STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505504	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Shores Health Center	9107 Fortuna Drive Mercer Island, WA 98040

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to initiate and/or thoroughly investigate the occurrences of events for 2 of 2 (Residents 10 & 5) sampled residents whose facility incident reports were reviewed. The facility failed to initiate an investigation for an injury of an unknown origin for Resident 10 and failed to thoroughly investigate falls for Resident 5. The failure to initiate and conduct thorough investigations left residents at risk for unidentified abuse and/or neglect, recurrence of events, and a decreased quality of life.Findings included.<Facility Policy>Review of the facility's Abuse Prevention Program policy, revised 09/22/2025, showed employees were required to promptly report all occurrences of possible abuse, mistreatment, or neglect of any resident. The policy showed all occurrences/accidents of unknown origin would be investigated and occurrence reports would be reviewed by the administrator and director of nursing. The policy showed the administrator or designee would conduct a thorough investigation within five days of the occurrence in accordance with state law.According to the facility policy titled, Accident and Incidents - Investigating and Reporting, dated July 2017, the facility would include circumstances surrounding the incident and any corrective actions as part of the investigation.<Resident 10> According to the 01/14/2026 admission Minimum Data Set (MDS – an assessment tool), Resident 10 admitted to the facility on [DATE] with diagnoses including arthritis, age-related osteoporosis without a current pathological fracture, and aftercare following a right hip replacement. The MDS showed Resident 10 did not have cognitive impairment. In an interview on 02/05/2026 at 9:03 AM, Resident 10 stated they originally came to the facility to receive therapy after hip surgery but suffered a right upper leg fracture and was now recovering from the fracture. Review of a 01/23/2026 social services progress note showed Resident 10 was making slow improvements and was not able to walk yet. The progress note showed the therapy department recommended Resident 10 have an x-ray as the resident was experiencing severe pain. Review of a 01/24/2026 x-ray report showed Resident 10's right upper leg bone was fractured. Review of a 01/26/2026 physician progress note showed Resident 10's physician gave orders to send the resident to the hospital for evaluation of their right leg fracture. Review of the facility provided incident log on 02/09/2026 showed there was no incident logged for January 2026 or February 2026 regarding Resident 10's right upper leg fracture. In an interview on 02/09/2026 at 9:37 AM, Staff A (Administrator) stated they did not have an investigation related to Resident 10's leg fracture. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/10/2026 at 10:40 AM, Resident 10 stated therapy was working with them and noticed one of their legs appeared longer than the other, so an x-ray was ordered. Resident 10 stated they did not have a fall and stated nobody hurt them. In an interview on 02/10/2026 at 1:48 PM, Staff B (Director of Nursing) stated Resident 10 did not experience trauma, falls, or any occurrence since their admission to the facility and the resident did not have any abnormal reports. Staff B stated the staff thought Resident 10 possibly admitted to the facility with the upper leg fracture, despite the x-ray being obtained two weeks after Resident 10 admitted to the facility. Staff B was asked how they determined Resident 10 did not experience trauma, falls, or other occurrences without an investigation. Staff B stated they went off reports from staff but did not complete a formal investigation or document staff reports. Staff B stated they did not interview Resident 10 regarding their leg fracture. Staff B stated they asked Resident 10 how everything was going upon their return from the hospital but stated they did not specifically ask Resident 10 if anyone hurt them. Staff B stated they did not complete an investigation regarding Resident 10's right leg fracture. In an interview on 02/11/2026 at 11:26 AM, Staff A stated they expected an injury of an unknown origin to be investigated. <Resident 5> According to the 01/24/2026 Quarterly MDS, Resident 5 admitted to the facility on [DATE]. The MDS showed Resident 5 had falls since admission. The MDS showed Resident 5 was Chinese and required an interpreter for communication. The MDS showed Resident 5 required one person assistance with transfers, mobility, toileting, and dressing. Review of a 10/18/2025 at risk for falls/fall related injury related to history of falls Care Plan (CP) showed Resident 5 had falls on 11/19/2025, 11/25/2025, 12/08/2025, 12/10/2025, 12/24/2025, 01/29/2026, and 02/02/2026. The CP showed interventions for Resident 5 included a well-lit room, frequent toileting, assessing physical needs such as repositioning, toileting, hydration needs, constipation, and pain. There were no new added interventions for the falls between 11/19/2025 and 12/08/2025. Review of the facility's investigation for Resident 5's fall on 11/19/2025 showed the resident stated they were trying to go to the bathroom and slid out of their chair. The section of the investigation report titled Care prior to fall included a review of the last time staff assisted Resident 5 to toilet, provided fluids, repositioned the resident, and medicated for pain. This section was marked N/A. The section of the investigation report titled Environmental conditions possibly related to fall prompted staff to review bed locks functioning, furniture needing repair, grab bar loose, lights on, noisy, obstacles in path, wet floor with/without sign in place, wheelchair locks not working, and quiet environment. This section was marked N/A. Review of the investigation for the 11/25/2025 fall showed Resident 5 stated they could not recall what happened or how they fell. The care prior to fall section of the investigation was not reviewed, marked N/A, and included last time staff assisted Resident 5 to toilet, provided fluids, repositioned, and medicated for pain. The environmental conditions possibly related to fall section of the investigation was marked N/A and included bed locks not working, furniture needs repair, grab bar loose, lights on, noisy, obstacles in path, wet floor with/without sign in place, wheelchair locks not working, and quiet environment. The investigation showed the fall occurred at 4:30 PM and the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigation report showed lights in room reviewed as N/A. The investigation did not identify if the call light was within reach for Resident 5. Review of the investigation for the 12/08/2025 fall showed staff marked N/A next to the residents' statement section of the investigation. An occurrence report showed Resident 5 told a family member they were trying to wash their clothes. Staff did not document if Resident 5's clothing issues were investigated. The care prior to fall section was not reviewed, marked N/A, and included last time staff assisted Resident 5 to toilet, provided fluids, repositioned, and medicated for pain. The environmental conditions possibly related to fall were marked as N/A and included bed locks not working, furniture needs repair, grab bar loose, lights on, noisy, obstacles in path, wet floor with/without sign in place, wheelchair locks not working, and quiet environment. The footwear reviewed section showed staff documented N/A for whether Resident 5 was wearing footwear. Staff did not document an assessment of injuries or pain. There was no investigation documented to show if Resident 5 was in their wheelchair or bed prior to the fall. Review of the investigation for the 12/10/2025 fall showed the conclusion to rule out abuse/neglect with general statements regarding Resident 5's abilities and previous CP interventions. There was no specific investigation related to the root cause of the fall. The incident report showed Resident 5 was toileted at 1:15 PM prior to the 2:00 PM fall. The investigation summary/conclusion statement was conflicting and showed Resident 5 was toileted five minutes prior to the fall. The care prior to fall section was not reviewed and marked N/A for this investigation and included the last time staff provided fluids to Resident 5, repositioned, and medicated for pain. The environmental conditions possibly related to fall section was marked N/A to include bed locks not working, furniture needs repair, grab bar loose, lights on, noisy, obstacles in path, wet floor with/without sign in place, wheelchair locks not working, and quiet environment. The investigation did not show if the call light was within reach for Resident 5. Review of the investigation for the 12/24/2025 fall showed the fall was unwitnessed. A neurological assessment was not included in Resident 5's health records or included with the investigation. Resident 5 stated they were trying to get to the bathroom. The care prior to fall section was not reviewed and marked N/A for this investigation. This section included the last time staff assisted Resident 5 to toilet, provided fluids, repositioned, and medicated for pain. The environmental conditions possibly related to fall section was marked as N/A and included bed locks not working, furniture needs repair, grab bar loose, lights on, noisy, obstacles in path, wet floor with/without sign in place, wheelchair locks not working, and quiet environment. The investigation did not include if Resident 5's call light was within reach. The investigation conclusion to rule out abuse/neglect showed general statements regarding Resident 5's abilities and previous CP interventions. There were no specific investigations related to the root cause of this fall. Review of the investigation for the fall on 01/29/2026 at 2:45 PM showed Resident 5 wanted to change clothes. The investigation showed no investigation regarding Resident 5's clothing, environmental conditions, or footwear. Cares prior to fall reviewed as N/A and included the last time hydration services were provided, the resident was repositioned, and last medicated for pain. The conclusion to rule out abuse/neglect showed general statements regarding Resident 5's abilities and previous CP interventions. The conclusion/investigation summary showed when asked why [they were] on the floor, the resident stated [they] were trying to get changed, get food, or go back to bed without assistance, thinking [they] could do it [themselves]. Review of the investigation for the fall on 01/29/2026 at 4:15 PM showed an incomplete neurological (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment of the unwitnessed fall. The investigation summary/conclusion showed Resident 5 stated [they were] trying to get changed, get food, or go back to bed without assistance, thinking [they] could do it [themselves]. The care provided prior to fall and environmental factors sections of the incident report were not investigated, no documentation of assisting Resident 5 with changing clothes or getting them food/fluids per their statement of reason for the fall. Review of the investigation for the fall on 02/02/2026 showed an incomplete neurological assessment for Resident 5's unwitnessed fall. Investigation summary showed Resident 5 again stated [they were] trying to get changed, get food, or go back to bed without assistance, thinking [they] could do it [themselves]. Resident 5's statement per assigned nurse at the time of the incident was they were hot and trying to get out of bed to take their jacket off. The investigation did not include investigating why Resident 5 was in bed with a jacket on. The investigation showed staff documented N/A for several of the care prior to fall and environmental factors as being investigated to rule out abuse/neglect. This investigation did not include documentation of the call light being within reach for Resident 5. Observation on 02/05/2026 at 8:33 AM showed Resident 5 sitting up in their wheelchair in the dining room. Resident 5's room showed their bed in low position, a perimeter mattress in place, and fall mats on the floor next to the bed. In an interview on 02/05/2026 at 5:10 PM, Resident 5's Power of Attorney stated Resident 5 was always hot, staff were aware and notified on several occasions to keep the resident cool. In an interview on 02/11/2026 at 10:22 AM Staff B stated they expected staff to thoroughly complete the incident report and investigate prior care provided, environmental factors, call light within reach, and reason for fall stated by Resident 5, but staff did not. Staff B stated they expected a neurological assessment to be completed for all unwitnessed falls, but they were not for Resident 5. Staff B stated the general statements in the 12/10/2025, 12/24/2025, 01/29/2026, and 02/02/2026 investigations were related to Staff B investigating the multiple recent falls. Staff B stated each investigation should reflect the specific incident, but they did not. Staff B stated they expected staff to complete a skin assessment, a fall risk assessment, assess the resident, document whether injuries were noted or not, and a pain assessment. Staff B stated they expected the resident's statement to be investigated to rule out abuse/neglect but they were not for Resident 5. Refer to F609 Reporting of Alleged Violations REFERENCE: WAC 388-97-0640(6)(a)(b).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs) for 4 of 5 residents (Resident 3, 5, 17, & 20) who were assessed to be dependent on staff for ADLs. Failure to provide ADL assistance as required left residents at risk of poor hygiene, diminished feelings of self-worth, and other negative health outcomes.Findings included.<Facility Policy>Review of the facility's March 2018 Activities of Daily Living, Supporting policy showed the facility would provide the services necessary to maintain good grooming and personal hygiene, including bathing, mobility, and toileting in accordance with the care plan, for residents who were unable to perform ADLs independently.Review of the facility's May 2013 Repositioning policy showed repositioning was an effective intervention to prevent skin breakdown, promote circulation, and provide pressure relief, and was critical for residents who were dependent upon staff for repositioning. Residents who were in bed should be on a every two-hour repositioning schedule, and residents in a chair should be on an every one-hour repositioning schedule. Staff were to monitor the need for incontinence care when changing the resident's position.Review of the facility's August 2022 Urinary Continence and Incontinence - Assessment and Management policy showed residents who were incontinent and required a check and change strategy, staff would check the resident's continence status at regular intervals and use incontinence products, with the primary goal to maintain dignity, comfort, and protect the resident's skin.<Resident 3> Review of an 11/30/2025 Comprehensive Minimum Data Set (MDS – an assessment tool) showed Resident 3 admitted to the facility on [DATE] with diagnoses including dementia (a decline in mental ability that interferes with daily life) and a broken hip. Resident 3 was dependent on staff for bed and chair mobility, transfers, and toileting hygiene, and was at risk for developing pressure ulcers/injuries. Review of a Care Plan (CP), dated 11/14/2025, showed interventions included to check Resident 3 for incontinence and change if wet/soiled and encourage/assist with frequent repositioning. Observation on 02/09/2026 at 7:58 AM showed Resident 3 sitting in their tilt-in-space wheelchair (a mobility device with ability to recline) in the dining room eating breakfast. Resident 3 asked staff if they could lie down. Staff agreed they could lie down after breakfast. Observation on 02/09/2026 at 8:31 AM showed Staff K (Certified Nursing Assistant – CNA) wheeled Resident 3 back to their room. Resident 3 remained in their wheelchair. Staff K did not reposition Resident 3 or check the resident for incontinence. Observations from 02/09/2026 at 8:33 AM to 02/09/2026 at 10:05 AM showed Resident 3 remained in their wheelchair and no staff entered their room. Observation on 02/09/2026 at 10:05 AM showed Staff K assisted Resident 3 with leg exercises and stretching while Resident 3 sat in their wheelchair. Observation on 02/09/2026 at 10:12 AM showed Staff K left Resident 3's room. Staff K did not check Resident 3 for incontinence. Observations from 02/09/2026 at 10:12 AM to 12:03 PM showed Resident 3 sat in their wheelchair, and no staff entered their room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 02/09/2026 at 12:03 PM showed Staff L (CNA) wheel Resident 3 to the dining room in their wheelchair. Staff L did not check Resident 3 for incontinence. Observation on 02/09/2026 at 12:28 PM showed Resident 3 ask staff repeatedly if they could go lie down. Staff told Resident 3 they could lie down after they finished lunch. Observation on 02/09/2026 at 12:56 PM showed Staff K wheel Resident 3 back to their room. Resident 3 remained in their wheelchair. Staff K did not reposition Resident 3 or check for incontinence. Observations from 02/09/2026 at 1:00 PM to 02/09/2026 at 2:32 PM showed Resident 3 remained in their wheelchair and no staff entered their room. In an interview on 02/09/2026 at 2:13 PM, Staff K stated they were covering for Staff L while they were on break. Staff K stated Staff L would likely put Resident 3 down for a nap soon and was not sure if they typically transferred Resident 3 to bed to check/change for incontinence. In an interview on 02/09/2026 at 2:32 PM, Staff L stated they typically checked/changed Resident 3 for incontinence before lunch and when they laid them down, roughly every three hours. Staff L stated they changed Resident 3's brief that morning with morning care. Staff L stated they did not check or change Resident 3 after that because they had to go on break, and they would need to confer with Staff K to see if they checked Resident 3. Staff L stated it was important to check/change Resident 3 frequently to make sure they were not sitting in urine or fecal matter and to prevent skin breakdown. Staff L stated Resident 3 was able to verbalize if they were uncomfortable and wanted repositioning. In an interview on 02/11/2026 at 11:17 AM, Staff K stated they covered for other staff while on breaks and never helped check Resident 3 for incontinence. Staff K stated Resident 3 often complained about wanting to go to bed. Review of an ADL Verification Worksheet for observations between 02/05/2026 and 02/09/2026 showed bladder and/or bowel incontinence care was provided to Resident 3 on 02/05/2026 – two times, 02/06/2026 – two times, 02/07/2026 – three times, 02/08/2026 – two times, and 02/09/2026 – three times. In an interview on 02/10/2026 at 1:39 PM, Staff C (Resident Care Manager) stated they expected staff to reposition dependent residents and check/change incontinent residents frequently, at least every two hours. Staff C stated residents sitting in chairs should be repositioned more frequently. Staff C stated CNA staff needed reeducation regarding those expectations. In an interview on 02/11/2026 at 12:05 PM, Staff B (Director of Nursing) stated they expected staff to reposition Resident 3 and check to see if their brief needed to be changed every two hours. Staff B said they expected staff to assist Resident 3 back to bed if they asked to lie down. <Resident 5> According to the 01/24/2026 Quarterly MDS Resident 5 was admitted to the facility on [DATE]. The MDS showed Resident 5 required staff assistance with bathing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 02/05/2026 ADL Deficit CP showed Resident 5 required complete set-up and staff assistance with bathing. In an interview on 02/05/2026 at 5:10 PM, Resident 5's representative stated staff were supposed to assist Resident 5 with showers twice weekly but did not. Resident 5's representative stated they would assist them with bathing because when they asked staff to assist Resident 5 with the twice weekly scheduled shower, staff would say they were unable or too busy. Resident 5's representative stated they requested staff to offer and provide showers five times a week, but staff stated they only provide bathing two times per week. Resident 5's representative stated they enjoyed more frequent showers because it helped wake them up, so they were not so sleepy all day. Resident 5's representative stated more showers to wake them up could help decrease Resident 5's falls. Record review on 02/07/2026 at 9:50 AM showed Resident 5 was scheduled to receive showers every Tuesday and Saturday. Review of Resident 5's ADL bathing report showed staff did not offer/provide bathing on 10/25/2025, 10/28/2025, 11/08/2025, 11/15/2025, 11/18/2025, 11/29/2025, 12/01/2025, 12/09/2025, 12/20/2025, 12/23/2025, 12/30/2025, 01/03/2026, 01/06/2026, 01/17/2026, 01/20/2026, 01/24/2026, 01/31/2026, or 02/03/2026 per the bathing schedule. In an interview and record review on 02/10/2026 at 9:58 AM Staff B reviewed Resident 5's ADL bathing report and stated staff should be offering/providing showers to Resident 5 every Tuesday and Saturday but did not. Staff B stated they expected staff to offer and provide per bathing schedule and document if the resident refused. Staff B stated they informed residents and/or their representatives they can only guarantee bathing twice weekly and if they wanted more, they needed to ask the CNA assigned to the resident and if the CNA was not too busy, they might be able to provide additional bathing. Staff B stated they do not add resident requests for more bathing to their CP and only expect staff to accommodate twice weekly per schedule. <Resident 17> According to the 01/15/2026 admission MDS, Resident 17 was admitted to the facility on [DATE]. The MDS showed Resident 17 required staff assistance with bathing. In an observation and interview on 02/06/2026 at 9:53 AM Resident 17 was lying in bed and stated they were not offered a shower since their admission to the facility. In an interview and record review on 02/10/2026 at 10:07 AM, Staff B stated Resident 17 was scheduled for showers every Monday and Thursday. Staff B reviewed Resident 17's ADL bathing report which showed no bathing was offered or provided since admission to the facility, for over four weeks. Staff B stated it was important to offer and provide bathing for dependent residents for general hygiene and feelings of self-worth. <Resident 20> According to the 02/05/2026 admission MDS Resident 20 admitted to the facility on [DATE]. The MDS showed Resident 20 required staff assistance with bathing. Review of a 01/30/2026 ADL Deficit CP showed Resident 20 required complete set-up and staff assistance with bathing. Review of Resident 20's shower schedule showed staff were to provide bathing assistance every Wednesday and Saturday. Review of Resident 20's ADL bathing report (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed no documented bathing was offered or provided since admission. In an interview on 02/05/2026 at 2:16 PM Resident 20 stated staff did not offer or provide them with a shower since their admission. In an interview on 02/10/2026 at 10:41 AM Staff B stated staff should offer Resident 20 showers every Wednesday and Saturday but have not since admission. Staff B stated it was important to offer residents bathing for hygiene and dignity. Refer to F605 Right to be Free from Chemical Restraints. Refer to F610 Investigate Abuse/Protect Resident During Investigation. Reference: WAC 388-97-1060(2)(c).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure acute medical delirium was ruled out prior to prescribing Antipsychotic (medications used to treat psychosis) medications for 1 of 3 sampled residents with Dementia (a decline in mental ability that interferes with daily life) (Resident 5) and to assess for adverse side effects related to the use of psychotropic medications for 3 of 3 sampled residents (Residents 5, 13, & 3) who were prescribed an Antipsychotic reviewed for unnecessary medications. Failure to rule out acute medical delirium prior to prescribing Antipsychotic medications placed Resident 5 at risk of medical complications, unnecessary psychotropic medication use, and a diminished quality of life. Failure to conduct/obtain an initial/baseline Abnormal Involuntary Movement (AIM) assessment for the use of antipsychotic medications and identify potential involuntary movement placed Residents 5, 13, and 3 at risk of unidentified presence and severity of AIMs related to Antipsychotic mediation side effects, medical complications, and a diminished quality of life.Findings included.<Policy>According to the facility policy titled Antipsychotic Medication Use, dated July 2022, residents would only receive antipsychotic medications when necessary to treat specific conditions for which they were indicated and effective. The attending physician and facility staff would identify acute (short-term) psychiatric episodes and differentiate them from enduring (long-term) psychiatric conditions. Antipsychotic medications would only be used if behavioral symptoms were not due to a medical condition or problem, such as pain, fluid or electrolyte imbalances, infections, vision or hearing impairment, or medication side effects which could be expected to improve or resolve with treatment or discontinuation of offending medications. Nursing staff were to monitor for adverse neurologic side effects, such as abnormal involuntary movements. <Resident 5> According to 01/24/2026 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 5 admitted to the facility on [DATE]. The MDS showed Resident 5 was without signs of delirium or behavioral concerns and had no indicators of psychosis. The MDS showed Resident 5 was compliant with cares and had a diagnosis of Alzheimer's Dementia without behavioral issues. The MDS showed Resident 5 was taking an Antipsychotic medication during the assessment period. The MDS showed Resident 5 required an interpreter for communication. The MDS showed Resident 5 had constipation and frequent pain that limited their day-to-day activities. Review of the 11/20/2025 Physiatrist (Physical Medicine/Rehabilitation Doctor) visit note, Resident 5 was a little agitated during the visit. The consultation report showed no interpreter was provided for communication. The consultation report showed the Physiatrist discontinued prescribed narcotics for pain management due to staff reporting intermittent confusion which was concerning for opiate induced delirium. The Physiatrist also recommended to continue monitoring Resident 5 for further behaviors as there may be underlying dementia. The report showed a recommendation for an Antipsychotic medication twice daily if no concerns for infectious process. Review of Resident 5's health records showed an Antipsychotic medication prescribed 11/20/2025 to be administered twice daily. Resident 5's records showed no behaviors documented from admission [DATE] through 11/20/2026. Review of November 2025, December 2025, January 2026, and February 2026 Medication Administration Records (MAR) showed Resident 5 was receiving the Antipsychotic medication. Resident 5's BM records showed they had a hard BM on 11/20/2025. Review of Resident (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5's health records showed no AIMs assessment was completed prior to starting the Antipsychotic medication on 11/20/2025. Observations on 02/05/2026 at 8:33 AM, 02/06/2026 at 8:53 AM, 02/09/2026 at 9:21 AM, 02/10/2026 at 11:14 AM, and 02/11/2026 at 9:23 AM showed Resident 5 calm and cooperative with staff and care. Observation 02/05/2026 at 8:33 AM showed a sign in Resident 5's room stating they spoke Cantonese. Review of the11/26/2025 Intermittent/Restlessness related to Dementia Care Plan (CP) Resident 5 was taking a routine Antipsychotic medication for agitation. In an interview on 02/11/2026 at 12:22 PM Staff B (Director of Nursing) stated Resident 5s records showed no documentation of behaviors prior to starting the Antipsychotic medication. Staff B stated the Physiatrist made a recommendation for the Antipsychotic medication for Dementia with agitation, based on agitation during their visit on 11/20/2025, after ruling out possible infection. Staff B stated no tests to rule out infection were conducted but should have been prior to starting the Antipsychotic medication. Staff B stated when a consultant makes a recommendation, they expected staff to have Resident 5's primary physician review the recommendation before implementing it. Staff B stated there wasn't any documentation the Physiatrists recommendations were reviewed by Resident 5's primary physician. Staff B stated they expected staff to complete an AIMs assessment on residents who are prescribed an Antipsychotic at time of prescribing and every 6months. Staff B stated staff did not complete an AIMS for Resident 5 at time of prescribing but should have to obtain the resident's baseline. Staff B stated AIMs assessments were important to monitor residents for side effects to Antipsychotic medications. <Resident 13> According to 01/22/2026 admission MDS Resident 13 admitted [DATE]. The MDS showed Resident 13 had a diagnosis of Dementia without behavioral disturbances or psychotic disorder. Review of Resident 13's records showed a 01/16/2026 admission order that included an Antipsychotic medication to be administered daily. Review of Resident 13's record showed no AIMS assessment was completed. Observations on 02/05/2026, 02/06/2026, 02/09/2026, 02/10/2026, and 02/11/2026 showed Resident 13 calm and cooperative with staff and care. In an interview on 02/10/2026 at 10:21 AM Staff B stated Resident 13 admitted on the Antipsychotic medication. Staff B stated staff did not complete an AIMs assessment on Resident 13 upon admission but should have. <Resident 3> Review of an 11/30/2025 comprehensive MDS showed Resident 3 admitted to the facility on [DATE] with diagnoses that included dementia and received an antipsychotic medication (used to treat mental disorders by reducing symptoms like hallucinations, delusions, and severe agitation) on a routine basis. Review of Resident 3's physicians orders showed the antipsychotic medication was ordered on (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/14/2025, the dosage was reduced on 12/12/2025, and the medication was discontinued on 01/05/2026. Review of Resident 3's records showed an AIMS assessment was completed on 01/06/2026, after the antipsychotic medication was discontinued. No previous AIMS assessments were found. In an interview on 02/11/2026 at 11:46 AM, Staff C (Resident Care Manager) stated they completed AIMS assessments for residents with their quarterly assessments but did not complete AIMS upon admission. Staff C stated Resident 3 did not have an AIMS completed until 01/06/2026. In an interview on 02/11/2026 at 12:05 PM, Staff B stated they expected staff to complete AIMS assessments on admission to get the resident's baseline status, and at least every six months thereafter. Refer to F645 PASARR Screening for Mood Disorder. Refer to F684 Quality of Care. Reference: WAC 388-97-0620(1)(a).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to log/report an allegation of neglect for 1 (Resident 10) of 1 residents reviewed. This failure placed residents at risk for unidentified neglect, avoidable pain, and other negative health outcomes.Findings included.<Facility Policy>Review of the facility's Abuse Prevention Program policy, revised 09/22/2025, showed all occurrences/accidents of unknown origin would be investigated and occurrence reports would be reviewed by the administrator and director of nursing. This policy showed the administrator or designee must report all reasonable suspicions of mistreatment including injuries of an unknown source.<Resident 10>According to the 01/14/2026 admission Minimum Data Set (MDS - an assessment tool), Resident 10 admitted to the facility on [DATE] with diagnoses including arthritis, age-related osteoporosis without current pathological fracture, and aftercare following a right hip replacement. The MDS showed Resident 10 did not have signs or symptoms of delirium and did not have cognitive impairment.In an interview on 02/05/2026 at 9:03 AM, Resident 10 stated they came to the facility to receive therapy after hip surgery but recently suffered a right upper leg fracture and they were now recovering from the fracture.Review of a 01/24/2026 x-ray report showed Resident 10's right upper leg bone was fractured, two weeks after their admission to the facility.Review of the facility provided incident log for January and February 2026 showed staff did not log or report the right upper leg fracture for Resident 10.In an interview on 02/10/2026 at 10:40 AM Resident 10 stated they did not have a fall and stated nobody hurt them.In an interview on 02/10/2026 at 1:48 PM, Staff B (Director of Nursing) stated Resident 10 was experiencing a high level of pain since their admission to the facility. Staff B stated there was no trauma or an occurrence since the resident's admission and staff felt Resident 10 possibly came with the fracture. Staff B stated they did not investigate Resident 10's fracture.In an interview on 02/11/2026 at 11:26 AM, Staff A (Administrator) stated injuries of unknown origins were reportable incidents.Refer to F610 Investigate/Prevent/Correct Alleged ViolationREFERENCE: WAC 388-97-0640(5)(a).

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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 record review and interview, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR - a mental health screening required before the transfer to a nursing home) assessments submitted for a Level II PASRR assessment after the 30 day exemption expired for 1 of 5 sample residents (Resident 4) and were completed for new mood disorders requiring antipsychotic medication for 1 of 5 residents (Resident 5) whose PASRRs were reviewed. This failure left residents at risk of inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs.Findings included.<Policy>According to the facility policy titled, Antipsychotic Medication Use, dated [DATE], the facility would ensure PASRR would be completed for residents taking Antipsychotic medications.<Resident 4> According to the [DATE] admission Minimum Data Set (MDS – an assessment tool), Resident 4 had a diagnosis of depression and received antidepressant medications during the assessment look-back period. The MDS showed staff assessed Resident 4 was not considered by the state level II PASRR process to have a Serious Mental Illness (SMI). Review of Resident 4's [DATE] level I PASRR assessment showed facility staff assessed Resident 4 as having a SMI of a mood disorder. Staff checked on the form Resident 4 did not require a level II evaluation due to exempted hospital discharge. This section of the form stated, Level II must be completed if scheduled discharge does not occur. Review of Resident 4's comprehensive records on [DATE] showed the resident remained in the facility past their exempted hospital discharge timeframe. Review of Resident 4's record showed staff did not send the level I PASRR for a level II PASRR evaluation as required. In an interview on [DATE] at 1:42 PM, Staff E (Social Service Director) stated their process was to follow the hospital exemption requirements. Staff E provided a [DATE] email showing they sent Resident 4's level I PASRR for a level II evaluation. Staff E stated they did not receive an evaluation back and did not follow up with the PASRR evaluators since [DATE], nearly eight months after. <Resident 5> According to the [DATE] Quarterly MDS Resident 5 admitted [DATE]. The MDS showed Resident 5 was taking an antipsychotic medication. The MDS showed resident 5 had diagnoses of Alzheimer's (progressive neurodegenerative disease characterized by memory loss) disease and Dementia (a decline in mental ability that interferes with daily life) without behavioral disturbances. Review of Resident 5's physician orders showed they were started on a new antipsychotic mediation for dementia with agitation. Resident 5's records showed no PASRR was done for new mood disorder requiring an antipsychotic medication. In an interview on [DATE] at 11:32 AM Staff E stated they expected a new PASRR to be completed when a resident had a significant change to include new psychiatric diagnosis and psychotropic medications, but it was not done for Resident 5. Staff E stated it was important to complete PASRRs for new mood disorders requiring antipsychotic medications to ensure they received necessary services to meet their mental health care needs. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Refer to F605 Right to be Free from Chemical Restraints. Reference: WAC 388-97-1915(1)(2)(a-c).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure person centered care plans were completed to address all aspects of resident care for 1 of 1 closed records resident (Residents 41) reviewed for death and 1 of 1 sample resident (Resident 5) reviewed for accidents. The facility failed to conduct care conferences for residents with their representatives and the applicable Interdisciplinary Team (IDT) members for 2 of 4 sample resident (Residents 9 & 20) reviewed for care planning. These failures placed residents at risk for inconsistent and/or inadequate care and treatment, a diminished quality of care, unmet care needs, unnecessary care, frustration, and other negative health outcomes.Findings included.<Policy>According to the facility policy titled, Care Plans, Comprehensive Person-Centered, date March 2022, the IDT would develop and implement a comprehensive, person-centered Care Plan (CP) that included measurable objectives and timetables to meet each resident's physical, psychosocial, and functional needs, in conjunction with the resident and their representatives, no more than 21 days after admission. Each resident had the right to participate in the development and implementation of their care plan and to be provided advance notice of care planning conferences. Care plans were revised as information about the resident and the resident's condition changed.<Person Centered Care Plans> <Resident 41> According to the 01/01/2026 admission Minimum Data Set (MDS – an assessment tool) Resident 41 admitted to the facility on [DATE]. The MDS showed Resident 41 was not receiving hospice services upon admission to the facility. The MDS showed Resident 41 had diagnoses of malnutrition and heart disease. Record review showed a 01/08/2026 hospice visit note with Resident 41. Resident 41's health records did not show a hospice CP or physician order for the hospice services. In an interview on 02/11/2026 at 8:43 AM Staff B (Director of Nursing) stated they expected staff to develop and follow a CP for residents receiving hospice service. Staff B reviewed Resident 41's records and stated staff should create a hospice CP for them but they did not. Staff B stated it was important to implement a hospice CP for residents receiving those services to ensure staff met their specific goals related to their hospice care. <Resident 5> According to the 01/24/2026 Quarterly MDS Resident 5 admitted to the facility on [DATE]. The MDS showed Resident 5 had two or more falls since admission to the facility. Review of Resident 5's health records showed falls occurred on 11/19/2025, 11/25/2025, 12/08/2025, 12/10/2025, 12/24/2025, 01/29/2026 (two falls), and 02/02/2026. Review of Resident 5's fall CP showed no new interventions were added for the falls on 11/19/2025 and 12/08/2025. In an interview on 02/11/2026 at 10:22 AM Staff B reviewed Resident 5's CP and stated they expected staff to implement new interventions with each fall to continue decreasing falls, but they did not for Resident 5's 11/19/2025 and 12/08/2025 falls. Staff B stated it was important to revise fall CP to prevent further falls and injury. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Care Conference> <Resident 20> According to the 02/05/2026 admission MDS Resident 20 admitted to the facility on [DATE] with no memory impairment. The MDS showed Resident 20 was receiving intravenous antibiotics and had a diagnosis of, but not limited to, cancer. In an interview on 02/05/2026 at 2:13 PM Resident 20 stated staff had not offered or conducted a care conference with them. In an interview and record review on 02/10/2026 at 10:07 AM, Resident 20's health records showed no care conference documentation. Staff B stated they expected admission care conferences to be offered and discussed with residents within one week of admission. Staff B stated Resident 20 was not offered a care conference, but staff should have discussed and documented it in the residents' records. Staff B stated it was important to include the residents and/or representatives in their care conference with their interdisciplinary team to ensure they were included in their plan of care and goals. <Resident 9> Review of an 01/03/2026 comprehensive MDS showed Resident 9 admitted to the facility on [DATE] with diagnoses that included a condition involving the breakdown of skeletal muscle tissue often leading to symptoms such as severe pain and weakness. Resident 9 was able to understand and to be understood. In an interview on 02/05/2026 at 9:24 AM, Resident 9 stated they were not sure what medications staff were administering, and they were frustrated they could not get answers to questions about their condition. In an interview on 02/02/2026 at 09:53 AM, Resident 9 stated they have not attended a care conference. In an interview on 02/11/2026 at 8:51 AM, Staff E (Social Services Director) stated Resident 9 was cognitively intact and was able to direct their care. Staff E stated the normal timeframe to conduct care conferences was within one to two weeks after admission, and they tried to conduct them within the first week when possible. Review of a 01/06/2026 progress note showed Staff E spoke to Resident 9's family member, who asked to postpone Resident 9's care conference until 01/14/2026 so they could attend. No documentation was found to show a care conference was ever conducted for Resident 9. In an interview on 02/11/2026 at 9:15 AM, Staff E stated Resident 9 never had a care conference with the interdisciplinary team. Refer to F658 Services Provided Meet Professional Standards. Refer to F610 Investigate Abuse/Protect Resident During Investigation. Reference: WAC 388-97-1020(1),(2)(a-d),(4)(c)(i-ii),(5)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure physician orders were obtained and clarified for 3 of 14 sampled residents (Residents 41, 17, & 6) reviewed. These failures placed residents at risk of unmet needs, and ineffective/or delayed treatments. Findings included.<Resident 41> According to the 01/01/2026 admission Minimum Data Set (MDS – an assessment tool) Resident 41 admitted to the facility on [DATE]. The MDS showed Resident 41 was not receiving hospice services upon admission to the facility. The MDS showed Resident 41 had diagnoses of, but not limited to, malnutrition and heart disease. Record review showed a 01/08/2026 hospice visit note with Resident 41. Resident 41's health records did not show a physician order for the hospice services. In an interview on 02/11/2026 at 8:43 AM Staff B (Director of Nursing) stated they expected staff to obtain a physician order for hospice service. Staff B reviewed Resident 41's records and stated staff did not obtain a physician order for the hospice services but should have. Staff B stated it was important to obtain a physician order for hospice services to ensure continuity of care. <Resident 17> According to the 01/15/2026 admission MDS Resident 17 admitted to the facility on [DATE]. The MDS showed Resident 17 was receiving Oxygen (O2) therapy during the assessment period. Review of Resident 17's 01/27/2026 Unable to Maintain O2 Saturation Care Plan (CP) showed staff were to administer O2 as ordered. Review of Resident 17's health records showed a 01/09/2026 physician order for one Liter per Minute (L/min) via nasal canula to keep blood O2 level greater than or equal to 92 percent. Resident 17's records showed they received 2-3L/min on 01/31/2026, 02/04/2026, 02/05/2026, 02/07/2026 with no documentation of physician notification. Resident 17's records showed no physician order to change O2 tubing. Observations on 02/06/2026 at 10:06 AM and 02/09/2026 at 9:50 AM showed undated O2 tubing connected to Resident 17's O2 machine. In an interview on 02/10/2026 at 10:24 AM Staff B stated they expected staff to obtain a physician order to change O2 tubing every Tuesday night shift and document. Staff B stated Resident 17 should have a physician order to change O2 tubing but did not. Staff B stated they expected staff to follow physician orders of O2 one L/min and if Resident 17 required more, Staff B expected staff to notify the physician and obtain an order. Staff B stated it was important to follow physician orders and update physicians of changes needed to ensure continuity of care. Staff B stated it was important to obtain a physician order to change O2 tubing or staff would not be notified of the need and not changing the tubing can place the resident at risk of infection. <Resident 6> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 01/11/2026 admission MDS showed Resident 6 admitted with diagnoses including multiple trauma fractures. The MDS showed Resident 6 received a blood thinning, injectable medication during the assessment period. Review of Resident 6's 02/09/2026 physician orders showed a 01/05/2026 order directing staff to administer an injectable blood thinner to Resident 6 twice daily. The order did not have a stop date or direct staff on how many days/weeks to continue the blood thinning medication. In an interview on 02/11/2026 at 12:22 PM, Staff C (Resident Care Manager) reviewed Resident 6's order for the injectable blood thinner and stated staff should clarify the order with the physician. In an interview on 02/11/2026 at 1:15 PM, Staff B reviewed Resident 6's order for the injectable blood thinner and confirmed the injectable blood thinner was not usually prescribed for long term use and should be clarified with the physician. Reference: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure accurate and complete skin assessments for 1 of 2 sample residents (Resident 3) reviewed for skin, implement the bowel protocol for 1 of 1 sample resident (Resident 5) reviewed for constipation, and manage fluid retention for 1 of 1 closed records (Resident 40) reviewed for hospitalizations. Failure to accurately assess and document skin conditions placed Resident 3 at risk of skin breakdown, infection, and decreased quality of life. Failure to implement the bowel protocol for constipation placed Resident 5 at risk of unmet care needs, bowel obstruction, pain, and decreased quality of life. Failure to manage fluid retention placed Resident 40 at risk of respiratory distress and other negative health outcomes.Findings included.<Facility Policy>Review of the facility's February 2014 Resident Examination and Assessment policy showed resident skin assessments included intactness, moisture, color, texture, and presence of bruises, pressure sores, redness, edema, and rashes. All assessment data obtained was documented in the resident's medical record.According to the facility policy titled, Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, dated September 2017, staff would identify risk factors related to bowel dysfunction such as alterations in Bowel Movements (BM). The policy showed nursing staff would assess residents for signs of fecal impaction, dehydration, perform abdominal assessments, digital rectal examinations, assess onset, duration, frequency, and severity of signs and symptoms. The policy showed staff would assess and treat residents for suspected bowel obstructions. According to the facility policy titled, Resident Examination and Assessment, dated February 2014, the staff would assess residents for stool consistency, constipation, and fecal impaction. The policy showed staff would notify the physician of any bowel abnormalities.According to the facility policy titled, Weight Assessment and Intervention, dated March 2022, the facility staff would evaluate undesired weight change from the resident's target weight range and the relationship between current medical condition or clinical situation. According to the facility policy titled, Nutrition (impaired)/Unplanned Weight Loss - Clinical Protocol, dated September 2017, the facility would report to the physician any significant weight changes or any abrupt persistent change from baseline. The policy showed the physician would evaluate for medical causes of the weight change. The policy showed residents with rapid weight gain, the staff would review for possible fluid and electrolyte imbalance as a cause. The policy showed staff and physicians would identify pertinent interventions based on identified causes and overall resident condition. According to the facility policy titled, Heart Failure - Clinical Protocol, dated November 2018, the physician would review and make recommendations on weight monitoring and when to report findings to the physician. The policy showed the physician would order medications with appropriate instructions, such as diuretic medications, for residents with heart failure. <Skin Assessments> <Resident 3> Review of an 11/30/2025 Comprehensive Minimum Data Set (MDS – an assessment tool) showed Resident 3 admitted to the facility on [DATE] with diagnoses including dementia (a decline in mental ability that interferes with daily life) and a broken hip. Resident 3 was dependent on staff for bed and chair mobility, transfers, and toileting hygiene, and was at risk for developing pressure ulcers/injuries. Review of Resident 3's 11/14/2025 Care Plan showed Resident 3 was at risk for pressure injury due to decreased mobility, extensive to total assistance with bed mobility and transfers, incontinence, and cognitive and communication impairment. Staff were to perform a complete assessment of the (continued on next page)

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	505504	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Shores Health Center	9107 Fortuna Drive Mercer Island, WA 98040

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin once weekly. Review of an 11/14/2025 physician's order directed staff to conduct a skin assessment for Resident 3 once weekly. Observations on 02/09/2026 from 7:58 AM to 2:32 PM showed Resident 3 continuously sat in their tilt-in-space wheelchair (a mobility device with ability to recline). Review of Resident 3's February 2026 Treatment Administration Record (TAR) showed a skin assessment was performed on 02/04/2026 with no documentation found to show the skin assessment findings. Review of Resident 3's January 2026 TAR showed skin assessments were performed on 01/07/2026, 01/14/2026, and 01/21/2026 with no documentation found to show the skin assessment findings. Review of Resident 3's December 2025 TAR showed skin assessments were performed on 12/03/2025, 12/10/2025, and 12/24/2025 with no documentation found to show the skin assessment findings. In an interview on 02/11/2026 at 11:46 AM, Staff C (Resident Care Manager) stated they were not aware of any skin problems for Resident 3. Staff C attempted to find documentation of Resident 3's skin condition in their record but could not. In an interview on 02/11/2026 at 12:05 PM, Staff B (Director of Nursing) stated residents had a skin check done on admission, and then every seven days. Staff B stated their electronic health records system prompted nurses to sign indicating Resident 3's skin check was completed but did not have a monitor set up for them to record their findings. Staff B stated nurses could document findings in progress notes. Staff B looked but did not find any progress notes showing skin assessment results for Resident 3. Staff B stated there was a new skin assessment form they instructed nurses to complete, but none were completed for Resident 3. Staff B stated it was important to document skin assessment findings to identify any problems that needed treatment and to determine interventions. <Bowel Management> <Resident 5> According to the 01/24/2026 Quarterly MDS Resident 5 admitted to the facility on [DATE]. The MDS showed Resident 5's bowel pattern was constipation. The MDS showed Resident 5 was dependent on staff assistance with toileting and transfers. In an interview on 02/05/2026 at 5:21 PM, Resident 5's representative stated Resident 5 was constipated frequently, and they would have to manually remove BMs that were the size of softballs and hard as a rock. Resident 5's representative stated they notified staff on several occasions but no new orders from the physician were obtained. Record review on 02/07/2026 at 11:13 AM showed Resident 5 had physician orders for an as needed laxative if no BM in three days, if no BM after that laxative, then a stronger laxative, and if no BM from that laxative, staff were to administer a stronger laxative and notify the physician. Resident 5's records showed no BM on 11/14/2025, 11/15/2025, 11/16/2025,11/21/2025, 11/22/2025, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/23/2025, 11/28/2025, 11/29/2025, 11/30/2025, 12/01/2025, 12/06/2025, 12/07/2025, 12/08/2025, 12/09/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 01/03/2026, 01/04/2026, 01/05/2026, 01/21/2026, 01/22/2026, and 01/23/2026. These records showed staff did not offer or administer the bowel protocol medications as ordered by the physician. In an interview on 02/10/2026 at 10:08 AM, Staff B reviewed Resident 5's BM monitor and medication administration records and stated Resident 5 did not have BMs on 11/14/2025, 11/15/2025, 11/16/2025,11/21/2025, 11/22/2025, 11/23/2025, 011/28/2025, 11/29/2025, 11/30/2025, 12/01/2025, 12/06/2025, 12/07/2025, 12/08/2025, 12/09/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/23/2025, 01/03/2026, 01/04/2026, 01/05/2026, 01/21/2026, 01/22/2026, and 01/23/2026. Staff B stated staff did not administer Resident 5 laxatives per the facility bowel protocol or physician's orders but should for each incident of no BM for three days. Staff B stated they expected staff to notify the physician when residents had constipation or if the bowel protocol was ineffective to ensure proper care for a resident's constipation. <Fluid Retention Management> <Resident 40> According to the 01/11/2026 Discharge MDS, Resident 40 admitted to the facility on [DATE]. The MDS showed Resident 40 had a diagnosis of heart failure. Review of Resident 40's records showed physician orders for a diuretic medication (used in heart failure for fluid retention/overload) to be administered for a three Pound (lb) weight gain in one day or five lb weight gain in one week. Resident 40's records showed their weight on 01/06/2026 was 231lbs, on 01/07/2026 was 241lbs, on 01/08/2026 was 242lbs, on 01/09/2026 was 244lbs, on 01/10/2026 their weight was not obtained, and on 01/11/2026 was 245 lbs. Resident 40's records showed the as needed diuretic medication was not administered. Resident 40's records showed a nursing progress note on 01/11/2026 that Resident 40's family requested staff check their weight and it was 245lbs. The progress note showed the family stated Resident 40's weight upon discharge from the hospital on [DATE] was 228lbs. The progress note showed the family requested to take Resident 40 to the hospital for the weight gain/fluid retention. Resident 40's records showed a 01/12/2026 Social Service note stating Resident 40 was admitted to the hospital for heart failure exacerbation with significant weight gain of fluid retention. The Social Service note showed Resident 40's family was upset with the facility for the mismanaged heart failure with fluid retention and did not want Resident 40 to be readmitted to the facility. Review of Resident 40's hospital transfer records showed the hospital obtained a weight of 226lbs on 01/05/2026 for Resident 40. In an interview on 02/09/2026 at 11:05 AM, Staff B stated Resident 40 did not receive the as needed diuretic medication per physician orders but should have. Staff B stated they were unsure the hospital admission for heart failure exacerbation could have been avoided if facility staff had administered the diuretic medication as ordered for Resident 40, but possibly. Refer to F677 ADL Care Provided for Dependent Residents. Reference: WAC 388-97-1060(1).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure chemicals were stored safely for 1 (Rose Unit) of 3 units reviewed. The failure to ensure that chemicals were secured placed residents at risk of injury, an unsafe environment, and other negative health outcomes.Findings included.<Facility Policy>According to the undated facility policy titled, Chemical Storage Policies and Procedures, the facility did not instruct staff to store chemicals behind locked doors, out of reach of residents to avoid accident hazards.<Rose Unit>Observation and interview on 02/05/2026 at 9:23 AM showed chemicals in the bathroom of room [ROOM NUMBER], on the wall in the hallway, on the side of the medication cart, and on the hallway railing outside of room [ROOM NUMBER]. The observed chemicals showed labels indicating the chemicals should be kept out of reach of children. Staff N (Registered Nurse -RN) stated chemicals were okay to store in residents' bathroom. Staff N stated the chemicals on the railing in the hallway should not be stored there because staff could misuse them. Staff O (RN Manager) stated chemicals should not be stored in residents rooms or within reach of residents.Interview on 02/05/2025 at 9:35 AM Staff P (Lead Housekeeper) stated chemicals should be locked behind a locked cabinet/door.In an interview on 02/05/2026 at 9:39 AM Staff A (Administrator) stated they expected staff to store chemicals behind locked doors for resident safety.Observation on 02/09/2026 at 8:22 AM showed a disinfectant chemical cleaner on the precaution cart outside of room [ROOM NUMBER], on the hallway wall, and on the side of the medication cart.In an interview on 02/09/2026 at 8:22 AM, Staff B (Director of Nursing) stated they expected chemicals to be stored behind locked doors. Staff B stated it was important to store chemicals behind locked doors for resident safety.Reference: WAC 388-97- 1060(3)(g).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to ensure drugs and biologicals were secured for 2 (Residents 20 & 37) observed with medications in their rooms and failed to ensure proper storage of drugs on 1 (Rose Medication Cart) of 2 facility medication carts. These failures placed residents at risk for receiving the wrong medications, contaminated medications, and non-assessed self-administration of medications by residents.Findings included.<Facility Policy>Review of the facility's Medication Labeling and Storage policy, revised 02/2023, showed medications and biologicals would be stored in the packaging, containers, or other dispensing system in which they were received. The policy showed over-the-counter medication labels would contain the medication name, strength, quantity, lot number, and expiration date. The policy showed medications would be stored in drawers, cabinets, rooms, refrigerators, carts, and boxes that were locked when not in use.<Medications at Bedside> <Resident 20> Observations on 02/05/2026 at 9:14 AM and 02/06/2026 at 10:11 AM showed a medication cup at Resident 20's bedside with two capsules in it. Resident 20 stated that they were pancreatic enzyme medications, and the resident only took them if they ate. In an interview on 02/06/2026 at 10:14 AM Staff N (Registered Nurse) stated Resident 20 would take the medication if they ate a lot and if they only ate a little, they would not take them. Staff N stated Resident 20 was not assessed for safety related to self-administration of medications, did not have a physician order, and was not care planned to self-administer their medications, but should be. <Resident 37> Observation and interview on 02/06/2026 at 8:46 AM showed a bag of saline syringes hanging on Resident 37's intravenous pump pole, a bottle of eye drop medication, and multiple, single-use eye drop medication vials on their bedside table. Resident 37 stated the nurses stored the syringes on the pole for when they administered the IV medications. Resident 37 stated they would self-administer the eye drops from the bottle and single use vials when they needed them. In an interview on 02/06/2026 at 10:14 AM Staff N stated Resident 37 brought their eye drop medications in on their own and Staff N informed them to have family bring them home because they did not have a physician order for the medications. Staff N stated they saw Resident 37 did not have their family bring them home and that they were still on their bedside table. Staff N stated staff should remove the medications and store them in the locked medication cart, obtain a physician order, assess Resident 37 for safety to self-administer, and update the care plan if appropriate, but did not. In an interview on 02/10/2026 at 9:58 AM, Staff B (Director of Nursing) stated staff should complete a self-administration assessment for residents that wanted to self-administer their medications. Staff B stated they expected staff to provide residents with a key for a locked drawer to store their medications after completion of the assessment, obtaining a physician order, and care planning self-administration for the residents. Staff B stated staff should not leave medications at Resident 20's or 37's bedside. Staff B stated it was important to store medications behind locked drawers for resident safety. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Rose Medication Cart> Observation of the [NAME] Medication Cart on 02/10/2026 at 9:31 AM showed a medication cup containing 30 white, round medication tablets. The cup was unlabeled, did not show the name of the medication, strength, or expiration date, and did not have a lid to contain the medications. In an interview at that time, Staff M (Registered Nurse) stated unlabeled medications were not safe and the unidentified white tablets should be disposed. In an interview on 02/11/2026 at 11:44 AM, Staff B stated all medications should be properly labeled, stored, and locked in the medication cart. REFERENCE: WAC 388-97-1300(2).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented for residents with indwelling medical devices for 1 of 2 residents (Resident 20) reviewed with indwelling devices, properly store urinary catheter bags, and perform hand hygiene during catheter care for 1 of 2 residents (Resident 13) reviewed for urinary catheter use. Failure to implement EBPs, perform hand hygiene during urinary catheter care, and properly store a urinary catheter bag placed residents at risk of infection and other negative health outcomes.Findings included.<Facility Policy>Review of the facility's August 2022 Enhanced Barrier Precautions policy showed EBPs were used as an infection prevention and control intervention for residents with indwelling medical devices (such as central lines and urinary catheters) to prevent the spread of multi drug-resistant organisms. EBPs included staff use of gowns and gloves during high-contact resident care activities including device care or use. EBP's remained in place for the duration of the resident's stay or until discontinuation of the indwelling medical device.<Resident 20>According to 02/05/2026 admission Minimum Data Set (MDS - an assessment tool) Resident 20 admitted to the facility on [DATE]. The MDS showed Resident 20 had diagnoses of cancer and malnutrition.Review of Resident 20's health records showed a 01/30/2026 physician order for Intravenous (IV) medications. Resident 20's records did not show physician orders for EBP.Observation on 02/05/2026 at 9:30 AM and 02/06/2026 at 10:14 AM showed Resident 20 with a right chest IV device and no EBPs were in place.In an interview on 02/10/2026 at 9:45 AM Staff B (Director of Nursing) stated Resident 20 should be on EBP for their right chest central IV port but was not. Staff B stated it was important to implement EBP for residents with indwelling devices to prevent infection.<Resident 13>According to the 01/22/2026 admission MDS, Resident 13 admitted to the facility on [DATE]. The MDS showed Resident 13 had an indwelling urinary catheter.Review of Resident 13's health records showed a 01/16/2026 urinary catheter care plan instructing staff to monitor the catheter bag for proper placement. Resident 13's records showed a physician order to perform urinary catheter care.Observation on 02/06/2026 at 9:38 AM showed Resident 13's urinary catheter bag lying on the floor, on the right side of the bed, uncovered. Observation on 02/09/2026 at 10:03 AM showed Staff Q (Certified Nursing Assistant) cleaning Resident 13's urinary catheter and changing their brief. Staff Q did not perform hand hygiene or change gloves between dirty and clean care. During catheter care, Staff Q touched Resident 13's furniture, call light, and clothing with the same, dirty gloves.In an interview on 02/09/2026 at 10:27 AM, Staff Q stated they should have washed their hands and changed gloves between dirty and clean care. Staff Q stated it was important for good hygiene and to prevent infection.In an interview on 02/11/2026 at 8:40 AM Staff B stated they expected staff to cover and secure catheter bags off the floor. Staff B stated they expected staff to perform hand hygiene and change gloves between dirty and clean care. Staff B stated it was important to store catheter bags off the floor, perform hand hygiene, and change gloves between dirty and clean care to prevent infections.Reference: WAC 388-97-1320(1)(c)(2)(a)(b).