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	04/11/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to have psychotropic medication (medications that affect a person's mental state) informed consent accurately completed prior to administering the medication for 1 of 5 sampled residents (Resident 100) when reviewed for unnecessary medication use. This failure placed the resident and/or their legal representative at risk for lack of knowledge to make an informed decision regarding the use of the medication, inaccurate data in the medical record, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 100 readmitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set (MDS, a required assessment tool) dated 03/03/2025 showed Resident 100 had diagnoses of depression and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs). Review of Resident 100's provider order dated 03/28/2025 showed the resident was prescribed olanzapine (an antipsychotic medication) two times a day for delirium (a mental state of confusion, disorientation, and not able to think or remember clearly) with agitation. Review of Resident 100's form titled, Informed Consent for Use of Psychotropic Medication, dated 03/28/2025, showed the diagnosed condition for which the medication was prescribed was for a psychotic disorder. Review of Resident 100's EHR on 04/09/2025 showed no diagnosis of psychotic disorder. During an interview on 04/09/2025 at 11:10 AM, Staff F, Licensed Practical Nurse Supervisor, stated Resident 100 was taking an antipsychotic medication. Staff F stated Resident 100's informed consent dated 03/28/2025 was not accurately filled out because the resident did not have a diagnosis of psychotic disorder, and this did not meet expectations. During an interview on 04/09/2025 at 11:27 AM, Staff B, Director of Nursing Services, stated Resident 100's informed consent for their prescribed psychotropic medication was not accurately completed because it showed Resident 100 had a diagnosis of psychotic disorder; however, the resident did not have that diagnosis. Staff B stated the expectation was for informed consents to be completed accurately. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-0260

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 46067 . Based on interview and record review, the facility failed to follow up on concerns of the resident council related to resident care for 3 of 4 resident council meetings minutes (November and December 2024, and January 2025) when reviewed. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . During an interview on 04/09/2025 at 8:37 AM, Resident 14 stated management did not follow up with concerns discussed during the resident council meetings. Review of the resident council minutes, dated 11/25/2024, showed concerns voiced by members regarding evening shift staff chatting at the nurse's station and not promptly responding to call lights. Review of the resident council minutes, dated 12/30/2024, showed concerns voiced by members regarding night shift staff on their cell phones and long call light wait times. Review of the resident council minutes, dated 01/27/2025, showed concerns voiced by members to include night shift staff on their cell phones and continued long call wait times. Review of the grievance log dates 11/2024 through 03/2025 showed no grievances that corresponded with concerns verbalized at resident council meetings. During an interview on 04/10/2025 at 1:57 PM, Staff G, Activities Supervisor, stated they did not initiate grievances related to concerns expressed during resident council meetings. Staff G stated if residents had grievance concerns during resident council meetings they should follow up with the social services department for assistance. During an interview on 04/11/2025 at 10:51 AM, Staff A, Administrator, stated it did not meet their expectation that specific concerns brought up in resident council had not been addressed and followed up on. Reference WAC 388-97-0920

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on interview and record review, the facility failed to obtain an advanced directive (AD, a legal document that establishes a representative to make medical decisions when you are unable to) and/or perform periodic reviews of AD for 1 of 3 sampled residents (Resident 16) when reviewed for AD. This failure placed the resident at risk of not having an established decision-maker, lack of ability to direct care, and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 16 initially admitted to the facility on [DATE] with diagnoses that included heart failure and diabetes (too much sugar in the blood). Resident 16 was able to make needs known. Review showed no AD was in place for Resident 16. During an interview on 04/08/2025 at 1:20 PM, Resident 16 stated they thought they had an AD, and the facility had the paperwork. Review of Resident 16's care plan conference/welcome meeting form dated 09/27/2024 showed Resident 16 had an AD, In place. Review of Resident 16's care plan conference/welcome meeting form dated 12/13/2024 showed See Care Plan related to AD. Review of the focused care plan for AD initiated on 10/14/2024 showed, Education given upon admission. Review showed interventions initiated on 10/14/2024 for Declines further assistance with AD at this time, and Staff will review my healthcare directives with me at least quarterly to verify that my wishes have not changed. Review of Resident 16's admission record on 04/07/2025 showed Resident 16 was their own responsible party and did not show Resident 16 had an AD. During an interview on 04/09/2025 at 8:53 AM, Staff D, Social Services Director, stated Resident 16 did not have an AD in place at this time. Staff D stated when Resident 16 readmitted to the facility on [DATE] they should have documented a discussion related to AD and that did not happen. During an interview on 04/09/2025 at 9:37 AM, Staff A, Administrator, stated ADs were to be reviewed upon admission, on a quarterly basis, and documented in the Resident's EHR. Staff A stated they were unable to locate an AD for Resident 16 and the resident's AD documentation did not meet expectations. Reference WAC 388-97.-0280 (3)(c)(i-ii), -0300 (1)(b)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to identify and report an allegation of abuse for 2 of 2 sampled residents (Residents 82 and 169) when reviewed for abuse. This failure placed the residents at risk of further abuse, psychological distress, and diminished quality of life. Findings included . Review of the facility's policy and procedure titled, Abuse, Neglect and Exploitation, dated 03/04/2025, showed the facility would identify the different types of abuse, investigate immediately when suspicions of abuse occurred, make efforts to ensure all residents were protected from physical and psychological harm as well as additional abuse during the investigation, and report all allegations to the administrator, state agency, and others as needed. Resident 82 Review of the electronic health record (EHR) showed Resident 82 was admitted to the facility on [DATE] with diagnoses to include fracture of right humerus (long bone of upper arm), type two diabetes (high blood sugar), insomnia (inability to sleep), and chronic pain syndrome. Resident 82 was able to communicate needs. Review of incident log for March 2025 showed Resident 82 was involved in a verbal altercation with a roommate on 03/18/2025. Review of the investigation report for the 03/18/2025 verbal altercation showed the incident was reported to the state hotline, but there was no documentation of this reporting. During an interview on 04/09/2025 at 12:40 PM, Staff B, Director of Nursing Services (DNS), stated they reported allegations to the state agency. Staff B was unable to provide documentation the 03/18/2025 verbal altercation had been reported to the state agency. Resident 169 During an interview and observation on 04/07/2025 at 11:54 AM, Resident 3 stated their previous roommate, Resident 169, was not treated with respect and dignity by a caregiver when providing care and Resident 3 had asked the caregiver to leave the room. Review of a grievance form, dated 02/21/2025, showed Resident 169 stated a staff member was negative towards them when they requested to be changed. Review showed the staff member got a huge grin, started singing, and winked at Resident 169 while they lay naked. Under the section Steps Taken to Investigate Grievance facility staff wrote Resident 169 was discharged home, and customer service training was provided to the staff member. There were no interviews from other residents, or Resident 3, and there was no investigation and reporting of the allegation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2025 at 10:38 AM, Staff A, Administrator, stated they were out of the facility during the time of the grievance for Resident 169. During an interview on 04/10/2025 at 10:51 AM, Staff B, DNS, stated there was no investigation to rule out abuse for Resident 169's grievance/allegation. Staff B stated the lack of investigation for Resident 169 did not meet expectations. Reference WAC 388-97- 0640(6)(a)(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49926 Based on observation, interview, and record review, the facility failed to thoroughly investigate an incident to rule out abuse for 1 of 2 sampled residents (Resident 82) when reviewed for abuse. This failure to conduct and document a thorough investigation and clearly identify the root cause and contributing factors, and follow-through with new interventions, placed the residents at risk for further abuse, psychological distress and diminished quality of life. Findings included . Review of the facility's policy and procedure titled Abuse, Neglect and Exploitation, dated 03/04/2025, showed the facility would identify and interview all involved persons, including the alleged victim, alleged perpetrator, and witnesses. It showed the investigation would focus on determining if abuse had occurred, the extent and cause, and provide complete and thorough documentation. Review of the electronic health record (EHR) showed Resident 82 was admitted to the facility on [DATE] with diagnoses to include fracture of right humerus (long bone of upper arm), type two diabetes (high blood sugar), insomnia (inability to sleep), and chronic pain syndrome. Resident 82 was able to communicate needs. Review of the incident log for February 2025 showed Resident 82 was involved in an altercation. Review of the incident report, dated 02/28/2025, showed Resident 48, who was in an electric scooter, bumped Resident 82's chair and caused the chair to spin around. Resident 82 was observed by other staff to have their head down and was taken to relax in other parts of the building. The plan was for the electric scooter to be removed from Resident 48. Review of Resident 48's EHR showed no record of any interventions after this occurrence. Review of the incident log for February 2025 showed no investigation about Resident 48 bumping Resident 82. Observation on 04/10/2025 at 1:15PM, showed Resident 48 leaning towards the right side of their scooter and operated their electric scooter with their left hand. During an interview on 04/09/2025 at 12:40 PM, Staff B, Director of Nursing Services, stated the facility investigated both residents when there was an altercation and was not sure why this did not happen after the 02/28/2025 altercation. Staff B stated the staff who did the investigation was new and needed more training. Reference WAC 388-97- 0640(6)(a)(b)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure risk factors were consistently monitored and addressed to minimize the risk for accident hazards for 2 of 7 sampled residents (Residents 103 and 100) when reviewed for accident hazards. The failure to consistently monitor and ensure identified elopement (refers to a resident wandering off and leaving the facility or designated area unattended) interventions for Resident 103 and to identify and minimize the risk factors for falls for Resident 100 placed them at risk for potential injury, negative outcomes, and decreased quality of life. Findings included . Review of a facility's policy titled, Resident Elopement Guideline, dated 01/2010, showed the facility was to assess residents for elopement risk factors and use elopement precautions as a means to prevent elopement and improve safety and to provide appropriate steps to prevent resident elopement. Resident 103 Review of the admission minimum data set (MDS, a required assessment tool), dated 01/17/2025, showed Resident 103 admitted on [DATE] with multiple diagnoses to include heart, kidney and lung disease, substance abuse and dementia (a decline in mental ability, specifically memory, thinking and behavior that significantly impacts daily life) and was an active smoker (cigarettes). The MDS showed the resident was able to make their needs known. Review of the electronic health record (EHR) showed the facility conducted a brief interview for mental status (BIMS, a standardized assessment tool used to evaluate cognitive function in individuals to assess orientation, memory and attention). Resident 103 scored a 5 on a 15-point scale (0-7 indicated a severe impairment, 8-12 moderate impairment and 13-15 intact cognition). Review Resident 103's EHR clinical record documentation entry dated 02/09/2025 by a facility staff showed the resident was at high risk for elopement due to impaired cognition, as indicated by a BIMS score of 5 out of 15, which confirmed cognitive impairment and diagnosis of dementia. Resident 103 ambulated (walks) independently and expressed a desire to leave the facility. The entry showed the resident was found in the parking lot attempting to catch a bus to visit a family member. Review of Resident 103's care plan, revised 02/07/2025, showed the resident was a high risk for elopement related to history of elopement and verbalized their need to leave due to polysubstance (multiple substances) abuse and BIMS score of 5 out of 15. Review of the facility's incident investigation record dated 2/07/2025 showed interventions to prevent reoccurrence would be for Resident 103 to be placed on one-on-one (1:1) supervision during the day and evening shifts with checks every 15 minutes at night. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Multiple observations on 04/07/2025 at 10:35 AM, 04/08/2025 at 9:55 AM, 04/09/2025 at 9:52 AM and 04/10/2025 at 2:22 PM showed Resident 103 with a certified nurse aide (CNA) either in the resident's room or with the resident in the facility's day room and provided 1:1 observation or conversed with the resident. During an interview on 04/09/2025 at 9:54 AM, Staff J, CNA, stated they were with Resident 103 on a 1:1 basis during the day shift and another aide came in only during the evening shift to take over with the 1:1 observations of the resident. During an interview on 04/09/2025 at 9:01 AM, Staff B, Director of Nursing Services (DNS), stated the facility had CNAs during the day and evening shift to monitor Resident 103 but did not have any 1:1 monitoring on night shift. Staff B stated the CNAs were supposed to monitor Resident 103 every 15 minutes on night shift. Review of Resident 103's EHR showed several entries staff had documented the resident exit seeking behaviors: Entry dated 02/10/2025 at 7:27 PM, continues on alert related to risk for elopement, continues going out of facility, constantly moving inside and outside facility, impulsive, poor safety awareness, continues 1:1 , confused, delusion and disoriented. On 02/16/2025 at 7:47 PM an entry was made by staff, continues exit seeking, continues trying to go out, denied pain in general, mood, cognition, and demeanor per baseline, confused, disoriented, decreased cognition. Entry on 3/18/2025 at 8:32 PM, .continues exit seeking mostly related to desire to smoke, very sneaky, also at risk for falls related to ambulatory, poor decision making, poor safety awareness, decrease cognition. An entry on 03/31/2025 at 8:26 PM, forgetful . continues exit seeking and looking for ways to go out and smoke, continues 1:1 related risk of elopement.; however, no documentation was reviewed within the Resident 103's EHR that documented, every 15-minute checks at night. During an interview on 04/09/2025 at 10:33 PM, Staff A, Administrator, stated the expectation would be if the residents who were on 1:1 observation and every 15 minutes checks at night then there should be some documentation in the EHR it was being done. 46067 Resident 100 Review of the EHR showed Resident 100 readmitted to the facility on [DATE] with diagnoses of depression, diabetes (too much sugar in the blood), and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs). Resident 100 was able to make needs known. Review of a care plan initiated 12/03/2024 showed Resident 100 was at risk for falls and had five falls in the month of February 2025. Interventions included a CALL DON'T FALL sign placed in line of sight to remind Resident 100 to use the call light for any transfers, toileting, or any other assistance and - Bed in lowest position when unattended. Observations on 04/07/2025 at 2:30 PM, 04/08/2025 at 1:31 PM and 04/09/2025 at 10:04 AM showed no CALL DON'T FALL sign posted in Resident 100's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 04/09/2025 at 10:04 AM showed Resident 100 laid on the bed in the highest position with their pants halfway on. Resident 100 stated the CNA was assisting with dressing but left the room to go and get something. Upon leaving room, Staff Q, CNA, came down the hall and stated they were going back into Resident 100's room to help them get dressed. During an interview on 04/09/2025 at 12:17 PM, Staff Q, CNA, stated they were not familiar with the resident and unaware if Resident 100 was a fall risk. During an interview on 04/09/2025 at 12:35 PM, Staff F, Licensed Practical Nurse Supervisor, stated the expectation was for CNAs to review and follow the care plan for each resident and Resident 100 should not have been left unattended. Staff F stated the CALL DON'T FALL sign was taken down temporarily but should have been put back on the wall immediately in Resident 100's room. During an interview on 04/09/2025 at 12:45 PM, Staff B, DNS, stated staff not following Resident 100's fall interventions did not meet expectations. Reference WAC 388-97-1060 (3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 . Based on observation, interview, and record review, the facility failed to ensure the use of an indwelling urinary catheter (a tube which drains urine from the bladder into a collection bag) was properly monitored to ensure it was functioning for 1 of 2 sampled residents (Resident 26) reviewed for urinary catheters. This failure placed the resident at risk for further complications, prolonged therapy, and unmet care needs. Findings included . Review of a facility's policy titled, Indwelling Catheter Use, dated 04/2023, showed if an indwelling catheter was in use, the facility provided appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that included but were not limited to ongoing monitoring for changes in condition related to potential catheter-associated urinary tract infections, recognizing, reporting and addressing such changes. Resident 26 Review of the quarterly minimum data set (MDS, an assessment tool) dated 01/24/2025 showed Resident 26 was admitted to the facility on [DATE] with multiple diagnoses to include heart and kidney disease, neurogenic bladder (a lack of bladder control due to a brain, spinal cord, or nerve problem), urinary tract infection and respiratory failure. In addition, the MDS showed Resident 26 was able to make their needs known, required extensive assistance with activities of daily living, and had an indwelling urinary catheter. Review of Resident 26's medication administration record (MAR), dated April 2025, showed the resident had an order dated 01/20/2025 for a indwelling urinary catheter and the facility's licensed nurses (LNs) were to provide urinary catheter care every shift. The LNs were to observe for potential complications involving signs and symptoms of infection catheter occlusion, catheter migration, and skin breakdown at the insertion site and to notify the provider if any complications were observed. In addition, an as necessary (PRN) provider order showed for the LN to change PRN for leakage, obstruction and urine culture. An additional order dated 01/21/2025 showed the LN was to check the foley catheter's functionality every shift for bladder outlet obstruction. Review of Resident 26's care plan initiated on 01/28/2025 showed the resident had an indwelling urinary catheter related to neuromuscular dysfunction (lack of control of muscles). Interventions included for LNs to check the functionality every shift. Additional interventions were for LNs to monitor and document for signs and symptoms of pain, blood-tinged urine, cloudiness, no output and change in behavior. Observation on 04/07/2025 at 10:15 AM showed Resident 26 laid in their bed with a foley catheter bag attached to the right lower bedframe which had yellow colored sediment in the drainage bag. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 04/08/2025 at 8:46 AM showed Resident 26's urinary drainage bag contained dark cloudy urine. Observation on 04/09/2025 at 12:33 PM showed Resident 26's urinary catheter drainage bag contained a scant amount of dark blood-tinged urine. The residents appeared anxious, and the respiratory rate was notably increased. Review of Resident 26's electronic health record (EHR) showed no new catheter was replaced from 04/07/2025 to 04/09/2025 and no additional documentation was noted that described the resident's urinary catheter drainage. During an interview and observation on 04/09/2025 at 1:01 PM, Resident 26 stated they felt like they needed to pee and had felt this way since yesterday evening. Resident 26 proceeded to lift up their hospital gown at the abdominal area and the abdomen appeared slightly distended (swollen). During an interview on 04/09/2025 at 1:03 PM, Staff M, Licensed Practical Nurse (LPN), stated they were unaware of the Resident 26's dark urine output, but would notify the provider who was currently in the facility. Observation on 04/09/2025 at 1:21 PM showed the facility's provider, Staff N, Advanced Registered Nurse Practitioner (ARNP), entered Resident 26's room, assessed the resident and ordered a bladder scan (a non-invasive ultrasound test used to assess the volume of urine in the bladder). The scan revealed 431 milliliters (MLs) of urine in the bladder. The provider ordered to remove the residents' foley catheter and replace it with a new one. Staff M and Staff L, LPN, discontinued the non-working foley catheter and replaced it with a new catheter. Immediate urinary drainage (yellow colored) was achieved. The resident's facial grimacing diminished, and respiratory rate returned to within normal limits. Resident 26 expressed relief a few minutes after the foley catheter was replaced and adequate urinary output was achieved. During an interview on 04/09/2025 at 1:57 PM, Staff B, Director of Nursing (DNS), stated it was their expectation the LNs assessed residents' urinary catheter and urinary output every shift and notify the provider if there were any issues with the foley catheters. Reference WAC 388-97-1060(3)(c)

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Agility Health and Rehabilitation	5520 Bridgeport Way West University Place, WA 98467

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure respiratory services were provided according to professional standards of practice for 1of 2 sampled residents (Resident 26) when reviewed for respiratory care. Failure to ensure oxygen delivery was provided according to the provider's order placed the resident at risk for discomfort, a potential negative outcome, and unmet needs. Findings included . Review of a facility's policy titled, Oxygen Use, dated 06/2023, showed oxygen was to be administered under the orders of the attending provider. Review of the quarterly minimum data set (MDS, an assessment tool) dated 01/24/2025 showed Resident 26 admitted to the facility on [DATE] with multiple diagnoses to include heart and kidney disease, neurogenic bladder (a lack of bladder control due to a brain, spinal cord or nerve problem), urinary tract infection and respiratory failure. In addition, the MDS showed Resident 26 was able to make their needs known, required extensive assistance with activities of daily living and had an indwelling urinary catheter. Review of Resident 26's provider's order dated 01/20/2025 showed oxygen at 3 liters per minute (LPM) via (per) nasal cannula (NC, a device used to deliver oxygen to a person in need of respiratory help) every shift. Review of Resident 26's care plan, revised 09/18/2024, showed Resident 26 was on oxygen therapy continuously related to chronic respiratory failure with chronic obstructive pulmonary disease (COPD, a group of lung diseases that causes a persistent airflow obstruction and breathing difficulties). Interventions included for licensed nurses (LNs) to administer oxygen as ordered. Observation on 04/07/2025 at 10:30 AM, 04/08/2025 at 8:52 AM, and 4/09/2025 at 12:40 PM, showed Resident 26 laid in bed, had a NC on with the oxygen flow rate set at 4.5 LPM (continuously). During an interview on 04/09/2025 at 12:41 PM, Staff M, Licensed Practical Nurse (LPN), stated the resident could have their oxygen increased depending on their oxygen saturation rate (a noninvasive measurement device to register oxygen saturation within the blood); however, Staff M stated there was no order to increase to 4.5 LPM so they would change the oxygen setting back to 3 LPM During an interview on 04/09/2025 at 1:03 PM, Staff B, Director of Nursing Services, stated their expectation would be if Resident 26's provider's order for oxygen was at 3 LPM then it should be set at that order rate and not changed without a provider's order. Reference WAC 388-97-1060(3)(j)(vi)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 38344 Based on observation and interview, the facility failed to post the actual hours worked for the nursing staffing hours daily for 5 of 5 days during the survey period (04/07/2025 - 04/11/2025) when reviewed for nurse staff posting. This failure prevented the residents, family members, and visitors from exercising their rights to know the actual numbers of available nursing staff in the facility. Findings included . Observations on 04/07/2025 at 3:08 PM, 04/08/2025 at 12:53 PM, 04/09/2025 at 8:18 AM, 04/10/2025 at 8:31 AM, and 04/11/2025 at 8:30 AM of the nurse staff posting showed actual hours worked for each discipline on each shift were documented, 0.00. During an interview on 04/11/2025 at 9:07 AM, Staff H, Staff Schedule Coordinator, stated they were responsible for posting the nursing staffing data information daily. Staff H stated actual hours worked were not posted; however, human resources kept track of all hours worked in their computer system. During an interview on 04/11/2025 at 9:18 AM, Staff K, Human Resources Specialist, stated they kept track of nurse staffing hours; however, they did not post them. During an interview on 04/11/2025 at 9:42 AM, Staff A, Administrator, stated they were not aware the nursing staffing actual hours were not being posted. Staff A stated the expectation was that the nurse staff postings be updated with actual hours worked at the beginning of each shift. No Associated WAC

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34567 Based on observation, interview, and record review, the facility failed to ensure a provider's order for blood pressure parameters were consistently followed for 1 of 5 sampled residents (Resident 81) and initiated non-pharmacological interventions (NPI) prior to the administration of as needed (PRN) pain medication for 3 of 5 sampled residents (Residents 100, 79, and 18) when reviewed for unnecessary medications. These failures placed residents at risk for receiving unnecessary medications, a diminished quality of life, and unmet needs. Findings included . Review of a facility document titled, Medication Ordering and Receiving From Pharmacy Provider, Medication with Boxed Warning, dated 01/2025, showed all licensed nurses (LNs) must be familiar with medications used by residents that carry a boxed warning relevant to the resident. In addition, nursing staff shall refer to boxed warning monitoring guidelines and appropriate references for specific health risk and signs and symptoms for monitoring. Nursing staff shall include the appropriate monitoring parameters on the residents and monitor for adverse consequences (i.e. assessing vital signs may be indicated if a medication was known to affect blood pressure and pulse rate). Resident 81 Review of the quarterly minimum data set (MDS, a required assessment tool), dated 02/21/2025, showed Resident 81admitted on [DATE] with multiple diagnoses to include heart, lung and kidney disease, and hypertension (high blood pressure). The electronic health record (EHR) showed the resident was able to make needs known and required assistance with activities of daily living (ADLs). Review of Resident 81's provider's order for midodrine (a medication used to treat hypotension [low blood pressure]) dated 02/15/2025 was to be administered by the LNs twice a day for hypotension and to hold for a systolic blood pressure greater than 120 (top blood pressure reading). Review of Resident 81's medication administration record (MAR) dated February, March and April 2025, showed multiple dates where LNs had administered the medication midodrine when the resident's blood pressure was greater than 120 systolic. The February 2025 MAR showed the LNs had administered the medication 11 out of 27 times, March 9 out of 62 times, and April 2025 the LNs administered the medication 5 out of 15 times. During an interview on 04/10/2025 at 2:43 PM, Staff L, Licensed Practical Nurse (LPN), stated if there were (provider's orders) blood pressure parameters to hold them for any systolic blood pressure greater than 120 then the expectation would be for the LN to hold the medication as ordered. During an interview on 04/10/2025 at 3:05 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation was the LNs were to hold any blood pressure medication as per the provider's order if there were parameters to hold. 38344 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 100 Review of the EHR showed Resident 100 readmitted to the facility on [DATE] and was able to make needs known. The quarterly MDS dated [DATE] showed Resident 100 had diagnoses of depression, diabetes (too much sugar in the blood), and bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs). Review of Resident 100's provider's orders showed an order dated 12/17/2024 for acetaminophen (a medication used to treat minor aches and pain) every six hours as needed for pain. Review of the MAR dated March 2025 and April 2025 from 04/01/2025 - 04/07/2025 showed the ordered as needed acetaminophen was provided three times in March and three times in April with no NPI documented as offered or provided. During an interview on 04/09/2025 at 1:27 PM. Staff F, Licensed Practical Nurse Supervisor, stated NPI should be offered/provided and documented in the MAR and/or progress notes prior to giving any as needed pain medication. Staff F stated Resident 100 had no NPI documented for as needed acetaminophen provided in March and April 2025. During an interview on 04/09/2025 at 1:34 PM, Staff B, DNS, stated Resident 100's documentation for NPI prior to being administered as needed acetaminophen three times in March and in April 2025 were not documented in the MAR or in a progress note and this did not meet expectations. 46067 Resident 79 Review of the EHR showed Resident 79 admitted to the facility on [DATE] with diagnoses of osteomyelitis (inflammation and infection of the bone), pressure ulcer and heart failure. Resident 79 required extensive assistance with most activities of daily living. Review of Resident 79's provider's orders showed an order dated 10/19/2024 for acetaminophen 650 milligrams every eight hours as needed for pain. Review of the MAR dated March 2025 showed the ordered as needed acetaminophen was provided seven times in March with no NPI documented as offered or provided. Review of the MAR dated April 2025 from 04/01/2025 - 04/08/2025 showed the ordered as needed acetaminophen was provided two times in April with no NPI documented as offered or provided. During an interview on 04/09/2025 at 1:27 PM, Staff F, Licensed Practical Nurse Supervisor, stated NPI should be offered/provided and documented in the MAR and/or progress notes prior to giving any as needed pain medication. During an interview on 04/09/2025 at 1:34 PM, Staff B, DNS, stated lack of NPI documentation did not meet expectations. 49926 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 18 Review of the EHR showed Resident 18 was admitted to the facility on [DATE] with diagnoses to include fractures of lumbar (low back) and thoracic (middle back), depression, and acute kidney failure. Resident 18 was able to communicate needs. During an interview on 04/08/2025 at 9:30 AM, Resident 18 stated their pain was all over the back, was worse with movement, and the pain prevented them from doing activities. Resident 18 stated the nurses were giving them pain medicine about two times a day, and there were no NPI used for their pain. Review of the MAR for March 2025 showed Resident 18 was receiving oxycodone (narcotic medication) on as needed basis 57 times without documentation of NPI that were tried prior to the medication. Reference WAC 388-97- 1060(3)(k)(j)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46067 Based on observation, interview, and record review, the facility failed to provide dental services for 1 of 4 sampled residents (Resident 56) when reviewed for dental services. This failure placed the resident at risk for dental problems, nutritional compromise, and a diminished quality of life. Findings included . Review of the electronic health record showed Resident 56 admitted to the facility on [DATE] with diagnoses of chronic kidney disease (damage of the kidney's which effects functioning) and diabetes (too much sugar in the blood). Resident 56 was able to make needs known. Observation on 04/07/2025 at 9:30 AM showed Resident 56 had broken and missing bottom teeth. Resident 56 stated they had been waiting to see the dental hygienist. Review of an oral exam document dated 06/14/2024 showed a recommendation for dental hygiene cleaning. Review of the EHR showed no documentation of follow up on the recommendation. During an interview on 04/10/2025 at 10:34 AM, Staff D, Social Services Director (SSD), stated they could not locate documentation that Resident 56 was seen by the dental hygienist but should have been. Reference WAC 388-97-1060 (3)(j)(vii)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38344 Based on observation, interview, and record review, the facility failed to provide prompt dental services for 2 of 4 sampled residents (Residents 6 and 82) when reviewed for dental. This failure placed the residents at risk for continued dental problems and a diminished quality of life. Findings included . Resident 6 Review of the electronic health record (EHR) showed Resident 6 readmitted to the facility on [DATE] with diagnoses that included heart failure, anxiety disorder, and depression. The significant change in condition minimum data set (MDS, a required assessment tool) dated 01/04/2025 showed Resident 6 had Obvious or likely cavity or broken natural teeth, inflamed or bleeding gums or loose natural teeth. Review showed Resident 6 was able to make needs known. Review of Resident 6's care plan intervention initiated on 05/24/2024 showed, Refer to dentist/dental hygienist for evaluation and recommendations. Review of Resident 6's dental prophylaxis (prevention) report dated 09/10/2024 showed a recommended treatment for a Recall [follow up], for Registered Dental Hygienist (RDH, a licensed healthcare professional who specializes in the prevention and treatment of oral diseases) maintenance in six months and the need for daily assistance brushing into the gumline. Review of Resident 6's progress note dated 12/16/2024 showed, Resident was seen by the Hygienist, here in the facility. Review of Resident 6's EHR on 04/10/2025 showed no RDH documentation that maintenance had been conducted at six months per recommendation on 09/10/2024. Review of the facility's dental hygienist list dated 03/21/2025 showed Resident 6's name on the list; however, it had No written next to the resident's name. Review of the facility's dental exam resident list dated 04/08/2025 did not include Resident 6's name to be seen. Review of Staff D, Social Services Director (SSD), email, dated 04/09/2025, to the dental scheduler showed, When hygienist was out last [RDH] was able to see everyone on the list. When can we schedule a visit to see the remaining group. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2025 at 9:25 AM, Staff D, Social Services Director (SSD), stated that the RDH came to the facility about every three months. Staff D stated Resident 6's progress note dated 12/16/2024 was documented in error because the resident was not seen by the RDH. Staff D stated Resident 6 was not seen by the RDH on 03/21/2025 and was not seen on 04/08/2025 for a dental exam. Staff D stated the email dated 04/09/2025 sent to the dental scheduler showed, When hygienist was out last, [RDH] was able to see everyone on the list was a typo because Resident 6 was on the list but was not seen by the RDH on 03/21/2025. Staff D stated they had not heard from the dental schedular related to the next time the RDH would come to the facility and they needed to follow up today (04/10/2025). During an interview on 04/10/2025 at 10:15 AM, Staff A, Administrator, stated Resident 6's communication related to dental needs could have been better. Staff A stated social services should have sent a follow up email to the dental schedular when the RDH did not see everyone on the list on 03/21/2025 prior to today (04/10/2025). 49926 Resident 82 Review of the EHR showed Resident 82 was admitted to the facility on [DATE] with diagnoses to include fracture of right humerus (long bone of upper arm), type two diabetes (high blood sugar), insomnia (inability to sleep), and chronic pain syndrome. Resident 82 was able to communicate needs. During an interview on 04/07/2025 at 10:33 AM, Resident 82 stated they did not have an upper denture, and their lower denture did not fit them. Resident 82 stated they had not seen the dentist and were not aware of plans to see them. Review of a dental consult dated 01/23/2025 showed Resident 82 was not in the room and the resident was not seen. A second dental consult dated 04/08/2025 showed Resident 82 was in the shower and the resident was not seen. During an interview on 04/09/2025 at 12:56 PM, Staff D, Social Service Director, stated Resident 82 missing the dentist appointment two times did not meet expectations. Reference WAC 388-97- 1060(3)(j)(vii)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46067 Based on observation, interview, and record review, the facility failed to serve food at proper temperatures and palatable taste when reviewed for kitchen services. These failures placed residents at risk for decreased nutritional intake, foodborne illness, and decreased quality of life. Findings included . During an interview on 04/07/2025 at 2:54 PM, Resident 30 stated the French fries and vegetables were served cold. During an interview on 04/07/2025 at 10:37 AM, Resident 100 stated the food Tastes bad and is served lukewarm. During an interview on 04/08/2025 at 9:03 AM, Resident 88 stated the food was horrible. Observation on 04/10/2025 at 11:42 AM showed Staff O, Cook, preparing resident plates. There were no observations of temperatures taken prior to service. Observation on 04/10/2025 at 12:59 PM showed a lunch test tray was received and reviewed. The test tray revealed a piece of country fried steak which was overcooked on the bottom. The mashed potatoes lacked palpability and flavor. Review of the Resident Council Minutes, dated 11/25/2024, showed dietary concerns related to food quality. Review of the Resident Council Minutes, dated 02/25/2025, showed various dietary concerns were discussed with the Dietary Manager. Review of the Resident Council Questionnaires for 04/2025 showed 5 out of 13 residents rated the food quality as poor. During an interview on 04/11/2025 at 11:16 AM, Staff E, Dietary Manager, stated the lack of temperatures did not meet their expectations. During an interview on 04/11/2025 at 11:32 AM, Staff A, Administrator, stated the expectation was for temperatures to be taken according to regulation and the lack of did not meet their expectations. Reference WAC 388-97-1100(1)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46067 Based on observation, interview, and record review, the facility failed to ensure food items were dated and meals/beverages were served at the appropriate temperatures when reviewed for kitchen services. These failures placed residents at risk for foodborne illnesses and diminished quality life. Findings included . Observation during the brief initial tour on 04/07/2025 at 9:12 AM showed multiple flavored syrups and large containers of seasonings to include Parsley, Paprika, Taco, Ground Pepper, Thyme, Ginger, [NAME] undated. Observation of tray line on 04/10/2025 between 11:17 AM and 11:39 AM showed Staff O, Cook, put all entrees and side items for the lunch meal on the steam table. Observation on 04/10/2025 at 11:42 AM, showed Staff O preparing resident plates. There were no observations of temperatures taken prior to service. Review of the lunch meal temperature log on 04/10/2025 at 12:00 PM showed temperatures for all items to include cold beverages. During an interview on 04/11/2025 at 11:16 AM, Staff E, Dietary Manager, stated Staff O admitted to not taking the temperatures of beverages but stated they did take the temperature of the food out of view. Staff E stated the lack of temperatures did not meet their expectations. During an interview on 04/11/2025 at 11:32 AM, Staff A, Administrator, stated the expectation was for temperatures to be taken according to regulation and the lack of tmeperatures did not meet their expectations. Reference WAC 388-97-1100 (3), -2980