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	06/09/2026

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to timely assess, investigate and implement interventions for significant weight loss for 1 of 3 sampled residents (Resident 112) reviewed for nutrition services. Resident 112, a resident identified as at risk for weight loss, experienced harm when they had a significant weight loss of 20 percent total body weight in a month, mild-moderate wasting as observed in temples and orbitals and appeared thin. This failure placed them at risk for functional decline, impaired wound healing, and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 112 admitted to the facility on [DATE] with diagnoses that included diabetes (uncontrolled blood sugar), weakness, and hemiplegia and hemiparesis affecting right side (partial loss of strength and near complete loss of voluntary movement) due to a stroke. Resident 112 was able to make needs known. On 06/04/2026 at 9:32 AM Resident 112 appeared gaunt and thin. Review of the EHR showed Resident 112 weighed 184 pounds on 03/14/2026, 150 pounds on 04/11/2026 and 146 pounds on 04/19/2026, a 20 percent loss in total body weight. Review of Resident 112's 02/10/2026 care plan showed staff were to monitor meal intake and offer meal replacement if Resident 112 ate less than 50 percent. Review of Resident 112's nutritional intake task documentation for March 2026 showed Resident 112 had less than 50 percent intake for one or more meals 26 out of 31 days. Review of Resident 112's nutritional intake task documentation for April 2026 showed Resident 112 had less than 50 percent intake for one or more meals 15 out of 30 days. Review of the nutritional intake task documentation from 05/14/2026 to 06/09/2026 showed Resident 112 had less than 50 percent intake for one or more meals for the 28 days. The EHR showed no documentation that staff offered Resident 112 meal replacement during March, April, May or June 2026. Review of the Kardex (Care Plan directive for staff) showed no intervention to offer Resident 112 a meal replacement. Review of a Dietary/Nutrition progress note dated 04/21/2026 showed, Resident is triggering for significant weight loss, will discuss feeding tube related to poor nutritional intake at 4/29/2026 care conference. Review of the quarterly Interdisciplinary Team care conference document dated 04/29/2026 showed Resident 112's dietary/nutrition status showed the following documentation, IDT reviewed with no concerns, changes, or questions at this time. Reivew did not show a feeding tube or other weigh loss strategies were implemented. Review of a Nutritional Assessment completed 05/07/2026 showed, Accounting for weight loss from 4/11/26 - 4/19/26 (not significant); suspect weight precision masked true weight loss as resident's clothes appeared to fit more loosely than on admit and mild-moderate wasting observed in temples and orbitals. Diagnosis- unintentional weight loss, swallowing difficulty and self-feeding difficulty. Continue regular diet; add fortified foods, large protein, evening snack and assistance with meals. During an interview on 06/05/2026 at 3:04 PM, Staff X, Regional Dietician, stated weight reports were pulled weekly and addressed by nursing staff and the Dietician on Tuesdays. Staff X stated based on Resident 112's documented weights in the EHR, the weight loss should have been addressed sooner than the 05/07/2026 progress note. Staff X stated the Certified Nursing Assistants (CNA) should have offered meal replacement and maybe they did but the facility did not have a place for the CNA to document if meal replacement was offered and accepted. Reference WAC 388-97-1060 (3)(h)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure care plans were accurate to include all needed care and/or remove discontinued/resolved health issues for 5 of 22 sampled residents (Residents 7, 5, 27, 4, and 98) reviewed for accuracy of care plans. This failure placed residents at risk of lack of care, unmet needs, inaccurate medical records, and a diminished quality of life. Findings included.Resident 7 Review of the electronic health record (EHR) showed Resident 7 admitted to the facility on [DATE] with diagnosis of stroke with right side weakness and had a pressure injury to the bottom. The resident was able to make needs known. During an interview on 06/03/2026 at 10:05 AM, Resident 7 stated their bottom was real sore. The resident was lying flat on their back with their feet/heels on the mattress. Review of the EHR on 05/03/2026 showed no actual pressure injury care plan. Review of the weekly skin assessment dated [DATE] showed Resident 7 had a stage two (through the top layers of skin) pressure ulcer to their bottom. During an interview on 06/08/2026 at 10:20 AM, Staff N, Licensed Practical Nurse (LPN), stated Resident 7 should have had a care plan for pressure injury but did not. During an interview on 06/08/2026 at 10:24 AM, Staff B, Director of Nursing Services (DNS), stated Resident 7 should have had a care plan in place for pressure injury but did not. Resident 5 Review of the EHR showed Resident 5 re-admitted to the facility on [DATE] with diagnoses to include heart failure and diabetes (high blood sugar). Resident 5 was able to make needs known. Review of the focused care plan for skin integrity initiated on 03/04/2026 showed Resident 5 had a right lower leg chronic venous leg ulcer/wound upon admission and was ongoing. Review of Resident 5's EHR on 06/05/2026 showed no documentation of a current venous wound on the right lower leg. Review of Resident 5's annual minimum data set assessment (MDS) dated [DATE] showed Resident 5 had 0 (zero) venous ulcers/wounds. During an interview on 06/08/2026 at 1:36 PM, Staff C, LPN, stated Resident 27 used to have a venous ulcer; however, it had resolved and the care plan should have been updated. Resident 27 Review of the EHR showed Resident 27 re-admitted to the facility on [DATE] with diagnoses to include cancer, peripheral vascular disease (slow circulation problem where blood vessels restrict (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood flow to parts of the body), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). Resident 27 was sometimes able to make needs known. Review of the care plan initiated on 12/18/2025 showed Resident 27 was on anticoagulant therapy (AC, medication used to prevent blood clots from forming or getting larger). It further showed Resident 27 had a focused care plan for thrush (a fungal/yeast infection) initiated on 04/14/2026. Review of Resident 27's EHR on 06/04/2026 showed no documentation of current AC therapy or a thrush infection. During an interview on 06/08/2026 at 1:45 PM, Staff C, LPN, stated Resident 27 was not currently taking an AC medication, and the care plan should have been updated at the time the AC was discontinued in January 2026. Staff C stated Resident 27 no longer had thrush and the focused care plan for thrush should have been resolved and that did not happen. During an interview on 06/08/2026 at 2:01 PM, Staff B, DNS, stated residents' care plans should be updated with resolution of conditions and/or completion of treatments. Staff B stated the expectation was that care plans reflected a resident's current status. Resident 4 Review of the EHR showed Resident 4 admitted to the facility on [DATE] with diagnoses to include surgical amputation, osteomyelitis (a swelling of bone tissue caused by infection), and diabetes. Resident 4 was able to make needs known. Review of Resident 4's provider's orders showed Resident 4 received an AC medication. Review of the plan of care, initiated 06/01/2026, showed no focus area related to Resident 4's use of an AC. During an interview on 06/09/2026 at 10:36 AM, Staff N, LPN, stated staff were aware of a resident's use of an AC medication by placing it into the plan of care. Staff N stated Resident 4's AC use was not included in their plan of care, and it should have been. During an interview on 06/09/2026 at 10:39 AM, Staff B, DNS, stated a resident's use of AC medication use should be included in their plan of care so staff were aware of what side effects to monitor. Staff B stated Resident 4's plan of care not including their AC use did not meet expectations. Resident 98 Review of the EHR showed Resident 98 was admitted to the facility on [DATE] with diagnoses to include cerebral infarction (when blood flow to an area of the brain is blocked or significantly reduced), diabetes, and end stage renal disease (when kidneys function can no longer filter waste and excess fluid from body). Resident 98 was able to communicate needs. During interview on 06/04/2026 at 9:10 AM and 06/08/2026 at 1:32 PM, Resident 98 stated they were unable to see and use their glasses and needed to see the eye doctor. Resident 98 had glasses nearby on the table and was not using them. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the significant change minimum data set (MDS, a required assessment) dated 03/31/2026 showed Resident 98 had alteration in visual function related to impaired vision and visual function would be addressed in the care plan. Review of the care plan created on 03/01/2026 showed Resident 98 had no problem, goal or intervention about their visual deficit and use of glasses. During an interview on 06/08/2026 at 1:32 PM, Staff H, Registered Nurse, stated visual deficits should be addressed in the care plan. During an interview on 06/09/2026 at 9:43 AM, Staff B, DNS, stated the lack of visual deficit on the care plan for Resident 98 did not meet expectations. Reference WAC 388-97-1020(1)(2)(a)(b)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to ensure bathroom call light pull cords were accessible to residents from the floor on 2 of 4 sampled halls (100 and 300) reviewed for call light systems. This failure placed residents at risk for inability to summon help in the event of an emergency, increased risk of injury and unmet or delayed care needs. Findings included. Observations on 06/03/2026 at 2:27 PM and 06/09/2026 at 9:30 AM showed the bathroom emergency call light pull cords in resident rooms 106, 107, 121 and 311 hung above the handrail on the wall and were not readily accessible to a resident if they were on the floor after a medical emergency or fall. During an interview on 06/09/2026 at 10:39 AM, when asked to look at the emergency call light pull cords in rooms 106, 107, 121, and 311, Staff Q, Maintenance Director, asked how long the pull cord had to be and stated they were unaware of any regulation related to bathroom call light pull cords. During an interview on 06/09/2026 at 11:09 AM, Staff A, Administrator, stated the expectation was that resident bathroom pull cords should be accessible to call for help if the resident was on the floor. Reference WAC 388-97-2280 (1)(a)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review, the facility failed to initiate a grievance for resident care concerns voiced at the resident council meeting for 1 of 4 resident council meetings minutes (May 2026) when reviewed. This failure placed residents at risk for unmet care needs, poor hygiene and a diminished quality of life. Findings included .During an interview on 06/08/2026 at 2:21 PM, Resident Council members stated the facility did not consistently provide resolutions to concerns discussed during resident council meetings. Review of the resident council minutes for May 2026 showed concerns voiced by members related to getting out of bed for meals and activities and a shortage on washcloths and towels. Review of the grievance logs for 02/2026 through 06/2026 showed no grievances that corresponded with concerns verbalized at the resident council meeting. During an interview on 06/08/2026 at 2:33 PM, Staff R, Activities Director, stated they did not initiate a grievance related to the residents' concerns but should have. During an interview on 06/09/2026 at 10:15 AM, Staff A, Administrator, stated it did not meet their expectations 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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean, sanitary and well-maintained resident environment for 2 of 22 sampled residents (Residents 112 and 67) reviewed for homelike environment. These failures placed residents at risk for reduced comfort, unsanitary conditions and a diminished quality of life. Findings included . Resident 112 Observation on 06/03/2026 at 10:16 AM and 06/06/2026 at 9:20 AM showed Resident 112's room had a single crack in the right windowpane extending the length of the window. During an interview on 06/09/2026 at 10:55 AM, Staff Q, Maintenance Director, stated the window had been broken for six months, they did not have the authority to purchase a replacement window, and facility administration was aware of the crack. During an interview on 06/09/2026 at 10:16 AM, Staff A, Administrator, stated they were unaware the window was cracked. Staff A stated the maintenance department conducted several monthly resident room audits and the window should have been noted and repaired. Staff A stated the cracked resident window did not reflect a homelike environment. Resident 67 Review of the electronic health record (EHR) showed Resident 67 admitted to the facility on [DATE] with a diagnosis of diabetes (when the body cannot process sugars) and the resident was able to make needs known. During an interview and observation on 06/03/2026 at 9:25 AM, Resident 67 stated Housekeeping does not sweep and mop, and they just finished cleaning their room but left the floors dirty. There was trash and a liquid spilled on the floor between the beds. During an interview and observation on 06/04/2026 at 11:31 AM, Resident 67 stated staff had still not swept or mopped, and the trash and spill was still observed on the floor between the beds. Review of the resident council notes for the month of March 2026 showed a resident request for housekeeping to ensure beds, nightstands and surrounding areas were cleaned thoroughly. Review of resident council notes for the month of April 2026 showed reported concerns for housekeeping not removing trash from under the bed for three days. During an interview on 06/09/2026 at 9:40 AM, Staff K, Housekeeping, stated the rooms should be swept and mopped every day. During an interview on 06/09/2026 at 9:59 AM, Staff A, Administrator, stated it was their expectation that the resident rooms be swept and mopped daily and as needed. Reference WAC 388-97-0880, -2040 .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to initiate a grievance after a resident concern regarding staff customer service for 1 of 3 sampled residents (Resident 138) reviewed for abuse/grievances. This failure placed residents at risk of unmet needs, higher likelihood of neglect, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 138 admitted to the facility on [DATE] with diagnoses to include pneumonia (a lung infection causing inflammation), chronic kidney disease, and diabetes (too much sugar in the blood). Resident 138 was able to make needs known. Observation and interview on 06/05/2026 at 12:02 AM showed Resident 138 sat in their wheelchair just inside their room door with an upset expression. Resident 138 stated they had turned on their call light because they needed assistance to use the restroom. Resident 138 stated a staff had entered their room, turned off their call light, and stated they would return to assist Resident 138. Resident 138 stated they had been waiting for fifteen to twenty minutes for the staff to return, and they were pissed they had to wait to use the restroom. Observation on 06/05/2026 at 12:28 PM showed Resident 138's concern regarding staff turning off their call light without assisting them was reported to Staff S, Licensed Practical Nurse. During an interview on 06/09/2026 at 10:03 AM, Staff A, Administrator, stated if a resident made a report that staff had turned off their call light without providing care, a grievance should be completed for the concern. Staff A stated turning off the call light without providing care increased the likelihood of neglect occurring if the staff member forgot to return. Staff A stated no grievance or investigation was initiated in response to Resident 138's concern, and this did not meet expectations. Reference WAC 388-97-0460

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the use of antipsychotic medications (medications affecting the mind) was appropriate by providing adequate monitoring or appropriate indications for its use for 1 of 5 sampled residents (Resident 50) reviewed for unnecessary medications. This failure placed the resident at risk for adverse side effects and a decreased quality of life. Findings included. Review of the facility policy titled Use of Psychotropic Medication, revised 04/23/2025, showed Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication and Pre-admission screening [PASRR, a mental health screening tool] and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility. Review of the electronic health record (EHR) showed Resident 50 admitted to the facility on [DATE] with diagnoses of dementia (a group of symptoms that effects memory) with behaviors, and depression. The resident was sometimes able to make needs known. Review of the facility initiated PASRR form dated 03/27/2026 showed Resident 50 had a diagnosis of depression and anxiety. Review of an updated PASRR form dated 04/06/2026 showed Resident 50 had a diagnosis of severe depression. Review of the provider orders showed Resident 50 was prescribed Risperidone (an antipsychotic medication) daily at bedtime for dementia with behaviors with a start date of 03/31/2026. Review of the EHR showed no order to monitor target behaviors related to the antipsychotic medication. Review of the EHR on 06/05/2026 showed no documentation that Resident 50 was reviewed on admission for the use of an antipsychotic medication. During an interview on 06/05/2026 at 10:56 AM, Staff N, Licensed Practical Nurse, stated Resident 50's diagnosis of dementia with behaviors was not an appropriate diagnosis for an antipsychotic medication and the resident should have a monitor for target behaviors for the antipsychotic in place but did not. During an interview on 06/05/2026 at 11:01 AM, Staff P, Social Services Director, stated Resident 50 should have been reviewed in the monthly psychotropic meeting on admission. Staff P stated dementia with behaviors was not an appropriate diagnosis for the use or Risperidone and related behaviors should have been monitored. Staff P stated Resident 50 did not display aggressive or violent behaviors; they just wandered frequently. During an interview on 06/05/2026 at 11:56 AM, Staff B, Director of Nursing Services, stated it was their expectation that Resident 50 should have been reviewed in the monthly psychotropic meeting, had target behaviors monitored and an appropriate diagnosis for the use of an antipsychotic. Reference WAC 388-97-1060(3)(k)(i), -0620(1)(a)

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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** Based on interview and record review, the facility failed to ensure incidents of potential abuse and/or neglect were identified and reported to the Administrator and/or the State Survey Agency for 2 of 7 sampled residents (Residents 27 and 7) reviewed for abuse and/or dignity. Failure to report allegations of abuse/neglect or verbal abuse placed residents at risk for additional abuse and a diminished quality of life. Findings included . Review of the Nursing Home Guidelines titled, The Purple Book, dated October 2015, showed The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the Administrator of the facility and to other officials in accordance with State law .including to the State survey and certification agency.Resident 27 Review of the electronic health record (EHR) showed Resident 27 re-admitted to the facility on [DATE] with diagnoses to include cancer, peripheral vascular disease (slow circulation problem where blood vessels restrict blood flow to parts of the body), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). Resident 27 was sometimes able to make needs known. During an interview on 06/03/2026 at 11:22 AM, Collateral Contact F, Family Member, stated a couple of days ago Resident 27 told them two nursing aids, one large and one smaller male nursing aids, had awaken them (Resident 27) in the middle of the night or early in the morning and started to rough handle them when trying to change them. Collateral Contact F stated they reported it to two nursing staff on Sunday (05/31/2026). Review of Resident 27's EHR on 06/04/2026 showed no documentation of an allegation of abuse. Review of the facility's June 2026 incident log from 06/01/2026 – 06/04/2026 showed no incident logged for Resident 27. During an interview on 06/05/2026 at 12:32 PM, Staff E, Certified Nursing Assistant, stated a few days ago Resident 27's family member had told them and a nurse that Resident 27 reported two nursing aids had been rough with them during care. Staff E stated the family member told them that Resident 27 stated that they had been left up all night in their wheelchair and had not eaten breakfast. Staff E stated they did not report the incident because they thought the nurse in the room would follow up. During an interview on 06/05/2026 at 12:54 PM, Staff A, Administrator, stated the nurse and/or Staff E should have reported Resident 27's allegation of abuse to the State, followed the facility's policy for abuse, and initiated an investigation. Staff A stated the way Resident 27's allegation was handled did not meet their expectations. Resident 7 Review of the EHR showed Resident 7 admitted to the facility on [DATE] with diagnoses of stroke with right side weakness and recent abdominal surgery. The resident was able to make needs known. During an interview on 06/03/2026 at 10:00 AM, Resident 7 was tearful and stated staff talk about them like they were not there and said they were fat. Resident 7 stated they had told the speech (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapist about the concern about a week ago. During an interview on 06/04/2026 at 1:44 PM, Staff L, Speech Therapist, stated Resident 7 did mention the concern but Resident 7's husband was in the room and stated this happened at the last facility. Staff L stated they would report it if the resident said this happened here but that was not what they understood. During a joint interview on 06/04/2026 at 3:05 PM, Resident 7 stated the incident happened here at the facility. Collateral Contact AA stated Resident 7 had told them about the incident just prior to reporting it to the speech therapist. During a joint interview on 06/04/2026 at 3:15 PM, Staff A, Administrator (ADM), and Staff B, Director of Nursing Services (DNS), stated it was their expectation that this be reported and investigated and this did not meet their expectations. Reference WAC 388-97-0640(5)(a)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set (MDS, a required assessment tool) accurately reflected the status of 2 of 22 sampled residents (Residents 112 and 21) reviewed for accuracy of assessments. This failure placed the residents at risk for inappropriate care planning, unmet care needs, and a diminished quality of life. Findings included . Resident 112 Review of the electronic health record (EHR) showed Resident 112 admitted to the facility on [DATE] with diagnoses that included diabetes (uncontrolled blood sugar), weakness, and hemiplegia and hemiparesis affecting right side (partial loss of strength and near complete loss of voluntary movement). Resident 112 was able to make needs known. Review of the EHR showed Resident 112 weighed184 pounds on 03/14/2026, 150 pounds on 04/11/2026 and 146 pounds on 04/19/2026. Review of Section K (Swallowing/Nutritional status) on the 05/06/2026 quarterly MDS showed Loss of 5 percent or more in the last month or loss of 10 percent or more in last 6 months marked NO or UNKOWN. During an interview on 06/08/2026 at 9:41 AM, Staff G, MDS/Licensed Practical Nurse (MDS/LPN), stated the dietician completed that part of the MDS; however, it should have reflected significant weight loss and been marked YES During an interview on 06/06/2026 at 2:56 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was that MDS assessments were coded accurately. Resident 21 Review of the EHR showed Resident 21 was admitted to the facility on [DATE] with diagnoses to include malignant neoplasm (cancer) of lung, secondary malignant neoplasm of brain and adrenal gland (small gland that produces hormones). Review of admission MDS dated [DATE] showed Resident 21 was able to communicate needs and did not have cancer diagnoses in section I for active diagnoses. During an interview on 06/05/2026 at 12:01 PM, Staff G, MDS/LPN, stated the cancer diagnosis was missing from the MDS and it should have been coded. During an interview on 06/09/2026 at 9:41 AM, Staff B, DNS, stated the expectation was for active diagnoses to be on the MDS. Reference WAC 388-97-1000(1)(a)(b)(4)(a)

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	505473	A. Building B. Wing	06/09/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 8 sampled residents (Resident 81) reviewed for bowel management and anticoagulant therapy. These failures placed the residents at risk for poor clinical outcomes, decreased comfort, and poor quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 81 admitted to the facility on [DATE] with diagnoses of a stage 4 (including bone and muscle) pressure injury to their bottom and sepsis (the body's response to severe infection). The resident was able to make needs known. <Bowel anagement> During an interview on 06/03/2026 at 10:35 AM, Resident 81 stated they had been having loose stools (bowel movement) for a couple weeks. Review of a provider note dated 06/02/2026 showed [Resident 81] stated has had 3 days of diarrhea with abdominal discomfort, Loperamide [medication to treat loose stools] was started as needed [PRN] for diarrhea management. If Loperamide did not aid in symptom relief, symptoms persist for more than 3 days to notify the provider. Review of the bowel monitor showed Resident 81 had two loose stools on 06/04/2026, three large loose stools on 06/05/2026 and two large loose stools on 06/06/2026, 06/07/2026 and 06/08/2026. During an interview on 06/05/2026 at 8:55 AM, Resident 81 stated it happens all the time. If they moved, they had wet stool. Resident 81 stated staff had not given them any medication for it. Review of the June 2026 medication administration record (MAR) showed no doses of Loperamide were documented as administered. Review of the EHR showed no documentation that the provider was notified of the three large loose stools on 06/05/2025. During an interview on 06/05/2026 at 8:54 AM, Staff M, Registered Nurse (RN), stated if a resident was having frequent loose stools they should report to the provider and give any PRN medications. During an interview on 06/05/2026 at 10:51 AM, Staff N, Licensed Practical Nurse (LPN), stated if a resident was having more than three loose stools in 24 hours the staff should have notified the provider and given any PRN medications and placed them on alert charting. During an interview on 06/05/2026 at 12:08 PM, Staff B, Director of Nursing Services (DNS), stated it was their expectation that staff notify the provider, place the resident on alert, test for infection if indicated and give any PRN medications. This did not happen for Resident 81 and should have. <Anticoagulant> Review of the EHR showed Resident 81 was receiving anticoagulant (blood thinning) injections daily with a start date of 05/21/2026. During an interview and observation on 06/03/2026, Resident 81 laid in bed with an indwelling urinary catheter (a tube used to drain urine from the bladder). There was dark red urine noted in the tube/bag. Resident 81stated It's never been like that. It's scary. Review of the EHR on 06/05/2026 showed no monitoring for bleeding and bruising related to being on anticoagulant therapy. Review of the progress notes on 06/05/2026 showed no documentation related to the blood in the urine and no alert charting. During an interview on 06/05/2026 at 10:39 AM, Staff O, Certified Nursing Assistant (CNA), stated Resident 81 had the blood in their catheter for a couple days. During an interview on 06/05/2026 at 10:42 AM, Staff M, RN, stated if Resident 81 was on an anticoagulant they should be monitored for bleeding and bruising. During an interview on 06/05/2026 at 10:44 AM, Staff N, LPN, stated Resident 81 should have had a monitor for bleeding order but did not and should have been placed on alert for bleeding but was not. During an interview on 06/05/2026 at 11:58 AM, Staff B, DNS, stated Resident 81 should have had an anticoagulant side effect monitor in place and should have been placed on alert for bleeding and this did not happen. Reference WAC 388-97-1060(1)-(3)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents with limited range of motion received the necessary services to maintain their level of functioning for 2 of 4 sampled residents (Residents 24 and 112) reviewed for limited range of motion (ROM). This failure placed residents at risk for further decline in range of motion, increased dependence, pain and a diminished quality of life. Findings included .Resident 24Review of the electronic health record (EHR) showed Resident 24 admitted to the facility on [DATE] with diagnoses that included ankylosis of left knee (stiffness and immobility of a joint), diabetes (uncontrolled blood sugar), and generalized muscle weakness. Resident 24 was able to make needs known. During an interview on 06/04/2026 at 9:20 AM, Resident 24 stated they were told they would be starting an exercise program after discharge from physical therapy. Resident 24 stated they had not been offered participation in a restorative program. Review of Resident 24's Physical Therapy Discharge summary dated [DATE] showed Discharge Recommendations: Restorative Range of Motion Program (bilateral lower extremity). Review of Resident 24's care plan initiated 12/25/2025 showed no Restorative program intervention. During an interview on 06/05/2026 at 12:48 PM, Staff D, Director of Rehabilitation (DOR), stated the facility failed to initiate and implement a restorative program for Resident 24 after discharge from physical therapy. Resident 112Review of EHR showed Resident 112 admitted to the facility on [DATE] with diagnoses that included diabetes, weakness, and hemiplegia and hemiparesis affecting right side (partial loss of strength and near complete loss of voluntary movement). Resident 112 was able to make needs known. Observations on 06/03/2026 at 1:25 PM and 06/04/2026 at 9:33 AM showed an elbow splint on a corner table in Resident 112's room. Review of the EHR showed an order to Apply right elbow extension splint on in AM for up to six hours per day, as tolerated three to six times per week. Review of a 06/04/2026 progress note showed, Discontinued restorative program and splinting per recommendations related to resident refusing. Updated care plan, tasks and restorative aid. Review of the restorative flow sheet from 05/14/2026 to 06/04/2026 showed Resident 112 refused splint assistance on three occasions. Documentation showed Resident 112 was re-approached by alternate staff and was agreeable to wear the splint. During an interview on 06/05/2026 at 11:16 AM, Staff Y, Restorative Aide, stated they did not have any experience with Resident 112 refusing splint assistance. Staff Y stated the best approach with Resident 112 was to explain that the splint would not be painful. During an interview on 06/05/2026 at 12:27 PM, Staff D, DOR, stated it was uncommon for three refusals in 30 days to warrant discontinuation of a restorative program. Staff D stated it did not meet expectations that the program was discontinued for three refusals. Reference WAC 388-97-1060(3)(d)

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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** Based on observation, interview, and record review, the facility failed to provide an environment that was free from accident hazards for 2 of 5 sampled residents (Residents 27 and 50) reviewed for accidents. Failure to provide a properly fitting wheelchair for Resident 27 and failure to implement interventions after a fall for Resident 50 placed the residents at risk for accidents or injuries and a decreased quality of life. Findings included .Resident 27 Review of the electronic health record (EHR) showed Resident 27 re-admitted to the facility on [DATE] with diagnoses to include cancer, peripheral vascular disease (slow circulation problem where blood vessels restrict blood flow to parts of the body), and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills). Resident 27 was sometimes able to make needs known. Observations on 06/03/2026 at 11:06 AM, 06/04/2026 at 2:11 PM, and 06/08/2026 at 9:17 AM showed Resident 27 in a slightly tilted back wheelchair with feet extended beyond the footrests and the back of Resident 27's lower legs above the ankle/heel area rested against the hard footrests. It showed a pillow either on the floor or behind the legs and not padding the actual footrests. Review of the focused care plan for skin integrity initiated on 04/27/2026 showed, padding to wheelchair footrests. During an interview on 06/08/2026 at 9:22 AM, Staff D, Director of Rehabilitation, stated Resident 27's feet extended past the wheelchair footrests. Staff D stated the footrests were too short and needed to be adjusted or replaced. Staff D stated staff should have notified therapy and that did not happen. Staff D stated Resident 27 needed to be assessed and wheelchair adjusted and/or modifications made to ensure a proper fit. During an interview on 06/08/2026 at 2:29 PM, Staff B, Director of Nursing Services (DNS), stated staff should have documented or put on the communication board for therapy to look at Resident 27's wheelchair for proper positioning, and looked at the care plan for better interventions related to the footrests. Staff B stated this did not meet their expectations. Resident 50 Review of the EHR showed Resident 50 admitted to the facility on [DATE] with diagnoses of dementia (a group of symptoms that effects memory), history of falls, and urinary tract infection (UTI). The resident was sometimes able to make needs known. Review of the plan of care for Resident 50 showed an entry dated 03/30/2026 for at risk for falls. Review of the EHR showed a progress note dated 05/17/2026 which stated Resident 50 had an unwitnessed fall in the 300 hallway. Review of the incident investigation showed interventions were added to monitor orthostatic blood pressures (a drop in blood pressure when moving from sitting to standing) and to refer to physical therapy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration record for the month of May showed an order for orthostatic blood pressure on 05/20/2026 that was not completed, and an order for orthostatic blood pressures for three days which showed the same blood pressure and pulse for all three positions on 05/22/2026, 05/23/2026 and 05/24/2026. During an interview on 06/04/2026 at 2:59 PM, Staff D, Director of Rehabilitation, stated they had not received a post fall referral for Resident 50. During an interview on 06/05/2026 at 12:07 PM, Staff B, DNS, Stated Resident 50 was not referred to therapy but it was discussed in clinical meeting. Staff B stated Resident 50 should have had their orthostatic blood pressures taken accurately to rule out orthostatic hypotension. Reference WAC 388-97-1060(3)(g)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent. A total of nine errors were made in thirty-one opportunities during a medication administration for 1 of 6 sampled residents (Resident 96) reviewed for medication administration. This placed the residents at risk for receiving medications that were not effective or less effective and a diminished quality of life. Findings included .Review of the provider's orders for June 2026 showed Resident 96 was prescribed nine oral medications with a specific time of administration to be given at 8:00 AM. Observation of medication administration on 06/08/2026 at 9:36 AM showed Staff J, Licensed Practical Nurse (LPN), prepared and administered these nine oral medications to Resident 96 (one hour and 36 minutes late). During an interview on 06/08/2026 at 10:13 AM, Staff J, LPN, stated the nurses had up to two hours to administer medications after the ordered time. During an interview on 06/08/2026 at 10:17 AM, Staff B, Director of Nursing Services, stated the medication administration time was one hour before and one hour after the specific time of the order, and the expectation was for nurses to follow orders including the correct time of administration and this did not meet expectations. Reference WAC 388-97-1060(3)(k)(ii)