STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505500	A. Building B. Wing	01/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellevue Post Acute	2424 156th Avenue Northeast Bellevue, WA 98007

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to provide appropriate infection surveillance for 5 of 6 months (July 2025, August 2025, September 2025, October 2025 & November 2025), reviewed for infection control. Additionally, the facility failed to ensure proper sanitization of vital sign (measurements of the body's essential functions) equipment were conducted by 1 of 2 staff (Staff Y), reviewed for medical equipment use, and failed to clean insulin (a medication that helps regulate blood sugar levels) pens (device used to inject insulin) prior to administration for 1 of 1 resident (Resident 4), reviewed for insulin administration. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.CLEANING OF INSULIN PENSRESIDENT 4Review of the manufacturer's recommendations titled, Insulin Aspart (rapid-acting insulin) Injection, revised in February 2023, showed, Pull of the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from a disposable needle. Screw the needle tightly onto your FlexPen [brand of pre-filled insulin pen]. Review of the manufacturer's recommendations titled, How to Use Your Lantus (or Glargine - long-acting insulin) Solostar Pen [brand of pre-filled insulin pen], dated August 2022, showed, Remove the pen cap with clean hands.Wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Observation on 01/09/2026 at 8:04 AM showed Staff I, Registered Nurse, was preparing Resident 4's insulin pens. Staff I removed the cap from Resident 4's insulin aspart pen and placed a new pen needle in. Staff I, then removed the cap from Resident 4's insulin glargine pen and placed a new pen needle in. Staff I did not clean Resident 4's insulin aspart and insulin glargine pen rubber seal with alcohol pads before placing the new needles onto the insulin pens. Staff I administered both aspart and glargine insulins to Resident 4. In an interview on 01/09/2026 at 9:33 AM, Staff I stated they would clean the insulin pen rubber seal before placing the new needles in. Staff I stated they should have cleaned [wiped] Resident 4's insulin pens' rubber seals with alcohol swabs before connecting the pen needles. A joint record review and interview on 01/10/2026 at 1:43 PM with Staff C, Charge Nurse, showed the manufacturer's recommendations for both, insulin aspart and insulin glargine pen, showed an instruction to wipe the [insulin pen] rubber stopper/seal with alcohol swab before placing/screwing a new needle onto the insulin pens. Staff C stated that the facility would follow the manufacturer's recommendations. Staff C further stated that staff [Staff I] should have wiped Resident 4's insulin pens' rubber seals with alcohol swab before connecting the pen needles. In an interview on 01/10/2026 at 2:08 PM, Staff B stated they expected insulin pens' rubber seals to be wiped with alcohol swab before placing new needles in. Staff B further stated that staff [Staff I] (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should have wiped Resident 4's insulin pens' rubber seals with alcohol swabs before connecting new pen needles. Reference: (WAC) 388-97- 1320 (1)(a)(5)(c). Findings included. INFECTION SURVEILLANCEReview of the facility's policy titled, Infection Prevention and Control Program, revised in October 2018, showed that Surveillance tools are used for recognizing the occurrence of infections, recording their number, and frequency, detecting outbreaks and epidemics [the rapid, unexpected spread of a disease].and detecting unusual pathogens [an agent that can cause disease] with infection control implications. It further showed that Data gathered during surveillance is used to oversee infections and spot trends. Review of July 2025 through December 2025 infection line listing (a template for data collection and tracking of infections) showed no documentation of infections from July 2025 through November 2025. Review of a nursing progress note, dated 07/03/2025, showed Resident 78's chest x-ray (a type of medical imaging that takes pictures inside the body) results were given to the physician, and antibiotic orders were ordered for pneumonia (lung infection). Review of Resident 64's laboratory results report, dated 07/30/2025, showed Resident 64 was positive for Klebsiella pneumoniae (a bacteria that can cause serious infections). In an interview on 01/09/2026 at 1:48 PM, Staff B, Director of Nursing, stated that they did not have a surveillance plan for identifying, tracking, or monitoring infections prior to December 2025, but we do now. When asked if there had been any infections in the facility from July 2025 through November 2025, Staff B stated, of course. When asked if those infections should have been on the infection line listing, Staff B stated, yes, absolutely. SANITIZATION OF MEDICAL EQUIPMENTSTAFF YObservation on 01/08/2026 at 8:55 AM showed Staff Y, Certified Nursing Assistant, took the vital signs for Resident 11. Then, Staff Y took the vital sign equipment into Resident 67's room and took their vital signs. Staff Y then took the vital sign equipment into the lounge and took Resident 57 and Resident 21's vital signs. Staff Y took the vital sign equipment into the hallway and took Resident 32's vital signs. Staff Y did not sanitize/disinfect the vital sign equipment between resident use. In an interview on 01/08/2026 at 9:12 AM, Staff Y stated that they were supposed to be [sanitizing the vital sign equipment] between residents. Staff Y further stated that they had not sanitized the vital sign equipment between residents and stated, it was my mistake. In an interview on 01/09/2026 at 1:48 PM, Staff B stated they expected staff to sanitize vital sign equipment before and after use on residents.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to designate a qualified staff person to serve as an Infection Preventionist (IP) to oversee the facility's infection prevention and control program. This failure placed the residents, staff, and visitors at risk for unmet infection control issues and lack of oversite of infection control practices.Findings included.Review of the facility's policy titled, Infection Prevention and Control Program, revised in October 2018, showed that The infection prevention and control program is coordinated and overseen by an infection prevention specialist (infection preventionist), or designee.In an interview on 01/05/2026 at 9:03 AM, Staff A, Administrator, stated that the facility did not currently have an IP and that Staff B, Director of Nursing, was responsible and was not certified.In an interview on 01/09/2026 at 1:48 PM, Staff B stated that they were responsible for the facility's infection prevention and control program. Staff B stated that they did not have specialized training in infection prevention and control and were not certified. Staff B further stated that absolutely, the facility should have a qualified IP.In an interview on 01/10/2026 at 1:54 PM, Staff A stated that there should have been a certified IP responsible for the facility's infection prevention and control program.Reference: (WAC) 388-97-1620 (2)(b)(i)(ii).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to provide a homelike environment when residents were served their meals on trays for 1 of 1 dining room (First Floor Dining Room), reviewed for dining observations. This failure placed the residents at risk for a less than homelike environment and a diminished quality of life.Findings included .Review of the facility's policy titled, Homelike Environment, revised in February 2021, showed, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The policy further showed, The facility staff and management minimizes, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting.Observation of the First Floor Dining Room on 01/05/2026 at 11:50 AM, showed Staff V, Certified Nursing Assistant (CNA), took a tray from a metal cart and served it to Resident 78. Staff V removed the cover from the plate and left the tray on the table. Staff U, CNA, took a tray from a metal cart, served it to Resident 11 and left the tray on the table. Staff U took another tray from a metal cart, served it to Resident 64 and left the tray on the table. Staff V and Staff U did not offer the residents if they would like their tray removed from the table. Staff V and Staff U went on to serve other residents their tray in the dining room, and they did not remove their tray or offer the residents if they would like their tray removed from the table. In another observation of the First Floor Dining Room on 01/05/2026 at 12:05 PM, showed Residents 36, 57, 64, 78, 21, 43, 80, 39, 11, 67, 30, 44, 41, and 59 were eating their meal on a tray. Observation of the First Floor Dining Room on 01/07/2026 at 12:15 PM, showed that Residents 13, 8, 57, 64, 18, 10, 21, 43, 80, 39, 11, 68, 67, 30, 41, 32, 44, and 59 were eating their meal on a tray. On 01/07/2026 at 12:40 PM, Resident 13 was asked if they liked having the tray with their meal, Resident 13 stated it bothered them, that it's [it is] in the way and that it was a disturbance. Resident 13 further stated that staff did not offer to remove the tray and that staff served their meal on a tray for every meal and that everyone on the table has one. In an interview and joint observation on 01/07/2026 at 12:42 PM, Staff U stated that they would serve residents' their meals in the tray in the dining room. Staff U stated that some residents would request it to be removed and that if residents did not like their meals on the tray, they would remove it. Joint observation showed that the residents that were remaining in the dining room were eating their lunch from the tray. Staff U stated that they did not offer to remove their meal from the tray.In an interview on 01/09/2026 at 11:56 AM, Staff C, Charge Nurse, stated that staff would leave the tray when the residents were served their meals in the dining room. In a follow-up interview at 1:45 PM, Staff C stated that they expected staff to remove the tray when serving residents their meals in the dining room. In an interview on 01/10/2026 at 9:11 AM, Staff A, Administrator, stated that they expected the residents to be able to eat safely in the dining room and to make it as homelike as reasonable. Reference: (WAC) 388-97-0880 (1).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the menu/meal tickets were followed for 3 of 8 residents (Residents 35, 27 & 32), reviewed for food services. This failure placed the residents at risk for unmet nutritional needs, potential negative outcomes and a diminished quality of life. Findings included . Review of the facility's policy titled, Food and Nutrition Services, revised in October 2017, showed, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. The policy further showed, If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager so that a new food tray can be issued. RESIDENT 35On 01/06/2026 at 9:33 AM, Resident 35 stated that the dietary staff did not follow their menu/meal ticket. Resident 35 stated that they were supposed to get fruit but didn't [did not] get any. On 01/08/2026 at 8:31 AM, Resident 35 stated that they did not get what was on their menu/meal ticket. Resident 35 stated, I didn't get a fruit cup. Review of Resident 35's menu/meal ticket showed a mixed fruit cup. Observation of their breakfast tray did not have a mixed fruit cup and that they had a plate of half of a banana. In a joint observation and interview on 01/08/2026 at 8:43 AM with Staff M, Certified Nursing Assistant (CNA), showed a mixed fruit cup on Resident 35's menu/meal ticket. A joint observation of Resident 35's breakfast tray did not show a mixed fruit cup and that they had a plate of half of a banana. Staff M stated that the plate of half of a banana was not a fruit cup. Staff M stated they have been having a lot of issues where residents were not receiving food items listed in their menu/meal ticket and that they had notified management about it. In an interview on 01/08/2026 at 9:26 AM, Staff D, Director of Food Services, stated that they had a few incidents where they had to change the menu. Staff D stated that if they were to change the menu, they would notify nursing staff of the change and that nursing staff would notify the residents of the change. When Staff D was informed that residents did not receive a mixed fruit cup for breakfast as stated in their menu/meal ticket and that they received a plate of half of a banana, Staff D stated that they did not notify nursing staff about the change and that they should have. In an interview on 01/10/2026 at 8:59 AM, Staff A, Administrator, stated that they expected dietary staff to follow the menu and expected the residents to receive the food items listed on their menu/meal ticket. RESIDENT 27On 01/06/2026 at 11:19 AM, Resident 27 stated that what is served isn't [is not] always what is on the menu. Observation on 01/08/2026 at 8:24 AM, showed Resident 27 was served half of a banana with their breakfast meal. The menu/meal ticket that came with the meal tray showed that the resident would receive a mixed fruit cup. It further showed that there was no mixed fruit cup on the tray. Resident 27 stated, they're [they are] giving subs [substitutes]. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT 32In a joint observation and interview on 01/08/2026 at 8:39 AM with Staff W, CNA, showed Resident 32 had half of a banana on their tray. It further showed that the menu/meal ticket showed mixed fruit cup and not a banana. Staff W stated that it's [it is] not a mixed fruit cup, it's a banana and it's probably a miscommunication with the kitchen. In an interview on 01/09/2026 at 11:27 AM, Staff X, CNA, stated that the menu and what the residents received matched 80% [percent] of the time and we don't know [if the menu changed] until it [the meal tray] shows up. In an interview on 01/09/2026 at 1:25 PM, Staff D stated that if there was a change in the menu, they let nursing know, so they will tell them [residents], they spread the word. Staff D stated that the menu/meal ticket should match what a resident received. When asked about yesterday's (01/08/2026) menu that showed mixed fruit cup and a banana was served instead, Staff D stated we went with the banana, since they were going bad. I forgot to let nursing know. In an interview on 01/10/2026 at 1:54 PM, Staff A stated they expected the menu/meal ticket to be followed. Staff A further stated that they expected that the menu/meal ticket would match what the residents received on their meal trays. Reference: (WAC) 388-97-1180 (1)(3) .

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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 foods were handled appropriately in accordance with professional standards of food safety for 1 of 6 Staff (Staff D), 1 of 1 Dry Storage Room, and 2 of 4 Refrigerators (Kitchen Walk-in Refrigerator & First Floor Food Refrigerator), reviewed for food services. The failure to perform hand hygiene, label and discard food items past the use by/best by date, placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life.Findings included. Review of the facility's policy titled, Preventing Foodborne Illness – Food Handling, revised in July 2014, showed, Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. Review of the facility's policy titled, Food Receiving and Storage, revised in November 2022, showed, Dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). The policy showed, All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date). The policy further showed, Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in August 2019, showed, This facility considers hand hygiene the primary means to prevent the spread of infections. The policy showed to use an alcohol-based hand rub containing at least 62 percent alcohol; or, alternatively, soap and water for the following situations: before donning (put on) sterile gloves, after removing gloves, before and after eating or handling food. The policy further showed, The use of gloves does not replace hand washing/hand hygiene. HAND HYGIENE Observation on 01/08/2026 at 12:28 PM, showed Staff D, Director of Food Services, entered the kitchen from the dining room and went to their office to answer the phone. When they were done, Staff D went inside the walk-in refrigerator. At 12:30 PM, Staff D came out of the walk-in refrigerator with a bowl, then walked over to the preparation station with the bowl and applied gloves. When Staff D was done in the preparation station, they removed their gloves and gave the bowl to an unknown person that was by the exit door to the dining room. Staff D did not perform hand hygiene when they entered the kitchen, before applying their gloves and after removing their used gloves. In an interview on 01/08/2026 at 12:47 PM, Staff D stated that staff were to perform hand hygiene before/after glove use, after they took the trash out, and before/after entering the kitchen. Staff D stated they were making pureed bread for a resident. Staff D further that they should have performed hand hygiene before they entered the kitchen and before/after glove use. In an interview on 01/09/2026 at 1:25 PM, Staff B, Director of Nursing, stated that they expected dietary staff to perform hand hygiene before/after entering the kitchen, and before/after glove use. DRY STORAGE ROOMObservation of the Dry Storage Room on 01/05/2026 at 8:15 AM, showed the following:-One opened container of vanilla extract with no opened date or used by/expiration date. -One unlabeled plastic bag of croutons with no open or use by date. -One opened container of Kikkoman (brand) Sweet and Sour Sauce with a best by date of 09/26/2025. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint observation on 01/05/2026 at 8:35 AM, Staff L, Cook, stated that food items that were past the use by or best by date would be thrown away. Staff L stated that everything that had been opened needed to have an open date and that they would ask Staff D how long it would be good for. A joint observation of the Dry Storage Room showed one opened container of vanilla extract with no opened date and used by/expiration date. Staff L stated that the container did not have an open date and that they could not find an expiration date. Staff L further stated that it should have had an open date. A joint observation showed one unlabeled plastic bag of croutons with no open or use by date. Staff L stated that after a food item was taken out of the original packaging it had to be labeled with the name of the ingredient, the open and use by date. Staff L stated that it should have been labeled and dated once it was opened. A joint observation showed one opened container of Kikkoman Sweet and Sour Sauce with a best by date of 09/26/2025. Staff L stated that it should have been discarded. WALK-IN REFRIGERATORIn a joint observation and interview on 01/05/2026 at 8:39 AM with Staff L, showed the Walk-in Refrigerator had a container of Sweet Baby Rays [brand] Korean Barbeque and Wing Sauce with a best by date of 11/27/2025 and one plastic bag labeled Peperoni [Pepperoni] with a use by date of 12/31/2025. Staff L stated that they should have been discarded. In a follow-up observation on 01/08/2026 at 9:05 AM, the Walk-in Refrigerator had the following:-One plastic container labeled cranberry sauce with a preparation date of 12/13 [12/13/2025] and without use by date. -One container of dill pickles dated 07/01 [07/01/2025] and without a use by/expiration date.-Three unlabeled and uncovered round pizza doughs on a sheet pan.-One unlabeled and uncovered raw chicken on a sheet pan. In an interview and joint observation on 01/08/2026 at 9:15 AM, Staff D stated that large containers were good for 30 days once they were opened. A joint observation showed an opened container of pickles dated 07/01 [07/01/2025]. Staff D stated that it should have been discarded. A joint observation showed one plastic container labeled cranberry sauce with a preparation date of 12/13 [12/13/2025] and without a use by date. Staff D stated it was good for seven days and that it should have been discarded. A joint observation showed three unlabeled and uncovered round pizza dough and one unlabeled and uncovered raw chicken on a sheet pan. Staff D stated that the pizza dough and raw chicken should have been covered and labeled when it was pulled [out of the freezer]. In an interview on 01/10/2026 at 9:04 AM, Staff A, Administrator, stated that if food items were past the use by/expiration date, they expected staff to throw it away. Staff A stated that food items should be labeled and dated. Staff A further stated that they expected staff to perform hand hygiene as required and to follow their hand hygiene protocol. FIRST FLOOR FOOD REFRIGERATORA joint observation and interview on 01/08/2026 at 3:41 PM with Staff C, Charge Nurse, showed the First-Floor Food Refrigerator had six unopened half pints of 2% (percent) milk cartons with best by date of 01/06 [01/06/2026]. Staff C stated that they needed to clarify with the kitchen staff to see if the milk could be given to residents after 01/06/2026. In an interview on 01/08/2026 at 3:45 PM, Staff D stated that the six milk cartons with best by date of 01/06/2026 should have been used by 01/06/2026 or should have been discarded on 01/07/2026. In an interview on 01/10/2026 at 1:05 PM, Staff A stated they expected foods to be stored as regulation requires. Staff A further stated that the milk cartons with best by date of 01/06/2026 in the refrigerator should not be used past 01/06/2026 and that they should have been removed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reference: (WAC) 388-97-1100 (3).

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to maintain a Quality Assessment and Assurance (QAA) committee that included the Infection Preventionist (IP), to conduct required Quality Assurance and Performance Improvement (QAPI) and QAA activities. This failure minimized the effectiveness of the interdisciplinary QAA team's ability to identify processes and outcomes related to infection control practices and disease management.Findings included .Review of the document provided by the facility on 01/05/2026 titled, QAA Committee Information, showed the committee met on a weekly basis in the facility conference room and consisted of the Administrator, Director of Nursing (DON), Medical Director, Social Services Director, Case Manager, Therapy Consultant, Charge Nurse, MDS (Minimum Data Set-an assessment tool) Director, Registered Dietitian, and Dietary Director. The document did not show that an IP was included in the QAA committee. Review of the facility's QAPI agenda/minutes dated 11/19/2025, showed a QAPI meeting was held. The minutes did not show that an IP attended the meeting. On 01/10/2026 at 10:05 AM, Staff B, DON, stated that there had not been an IP at their facility and had recently just hired one within the last three days. Staff B stated that they would have expected an IP to be a part of their QAA committee. On 01/10/2026 at 11:26 AM, Staff A, Administrator, stated that an IP was a required QAA committee member and that they did not have one prior and would have expected to have one.Reference: (WAC) 388-97-1620(2)(b)(i).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to consistently follow an established Antibiotic (antimicrobial substance/medication to treat/prevent infections) Stewardship Program (to promote the appropriate use of antibiotics) and complete monthly surveillance for 5 of 6 months (July 2025, August 2025, September 2025, October 2025 & November 2025), reviewed for antibiotic stewardship program. In addition, the facility failed to ensure appropriate antibiotic use were followed for 1 of 4 residents (Resident 3), reviewed for unnecessary medication. These failures placed residents at risk for potential adverse outcomes associated with inappropriate/unnecessary use of antibiotics and an increased risk for multi-drug-resistant organisms (microscopic organisms that are resistant to many antibiotics).Findings included. MONTHLY SURVEILLANCEReview of the facility's policy titled, Antibiotic Stewardship, revised in December 2016, showed, The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. Review of the facility's policy titled, Infection Prevention and Control Program, revised in October 2018, showed that Antibiotic usage is evaluated and practitioners are provided feedback on [antibiotic usage] reviews. Review of July 2025 through December 2025 infection line listing (a template for data collection and tracking of infections) showed no documentation of infections or antibiotic use from July 2025 through November 2025. Review of a nursing progress note dated 07/03/2025, showed that Resident 78 was started on Augmentin (antibiotic) and Doxycycline (antibiotic) for Klebsiella pneumoniae (a bacteria that can cause serious infections). Review of a nursing progress note dated 07/29/2025, showed that Resident 64 was started on Macrobid [antibiotic] for UTI [Urinary Tract Infection-infection of the bladder]. Review of a nursing progress note dated 11/17/2025, showed that Resident 68's urine analysis or lab [laboratory-a facility where tests are conducted on specimens to obtain information about a resident's health, aiding diagnosis, treatment and prevention of a disease] result came back and Augmentin was ordered. In an interview on 01/09/2026 at 1:48 PM, Staff B, Director of Nursing, stated that the facility had not been formally tracking antibiotic use before December [2025]. When asked if there had been any residents on antibiotics from July 2025 through December 2025, Staff B stated, absolutely. When asked if those antibiotics had been tracked, Staff B stated, from July [2025] to December [2025], I can't [cannot] speak to that, now it will be on the [infection] line listing. Staff B further stated that antibiotic use had not been reviewed/discussed at the facility's QAPI (Quality Assurance Performance Improvement) meetings, it wasn't [was not] one of our focuses. RESIDENT 3Review of the facility's policy titled, Antibiotic Stewardship – Orders for Antibiotics, revised in December 2016, showed, When a culture and sensitivity (C&S [a lab procedure used to identify specific microorganisms, such as bacteria or fungi, that cause an infection and determine which medications will be most effective for treatment]) is ordered, it will be completed, and: Lab results and the current clinical situation will be communicated to the prescriber as soon as (continued on next page)

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	505500	A. Building B. Wing	01/10/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	available to determine if antibiotic therapy should be started, continued, modified, or discontinued. Review of Resident 3's physician orders printed on 01/09/2025 showed the following orders:-Urinalysis (urine test), C&S if indicated. STAT [immediately] for hematuria [blood in the urine], possible for UTI with an order date of 12/31/2025.-Bactrim DS (antibiotic) oral tablet. Give 1 tablet by mouth two times a day for UTI for seven days with an order date of 01/05/2026. Review of Resident 3's urinalysis lab results report dated 01/01/2026 did not show C&S results or documentation that the results were pending. In an interview and joint record review on 01/09/2026 at 8:12 AM, Staff K, Registered Nurse, stated that Resident 3 was started on an antibiotic due to confusion and hematuria. A joint record review of Resident 3's urinalysis lab results dated 01/01/2026 did not show the C&S results or documentation that the results were pending. Staff K stated that they did not see it and that the results may be pending. Staff K further stated that sometimes the physician would start an antibiotic and would review it when they received the C&S results. In a joint record review and interview on 01/09/2026 at 8:39 AM with Staff C, Charge Nurse, showed a physician order for urinalysis with C&S if indicated on 12/31/2025. A joint record review of Resident 3's urinalysis lab results dated 01/01/2026 did not show C&S results or documentation that the results were pending. Staff C stated they did not know what happened and would call the lab and clarify. When asked if residents were started on antibiotics prior to getting the C&S results, Staff C stated, Sometimes, yes and that it depended on the resident's condition. Staff C further stated that when they received the C&S results, the physician would review it and would make changes to the residents' antibiotics as needed. In an interview on 01/09/2026 at 11:24 AM, Staff P, Medical Director, stated that if a resident had symptoms of UTI, they would start with a urinalysis C&S if indicated and that they would not start treatment without it. Staff P stated that C&S took 48 to 72 hours to complete. They would start a broad-spectrum antibiotic and then based on the C&S results, they would review it and see if the resident needed to start a new treatment or if the treatment needed to be changed. Staff P stated that if the urinalysis was positive for infection, they would have expected C&S to have been completed. Staff P further stated that they were waiting for Resident 3's C&S result, stating, It didn't [did not] show up and that it should have been completed. In an interview on 01/09/2026 at 1:35 PM, Staff B stated that they expected urinalysis C&S to be completed if it was indicated. Staff B stated that they should get the C&S result back within 72 hours and that if they did not get the results back within 72 hours, staff should call the lab. Staff B further stated that Resident 3's urinalysis C&S should have been completed. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) had the required 12 hours of training, and/or include abuse/neglect, and dementia (memory loss) management training annually for 3 of 6 staff (Staff M, S & T), reviewed for sufficient and competent nurse staffing. This failure placed the residents at risk for unmet care needs and potential negative outcomes.Findings included.Review of the facility's assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents), updated on 10/14/2025, showed, Required in-service training for nurse aides. In service training must: Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. Include dementia management training and resident abuse prevention training.STAFF MReview of the undated facility's employee record for Staff M, CNA, showed they were hired on 06/19/2023. It further showed no documentation that Staff M received the required 12 hours of annual training.STAFF SReview of the undated facility's employee record for Staff S, CNA, showed they were hired on 11/20/2024. It further showed no documentation that Staff S received the required 12 hours of annual training, including abuse and neglect, and dementia management training.STAFF TReview of the undated facility's employee record for Staff T, CNA, showed they were hired on 07/20/2023. It further showed no documentation that Staff T received the required 12 hours of annual training, including abuse and neglect, and dementia management training.In an interview and joint record review on 01/09/2026 at 3:48 PM, Staff E, Staffing Coordinator, stated that CNAs needed 12 hours of training annually that included abuse/neglect and dementia training. A joint record review of Staff M's employee record showed they received 6.25 hours of training. A joint record review of Staff S's employee record showed they received 5.15 hours of training and did not include abuse/neglect and dementia training. A joint record review of Staff T's employee record showed they received 7.35 hours of training and did not include abuse/neglect and dementia training. Staff E stated Staff M, Staff S, and Staff T did not have 12 hours of annual training as required and that Staff S and Staff T did not have abuse/neglect and dementia training and that they should have.On 01/10/2026 at 9:56 AM, Staff B, Director of Nursing, stated they would expect CNAs to have 12 hours of training annually and would expect to include abuse/neglect and dementia training upon hire. Staff B further stated that Staff M, Staff S, and Staff T should have had 12 hours of training and may have received it prior to their administration and would say it would be doubtful to provide those things.Reference: (WAC) 388-97-1680(2)(a)-(c).

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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 issue a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) before the Medicare (federal health insurance program) coverage ended for 1 of 3 residents (Resident 90), reviewed for beneficiary notification. This failure placed the resident and/or their representative at risk of not being fully informed and losing their right to an appeals process.Findings included.Review of the facility's policy titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised in September 2022, showed residents would be informed in advance when changes would occur to their bills. The policy further showed that if the director of admissions or benefits coordinator believed that Medicare would not pay for an otherwise covered skilled service, the resident or representative would be notified in writing why the service(s) may not be covered and the resident's potential liability for payment of the non-covered service(s).Review of the SNF Beneficiary Notification Review form received on 01/07/2026 showed Resident 90 received Medicare Part A (Medically necessary skilled nursing, therapy (physical, occupational, speech), and semi-private rooms for up to 100 days per benefit period) Skilled Services from 08/29/2025 to 10/27/2025. Further review of the document did not show that a SNF ABN was provided to Resident 90.Review of Resident 90's Electronic Health Record did not show documentation that a SNF ABN was provided to Resident 90 prior to their last covered day (10/27/2025).Review of Resident 90's progress note dated 11/02/2025, showed they discharged on 11/02/2025 from the facility back into the community.On 01/10/2026 at 10:37 AM, Staff F, Director of Social Services, stated a SNF ABN was given to residents when they were provided with a Medicare non-coverage notice. Staff F stated it was important to give residents a SNF ABN because it would give them information about their last covered date and their right to appeal. Staff F stated Resident 90's last covered date was 10/27/2025 and that they discharged on 11/02/2025. Staff F further stated that they did not provide Resident 90 a SNF ABN and that they should have.On 01/10/2026 at 11:30 AM, Staff A, Administrator, stated they would expect a SNF ABN notice to be given to a resident as required.Reference: (WAC) 388-97-0300(1)(e)(5).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to conduct a thorough investigation for 1 of 1 resident (Resident 45), reviewed for abuse investigations. This failure placed the resident at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions.Findings included .Review of the facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised in September 2024, showed all reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are thoroughly investigated. The policy showed any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The policy further showed the individual conducting the investigation at a minimum would interview the resident (as medically appropriate) or the resident's representative, staff members who had contact with the resident during the period of the alleged incident, and other residents to whom the accused employee provided care or services for.Review of Resident 45's admission Minimum Data Set (an assessment tool) dated 11/17/2025, showed they were cognitively intact.On 01/05/2026 at 12:19 PM, Resident 45 stated that they had received neglectful care when Staff N, Certified Nursing Assistant (CNA), had denied them a salad on one occasion and had left them soiled on more than one occasion and it made them feel bad.Review of Resident 45's investigation dated 01/07/2026, showed on 01/05/2026 at approximately 1:30 PM, the facility was informed by a. surveyor that [Resident 45] made an allegation that she was being neglected. She claims that it takes too long for call lights to be answered and that is neglectful. She also claims that she asked for a salad at one point in time and the CNA [Staff N] wouldn't [would not] get it for her. She claims that at night the male CNAs will come to check on her and just stand and her doorway and not come in to help her at all. Further review of the investigation did not include the alleged staff or other residents' interviews.On 01/09/2026 at 1:19 PM, Staff N stated that Resident 45 had requested a turkey burger and not a salad and that the kitchen did not have all the condiments for a turkey burger. Staff N stated that they tried to ask Resident 45 if they still wanted what was available and that Resident 45 and their representative told Staff N, they did not want them to care for Resident 45. Staff N further stated they were not aware of the allegations Resident 45 had made towards them and was not interviewed by facility staff regarding the allegations.On 01/10/2026 at 9:34 AM, Staff E, Staffing Coordinator, stated that denying a resident food or leaving the resident soiled could be potential allegations of abuse or neglect. Staff E stated that the allegations would need to be reported into the state, thoroughly investigated, and suspend the alleged staff until the allegation was investigated. Staff E stated they were not aware of the allegations Resident 45 made towards Staff N and that Staff N had not been suspended.In an interview and joint record review on 01/10/2026 at 10:08 AM, Staff B, Director of Nursing, stated they expected staff to follow their abuse/neglect policies and investigations to be thorough. Staff B stated they would expect the alleged staff to be interviewed and taken off the schedule until a determination was made. Staff B stated they would expect to interview other residents to give them the opportunity to report any issues. A joint record review of Resident 45's investigation dated 01/07/2026 did not show Staff N and/or other residents' interviews were included in the investigation. Staff B stated they should have interviewed Staff N and other residents that Staff N had cared for.On 01/10/2026 at 11:30 AM, Staff A, Administrator, stated they would expect staff to follow their abuse and neglect policies and expected an investigation to be complete and thorough. Staff A stated that they were primarily responsible for completing an investigation. When asked if the alleged staff was interviewed for Resident 45's investigation, Staff A stated that Resident 45 had not named Staff N as the alleged staff. Staff A stated that Resident 45 mentioned another name that started with the letter D and that they were not employed at the facility. When asked if that statement/interview from Resident 45 was included in the investigation to support that, Staff A stated no and that they should have included it. Reference: (WAC)388-97-0640(6)(a)(b).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to provide a written transfer/discharge notice as required for 2 of 3 residents (Residents 6 & 64), reviewed for hospitalization. This failure placed the residents at risk for lack of knowledge regarding their protection of resident rights during transfers, and a diminished quality of life.Findings included. Review of the facility's policy titled, Transfer or Discharge Notice, revised in March 2021, showed residents and/or representatives are notified in writing and in a language and format they understand, at least thirty days prior to a transfer or discharge. The policy showed under certain circumstances, the notice would be given as soon as practicable but before the transfer or discharge. The policy further showed the resident and representative would be notified in writing the specific reason, date, location for the transfer/discharge, an explanation of the resident's rights to appeal, and contact information for the Office of the State Long-term Care Ombudsman (an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations). RESIDENT 6Review of the nursing progress note dated 11/02/2025, showed Resident 6 was transferred to the hospital for a change in condition. Review of the discharge Minimum Data Set (an assessment tool) dated 11/02/2025, showed Resident 6 had an unplanned discharge to a Short-Term General Hospital. Review of Resident 6's Electronic Health Record (EHR- progress notes, miscellaneous tab) showed no documentation that a written notice of transfer/discharge was provided to Resident 6 and/or their representative. On 01/07/2026 at 1:59 PM, Staff F, Director of Social Services, stated that they recently downloaded the notice of transfer/discharge and caught that they had to provide them to all residents that transferred or discharged from the facility. Staff F stated there was no notice of transfer/discharge provided to Resident 6. On 01/10/2026 at 8:14 AM, Staff A, Administrator, stated they would expect a written notice of transfer/discharge to be given when it was required. RESIDENT 64Review of Resident 64's EHR (progress notes and miscellaneous tab from 01/05/2025 through 01/05/2026) showed Resident 64 was transferred to the hospital on [DATE] and did not show documentation that Resident 64 and/or their representative were provided with a written notice of transfer/discharge. In an interview and joint record review on 01/07/2026 at 1:57 PM, Staff F stated that their process had been to notify resident representatives with a phone call when a resident was transferred to the hospital and had not been providing a written notice of transfer/discharge. A joint record review of Resident 64's EHR showed no documentation that Resident 64 and/or their representative were provided with a written notice of transfer/discharge when they transferred to the hospital on [DATE]. Staff F stated, no, they [Resident 64] were not given that form. In an interview on 01/10/2026 at 1:54 PM, Staff A stated that a written notice of transfer/discharge (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have been provided to Resident 64 and/or their representative when they transferred to the hospital on [DATE]. Reference: (WAC) 388-97-0120 (2) (a-c) .

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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 1 resident (Resident 9), reviewed for significant change in condition. The failure to complete a 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 the Hospice SNF [Skilled Nursing Facility] Notification Form, dated 11/03/2025, showed Resident 9 started hospice services on 11/03/2025.Review of Resident 9's SCSA MDS dated [DATE] showed it was completed on 11/30/2025, 27 days after hospice election (13 days late).In an interview and joint record review on 01/10/2026 at 11:08 AM, Staff H, Regional MDS Consultant, stated they expected MDS assessment to be completed accurately and timely. A joint record review of the hospice notification form showed Resident 9 was admitted to hospice on 11/03/2025. Staff H stated that hospice admission date of 11/03/2025 was equivalent to the determination date. A joint record review of Resident 9's SCSA MDS dated [DATE] showed it was completed on 11/30/2025. A joint record review of the RAI manual MDS assessment summary showed that SCSA MDS should be completed 14 days after determination that significant change in resident's status occurred. Staff H stated that Resident 9's SCSA should have been completed 14 days after 11/03/2025, by 11/17/2025. Staff H further stated that Resident 9's assessment was completed late.In an interview on 01/10/2026 at 2:46 PM, Staff B, Director of Nursing, stated they expected MDS assessments to be completed timely and accurately. Staff B stated Resident 9'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 2 of 16 residents (Residents 9 & 19), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments were coded on the MDS regarding injections and prognosis (an estimate about whether a patient [resident] will recover from an illness) 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 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. Count the number of days that the resident received any type of injection while a resident of the nursing home. Record the number of days that any type of injection (e.g., subcutaneous [into the layer of fat just beneath the skin], intramuscular [into the muscle], or intradermal [into the middle layer of the skin]) was received in Item N0300. The RAI further showed that to answer item J1400 (Prognosis), Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? required physician documentation.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).Review of the facility's policy titled, Hospice (compassionate care provided to individuals who are in the final stages of a terminal illness) Program, revised in July 2017, showed that the facility would obtain a physician certification of terminal illness specific to the resident from the hospice provider.INJECTIONSRESIDENT 9Review of Resident 9's admission MDS dated [DATE] showed, 1 [one] injection (N0300) was marked in Section N (Medications).Review of the October 2025 Medication Record Administration (MAR) showed Resident 9 received one tuberculin (a combination of proteins that are used in the diagnosis of tuberculosis [TB- a bacterial infection that mainly affects the lungs]) intradermal injection on 10/22/2025 and one influenza vaccine (or flu - used to prevent influenza [an infection of the nose, throat, and lungs]) intramuscular injection on 10/23/2025, a total of two injections during the look back period (10/21/2025 to 10/27/2025).In an interview and joint record review on 01/09/2026 at 3:48 PM, Staff G, MDS Coordinator, stated they followed the RAI manual for completion of MDS assessments. Staff G stated that intradermal and intramuscular injections were counted in item N0300 (Injections). A joint record review of Resident 9's admission MDS showed N0300 was marked for one injection. Staff G stated that Resident 9 received one injection. A joint record review of the October 2025 MAR showed Resident 9 received one tuberculin injection and one flu vaccine injection. Staff G stated Resident 9 received two injections and that their MDS was inaccurate.RESIDENT 19Review of Resident 19's admission MDS dated [DATE] showed, 0 [zero] injection (N0300) was marked in Section N.Review of the October 2025 MAR showed Resident 19 received one tuberculin intradermal injection on 10/28/2025 during the look back period (10/27/2025 to 11/02/2025).A joint record review and interview on 01/09/2026 at 3:50 PM with Staff G, showed Resident 19's admission MDS was marked 0 [zero] injections in N0300 and a record review of Resident 19's October 2025 MAR showed they received one injection during the look back period. Staff G stated Resident 19 received one tuberculin injection and that their MDS was inaccurate.PROGNOSISRESIDENT 9Review of the Hospice SNF [Skilled Nursing Facility] Notification (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Form, dated 11/03/2025, showed Resident 9 started hospice services on 11/03/2025.Review of the electronic health records (progress notes and miscellaneous/documents tab from 10/21/2025 to 01/06/2026) had no documentation to show that Resident 9 had a doctor's note and/or a certification of terminal illness indicating that Resident 9 had a life expectancy of less than six months.Review of the SCSA MDS dated [DATE] showed that J1400 (Prognosis) was marked 1 [yes] indicating that Resident 9 had a condition or chronic disease that may result in a life expectancy of less than six months.In an interview and joint record review on 01/09/2026 at 3:55 PM, Staff G stated that to mark that on the MDS, a resident would have had a prognosis of life expectancy of less than six months, and it required physician's documentation or hospice certification. A joint record review of Resident 9's SCSA MDS showed it was marked 1 [yes] in J1400. Staff G stated that Resident 9 started hospice services on 11/03/2025. A joint record review of Resident 9's progress notes and miscellaneous tab showed no documentation indicating that Resident 9 had a life expectancy of less than six months. Staff G stated they were going to look for Resident 9's hospice certificate.In an interview and record review on 01/10/2026 at 11:08 AM, Staff H, Regional MDS Consultant, stated that item J1400 would be coded 1 [Yes], after verifying that there was a physician's documentation showing that the resident had a life expectancy of less than six months. A joint record review of Resident 9's SCSA MDS showed item J1400 was marked 1 [yes]. Staff H stated that item J1400 would be marked 0 [No] if there was no documentation to show that a resident had a prognosis of less than six months to live during the look back period.In an interview on 01/10/2026 at 2:46 PM, Staff B, Director of Nursing, stated they expected MDS to be completed accurately and timely. Staff B stated that Resident 9 did not have a certification of terminal illness during the look back period. Staff B stated that Staff A, Administrator, obtained Resident 9's certificate of terminal illness today (01/10/2026), just got it today. Staff B further stated that Resident 9's and Resident 19's MDS should have been completed accurately.Reference: (WAC) 388-97-1000 (1)(b).

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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 Level II (or Level 2) 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) referral was made for 1 of 5 residents (Resident 19), reviewed for PASRR screening. This failure placed the resident at risk for unmet care needs and a diminished quality of life.Findings included.Review of the facility's policy titled, admission Criteria, revised in March 2019, showed, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The facility conducts a Level I [or Level 1] PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.Review of a Level 1 PASRR form, revised in June 2025, showed, Exempted Hospital discharge: .a person may be admitted to a NF [nursing facility] directly from a hospital after receiving acute inpatient care at the hospital; the NF admission is to treat the condition for which the person was hospitalized ; and the person's attending physician, ARNP [Advanced Registered Nurse Practitioner], or physician's assistant certifies that the person requires fewer than 30 days of nursing facility services.Review of a progress note dated 10/27/2025 showed Resident 19 was admitted to the facility on [DATE].Review of the diagnoses sheet printed on 01/07/2026 showed Resident 19 had diagnoses that included psychosis (loss of contact with reality) and anxiety (having excessive/persistent worry and fear).Review of Resident 19's Level 1 PASRR dated 10/21/2025 showed that Section IA (SMI Indicators) was marked for mood disorders (conditions that significantly impact a person's emotional state, leading to prolonged periods of extreme sadness, hopelessness, or irritability) and anxiety. Further review showed that Section IV (Service Needs and Assessor Data), was marked, No level 2 evaluation indicated at this time due to exempted hospital discharge: Level 2 must be completed if scheduled discharge does not occur [after 30 days from admission].Review of the electronic health records (progress notes and miscellaneous/documents tab from 10/27/2025 through 01/09/2026) showed Resident 19 had no new Level 1 PASRR completed after 30 days of admission and that no Level 1 PASSR was sent to the PASRR Coordinator.In an interview and joint record review on 01/09/2026 at 4:41 PM, Staff F, Director of Social Services, stated that Level 1 PASRR forms marked as exempted hospital discharge were for residents who were expected to be in the facility for less than 30 days. Staff F stated that their process was to send the exempted Level 1 PASRR form to the PASRR Coordinator on day 31 from admission. A joint record review of the Level 1 PASRR form dated 10/21/2025, showed that Resident 19 had SMIs and it was marked that Level 2 evaluation was not indicated due to exempted hospital discharge. Staff F stated that Resident 19's Level 1 PASRR form should have been sent to the PASRR Coordinator after the 30th day, on 11/28/2025 or 11/29/2025.In an interview on 01/10/2026 at 1:05 PM, Staff A, Administrator, stated that residents who admitted with hospital exemption Level 1 PASRR that had not discharged by day 30, would have a new Level 1 PASRR completed and sent to the PASRR Coordinator on day 31. Staff A stated that Resident 19's Level 1 PASRR should have been sent to the PASRR Coordinator after 30 days of admission.Reference: (WAC) 388-97-1915 (1)(2) (a-c).

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has 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 notify the State Pre-admission Screening and Resident Review (PASARR or PASRR-an assessment used to identify people [residents] referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities, or related conditions are not inappropriately placed in nursing facilities for long term care) Coordinator after a significant change in status occurred for 1 of 1 resident (Resident 9), reviewed for PASRR screening. This failure placed the resident at risk for unmet care needs and a diminished quality of life.Findings included.Review of the facility's policy titled, admission Criteria, revised in March 2019, showed, All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The facility conducts a Level I [or Level 1] PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II [or Level 2] (evaluation and determination) screening process. The social worker is responsible for making referrals to the appropriate state-designated authority.Review of a face sheet printed on 01/06/2026 showed Resident 9 was admitted to the facility on [DATE].Review of the Hospice [compassionate care provided to individuals who are in the final stages of a terminal illness] SNF [Skilled Nursing Facility] Notification Form, dated 11/03/2025, showed Resident 9 started hospice services on 11/03/2025.Review of Resident 9's Level 1 PASRR dated 11/07/2025 showed it was completed due to significant change on 11/03/2025. The Level 1 PASRR Section IA (SMI Indicators) was marked yes for mood disorders. Further review showed, Level 2 evaluation referral required for significant change.Review of the electronic health records (progress notes and miscellaneous/documents tab from 10/21/2025 through 01/07/2026) showed no documentation that Resident 9's Level 1 PASRR form dated 11/07/2025 was sent to the PASRR Coordinator.In an interview and joint record review on 01/09/2026 at 4:32 PM, Staff F, Director of Social Services, stated that Level 1 PASRR forms were completed when residents were admitted to hospice services and then sent to the PASRR Coordinator for Level 2 evaluation. A joint record review of Resident 9's Level 1 PASRR dated 11/07/2025 showed a hospice admission of 11/03/2025 with SMI of mood disorders and it was marked for level 2 evaluation referral for significant change. Staff F stated that Resident 9 was admitted to hospice services and that a new Level 1 PASRR was completed. Staff F further stated that Resident 9's Level 1 PASRR was sent to the PASRR Coordinator on 01/05/2026 and that it should have been sent after it was completed on 11/07/2025.In an interview on 01/10/2026 at 1:05 PM, Staff A, Administrator, stated they expected Level 1 PASRR forms with Level 2 recommendations to be sent to the PASRR Coordinator timely after they were completed.Reference: (WAC) 388-97-1975 (7).

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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. Based on interview and record review, the facility failed to monitor a resident taking a diuretic (medication used to help remove extra fluid from the body) medication and failed to notify the provider of weight gain for 1 of 5 residents (Resident 5), reviewed for unnecessary medications. This failure placed the resident at risk for unrecognized weight gain, medical complications, and a diminished quality of life.Findings included.Review of a physician note dated 09/30/2025 showed that Resident 5 had diagnoses that included Chronic Heart Failure (CHF-a condition where the heart muscle cannot pump blood efficiently, causing fluid back up in the lungs).Review of Resident 5's physician orders printed on 01/06/2026, showed an order for furosemide (a diuretic medication) for fluid retention. It further showed an order to weigh the resident daily and to call the cardiologist [a doctor specializing in treating heart conditions] if the resident gained three pounds (lbs. -a unit of measurement) in 24 hours or five lbs. in a week.Review of Resident 5's CHF care plan, initiated on 05/08/2024, showed the intervention to monitor/document/report to MD [Medical Doctor] .changes in weight.Review of Resident 5's weights from 11/26/2025 through 01/05/2026 showed the following weights:-11/07/2025:139 lbs. and 11/08/2025:146.6 lbs. (7.6 lbs. weight gain in 24 hours)-11/28/2025:139.6 lbs. and 11/29/2025:144 lbs. (4.4 lbs. weight gain in 24 hours)-12/23/2025: 138.8 lbs. and 12/24/2025:145.4 lbs. (6.6 lbs. weight gain in 24 hours)-12/29/2025: 137 lbs. and 12/30/2025: 142.6 lbs. (5.6 lbs. weight gain in 24 hours)In an interview and joint record review on 01/10/2026 at 8:54 AM, Staff J, Registered Nurse, stated that they followed physician orders. A joint record review of Resident 5's physician orders showed an order to call the cardiologist if the resident gained three lbs. in 24 hours or five lbs. in a week. A joint record review of Resident 5's weights from 11/26/2025 through 01/05/2026 showed the above weights. Staff J stated that on 11/08/2025, 11/29/2025, 12/24/2025, and 12/30/2025, Resident 5 had more than a three lb. weight gain in 24 hours. Staff J stated that the cardiologist had not been notified when Resident 5 had more than a three lb. weight gain in a 24-hour period.In an interview and joint record review on 01/10/20206 at 9:19 AM, Staff C, Charge Nurse, stated that if there was physician order to notify a physician for weight gain then they expected staff to notify [the physician] .and document. A joint record review of Resident 5's physician orders showed an order to call the cardiologist if the resident gained three lbs. in 24 hours or five lbs. in a week. A joint review of Resident 5's weights from 11/26/2025 through 01/05/2026 showed the above weights. Staff C stated that on 11/08/2025, 11/29/2025, 12/24/2025, and 12/30/2025, Resident 5 had more than a three lb. weight gain in a 24-hour period. Staff C stated that they expected staff to reweigh the resident if there was a weight gain and I don't [do not] see here that it was done. Staff C further stated that the cardiologist had not been notified when Resident 5 had more than a three lb. weight gain in 24 hours.In an interview and joint record review on 01/10/2026 at 1:16 PM, Staff B, Director of Nursing, stated that staff should follow physician orders and if there was a question, they expected staff to get clarification. Staff B stated that they expected staff to monitor weights for residents on diuretic medications. A joint record review of Resident 5's physician orders showed an order to call the cardiologist if the resident gained three pounds lbs. in 24 hours or five lbs. in a week. Staff B stated that they expected staff to follow the order and call the cardiologist and alert our own doctor. Staff B further stated that it was important to monitor and notify the physician if there was a weight gain in a resident with CHF.Reference: (WAC) 388-97-1060 (1).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 6 residents (Resident 15), reviewed for unnecessary medications. The failure to administer medication in accordance with professional standards of practice placed the resident at risk for negative outcomes and a diminished quality of life.Findings included .Review of the facility's policy titled, Medication Labeling and Storage, revised in February 2023, showed, multi-dose vials that have been opened or accessed (e.g. [example], needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. The policy further showed, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.Review of the facility's policy titled, Administering Medications, revised in [DATE], showed, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.Review of the online manufacturer's recommendations titled, Insulin [medication that regulates sugar in the blood] Lispro Kwikpen [or Humalog (brand name) - a rapid-acting insulin pen (device used to inject insulin)], revised in [DATE], showed, Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen.Review of the facility's pharmacy document titled, Injectable [substance administered into the body using a needle and syringe] Diabetic [or diabetes - disease that results in too much sugar in the blood] Medications and Supplies - Expiration Date Reference List, revised in [DATE], showed that insulin Lispro (Humalog) expired 28 days after it was first opened.Review of Resident 15's [DATE] Medication Administration Record (MAR), showed an order for Insulin Lispro (Humalog) Solution 100 Unit/milliliter (unit of measurement) - Inject as per sliding scale: if 251 - 300 [Blood Sugar (BS - concentration of sugar in the blood)] = 2 units; 301 - 350 = 3 units; 351 - 400 = 4 units; 401 - 999 = 5 units Notify MD [Medical Doctor] BS > [more than] 401 OR < [less than] 80, [inject] subcutaneously [into the layer of fat just beneath the skin], before meals for diabetes. The MAR further showed Resident 15 received 2 units of insulin Lispro on [DATE] at 4:30 PM for BS of 290, 4 units on [DATE] at 7:30 AM for BS of 378, and 2 units on [DATE] at 11:30 AM for BS of 272.Review of Resident 15's insulin Lispro pharmacy label instructions with an open date of [DATE], showed, Store using directions provided. Throw away any medicine that remains 28 days after first use.A joint observation and interview on [DATE] at 4:09 PM with Staff C, Charge Nurse, showed Resident 15 had an insulin Lispro pen with an open date of [DATE]. A joint record review of Resident 15's insulin Lispro pharmacy label showed, Throw away any medicine that remains 28 days after first use. Staff C stated that Resident 15's insulin should have been discarded 28 days after it was first opened. Staff C further stated that Resident 15's insulin was good through [DATE] and that it should have been discarded after that date.A joint record review and interview on [DATE] at 4:46 PM with Staff C, showed the [DATE] MAR, indicated that Resident 15 received 2 units of insulin Lispro on [DATE] before dinner, 4 units on [DATE] before breakfast, and 2 units on [DATE] before lunch. Staff C stated that Resident 15 should not have been given insulin doses from the insulin Lispro pen opened on [DATE] after [DATE].In an interview on [DATE] at 11:57 AM, Staff O, Pharmacist Consultant, stated that insulin Lispro should be discarded 28 days after it was first opened. Staff O stated that the effectiveness of medications decreases after their recommended time of use or expiration date. Staff O further stated that the insulin Lispro opened on [DATE] should not be provided to a resident after the 28th day.In an interview and joint record review on [DATE] at 2:10 PM, Staff B, Director of Nursing, stated they expected medications to be discarded by their expiration date. A joint record review of the insulin pharmacy label and [DATE] MAR showed Resident 15's insulin Lispro pen pharmacy label had an open date of [DATE](continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and received insulin from the same insulin pen on [DATE] and [DATE]. Staff B stated that Resident 15 insulin Lispro should have been discarded after [DATE].Reference: (WAC) 388-97-1300 (1)(b)(i)(3)(a).

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Medication Regimen Review (MRR- a comprehensive assessment of resident's medications, performed by a pharmacist [a qualified professional to provide expert advice on medication management, safety, and regulatory compliance]) recommendations were completed accurately and in a timely manner for 2 of 6 residents (Residents 15 & 5), reviewed for unnecessary medications. These failures placed the residents at risk for experiencing adverse side effects, receiving unnecessary medications, medical complications, and a diminished quality of life.Findings included . Review of the facility's policy titled, Medication Regimen Review, revised on 03/02/2020, showed, Facility should encourage Physician/Prescriber or other Responsible Parties receiving the MRR and the Director of Nursing to act upon the recommendations contained in the MRR. The policy further showed, If an irregularity does not require urgent action but should be addressed before the consultant pharmacist's next monthly MRR, the facility staff and consultant pharmacist will confer on the timeliness of attending physician responses to identified irregularities based on specific resident's clinical condition. RESIDENT 15Review of a face sheet printed on 01/06/2026 showed that Resident 15 was admitted to the facility on [DATE] with diagnoses that included hypertension (high Blood Pressure (BP - measurement that shows how hard the heart is pumping to move blood through the body). Review of Resident 15's Pharmacist's Report to Nursing MRR recommendation performed between 11/17/2025 and 11/18/2025, showed, Review process for documentation of medication administration with staff. Add BP & Pulse [heartbeat] documentation on the MAR [Medication Administration Record] dated 11/18/2025. Further review showed that it was updated [completed recommendation] on 12/10/2025. Review of Resident 15's Recommendation Outcomes received between 12/15/2025 and 12/17/2025, showed, This resident must be assessed before administering the medication to ensure the parameters are met for administration. TEMP [Temperature] IS RECORDED RATHER THAN PULSE on the MAR. Amlodipine [medication to treat hypertension] is not likely to affect temp dated 11/18/2025. Further review showed that the order was updated on 01/07/2026 by Staff B, Director of Nursing. Review of Resident 15's December 2025 MAR showed an order for Amlodipine 10 milligrams (unit of measurement) give one tablet by mouth once a day for hypertension. Hold Systolic Blood Pressure (pressure produced when the heart contracts and pushes out blood) less than 100 or pulse less than 55 with an order date of 10/18/2025. Further review of the December 2025 MAR showed that blood pressure and temperature were documented and not the pulse. In an interview and joint record review on 01/09/2026 at 12:06 PM, Staff C, Charge Nurse, stated that they completed the MRR recommendations as soon as possible. A joint record review of Resident 15's Pharmacist's Report to Nursing MRR recommendation dated 11/18/2025 showed to Review process for documentation of medication administration with staff. Add BP & Pulse documentation on the MAR. Joint record review of Resident 15's December 2025 MAR showed that blood pressure and temperatures were documented and not the pulse. Staff C stated that they would have expected the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MRR recommendation to have been followed correctly. A joint record review of Resident 15's Recommendation Outcomes received between 12/15/2025 and 12/17/2025, showed, This resident must be assessed before administering the medication to ensure the parameters are met for administration. TEMP [Temperature] IS RECORDED RATHER THAN PULSE on the MAR. Amlodipine [medication to treat hypertension] is not likely to affect temp dated 11/18/2025. Further review showed that it was updated on 01/07/2026 by Staff B. Staff C stated that their goal was to complete the MRRs as soon as possible. In an interview on 01/09/2026 at 1:29 PM, Staff B stated that they would have expected the MRR recommendation to be completed within a week to 10 days, fast if possible and that they would have expected it to be competed accurately per the recommendation. Staff B further stated that they expected Resident 15's MRR recommendation to have been completed accurately and completed within 10 days. RESIDENT 5Review of Resident 5's physician orders, printed on 01/06/2026, showed orders for digoxin (a medication that helps the heart pump more strongly and control its rate) and alendronate (a medication to slow bone breakdown). Review of the September 2025 MRR showed the pharmacist found that Resident 5 had a laboratory (lab) order for a digoxin level (a blood test) and that test results are missing from Resident 5's Electronic Health Record (EHR). It showed that the pharmacist recommended to order lab test if the result remains unavailable and follow-up to ensure results are documented in the chart. Review of Resident 5's EHR (progress notes, results, physician orders, miscellaneous from 01/05/2025 through 01/06/2026) showed no documentation that there was follow up on the MRR recommendation. Review of the October 2025 MRR showed the pharmacist found that Resident 5 had a lab order for a digoxin level and that test results are missing from Resident 5's EHR. It showed that the pharmacist recommended to order lab test if the result remains unavailable and follow-up to ensure results are documented in the chart. The MRR further showed that the recommendation was marked as reviewed on 11/07/2025. Review of Resident 5's EHR showed that a digoxin level was completed on 11/05/2025. Review of the November 2025 MRR showed that the pharmacist recommended to discontinue alendronate. Review of the December 2025 MRR showed that the pharmacist recommended to discontinue alendronate. Review of Resident 5's EHR showed that alendronate was discontinued on 01/07/2026. In an interview and joint record review on 01/10/2026 at 9:19 AM, Staff C stated that Staff B gave the MRR recommendations to nursing and we work on the recommendations as soon as we can. Staff C stated that MRR recommendations should be followed up on as soon as possible. A joint record review of the September 2025 and October 2025 MRR showed that the pharmacist found that Resident 5 had a lab order for a digoxin level and that test results are missing from Resident 5's EHR. It showed that the pharmacist recommended to order lab test if the result remains unavailable and (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up to ensure results are documented in the chart. Staff C stated that the digoxin level was performed on 11/05/2025 and that it should have been done earlier, as soon as [the MRR recommendation] was received. A joint record review of the November 2025 and the December 2025 MRR showed that the pharmacist recommended to discontinue alendronate. A joint record review of Resident 5's EHR showed that alendronate was discontinued on 01/07/2026. Staff C stated that the recommendation to discontinue the alendronate was not addressed until 01/07/2026 and that it was not followed up timely. In an interview on 01/10/2026 at 1:16 PM, Staff B stated that they were responsible for following up on MRR recommendations and that there should be a response to the recommendations as soon as possible. Reference: (WAC) 388-98-1300 (4)(c) .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 physician's orders with parameters were followed when administering medications for 2 of 5 residents (Residents 5 & 19), reviewed for unnecessary medications. This failure placed the residents at risk for side-effects related to the medications, medical complications, and a diminished quality of life.Findings included. Review of the facility's policy titled, Administering Medications, revised in April 2019, showed, Medications are administered in accordance with prescriber orders, including any required time frame. Medications errors are documented, reported, and reviewed by the QAPI [Quality Assurance and Performance Improvement] committee to inform process changes and or the need for additional staff training. It further showed to check and verify vital signs (measurements of the body's essential functions) if necessary, prior to administering medications. RESIDENT 5BLOOD SUGAR MONITORING AND INSULIN ADMINISTRATIONReview of Resident 5's physician orders, printed on 01/06/2026, showed an order for insulin glargine (long-acting medication that regulates sugar in the blood) 2 (two) times a day with the instructions to hold for a blood sugar of 120 or less. Review of the November 2025 through January 2026 Medication Administration Records (MAR) showed the following dates that insulin glargine was given when Resident 5's blood sugar was below 120:-11/02/2025: blood sugar-111-12/07/2025: blood sugar-101-12/24/2025: blood sugar-103-12/29/2025: blood sugar-98-01/04/2026: blood sugar-117-01/09/2026: blood sugar-119 HEART RATE MONITORING AND METOPROLOL ADMINISTRATIONReview of Resident 5's physician orders, printed on 01/06/2026, showed an order for metoprolol (medication to treat high blood pressure [measurement that shows how hard the heart is pumping to move blood through the body]) twice a day, with the instruction to hold for a heart rate less than 55. Review of the November 2025 through January 2026 MARs, showed the following dates that metoprolol was given when Resident 5's heart rate was less than 55:-11/26/2025: heart rate-50-11/28/2025: heart rate-53-12/08/2025: heart rate-51-12/09/2025: heart rate-53-12/14/2025: heart rate-49-12/18/2025: heart rate-50-12/28/2025: heart rate-48 In an interview on 01/10/2026 at 8:54 AM, Staff J, Registered Nurse, stated that if a medication had parameters, they would hold the medication if it was outside the parameters. In an interview and joint record review on 01/10/2026 at 9:19 AM, Staff C, Charge Nurse, stated that they expected staff to follow parameters for medications. A joint record review of Resident 5's November 2025 through January 2026 MARs showed that insulin glargine was given to Resident 5 when their blood sugar was below 120 on the above dates. Staff C stated, it [insulin glargine] should have been held. Further joint record review of the MARs showed that metoprolol was given to Resident 5 when their heart rate was less than 55 on the above dates. Staff C stated, it (metoprolol) was given, should have been held. In an interview on 01/10/2026 at 1:16 PM, Staff B, Director of Nursing, stated that they expected staff to follow physician orders. Staff B stated that if a medication had parameters, they expected staff to follow parameters. Staff B further stated they expected staff to hold the medication and (continued on next page)

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	505500	A. Building B. Wing	01/10/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify the doctor and get further instructions. RESIDENT 19NON-PHARMACOLOGICAL INTERVENTIONS FOR PRN PAIN MEDICATIONReview of a face sheet printed on 01/05/2026 showed Resident 19 was admitted to the facility on [DATE]. Review of the October 2025 through January 2026 MARs showed that Resident 19 had orders for:- Oxycodone (a narcotic- controlled medication used to relieve pain) 5 milligrams (mg-unit of measurement) one tablet every four hours as needed (PRN) for pain level of 5 (five) to 7 (seven).- Oxycodone 5 mg, 2 tablets every four hours PRN for pain level of 8 (eight) to 10.- Pain monitoring-Observe every shift: If pain present offer nonpharmacological Interventions before giving prn pain medications. Indicate which intervention(s) were attempted: 0) Not applicable 1) Ice applied 2) Distraction 3) Relaxation 4) Superficial massage 5) Breathing techniques 6) Spiritual Practices 7) Environmental Modifications 8) Positioning/Repositioning * If non-verbal document body language, facial expression & [and] behaviors before & [and] after.Further review of the MARs showed Resident 19 received their PRN oxycodone from October 2025 through January 2026 without documented evidence that non-pharmacological interventions were attempted before Resident 19 was given their PRN oxycodone. In an interview and joint record review on 01/10/2026 at 10:00 AM, Staff J, Registered Nurse, stated that their process for providing PRN pain medications was to assess residents' pain level, offer non-pharmacological interventions such as ice packs or repositioning before providing the PRN pain medication, check orders for available PRN pain medications, provide pain medications, and document in residents' MAR. A joint record review of October 2025 through January 2026 MARs showed that Resident 19 received their Oxycodone 5 mg every four hours PRN for pain level of 5 to 7 on the following dates: 10/30/2025 to 11/27/2025, 11/29/2025, 11/30/2025, 12/01/2025 to 12/15/2025, 12/17/2025, 12/19/2025 to 12/22/2025, 12/24/2025 to 12/27/2025, 12/30/2025, 12/31/2025, and 01/01/2026 to 01/09/2026.Further joint record review of the MARs showed Resident 19 received Oxycodone 5 mg tablet, 2 tablets by mouth every four hours PRN for pain level of 8 to 10 on the following dates: 11/03/2025, 11/09/2025, 11/16/2025, 11/17/2025, 11/22/2025, 11/24/2025 to 11/29/2025, 12/01/2025, 12/04/2025, 12/06/2025, 12/07/2025, 12/09/2025, 12/12/2025 to 12/19/2025, 12/22/2025 to 12/25/2025, 12/27/2025 to 12/30/2025, 01/01/2026, 01/02/2026, and 01/04/2026 to 01/08/2026.Staff J stated that Resident 19 was given one tablet and/or 2 tablets of PRN oxycodone from October 2025 through January 2026. A joint record review of the MARs showed non-pharmacological interventions were not documented when PRN pain medications were given to Resident 19 from October 2025 through January 2026. Staff J stated that Resident 19 should have been provided non-pharmacological interventions for pain before their PRN oxycodone was given to them. A joint record review and interview on 01/10/2026 at 1:52 PM with Staff C, showed Resident 19 received their PRN oxycodone on the above dates without documented evidence that non-pharmacological interventions were attempted and/or provided to Resident 19 before administering their PRN oxycodone from October 2025 through January 2026. Staff C stated that staff (nurses) should have offered and/or provided Resident 19 with non-pharmacological interventions before giving them their PRN oxycodone and that it should have been documented in Resident 19's MAR. PAIN LEVEL AND USE OF PRN OXYCODONEReview of October 2025 through January 2026 MARs showed the following dates that Resident 19 received their PRN oxycodone 5 mg when Resident 19's pain level was outside the parameters of 5 to 7:- Pain level of 1 [one] on 12/17/2025- Pain level of 3 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[three] on 11/27/2025 and 12/01/2025- Pain level of 4 [four] on 10/31/2025, 11/22/2025, 11/29/2025 and 11/30/2025.- Pain level of 5 on 01/05/2026- Pain level of 6 [six] on 01/04/2026- Pain level of 7 on 01/01/2026 through 01/09/2026- Pain level of 8 on 11/01/2025, 11/02/2025, 11/05/2025 through 11/07/2025, 11/10/2025 through 11/13/2025, 11/15/2025, 11/18/2025, 11/20/2025, and 12/31/2025 when the instruction in the MAR was to give one tablet of oxycodone 5 mg for pain level of 5 to 7.Further review of the MAR showed Resident 19 received their PRN oxycodone 5 mg, 2 tablets when their pain level was outside the parameters of 8 to 10:- Pain level of 4 on 11/22/2025- Pain level of 5 on 11/03/2025 and 01/05/2026- Pain level of 6 on 01/04/2026- Pain level of 7 on 11/09/2025, 11/17/2025, 11/24/2025, 11/25/2025, 11/27/2025, 12/07/2025, 12/15/2025, 12/22/2025, 12/25/2025, 12/29/2025, 01/02/2026, and 01/04/2026 to 01/08/2026 when the instruction in the MAR was to give 2 tablets of oxycodone 5 mg for pain level of 8 to 10. A joint record review and interview on 01/10/2026 at 10:05 AM with Staff J, showed Resident 19 was given their PRN oxycodone 1 tablet and/or 2 tablets when Resident 19's pain was outside the pain parameters. Staff J stated that Resident 19 should not have been given 1 tablet of oxycodone if their pain level were below 5 and that they should have been given 2 tablets of PRN oxycodone if their pain level were above 7. Staff J further stated that Resident 19 should not have been given 2 tablets of PRN oxycodone when their pain level was below 8. In an interview and joint record review on 01/10/2026 at 1:55 PM, Staff C stated they expected doctor's orders for PRN pain medications to be followed as written. Staff C stated that if residents requested to have their PRN pain medication outside their ordered parameters, the doctor would need to be notified. A joint record review of October 2025 through January 2026 MARs showed Resident 19 received PRN oxycodone outside parameters on the above dates. Staff C stated that Resident 19 should not have been given 1 PRN oxycodone tablet when their pain level was below 5 and/or above 7 and should not have been given 2 PRN oxycodone tablets for pain levels below 8. In an interview on 01/10/2026 at 2:26 PM, Staff B stated they expected doctor's orders to be followed as written and that non-pharmacological pain interventions were administered and/or offered to the residents before they were given PRN pain medications. Staff B stated that Resident 19 should not have been given 1 tablet of oxycodone for pain levels below 5 and/or above 7, nor 2 tablets for pain levels below 8. Staff B further stated that Resident 19 should have been provided with non-pharmacological pain interventions prior to administering their PRN oxycodone. Reference: (WAC) 388-97-1060 (3)(k)(i).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications and/or biologicals were discarded when expired for 1 of 2 medication carts (Team-One Second Floor Medication Cart), reviewed for medication storage. This failure placed the residents at risk of receiving compromised medications and related complications.Findings included.Review of the facility's policy, Medication Labeling and Storage, revised in February 2023, showed, multi-dose vials that have been opened or accessed (e.g. [example], needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. The policy further showed, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.Review of the online manufacturer's recommendations titled, Insulin [medication that regulates sugar in the blood] Lispro Kwikpen [or Humalog (brand name) - a rapid-acting insulin pen (device used to inject insulin)], revised in [DATE], showed, Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen.Review of the facility's pharmacy document titled, Injectable [substance administered into the body using a needle and syringe] Diabetic [disease that results in too much sugar in the blood] Medications and Supplies - Expiration Date Reference List, revised in [DATE], showed that insulin Lispro expired 28 days after it was first opened.Review of Resident 15's insulin Lispro pharmacy label instructions with an open date of [DATE], showed, Store using directions provided. Throw away any medicine that remains 28 days after first use.A joint observation and interview on [DATE] at 4:09 PM with Staff C, Charge Nurse, showed Resident 15 had an insulin Lispro pen with an open date of [DATE]. A joint record review of Resident 15's insulin Lispro pharmacy label instructed, Throw away any medicine that remains 28 days after first use. Staff C stated that Resident 15's insulin should have been discarded 28 days after it was first opened and that Resident 15's insulin should have been thrown away after [DATE].In an interview on [DATE] at 2:10 PM, Staff B, Director of Nursing, stated that Resident 15's insulin pen opened on [DATE] should have been discarded after [DATE].Reference: (WAC) 388-97-1300 (2).

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the required specialized rehabilitative services for 1 of 2 residents (Resident 15), reviewed for rehabilitation services. This failure placed the resident at risk for decline in function, unmet care needs and a diminished quality of life.Findings included .Review of the facility's policy titled, Scheduling Therapy Services, revised in July 2013, showed, Therapy Services shall be scheduled in accordance with the resident's treatment plan.Review of the admission Minimum Data Set (an assessment tool) dated 10/24/2025, showed that Resident 15 was admitted to the facility on [DATE] and that they were cognitively intact.On 01/06/2026 at 12:25 PM, Resident 15 stated that the last time they received Physical Therapy (PT) was two weeks ago.Review of Resident 15's physician's orders showed an order PT/OT [Occupational Therapy] to eval [evaluate] and treat. Partial WBAT [partial weight bearing as tolerated] with an order date of 12/04/2025.Review of Resident 15's PT Evaluation & [and] Plan of Treatment dated 12/11/2025, showed, frequency: 2 [two] time(s)/[a] week and that the certification period was from 12/11/2025 through 02/23/2026.Review of Resident 15's PT notes showed no documentation that they received PT services from 12/19/2025 through 01/05/2026 (18 days).In an interview and joint record review on 01/09/2026 at 10:00 AM, Staff R, Physical Therapist, stated that residents would be seen however times it was stated on their plan of treatment. If the resident refused, they would re-attempt at least three times and would put in a missed visit and reason why the treatment was missed. A joint record review of Resident 15's PT Evaluation & Plan of Treatment showed that Resident 15's plan of treatment frequency was two times a week. Staff R stated that they could not find any documents as to why Resident 15 did not receive PT services from 12/19/2025 through 01/05/2026 and stated to talk to Staff Q, Director of Rehab.In an interview on 01/09/2026 at 10:39 AM, Staff Q stated that Resident 15 did not receive PT services for two weeks due to staffing shortage and that they were not able to schedule them. Staff Q further stated that if they did not have a staffing shortage, they would have expected Resident 15 to receive PT services two times a week.In an interview on 01/10/2026 at 8:54 AM, Staff A, Administrator, stated that they expected residents to receive therapy services per their treatment plan. When asked if they expected Resident 15 to receive therapy two times a week per their treatment plan, Staff A stated, yes, if that's [that is] what's [what is] ordered.Reference: (WAC) 388-97-1280 (1)(a).

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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 ensure the COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases can cause difficulty breathing and could result in impairment or death) vaccine was offered to 1 of 5 residents (Resident 5), reviewed for immunizations. The failure to educate and offer the COVID-19 vaccination placed the resident at risk for contracting the COVID-19 virus and related complications.Findings included.Review of the facility's policy titled, Coronavirus (COVID-19)-Vaccination of Residents, revised in June 2022, showed that Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized. It showed that Vaccine recommendations and schedules are consistent with the Centers for Disease Control and Prevention (CDC).Review of the CDC online document titled, Staying Up to Date with COVID-19 Vaccines, dated 11/19/2025, recommended a 2025-2026 COVID-19 vaccine for people ages 6 months and older. It further showed that getting the 2025-2026 COVID-19 vaccine is especially important if you.are living in a long-term care facility.Resident 5 was admitted to the facility on [DATE].Review of the Resident 5's Electronic Health Record (EHR - progress notes, miscellaneous, and immunizations tab), showed the last documented COVID-19 vaccine for Resident 5 was administered on 04/14/2022. It further showed no documentation that Resident 5 was offered the most recent COVID-19 (2025-2026 COVID-19) vaccine.In an interview and joint record review on 01/09/2026 at 1:48 PM, Staff B, Director of Nursing, stated that they offered the COVID-19 vaccination to residents on admission and annually. A joint record review of the CDC online document titled, Staying Up to Date with COVID-19 Vaccines, dated 11/19/2025, recommended a 2025-2026 COVID-19 vaccine for people ages 6 months and older. A joint record review of Resident 5's EHR showed that the most recent COVID-19 vaccination was on 04/14/2022. Staff B stated that Resident 5 was not offered the most recent COVID-19 vaccine.Reference: (WAC) 388-97-1620(2)(b)(i)(ii).

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview, and record review, the facility failed to ensure the survey result binder included the results for 4 of 8 complaint surveys (08/12/2025, 09/16/2025, 10/14/2025 & 12/09/2025) that resulted in citations since the last annual survey. This failure prevented residents, residents' representatives and visitors from exercising their right to review past survey results and the facility's plan of correction.Findings included.Review of the state inspection survey results binder on 01/07/2026 at 8:36 AM and at 1:35 PM and on 01/10/2026 at 10:12 AM, showed that it did not include the results for the complaint surveys and plan of corrections from 08/12/2025, 09/16/2025, 10/14/2025, and 12/09/2025.In an interview and joint record review on 01/10/2026 at 1:54 PM, Staff A, Administrator, stated that they expected the survey results binder to include annual surveys and any complaints that occur. Joint record review of the survey binder showed the following complaint surveys results and associated plans of corrections were missing for 08/12/2025, 09/16/2025, 10/14/2025, and 12/09/2025. Staff A stated that the missing survey results should be in the binder, I missed that.Reference: (WAC) 388-97-0480(1)(b)(c).