| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 505483 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Alaska Gardens Health and Rehabilitation | 6220 South Alaska Street<br>Tacoma, WA 98408 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were screened for additional mental health supports through the Pre-admission and Resident Review (PASARR, a mental health screening tool) process for 2 of 5 sampled residents (Residents 97 and 6) reviewed for PASARR. This failure placed residents at risk of unidentified mental health needs, avoidable decline in mental health, unintended increase in negative behaviors, and a diminished quality of life. Findings included.Resident 97<br><br>Review of the electronic health record (EHR) showed Resident 97 admitted to the facility on [DATE] with diagnoses to include vascular dementia (a decline in mental abilities caused by reduced blood flow to the brain), depression, and adjustment disorder (stress-related mental health condition triggered by a significant life change or traumatic event). Resident 97 was able to make needs known.<br><br>Review of the PASARR level one, dated 04/10/2026, showed Resident 97 had no mental health diagnoses and did not require a PASARR level two.<br><br>During an interview on 05/07/2026 at 12:17 PM, Staff G, Regional Social Services, stated Resident 97's PASARR was inaccurate, needed modifications, and did not meet expectations.<br><br>During an interview on 05/07/2026 at 12:27 PM, Staff A, Administrator, stated PASARR level one was completed by the admitting hospital, should be corrected if inaccurate, and Resident 97's inaccurate PASARR did not meet expectations.<br><br>Resident 6<br><br>Review of the EHR showed Resident 6 admitted to the facility on [DATE] with diagnoses to include heart failure, respiratory failure, and post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or traumatic event). Resident 6 was able to make needs known.<br><br>Review of Resident 6's PASARR level one, dated 03/30/2026, showed no serious mental illness indicators marked on the form and showed no PASARR level two indicated.<br><br>Review of Resident 6's EHR showed no other documented PASARR level one or PASARR level two.<br><br>During an interview on 05/05/2026 at 11:55 AM, Staff D, Social Services Director (SSD), stated PASARR documentation was obtained from the hospital during the admission process, was reviewed for accuracy, and, if inaccurate, another PASARR level one would be completed. Staff D stated Resident 6's PASARR level one did not include their diagnosis of PTSD, and they should have had<br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | another PASARR level one completed to include PTSD.<br><br>During an interview on 05/05/2026 at 12:15 PM, Staff A, Administrator, stated Resident 6's PASARR level one was not accurate and another PASARR level one needed to be conducted. Staff A stated they were unable to locate another PASARR level one or level two in Resident 6's EHR and this did not meet their expectations.<br><br>Reference WAC 388-97-1915(1)(2)(a)-(c) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation and interview, the facility failed to ensure proper storage and labeling of medications for 2 of 3 sampled medication carts (Hallways 400 and 500) reviewed for medication storage and labeling. This failure placed residents at risk of receiving expired medications, ineffective treatment, and a diminished quality of life. Findings included.Findings included. Observation of a medication cart on 500 hall on 05/05/2026 at 1:37 PM with Staff S, Licensed Practical Nurse (LPN), showed an open vial of insulin (a medication used to lower sugar in the blood) with no date. Observation showed an open bottle of eye drops with no date. During an interview on 05/05/2026 at 1:37 PM, Staff S, LPN, stated upon opening a vial of insulin or a bottle of eye drops, they should be dated immediately. Staff S stated both the vial of insulin and bottle of eye drops should have been dated immediately upon opening them. Staff S stated they would dispose of the undated vial and bottle. Observation of a medication cart on 400 hall on 05/06/2026 at 9:53 AM with Staff T, Registered Nurse (RN), showed two open bottles of eye drops with no dates on them. During an interview on 05/06/2026 at 9:52 AM, Staff T, RN, stated both bottles of eye drops should have been dated as soon as they were opened. Staff T stated they would get new eye drops and dispose of the undated bottles. During an interview on 05/07/2026 at 10:30 AM, Staff B, Director of Nursing/Registered Nurse (DNS/RN), stated if an eye drop was opened it should have been dated immediately. Staff B stated if an open multidose vial or bottle was found without a date on it, it should be discarded immediately. Reference WAC 388-97-1300(2) |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident hospital transfer documentation was completed as required to include the basis for hospital transfer, specific resident needs, and what information was conveyed to the receiving provider for 1 of 4 sampled residents (Resident 14) reviewed for hospitalization. This failure placed residents at risk of potential delays in emergent hospital treatment and potential medical complications. Findings included.Review of the electronic health record (EHR) showed Resident 14 readmitted to the facility on [DATE] with diagnoses of respiratory failure, high blood pressure, and anxiety disorder. Resident 14 was able to make needs known. Review of the progress note dated 04/28/2026 showed Resident 14 complained of not being able to breathe, was diaphoretic (excessive sweating without heat or physical exertion), and a breathing treatment was provided. The provider agreed to send Resident 14 out for further evaluation and emergency transportation took Resident 14 to the hospital. Review of the EHR showed Resident 14 was discharged from the facility on 04/28/2026 and readmitted to the facility on [DATE]. No documentation was found to show what information was provided or communicated to the receiving facility, as required. During an interview on 05/07/2026 at 1:11 PM, Staff C, Licensed Practical Nurse/Care Coordinator (LPN/CC), stated documentation that should be sent to the hospital for a transfer included a Skilled Nursing/Nursing Facility (SNF/NF) to Hospital Transfer form, the resident's face sheet (profile/admissions record, with resident information), and the medication and treatment administration records. Staff C stated they were unable to locate what transfer documentation was provided to the hospital for Resident 14's transfer on 04/28/2026. Staff C stated they were unable to locate a SNF/NF to Hospital Transfer form completed for Resident 14's transfer to the hospital on [DATE] and there should have been. During an interview on 05/07/2026 at 1:21 PM, Staff B, Director of Nursing Services, stated they were unable to locate a SNF/NF to Hospital Transfer form completed for Resident 14's transfer to the hospital on [DATE] and this did not meet their expectations. Reference WAC 399-97-0120(1)(2)(a), -(d)(3)(a)(4)(b)(5), -0080, -0140(1)(a)-(c)(i)-(iii) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' care plans were revised and accurately reflected the resident's status and care needs for 2 out of 21 sampled residents (Residents 6 and 71) reviewed for care planning and revision of care plans. Failure to address Resident 6's generalized anxiety disorder with target behaviors and interventions and Resident 71's dentures placed the residents at risk for unmet care needs, medical complications, inaccurate care plan documentation, and a diminished quality of life. Findings included.Resident 6Review of the electronic health record (EHR) showed Resident 6 admitted to the facility on [DATE] with diagnoses to include heart failure, respiratory failure, and post-traumatic stress disorder (PTSD, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or traumatic event). Resident 6 was able to make needs known. Review of the EHR showed the Resident 6 had a diagnosis of generalized anxiety disorder and was prescribed and administered a psychotropic medication (medication to manage mental health conditions). Review of the current care plan on 05/05/2026 showed Resident 6 had documentation to monitor side effects for antipsychotic medication (to manage psychosis/difficult to distinguish what is real from what is not), anticonvulsant medication (used to treat epilepsy/seizures, temporary changes in movement, behavior, consciousness, or feelings); however, Resident 6 was not prescribed these medications. The care plan showed Resident 6 had PTSD; however, it did not show the diagnosis of generalized anxiety disorder nor what behaviors to monitor for and interventions to implement related to the diagnoses of PTSD or anxiety disorder. During an interview on 05/06/2026 at 11:49 AM, Staff F, Licensed Practical Nurse/Care Coordinator (LPN/CC), stated Resident 6 was not taking and had not been prescribed antipsychotic or anticonvulsant medications; however, they were taking a psychotropic medication for their anxiety disorder. Staff F stated Resident 6's care plan did not meet expectations because it did not accurately reflect Resident 6's current status related to prescribed medications, did not include the diagnosis of anxiety disorder, and did not have target behaviors to monitor for anxiety disorder or PTSD listed. During an interview on 05/06/2026 at 1:37 PM, after reviewing Resident 6's care plan, Staff B, Director of Nursing Services (DNS), stated it did not meet their expectations related to psychotropic medications, target behaviors to watch for with interventions, and addressing the resident's diagnosis of generalized anxiety disorder. Resident 71Review of the EHR showed Resident 71 admitted to the facility on [DATE] with diagnoses to include PTSD, high blood pressure, and depression. Resident 71 was able to make needs known. Observation on 05/06/2026 at 11:30 AM showed a denture cup by the sink with Resident 71's name handwritten on the lid and new dentures, upper and lower with a date of 01/12/26. During an interview on 05/06/2026 at 11:30 AM, Resident 71 stated they had gotten new dentures; however, the bottom dentures did not fit well, and they were told to use a denture adhesive. Resident 71 stated they were provided with the adhesive to use on the lower dentures, but they still did not fit right but had not told staff yet. Review of Resident 71's current focused care plan for oral/dental health problems, initiated on 06/23/2026, showed the resident was edentulous (no natural teeth/toothless) and had difficulty chewing. It did not show Resident 71 had dentures or any interventions related to denture use or maintenance. During an interview on 05/06/2026 at 12:26 PM, Staff E, Certified Nursing Assistant (CNA), stated they had not seen Resident 71 wear dentures and were not aware they had new dentures that did not fit. During an interview on 05/06/2026 at 12:41 PM, Staff C, LPN/CC, stated they had recalled passing out new dentures to Resident 71 sometime in January 2026; however, they were not aware that they did not fit Resident 71. Staff C stated Resident 71's care plan did not show they got new dentures and should have been updated with interventions put into place when the dentures were obtained. During an interview on 05/06/2026 at 1:06 PM, Staff B,<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | DNS, stated Resident 71's care plan should have reflected that they received dentures with interventions put into place. Staff B stated this did not meet expectations. Reference WAC 388-97-1020(2)(c)(d) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide individualized activities for 1 of 3 sampled residents (Residents 5) reviewed for activities. This failure placed residents at risk of boredom, isolation, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 5 admitted to the facility on [DATE] with diagnoses that included anxiety disorder, depression, and weakness. The admission minimum data set (MDS, an assessment tool), dated 01/14/2026, showed Resident 5 was cognitively intact. During an interview on 05/03/2026 at 11:09 AM, Resident 5 stated they were unable to attend in person activities because of their legs. Resident 5 stated there were no activities offered to them in their room and they would like to have more activities to occupy them. Observation on 05/03/2026 at 11:09 AM showed Resident 5 laid in bed with the TV on. During an interview on 05/06/2026 at 11:23 AM, Resident 5 stated they did not remember the last time activities staff visited them to offer activities. Resident 5 stated they would mostly lay in their bed and watch TV. Resident 5 stated the activities staff would need to offer something they were able to do because they had difficulty doing some activities. Review of the activities care plan dated 12/26/2026 showed Resident 5 had a goal to participate in activities two to three times per week. Review of the progress notes showed activity staff visited Resident 5 on 12/22/2026 at 10:45 AM to provide a welcome packet and encouraged Resident 5 to participate in daily activities. Review of the progress notes showed no further documentation of activities. During an interview on 05/06/2026 at 11:00 AM, Staff H, Activities Aide, stated they remembered visiting Resident 5 once or twice in the past. Staff H stated if a resident was unable to come to activities, they would offer room visits at which time they would offer puzzles, arts and crafts, visiting, and chatting. Staff H stated documentation of all activities was placed in the tasks. Review of the task showed no documentation of activities for the past 30 days. During an interview on 05/06/2026 at 11:57 AM, Staff J, Activities Director, stated they had paper documentation of room visits with Resident 5. Staff J stated Resident 5 was on a list for room visits every Monday and Wednesday. Review of the room visit documentation showed activity staff visited Resident 5 four times on 01/26/2026, 02/06/2026, 03/10/2026, and 04/08/2026. During an interview on 05/06/2026 at 11:35 AM, Staff A, Administrator, stated offering of activities would depend on what the care plan said. Staff A stated if a resident was offered activities, it should be documented. Reference WAC 388-97-0940(1)(2) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consistently implement pressure reducing strategies for 1 of 3 sampled residents (Resident 90) reviewed for pressure injuries. This failure placed residents at increased risk for pressure injuries, poor clinical outcomes, and a decreased quality of life.Findings included.According to NIH.gov, a diabetic foot ulcer (DFU) is an open sore or wound on the foot of a person with diabetes, and it is most commonly located on the plantar surface, or bottom of the foot. Pressure offloading serves as one of the primary treatments of DFU in ulcers accompanied by neuropathy (inability to feel).Review of the electronic health record showed Resident 90 was admitted to the facility on [DATE] with diagnoses of left hip fracture with surgical repair, a blood clot of the left lower leg, and dementia (a group of symptoms that affect memory). The resident was not able to make needs known. The resident was dependent on facility staff for mobility.Observation on 05/03/2026 at 12:47 PM showed Resident 90 seated in a reclined position in their wheelchair, and their left foot/heel was rested on a footrest strap. There was a bandage in place to the resident's left heel and no pressure relieving boots were observed on the resident's feet.Review of the baseline care plan, dated 12/06/2025, showed an intervention for skin at risk: elevate heels and heel float boots as resident allows.Review of the admission skin assessment, dated 12/06/2025, showed Resident 90 had no wound on their left heel.Review of a care plan goal, dated 12/29/2025, showed The resident's pressure ulcer will show signs of healing and remain free from infection by/through review date. With an intervention for Elevate/float heels when in bed to offload pressure as resident allows.Review of the initial wound notes from the wound care provider, dated 01/05/2026, showed a recommendation to heel float with pillows or wedge, sage/moon boots.Review of the weekly skin assessment, dated 02/16/2026, showed Resident 90's left heel wound had resolved.<Re-opening of Wound>Review of the weekly skin assessment dated [DATE] showed Resident 90 had a new/reopened wound that was very painful to touch.Review of contracted wound care provider notes, dated 04/27/2026, documented, DFU to the left heel is reopened even after epithelial tissue has closed over wound bed, wound bed is in final stage of remodeling. wounds are elevated risk for reopening. Prior to debridement (removal of unhealthy tissue) procedure, wound described as full thickness - wound base: no epithelial (final skin layer that closes the wound), 1-10% granulation (healthy/new tissue), 76-100% slough (by product of the inflammatory phase of wound healing), no eschar (dead tissue) with the following measurements: 0.8 centimeters (cm) x 0.9 x 0.2.During an interview on 05/04/2026 at 1:15 PM, Collateral Contact 1 (wound care provider) stated Resident 90's heel wound was a DFU and had resolved but reopened a few weeks ago and they had recommended Resident 90 to wear the pressure relieving boots at all times.Review of the current care plan, reviewed 05/05/2026, showed no new interventions were added to Resident 90's plan of care following the 04/22/2026 wound identification.Observations on 05/05/2026 between 8:33 AM and 10:30 AM showed Resident 90 laid in bed with their heels directly on the mattress (not floated and no boots on).Observation on 05/05/2026 at 10:42 AM showed Resident 90 reclined in their wheelchair, and their left foot/heel was resting on the footrest strap. There was a bandage in place and no boots on the resident's feet.During an interview on 05/05/2026 at 2:23 PM, Staff Q, Certified Nursing Assistant, stated Resident 90 had never refused to wear the boots or float their heels and if they had the boots on, they left them on.During an interview on 05/05/2026 at 10:33 AM, Staff C, Licensed Practical Nurse/Care Coordinator (LPN/CC), stated if a resident had a heel wound, they would speak with the wound care provider and follow their recommendations such as floating heels or boots. Staff C stated Resident 90 should have had their plan of care updated with a new intervention when the wound to their left heel reopened on 04/22/2026.During an interview on 05/05/2026 at 10:48 AM, Staff B, Director of Nursing Services, stated it was their expectation that Resident 90 was assessed and the plan of care updated when<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | their left heel wound reopened on 04/22/2026. Staff B stated Resident 90's heels should have been floated and boots applied per the care plan.Reference WAC 388-97-1060(3)(b) |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to address residents' hearing and vision needs for 1 of 2 sampled residents (Resident 112) reviewed for communication-sensory. This failure placed the residents at risk of not being able to participate in activities, difficulty communicating, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 112 admitted to the facility on [DATE] with diagnoses to include leg fracture, dementia (a decline in mental ability severe enough to interfere with daily life), and hearing loss in both ears. Resident 112 was able to make needs known. During an interview and observation, Resident 112 stated they lost their glasses and were given readers but did not wear them because they were worried wearing glasses that were not their prescription would further degrade their vision. Observation did not show glasses in Resident 112's room. Observation showed Resident 112 was hard of hearing, required an elevated voice to hear, and required questions to be repeated to understand. Resident 112 stated they did not use a hearing aid. Review of the admission minimum data set assessment (MDS), dated [DATE], showed Resident 112 had adequate hearing with hearing aid and adequate vision with corrective lenses. Review of the significant change MDS, dated [DATE], showed Resident 112 had moderate difficulty hearing and did not use a hearing aid and impaired vision and did not use corrective lenses. Review of the care plan, initiated 02/24/2026, showed Resident 112 had impaired vision with interventions to arrange consultation with eye care practitioners as needed and remind Resident 112 to wear their glasses. Review did not show a focus area or interventions related to Resident 112's hearing loss or use of hearing aids. Review of a Resident Clothing List, undated, showed Resident 112 admitted to the facility with one pair of eyeglasses and one Super Ear headset personal sound amplifier. Observation and interview on 05/06/2026 at 1:55 PM showed Resident 112 in bed without eyeglasses or hearing device. Observation showed a personal sound amplifier in the top drawer of Resident 112's bedside table. Resident 112 stated they did not know where their glasses were. During an interview on 05/07/2026 at 11:20 AM, Staff K, Certified Nursing Assistant (CNA), stated they worked with Resident 112. Staff K stated Resident 112's hearing was strained and they did not use a hearing device or glasses. During an interview on 05/07/2026 at 11:24 AM, Staff L, Registered Nurse/Resident Care Manager (RN/RCM), stated the facility ensured residents with hearing or vision difficulties would receive services for these issues by being assessed at admission, referred to a provider as needed to obtained hearing aids or glasses, and be included in the plan of care. Staff L stated Resident 112 had hearing loss as a diagnosis and used a personal amplified device. Staff L stated Resident 112's use of hearing device should have been included in the plan of care to inform staff of the device. Staff L stated Resident 112 should have been referred to an eye care practitioner to be assessed for corrective lenses, and CNA should be aware of Resident 112's use of glasses to assist them in using them. During an interview on 05/07/2026 at 11:43 PM, Staff B, Director of Nursing Services, stated Resident 112's services to improve or maintain hearing and vision did not meet expectations, and the facility should of referred Resident 112 to eye and ear care practitioners to address these areas. Reference WAC 388-97-1060(3)(a) |

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|---|---|
| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for 2 of 4 sampled residents (Residents 53 and 14) reviewed for respiratory care. Failure to transcribe/obtain and follow physician orders for oxygen (O2) therapy with indication for use, consistently monitor O2 saturation (Sats, measuring the percentage amount of O2 in the blood), and/or ensure O2 tubing was regularly changed and maintained, placed the residents at risk for unmet needs and potential negative outcomes. Findings included .Resident 53Review of the electronic health record (EHR) showed Resident 53 admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, lung disease that causes restricted airflow and breathing problems) and chronic (long lasting/ongoing) respiratory failure with hypoxia (low levels of O2 in the blood). Resident 53 was able to make needs known. Observation on 05/03/2026 at 11:45 AM, 05/04/2026 at 1:14 PM, and 05/06/2026 at 10:29 AM showed Resident 53 laid in bed receiving O2 set to 2 liters (L, the flow of O2 being delivered per minute) via nasal canula (NC, devise to deliver O2 through a tube into the nose). Review of an order, dated 02/15/2026, showed Resident 53 was prescribed O2 at 1 to 4 L per minute, continuously, via a NC. This order did not show indication for use or acceptable O2 sats parameters to maintain to know what liter flow to use for the O2 therapy. Review of the April and May 2026 medication administration records (MAR) showed no documented order for the use of O2 therapy for Resident 53. Review of the April and May 2026 treatment administration records (TAR) showed Resident 53 had orders, dated 12/31/2025, to change O2 tubing if damaged or visibly soiled as needed; however, there was no order for O2 therapy. Review of Resident 53's EHR showed O2 sats were inconsistently being documented daily from 04/01/2026 - 05/04/2026. During an interview on 05/06/2026 at 2:16 PM, Staff C, Licensed Practical Nurse/Care Coordinator (LPN/CC), stated Resident 53's order for O2, dated 02/15/2026, was missing an indication for use, O2 sats parameters, and needed to be clarified with the provider. Staff C stated Resident 53's April and May 2026 MAR and TAR did not show documentation of O2 therapy being provided per provider's order. Staff C stated Resident 53's O2 sats were not being documented daily and/or every shift consistently in the EHR, and this did not meet expectations. During an interview on 05/07/2026 at 10:20 AM, after reviewing Resident 53's EHR, Staff B, Director of Nursing Services (DNS), stated Resident 53's order for O2 therapy was missing indication for use and O2 sats parameters. Staff B stated Resident 53's April and May 2026 MAR and TAR did not show documentation of being provided O2 and there should have been. Staff B stated Resident 53's O2 therapy care, services, and documentation did not meet their expectations. Resident 14Review of the EHR showed Resident 14 readmitted to the facility on [DATE] with diagnoses of respiratory failure, high blood pressure, and anxiety disorder. Resident 14 was able to make needs known. Observations on 05/03/2026 at 1:39 PM, 05/04/2026 at 1:33 PM, 05/05/2026 at 11:48 AM and 05/06/2026 at 10:36 AM showed Resident 14 in their room receiving O2 at 6 L via NC. During an interview on 05/05/2026 at 11:48 AM, Resident 14 stated they needed O2 therapy to breathe. Review of Resident 14's focused care plan for altered respiratory status/difficulty breathing, initiated on 11/26/2025, showed the resident was dependent on O2 use and was to be provided O2 per provider's orders. Review of Resident 14's provider orders on 05/04/2026 showed no orders for O2 therapy or for changing O2 tubing. During an interview on 05/07/2026 at 10:05 AM, Staff C, LPN/CC, stated Resident 14 was on O2 therapy continuously via NC; however, they were unable to locate O2 therapy orders to include changing of O2 tubing in Resident 14's EHR and there should have been. Staff C stated Resident 14's orders for O2 therapy and changing of O2 tubing were discontinued on 04/29/2026 after they were discharged to the hospital and did not get added back to the MAR or TAR when they readmitted to the facility on [DATE]. During an interview on 05/07/2026 at 11:06 AM, Staff B, DNS, stated Resident 14 should have had O2 therapy orders in place and this did not meet their expectations. Reference WAC 388-97-1060(3)(j)(iv)-(vi) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505483 | A. Building<br>B. Wing | 05/07/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0790<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide routine and 24-hour emergency dental care for each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received needed dental care for 1 of 3 sampled residents (Resident 112) reviewed for dental. This failure placed the residents at risk of dental pain, decreased nutritional intake, unintended weight loss, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 112 admitted to the facility on [DATE] with diagnoses to include leg fracture, dementia (a decline in mental ability severe enough to interfere with daily life), and hearing loss in both ears. Observation on 05/03/2026 at 1:43 PM showed Resident 112 had missing lower teeth. Review of the admission minimum data set assessment (MDS), dated [DATE], showed Resident 112 had obvious or likely cavities or broken natural teeth. Review of the care plan, dated 02/24/2026, showed Resident 112 had oral/dental health problems related to likely cavities/broken teeth with an intervention to coordinate dental care and provide transportation. During an interview on 05/06/2026 at 1:54 PM, Staff G, Regional Social Services, stated Resident 112's dental needs were captured on the 02/24/2026 MDS and they were not referred for dental services. During an interview on 05/07/2026 at 10:53 AM, Staff M, Social Services Director, stated the facility identified dental needs on admission through the MDS, and resident needing dental services should be referred to social services to be scheduled for assessment by a dental care practitioner. Staff M stated Resident 112 should have been referred to dental services after the 02/24/2026 MDS assessment, and the lack of referral did not meet expectations. During an interview on 05/07/2026 at 11:35 AM, Staff B, Director of Nursing Services, stated residents with identified dental needs should be referred for follow-up with a dentist. Staff B stated Resident 112 should have been referred to the in-house dental provider, and the lack of referral did not meet expectations. Reference WAC 388-97-1060(3)(j)(vii) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately document the amount of food eaten for 1 of 3 sampled residents (Resident 13) reviewed for nutrition. This failure placed residents at risk of inaccurate assessments, lack of timely interventions, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 13 admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (too much sugar in the blood), dysphagia (difficulty swallowing), and protein-calorie malnutrition (lack of nutrients in the body). The quarterly minimum data set (MDS, an assessment tool), dated 02/12/2026, showed Resident 13 was moderately cognitively impaired. Observation on 05/05/2026 at 12:09 PM showed a meal tray was delivered to Resident 13 in their room. Observation showed the meal tray was set up on a bedside table next to Resident 13's bed. Observation showed Resident 13 was eating slowly. Observation showed Resident 13 ate less than 25% of their meal and laid back in the bed and closed their eyes. Observation showed staff entered the room and removed the meal tray. Review of the Point of Care (POC) documentation for lunch on 05/05/2026 showed Resident 13 ate 76-100% of their meal. During an interview on 05/06/2026 at 1:20 PM, Staff R, Certified Nursing Assistant (CNA), stated Resident 13 typically would eat between 25-50% of their meals and never ate all of their food. Staff R stated if they did not pick up a tray, they would ask their coworker what the resident ate to document it in POC. Staff R stated Resident 13 ate well on 05/05/2026. Staff R stated they were told Resident 13 ate 75-100% of their lunch, so that is what they documented. During an interview on 05/07/2026 at 8:30 AM, Staff F, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated staff should document the amount eaten in POC under meal intake. Staff F said POC would show them the options and staff would use the correct space to document. Staff F stated if documentation was not accurate, it would affect the dietician's ability to have accurate information about caloric intake and the nutritional needs of Resident 13. During an interview on 05/07/2026 at 10:30 AM, Staff B, Registered Nurse/Director of Nursing Services (RN/DNS), stated it is their expectation for all staff to document meal intake accurately. Reference WAC 388-97-1720(1)(a)(i)-(iv)(b) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light system was functioning for 1 of 3 call light panels (500 hall) when reviewed for call lights. This failure placed residents at risk of inability to receive timely assistance, possible neglect, and a diminished quality of life. Findings included.Observation on 05/03/2026 at 11:04 AM showed the call light panel in the 500 hall with room [ROOM NUMBER] lit, but the call light above room [ROOM NUMBER] was not lit. Observation on 05/04/2026 at 1:13 PM showed the call light panel in the 500 hall with room [ROOM NUMBER] lit, but the call light above room [ROOM NUMBER] was not lit. Observation on 05/07/2026 at 12:37 PM showed the call light panel in the 500 hall with room [ROOM NUMBER] lit, but the call light above room [ROOM NUMBER] was not lit. Observation on 05/07/2026 at 1:17 PM showed the call light panel in the 500 hall with room [ROOM NUMBER] continued to be lit, but the call light above room [ROOM NUMBER] was not lit. Review of the maintenance log for the 500 hall showed entries for call light not turning off on 03/03/2026, 03/06/2026, 04/10/2026, and 05/03/2026. Observation on 05/07/2026 at 1:20 PM showed the call light for room [ROOM NUMBER] bed B did not light above the door or at the call panel. During an interview on 05/07/2026 at 2:29 PM, Staff N, Maintenance Director, stated they ensured the call light system was functioning correctly by performing periodic audits and reviewing the maintenance binder at each nurses' station when nursing staff would log needed call light repairs. Staff N stated they had just repaired room [ROOM NUMBER] bed B's call light cord as it was not functioning. Staff N stated the call light system in the 500 hall would sometimes have lights lit on the panel but the call lights at the door would not be on. Staff N stated they resent the system when this occurred to clear the error. During an interview on 05/07/2026 at 3:42 PM, Staff A, Administrator, stated the facility ensured the call light system was functioning correctly by performing periodic audits and reviewing the maintenance binder at each nurses' station. Staff A stated the light on the call light panel should turn off when the light at the door was turned off, and observations of them not turning off did not meet expectations. Staff A stated resetting the panel each time the error occurred was a sustained repair of the system. Reference WAC 388-97-2280(1)(a) |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on observation, interview, and record review, the facility failed to post the daily nurse staffing data in a prominent place to include name of facility and total number and actual hours worked for 5 of 5 observed days during the survey period (05/03/2026 -05/07/2026) reviewed for nurse staff posting. This failed practice prevented residents, family members and visitors from knowing the facility's actual number of available nursing staff. Findings included.Observations on 05/03/2026 at 9:00 AM showed the front entrance, receptionist desk, and lobby areas with no daily nurse staffing data posted. Observations on 05/04/2026 at 11:00 AM, 05/05/2026 at 6:16 AM, 05/06/2026 at 8:55 AM, and 03/07/2026 at 8:51 AM showed the daily nurse staff data postings without the facility's name and with no actual total number or actual nursing staff hours documented (the form showed Actual Scheduled Staff and Actual Scheduled Hours), located in a glass covered bulletin board to the left of a wall picture and grandfather clock, after walking through the front entrance and when taking a left towards the 100/200 halls. If a person were to take a right towards the 300 hall, they may not have been able to view the daily nurse staff data. Observation of the daily staff data posting on 05/05/2026 at 6:16 AM showed postings for the previous day (05/04/2026). Observation on 05/05/2026 at 8:03 AM showed posting for the correct date of 05/05/2026. During an interview on 05/07/2026 at 1:33 PM, Staff O, Staffing Coordinator, stated people could miss seeing the nursing staff daily postings if they were to take a right after going through the lobby because the bulletin board was the only location for postings. Staff O stated they did not know why the nursing staff daily posting form did not have the facility's name on it and the form had been that way since they started working in February 2026. Staff O stated they filled out the form and posted the actual scheduled staff and actual scheduled hours on the form in the morning when they came in around 8:00 AM; however, actuals, were not posted. During an interview on 05/07/2026 at 1:56 PM Staff A, Administrator, stated nurse staff daily postings were posted the day before for the next day and on Friday they were posted for days through the weekend. Staff A stated typically the postings were updated/revised the next day within 24 hours as needed. Staff A stated they were unable to explain why the form did not have the facility's name on it and that actuals were not posted just scheduled. Reference WAC 388-97-1620(2)(b)(i) |