfer. Abuse and Neglect was unsubstantiated as Resident stated they attempted to transfer to the bathroom without assistance, forgetting to lock their wheelchair and fell.Further review of the investigative documents showed Resident 2 was found on the floor at 1:00 PM with 02 running at 2 Liters per Minute (lpm). The resident was last attended at 11:45 AM, when their briefs were wet and they voided urine, they were last seen at 12:04 PM when a nurse administered as needed pain medication.The investigation did not address what may have occurred between 12:04 PM and 1:00 PM. For example, did the resident eat lunch, and did the nurse follow up to determine if the pain medication was effective.On 09/19/2025 at 1:48 PM the posted lunch meal time for Resident 2's hallway was 12:15 PM, with a note that times may vary up to 15 minutes before or after.In an interview on 09/19/2025 at 2:31 PM Staff C, Assistant Director of Nursing, stated they would expect the nurse to follow up regarding the pain medications in 30 minutes to one hour after administered. Staff C stated Resident 2 was toileted at 11:45 AM, came back from the bathroom, asked for pain medication, which was administered at 12:04 PM. Staff C stated Resident 2 was impulsive and would get up, but could not go to the bathroom by themselves.The investigation did not include statements from the staff who delivered the resident's lunch, picked up the resident's lunch tray, or the nursing assistant assigned to Resident 2's care or from the student who found the resident on the floor.In an interview on 09/19/2025 at 2:31 PM Staff C confirmed as part of the investigation they would expect to find out from staff what they were doing at that time.Review of the July Medication Administration Record (MAR) showed 07/28/2025 orders for Oxygen at 6 lpm per Nasal Cannula (NC) continuously, to maintain the SpO2 (blood oxygen saturation level) at 90% or greater. Therefore, the resident was not receiving oxygen at the physician ordered rate when they fell.The resident was sent to the emergency room and diagnosed with a right distal radius (wrist) and a right intertrochaneteric femur (hip) fracture.Review of July 2025 and August 2025 Abuse Reporting Logs showed the fall with significant injury was not reported. In an interview on 09/19/2025 at 2:44 PM, Staff B, Director of Nursing, confirmed the incident was not, but should have been reported on the log as a substantial injury reasonably related to the fall.DEATH INVESTIGATIONDuring an interview on 09/08/2025 at 12:04 PM Resident 4 stated the night before a resident next door to them had choked and died at the facility.During an interview on 09/08/2025 at 12:44 PM when asked, Staff C stated Resident 2 passed unexpectedly, after having been provided a lunch meal. When asked if the resident choked, Staff C stated

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure respiratory care and services were provided in accordance with Physician's orders and accepted professional standards of practice for 4 of 5 residents (Resident 2, 7, 8 & 9) reviewed for respiratory services. This failure placed the residents at risk for respiratory complications, unmet needs and diminished quality of life.Findings included .Review of the facility Oxygen Administration policy revised 07/03/2024 showed oxygen was administered to residents who needed it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. According to the policy Oxygen would be administered under orders of a physician, staff shall change oxygen tubing and mask/cannula weekly and as needed, change humidifier bottle when empty, weekly or per facility policy, or as recommended by the manufacturer. Oxygen delivery by Nasal Cannula (NC) requires humidification at flow rates greater than 4 Liters per Minute (lpm).RESIDENT 2Review of the 06/15/2025 History and Physical showed Resident 2 had multiple diagnoses including chronic hypoxic respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea, used a Continuous Positive Airway Pressure (CPAP) at night, but the machine broke two weeks prior and the resident was unable to replace it. The resident was on 6 lpm NC at baseline. Resident arrived at the Emergency Department on 10 lpm delivered through a non-rebreather mask (delivers high concentrations of oxygen, using one-way valves to prevent rebreathing exhaled air).Resident 2 was discharged from the hospital to the facility on [DATE]. Review of the Post Acute & Transition of Care Orders showed Resident 2 needed to be on Bi-level Positive Airway Pressure (BiPAP) while sleeping, at nighttime and as needed for SOB. Review of 06/23/2025 hospital records showed the BiPAP needed to be set up prior to discharge. Review of the June 2025 Treatment Administration Record (TAR) showed 06/23/2025 order for oxygen at 6 lpm per NC continuously, which staff documented as done.A 06/24/2025 7:00 PM Nurses Note showed they titrated the oxygen (O2) down to 4 lpm. An 8:41 PM Nurse's Note showed the resident had shortness of breath (SOB) on exertion and when lies flat, gets easily SOB, SpO2 (blood oxygen saturation level) 94% at 4 lpm via NC continuous. A 06/25/2025 9:47 PM Nurse's Note showed Resident 2 was on 4 lpm via NC. Review of the 06/24/2025 Provider Admit Visit Encounter Note showed Resident 2 was admitted for acute respiratory failure related to not using CPAP for two weeks due to equipment malfunction. Baseline Supplemental 6lpm NC, with a goal of Sa02 88-92%, and instructions to staff to monitor and call Provider for evidence of acute exacerbation, wheezing, SOB, increased O2 requirement.A 06/28/2025 2:30 PM Nurse's Note showed Resident 2 had SOB on exertion, SOB when lied flat, mild SOB at rest and was on 02 at 4 lpm via NC.Review of the June 2025 TAR showed a 06/28/2025 order for oxygen at 2-4 lpm per NC continuously every shift. Staff initialed indicating the order was followed but did not note the oxygen rate delivered.A 06/29/2025 10:22 PM, Nurse's Note showed 02 at 6 lpm via NC was maintained. A 06/30/2025 10:09 PM, Nurse's Note showed Resident 2 was on 02 at 6 lpm via NC. Similarly, on 07/01/2025 at 9:32 PM, and 07/03/2025 at 9:32 PM.According to a 07/06/2025 7:56 PM Nurse's Note, when Resident 2's oxygen was decreased to 3 lpm, the resident insisted they needed oxygen at 6 lpm, stated, my doctor told me I need 6 Liters. When they were instructed about why they did not need 6 lpm the resident got upset, defensive, and accusatory.A 07/20/2025 2:47 PM Nurse's Note showed Resident 2 had labored breathing, complained of SOB, cough and chest pain. Resident 2 was sent out to the hospital for further evaluation.Review of the After Visit Summary showed Resident 2 was hospitalized from [DATE]-[DATE] with a primary diagnosis of COPD Exacerbation.Review of the facility census showed Resident 2 was readmitted to the facility on [DATE].A 07/23/2025 4:47 PM Infection Control note showed Resident 2 was unable to sustain a saturation of above 90% on 10 liters of oxygen. Notifications were completed and the resident was sent back to the hospital. Review of the 07/28/2028 hospital discharge records showed a discharge diagnosis of acute on chronic hypoxic hypercapnic respiratory failure (a condition in which the body fails to remove carbon dioxide CO2 from the blood) secondary to COPD and Interstitial Lung Disease - ILD exacerbation (lung damage with inflammation and scaring, making it difficult for lungs to exchange oxygen and CO2). The resident was discharged on baseline oxygen of 6 liters.Review of the July Medication Administration Record (MAR) showed 07/28/2025 orders for oxygen at 6 lpm per NC continuously - Maintain SpO2 90% or greater.Record review showed Resident 2 was hospitalized from [DATE] - 08/08/2025 following a fall with fractures.Review of 08/08/2025 hospital discharge orders showed orders for continuous oxygen at 4-6 liters via NC, with a

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure medically-related social services were provided for 1 of 4 residents (Resident 2) reviewed for respiratory services. The failure to involve facility social workers for residents demonstrating behaviors of rejection of care placed residents at risk for unmet health needs and other negative health outcomes.Findings included .RESIDENT 2Review of Minimum Data Sets (MDS - an assessment tool), dated 07/31/2025, 08/14/2025 and 09/03/2025 showed Resident 2 was cognitively intact and did not reject care that was necessary to achieve the resident's goals for health and well-being.Review of a 07/07/2025 8:41 PM Nurse's Note showed Resident 2 continued removing oxygen tubing on and off, kept bed in flat position, when encouraged to have head of bed up to ease breathing, became upset. Resident 2 was resistant to care, declined shower offered, encouraged to have shower, kept refusing.Review of a 07/08/2025 11:39 AM note written by Staff D, Resident Care Manager, showed Resident 2 was non compliant with diet, aware of risks and benefits and risks for complications related to diabetes and other conditions. Daughter also aware of this and stated she will help with resident's non compliance with over all care and medical recommendations.Review of a 07/08/2025 6:00 PM Nurse's Note showed Resident 2 refused to have head of bed elevated, lied flat and got angry at staff when encouraged. During an interview on 10/03/2025 at 11:25 AM, Staff D, stated it was up to Resident 2 if they wanted to sit up in bed or not, and they were able to use the remote control.Review of a 07/28/2025 4:15 PM Nurse's Note documented by Staff D, showed that Resident 2's representative was notified Resident 2 was noncompliant with BIPAP, care and treatment. A 07/30/2025 Nurse's Note showed Resident 2 refused to use the PAP machine. Review of the August 2025 Medication Administration Record (MAR) showed 08/21/2025 orders for Oxygen (02) at 6-8 Liters Per Minute (lpm) via mask continuously to maintain SpO2 (blood oxygen saturation level) at 88-92%. May use NC (nasal cannula) during meals. If patient refuses to use mask inform provider.Review of an 08/20/2025 Nurse's Note showed Resident 2 breathed better with mask on, but kept removing mask. When encouraged to keep it on, yelled out no and requested to be put back on NC.During an interview on 10/03/2025 at 11:25 AM, Staff D stated Resident 2 had a lot of noncompliance. Staff D referred to a 08/24/2025 8:20 AM Administration Note that showed Resident 2 was on 7 lpm 02 and refused to have the mask on. Staff D stated they would encourage Resident 2 to keep it on and Resident 2 would keep removing it and request to be put back on NC. Staff D stated Resident 2 was non-compliant with fluid restrictions also.Review of Administration Notes showed Resident 2 refused to use the CPAP on 09/04/2025, and 09/06/2025. Review of a written notification to the provider (SBAR) dated 09/06/2025 at 9:00 PM showed the nurse documented the situation as Resident 2 continuously refusing CPAP, complained the setting was too strong for them and wanted to readjust the setting. The provider did not acknowledge the notification until 09/09/2025, after the resident passed away on 09/07/2025.During an interview on 10/02/2025 at 2:46 PM, Resident 2's representative stated they had been in the facility months prior (beginning of July 2025) and explained their concerns regarding Resident 2 refusing the Bi-level Positive Airway Pressure (BiPAP), laying in bed, and not being showered. Resident 2's representative said they told the six people in the room, if there were any problems to call them. Resident 2's representative stated the facility staff were going to communicate with them anytime Resident 2 refused Continuous Positive Airway Pressure (CPAP), BIPAP, and anytime he refused from that point forward they would call so they could go into the facility and talk to Resident 2. Resident 2's representative stated they did not receive a call from that point on.During an interview on 10/03/2025 at 11:25 AM, Staff D Resident Care Manager (RCM) stated when Resident 2's representative was in the facility they were talking about Resident 2 refusing showers, and they told Resident 2's representative that they would call if Resident 2 refused showers.Review of the 09/01/2025 Care Plan Report showed no behavior care planned interventions to address Resident 2's refusals of care. During an interview on 10/03/2025 at 12:02 PM, Staff N, Social Services Director, stated they were unaware of Resident 2's refusals. Staff N stated they would expect nursing to notify family, and for social services to be notified to explore potential reasons for the refusals, and if necessary to discuss refusals in care conferences, code the MDS and develop a plan of care.REFER TO: WAC 388-97-0960(1)