STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505485	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Grove Health Care Center	400 - 29th Street Northeast Puyallup, WA 98373

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff and functional call light systems were in place across multiple units and shifts to meet residents' basic care needs, including timely response to call lights and assistance with activities of daily living. This deficient practice was systemic in nature, resulting in delayed responses, unmet care needs, and inadequate supervision for residents, and placed residents at risk for an unsafe environment, avoidable discomfort, incontinence, skin breakdown, delayed medication administration, and diminished quality of life.Findings included .Observation on 01/07/2026 at 10:47 PM showed the 100 and 200 Hall call light boards disconnected and showed blue screens saying Disconnected: click to configure connection with constant beeping. Observation on 01/13/2026 at 8:26 AM showed the [NAME] Care (call light system) at the North and South nursing station showed call lights for resident rooms were visually seen on the screen but were not audible. Observation showed the audible display on the screen with an X through it. During an interview on 01/05/2026 at 2:40 PM, Resident 19 stated sometimes they waited more than an hour for their call light to be answered and when staff arrived, they would turn the light off, not meet the need and leave. During an interview on 01/06/2026 at 10:09 AM, Resident 17 stated they had an hour wait for their call light to be answered on day shift. Resident 17 stated one night they waited four hours in a wet brief before staff came to assist. During an interview on 01/06/2026 at 9:51 AM, Resident 99 stated, They take long time to answer my call light, sometimes it can take a half hour to get help mostly on evenings and night shifts. During an interview on 01/05/2026 at 4:10 PM, Resident 41 stated, They do not have enough staff, the wait is a long time for medications. During an interview on 01/06/2026 at 8:57 AM, Resident 6 stated, They need more staff, sometimes other residents have to call out for help because they wait too long and Sometimes I wait over a week to get a shower and have my sheets changed. Review of Resident Council Minutes for the months 07/2025, 09/2025, 11/2025 and 12/2025 showed the following resident concerns: Long call wait times during night shift, lack of staff to assist residents to activities, call lights being turned off prior to needs being fulfilled, and lack and difficulty finding nursing aides following breakfast. During an interview on 01/13/2026 at 8:42 AM, Staff EE, Certified Nursing Assistant (CNA), stated staff call outs were a problem at the facility. Staff EE stated the North Hall shower aide quit due to regularly being required to work the floor when staff called out. Staff EE stated while working short staffed they were not able to provide all necessary care to their assigned residents. During an interview on 01/13/2026 at 8:30 AM, Staff GG, Restorative Nursing Aide, stated they had been regularly providing resident care on the floor due to short staffing for the past few weeks. Staff GG stated they had residents scheduled for restorative that they would not get to that day due to working the floor. Staff GG stated residents who did not get their restorative would be scheduled for the next available shift they were not working the floor. During an interview on 01/12/2026 at 3:13 PM, Staff Q, CNA, stated they often worked short staff and were unable to provide showers to residents. Staff Q stated the shower aid quit about two months ago and had not been replaced. During an interview on 01/12/2026 at 2:38 PM, Staff FF, Staffing Coordinator, stated adequate staff were scheduled daily; (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	however, staff call outs were an ongoing problem. Staff FF stated the facility has had as many as four CNAs call out on the same shift. During an interview on 01/13/2026 at 11:40 PM, Staff A, Administrator, stated they were aware of long call wait times and were currently in the process of hiring additional nursing staff. Staff A stated short staffing was caused by staff callouts and the facility had implemented new disciplinary policies related to staff who ?no call no show' or habitually call out. FOR ADDITIONAL INFORMATION REFER TOFed - F - 0677- Activities of Daily Living for Dependent ResidentsFed - F - 0730- Nurse Aide Performance Review and 12 Hours and year In-Service Reference WAC 388-97-1080 (1), 1090 (1)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to conduct performance evaluations for 5 of 5 Certified Nursing Assistants (CNA) (Staff D, F, GG, EE, and PP) in the last 12 months. These failures placed the residents at risk of receiving less than optimal care. Findings included .Review of Staff D, F, GG, EE and PP, CNAs, employee files found no documentation that the annual performance evaluations had been conducted. During an interview on 01/12/2026 at 3:28 PM, Staff AA, Human Resources/Payroll, stated that they were aware that the CNAs needed performance evaluations yearly; however, they had not been completed. During an interview on 01/13/2026 at 11:40 AM, Staff A, Administrator, stated due to staff changes, performance evaluations were not completed, and this did not meet expectations. Reference WAC 388-97-1680

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure foods were palatable, prepared, and served in a manner acceptable to residents across the facility, as evidenced by widespread and ongoing resident complaints regarding food quality, taste, temperature, portion size, and accuracy of meal trays. This deficient practice affected multiple residents over an extended period of time, resulting in residents refusing meals, requesting frequent substitutions, and reporting unmet nutritional needs, placing residents at risk for reduced nutritional intake, avoidable weight loss, delayed medical improvement, and diminished quality of life. Findings included.<RESIDENT INTERVIEWS> During an interview on 01/05/2026 at 12:26 AM, Resident 19 stated they would not feed the facility's food to their pet because it did not taste good. During an interview on 01/05/2026 at 3:51 PM, Resident 115 stated the facility's food was terrible and was often greasy so they could not eat it. During an interview on 01/05/2026 at 1:20 PM, Resident 40 stated the facility's food was terrible because it did not taste good, was bland, and the vegetables were mushy. Resident 40 stated the facility's administration was aware of resident complaints regarding food but failed to improve the food quality. During an interview on 01/05/2026 at 3:53 PM, Resident 15 stated the facility's food was not good and rated it 2 out of 10. Resident 15 stated the food was bland. During an interview on 01/05/2026 at 11:20 AM, Resident 53 stated the facility's food did not taste good and when alternative items were requested from the kitchen it was not provided. During an interview on 01/05/2026 at 11:31 AM, Resident 117 stated they did not eat pork, but would still be served pork. Resident 117 stated the food items provided were frequently not the same as the menu and sometimes items would be missing from the tray. Resident 117 stated the food portions were small. During a follow-up interview on 01/06/2026 at 9:25 AM, Resident 117 stated their breakfast was not good as the eggs were bland. Resident 117 stated the meal ticket showed cold cereal, but they did not receive it. During an interview on 01/05/2026 at 2:43 PM, Resident 72 stated all meals at the facility were terrible. During an interview on 01/06/2026 at 9:01 AM, Resident 6 stated sometimes they were unable to identify what food items they had been served and they did not match what items were on the menu. Resident 6 stated they did not get enough to eat because of concerns about the facility's food. During an interview on 01/06/2026 at 10:04 AM, Resident 3 stated the facility's food was disgusting. Resident 3 stated they told facility staff about their food concerns, but they don't listen. During an interview on 01/05/2026 at 9:33 AM, Resident 13 stated the food arrived warm and they had to ask staff to microwave their food to increase the temperature. During an interview on 01/05/2026 at 3:05 PM, Resident 14 stated the facility's food was really bad. Resident 14 stated the food was mushy and not edible. Resident 14 stated they had to request a sandwich for lunch because the food served was not palatable. During an interview on 01/05/2026 at 11:48 AM, Resident 11 stated the facility's food was not good and they frequently had to request substitutions. During an interview on 01/05/2026 at 11:10 AM, Resident 96 stated the facility frequently ran out of items on the menu, so they were served a substitute two to three times a week. During an interview on 01/05/2026 at 3:31 PM, Resident 98 stated the facility's food was terrible and they often sent the food back to the kitchen. During an interview on 01/06/2026 at 9:56 AM, Resident 99 stated the facility's food was bland and usually did not taste good. Resident 99 stated the portion sizes were small, and they had to request more food from the kitchen. <FOOD COMMITTEE> Review of Resident Council Minutes, dated 07/07/2025, showed the following concerns during the Dietary Committee section: 1) Watery scrambled eggs; 2) French toast regularly undercooked; 3) Brussel sprout and cauliflower were served burnt; 4) Carrots were mushy and overdone; 5) Coffee was often served colder than preferred; and 6) Breakfast was served colder than preferred. The Improvements area showed, R.C.'s [Resident Council] perception is that there has been a rapid decline in the quality of the product. Review of Resident Council Minutes, dated 08/11/2025, showed the following concerns during the Dietary Committee section: 1) [NAME] was served too often; 2) Meals with only starches and no meat (i.e. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	mac and cheese with scalloped potatoes); 3) Hardboiled eggs being too firm; 4) Meals with double noodles; 5) Scrambled eggs described as sour; and 6) Gilled cheese sandwiches served under grilled. Review of Resident Council Minutes, dated 09/08/2025, showed the following concerns during the Dietary Committee section: 1) Food served at appropriate temperatures 75% of the time; 2) Requesting less rice and more variety; 3) Chicken with rice served for lunch and chicken and rice casserole served for dinner; and 4) Constantly served items not on the menu with missing or substituted items. Review of Resident Council Minutes, dated 10/06/2025, showed the Dietary Committee section requested better presentation of food to include receiving dry napkins and items placed uniformly on the tray. Review of Resident Council Minutes, dated 11/10/2025, showed the following concerns during the Dietary Committee section: 1) [NAME] served too often; and 2) Vegetables regularly overcooked. Review of Resident Council Minutes, dated 12/08/2025, showed the following concerns during the Dietary Committee section: 1) Vegetables often served overcooked; 2) [NAME] served too often; 3) Breakfast frequently served cold; and 4) Not receiving requested alternative items. Review showed the Resident Council requested an explanation why they were told basic items were unavailable and reported they had been told by staff there was no sugar, bread, jelly, fruit, etc at various times the previous month. <GRIEVANCES> Review of a Complaint/Grievance Report, dated 07/02/2025, showed Resident 120 reported, When my meals come, they're cold, but my liquids are warm. Review of a Complaint/Grievance Report, dated 07/09/2025, showed Resident 121 reported, Food is crap. Review of a Complaint/Grievance Report, dated 07/18/2025, showed Resident 49 reported, I haven't been able to eat any of the meals for five days. No silverware, only plastic. I wouldn't serve it to a dog. Review of a Complaint/Grievance Report, dated 07/18/2025, showed Resident 102 reported, No silverware. The food is awful here. Not edible. It tastes like [expletive]. Review of a Complaint/Grievance Report, dated 07/29/2025, showed Resident 122 reported, Kitchen is serving foods [they are] not able to eat. Review of a Complaint/Grievance Report, dated 07/31/2025, showed Resident 123 reported, I never got a dinner tray last night. Review of a Complaint/Grievance Report, dated 08/03/2025, showed Resident 123's family member reported Resident 123 had arrived at the facility at 3:00 PM and called them at 8:30 PM to report they had not received a food tray. Resident 123 stated they called the facility at 9:00 PM to request Resident 123 receive food, but they were not provided with a meal until after midnight. Review of a Complaint/Grievance Report, dated 08/07/2025, showed Resident 123 reported, Filled out menu daily, did not get what they ordered, or they would write it on the ticket in big red letters they ran out. Review of a Complaint/Grievance Report, dated 08/20/2025, showed Resident 124 reported, Food is horrible and tasteless. Review of a Complaint/Grievance Report, dated 10/03/2025, showed Resident 37 reported they sometimes received pureed diet, but their ordered diet was regular soft and bite sized. Review of a Complaint/Grievance Report, dated 10/26/2025, showed Resident 122 reported they were not receiving enough food. Review of a Complaint/Grievance Report, dated 12/21/2025, showed Resident 78 reported, Not the right breakfast items according to the menu and tray ticket. Review of a Complaint/Grievance Report, dated 12/29/2025, showed Resident 125 reported concerns about food not being on tray as stated on meal ticket. Review of a Complaint/Grievance Report, dated 12/31/2025, showed Resident 125 reported they did not like the food they received. During an interview on 01/14/2026 at 9:17 AM, Staff CC, Dietary Manager, stated the facility held a dietary committee meeting monthly to ensure residents found the facility's food palatable. Staff CC stated they were aware of concerns related to food quality and felt the issue was with the quality of the product the kitchen was allowed to purchase. Staff CC stated the frequent concerns with food quality and not receiving requested items did not meet their expectations. During an interview on 01/14/2025 at 10:22 AM, Staff A, Administrator, stated the expectation was for residents to consider the facility's food to be palatable. Staff A stated they were aware of the residents' concerns related to palatability of the facility's food and they were working with their regional group to resolve the issue. Staff A stated the residents' statements, dietary committee concerns, and grievances related to food did not meet expectations. Reference WAC 388-97-1100(1)(2)

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility failed to maintain a full-time qualified social worker. This failure placed residents at risk of lacking medically related social services and a diminished quality of life. Findings included.Review of facility licensing data, effective 06/01/2020, showed the facility was licensed for 130 beds.During an interview on 01/08/2026 at 2:13 PM, Staff V, Social Services Assistant, stated the facility's Social Services Director had been on maternity leave for two weeks and they were handling the qualified social worker duties until they returned. Staff V stated they were told they would receive assistance during the social services director's leave but were unsure when this help would arrive. Staff V stated they did not have formal education in the field of social work.During an interview on 01/08/2026 at 2:29 PM, Staff A, Administrator, stated the facility was licensed for 130 beds. Staff A stated the facility employed a qualified social worker to ensure residents had access to medically related social services. Staff A said the qualified social worker should have a bachelor's degree in social services and be employed full-time. Staff A stated the social services director has been on leave since around 12/19/2025 and would be on leave for at least two more weeks. Staff A stated they were a qualified social worker, and a qualified social worker was available via phone or email, but they were not serving as full-time qualified social worker at this time.Reference WAC 388-97-0960(2)(a)(b).

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and appropriate medication practices by leaving medications unattended at the bedside for residents who were not assessed or approved to self-administer medications for 3 of 3 sampled residents (Residents 40, 15, and 114) reviewed for accident hazards. This practice was inconsistent with the residents' interdisciplinary team (IDT) assessment and care plan and placed the residents at risk for adverse medication outcomes.Findings included. Review of the facility's policy titled, Self-Administration of Medications, dated February 2021 showed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. It showed, Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. Resident 40 Review of the electronic health record (EHR) showed Resident 40 readmitted to the facility on [DATE] with diagnoses to include respiratory failure, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, leading to disorganized thinking), and post-traumatic stress disorder (PTSD, a mental health condition where someone feels stressed and scared long after a traumatic event). Resident 40 was able to make needs known. Observation and interview on 01/05/2026 at 10:09 AM, showed Resident 40 sitting at the bedside with a bottle of multiple vitamins with minerals (a supplement used to treat or prevent general nutritional deficiencies) and a bottle of Prevagen oral capsules (a supplement used to support memory and brain function) on the overbed table next to the bed. Resident 40 stated they gave those medications to themself and the nurses were aware. Observation and interview on 01/07/2026 at 1:11 PM showed a tube of Preparation H medicated cream (used to treat hemorrhoids/inflamed or swollen veins in the anus or lower rectum) on the bottom shelf in the bathroom and Resident 40 stated it was their personal item. Review of the focused care plan for self-administration of medications, initiated on 12/28/2022 and revised on 09/10/2025, showed Resident 40 would self-administer supplements in accordance with the dosage and frequency prescribed by the physician and to complete the self-medication assessment per protocol. Review of Resident 40's order summary report, dated 01/06/2026, showed an order for, Resident MAY NOT administer own meds [medications], dated 09/18/2025. Review of the medication self-administration evaluation form, dated 12/29/2025, showed Resident 40 was not approved to self-administer medications and a licensed nurse was to administer medications to the resident. Review of Resident 40's January 2026 medication administration record (MAR) from 01/01/2026 - 01/06/2026 showed an order with a start date 09/19/2026 for multiple vitamins-minerals one tablet orally one time a day supplement and to supervise self-administration. Documentation showed it was provided per the order. Review showed an order with a start date of 09/19/2026 for Prevagen oral capsule 20 milligrams (mg) orally one time day supplement, unsupervised self-administration/this medication included: vitamin D 50 micro gram (mcg) and apoaquorin 20 mg, and for resident to self-administer the supplement, scheduled for 7:00 AM. Documentation showed U-SA (unsupervised self-administer), not initialed/signed by a licensed nurse. This MAR showed no orders for Preparation H medicated cream. During an interview on 01/07/2026, Staff L, Registered Nurse (RN), stated Resident 40 had active orders for multiple vitamins with minerals that was provided in a medication cup and the resident supervised while taking it and should not have been left at the bedside. Staff L stated that the order for the Prevagen oral capsule supplement was able to be self-administered unsupervised. Staff L stated that they only provided Resident 40 with the multiple vitamins with minerals and not Prevagen. Staff L stated the medication self-administration evaluation form dated 12/29/2025 showed Resident 40 was not approved to self-administer medications. Staff L stated once Resident 40's medication self-administration evaluation form was completed on 12/29/2025, and was not approved to self-administer medications, the provider should have been notified, the order to (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	self-administration evaluation dated 12/29/2025 that showed the resident was not approved to self-administer medications. Staff B stated they were told last night (01/07/2026) that Resident 114 had Aspercreame Lidocaine medication at the bedside and did not have a provider order for the medication or to have medication at the bedside and this did not meet their expectations. Reference WAC 388-97-0440, -1060(3)(I)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide written bed hold notice at the time of transfer to the hospital for 4 of 4 sampled residents (Residents 1, 40, 7 and 8) when reviewed for hospitalization and failed to provide written notice of transfer/discharge and recapitulation of their stay for 2 of 4 sampled residents (Residents 40 and 111) when reviewed for discharge. These failures placed the residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life.Resident 1 Review of the electronic health record (EHR) showed Resident 1 admitted to the facility on [DATE] with diagnoses of diabetes (when the body doesn't process sugars) and respiratory failure. The resident was able to make needs known. Review of the progress notes showed Resident 1 was transferred to the hospital on [DATE]. No documentation was found that the resident was offered a bed hold. During an interview on 01/09/2026 at 12:18 PM, Staff B, Director of Nursing Services (DNS), stated bed holds should be offered to include the price per night when a resident is transferred to the hospital. This did not meet expectations for Resident 1. Resident 40 Review of the EHR showed Resident 40 readmitted to the facility on [DATE] with diagnoses to include respiratory failure, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, leading to disorganized thinking), and high blood pressure. Resident 40 was able to make needs known. Review of the discharge minimum data set assessment (MDS) dated [DATE] showed Resident 40 had an unplanned discharge to the hospital on [DATE] with return anticipated. Review of Resident 40's bed hold policy notice and authorization form dated 09/11/202 showed it was not completely filled out and was missing the year, the cost to hold the bed, and was not signed by the resident or representative. Review of Resident 40's skilled nursing facility (SNF)/ nursing facility (NF) hospital transfer form dated 09/11/2025 showed it was inaccurately filled out. It showed the date of transfer was 5/15/2025, and did not show documentation that the form was sent to the hospital with the resident at the time of transfer. Review of Resident 40's Department of Social and Health Services (DSHS) Nursing Home Transfer or Discharge Notice dated 09/11/2025 was not signed by the resident or representative. Review of Resident 40's EHR showed no documentation that the resident received in writing of the reason for the transfer to hospital on [DATE]. Review showed no documentation that the receiving hospital was conveyed required information at the time of transfer on 09/11/2025. During an interview on 01/12/2026 at 3:21 PM, Staff M, Business Office Manager (BOM), stated (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 40's bed hold did not meet expectations because they forgot to put the rate of the bed hold, and the year/date seemed to have been cut off. Staff M stated they should have documented that Resident 40 refused to sign the bed hold instead of just documenting on the form that the resident declined the bed hold. During an interview on 01/13/2026 at 11:17 AM, Staff B, DNS, stated Resident 40's bed hold dated 09/11/202 should have had the correct year documented, the rate for the bed hold, and should have been signed by the resident or documentation to show the resident refused to sign. Staff B stated they did not know why Resident 40's SNF/NF to Hospital Transfer form dated 09/11/2025 had incorrect dates. Staff B stated this form should have been filled out correctly and sent with Resident 40's transfer to the hospital. Staff B stated they were unable to locate documentation that Resident 40 received written notice for their transfer to the hospital on [DATE] and there should have been. Resident 7 Review of the EHR showed Resident 7 admitted to the facility on [DATE] with diagnoses that included a stroke (medical emergency that occurs when blood flow to the brain is interrupted) and muscle weakness. Resident 7 was able to make needs known. Review of Resident 7's EHR showed hospitalization on 10/27/2025 and readmission to the facility on [DATE]. Review of the EHR showed an incomplete bed hold dated 10/28/2025. During an interview on 01/09/2025 at 8:50 AM, Staff M, BOM, stated they did not complete the form because long term care residents were not charged for bed holds. During an interview on 01/13/2025 at 11:40 AM, Staff A, Administrator, stated the expectation was for bed holds to be offered, completed and thoroughly documented when a resident was transferred to the hospital. Resident 8 Review of the EHR showed Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include hemorrhage in brain stem (Bleeding in brain stem), gastrostomy (surgically placed external opening into stomach), depression, anxiety and cognitive communication deficit. Resident 8 was not always able to communicate needs. During a phone interview on 01/05/2026 at 2:27 PM, Collateral Contact Z, stated Resident 8 has been discharged to the hospital multiple times, but the last time the facility did not offer a bed hold. Review of the EHR showed Resident 8 was discharged to hospital on [DATE] and returned on 12/31/2025. Review of the EHR showed Resident 8 had a Bed Hold Policy Notice and Authorization form in their record that was not signed or had verbal notification about bed hold. During an interview on 01/08/2026 at 2:16 PM, Staff J, Licensed Practical Nurse, stated the process for discharge to hospital was for the nurses to obtain the bed hold and fill out the paper form, when that was not possible there was a follow up from the office. Staff J stated the paperwork about the bed hold on Resident 8 was missing. During an interview on 01/09/2026 at 12:48 PM, Staff B, DNS, stated the bed hold documentation for (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 8 did not meet expectations. Resident 111 Resident 111 admitted to the facility on [DATE] with diagnoses to include diabetes, chronic pain and depression (mood disorder). Resident 111 was able to make needs known. Review of the EHR showed Resident 111 discharged from the facility on 11/13/2025. The EHR did not have documentation detailing the discharge. During an interview on 01/13/2026 at 10:13 AM, Resident 111 stated they left the facility against medical advice on 11/13/2025 due to the conditions at the facility. Resident 111 stated staff were aware of the discharge which was in the afternoon. Resident 111 stated the facility did not provide them with any medications or paperwork. During an interview on 01/14/2026 at 9:54 AM, Staff V, Social Services Assistant (SSA) stated when residents discharge the Discharge Planned Documentation assessment (discharge summary) in the medical record was to be completed for all residents. Staff V stated they were unable to locate documentation of a completed assessment for Resident 111. During an interview on 01/14/2026 at 10:08 AM, Staff A, Administrator, stated the expectation was that all discharge documents to include the discharge summary were completed for all residents including self-initiated discharges. Staff A stated the document should have been provided to the resident/resident representative by mail. Reference WAC 388-97-0120(4)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 assessment (MDS) accurately reflected the status for 3 of 27 sampled residents (Residents 10, 8 and 40) reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care and a diminished quality of life. Resident 10 Review of the electronic health record (EHR) showed Resident 10 admitted to the facility on [DATE] with diagnoses to include schizoaffective disorder (mental health condition with mood disorder symptoms), depression (mood disorder), and anxiety (emotion associated with worry, fear or panic). Resident 10 was able to make needs known. During an interview on 01/05/2026 at 11:36 AM, Resident 10 stated they were unable to hear anything in their left ear. Resident 10 stated they preferred for anyone speaking to them to come to their right side so they could hear clearly. Review of Resident 10's care plan dated 09/24/2022 showed the resident has impaired communication as evidenced by left ear deafness. Review of the quarterly MDS dated [DATE] showed the Hearing section marked minimal difficulty for ability to hear. During an interview on 01/09/2026 at 9:38 AM, Staff G, MDS Nurse, stated when a resident had total loss of hearing in one ear they should be assessed as moderate difficulty. Staff H stated the MDS was coded incorrectly. During an interview on 01/09/2026 at 9:47 AM, Staff H, Assistant Director of Nursing (ADON), stated the expectation was if a resident had a complete hearing deficit in one ear the MDS should have been coded as moderate. Staff H stated the expectation was for the MDS to be coded accurately. Resident 8 Review of the EHR showed Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include hemorrhage in brain stem (bleeding in brain stem), gastrostomy (surgically placed external opening into stomach), major depression, anxiety, psychotic disorder with delusions (fixed, false beliefs held with extraordinary conviction despite clear evidence of the contrary), and cognitive communication deficit. Resident 8 was not always able to communicate needs. Review of the EHR showed Resident 8 had a level 2 Pre-admission Screening and Resident Review (PASSAR, a federally mandated, in-depth evaluation for individuals with mental illness) completed on 09/12/2024. Review of the annual MDS, dated [DATE], showed Resident 8 was receiving antipsychotics and antianxiety medications (drugs that alters brain chemistry to affect mental process). Review of the annual MDS dated [DATE] showed Resident 8 was not assessed as having level 2 PASARR. During an interview on 01/09/2026 at 1:28 PM, Staff G, MDS Nurse, stated the MDS for Resident 8 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was inaccurate for PASSAR, and it should be correct. During an interview on 01/14/2026 at 9:19 AM, Staff B, Director of Nursing Services, stated the expectation was for the MDS assessment to correctly reflect the residents' statuses, and Resident 8's annual MDS dated [DATE] did not meet expectations. Resident 40 Review of the EHR showed Resident 40 readmitted to the facility on [DATE] with diagnoses to include personality disorder (a mental health condition where people have a lifelong pattern of seeing themselves and reacting to others in ways that causes problems), schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, leading to disorganized thinking), and post-traumatic stress disorder (PTSD, a mental health condition where someone feels stressed and scared long after a traumatic event). Resident 40 was able to make needs known. Review of Resident 40's EHR showed a level 2 PASSAR was completed on 05/01/2020. Review of the care plan dated 10/19/2022 showed Resident 40 met PASSAR level 2 determination related to diagnoses of serious mental illness. Review of Resident 40's MDS dated [DATE] section A1500 showed Resident 40 was coded No. for having a PASSAR level 2 with serious mental illness. During an interview on 01/08/2026 at 1:06 PM, Staff G, MDS Nurse, stated Resident 40's admission MDS dated [DATE] was coded incorrectly and should have been coded yes for having a PASSAR level 2 with serious mental illness. During an interview on 01/08/2026 at 2:14 PM, Staff B, DNS, stated Resident 40's admission MDS dated [DATE] was not coded correctly for level 2 PASSAR and should have been coded Yes. Staff B stated Resident 40's admission MDS needed to be modified. Reference WAC 388-97-1000(1)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed ensure care plans were reviewed and revised for 5 of 22 residents (Residents 12, 8, 2, 37 and 51) reviewed for care plan review. This failure placed the residents at risk for injuries, unmet needs, care not provided as ordered and a diminished quality of life.Resident 12 Resident 12 admitted to the facility on [DATE] with diagnoses to include diabetes (high blood glucose), high blood pressure and muscle weakness. Resident 12 was able to make needs known. Observation and interview on 01/05/2026 at 10:57 AM, showed Resident 12 with a wander guard device on their left wrist. Resident 12 stated they did not know what the device was for. Observations on 01/06/2026 at 4:08 PM, 01/08/2026 at 11:46 AM, 01/09/2026 at 8:28 AM and 2:30 PM and 01/12/2026 at 3:13 PM showed Resident 12 asleep in bed with the wander guard in place. Review of the electronic health record (EHR) showed the most recent Elopement Risk assessment was completed on 06/06/2025. During an interview on 01/09/2026 at 11:06 AM, Staff J, Licensed Practical Nurse (LPN) stated when a physical restraint was being considered for a resident, a device evaluation was to be completed and updated quarterly or as needed. Staff J stated the evaluation was not completed for Resident 12 but should have been. During an interview on 01/12/2026 at 12:36 PM, Staff B, Director of Nursing Services (DNS), stated it did not meet their expectations that a device evaluation had not been completed. Staff B stated Resident 12 had no incidents of exit seeking in over a year and should have been reassessed to make sure the wander guard was appropriate and the care plan should have been revised. Resident 8 Review of the EHR showed Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include hemorrhage in brain stem (Bleeding in brain stem), gastrostomy (surgically placed external opening into stomach) major depression, anxiety, psychotic disorder with delusions (fixed, false beliefs held with extraordinary conviction despite clear evidence of the contrary) and cognitive communication deficit. Resident 8 was not always able to communicate needs. During a phone interview on 01/05/2026 at 2:27 PM, Collateral Contact Z, stated Resident 8 was on restorative program (nursing exercise program) but was not currently. Review of the care plan initiated on 06/24/2024, showed Resident 8 was receiving Restorative program. During an interview on 01/09/2026 at 12:43 PM, Staff B, DNS, stated Resident 8 was now receiving therapy and the care plan (CP) for Restorative should have been discontinued from the CP. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2 Review of the EHR showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include urinary tract infection, urinary retention, diabetes (high blood sugar), anxiety, and polyneuropathy (damage to nerves that cause different symptoms of numbness, pain and weakness). Resident 2 was able to communicate needs. Review of EHR showed Resident 2 had a urinary catheter that was removed in December 2025 and there was a provider progress note dated 12/21/2025 that explained how Resident 2 was urinating fine without the catheter. Review of the care plan dated 11/07/2025 showed Resident 2 was requiring indwelling foley catheter (urinary). During an interview on 01/12/2026 at 1:08 PM, Staff B, DNS, stated the expectation was to update the care plan immediately and Resident 2's care plan did not meet expectations. Resident 37 Review of the EHR showed Resident 37 admitted to the facility on [DATE] with a diagnosis of Dementia (a set of symptoms that effects memory) and was not able to make needs known. Review of the care plan dated 11/24/2025 showed the resident had a focus area of Resident is at risk for complications related to the use of psychotropic drugs, initiated on 01/01/2024 and revised on 11/07/2025. Review of the Providers orders showed Resident 37 had discontinued all psychotropic medications on 12/12/2024 and had discontinued all behavior monitors on 10/23/2024. During an interview on 01/12/2026 at 9:22 AM, Staff V, Social Services Assistant stated care plans should be revised when orders were changed or they were given a new psychotropic medication. During an interview on 01/12/2026 at 10:13 AM, Staff B, DNS stated it was their expectation that Resident 37's care plan be revised and accurately reflect the resident's needs. Resident 51 Review of the EHR showed Resident 51 readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, group of conditions that cause difficulty in breathing), heart failure, and respiratory failure. Resident 51 was able to make needs known. Observation on 01/08/2026 at 3:22 PM showed Resident 51 laid in bed with oxygen infusing via nasal canula (NC, flexible tube used to deliver oxygen through the nose) connected to an oxygen concentrator (medical device used to provide oxygen) with oxygen flowing at a rate of four liters per minute. Review of the provider order dated 11/17/2025 showed Resident 51 was prescribed oxygen at four liters per minute continuously via NC. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 51's care plan showed a focused care plan for COPD initiated on 10/04/2020 with an intervention to administer oxygen as ordered/indicated at three liters continuous to maintain saturation levels (the percentage of red blood cells carrying oxygen) greater than or equal to 90% initiated on 10/06/2020. Review showed a focused care plan for Resident 51 at risk for respiratory complications related to Covid (a highly contagious respiratory disease) initiated on 05/12/2025. Review of Resident 51's EHR on 01/08/2026 did not show the resident was actively positive for Covid. During an interview on 01/12/2026 at 1:34 PM, Staff R, Licensed Practical Nurse (LPN), stated Resident 51's care plan showed an intervention for oxygen at three liters, but the resident's current order was for four liters, and the care plan needed to be revised. Staff R stated Resident 51's focused care plan for at risk for complications related to Covid needed to be revised because Resident 51 did not have Covid. During an interview on 01/12/2026 at 2:34 PM, Staff B, DNS, stated Resident 51's current care plan did not meet their expectations because it showed the resident's oxygen liter flow was three liters and had risk for respiratory complications related to Covid; however, Resident 51's oxygen order was for four liters and the resident did not have Covid. Staff B stated that Resident 51's care plan needed to be revised. Reference WAC 388-97 -1020(3)(5)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide the necessary care and services to maintain personal hygiene for 3 of 5 residents (Residents 117, 99 and 17) when reviewed for activities of daily living. This failure placed the residents at risk for unmet needs, decreased sense of self-worth and a diminished quality of life. Findings included.Resident 117 Review of the electronic health record (EHR) showed Resident 117 admitted to the facility on [DATE] with diagnoses to include obesity (having unhealthy amount of extra body fat), history of falling, and presence of left artificial (manmade) knee joint. Resident 117 was able to make needs known. During an interview on 01/07/2026 at 9:49 AM, Resident 117 stated they had a shower a couple of days ago; however, when they asked for one, they did not always get one. Resident 117 stated they had asked a staff member how often they could have a shower and were told they just had to ask for one but that was not true, because they have had only one shower since they had been at the facility even though they had asked. During an interview on 01/09/2026 at 11:23 AM, Resident 117 stated staff had asked them if they had a shower in December 2025 and they told them no, they had only one shower in January 2026. Resident 117 stated they did not know why they were asked about showers because they thought staff should be able to check their chart for that information. Resident 117 stated they were not offered a bed bath or another shower, but they would prefer a shower. During an interview on 01/12/2026 at 10:25 AM, Resident 117 stated they had asked yesterday (01/11/2026) for a shower and did not get one. Resident 117 stated they would ask again today because they were not able to take a shower by themselves. Review of Resident 117's Medicare 5-day minimum data set assessment (MDS) dated [DATE] showed shower/bathing Not attempted due to medical condition or safety concerns. Review of the focused care plan for ADL self-care performance deficit, initiated on 12/30/2025, showed Resident 117 required one staff assistance with bathing/showering and did not show when Resident 117 was scheduled to have a shower. Review of the shower schedule for the 100 hall on 01/12/2026, located in front of a binder at the south nurse's station showed a schedule for day shift and evening shifts. Review showed Resident 117's room/bed was scheduled to have a shower on Tuesdays on the evening shift (one day a week). Review of Resident 117's point of care bathing documentation on 01/12/2026 in the EHR showed no information available. During an interview on 01/12/2026 at 12:37 PM, Staff S, Certified Nursing Assistant (CNA) stated there was a shower schedule and was able to locate the schedule at the south nurse's station. Staff S stated they had never provided a shower to Resident 117, but they usually worked the night shift. During an interview on 01/12/2026 at 1:06 PM, Staff R, Licensed Practical Nurse (LPN), stated residents were usually scheduled at least two showers a week; however, they did not currently have a shower aid today for the South halls (100 halls) but sometimes they did. Staff R stated if there was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not a shower aid scheduled then the aids on the floor were to provide showers per the shower schedule. Staff R stated they did not think every aid on the floor ended up giving showers that needed to be provided if there was no shower aid. During an interview on 01/12/2026 at 2:01 PM, Staff B, Director of Nursing Services (DNS), stated Residents were offered and/or scheduled a shower twice a week and were asked on admission if they preferred a shower once or twice a week. Staff B was provided the shower schedule obtained from the south nurse's station and asked if it was a current schedule and Staff B stated Yes. Staff B stated showers should be documented in the computer system by the aids/CNA's. Staff B stated showers should be provided as scheduled and/or requested and resident's shower preferences and schedule should be care planned. Resident 99 Review of the EHR showed Resident 99 admitted to the facility on [DATE] with diagnoses to include heart failure, diabetes (too much sugar in the blood), and muscle weakness. Resident 99 was able to make needs known. During an interview on 01/06/2026 at 10:10 AM, Resident 99 stated they had been asking for a shower since being admitted to the facility and finally got one shower about three days ago. Resident 99 stated they should be offered showers and not have to keep asking for one. During an interview on 01/07/2026 at 10:02 AM, Resident 99 stated they had been told they could have a shower once or twice a week, but they had only had one shower since they have been at the facility. During an interview on 01/08/2026 at 9:15 AM, Resident 99 stated they still had not been offered another shower but wished staff would offer them a shower. During an interview on 01/12/2026 at 10:02 AM, Resident 99 stated they still had not been provided with another shower and would ask again today because they have had only one shower since being at the facility. Review of the admission MDS dated [DATE] showed Resident 99 required substantial/maximal assistance with shower/bathes. Review of the focused care plan for ADL self-care performance deficit, initiated on 12/11/2025, showed Resident 99 required two staff assistance with bathing/showering and did not show when Resident 99 was scheduled to have a shower. Review of the shower schedule for the 100 hall on 01/12/2026 located in front of a binder at the south nurse's station showed a schedule for day shift and evening shifts. Review showed Resident 117's room/bed was scheduled to have a shower on Tuesdays on the day shift (one day a week). Review on 01/12/2026, of Resident 99's point of care documentation for bathing, showed showers were provided on 12/14/2025, 12/18/2025, 12/23/2025, 12/31/2025 and 01/06/2026 in the prior 30 days. It showed Staff S, CNA, provided Resident 99 a shower on 01/04/2026 at 4:25 PM. During a joint interview on 01/12/2026 at 12:54 PM, Resident 99 stated they knew Staff S, but Staff S (continued on next page)

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Linden Grove Health Care Center	400 - 29th Street Northeast Puyallup, WA 98373

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had never provided them with a shower. Staff S stated they did not recall giving Resident 99 a shower or a bed bath and did not know how it got documented that they provided a shower on 01/04/2026 at 4:25 PM. During an interview on 01/12/2026 at 2:06 PM, Staff B, DNS, stated they were not aware that Staff S, CNA, had documented on 01/04/2026 at 4:24 PM that a shower was provided to Resident 99; however, both Resident 99 and Staff S stated the shower was not provided. Staff B stated showers were not consistently offered/provided or documented as required and this did not meet their expectations. Resident 17 Review of the EHR showed Resident 17 admitted to the facility on [DATE] with diagnoses of chronic pain syndrome and major depressive disorder. The resident was able to make needs known. During an interview and observation on 01/06/2026 at 10:21 AM, Resident 17 stated I have not had a shower or bed bath since May they don't help me wash my face or brush my hair or teeth, they only come in if i call them. Resident 17 had a brown and white substance on their teeth and a visible knot in their hair. Review of Resident 17s care plan dated 02/05/2025 showed the resident required one staff maximum assistance with bed baths, personal hygiene and oral care. Review on 01/06/2026 of Resident 17's point of care documentation for bathing showed four documented bed baths in the prior 30 days provided by Staff Q, Certified Nursing Assistant (CNA). Review of the shower schedule for the 100's hall on 01/12/2026 located in front of a binder at the south nurse's station showed a schedule for day shift and evening shifts. Review showed Resident 17's room/bed was scheduled to have a shower on Monday on the day shift (one day a week). During an interview on 01/12/2026 at 1:06 PM, Staff R, Licensed Practical Nurse stated the facility does not have a shower aide right now and the CNA's on the floor should provide the showers. During an interview on 01/07/2026 at 9:09 AM, Staff Q stated they did not wash their hair during a bed bath and they did not offer oral care or hair brushing to Resident 17 unless they ask. Staff Q stated they used the shower/bathing documentation to document a skin condition they had noticed but had not provided a bed bath. During an interview on 01/09/2026 at 11:22 AM, Staff C, CNA stated they only gave bed baths/showers if a resident requests, and Resident 17 would request supplies if they wanted to brush their teeth or hair. When asked if setting up Resident 17 for brushing teeth and washing face and hands was part of morning care, Staff C stated No. During an interview on 01/12/2026 at 9:12 AM, Staff B, DNS, stated it was their expectation that the assigned CNA's should provide showers/bed baths if they did not have a shower aide. Staff B stated it was their expectation that morning care for all residents includes setting the residents up to wash their face, and brush their hair and teeth. Reference WAC 388-97 -1060(2)(c)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **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 3 of 3 sampled residents (Residents 40, 42 and 51) when reviewed for respiratory care. Failure to obtain and/or follow physician orders for oxygen (O2) therapy, ensure O2 saturation (Sats, the percentage of red blood cells carrying O2 in the blood) was ordered with parameters, care plan, and ensure O2 concentrators (a device used for O2 therapy) filters (used to protect the resident from particulate matter) were cleaned and maintained routinely, placed residents at risk for unmet needs and potential negative outcomes.Findings included . Resident 40 Review of the electronic health record (EHR) showed Resident 40 readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (COPD, group of conditions that cause difficulty in breathing), respiratory failure, and high blood pressure. Resident 40 was able to make needs known. Review of Resident 40's quarterly minimum data set assessment (MDS) dated [DATE] showed that the resident received 02 therapy. Multiple observations on 01/06/2026 at 10:22 AM, 01/07/2026 at 8:47 AM, 01/08/2026 at 8:31 AM, 01/08/2026 at 1:00 PM, and 01/09/2026 at 10:00 AM showed Resident 40 in their room and the O2 concentrator was near the bed not in use. During an interview on 01/08/2026 at 8:31 AM, Resident 40 stated that they only used O2 at night. Review of Resident 40's EHR showed a provider order dated 09/18/2025 for O2 at 3 liters per minute via nasal canula (NC, flexible tube used to deliver oxygen through the nose) continuously for pneumonia every shift and pulse oximetry (device used to measure O2 saturation) every shift to keep O2 Sats greater than or equal to 90%. Review showed no orders to clean the filter on the O2 concentrator located in Resident 40's room. Review of the EHR on 01/08/2026 did not show Resident 40 had a current diagnosis of pneumonia. Review of Resident 40's January 2026 TAR from 01/01/2026 - 01/07/2026 showed documentation that the resident received O2 per provider orders and O2 Sats were documented and were within the O2 parameters. However, there was no order or documentation to show the O2 concentrator filter was being cleaned. During an interview on 01/12/2026 at 1:15 PM, Staff R, Licensed Practical Nurse (LPN), stated O2 provider orders should be followed. Staff R stated they had not seen Resident 40 use the O2 concentrator in their room; however, they usually worked from 6:00 AM to 6:00 PM. Staff J stated that Resident 40 had an order dated 09/18/2025 for O2 at 3 liters per minute continuously for pneumonia. Staff J stated Resident 40 did not have pneumonia at that time and had not received O2 continuously and the January 2026 TAR should have shown refused if Resident 40 did not want the O2 continuously. Staff J stated that Resident 40 did not have order to change the filter on the O2 concentrator and there should have been. During an interview on 01/12/2026 at 2:20 PM Saff B, Director of Nursing Services (DNS), stated residents with orders for O2 therapy via a O2 concentrator should have O2 Sats monitored every shift with O2 Sats parameters of when to notify the provider when outside parameters, O2 liters and if O2 should be continuously or as needed, to change O2 tubing once a week, and orders to clean the O2 concentrator filter. Staff B stated Resident 40's O2 orders showed it was continuously for pneumonia but the resident did not have pneumonia, documentation should have shown refusal of O2 therapy if O2 was not utilized and the provider should have been notified. Staff B stated Resident 40 should have had an order to clean the filter on the concentrator. Staff B stated Resident 40's oxygen care and services did not meet their expectations. Resident 42Review of the EHR showed Resident 42 admitted to the facility on [DATE] with diagnoses to include COPD, heart failure, and respiratory failure. Resident 42 was sometimes able to express needs. Review of Resident 42's quarterly MDS dated [DATE] showed that the resident received O2 therapy. Observation and interview on 01/08/2026 at 3:28 PM showed Resident 42 laid in bed with O2 NC in place connected to a humidifier (used to add moisture to O2) and an O2 concentrator at 2 liters per minute. Resident 42 stated they needed the O2 due to shortness of breath. Review of Resident 42's EHR showed a provider order (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 10/09/2025 for O2 at 2 liters per minute continuously for shortness of breath. Document O2 saturations every shift. This order did not show O2 Sats were ordered with parameters of when to inform the provider. Review of Resident 42's January 2026 TAR from 01/01/2026 - 01/08/2026 showed order dated 10/09/2025 for O2 at 2 liters was provided with O2 Sats documented per provider order; however, no O2 Sats parameters were noted in the order. During an interview on 01/12/2026 at 1:29 PM, Staff R, LPN, stated Resident 42's order dated 10/09/2025 for O2 and O2 Sats should have included O2 Sats parameters of when to notify the provider and this did not meet expectations. Staff R stated the order needed to be clarified with the provider to include O2 Sats parameters. During an interview on 01/12/2026 at 2:29 PM, Staff B, DNS, stated Resident 42's O2 orders should be clarified with the provider to obtain O2 Sats parameters. Resident 51Review of the EHR showed Resident 51 readmitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease, heart failure, and respiratory failure. Resident 51 was able to make needs known. Review of Resident 51's Medicare 5-day MDS dated [DATE] showed that the resident received O2 therapy. Observation on 01/08/2026 at 3:22 PM showed Resident 51 laid in bed with O2 infusing via NC connected to an O2 concentrator with O2 flowing at a rate of 4 liters per minute. Review of the provider order dated 11/17/2025 showed Resident 51 was prescribed O2 at 4 liters per minute continuously via NC every shift related to COPD. Post treatment: evaluate heart rate, respiratory rate, pulse oximetry, skin color, and breath sound. This order did not show parameters for O2 saturation or when to notify the provider related to O2 saturations and O2 therapy. Review of Resident 51's care plan showed a focused care plan for COPD initiated on 10/04/2020 with an intervention to administer oxygen as order/indicated and to maintain saturation levels greater than or equal to 90% initiated on 10/06/2020. Review of Resident 51's January 2026 TAR from 01/01/2026 - 01/08/2026 showed an order with a start date of 11/17/2025 for O2 at 4 liters via NC every shift and documentation showed that O2 was provided per orders to include documented O2 Sats; however, the order did not include O2 Sats parameters, and post treatment to evaluate heart rate, respiratory rate, skin color, and breath sound was not documented in the TAR. During an interview on 01/12/2026 at 1:34 PM, Staff R, LPN, stated Resident 51's O2 order dated 11/17/2025 was missing O2 Sats parameters and the order needed to be clarified with the provider. Staff R stated this O2 post treatment order to evaluate heart rate, respiratory rate, skin color, and breath sounds were not documented on the TAR; however, it was documented as completed per provider order and if there was a problem then the provider would be notified. During an interview on 01/12/2026 at 2:34 PM, Staff B, DNS, stated they saw that Resident 51's O2 orders did not have O2 Sats parameters and should have. Staff B stated that Resident 51's O2 order that included post treatment to evaluate heart rate, respiratory rate, skin color, and breath sound was not documented in the TAR and/or in a progress note or EHR consistently and this did not meet their expectations. Reference WAC 388-97-1060 (3)(j)(iv)-(vi)

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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** Based on interview and record review, the facility failed to ensure medications were administered only when necessary and in accordance with provider orders for 4 of 7 sampled residents (Residents 4, 115, 2, and 99) when reviewed for unnecessary medications/pain management. Failure to ensure non-medicated methods of pain relief were used before pain medications and ensuring blood pressure medications were provided per parameters placed residents at risk of using unnecessary medications, avoidable side effects, and a diminished quality of life. Findings included.Resident 4 Review of the electronic health record (EHR) showed Resident 4 re-admitted to the facility on [DATE] with diagnoses to include diabetes (high blood glucose), congestive heart failure (when the heart is unable to pump blood efficiently) and depression. Resident 4 was able to make needs known. Review of Resident 4's current providers orders showed the resident received Roxicodone (a narcotic pain medication) every eight hours as needed (PRN) for pain. The provider's order directed staff to document nonpharmacological interventions (NPI, nonmedicated forms of controlling pain, e.g. massage, heating, repositioning, etc.). Review of Resident 4's December 2025 Medication Administration Record (MAR) showed Roxicodone was administered 12/19/2025, 12/20/2025, 12/25/2025, and 12/30/2025. Documentation of NPI being offered/provided prior to the administration of the Roxicodone showed not applicable (N/A). Review of Resident 4's January 2026 MAR showed Roxicodone was administered 01/01/2026 and 01/03/2026. Documentation of NPI being offered/provided prior to the administration of the Roxicodone showed N/A. During an interview on 01/12/2026 at 12:18 PM, Staff DD, Licensed Practical Nurse (LPN), stated they did not offer NPI to Resident 4 prior to administering the pain medication but should have. During an interview on 01/13/2026 at 12:22 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was for staff to offer and document NPI prior to administration of PRN pain medications. Resident 115 Review of the EHR showed Resident 115 admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a chronic autoimmune disease affecting brain, spinal cord, and optic nerves), diabetes, and anxiety. The resident was able to make needs known. Review of the provider's current orders showed Resident 115 received as needed (PRN) pain medications to include: acetaminophen (an over-the-counter pain medication), ibuprofen (an over-the-counter pain medication), oxycodone (an opioid pain medication), and tizanidine (a muscle relaxant). Review showed for facility staff to provide NPI prior to their use. Review of the MAR for January 2026 showed Resident 115 received the following PRN pain medications without the use of NPI: ibuprofen two times, oxycodone 10 times, and tizanidine one time. During an interview on 01/13/2025 at 2:25 PM, Staff P, LPN, stated the facility ensured PRN pain (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications were necessary by providing NPI prior to their usage. Staff P stated Resident 115 received PRN pain medications without NPI and this did not meet expectations. During an interview on 01/14/2025 at 10:40 AM, Staff B, DNS, stated nursing staff should attempt to provide NPI prior to administering PRN pain medications. Staff B stated Resident 115 received PRN pain medications without NPI and this did not meet expectations. Resident 2 Review of the EHR showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include hypertensive chronic kidney disease (condition where high blood pressure and kidney damage coexist in a bidirectional relationship), diabetes, anxiety, and polyneuropathy (damage to nerves that cause different symptoms of numbness, pain and weakness). Resident 2 was able to communicate needs. Review of the January 2026 MAR showed Resident 2 had an order for amlodipine and carvedilol (medicine that controls blood pressure and heart functions) every day, and the nurse was to hold administration of the medications when the systolic (upper number) blood pressure was below 100 and heart rate was below 60. Review of the MAR showed on 01/03/2026 Resident 2 received both medications despite the heart rate being 56. Review of the January 2026 MAR showed Resident 2 was administered PRN acetaminophen on 01/01/2026, 01/03/2026, and PRN oxycodone on 01/03/2026 and 01/05/2026 without documenting NPI prior medications. Review of December 2025 MAR showed Resident 2 had as need it acetaminophen 19 times, and oxycodone three times without documenting NPI. During an interview on 01/12/2026 at 1:08 PM, Staff B, DNS, stated the expectation for the nurses was to follow orders and hold blood pressure medications per parameters. Staff B stated the nurses were expected to try and document NPI prior as need it pain medications. Staff B stated the documentation for Resident 2 did not meet expectations. Resident 99 Review of the EHR showed Resident 99 admitted to the facility on [DATE] with diagnoses to include diabetes, chronic venous hypertension of unknown cause (high pressure in leg veins due to faulty valves, causing swelling, pain, skin changes, cramps, and ulcers/open wound) with ulcer of bilateral lower extremity (both lower legs/ankles/feet), and fibromyalgia (a long-term condition causing the brain and spinal cord to become overly sensitive to pain signals, amplifying them). Resident 99 was able to make needs known. During an interview on 01/06/2026 at 10:06 AM, Resident 99 stated the staff did not always manage their pain. Review of Resident 99's focused care plan for alteration in comfort, initiated on 12/11/2025, showed interventions, initiated on 12/11/2025, to include: Monitor for non-verbal signs/symptoms of pain and (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medicate, as ordered, and Medicate resident, as ordered, for pain and monitor for effectiveness and side effects. Report to physician, as indicated. Review of the provider order, dated 01/02/2026, showed Resident 99 was prescribed Tylenol 1000 milligrams (mg) by mouth every six hours as needed for a pain level of 1 – 4 out of 10 (0 = no pain and 10 = worst pain imaginable) with NPI listed. Review of Resident 99's January 2026 MAR from 01/01/2026 – 01/08/2026 showed an order for Tylenol 1000 milligrams (mg) by mouth every six hours as needed for a pain level of 1 – 4 out of 10 with NPI listed, with a start date of 01/02/2026. Review showed Tylenol was provided on 01/06/2026 for a pain level of 4; however, NPI was documented NA. During an interview on 01/13/2026 at 10:53 AM, Staff B, DNS, stated Resident 99's January 2026 MAR was documented NA on 01/06/2026 and should have been marked for the NPI provided or refused and this did not meet their expectations. Reference WAC 388-97-1060(3)(k)(i)

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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. Based on observation, interview, and record review, the facility failed to ensure resident refrigerators were maintained to ensure food was safely stored for 2 of 2 sampled refrigerators (100 and 200 Hall Refrigerators) when reviewed for kitchen. This failure placed residents at risk of foodborne illness, avoidable discomfort, and a diminished quality of life. Findings included.Review of the facility policy titled, Safe Handling of Foods from Visitor, revised 03/28/2024, showed, Label foods with resident's name, and the current date and ?use by date'. Items will be thrown out after 48 hours and Have temperature monitored daily for refrigeration < 41 F. Observation on 01/07/2026 at 11:54 PM showed the 100 Hall Resident Refrigerator contained the following items: 1) A bag teriyaki in Styrofoam packaging inside with a receipt showing the order was placed on 01/01/2026; 2) A cup of soup with no date label; 3) A plastic container teriyaki dated 12/08/2025; 4) A box of fried chicken with no date or resident name; 5) A bag with lettuce with brown spot spoilage with no date or name; 6) A half sub sandwich with receipt showing 12/23/2025 pick-up; 7) A container of nutritional formula opened with packaging showing In medical setting throw away after 24 hours with no date label and, when opened, showed dried substance in spout and floating items in formula; 8) A container of French onion dip with best by date of 11/03/2025; 9) Four strawberry banana yogurts with a best by date of 12/12/2025; 10) A Tupperware of vegetable dish with no date label; 11) Two pieces of pizza in original full pie cardboard box with no date label; 12) A plastic to go container of Chinese food with date label of 12/20/2025; 13) A bag with two pieces of cornbread in Ziplock bags and a container with a meal with no date label; 14) An opened water bottle with frozen yellow solid inside with no date label or resident name; 15) A plastic box of grapes with no date label showing grapes were wrinkled; 16) A bag with sandwich makings to include mayo, sliced meat, and lettuce and meat showed sold on 12/02/2025; 17) A plastic box with a pasta dish without date label and resident name; 18) A cardboard takeaway box with unidentifiable food with no date label; and 19) Numerous small plastic containers of condiments with illegible date or a date which was out of range. Observation on 01/08/2026 at 12:12 AM showed the 200 Hall Resident Refrigerator contained the following items: 1) A bag of fast food with a 01/02/2026 date; 2) A bag with a container of ribs and two fruit trays with no date label and the two fruit cups showed sell by date of 12/23/2025; 3) A container of tartar sauce with a 08/01/2025 use by date; 4) A plastic bag with salad dated 12/18/2025; 5) A container with a soup with no resident name or date; 6) A jar of homemade chicken broth and an orange with note showing placed on 12/20/2025; 7) A container of salad with no name or date; and 8) A paper bag with half eaten pastry with no name or date. Review of the temperature logs for the 100 and 200 Hall Refrigerators showed Refrigerator Temp 36-46 Degrees Fahrenheit. During an interview on 01/14/2026 at 9:26 AM, Staff CC, Dietary Manager, stated nursing staff was responsible for maintaining the resident refrigerators' safe food storage. Staff CC stated food should be thrown away after 48 hours and food should be stored at 41 F or below. Staff CC stated the temperature log sheets used to monitor the resident refrigerators showed an acceptable range of 34-46 F, and this was inaccurate. During an interview on 01/14/2026 at 10:26 AM, Staff A, Administrator, stated the observations of food outside of date range and temperature logs indicating inaccurate safe food temperatures did not meet expectations. Reference WAC 388-97-1100(3), -2980

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program to prevent the transmission of communicable diseases and infections by completing the analyzation of infection control data, identifying trends, and completing follow-up activities in response to those trends for 3 of 3 months (October, November and December 2025) when reviewed for Infection Control. The facility also failed to implement transmission-based precautions (TBP) for 2 of 4 halls when reviewed for TBP. These failures placed residents and staff at risk for communicable diseases and infections, poor clinical outcomes, and a decreased quality of life. Findings included. Review of the facility document titled Infection Prevention and Control Program dated 01/21/2025 showed they followed accepted infection prevention and control standards set by the Centers for Disease Control. <Tracking/Trending> Review of the facility provided infection control surveillance documentation for October, November and December 2025 showed infections had not been tracked to determine potential spread using a map or other tracking tool, further review showed no documented analysis of the monthly infection data to identify trends or interventions to address trends for all 3 months. During an interview on 01/12/2026 at 12:12 PM, Staff H, Licensed Practical Nurse/Assistant Director of Nursing, acting Infection Preventionist stated it was their expectation that all new infections be identified and tracked on the infection control line list and map daily and should be analyzed monthly and implement education or changes if trends were identified. <TBP> Review of the Aerosol/Contact precautions sign posted outside of room [ROOM NUMBER], undated, showed staff must perform hand hygiene and put on a gown, gloves, an N95 respirator and eye protection when entering the room. Observation on 01/05/2026 at 12:32 PM showed Staff O, Registered Nurse, entered room [ROOM NUMBER] with a surgical mask and no eye protection. Staff O Provided the resident medications and exited the room. Review of the Enhanced Barrier Precautions sign posted outside room [ROOM NUMBER], undated showed staff must perform hand hygiene and wear a gown and gloves for all high contact activities such as dressing, Bathing, transferring, or changing linens. Observation on 01/07/2026 at 9:13 AM showed Staff Q and another unidentified Staff enter room [ROOM NUMBER] and provide personal high contact care to the resident without wearing a required gown. During an interview on 01/12/2026 at 12:55 PM, Staff B, Director of Nursing Services stated it was their expectation that the infection preventionist track all facility infections and map them daily and the infection surveillance data should be analyzed monthly to identify trends. This did not happen for the months of October, November and December 2025 and should have. Staff B stated it was their expectation that staff follow the directions on the transmission-based precautions signs posted outside of the resident rooms. Reference WAC 388-97 -1320(1)(a)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer pneumococcal vaccines for 3 of 7 residents who consented to the vaccine (Residents 5,19 and 35) and failed to provide education on the risks and benefits of vaccines for 3 of 7 residents (Residents 42, 63 and 65) when reviewed for immunizations. These failures placed the residents at risk for communicable diseases and denied the residents the opportunity to make an informed decision regarding receiving immunizations. Findings included.Review of the facility policy titled Pneumococcal Vaccine dated August 2025 showed the facility would assess all residents on admission for the eligibility to receive the pneumococcal vaccine and when indicated provide the vaccine information sheet (VIS) and education on the risks and benefits and administer the vaccine within 30 days of admission if consented. Resident 5 Review of the electronic health record (EHR) on 01/11/2026 showed Resident 5 admitted to the facility on [DATE] with a diagnosis of dementia (loss of cognitive function that interferes with daily life). Resident 5's legal guardian had consented for the resident to receive the Pneumococcal vaccine on 11/21/2025. There was no documentation found that the resident had received the vaccine. Resident 19Review of the EHR on 01/11/2026 showed Resident 19 admitted to the facility on [DATE] with a diagnosis of skin infection and had consented to receive the Pneumococcal vaccine on 10/26/2025. There was no documentation found that the resident had received the vaccine. Resident 35Review of the EHR on 01/11/2026 showed Resident 35 admitted to the facility on [DATE] with a diagnosis of diabetes (when the body cannot process sugars). Resident 35's responsible family member had consented for the resident to receive the Pneumococcal vaccine on 07/16/2025. No documentation was found that the resident had received the vaccine. Resident 42Review of the EHR showed Resident 42 admitted to the facility on [DATE] and was offered the Pneumococcal vaccine and had declined. No documentation was found that the resident received the VIS or was educated on the risks and benefits of the vaccine. Resident 63Review of the EHR showed Resident 63 admitted to the facility on [DATE] and was offered the Pneumococcal vaccine and had declined. No documentation was found that the resident received the VIS or was educated on the risks and benefits of the vaccine. Resident 65Review of the EHR showed Resident 65 admitted to the facility on [DATE] and was offered the Pneumococcal vaccine and had declined. No documentation was found that the resident received the VIS or was educated on the risks and benefits of the vaccine. During an interview on 01/12/2026 at 12:06 PM, Staff H, Licensed Practical Nurse/Assistant Director of Nursing, acting infection preventionist stated it was their expectation that residents are assessed, educated and offered the pneumococcal vaccines on admission and if they consent should receive it within a week of consent. During an interview on 01/12/2026 at 12:50 PM, Staff B, Director of Nursing Services stated it was their expectation that residents receive the VIS form and were educated on the risks and benefits when they were offered the vaccines and if the resident consented to the vaccine it should have been ordered from the pharmacy and given right away. Staff B stated that the pneumococcal vaccines for Residents 5,19,35, 42,63 and 65 did not meet expectations. Reference WAC 388-97 -1340(1)(2)(3)

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Linden Grove Health Care Center	400 - 29th Street Northeast Puyallup, WA 98373

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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** Based on interview and record review, the facility failed to ensure a resident was provided risks/benefits and provided consent prior to being administered psychotropic (mind altering) medications for 1 of 5 sampled residents (Resident 114) when reviewed for unnecessary medications. This failure placed the resident at risk of unknown side effects, inability to advocate in their medication regimen, and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 115 admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a chronic autoimmune disease affecting brain, spinal cord, and optic nerves), diabetes (too much sugar in the blood), and anxiety. The resident was able to make needs known. Review of the provider's orders showed Resident 115 received the following psychotropic medications: citalopram hydrobromide (an antidepressant), alprazolam (an antianxiety), and methylphenidate (an antidepressant). Review of the EHR did not show Resident 115 was provided risks/benefits and provided consent for the use of the psychotropic medications. During an interview on 01/13/2025 at 2:25 PM, Staff P, Licensed Practical Nurse, stated the facility provided risks/benefits and obtained consent prior to providing residents with psychotropic medications and it was documented on a consent form. Staff P stated Resident 115 received psychotropic medications. During an interview on 01/14/2025 at 10:01 AM, Staff P stated they were unable to locate consent forms for Resident 115's psychotropic medications. During an interview on 01/14/2025 at 10:40 AM, Staff B, Director of Nursing Services, stated residents were provided risks/benefits and provided consent prior to using psychotropic medications. Staff B stated Resident 115 used multiple psychotropics and the lack of consent forms for these medications did not meet expectations. Reference WAC 388-97-0260, -0300(3)(a), -1020(4)(a)(b)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to reasonably accommodate a resident's expressed preference for grooming services by not assisting the resident with accessing a haircut after onsite salon services were discontinued for 1 of 22 sampled residents (Resident 4) when reviewed for resident rights. This failure placed the resident at risk for lack of dignity and diminished quality of life.Findings included.Review of the electronic health record (EHR) showed Resident 4 re-admitted to the facility on [DATE] with diagnoses to include diabetes (high blood glucose), congestive heart failure (when the heart is unable to pump blood efficiently) and depression. Resident 4 was able to make needs known. During an interview on 01/09/2026 at 10:35 AM, Resident 4 stated they had been waiting for a haircut and had informed staff multiple times. Resident 4 stated upon admission the facility had a hairdresser who came regularly but had not been providing services for several months. During an interview on 01/09/2026 at 10:39 AM, Staff BB, Receptionist, stated they had been responsible for coordinating grooming appointments by communicating resident requests to the hairdresser. Staff BB stated hairdresser services had not been available for approximately one and a half years. Review of Resident Council Minutes dated 09/08/2025 showed a resident concern related to when the facility would have a hairdresser taking appointments. Resident Council Minutes dated 10/06/2025 showed the response to the concern: An offer was made to a hairdresser by the facility, and they were waiting to see if the offer was accepted. Resident Council Minutes dated 11/12/2025 showed and updated that the facility and the hairdresser were in wage negotiations. Review of the admission Packet document entitled Facility Rules, undated, showed, Salon Services- Please see Social Services Department for a listing of services, to schedule an appointment and pricing information. During an interview on 01/12/2026 at 12:33 PM, Staff B, Director of Nursing Services (DNS), stated the facility did not currently have a hairdresser. Staff B stated the last consistent hairdresser they had was in 2023, but they were working on hiring someone. Staff B stated the expectation was residents who wanted haircuts should have been accommodated. Reference WAC 388-97-2280

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to ensure that Skilled Nursing Facility (SNF) Advanced Beneficiary Notices (ABN, a notification that provides an estimated cost of continuing services which may no longer be covered by Medicare. Beneficiaries may choose to continue the services but may be financially liable), was provided timely and/or completed as required for 2 of 3 sampled residents (Residents 93 and 23) when reviewed for Beneficiary Notification. This failure placed residents at risk of not upholding their right to make informed choices about further treatment or services as required by the Medicare Program.Findings included . Resident 93Review of a Notice of Medicare Non-Coverage (NOMNC), dated 07/30/2025, showed the facility informed Resident 93 that skilled nursing services would end on 08/01/2025 and the form was signed by the resident or representative on 07/30/2025. Resident 93's SNF ABN dated 08/04/2025 showed it was provided and signed by the resident or representative on 08/04/2025 (three days after the last covered date of skilled services ended on 08/01/2025). During an interview on 01/13/2026 at 10:41 AM, Staff M, Business Office Manager (BOM), stated a SNF ABN should be provided the same day as the NOMNC. Staff M stated they should have had Resident 93's SNF ABN form signed on the same day the NOMNC was signed on 07/30/2025. During an interview on 01/13/2026 at 2:24 PM, Staff A, Administrator, stated their expectation was that SNF ABN be provided no more than 48 hours when the last covered date of Part A Service had been determined and the resident was to remain in the facility.Staff A stated Resident 93's SNF ABN dated 08/04/2025 was not signed timely and did not meet their expectations. Resident 23 Review of a NOMNC, dated 09/19/2025, showed the facility informed Resident 23 skilled nursing services would end on 09/21/2025 and the form was signed by the resident or representative on 09/10/2025. Resident 23's SNF ABN dated 09/19/2025 showed it was not signed by the resident or a representative. During an interview on 01/13/2026 at 10:41 AM, Staff M, BOM, stated whoever completed the NOMNC for Resident 23 on 09/19/2025 did not get a signature for the resident's SNF ABN dated 09/19/2025 and this did not meet their expectations. During an interview on 01/13/2026 at 2:24 PM, Staff A, Administrator, stated Resident 23's SNF ABN dated 09/19/2025 should have been signed by the resident or representative and this did not meet their expectations. Reference WAC 388-97-0300(1)(e)(5)(6)

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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, interview, and record review, the facility failed to provide a homelike environment to include a mattress for a bed frame for 1 of 22 sampled Residents (Resident 8) reviewed for homelike environment. This failure placed the Resident at risk for decreased mood and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 8 was admitted to the facility on [DATE] with diagnoses to include hemorrhage in brain stem (bleeding in brain stem), depression, anxiety, and cognitive communication deficit. Resident 8 was not always able to communicate needs. Observation on 01/05/2026 at 9:55 AM showed Resident 8 in their room with a bed frame that had exposed metal frame. Observation on 01/07/2026 at 8:56 AM, showed Resident 8 in their bed with second bed near them with no mattress or covers. Observation on 01/08/2026 at 9:56 AM showed Resident 8 laying in their bed with bed frame nearby with no mattress and no covers. Observation on 01/09/2026, 01/12/2026, and 01/13/2026 showed Resident 8 in their room with the bed frame with no mattress and no covers. During an interview on 01/13/2026 at 10:34 AM, Staff H, Assistant Director of Nursing/Licensed Practical Nurse (ADON/LPN), stated the bed should be made and have a mattress, that was not a homelike environment and did not meet expectations. Reference WAC 388-97-0880

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a follow up assessment for a Wander Guard (device that alarms and restricts movement in and out of doors) for 1 of 3 sampled residents (Resident 13) when reviewed for physical restraints. This failure placed the Resident at risk for unmet needs, decline in mood, and diminished quality of life. Findings included.Review of the facility's policy Use of Restraints, undated, showed under section 1 Physical Restraints were defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restrict normal access to one's body and under section 16, The assessment reviews are to be at least quarterly to determine reduction. Review of the electronic health record (EHR) showed Resident 13 was admitted to the facility on [DATE] with diagnoses to include dementia (term for decline in mental abilities including thinking, memory and reasoning), asthma (chronic lung disease causing narrow airways), hypertension (elevated blood pressure), and malnutrition. Resident 13 was able to communicate needs. Review of the annual minimum data set assessment (MDS), dated [DATE], showed Resident 13 was using a Wander Guard daily. During an interview and observation on 01/05/2026 at 3:22 PM, Resident 13 stated they would like to go outside, but whoever takes me outside needs to get a star and was pointing towards their left wrist wander guard bracelet. Review of the EHR showed a document called Restraint Evaluation/Reduction dated 02/28/2025 with recommendation/Plan to re-evaluate in six months. During an interview on 01/08/2026 at 2:23 PM, Staff J, Licensed Practical Nurse, stated when residents were actively going out of the facility they got a wander guard, and were not sure on how frequently the residents should be reassessed. During an interview on 01/09/2026 at 12:50 PM, Staff B, Director of Nursing Services, stated the reassessment of Resident 13's Wander Guard should have been done sooner and that did not meet the expectation. Reference WAC 388-97-0620

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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 interview and record review, the facility failed to ensure psychotropic medications (medications affecting the mind) were prescribed to treat a specific condition for 2 of 5 sampled residents (Residents 13 and 115) when reviewed for unnecessary medications. This failure placed residents at risk for avoidable side effects, chemical restraint, and a diminished quality of life. Findings included.Resident 13 Review of the facility's policy Psychotropic Medication Use revision date 03/01/2025 showed under section 7, All medications used to treat behaviors must have clinical indication and be monitored for efficacy, risks, benefits and harm or adverse consequences, and under section10, If provider orders psychotropic medication in the absence of a diagnosis, the facility should ensure that the ordering prescriber reviews the medication plan and consider a gradual dose reduction (GDR). Review of the electronic health record (EHR) showed Resident 13 was admitted to the facility on [DATE] with diagnoses to include dementia (term for decline in mental abilities including thinking, memory and reasoning), asthma (chronic lung disease causing narrow airways), hypertension (elevated blood pressure), and malnutrition. Resident 13 was able to communicate needs. Review of the annual minimum data set (MDS, a required assessment), dated 11/18/2025, showed Resident 13 was not having any behaviors and was receiving antipsychotic medications (drugs that alters brain chemistry to affect mental processes). Review of the Care Area Assessment from the annual MDS was not completed to explain reasoning about use of the medication and care planning. Review of the provider's orders showed Resident 13 was ordered and administered Seroquel (antipsychotic medication) for agitation starting 05/03/2025. Review of the EHR showed Resident 13 did not have behavior monitoring, no adverse side effects monitoring, and there was no care plan about the use of an antipsychotic medication. During an interview on 01/08/2026 at 2:23 PM, Staff J, Licensed Practical Nurse (LPN), stated the process for antipsychotic medications was to have consent, behavior monitor, monitoring of adverse side effects and have a care plan. Staff J could not explain Resident 13's records. During an interview on 01/09/2026 at 12:53 PM, Staff B, Director of Nursing Services (DNS), stated Resident 13's record and use of antipsychotic medication did not meet expectations. Resident 115 Review of the EHR showed Resident 115 admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a chronic autoimmune disease affecting brain, spinal cord, and optic nerves), diabetes (too much sugar in the blood), and anxiety. The resident was able to make needs known. Review of the current provider's orders showed Resident 115 received the following psychotropic medications: citalopram hydrobromide (an antidepressant) and methylphenidate (an antidepressant). Review of the diagnoses list did not show Resident 115 had a diagnosis of depression. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/13/2025 at 2:25 PM, Staff P, LPN, stated residents should only receive psychotropic medications to treat specific diagnoses, and, if there was no diagnosis for a prescribed medication, they would contact the provider for the correct diagnosis. Staff P stated Resident 115 received antidepressants, did not have a documented diagnosis of depression, and this did not meet their expectations. During an interview on 01/14/2025 at 10:40 AM, Staff B, DNS, stated psychotropic medications should be used to treat specific diagnoses. Staff P stated Resident 115 received antidepressants, did not have a diagnosis of depression, and this did not meet expectations. Staff B stated facility nursing staff should have contacted the provider to notify them of the lack of depression diagnosis. Reference WAC 388-97-0620(1)(a)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their written abuse policies by failing to identify potential mental abuse for 1 of 3 sampled residents (Resident 46) when reviewed for abuse. Additionally, the facility failed to conduct and/or obtain reference checks/information from previous or current employers prior to hire for 5 out of 5 sampled staff (Staff D, Staff JJ, Staff C, Staff HH, and Staff H) and to complete timely criminal background checks for 2 out of 5 sampled staff (Staff D and C) when reviewed for abuse and neglect prevention. These failures placed the residents at risk for abuse, mental suffering, and a diminished quality of life. Findings included .Review of the facility's policy titled, Abuse Prohibition, revised on 10/25/2024 showed the center/facility would implement an abuse prohibition program that included;Screening of potential hires;Identification of possible incidents or allegations which need investigation;Investigation of incidents and allegations;Protection of patients during investigations; andReporting of incidents, investigations, and Center response to the results of their investigations.Review showed, Mental Abuse includes, but not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation. <Allegation of Mental Abuse> Review of the electronic health record (EHR) showed Resident 46 admitted to the facility on [DATE] with diagnoses to include heart failure, bipolar disorder (causes extreme mood swings, shifting between manic highs and depressive lows), and respiratory failure. Resident 46 was able to make needs known. During an interview on 01/09/2026 at 10:09 AM, Resident 46 stated, they were very upset and got no sleep last night. Resident 46 stated, Twice I have been singled out because I am gay. Resident 46 stated the first lady was a black evangelistic preacher woman that came from outside the facility and said, You got to pray every day, and that they could not judge anybody but themselves. I finally told her that was enough, and they wheeled themself out of the activity. Resident 46 stated the incident happened last Sunday (01/03/2026), and they did not file a grievance; however, they did talk to the Administrator yesterday (01/08/2026). During a follow up interview on 01/09/2026 at 10:20 AM, Resident 46 stated the second time they were singled out for being gay was yesterday (01/08/2026). Resident 46 stated they were listening to music on their headphones in the dinning room while looking out the window and at around 3:00 PM Staff N, Activity Director, walked up from behind and introduced them to a blonde-haired woman. They decided to move bible study from the activity room to the dining room and then the discussion went to religion. Resident 46 stated they told them that they were gay and the blonde lady said, I can't go along with that. Resident 46 stated they did not want religion shoved down their throat and they turned and got out of there. Resident 46 stated they talked to Staff N, Activity Director, and apparently they already knew about the incident and tried to console them (Resident 46) by saying that they (Staff N) was sure the lady did not mean anything bad. Resident 46 stated they were already in the dining room when they moved the bible study and so they did not go to bible study but the bible study came to them. Review of the facility's January 2026 incident reporting log from 01/01/2026 - 01/08/2026 showed no incident report logged for Resident 46. Review of the facility's January 2026 grievance/concern log showed Resident 46 had a grievance logged on 01/08/2026 related to Religion Preference, that was Pending, and the activities department was responsible for the investigation. During an interview on 01/09/2026 at 12:31 PM Staff N, Activity Director, stated that the Administrator told them on 01/08/2026 that Resident 46 complained about Collateral Contact KK, Volunteer/Activities and Collateral Contact NN, Volunteer/Bible Study. Staff N stated that they talked to Resident 46 the evening of 01/08/2026 and Resident 46 told them that they felt both volunteers were preaching to them about being homosexual. Staff N stated Resident 46 told them that Collateral Contact NN, Volunteer, told Resident 46 I can't go along with that. Staff N stated it was not clear what had been said to Resident 46. Staff N stated they (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	talked to Collateral Contact NN, Volunteer, and they did not have the interaction Resident 46 seemed to think they had, and it was not even on their radar. Staff N stated they talked to Collateral Contact KK, Volunteer/Activities, and they had no idea what Resident 46 was talking about. Staff N stated Resident 46 had not expressed to them that they felt shamed for being gay; but Resident 46 did say that to someone else but was not sure who. Staff N stated it was relayed to them that Resident 46 was being shamed for being gay by the volunteers trying to pray the gay out of them. During an interview on 01/09/2026 at 3:38 PM Collateral Contact KK, Volunteer/Activities, stated Resident 46 had never showed anger and had always been jolly towards them. Collateral Contact KK, stated they were surprised to hear from Staff N, Activity Director, that Resident 46 thought that they were trying to pray the gay away from the resident. Collateral Contact KK,, stated they had seen Resident 46 on 01/05/2026 in the hallway and there was no issue. Review of Resident 46's Complaint/Grievance Report dated 01/08/2026 showed it was not a reportable incident. It showed Resident 46 was offered bible soul salvation when they did not want any religion preached to them. It showed that Staff A, Administrator, had informed Staff N, Activity Director of the complaint/grievance related to both volunteers on 01/08/2026. It showed both Collateral Contact KK, Volunteer/Activities, and Collateral Contact NN, Volunteer/Bible Study, were interviewed by Staff N, Activity Director. Attached to Resident 46's Complaint/Grievance Report were written statements by Staff A and Staff N. Review showed the plan was that Resident 46's preferences, to not be offered religious services or faith-based outreach, would be communicated to staff and volunteers and respected moving forward and Resident 46 agreed with the resolution. However, this report did not include Staff N, Activities Director, interview statement provided during an interview on 01/09/2026 at 12:31 PM when they stated Resident 46 had not expressed to them that they felt shamed for being gay; but Resident 46 did say that to someone else but was not sure who. (Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience shame). During an interview on 01/13/2026 at 8:45 AM, Staff A, Administrator, stated that if there was potential that a resident was abused it should be reported to the State Hotline as soon as possible and/or within two hours. Staff A stated that intention of causing mental anguish to a resident did not make a difference in reporting and investigating potential allegations of mental abuse. Even if it was not willful by the staff or person it was how the residents perceived them. Staff A stated that after they talked to Resident 46 on 01/11/2026 they were able to resolve the grievance initiated on 01/08/2026 and rule out abuse. Staff A stated that Resident 46 had never told them that they felt shamed by the volunteers. Staff A stated that Staff N, Activity Director, had not told them that it was relayed to them that they thought Resident 46 felt shamed by the volunteers for being gay. Staff A stated that this should have been reported to the abuse hotline, the Director of Nursing Services and to myself and an incident investigation initiated at that time. <New Hire Reference Checks> Review of the facility's employee list with dates of hire provided on 01/05/2025 showed/included the following staff hire dates:-Staff D, Certified Nursing Assistant (CNA) hired on 04/02/2025-Staff JJ, Licensed Practical Nurse (LPN) hired on 08/06/2025-Staff C, CNA, hired on 06/25/2026-Staff HH, Social Services Director (SSD), hired on 03/10/2025-Staff H, LPN/Assistant Director of Nursing Services (ADON) hired on 01/01/1995 During an interview on 01/14/2026 at 12:50 PM Staff A, Administrator, stated that the expectation was that references were done upon hire. Staff A stated that references were done on paper and then were switched to online and they got lost. The facility was unable to locate references for Staff D, Staff JJ, Staff C, Staff HH, and Staff H. Staff A stated that this did not meet expectations. <Background Checks> During an interview on 01/12/2026 at 2:36 PM, Staff AA, Human Resources/Payroll (HR), stated Staff D, Certified Nursing Assistant (CNA) was hired on 04/02/2025. Review of Staff D's personnel file showed a background check dated 08/05/2025 (four months after the hire date). During an interview on 01/12/2026 at 3:05 PM, Staff AA, HR, stated Staff C, CNA, was hired on 06/25/2025. Review of Staff C's personnel file showed a background check dated 07/30/2025 (more than a month after hire date). Staff AA, HR, stated the background checks (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Linden Grove Health Care Center	400 - 29th Street Northeast Puyallup, WA 98373

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were done late. During an interview on 01/14/2026 at 12:50 PM, Staff A, Administrator, stated the background checks were to be completed upon hire and Staff C and D background checks did not meet expectations. Reference WAC 388-97-0640(2)(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 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 identify and report an allegation of abuse for 1 of 3 sampled residents (Resident 46) when reviewed for abuse. This failure placed the resident at risk of further abuse, psychological distress, and diminished quality of life. Findings included .According to the Nursing Home Guidelines also known as the Purple Book, sixth edition, dated October 2015, reporting requirements included that staff to resident abuse, neglect, mistreatment, sexual or physical abuse/assault were to be reported to the Department of Social and Health Services (DSHS) state hotline, the police, and logged on the DSHS reporting log within five days Review of the facility's policy titled, Abuse Prohibition, revised on 10/25/2024 showed the center/facility would implement an abuse prohibition program. Review showed, Mental Abuse includes, but not limited to humiliation, harassment, and threats of punishment or deprivation. Mental abuse may occur through either verbal or nonverbal conduct which causes or has the potential to cause the patient to experience humiliation, intimidation, fear, shame, agitation, or degradation. Review showed, Report allegations involving abuse (physical, verbal, sexual, mental) not later than two (2) hours after the allegation is made. Review of the electronic health record (EHR) showed Resident 46 admitted to the facility on [DATE] with diagnoses to include heart failure, bipolar disorder (causes extreme mood swings, shifting between manic highs and depressive lows), and respiratory failure. Resident 46 was able to make needs known. During an interview on 01/09/2026 at 10:09 AM Resident 46 stated, they were very upset and got no sleep last night. Resident 46 stated, Twice I have been singled out because I am gay. Resident 46 stated the first lady was a black evangelistic preacher woman that came from outside the facility and said, You got to pray every day, and that they could not judge anybody but themselves. The finally told her that was enough and they wheeled themself out of the activity. Resident 46 stated the incident happened last Sunday (01/03/2026), and they did not file a grievance; however, they did talk to the Administrator yesterday (01/08/2026). During a follow up interview on 01/09/2026 at 10:20 AM, Resident 46 stated the second time they were singled out for being gay was yesterday (01/08/2026). Resident 46 stated they were listening to music on their headphones in the dinning room while looking out the window and at around 3:00 PM Staff N, Activity Director, walked up from behind and introduced them to a blonde-haired woman. They decided to move bible study from the activity room to the dining room and then the discussion went to religion. Resident 46 stated they told them that they were gay and the blonde lady said, I can't go along with that. Resident 46 stated they did not want religion shoved down their throat and they turned and got out of there. Resident 46 stated they talked to Staff N, Activity Director, and apparently they already knew about the incident and tried to console them (Resident 46) by saying that they (Staff N) was sure the lady did not mean anything bad. Resident 46 stated they were already in the dining room when they moved the bible study and so they did not go to bible study but the bible study came to them. Review of the facility's January 2026 incident reporting log from 01/01/2026 - 01/08/2026 showed no incident report logged for Resident 46. Review of the facility's January 2026 grievance/concern log showed Resident 46 had a grievance logged on 01/08/2026 related to Religion Preference, that was Pending, and the activities department was responsible for the investigation. During an interview on 01/09/2026 at 12:31 PM Staff N, Activity Director, stated that the Administrator told them on 01/08/2026 that Resident 46 complained about Collateral Contact KK, Volunteer/Activities and Collateral Contact NN, Volunteer/Bible Study. Staff N stated Resident 46 had not expressed to them that they felt shamed for being gay; but Resident 46 did say that to someone else but was not sure who. Staff N stated it was relayed to them that Resident 46 was being shamed for being gay by the volunteers trying to pray the gay out of them. Review of Resident 46's Complaint/Grievance Report dated 01/08/2026 showed it was not a reportable incident. During an interview on 01/13/2026 at 8:45 AM, Staff A, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator, stated that if there was potential that a resident was abused it should be reported to the State Hotline as soon as possible and/or within two hours. Staff A stated that intention of causing mental anguish to a resident did not make a difference in reporting and investigating potential allegations of mental abuse. Even if it was not willful by the staff or person it was how the residents perceived them. Staff A stated that after they talked to Resident 46 on 01/11/2026 they were able to resolve the grievance initiated on 01/08/2026 and rule out abuse. Staff A stated that Resident 46 had never told them that they felt ashamed by the volunteers. Staff A stated that Staff N, Activity Director, had not told them that it was relayed to them that they thought Resident 46 felt shamed by the volunteers for being gay. Staff A stated that this should have been reported to the abuse hotline, the Director of Nursing Services and to myself and an incident investigation initiated at that time. Reference WAC 388-97- 0640(5)(6)(a)(c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review, the facility failed to implement a comprehensive plan of care for 2 of 22 sampled residents (Residents 8 and 17) when reviewed for care plans. These failures placed the residents at risk for unmet care needs and a decreased quality of life. Findings included.Resident 8 Review of the Electronic Health Record (EHR) showed Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include hemorrhage in brain stem (Bleeding in brain stem), gastrostomy (surgically placed external opening into stomach), major depression, anxiety, psychotic disorder with delusions (fixed, false beliefs held with extraordinary conviction despite clear evidence of the contrary) and cognitive communication deficit. Resident 8 was not always able to communicate needs. Review of the provider's orders dated 12/31/2025 showed Resident 8 was to have nothing by mouth (NPO) status. Observation on 01/05/2026 at 9:55 AM, showed Resident 8 in their room with a pole and machine that was connected to a bag of water and a tube feeding formula, being administered liquids into their stomach via a tube. Review of the care plan dated 11/22/2024 Showed Resident 8 with focus area Resident exhibits or is at risk for Dehydration, there were no instructions on how Resident 8 was to receive fluids. During an interview on 01/09/2026 at 12:44 PM, Staff B, Director of Nursing Services (DNS), stated the expectation was for Residents that have NPO status to have a care plan and directives for staff on how they receive fluids. Staff B stated the care plan for Resident 8 did not meet expectations. Resident 17 Review of the EHR showed Resident 17 admitted to the facility on [DATE] with diagnoses of chronic pain syndrome and major depressive disorder. The resident was able to make needs known. Review of the plan of care dated 01/06/2026 for Resident 17 showed the resident required two caregivers for all interactions, care in pairs. Observation and interview on 01/09/2026 at 11:22 AM showed Staff C, Certified Nursing Assistant (CNA) was providing a brief change and personal hygiene to Resident 17. When asked if Resident 17 required care in pairs, Staff C stated No. During an interview on 01/12/2026 at 9:12 AM, Staff B, DNS, stated it was their expectation that staff followed the plan of care and if a resident required care in pairs they have a second staff member for all interactions. Reference WAC 388-97-1020(1),(2)(a)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a device to prevent pressure ulcers was applied per provider's order for 1 of 3 residents (Resident 114) when reviewed for pressure ulcers. This failure placed residents at risk for avoidable skin injury, pain, decrease in activities of daily living, and a diminished quality of life.Findings included. Review of the electronic health record (EHR) showed Resident 114 admitted to the facility on [DATE] with diagnoses to include cerebral infarction (a type of stroke where part of the brain dies because its blood supply gets blocked), high blood pressure, and atherosclerosis (narrowing of blood vessels, restricting blood flow) of both legs. Resident 114 was able to make needs known. During an interview on 01/07/2026 at 9:15 AM, Resident 114 stated their left heel was sensitive and they were supposed to wear a boot on their left heel, but the staff forgot about it. Resident 114 stated that staff had told them a couple of times that they were going to get a boot for their left foot, but they never got it. Multiple observations on 01/07/2026 at 9:15 AM, 01/08/2026 at 8:50 AM, 01/09/2026 at 10:16 AM, and 01/12/2026 at 1:51 PM showed Resident 114 lying in bed with no boot in place on the left foot. Review of the admission minimum data set assessment (MDS) dated [DATE] showed Resident 114 was at risk of developing a pressure ulcer/skin wound injury. Review of the provider order dated 10/14/2025 showed Resident 114 was to have a foam boot applied to the left foot every shift for left heel protection. Review of Resident 114's focused care plan for skin breakdown initiated on 09/17/2025 showed no intervention for a foam boot to the left foot. During an interview on 01/09/2026 at 9:09 AM, Staff U, Certified Nursing Assistant (CNA), stated they had never seen Resident 114 wear a foam boot on their left foot. Staff U stated Resident 114's care plan and Kardex (directions/information used to provide care to the residents) did not show that they were to have a foam boot placed on the left foot. During an interview on 01/12/2026 at 1:51 PM, Staff R, Licensed Practical Nurse, stated Resident 114 did not have a foam boot to the left foot in place and was unable to locate a boot in the resident's room. Staff R stated Resident 114 had a provider order dated 10/14/2025 to apply a foam boot to the left foot every shift for left heel protection. Staff R stated Resident 114's January 2026 treatment administration record (TAR) showed documentation that the foam boot had been applied; however, they knew it had not been applied, and this did not meet expectations. During an interview on 01/12/2026 at 2:11 PM, Staff B, Director of Nursing Services, stated Resident 114 had an order for a foam boot to the left foot and the January 2026 TAR showed it was being documented it had been applied every shift; however, it was not. Staff B stated Resident 114's provider's order should have been followed, and this did not meet expectations. Reference WAC 388-97- 1620(2)(b)(i)(ii),(6)(b)(i)

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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 provide quality of care related to monitoring of resident weights, bowel management/treatments, or edema management/treatment for 4 of 22 sampled resdients (Residents 5, 2, 13, and 99) when reviewed for quality of care. This failure placed residents at risk of unintended weight loss, untreated constipation, discomfort, unmitigated swelling, and a diminished quality of life. Findings included.Resident 5 Resident 5 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (mental health condition with significant mood swings) and adult failure to thrive (significant decline in health and functional abilities). Resident 5 was able to make needs known. Review of Resident 5's electronic health record (EHR) showed Resident 5 weighed 147 pounds on 11/10/2025 and 123 pounds on 12/02/2025. Review of a progress note dated 12/05/2025 showed, Weight warning: MDS: five percent change over 30 days. Resident noted with variable meal intake, order placed to reweigh. Review of the EHR showed no additional weights were taken. Review of a Change of Condition Evaluation dated 01/06/2025 completed by Staff J, Licensed Practical Nurse (LPN), showed it was reported that Resident 5 had a five percent weight loss within the past 30 days. Review shows the provider was notified on 01/06/2026 and recommended the facility to monitor. Review of Resident 5's care plan showed no new interventions related to monitoring the resident's weight. Review of Resident 5's EHR showed meal intake was not documented for all meals throughout the day. During an interview on 01/13/2026 at 12:22 PM, Staff J, LPN, stated the Change of Condition Evaluation to notify the provider should have been completed as soon as staff was aware Resident 5 had significant weight loss. Staff J stated the lack of monitoring Resident 5's meal intake and weights did not meet expectations. During an interview on 01/13/2026 at 12:22 PM, Staff B, Director of Nursing Services (DNS), stated when there was a change in condition related to weight, staff were expected to contact the provider and dietician within 24 hours. Staff B stated the guardian should have been notified and any recommendations from the provider should have been implemented immediately. Resident 2 Review of the EHR showed Resident 2 was admitted to the facility on [DATE] with diagnoses to include urinary tract infection, urinary retention, diabetes (high blood sugar), anxiety, and polyneuropathy (damage to nerves that cause different symptoms of numbness, pain and weakness). Resident 2 was able to communicate needs. Review of the EHR showed Resident 2 did not have documented bowel movements on 12/26/2025, 12/27/2025, 12/28/2025, 12/29/2025 and 12/30/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of December medication administration record showed laxative medications available and not administered. During an interview on 01/08/2026 at 12:39 PM, Staff H, LPN, stated the bowels were monitored electronically daily, and the nurses were notified with a report from the EHR system. Staff H stated the nurses were to start as needed laxatives after two days of no bowel movements and follow up every shift till results were achieved. Resident 13 Review of the EHR showed Resident 13 was admitted to the facility on [DATE] with diagnoses to include dementia (term for decline in mental abilities including thinking, memory and reasoning), asthma (chronic lung disease causing narrow airways), hypertension (elevated blood pressure), and malnutrition. Resident 13 was able to communicate needs. During an interview on 01/05/2026 at 9:42 AM, Resident 13 stated that they had constipation sometimes and did not take medications. Review of the EHR showed Resident 13 did not have bowel movements documented for 12/25/2025, 12/26/2025, 12/27/2025 and 12/28/2025. Review of the providers' orders showed as need it medications for constipation that were available and not given in December of 2025. During an interview on 01/07/2026 at 9:04 AM, Staff W, Certified Nursing Assistant, stated the process for bowel management was to ask the residents about their bowel movements, document the results and report to the nurse. During an interview on 01/12/2026 at 1:08 PM, Staff B, DNS, stated the documentation of the bowel management did not meet expectations. Resident 99 Review of the EHR showed Resident 99 admitted to the facility on [DATE] with diagnoses to include heart failure, diabetes (too much sugar in the blood), and chronic venous hypertension of unknown cause (high pressure in leg veins due to faulty valves, causing swelling, pain, skin changes, cramps, and ulcers/open wound) with ulcer of bilateral lower extremity (both lower legs/ankles/feet). Resident 99 was able to make needs known. Observation and interview on 01/06/2026 at 10:08 AM showed Resident 99's lower legs/feet were both wrapped in gauze with non-skid socks on both feet. Resident 99 stated they thought they were to have compression bandages, but the staff did not use them. Review of Resident 99's EHR showed a provider order dated 01/02/2026 for wound care that included wound care instructions for cleansing and medication application. The order included providing two-layer compression wraps and start wraps to include entire foot (not toes) and extend wrap to two fingers below the knee, one time a day every Friday for compression wraps and as needed for soilage and drainage. Observation on 01/07/2026 at 10:02 AM showed Resident 99 sitting on the side of the bed watching television, with lower legs/feet wrapped in gauze dated 1/6/26 at 2030 [10:30 PM]. This was not the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two-layer compression wraps as ordered on 01/02/2026 by the provider. Observation and interview on 01/09/2026 at 8:09 AM showed Collateral Contact T, Physician Assistant (PA), and two other staff members were completing Resident 99's wound treatment. Collateral Contact T was almost done double wrapping Resident 99's left leg with the second wrap. Resident 99 stated this was the second time the compression wraps had been applied because they ran out of the compression wraps and only applied gauze. Collateral Contact T stated the double layer compression wraps were to help with the edema/swelling. Collateral Contact T stated they had removed gauze from Resident 99's lower legs/feet prior to conducting the wound treatment and this did not meet their expectations and would be informing the Director of Nursing Services (DNS). Review of the January 2026 treatment administration record (TAR) from 01/01/2026 – 01/11/2026 showed an order for wound care with two-layer compression wraps which were documented as completed per provider orders on 01/02/2026, 01/06/2026 and 01/09/2026. Review of Resident 99's EHR showed a provider order dated 12/11/2025 for Bumetanide (diuretic medication used to help the body get rid of excess salt and water) give 1 milligram (mg) tablet by mouth one time a day for fluid retention every day at 8:00 AM. Review showed a provider order dated 12/16/2025 for Bumetanide give 0.5 mg by mouth one time a day for fluid retention every day at 9:00 AM. Review of Resident 99's January 2026 medication administration record (MAR) from 01/01/2026 – 01/11/2026 showed Resident 99's order dated 12/11/2025 for Bumetanide 1 mg daily at 8:00 AM and order dated 12/16/2025 for Bumetanide 0.5 mg daily at 9:00 AM was documented as provided for both orders. Review of Resident 99's pharmacy consultation report dated 12/12/2025 showed medication review for Bumetanide 0.5 mg one tab by mouth every day was entered into Residents 99's EHR as 1 mg, one tab by mouth every day. Recommendation showed to please consider clarifying orders with the prescriber. During an interview on 01/13/2026 at 9:35 AM, Staff J, LPN, stated they were not made aware until 01/09/2026 that Resident 99 had both lower legs/feet wrapped in gauze and not the ordered two-layer compression wraps. Staff J stated they were doing wound rounds with Collateral Contact T, PA, when they found out about it. Staff J stated the provider orders should have been followed. Staff J stated they saw that Resident 99 had two orders for Bumetanide; however, discharge orders from the hospital dated 12/11/2025 showed the dose for Bumetanide was for 1 mg daily and was not sure why the pharmacy note showed it should have been 0.5 mg. Staff J stated the provider needed to be notified of this medication error and an incident report initiated. Staff J stated Resident 99's edema care and services did not meet expectations. During an interview on 01/13/2026 at 11:04 AM, Staff B, DNS, stated if provider ordered treatment supplies were not available then staff should try to get the supplies and if unable then the provider should be informed to obtain alternate orders. Staff B stated they were made aware of Resident 99's lack of two-layer compression wraps on Friday 01/09/2026 after wound rounds were completed and this did not meet their expectations. Staff B stated Resident 99's treatment supplies should have been available and provider orders followed. Staff B stated Resident 99's two orders for Bumetanide needed to be clarified with the provider and followed up with pharmacy. Staff B stated Resident 99's care and services related to edema did not meet expectations. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference WAC 388-97-1060(1)

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Linden Grove Health Care Center	400 - 29th Street Northeast Puyallup, WA 98373

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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** Based on observation, interview, and record review, the facility failed to thoroughly investigate the root cause of a fall, ensure new interventions were appropriately developed or timely initiated and analyzed in an effort to prevent future falls, failed to maintain safe food storage in a resident's personal refrigerator, and/or left unsecured chemicals in a resident's bathroom for 2 of 5 sampled residents (Residents 114 and 40) when reviewed for accidents. These failures placed residents at risk of injuries, foodborne illness, negative outcomes, and a diminished quality of life.Findings included. <Falls> Resident 114 Review of the electronic health record (EHR) showed Resident 114 admitted to the facility on [DATE] with diagnoses to include cerebral infarction (a type of stroke where part of the brain dies because its blood supply gets blocked), high blood pressure, muscle weakness, and acquired absence of right leg above the knee. Resident 114 was able to make needs known. During an interview on 01/05/2026 at 3:36 PM, Resident 114 stated they had fallen about three or four weeks ago in the bathroom when they tried to transfer themselves. During a follow up interview on 01/08/2026 at 8:50 AM, Resident 114 stated they had fallen twice in the bathroom because both times they had tried to transfer from the toilet to the wheelchair. Resident 114 stated getting on the toilet was easy; however, getting off the toilet to transfer to the wheelchair was hard. Review of the admission minimum data set assessment (MDS) dated [DATE] showed Resident 114 had no falls. Review of the care plan initiated on 09/17/2025 showed Resident 114 was at risk for falls. Review of the facility's December 2025 and January 2026 incident reporting logs showed Resident 114 had falls on 12/04/2025 at 5:35 PM and on 12/17/2025 at 11:30 AM. Review of the incident report investigation dated 12/17/2025 showed an aid informed the nurse that Resident 114 had an unwitnessed fall in their bathroom. Review showed Resident 114 was found sitting on the floor on their bottom with their left leg stretched and shoe on. Review showed Resident 114 stated they were trying to transfer themselves into their chair. This incident report did not show when the last time Resident 114 was toileted or last observed/provided care prior to the fall and did not show the assigned aid had been interviewed or witness statement obtained related to this fall. It showed the root cause was self-transferring to prepare for dinner. The root cause did not include that Resident 114's self-transfer was from the toilet to the chair. It showed the new interventions were to Assist with transferring to wheelchair prior to meals with frequent visual safety checks. Interventions did not show how often frequent visual safety checks were. Resident 114's attached care plan showed the new interventions were initiated on 12/11/2025 (seven days after the fall). Review of the incident report investigation dated 12/17/2025 showed Resident 114 was found sitting on their bottom on the floor in front of the toilet with sock and shoe on left foot. Review showed Resident 114 stated they went to the bathroom by themselves and when they tried to transfer themselves back into the chair they fell. Review showed root cause was Self-transferring to toilet before lunch. Review showed a new intervention was, Staff to assist with toileting before and after meals. This incident report did not show when the last time Resident 114 was toileted or last observed/provided care prior to the fall and did not show the assigned aid had been interviewed or witness statement obtained related to this fall. During an interview on 01/08/2026 at 10:47 AM, Staff P, Licensed Practical Nurse (LPN), stated usually when a resident had a fall in the bathroom, they would look at the resident's transfer status, the last time the resident was toileted, and should obtain staff statements. Staff P stated Resident 114's incident report investigation dated 12/04/2025 looked like the resident fell from the toilet trying to transfer into the chair. Staff P stated the new interventions were initiated on Resident 114's care plan on 12/11/2026 and should have been initiated sooner. Staff P stated maybe the interventions could have been more specific to toileting and it did not show how often frequent safety checks were to be done. During an interview on 01/08/2026 at 11:09 AM, Staff B, Director of Nursing Services (DNS), stated Resident 114's incident report dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/04/2026 showed that the resident fell while trying to transfer from the toilet to their wheelchair. Staff B stated Resident 114's new intervention should have been to assist with toileting before meals. Staff B stated the new interventions were care planed on 12/11/2026 and should have been care planned on 12/04/2025 or 12/05/2025 to meet their expectations. Staff B stated the aid assigned to care for Resident 114 should have been interviewed and they were unable to locate documentation that they were. In continued interview on 01/08/2026 at 11:09 AM, after reviewing Resident 114's incident report investigation dated 12/17/2026, Staff B, DNS, stated the aid assigned to care for Resident 114 should have been interviewed and they were unable to locate documentation that they were. If interviewed, the aid could have said when the resident was last toileted, last assisted, and the last safety checked was done. Staff B stated this incident report investigation did not meet their expectations. < Safe Food Storage> Resident 40 Review of the EHR showed Resident 40 readmitted to the facility on [DATE] with diagnoses to include respiratory failure, schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, leading to disorganized thinking), and post-traumatic stress disorder (PTSD, a mental health condition where someone feels stressed and scared long after a traumatic event). Resident 40 was able to make needs known. During an interview on 01/07/2026 at 8:47 AM, Resident 40 stated their refrigerator was clean and organized and there was no need to look in it. Resident 40 stated they only kept water and milk in the refrigerator, no food, and the freezer had ice cream and milk. During an interview and observation on 01/12/2026 at 8:58 AM, Staff EE, Certified Nursing Assistant (CNA), stated they were not sure where Resident 40 was; however, they were not in their room at this time. Staff EE stated they would usually put milk or ice cream in the freezer for Resident 40. Staff EE opened the refrigerator, and it had three containers of Ensure Plus that expired on 01/10/2026, a container of dressing that expired on 01/04/2026, a green salad that expired on 01/09/2026, a half of a sandwich in a plastic bag with unidentifiable/label dated 12/2. Staff EE opened the freezer and showed ice cream and a cup of liquid dated 01/15/2026 and all items were frozen solid. Staff EE stated expired food items should not be in the refrigerator. Staff EE showed a refrigerator temperature log tapped to the side of the refrigerator dated January 2026 that was blank and showed the dates of one (1) through nine (9) crossed out with a line and the rest of the dates of the month were blank. Staff EE stated they were not sure who was responsible for cleaning and checking items in the refrigerator or filling out the temperature log but would find out. During an interview on 01/12/2026 at 9:27 AM, Staff EE, CNA, stated Staff R, LPN, told them the CNAs were to clean the refrigerators and to remove the expired items from Resident 40's refrigerator. During a follow-up interview on 01/12/2026 at 9:37 AM, Staff EE, CNA, stated Staff R, LPN, told them that the CNAs were to log refrigerator temperatures when they cleaned the refrigerator daily. During an interview on 01/13/2026 at 2:29 PM, Staff B, DNS, stated the licensed nurses were responsible for cleaning the refrigerators, checking food to ensure food had dates and were removed prior to expiration, checking the refrigerator temperatures and logging them on the temperature log. Staff B stated they were not aware that Resident 40 had expired food items in their refrigerator and that the refrigerator temperature log was not filled out. Staff B stated this did not meet their expectations. <Unsecured Chemicals> Observation and interview on 01/07/2026 at 8:47 AM showed a container of Clorox 2/Stain Remover and a container of Woolite, and both chemicals were located unsecured on top of the toilet tank cover in Resident 40's bathroom. Resident 40 stated those were their personal items. During an interview on 01/12/2026 at 9:27 AM, Staff EE, CNA, stated the container of Clorox and Woolite on the back of Resident 40's toilet tank both showed, Keep out of reach of children on the labels. Staff EE stated those items should be locked up for safety. During a follow-up interview on 01/12/2026 at 9:37 AM, Staff EE, CNA, stated Staff R, LPN, told them to remove the chemicals from Resident 40's bathroom and bring the chemicals to them for safekeeping. During an interview on 01/13/2026 at 2:29 PM, Staff B, DNS, stated chemicals should be in a locked cabinet or area and should not be kept unsecured in a resident's bathroom. Staff B stated they were not aware Resident 40 had unsecured chemicals in their bathroom and this did not meet their expectations. Reference WAC 388-97- -1060(3)(g)

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F 0692 Level of Harm - Minimal harm or potential for 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 interview, and record review, the facility failed to ensure residents with significant weight loss were identified, assessed and that interventions were implemented for 1 of 5 sampled residents (Resident 5) when reviewed for nutrition. This failure placed the resident at risk of malnourishment, poor healing, and a diminished quality of life. Findings included.Review of the electronic health record showed Resident 5 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (mental health condition with significant mood swings) and adult failure to thrive (significant decline in health and functional abilities). Resident 5 was able to make needs known. Review of Resident 5's EHR showed Resident 5 weighed 147 pounds on 11/10/2025 and 123 pounds on 12/02/2025. Review of a progress note dated 12/05/2025 showed, Weight warning: MDS: five percent change over 30 days. Resident noted with variable meal intake, order placed to reweigh. Review of the EHR showed no documentation Resident 5 was reweighed nor were any additional weights taken. Review of a Change of Condition Evaluation dated 01/06/2025 completed by Staff J, Licensed Practical Nurse (LPN), showed it was reported that Resident 5 had a five percent weight loss within the past 30 days. Review showed the provider was notified on 01/06/2026 and recommended the facility to monitor. Review of Resident 5's care plan showed no new interventions related to monitoring the resident's weight. Review of Resident 5's EHR showed meal intake was not documented for all meals throughout the day. During an interview on 01/13/2026 at 12:22 PM, Staff J, LPN, stated when significant weight loss was identified the provider should have been notified the same day. Staff J stated a weight variance meeting with the Dietician and Director of Nursing should have been conducted but did not. During an interview on 01/13/2026 at 12:22 PM, Staff B, Director of Nursing Services (DNS), stated when there was a change in condition related to weight loss staff were expected to contact the provider and Dietician within 24 hours. Staff B stated recommendations from the provider should have been implemented immediately and the lack of monitoring Resident 5's meal intake and weights did not meet expectations. Reference WAC 388-97-1060 (3)(h)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a feeding tube directly into stomach or small intestines) was administered in accordance with provider's orders and professional standards of practice for 1 of 2 sampled residents (Resident 8) when reviewed for enteral nutrition. The facility failed to have a system in place which ensured the amount of formula (liquid food product) and water a resident receives was reconciled with the amount they were ordered to receive. This failure placed the Resident at risk for inadequate nutrition, dehydration, and diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include hemorrhage in brain stem (bleeding in brain stem), gastrostomy (surgically placed external opening into stomach), major depression, anxiety, and cognitive communication deficit. Resident 8 was not always able to communicate needs. Observation on 01/05/2026 at 9:55 AM showed Resident 8 in their room with a pole and a machine that was connected to a bag of water and a tube feeding formula, administering liquids in their stomach via tube. Review of the provider's orders dated 12/31/2025 showed Resident 8 had enteral feed order to provide Jevity (formula) at 60 milliliters (ml) every hour for 22 hours starting at 2:00 PM and ending at 12:00 noon, and to have 150 ml of water flush every four hours with total of 1760 ml/2640 calories of formula and 2137 ml of free water. Review of the January 2026 medication administration record showed Resident 8 was provided 80 ml every day. During an interview on 01/09/2026 at 12:44 PM, Staff B, Director of Nursing Services, stated the process for documentation of enteral nutrition was to have amount of formula and water documented every shift and total for the day. Staff B stated documentation for Resident 8's enteral nutrition did not meet expectations. Reference WAC 388-97-1060(3)(f)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide pain management that is consistent with professional standards for 2 of 3 residents (Residents 99 and 17) when reviewed for pain management. Failure to administer pain medications per providers ordered parameters placed the residents at risk for uncontrolled pain and decreased quality of life. Findings included.Resident 99 Review of the electronic heath record (EHR) showed Resident 99 admitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood), and chronic venous hypertension of unknown cause (high pressure in leg veins due to faulty valves, causing swelling, pain, skin changes, cramps, and ulcers/open wound) with ulcer of bilateral lower extremity (both lower legs/ankles/feet), and fibromyalgia (a long-term condition causing the brain and spinal cord to become overly sensitive to pain signals, amplifying them). Resident 99 was able to make needs known. During an interview on 01/06/2026 at 10:06 AM, Resident 99 stated the staff did not always manage their pain. Resident 99 stated they were not in pain at that time; however, when they had been in pain they were provided with Tylenol (used to treat mild to moderate pain) and it did not help enough with the pain. Resident 99 stated they had asked for oxycodone (an opioid medication used to treat moderate to severe pain) the other day and were told they had discontinued that medication. Review of Resident 99's focused care plan for alteration in comfort initiated on 12/11/2025 showed interventions initiated on 12/11/2025 included: Monitor for non-verbal signs/symptoms of pain and medicate, as ordered. Advise resident to request pain mediation before pain becomes severe. Medicate resident, as ordered, for pain and monitor for effectiveness and side effects. Report to physician, as indicated. Monitor frequency of episodes of breakthrough pain to determine the need for pain medication adjustment. Review of the provider order dated 01/02/2026 showed Resident 99 was prescribed Tylenol 1000 milligrams (mg) by mouth every six hours as needed for a pain level of 1 – 4 out of 10 (0 = no pain and 10 = worst pain imaginable) with non-pharmacological interventions (NPI, methods that don't involve medication) listed. Review showed an order dated 12/11/2025 for Pain monitor every shift. Review of Resident 99's January 2026 medication administration record (MAR) from 01/01/2026 – 01/08/2026 showed an order for Tylenol 1000 milligrams (mg) by mouth every six hours as needed for a pain level of 1 – 4 out of 10 with NPI listed, had a start date of 01/02/2026. Review showed Resident 99 received Tylenol on 01/02/2026 for a pain level of 6 and on 01/07/2026 for a pain level of 5 both, were outside of parameters of 1 – 4 out of 10. Review showed an order for pain monitor every shift with a start date of 12/11/2025, Resident 99 had pain levels ranging from 2 – 6 out of 10 on six occasions; however, Tylenol and NPIs were not provided. Review showed Tylenol was provided on 01/06/2026 for a pain level of 4; however, NPI was documented NA. During an interview on 01/13/2026 at 9:58 AM, Staff J, Licensed Practical Nurse (LPN) stated Resident 99's documentation in the EHR showed as needed Tylenol provided on 01/02/2026 and 01/07/2026 and was effective, even though pain levels were outside parameters of 1-4/10; however, the provider should have been notified of resident's pain levels higher than 4 to provide further instruction. Residents reporting pain should be assessed, NPI's provided, and if not effective then offer/provide ordered as needed pain medication. Staff J stated the January 2026 MAR showed (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 99 had reported pain levels ranging from 2-6 and NPI or Tylenol were not consistently offered/provided, and this did not meet expectations. During an interview on 01/13/2026 at 10:53 AM, Staff B, Director of Nursing Services (DNS) stated if a Resident had pain levels higher than the as needed ordered pain medication parameters then the provider should be notified to obtain a new order or clarify the current pain level parameters ordered. Staff B stated when a resident reports pain levels 1 – 10 then the nurse should offer/provide NPI and if not effective then provide ordered as needed pain medication. Staff B stated Resident 99's pain management and documentation did not meet expectations because Resident 99's documented reported levels of pain were not consistently documented to show NPI were provided and/or Tylenol offered/provided as needed. Resident 17 Review of the EHR showed Resident 17 admitted to the facility on [DATE] with diagnosis of chronic pain syndrome. The resident was able to make needs known. During an interview and observation on 01/06/2026 at 10:26 AM, Resident 17 stated I am in a lot of pain all the time. Resident appeared guarded, curled in the bed, and grimacing. Review of the EHR showed a provider order dated 02/19/2025 for Hydromorphone (a narcotic pain medication) two milligram tablets. The resident was to receive one tablet for pain levels of 4-6 or two tablets for pain levels of 7-10 every 6 hours as needed for pain. Review of the January 2026 medication administration record showed Resident 17 reported a pain level of 7 twice on 01/01/2026 and was administered one tablet. On 01/03/2026 the resident reported pain levels of 7 and 8 and received one tablet. On 01/04/2026 the resident reported pain levels of 9 and 8 and received one tablet, and on 01/07/2026 the resident reported pain levels of 8 and 9 and received one tablet. During an interview on 01/09/2026 at 12:46 PM, Staff H, Licensed Practical Nurse/Assistant Director of Nursing stated it was their expectation that staff follow the parameters in the providers orders, Staff H stated Resident 17's pain medication administration did not meet their expectations. During an interview on 01/12/2026 at 9:18 AM, Staff B, DNS, stated it was their expectation the nursing staff follow the provider orders and should have administered two tablets for pain levels of 7 or greater for Resident 17. Reference WAC 388-97 1060(1) -1620(2)(b)(i)(ii)

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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 two errors were made in twenty-seven opportunities equaling a 7.4% medication error rate during medication administration for 2 of 3 sampled residents (Residents 7 and 52) when reviewed for medication administration. This failure placed the residents at risk of receiving medications that were not effective or less effective and a diminished quality of life. Finings included. Observation on 01/09/2026 at 8:14 AM, showed Staff Y, Licensed Practical Nurse (LPN), administering medications to include vitamin C 500mg to Resident 7. Review of the January 2026 medication administration record (MAR) showed Resident 7 did not have an order for Vitamin C 500mg and had received the wrong medication. Review of the January 2026 MAR showed Resident 7 had an order for cyanocobalamin (vitamin B12) 500mcg that was not administered. Observation on 01/09/2026 at 7:57 AM showed Staff K, LPN, administering medications to Resident 52 to include Folic acid 1000mcg from an over-the-counter container, and Folic acid 1mg from pharmacy packaging. Review of the January 2026 MAR showed Resident 52 did not have two orders for folic acid and received the wrong medication. Review of the January 2026 MAR showed Resident 52 had an order for Prenatal vitamins with ferrous fumarate-folic acid that was not administered. During an interview on 01/09/2026 at 1:11 PM, Staff B, Director of Nursing Services, stated the licensed nurses were to follow the provider's orders when administering medications and that did not meet expectations. Reference WAC 388-97-1060(3)(k)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to secure (lock) 1 of 4 treatment Carts (Cart South 2) and 1 of 6 medication Carts (Cart South 3) when reviewed for medication storage. This failure placed residents at risk for medication diversion and misuse, lack of safety, poisoning, and a diminished quality of life. Findings included.Review of the Facility's policy titled, Storage of Medications, revised on November 2020, showed, Drugs and biological used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications. Observation on 01/07/2026 at 10:56 PM, showed the treatment Cart South 2 was unlocked without nurse supervision for 10 minutes. Staff X, Licensed Practical Nurse (LPN), was called to lock the cart. During an interview on 01/07/2026 at 11:00 PM, Staff X stated the nurse responsible for Cart South 2 was on break. Staff X stated the cart should have been locked. Observation on 01/09/2026 at 7:38 AM, showed Staff Y, LPN, was administering medication to a resident and left the medication Cart South 3 unlocked and not in visual supervision while turning towards the Resident to administer medications. During an interview on 01/09/2026 at 1:11 PM, Staff B, Director of Nursing Services (DNS), stated the medication and treatment carts should have been locked when nurses were not next to the cart. Observation on 01/12/2026 at 10:36 PM, showed medication Cart South 3 was left unlocked for eight minutes. Staff J, LPN, was called to lock the medication cart. During an interview on 01/12/2026 at 10:44 AM, Staff J, LPN, stated Cart South 3 should have been locked. During an interview on 01/12/2026 at 1:08 PM, Staff B, DNS, stated the unlocked medication and treatment carts did not meet expectations. Reference WAC 388-97-1300(2)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide COVID-19 immunizations for 2 of 7 residents (Residents 26 and 19) reviewed for COVID-19 immunization. This failure placed the residents at an increased risk for complications related to COVID-19 infection that could result in severe illness or death. Findings included.Review of the facility policy titled Coronavirus Disease (Covid-19) - Vaccination of Residents undated, showed each resident would be offered the Covid-19 vaccine and if the resident or their representative consents to the vaccine the facility would provide the vaccine at the facility or arrange with an outside service. Resident 26Review of the electronic health record (EHR) showed Resident 26 admitted to the facility on [DATE] with a diagnosis of diabetes (when the body cannot process sugars) and had consented to receive the Covid-19 vaccine on 12/16/2025. No documentation was found in the EHR of the administration of the vaccine. Resident 19Review of the EHR showed Resident 19 admitted to the facility on [DATE] with a diagnosis of skin infection. The resident had consented to receive the Covid-19 vaccine on 10/26/2025. No documentation was found in the EHR of the administration of the vaccine. During an interview on 01/12/2026 at 12:06 PM, Staff H, Licensed Practical Nurse/Assistant Director of Nursing, acting Infection Preventionist stated it was their expectation that residents are assessed, educated and offered the Covid-19 Vaccine and if they consent should receive it within a week of consent. During an interview on 01/12/2026 at 12:50 PM, Staff B, Director of Nursing Services stated it was their expectation that resident receive the VIS form and are educated on the risks and benefits when they are offered the vaccines and if the resident consents to the vaccine it should be ordered from the pharmacy and administered as soon as available Reference WAC 388-97 -1620(2)(b)(i)(ii)