STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505488	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Beach Rehab	19235 - 15th Avenue Northwest Shoreline, WA 98177

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 chlorine test strips (used to measure the concentration of free available chlorine in sanitizing solutions) were not expired in accordance with professional standards for 1 of 1 kitchen, reviewed for dinnerware sanitization and storage. This failure placed the residents at risk for unsanitary dining conditions and a diminished quality of life.Findings included .Review of the facility's policy titled Dishwashing Machine Use, revised in March 2010, showed, Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation.During a joint observation and interview on 02/23/2026 at 8:33 AM, Staff R, Culinary Aide, checked the dishwasher temperature and the chemical sanitation Parts Per Million (ppm - unit of measure for concentration) range. Staff R used [Brand name] Chlorine Test Paper. Staff R stated that the test strip results should be between 50 ppm to 100 ppm. A joint observation of the Chlorine Test Paper showed that the strip Staff R had used was expired on 01/01/2026. Staff R stated they had expired and someone had forgotten to throw them away and get a new one.On 02/23/2026 at 8:33 AM, Staff S, Registered Dietitian, stated that the facility used a low-temperature dishwasher with chemical sanitization.On 02/23/2026 at 10:05 AM, Staff U, Culinary Services Manager, stated staff should check the expiration date of the chlorine test strips before use and had missed that.In a follow-up interview on 02/24/2026 at 2:29 PM, Staff S stated that they would expect kitchen staff to test the dishwasher chemical sanitization before meals and would expect staff to check the expiration date of the chlorine test strips before use. Staff S further stated that it would be important because if the chlorine test strips were expired, they could give a false reading and could be inaccurate.On 02/25/2026 at 10:30 AM, Staff A, Administrator, stated they would expect the chlorine test strips in the kitchen to not be used if expired.Reference: (WAC) 388-97-1100(3), 2980 (6).

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview and record review, the facility failed to develop a system that ensured the right to file grievances anonymously for 5 of 8 residents (Resident 26, 37, 10, 100 & 104), reviewed for grievances. This failure placed the residents at risk for unresolved concerns, unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy titled, Grievance Policy, revised in January 2017, showed, Grievance may be filed orally or in writing and with the right to file anonymously. Review of the facility's undated document titled, Resident Grievance/Complaint Procedures, did not show documentation of a system to file grievances anonymously. Review of the facility's undated form titled, Grievance Communication Form, did not show documentation of a system to file grievances anonymously. Observation and record review on 02/19/2026 at 10:24 AM, showed an undated document titled, Grievance/Complaint Procedures, in an enclosed glass bulletin board outside the administrator's office. Review of the undated document showed, [Grievance] Forms can be obtained from the wall mounted outside the administrator's office. Further observation did not show a rack for grievance forms or a locked box to file a grievance form anonymously. During a meeting on 02/20/2026 at 10:00 AM with the Resident Council (a group of residents meeting regularly to discuss about their care and daily living in the facility), Residents 26, 37, 10 & 100, stated, No when asked if they were able to file their grievances anonymously. RESIDENT 26On 02/20/2026 at 10:00 AM, when asked about the process of filing their written grievance form, Resident 26 stated that they had to write their name on the grievance form and would give it directly to a staff or they would slide it under the administrator's office door. Resident 26 stated that there was a rack outside the administrator's office where they could put the grievance form and that the rack was no longer available. Resident 26 further stated, No, when asked if they were able to file their grievance anonymously. RESIDENT 37On 02/20/2026 at 10:00 AM, Resident 37 stated that they had to write their room number in the grievance form and would give it to a staff. Resident 37 stated, No, when asked if they were able to file their grievance anonymously. RESIDENT 10On 02/20/2026 at 10:00 AM, Resident 10 stated, No, when asked if they were able to file their grievance anonymously. RESIDENT 100On 02/20/2026 at 10:00 AM, Resident 100 stated, No, when asked if they were able to file their grievance anonymously. RESIDENT 104In an interview on 02/23/2026 at 11:29 AM, Resident 104 stated that they were not sure about filing grievances anonymously. In an interview on 02/23/2026 at 2:25 PM, Staff H, Social Services Assistant, stated that residents would hand in their written grievances to us or slide it under the [office] door. Staff H further stated, No, when asked if there was a locked box for residents to file/put in their grievances anonymously. In an interview on 02/23/2026 at 2:54 PM, Staff A, Administrator, stated that grievance forms were handed directly to them or slid under their door. Staff A stated that they had a rack outside their office where grievance forms where placed. Staff A stated that they had decided to remove the rack about a week or a week and a half ago due to some residents taking the completed grievance forms from the [opened] rack. Staff A stated that they did not have a closed or a locked box to put in the completed grievance forms. Staff A further stated that they expected residents to be able to file their written grievances anonymously. Reference: (WAC) 388-97-0460 (1).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 properly store the Continuous Positive Airway Pressure (CPAP - a therapy that pumps air into the lungs through the nose or nose and mouth that keeps the airway open) mask when not in use, administer CPAP as ordered, and monitor oxygen (O2) saturation (the amount of oxygen in the blood) for 3 of 6 residents (Resident 52, 2 &104), reviewed for respiratory care. These failures placed the residents at risk for unmet care needs, respiratory infections, and related complications.Findings included . Review of the facility's policy titled, CPAP/BiPAP [Bilevel Positive Airway Support-used to assist breathing by delivering air through a mask that covers the nose, mouth, or both] Support, dated July 2025, showed the purpose of CPAP/BiPAP was to improve O2 levels present in the blood in residents with OSA [Obstructive Sleep Apnea - a sleep disorder that is marked by pauses in breathing of ten seconds or more during sleep and causes unrestful sleep] . The policy further showed, Review the resident's medical record to determine his/her baseline O2 saturation [using a pulse oximeter-a non-invasive device] . RESIDENT 52Review of the admission record printed on 02/22/2026, showed Resident 52 was admitted to the facility on [DATE] with diagnosis that included OSA. Review of the February 2026 Treatment Administration Record (TAR) showed that Resident 52 had an order for, CPAP: Clean face mask with soap and water, air dry, and store in plastic bag every day shift with a start date of 12/01/2025. Observations on 02/17/2026 at 1:54 PM and on 02/18/2026 at 10:03 AM, showed Resident 52's CPAP machine was sitting on their nightstand, and the CPAP nasal mask was not covered and sitting on the CPAP machine. Further observation showed there were two urine-filled urinals hanging on the nightstand drawer. Observation on 02/19/2026 at 9:44 AM, showed Resident 52's CPAP machine was sitting on the resident's nightstand, and the CPAP nasal mask was not covered and sat on the CPAP machine. Observation on 02/20/2026 at 8:25 AM, Resident 52's CPAP tubing and the nasal mask were hanging below the resident's bed and touching the ground. In an interview and joint record review on 02/24/2026 at 10:00 AM, Staff N, Registered Nurse (RN), stated that CPAP nasal mask would be stored in a bag when not in use. A joint record review of the February 2026 TAR showed that Resident 52 had an order to clean face mask and store it in plastic bag every day shift. Staff N stated that the CPAP mask should be stored in the bag when not in use. In an interview on 02/24/2026 at 11:08 AM, Staff F, Resident Care Manager (RCM), stated that CPAP masks would be stored in a plastic bag when not in use. In an interview on 02/24/2026 at 2:37 PM, Staff B, Director of Nursing Services, stated it was their expectation that CPAP nasal masks would be stored in a plastic bag when they were not in use. RESIDENT 2 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission record printed on 02/18/2026 showed Resident 2 had a diagnosis of OSA. Review of the Order Summary Report printed on 02/18/2026 showed Resident 2 had an active order for a CPAP pressure settings of 12-20 cm H2O (centimeter of water-a unit of measurement for airway pressure) via a full humidified (with added moisture) mask. Review of the Respiratory Therapy (Nursing) care plan printed on 02/23/2026 showed Resident 2 had impaired respiratory function requiring CPAP treatment related to OSA. Review of Resident 2's physician progress note dated 02/12/2026 showed to use CPAP for all sleep. In an interview on 02/18/2026 at 11:13 AM Resident 2 stated that they had not used their CPAP and that They [staff] need to change the filter [CPAP machine]. Observation on 02/19/2026 at 7:17 AM showed Resident 2 was asleep with slight snoring sound and was not using their CPAP machine. Another observations on 02/20/2026 at 7:28 AM and at 11:23 PM showed Resident 2 was asleep and was not using their CPAP machine. In an interview and joint observation on 02/21/2026 at 12:15 AM, Staff T, RN, stated that CPAP was to be administered when they [residents] are about to sleep. Staff T stated that Resident 2 had an order for CPAP due to OSA. A joint observation showed Resident 2 was sleeping and was not using their CPAP. Staff T stated that they were expected to administer CPAP to Resident 2. In an interview and joint record review on 02/24/2026 at 9:17 AM, Staff F stated that the use of CPAP was important for residents with OSA to prevent them from desatting [desaturation-drop in the amount of O2 in the blood] or O2 level will drop. A joint record review of the physician order showed Resident 2 had an order for CPAP. When informed about the times Resident 2 was observed without their CPAP mask, Staff F stated that they expected staff to administer Resident 2 their CPAP. RESIDENT 104 Review of the admission record printed on 02/17/2026, showed Resident 104 was re-admitted on [DATE] and had diagnoses that included respiratory failure with hypoxia (oxygen deficiency) and OSA. Review of the Order Summary Report printed on 02/23/2026 showed Resident 104 had a physician order for O2 at two liters per minute (LPM) to maintain sats (saturation) equal to (or) greater than 92 percent for shortness of breath. The order summary report further showed O2 at two liters per minute via nasal cannula [a plastic tubing that delivers O2 through the nostrils] at bedtime for severe nocturnal [night] desaturation as needed. Review of Resident 104's O2 therapy care plan dated 02/02/2026 showed, Monitor O2 saturation while providing daily cares. Review of Resident 104's cardiology [doctors/healthcare providers specializes in heart] consultation note dated 02/09/2026 showed, Monitor oxygen sats [saturation]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the electronic health record under vital signs did not show Resident 104's oxygen saturation was monitored on the following dates: 02/04/2026, 02/05/2026, 02/08/2026, 02/10/2026, 02/11/2026, 02/14/2026, 02/16/2026, 02/17/2026, 02/20/2026, and 02/22/2026. In an interview on 02/17/2026 at 11:28 AM, Resident 104 stated, The oxygen is not being provided to me and that they were supposed to use oxygen. In an interview and joint record review on 02/24/2026 at 9:37 AM, Staff F stated that staff monitored residents' respiratory status. Staff F stated that they use a pulse oximeter to measure a resident O2 saturation level. When asked, Staff F stated, It is important [to measure O2 saturation] because it will indicate desaturation and will tell you if they [residents] are going into respiratory distress. A joint record review of Resident 104's physician order showed they had orders for oxygen at two LPM to maintain (O2) saturation equal to or greater than 92 percent for shortness of breath and severe nocturnal desaturation. A joint record review of the vital signs records did not show Resident 104's O2 saturation was monitored on the following dates: 02/04/2026, 02/05/2026, 02/08/2026, 02/10/2026, 02/11/2026, 02/14/2026, 02/16/2026, 02/17/2026, 02/20/2026 and 02/22/2026. Staff F stated that they expected Resident 104's O2 saturation to have been monitored to know if they were having desaturation. In an interview on 02/24/2026 at 10:51 AM, Staff B stated that they expected staff to have administered Resident 2 their CPAP and monitored Resident 104's O2 saturation to assess their respiratory status. Reference: (WAC) 388-97-1060 (3)(j)(vi) .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to document medication administration in accordance with professional standards for 4 of 6 residents (Residents 46, 90, 29 & 93), reviewed for medication administration. This failure placed the residents at risk for medication errors, negative outcomes, and a diminished quality of life.Findings included.Review of the facility's policy titled, Medication Administration, revised in April 2019, showed, the individual administering the medication initials the resident's MAR [Medication Administration Record] on the appropriate line after giving each medication and before administering the next ones.RESIDENT 46Review of Resident 46's February 2026 MAR showed they had orders for the following medications:- Cranberry (supplement), 1 (one) tablet- Senna (stool softener), 2 (two) tablets- Lactulose (stool softener) oral solution, 15 milliliters (a unit of measurement)- Excedrin (pain reliever), 2 tablets- Aripiprazole (mood stabilizer), 1 tablet- Lamotrigine (mood stabilizer), 1 tablet- Oxycodone (pain reliever), 1 tabletObservation on 02/23/2026 at 8:33 AM, showed Staff K, Licensed Practical Nurse, was preparing Resident 46's morning medications. Staff K poured 1 cranberry tablet, 2 senna tablets, 2 Excedrin tablets, 1 aripiprazole tablet, 1 lamotrigine tablet, and 1 oxycodone tablet in a medication cup; and 15 ml of lactulose in another medication cup. Staff K documented, Yes [medication administered] and saved/signed it in Resident 46's EMAR (Electronic MAR) before taking the medications to Resident 46. Staff K then entered Resident 46's room and administered their medications.RESIDENT 90Review of the February 2026 MAR showed Resident 90 had orders for the following medications:- Acetaminophen (pain reliever), 2 tablets- Fish oil (supplement), 1 capsule- Folic acid (supplement), 3 (three) tablets- Ropinirole (helps control movement disorders), 2 tablets- Prednisone (treats inflammation), 1 tabletObservation on 02/23/2026 at 8:37 AM, showed Staff K was preparing Resident 90's medications. Staff K poured 2 acetaminophen tablets, 1 fish oil capsule, 1 folic acid tablet, 2 ropinirole tablets, and 1 prednisone tablet in a medication cup. Staff K documented, Yes and saved/signed it in Resident 90's EMAR taking the medications to Resident 90. Staff K then entered Resident 90's room and administered their medications.RESIDENT 29Review of the February 2026 MAR showed Resident 29 had orders for the following morning medications:- Linzess (stool softener), 1 capsule- Fluticasone (treats nasal congestion), [with instructions to administer] 1 spray on both nostrils- Metoprolol (treats high blood pressure), 1 tablet- Senna, 2 tablets- PreserVision (supplement), 1 tablet- Multivitamin (supplement), 1 tablet- Apixaban (blood thinner), 1 tablet- Torsemide (water pill), 1 tablet- Morphine (pain reliever), 1/2 (half a) tablet- Allopurinol (for gout - joint pain), 1 tabletObservation on 02/23/2026 at 8:43 AM, showed Staff K was preparing Resident 29's medications. Staff K took a fluticasone nasal spray out of the medication cart; poured 1 linzess capsule, 1 multivitamin tablet, 2 senna tablets, 1 PreserVision tablet, 1 apixaban tablet, 1 allopurinol tablet, 1 metoprolol tablet, 1 torsemide tablet, and one-half morphine tablet in a medication cup. Staff K documented, Yes and saved/signed it in Resident 29's EMAR before taking the medications to Resident 29. Staff K then entered Resident 29's room and administered their medications.RESIDENT 93Review of the February 2026 MAR showed Resident 93 had orders for the following morning medications:- Aspirin (pain reliever/prevent blood clot), 1 tablet- Bupropion (for mood disorder), 1 tablet- Fluoxetine (for mood disorder), 1 tablet- Probiotic (supplement), 1 capsule- Acetaminophen, 2 tabletsObservation on 02/23/2026 at 9:07 AM, showed Staff K was preparing Resident 93's medications. Staff K poured 2 acetaminophen tablets, 1 aspirin tablet, 1 probiotic capsule, 1 fluoxetine tablet, and 1 bupropion tablet in a medication cup. Staff K documented, Yes and saved/signed it in Resident 93's EMAR before taking the medications to Resident 93. Staff K then entered Resident 29's room and administered their medications.In an interview on 02/23/2026 at 2:38 PM, Staff K stated that they signed the MARs as given before they administered Residents 46, 90, 29 and 93's morning medications.In an interview on 02/25/2026 at 1:47 PM, Staff I, Resident Care Manager, stated they (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expected nurses signed the residents' MAR after medication was taken and swallowed by the resident. The nurses are not supposed to pre-sign it [the MAR]. Staff I further stated that the nurse [Staff K] should have signed Residents 46, 90, 29 and 93's MARs after the residents took their medications.In an interview on 02/25/2026 at 2:29 PM, Staff B, Director of Nursing Services, stated they expected nurses to sign residents' MARs after the residents took their medications.Reference: (WAC) 388-97-1300(3)(a).

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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 ensure infection control practices were followed by 4 of 12 staff (Staff W, K, O & P) and for 2 of 2 residents (Residents 29 & 44), reviewed for infection control. The failure to properly transport clean clothes, use Personal Protective Equipment (PPE-face shield/goggles, gowns) before entering a droplet precaution (measure taken to prevent spread of germs transmitted when a person coughs, sneezes, talks or breaths) room and during wound care, disinfect a glucometer (a device used to measure blood sugar level) and pen injector (device used to inject Liraglutide [medication that helps regulate blood sugar levels]), and ensure a urine-filled urinal was not placed next to a resident's meal tray, placed the residents, visitors, and staff at risk for infection and related complications.Findings included. Review of the facility's policy titled, Infection Prevention and Control Program, dated October 2025, showed, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy showed that prevention of infection included implementation of appropriate Enhanced Barrier Precautions (EBPs-precaution to protect residents from multidrug-resistant organism [MDRO -a germ that is resistant to medications that treat infections]) and Transmission Based Precaution (a specialized infection control measure used to prevent the spread of specific infections) and following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC-a public health agency). The policy further showed, Those with potential direct exposure.are trained in and required to use appropriate precautions and personal protective equipment. According to Centers for Disease Control and Prevention online publication titled, Appendix D-Linen and laundry management, dated 03/19/2024, showed, Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Review of the facility's policy titled, Enhanced Barrier Precautions, revised in April 2025, showed the use of gown for high-contact resident care activities that included wound care (any skin opening requiring a dressing). TRANSPORTING CLEAN CLOTHES STAFF W Observation on 02/19/2026 at 2:03 PM showed Staff W, Laundry Aide, was transporting clean clothes and delivering them to the residents' room. Further observation showed the clean clothes on the rolling clothing rack were not fully covered while being transported by Staff W. Observation on 02/19/2026 at 2:17 PM, showed Staff W was transporting the rolling clothing rack when the white linen covering the cart fell to the floor. Staff W picked up the white linen and placed it back on top of the rolling clothing cart containing clean clothes. In an interview on 02/19/2026 at 2:20 PM, Staff W stated that they were expected to fully cover clean clothes with a clean linen when transporting them to the units. When asked about their recent transport, Staff W stated that the clean clothes were not fully covered and that the white linen covering should not have been placed back on the clothing rack. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/25/2026 at 10:53 AM, Staff X, Laundry Manager, stated that their process was to transport clean linens/clothes on a covered cart. Staff X stated, I expect the clothes are fully covered. When asked about the linen that fell on the floor, Staff X further stated, I want them [the staff] to put it in the dirty laundry and not put it back on the rack. In an interview on 02/25/2026 at 11:25 AM, Staff C, Infection Preventionist, stated that they expected staff to fully cover linens/clothes when transporting them to the unit. Staff C further stated, Once it [the linen] is on the floor, it is considered soiled. I expect them [the staff] to have it placed in the dirty laundry. USE OF PPE-DROPLET PRECAUTION STAFF K Observation on 02/19/2026 at 9:25 AM, showed Staff K, Licensed Practical Nurse, was putting on a gown, gloves, and entered room [ROOM NUMBER] (a droplet precaution room). Staff K was wearing a dark-rimmed eyeglasses and was not using eye protection (face shield or goggles) when they entered room [ROOM NUMBER]. In an interview and joint record review on 02/19/2026 at 10:05 AM, Staff K stated that they were expected to wear PPE when providing care for residents on droplet precautions. A joint record review of the signage posted outside room [ROOM NUMBER] showed staff must wear eye protection. When asked, Staff K stated that they were wearing their prescription eyeglasses and was not sure whether it [eyeglasses] is counted [as PPE] or not. In an interview on 02/25/2026 at 10:02 AM, Staff C stated that they expected staff to wear proper PPE for residents on droplet precautions. Staff C stated that prescription eyeglasses were not considered PPE and that Staff K was expected to wear a face shield or goggles upon entering room [ROOM NUMBER]. In an interview on 02/25/2026 at 11:32 AM, Staff B, Director of Nursing Services, stated that they expected staff to follow droplet precautions which included use of face shield or goggles. Staff B further stated that they expected staff to fully cover clean linens/clothes during transportation to the unit and that the linen on the floor is considered soiled and it should have been placed to [the dirty] laundry. WOUND CARE-EBPSTAFF O AND STAFF PRecord review of the wound evaluation dated 02/12/2026 showed Resident 20 had a bed sore on their sacrum (between the lower back and the tailbone) that required a dressing change three times a week. Observation on 02/19/2026 at 8:29 AM, showed Staff O, Nurse Practitioner, and Staff P, Registered Nurse, were providing wound care for Resident 20. Staff O and Staff P provided wound care to Resident 20 wearing gloves and were not wearing gown. In an interview on 02/19/2026 at 8:51 AM, Staff O and Staff P were asked regarding PPE requirements for wound care, they stated that residents on precautions were identified by signage and a PPE cart outside their room and that there was no signage or PPE cart outside Resident 20's room. Staff O and Staff P stated that they were aware that wound care required EBP, and a gown should have been worn during Resident 20's wound treatment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Beach Rehab	19235 - 15th Avenue Northwest Shoreline, WA 98177

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/23/2026 at 8:52 AM, Staff C stated that wound care should be on EBP and gloves and gown should be worn during wound treatment. Staff C further stated that Staff O and Staff P should have worn gowns during wound treatment. In an interview on 02/24/2026 at 2:28 PM, Staff B stated that their expectation was for staff to wear gloves and gown during wound care treatment. GLUCOMETER DISINFECTIONRESIDENT 29Review of the facility's policy titled, Obtaining a Fingerstick Glucose Level, revised in October 2011, showed, Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Review of the February 2026 physician orders showed Resident 29 had an order to check their blood sugar levels before meals and at bedtime prior to administration of insulin (a medication that helps regulate blood sugar level). During an observation and interview on 02/23/2026 at 8:44 AM, Staff K was using a glucometer to check Resident 29's blood sugar level. Staff K then used an alcohol wipe to clean the glucometer. Staff K stated it was their practice to clean glucometers with alcohol wipes after every use. Staff K stated they had two glucometers in their medication cart that they used interchangeably to check the blood sugar level of eight residents. Staff K further stated that they were told not to use the Sani-cloth [brand name- sanitizing wipes] because it was too harsh on the glucometers. In an interview on 02/25/2026 at 1:01 PM, Staff C stated they expected glucometers to be disinfected with Sani-cloth wipes or bleach-based wipes after every use. Staff C stated that Staff K should have cleaned the glucometer with a Sani-cloth wipe after it was used for Resident 29. In an interview on 02/25/2026 at 2:44 PM, Staff B stated that Staff K should have used Sani-cloth wipes to clean the glucometer after it was used to check Resident 29's blood sugar level. CLEANING OF LIRAGLUTIDE PEN INJECTORReview of the facility's policy titled, Medication Administration, revised in April 2019, showed, Staff follows established facility infection control procedures (. antiseptic technique [procedure to prevent spread of germs] .) for the administration of medications. Review of the manufacturer's recommendations titled, Liraglutide Injection, revised in February 2025, showed, .Pull off pen cap.Wipe the rubber stopper with an alcohol swab. Remove protective tab from outer needed cap. Push outer needle cap containing the needle straight onto the pen, then screw needle on until secure. Observation on 02/23/2026 at 8:46 AM, showed Staff K was preparing Resident 29's Liraglutide dose. Staff K removed the cap from Resident 29's Liraglutide pen, placed a new pen needle in and administered it to Resident 29. Staff K did not clean the Liraglutide pen rubber seal [with alcohol wipes] before placing the new needle onto the pen. Staff K stated they should have cleaned the Liraglutide rubber seal with an alcohol wipe prior to connecting the pen needle. In an interview on 02/25/2026 at 1:10 PM, Staff C, stated they expected nurses to clean the pen injector rubber seal with alcohol wipes prior to connecting pen needles. Staff C further stated that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff K should have cleaned Resident 29's Liraglutide rubber seal with an alcohol wipe before connecting the pen needle. In an interview on 02/25/2026 at 2:47 PM, Staff B stated that Staff K should have cleaned Resident 29's Liraglutide pen rubber seal with alcohol wipe prior to connecting the pen needle. URINAL NEXT TO MEAL TRAYRESIDENT 44Observation on 02/19/2026 at 2:45 PM, showed a urine-filled urinal on Resident 44's side table next to their meal tray. A joint observation and interview on 02/19/2026 at 2:54 PM with Staff L, Certified Nursing Assistant, showed Resident 44's urinal filled with urine was on their bedside table next to their meal tray. Staff L stated that Resident 44's urinal should not have been on the table next to their meal tray and that it should have been emptied. In an interview on 02/25/2026 at 1:02 PM, Staff C stated they did not expect urinal filled with urine to be placed next to their meal tray. Staff C further stated that Resident 44's urinal should have been emptied and placed away from their bedside table. In an interview on 02/25/2026 at 2:40 PM, Staff B stated they did not expect Resident 44's urinal to be on their bedside table next to their meal tray. Reference: (WAC) 388-97- 1320 (1)(a)(3)(5)(c).

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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. Based on interview and record review, the facility failed to ensure an informed consent explaining the risks/benefits for psychotropic medication (alters mood, perception, and behavior) was completed prior to medication administration for 1 of 5 residents (Resident 12), reviewed for unnecessary medications. This failure placed the resident and/or their representative at risk of not being fully informed of the risks and benefits before making decisions about medications prior to administration.Findings included .Review of the facility's policy titled, Psychotropic Medication Use, revised in July 2022, showed, Residents (and/or representatives) have the right to decline treatment with psychotropic medications. The policy further showed, The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.Review of Resident 12's February 2025 Medication Administration Record (MAR) showed an as needed (PRN) order for lorazepam (an antianxiety) medication was administered.Review of Resident 12's January 2025 through February 14, 2025, progress notes did not show whether Resident 12 or their representative received informed consent regarding lorazepam and whether they agreed to start the medication.Review of Resident 12's Consent for use of Psychotropic Medication Therapy - V 3, dated 01/09/2025, showed lorazepam was prescribed for Generalized Anxiety Disorder. The consent showed under section, D. Informed Consent, the Patient [resident] does not give consent to the use of the prescribed medication and understands the risk/s associated with not accepting the prescribed medication. The consent further showed under section D 3. The responsible party that was informed.Further review of Resident 12's electronic health record evaluations showed no other informed consent was given to Resident 12 or their representative prior to receiving lorazepam in February 2025.Review of Resident 12's Anti-Anxiety Psychotropic Medication Disclosure and Consent, dated 04/01/2025, showed a consent for lorazepam that did not show whether the resident and/or representative accepted or declined the medication.On 02/24/2026 at 10:53 AM, Staff I, Resident Care Manager, stated that when a resident began a psychotropic medication they would obtain consent from the resident or representative. Staff I stated the consent would inform the resident and/or representative what the medication was and the risks and benefits of the medication. Staff I further stated if the resident or representative disagreed with taking the medication they would not start it and document it in the progress notes.In a joint record review and interview on 02/24/2026 at 10:58 AM with Staff I showed an incomplete consent for lorazepam dated 04/01/2025. Staff I stated that the form was not complete and that they should have checked the box to indicate whether they accepted or declined the medication. Staff I further stated that lorazepam was an order from hospice (end of life care) and that they would have expected to obtain informed consent and make a progress note. A joint record review of Resident 12's progress notes showed no documentation that the informed consent was reviewed with the resident and or their representative and whether they had agreed to begin the medication. Staff I stated they should have made a progress note.On 02/25/2026 at 10:22 AM, Staff B, Director of Nursing Services, stated they would expect staff to obtain consent from the resident and/or representative prior to starting a psychotropic medication. Staff B further stated the consent would be important because it would inform the resident and/or representative about the medication, risks and benefits, and when consent was given.Reference: (WAC) 388-97-0260.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents were evaluated and assessed, and/or a physician order was obtained for safe administration of medication for 2 of 3 residents (Residents 92 & 64), reviewed for self-administration of medication. This failure placed the residents at risk for inaccurate and unsafe medication administration, adverse side effects, medical complications, and a diminished quality of life.Findings included.Review of the facility's policy titled, Medication Administration, revised in April 2019, showed, Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do safely.RESIDENT 92Review of Resident 92's Electronic Health Records (EHR) under evaluations tab from 01/24/2025 to 02/19/2026 showed no documentation to indicate that Resident 92 had a self-administration of medication evaluation.Review of a physician orders printed on 02/18/2026 showed no documentation to indicate that Resident 92 had an order for self-administration of medication.Review of the February 2026 Medication Administration Record (MAR) showed Resident 92 were given the following medications in the morning of 02/17/2026:- Amlodipine for high blood pressure), 1 (one) tablet- Aspirin (used to lower the risk of heart attack, stroke [blockage of blood supply to the brain], or blood clot [a mass that forms when blood hardens from a liquid to a solid]), 1 tablet- Atenolol (for high blood pressure), 1.5 (one and one-half) tablet- Lisinopril (for high blood pressure), 1 tablet- Spironolactone (for high blood pressure), 1 tablet- Acetaminophen (for pain), 2 (two) tablets- Calcium Carbonate (for heartburn, supplement), 2 tablets- Carbamazepine (for epilepsy [a medical condition that causes people to have repeated seizures - bursts of electrical activity in the brain that can cause changes in awareness, behavior, movements or feelings]), 1 tabletObservation on 02/17/2026 at 10:29 AM showed Resident 92 had eight and one-half tablets in a medication cup and another medication cup with two big tablets on their bedside table. Resident 92 stated, they [the nurse] just brought them in. When asked if they knew what medication they were taking, Resident 92 stated, I don't [do not] remember the names.In an interview and joint record review on 02/24/2026 at 10:43 AM, Staff M, Licensed Practical Nurse, stated they would leave medications at bedside for residents who had orders to leave them at bedside and for residents who were evaluated for self-administration of medications. A joint record review of Resident 92's February 2026 MAR showed Resident 92 was given 1 amlodipine tablet, 1.5 atenolol tablet, 1 aspirin tablet, 1 lisinopril tablet, 1 spironolactone tablet, 2 acetaminophen tablet, 1 carbamazepine tablet, and 2 calcium carbonate tablets. Staff M stated they provided Resident 92 with eight and one-half tablets in one medication cup and 2 tablets of calcium carbonate in another medication cup and left them in Resident 92's room. Staff M stated Resident 92 did not have orders for medications to be left at bedside or that they were on self-administration of medication program. Staff M further stated they should not have left the medications with Resident 92 and that they should have waited for Resident 92 to take all their medications.In an interview and joint record review on 02/25/2026 at 1:22 PM, Staff J, Resident Care Manager, stated they did not expect nurses to leave medications in residents' room. A joint record review showed Resident 92 did not have a physician order to leave medications at bedside and/or a self-administration of medications evaluation in place. Staff J stated that Resident 92 did not have orders for self-administration of medications and that Staff M should have stayed with Resident 92 until they took their medications.RESIDENT 64Review of the physician orders printed on 02/18/2026 showed no documentation to indicate that Resident 64 had an order for self-administration of medications.Review of the evaluations tab from 03/19/2025 to 02/21/2026 showed no documentation to indicate that Resident 64 had a self-administration of medication evaluation.Review of the February 2026 MAR showed Resident 64 had the following oral medication scheduled between 7:00 AM to 10:00 AM:- Amlodipine, 1 tablet- Lamotrigine (for bipolar disorder [mental health condition that causes extreme mood swings]), 1 tablet- Acetaminophen, 1 tablet- Mirabegron (for overactive bladder (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[condition that causes sudden urges to urinate]), 50 milligram (unit of measurement) tabletOn 02/24/2026 at 9:41 AM, Resident 64 was observed taking her oral medications from a medication cup in their room. Resident 64 stated they were taking medications for blood pressure, for bladder, Tylenol [or acetaminophen], and a medication for bipolar disorder. When asked if a facility staff had evaluated them for self-administration of medications, Resident 64 stated, No.In a joint record review and interview on 02/24/2026 at 10:57 AM with Staff M, the February 2026 MAR showed Resident 64 was given the following morning medications: 1 amlodipine tablet, 1 lamotrigine tablet, 1 mirabegron tablet, and 1 acetaminophen tablet. Staff M stated they left Resident 64 with their medications and that they should have watched them take their medications before leaving their room.A joint record review and interview on 02/25/2026 at 1:30 PM with Staff J, did not show that Resident 64 had a physician order for self-administration of medications. Staff J stated, the nurse [Staff M] should not have left the medications at bedside, and should have waited next to the resident [Resident 64] until they took all their medications.In an interview on 02/25/2026 at 2:50 PM, Staff B, Director of Nursing Services, stated that they did not expect nurses to leave medications at residents' bedside if they [the residents] are not on self-med [self-administration of medication] program. Staff B further stated that the nurse [Staff M] should have stayed with Residents 92 and 64 until they took all their medications.Reference: (WAC) 388-97-0440,1060 (3)(I).

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review, the facility failed to ensure dignity was provided during dining observations for 2 of 10 residents (Residents 89 & 47), reviewed for dining. The failure to ensure licensed nurses refrained from administration of medications during resident meals placed the residents at risk for a diminished quality of life.Findings included.Review of the facility's policy titled, Dignity, revised in October 2025, showed, Residents are treated with dignity and respect at all times.RESIDENT 89Observation on 02/17/2026 at 12:54 PM, showed multiple residents were eating their meals in the dining room. Staff K, Licensed Practical Nurse, entered the dining room and mixed Resident 89's medication with yogurt. Resident 89 took their medication in the dining room.An additional observation on 02/19/2026 at 1:03 PM, showed multiple residents were eating their meals in the dining room. Staff K administered Resident 89 their medication in the dining room.RESIDENT 47Observation on 02/17/2026 at 1:04 PM showed Staff K administered Resident 47 their medication in the dining room while multiple residents were present eating their meals.In an interview and joint record review on 02/19/2026 at 1:12 PM, Staff K stated medication could be administered in the dining room if it was necessary for the routine of the resident. Staff K stated that administering medication to Resident 89 and Resident 47 was a part of the residents' routine. Staff K stated that this should be reflected in the residents' care plan. A joint record review of Resident 89's care plan did not show that they preferred medication in the dining room as part of their routine. A joint record review of Resident 47's care plan did not show that they preferred medication in the dining room as part of their routine. Staff K stated that the care plans did not reflect their routine and that they should have.On 02/24/2026 at 11:28 AM, Staff I, Resident Care Manager, stated that medication should not be administered during mealtimes in the dining room because residents were eating their meal and for privacy. Staff I stated that if a resident wanted their medication in the dining room, they would expect their care plan to reflect that. Staff I further stated that Resident 89 and Resident 47's care plan did not reflect that.On 02/25/2026 at 10:24 AM, Staff B, Director of Nursing Services, stated that the facility staff knew the residents and their routine and did not really expect to care plan if a resident took their medication in the dining room as part of their routine.Reference: (WAC) 388-97-0860 (1).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed timely for 1 of 6 residents (Resident 107), reviewed for significant change in condition. The failure to complete an SCSA timely placed the resident at risk for unmet care needs and a diminished quality of life.Findings included .Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed that a SCSA is required to be performed when a terminally ill resident enrolls in a hospice (compassionate care provided to individuals who are in the final stages of a terminal illness) program or changes hospice providers and remains a resident at the nursing home. The Assessment Reference Date (ARD - observation period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the ARD) must be within 14 days from the effective date of hospice election. The RAI manual further showed that the assessment should be completed no later than 14 days after the determination was made (determination date [or effective date of hospice election] plus 14 calendar days).Review of a document titled, Certificate of Terminal Illness, dated 12/15/2025, showed Resident 107 started hospice services on 12/14/2025.Review of Resident 107's SCSA MDS dated [DATE] showed it was completed on 01/02/2026, 19 days after hospice election (five days late).During a phone interview and joint record review on 02/25/2026 at 12:22 PM with Staff E, MDS Coordinator, stated they followed the RAI manual to complete MDS. A joint record review of Resident 107's SCSA MDS dated [DATE] showed it was completed on 01/02/2026. A joint record review of the certificate of terminal illness document showed Resident 107 was admitted to hospice on 12/14/2025. Staff E stated that the hospice admission date of 12/14/2025 was equivalent to the determination date. A joint record review of the RAI manual MDS assessment summary showed that SCSA MDS should be completed no later than 14 days after determination that significant change in resident's status occurred. Staff E stated they would consult with their supervisor to check for completion timeframe.In an interview on 02/25/2026 at 12:40 PM, Staff D, Case Manager, stated that Resident 107's assessment was five days late and that it should have been completed timely.In an interview on 02/25/2026 at 2:25 PM, Staff B, Director of Nursing Services, stated they expected MDS assessments to be completed timely and accurately. Staff B stated Resident 107's assessment should have been completed timely.Reference: (WAC) 388-97-1000 (3)(b).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess 3 of 24 residents (Residents 68, 13 & 8), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure resident assessments were completed accurately on the MDS regarding dialysis (treatment that helps body remove extra fluid and waste products from blood when the kidneys cannot), medication, and smoking placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life.Findings included. According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated in October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). RESIDENT 68Review of the admission record printed on 02/21/2026, showed Resident 68 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease (last stage of kidney disease where kidneys no longer work) and dependence on renal dialysis. Review of a nursing progress note dated 01/16/2026 showed Resident 68 was on dialysis. Review of Resident 68's admission MDS dated [DATE], showed that dialysis was not marked under Section O (special Treatments, Procedures, Programs). In a phone interview and joint record review on 02/23/2026 at 1:33 PM, Staff E, MDS Coordinator, stated that they would follow the RAI manual and review the resident's medical records to complete MDS assessments. A joint record review of Resident 68's Electronic Health Record showed the resident was on dialysis during the assessment period. A joint record review of Resident 68's admission MDS dated [DATE] showed dialysis was not marked on the MDS. Staff E stated that Resident 68's dialysis was not marked on the MDS, it was a coding error, and that MDS correction would be completed. In an interview on 02/24/2026 at 2:30 PM, Staff B, Director of Nursing Services, stated that the facility would use the RAI manual as guidance for MDS completion, and that they would expect staff to follow the manual when completing MDS assessments. RESIDENT 13 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the significant change MDS dated [DATE] showed Resident 13's MDS Section N0415 (High-Risk Drug Classes: Use of Indication) was not marked for antianxiety medication during the assessment period. Review of the January 2026 Medication Administration Record (MAR) printed on 02/22/2026 showed Resident 13 had received antianxiety medication during the assessment period. During a phone interview and joint record review on 02/24/2026 at 3:31 PM, Staff E stated that they followed the RAI manual in completing the MDS. A joint record review of Resident 13's significant change MDS dated [DATE] did not show antianxiety medication was marked. A joint record review of the January 2026 MAR showed Resident 13 had received Buspirone- an antianxiety medication during the 7-day look back period. Staff E stated that the MDS was not accurate and was miscoded. RESIDENT 8Review of Resident 8's progress note dated 09/08/2025 showed, . Continues to smoke 1 [one] cigarette daily. Current light daily smoker – 1 - [to] 2 [two] cigarettes daily. Review of a Smoking Safety Evaluation, dated 09/11/2025, showed Resident 8 required supervision with smoking. Review of Resident 8's annual MDS dated [DATE] showed J1300 (Current Tobacco Use) in Section J (Health Conditions) was marked No, indicating that Resident 8 did not use or smoked tobacco during the look-back period (09/05/2025 to 09/11/2025). During a phone interview and joint record review on 02/25/2026 at 12:22 PM, Staff E stated they followed the RAI manual to complete MDS. Staff E stated that they would mark Yes in section J1300 if they would find documentation showing that residents used or smoked tobacco during the look-back period. A joint record review showed Resident 8's annual MDS dated [DATE] was marked No for tobacco use. A joint record review of a progress note dated 09/08/2025 and a smoking safety evaluation dated 09/11/2025 showed Resident 8 used and/or smoked tobacco during the look-back period. Staff E stated Resident 8 smoked during the look-back period and that their MDS was inaccurate for tobacco use. In an interview on 02/25/2026 at 2:25 PM, Staff B stated they expected MDS to be completed accurately. Reference: (WAC) 388-97-1000(1)(b).

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	505488	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Richmond Beach Rehab	19235 - 15th Avenue Northwest Shoreline, WA 98177

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASARR or PASRR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness (SMI), Intellectual Disabilities (ID); or related conditions are not inappropriately placed in nursing homes for long term care) form was followed up on or sent out for a Level II PASARR referral for 2 of 6 residents (Residents 15 & 12), reviewed for PASARR Screening. This failure placed the residents at risk for not receiving the care and services appropriate for their needs.Findings included.On 02/24/2026 at 9:40 AM, Staff H, Social Service Assistant, stated they would send in a referral for a Level II PASARR for anyone who had a diagnosis of a mental illness. Staff H stated they would send medical records including a face sheet, diagnoses, medication, and progress notes. Staff H stated that they would email this information and expect to follow up within a month. Staff H further stated it would be important for a resident to be evaluated for a Level II PASARR to see if there was anything the resident could get extra help with or was available to them.RESIDENT 15Resident 15 admitted to the facility on [DATE] with diagnoses that included Post-Traumatic Stress Disorder (PTSD- mental health condition triggered by experiencing or witnessing terrifying, life-threatening events like combat, abuse, or disasters), Anxiety Disorder (persistent, excessive fear or worry that interferes with daily life), Major Depressive disorder (MDD- persistent, intense sadness or a loss of interest in activities), Schizophrenia (a severe, chronic mental disorder that causes a disconnection from reality, characterized by hallucinations [vivid, involuntary sensory perceptions], delusions (false beliefs), and disorganized thinking), paranoid personality disorder (long-term, pervasive pattern of unwarranted distrust and suspicion of others), visual hallucinations, adjustment disorder with mixed anxiety and depressed mood, and auditory (hearing) hallucinations.On 02/24/2026 at 9:43 AM, Staff H stated that Resident 15 had diagnoses that included anxiety, PTSD, unspecified schizophrenia, visual hallucinations, paranoia, and adjustment disorder. Staff H stated that they emailed for a Level II PASARR referral on 11/05/2025 and did not see an evaluation yet. Staff H further stated that they had not followed up since 11/05/2025 and that they should have.RESIDENT 12Resident 12 admitted to the facility on [DATE] with diagnoses that included anxiety disorder, auditory hallucinations, visual hallucinations, delusional disorders, and MDD.Review of Resident 12's PASARR form dated 12/11/2024, showed they had SMI and a Level II PASARR referral was needed.Review of an email dated 12/10/2024 showed Staff H, had reached out to a PASARR evaluator stating, Please review for level II for [Resident 12]. The email further showed a response of, This has been received. Can you please send the completed PASRR Level I? The email showed no further documentation that the facility staff provided the requested information.Review of Resident 12's Level II PASRR Invalidation Assessment, dated 11/22/2025 showed a date of referral of 12/11/2024. The Invalidation Assessment further showed, 6. Other: Medical records not received, and that Admin closing case due to records not received.On 02/24/2026 at 9:53 AM, Staff H stated that they had just realized that the PASARR coordinator had not received Resident 12's medical records and would resend them. Staff H stated that they would have expected to send the medical records prior.On 02/25/2026 at 9:23 AM, Staff G, Social Services Director, stated that they expected to review PASARRs on admission and send them out for a Level II referral if required. Staff G stated that they expected staff to follow up every month.In a follow up interview on 02/25/2026 at 12:53 PM, Staff G stated that this was the best we could come up with [email from 12/10/2024], and that the email with the initial records had been deleted and could not provide other supporting documentation.On 02/25/2026 at 10:28 AM, Staff A, Administrator, stated that they expected staff to routinely (monthly) talk to the PASARR assessor to continue checking in to have either a Level II PASARR evaluation or invalidation. Staff A further stated that they would expect there to be documentation to show that they were following up with a resident's PASARR.Reference: (WAC) 388-97-1915 (4).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure care plans were revised accurately to reflect changes related to discontinuation of medications for 2 of 22 residents (Residents 13 & 12), reviewed for care planning. This failure placed residents at risk for unidentified and unmet care needs, and a diminished quality of life.Findings included. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated July 2025, showed, Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. RESIDENT 13 Review of the Behavior Monitor care plan printed on 02/22/2026 showed Resident 13 takes Venlafaxine.and Mirtazapine [both medications used to treat depression (persistent feelings of sadness and loss of interest)]. Review of the Order Summary Report printed on 02/18/2026, did not show Resident 13 had orders for Venlafaxine and Mirtazapine. Review of Resident 13's December 2025 Medication Administration Record (MAR) showed Venlafaxine was discontinued on 12/07/2025 and Mirtazapine was discontinued on 12/08/2025. In an interview and joint record review on 02/24/2026 at 8:39 AM, Staff V, Resident Care Manager (RCM), stated, We do review and update [the] care plan as a team. Also, if there are changes to the medication.we update them. A joint record review of the Behavior Monitor care plan showed Resident 13 takes Venlafaxine.and Mirtazapine . When asked if Resident 13 was taking both medications, Staff V stated that both medications were discontinued in December 2025. Staff V further stated, It [behavior monitor care plan] does not look like it was updated. In an interview on 02/24/2026 at 10:33 AM, Staff B, Director of Nursing Services, stated that they reviewed resident's care plan with any change in condition. Staff B stated, Yes when asked if they expected Resident 13's behavior monitor care plan to have been revised and/or updated. Staff B further stated, The care plan should be reflecting [Resident 13's] status. RESIDENT 12Review of Resident 12's alteration in cognition and communication care plan, revised on 04/08/2025, showed Resident 12 takes Rivastigmine [medication used to treat mild to moderate dementia] for memory loss due to Lewy Body Dementia [a type of dementia]. An additional care plan revised on 12/31/2024 showed Resident 12 had alteration in vision related to vision loss and Medication: Prednisone [medication used to treat inflammation], carboxymethylcellulose [an artificial tear to relieve dry eyes]. Review of Resident 12's February 2026 MAR did not show an active order for rivastigmine, prednisone, or carboxymethylcellulose. On 02/24/2026 at 10:12 AM, Staff K, Licensed Practical Nurse, stated that they would expect a care plan to be updated or revised to reflect the medication the resident was currently on. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/24/2026 at 11:18 AM, Staff I, RCM, stated that the RCMs were responsible for revising the care plan, quarterly and as needed. A joint record review of Resident 12's care plan showed that the resident had medication for rivastigmine, prednisone, and carboxymethylcellulose. Staff I stated that Resident 12 had discontinued medications and did not currently take those and that the care plan should have been revised to reflect that. On 02/25/2026 at 10:27 AM, Staff B stated that they would expect resident care plans to be revised when medication was discontinued. Reference: (WAC) 388-97-1020 (5)(b) .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure the pneumococcal vaccine (used to prevent pneumonia [a lung infection]) was up to date for 1 of 5 residents (Resident 3), reviewed for pneumococcal immunizations. This failure placed the resident at risk for acquiring, transmitting, and/or experiencing potential complications from pneumococcal disease.Findings included. Review of the facility's policy titled, Pneumococcal Vaccine, dated October 2025, showed that all residents would be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy further showed, Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination. According to CDC's official website publication titled, Adult Immunization Schedule Notes, dated 10/07/2025, showed an adult who had previously received both PCV [Pneumococcal Conjugate Vaccine-a type of vaccine]13 and PPSV [Pneumococcal Polysaccharide Vaccine- a type of vaccine]23 but NO PPSV23 was received at age [AGE] years or older will have one dose PCV20 or one dose PCV21 at least 5 [five] years after the last pneumococcal vaccine dose. Review of the admission record printed on 02/25/2026 showed Resident 3 was admitted to the facility on [DATE]. Review of the immunization record showed Resident 3 had received PPSV23 on 02/14/2001 and PCV13 on 11/12/2018. Review of the Vaccination History and Consent dated 03/10/2024 showed Resident 3 had agreed to Prevnar 20 (or PCV20) administration. Review of the Electronic Health Record (EHR) did not show Resident 3 had received Prevnar 20. In an interview and joint record review on 02/25/2026 at 8:30 AM, Staff C, Infection Preventionist, stated that they followed the CDC guidelines for pneumococcal vaccination schedule for residents. Staff C stated that Resident 3 had signed a consent dated 03/10/2024 to receive Prevnar 20. A joint record review of the EHR did not show Resident 3 was provided the Prevnar 20. Staff C stated, No, there is no documentation that it [Prevnar 20] was administered. Staff C further stated that they expected Resident 3 to have received Prevnar 20. In an interview on 02/25/2026 at 11:44 AM, Staff B, Director of Nursing Services, stated that they expected Resident 3 to have received their pneumococcal vaccination per CDC guidelines. Reference: (WAC) 388-97-1340(2).