STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505507	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelton Health and Rehabilitation	153 Johns Court Shelton, WA 98584

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure psychotropic medications (any drug that affects the brain activities associated with mental processes and behavior) were regularly monitored and documented on, including the interventions, for 5 of 5 sampled Residents (6, 7, 9, 45, and 50) reviewed for unnecessary medications. This failure placed residents at risk of unnecessary medication usage and a diminished quality of life. Findings included .Resident 6Resident 6 was admitted to the facility on [DATE]. Review of the Quarterly minimum data set (MDS, an assessment tool), dated 02/09/2026, showed the resident had moderate cognitive impairment, a diagnosis of anxiety disorder, and received antidepressant and antianxiety medication during the assessment period. Review of the electronic health record showed Resident 6 had the following psychotropic medication (drugs that alter brain chemistry to treat mental health conditions) orders:a) A 03/19/2026 order for alprazolam (an antianxiety medication) every eight hours as needed for 120 days for anxiety disorder.b) A 02/18/2026 order for duloxetine (an antidepressant) daily for dysthymic disorder (a chronic, long-term form of mild-to-moderate depression that lasts for at least two years).c) A 02/11/2026 order for escitalopram (an antidepressant) daily for depression. An impaired psychosocial wellbeing related to depression and anxiety disorders care plan, initiated 01/21/2026, directed staff to monitor for Anxious, Panic, self-isolation and refusal of care. The care plan did not identify what psychotropic medications Resident 6 was receiving or what target behavior(s) each medication was initiated to treat. Review of the March 2026 MAR and TAR showed there was no direction to nurses to monitor target behaviors associated with the resident's use of alprazolam, duloxetine, or escitalopram. Review of Resident 6's Point of Care charting, a program where Certified Nursing Assistants (CNAs) document care, showed CNA's were directed to monitor Resident 6 for the following behaviors: grabbing others; hitting others; kicking others; pushing others; physical aggression towards others; scratching others; accusing others; cursing others; expressing frustration/.anger at others; screaming at others, threatening others; disruptive sounds; disrobing in public; entering others personal space, public sex acts; repetitive motions; rummaging; spitting; throwing/smearing food; throwing body waste; agitation; anxiousness/restlessness; elopement; pacing; panic neglecting self-care; picking at self; refusing care; sad/tearful; self-injury; hoarding; withdrawn/isolation; and wandering. The behavior monitor did not identify what behaviors, if any, were specific to Resident 6 or which behaviors were being targeted by which medication. On 03/26/2026 at 3:09 PM, Staff B, Director of Nursing Services (DNS), explained that behavior monitors were used to monitor the frequency of target behaviors, which helped the facility assess the effectiveness of the medication. When asked how someone could determine the effectiveness of a medication based on the frequency target behaviors were demonstrated, if the behaviors a medication was initiated to target were never identified, Staff B provided no response. Review of Resident 6's as needed alprazolam order history showed the resident had an active order for alprazolam every eight hours as needed, for the following time periods:a) 01/19/2026 - 02/05/2026 (15 days). b) 02/10/2026 - 02/24/2026 (15 days); the electronic health record (EHR) showed there was no provider documented (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	clinical rationale for the extension of the as needed alprazolam.c) 02/26/2026- 03/09/2026 (14 days); the EHR) showed there was no provider documented clinical rationale for the extension of the as needed alprazolam.d) On 03/10/2026 Resident 6's as needed alprazolam order was extended for an additional 120 days. A pharmacy recommendation, dated 03/06/2026, documented Resident 6 had been receiving as needed alprazolam since 01/23/2026 and instructed if the provider wanted to extend the prescription, they must document a clinical rationale for the extension and indicate a specific duration in days for the extension. Further review showed the provider checked the box for extending the as needed alprazolam for 120 days and documented panic disorder as the clinical rationale for the extension. On 03/27/2026 at 2:29 PM, Staff B, DNS, was asked for a copy of the provider documented rationales for each time Resident 6's as needed alprazolam was extended beyond 14 days. No further documentation was provided. Review of the February 2026 MAR showed there were no non-pharmacological interventions identified for nurses to attempt prior to administering Resident 6's as needed alprazolam, which was administered 23 times during the month. On 03/27/2026 at 2:29 PM, documentation of the non-pharmacological interventions facility nurses attempted prior to administering the as needed alprazolam was requested. On 03/30/2026 at 1:58 PM, Staff B responded in an email that she was unable to find that any non-pharmacological interventions were attempted prior to administration of Resident 6's as needed alprazolam. Resident 50Resident 50 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively impaired, had diagnoses of depressive disorder (a serious, common mood disorder causing persistent sadness, loss of interest, and low energy that interferes with daily life), psychotic disorder (a mental health condition characterized by a loss of contact with reality, where individuals struggle to distinguish what is real from what is not) and received antipsychotic and antidepressant medication during the assessment period. Review of Resident 50's electronic health record (EHR) showed orders for the following psychotropic medications (rugs that affect the mind, emotions, and behavior by altering chemical levels in the brain):a) Aripiprazole (an antipsychotic) once a day for psychosis, dated 03/05/2026.b) Escitalopram (an antidepressant) once a day for depression. Review of the 02/10/2026 Psychoactive Drug Consent for aripiprazole showed verbal consent was obtained from Resident 50's representative for the treatment of unspecified psychosis. Further review of the document showed the sections for non-pharmacological interventions in use prior to start of medication, benefits of medication use, and indication for use (target behaviors) were all left blank. An impaired psychosocial well-being related to depression and psychosis care plan, initiated 02/10/2026, documented the resident was on behavior monitoring for 30 days to establish target behaviors, triggers and interventions. Staff were instructed to monitor for refusals and self-isolation, as well as for adverse side effects associated with antidepressant and antipsychotic medications. The care plan did not identify what medications Resident 50 was receiving or the target behaviors they were initiated to treat. Review of the EHR showed no documentation that staff asked/discussed what associated behaviors Resident 50 had demonstrated related to their diagnosed psychotic disorder and depressive disorder. The March 2026 MAR showed there were no target behaviors identified or being monitored. Review of Resident 50's Point of Care behavior monitor showed it was the same prefabricated behavior monitor as Resident 6 had. The behavior monitor did not identify which behaviors were targeted by which medication. On 03/26/2026 at 12:31 PM, Staff C, Resident Care Manager, explained during the facility's psychotropic meetings, behavior monitors to were used to assess the effectiveness of psychotropic medications. When asked what specific behaviors were targeted by the aripiprazole versus the behaviors that were targeted by the escitalopram Staff C, said, We are monitoring for (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behaviors, but again I cannot see a differentiation (of which behavior(s) were targeted by what medication). Resident 9 Resident 9 was admitted to the facility on [DATE] with diagnoses of depressive disorder (mental health condition characterized by persistent feeling of sadness or loss of interest) and post-traumatic stress disorder (mental health condition that can develop after a person experiences or witnesses a traumatic event). According to the Quarterly MDS, dated [DATE], Resident 9 was moderately cognitively impaired. Resident 9 had a provider order, dated 03/17/2026, for Seroquel (antipsychotic medication that affects brain chemicals and may stabilize mood, thinking and behavior) to be given daily for post-traumatic stress disorder. Resident 9 had another provider order, dated 02/24/2026, for venlafaxine, (an antidepressant medication), to be given daily for major depressive disorder. Further review of Resident 9's orders showed there were no behavior monitors ordered for the licensed nursing staff to document behaviors related to the antipsychotic or the antidepressant. Resident 9's Behavior Monitoring & Interventions task documentation (where Certified Nursing Assistants were to document observed behaviors) reviewed from 03/01/2026 through 03/30/2026, showed an area to document sad/tearful, but did not indicate which medication or diagnosis this behavior was being monitored for. On 03/26/2026 at 12:22 PM Staff C, Resident Care Manager, Registered Nurse, said his expectation was for Resident 9's antidepressant and antipsychotic medications to have target behavior monitoring in place. When asked if the antipsychotic medication target behaviors were being monitored, Staff C said they had monitors in place. When asked if there were specific monitors, Staff C said sad and tearful was on the care plan. When asked if Resident 9 was taking both the antipsychotic and the antidepressant for sad and tearful, Staff C said they could not answer without reading more in the chart. Resident 45 Resident 45 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and restlessness and agitation. The admission MDS, dated [DATE], showed Resident 45 was cognitively intact and taking an antipsychotic and an antidepressant. Review of Resident 45's current orders, showed they were taking an antidepressant, trazodone, ordered on 03/18/2026, and they were no longer taking an antipsychotic. Further review of Resident 45's orders, showed there was no behavior monitor ordered for the licensed nursing staff to document behaviors related to the antidepressant. Review of Resident 45's psychoactive drug consent, dated 12/29/2025, indicated they were taking the antidepressant for the following behaviors/actions/thoughts: feeling sad, little interest or pleasure in doing things, low motivation, loss of interest in food, and sleeplessness. The indication for Resident 45 using an antipsychotic medication at this time, was for agitation, elevated mood, and poor (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emotional control. Resident 45's psychoactive drug consent, dated 03/23/2026, indicated Resident 45 was taking the antidepressant for the following behaviors/actions/thoughts: sleeplessness. Review of Resident 45's psychosocial well-being care plan, last revised on 01/28/2026, showed Resident 45 had anxiety disorder and depression with target behaviors listed as agitation, anger, cursing, grabbing, hitting, kicking, screaming, yelling, throwing fecal matter at staff, racist slurs, non-complaint with cares, and accusing of others. This care plan listed Resident 45 as taking an antipsychotic medication and an antidepressant/anxiolytic (anti-anxiety). There was no clear distinction of which target behaviors were being treated by which psychotropic medication, nor was there a distinction between observed behaviors not being treated by medication and target behaviors being treated by the psychotropic medication. During an interview on 03/26/2026 at 10:42 AM, Staff C, Resident Care Manager/ Registered Nurse, said that psychoactive drugs require a monitor for behaviors and adverse side effects. For Resident 45, Staff C said their care plan had their behavior monitors listed. When asked how the facility knew which behaviors were being treated/monitored for each class of psychotropic medication listed on the care plan, Staff C said they did not know if they were differentiated on Resident 45's care plan. Staff C acknowledged Resident 45's antidepressant would not be used for treating racists slurs. Staff C showed the facility had a generalized behavior monitor, recorded by the Certified Nursing Assistants (CNAs). When asked if Resident 45 had a antidepressant specific behavior monitor in place, with staff tracking if the behaviors did or did not happen related to this antidepressant, Staff C said they could not say the behavior monitor was specific to the antidepressant. During an interview on 03/26/2026 at 1:16 PM, Staff B, Director of Nursing Services, said their expectation for behavior monitors related to psychotropic medications, was for there to be open ended behavior monitoring on admission, they should be on an alert for medications, and then after a month or so the facility could narrow down (behaviors) and update/adjust the care plan. Staff B said they expected staff to chart under the task (this was the CNAs' charting) and nursing charting. When asked about Resident 45 and how staff would know how to consistently document racial slurs under their generic behavior monitor (for the CNAs), Staff B said social work was supposed to go back and follow up and tweak the care plan. When asked if they had behavior monitors for each psychotropic drug, Staff B said yes, it was under the tasks and nursing charting. Resident 7 Resident 7 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder. Resident 7's Quarterly MDS, dated [DATE], documented the resident was moderately cognitively impaired and required partial to moderate assistance with activities of daily living. The MDS documented Resident 7 was on an antipsychotic and an antidepressant . Review of the EHR showed Resident 7 had orders for scheduled psychotropic and antidepressant medications: -Aripiprazole one time a day related to Major Depressive Disorder, order dated 04/28/2025 -Venlafaxine one time a day for depression, order dated 08/07/2025 -Venlafaxine one time a day related to Major Depressive Disorder, order dated 12/17/2025 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/2026 at 12:31 PM, Staff C, Resident Care Manager/Registered Nurse, said Resident 7 had behaviors such as being tearful, sad, and really liked their Pepsi. Staff C said they try to console Resident 7 and redirect them when they have these behaviors. Staff C said the behaviors and interventions being documented by the CNAs were similar to other residents who were on an antidepressant and antipsychotic and not specific to Resident 7. They were the same monitors and interventions in place similar to the other residents. On 03/27/2026 at 8:16 AM, Staff K, Registered Nurse Med Nurse, was asked where they would document if Resident 7 was having behaviors and Staff K responded by saying I would have to put in a progress note. Staff K was asked if they documented Resident 7's behaviors every shift and they said only if it was noteworthy or Resident 7 was on alert. On 03/27/2026 at 8:22 AM, Staff J, Licensed Practical Nurse, said they could chart Resident 7's behaviors everyday but did not unless it was something new. Staff J said they would write a progress note. Reference WAC 388-97-0620 (1)(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure notification to the Office of the State Long-Term Care Ombudsman (resident advocates) occurred for residents transferred to the hospital for 3 of 3 sampled residents (Residents 3, 6, & 67) reviewed for hospitalization and 1 of 1 Resident (Resident 69) reviewed for Against Medical Advice (AMA) discharge. This failure placed residents at risk of a lack of advocacy and possible unidentified or unmet care needs. Findings included .Resident 3 Resident 3 was admitted to facility on 07/13/2022. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/23/2026, documented Resident 3 was severely cognitive impaired. Resident 3 was transferred to the hospital on [DATE]. The electronic health record (EHR) showed no documentation the Ombudsman was notified of the transfer. Resident 6 Resident 6 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 6 was severely cognitive impaired. Resident 6 was transferred to the hospital on [DATE]. The EHR showed no documentation the Ombudsman was notified of the transfer. Resident 67 Resident 67 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 6 was severely cognitive impaired. Resident 67 was transferred to the hospital on [DATE]. The EHR showed no documentation the Ombudsman was notified of the transfer. On 03/25/2026 at 10:35 AM, Staff I, Social Services Assistant (SSA), said they started this position in January 2026 and would have to look for the Ombudsman notifications for those specific residents. On 03/26/2026 at 11:06 AM, Staff I said they were not able to locate the Ombudsman notification for the specific residents. When asked if the EHR should have documented the Ombudsman notification for each resident, Staff I, said yes, it should have. On 03/26/2026 at 11:57 AM, in a joint interview with Staff A, Administrator and Staff B, Director of Nursing Services (DNS), both staff said the EHR should have had documentation showing the Ombudsman was notified of the listed residents' transfers. Resident 69 Resident 69 was admitted to the facility on [DATE]. The admission MDS, dated [DATE], documented Resident 69 was moderately cognitively impaired. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the EHR showed Resident 69 was discharged AMA on 02/22/2026. On 03/24/2026 at 3:11 PM, Staff H, Social Services Director, said they would follow-up the next day when asked if they had the ombudsman notification from Resident 69. A review of the Nursing Home Transfer and Discharge Notice for Resident 69 documented the resident left AMA on 02/22/2026 and was signed by Staff I, SSA on 03/25/2026. On 03/25/2026 at 11:51 AM, an email from Staff A, Administrator, said Resident 69 was not included in the ombudsman notification because when they ran the report for discharges, the AMA residents were not included. On 03/26/2026 at 8:20 AM, Staff I, said they sent the Ombudsman the Nursing Home Transfer and Discharge Notice for Resident 69 on 03/25/2026. Staff I, said they tried to send them every Friday and this one was sent late. Reference WAC 388-97-0160

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review, revise and implement a comprehensive plan of care to include, resident behavior monitoring and specific interventions, and guardianship for 6 of 16 sampled Residents (6, 7, 54, 9, 45, and 50) reviewed for comprehensive care plans. This failure to establish care plans that were comprehensive placed residents at risk of receiving inappropriate and inadequate care to meet their individualized needs.Findings included.Resident 7 Resident 7 was admitted to the facility on [DATE] with a diagnosis of major depressive disorder (a serious mental health condition characterized by persistent sadness, low mood, and loss of interest in activities for at least two weeks). Resident 7s Quarterly Minimum Data Set (MDS, an assessment tool), dated 12/18/2025, documented the resident was moderately cognitively impaired and required partial to moderate assistance with activities of daily living. The MDS documented Resident 7 was on an antipsychotic and antidepressant. Review of the electronic health record (EHR), showed Resident 7 orders for scheduled psychotropic and antidepressant medications: -Aripiprazole Tablet by mouth one time a day related to Major Depressive Disorder, order dated 04/28/2025 -Venlafaxine one time a day for depression, order dated 08/07/2025 -Venlafaxine one time a day related to Major Depressive Disorder, order dated 12/17/2025 On 03/26/2026 at 12:31 PM, Staff C, Resident Care Manager/Registered Nurse, said Resident 7 had behaviors such as being tearful, sad, and really liked their Pepsi. Staff C said they try to console Resident 7 and redirect them. Staff C said, Resident 7's care plan listed behaviors and interventions but they were not specific to Resident 7 and specify which medications they were for. Resident 45 Resident 45 was admitted to the facility on [DATE] with diagnoses of anxiety, depression, and restlessness and agitation. The admission MDS, dated [DATE], showed Resident 45 was cognitively intact. Review of Resident 45's current orders, showed they were taking an antidepressant, trazodone, ordered on 03/18/2026, and they were no longer taking an antipsychotic. Review of Resident 45's psychosocial well-being care plan, last revised on 01/28/2026, showed Resident 45 had anxiety disorder and depression with target behaviors listed as agitation, anger, cursing, grabbing, hitting, kicking, screaming, yelling, throwing fecal matter at staff, racist slurs, non-complaint with cares, and accusing of others. This care plan listed Resident 45 as taking psychotropic medications that included both an antidepressant/anxiolytic (anti-anxiety) and an antipsychotic. There was no clear distinction of which target behaviors were being treated by which psychotropic medication, nor was there a distinction between observed behaviors not being treated by medication and target behaviors being treated by the psychotropic medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/26/2026 at 10:42 AM, Staff C, Resident Care Manager/ Registered Nurse, when asked how the facility knew which behaviors were being treated/monitored for each class of psychotropic medication listed on the care plan, Staff C said they did not know if they were differentiated on Resident 45's care plan. Staff C reviewed Resident 45's chart and confirmed Resident 45 was not currently taking an antipsychotic despite having it listed on their care plan. Staff C said care plans should be updated when there was a new medication change. Resident 54 Resident 54 was admitted to the facility on [DATE] with a diagnosis of dementia. The Annual MDS, dated [DATE], showed Resident 54 had severe cognitive impairment. Review of Resident 54's EHR, showed they had a guardian (court appointed decision maker). Review of Resident 54's care plans, reviewed on 03/27/2026, showed no care plan existed related to the guardianship or family involvement related to information. Review of Resident 54's care conferences on 06/04/2025, 09/08/2025, and 12/11/2025, showed no mention that family was included in the meeting. During an interview on 03/23/2026 at 11:46 AM, Resident 54's family member (CC1), said they were not included in care conferences, they had wanted to be included in them, and wanted to be updated on Resident 54. CC1 said that months ago it had been difficult to get a list of Resident 54's medications. CC1 stated, We felt like they were treating us like nothing because she had a guardian, even though we petitioned for that. We have felt like our hands are tied and don't get updates. During an interview on 03/26/2026 at 4:15 PM, Resident 54's guardian (CC2), said CC1 was allowed to get information on Resident 54 and had been able to the whole time. CC2 said CC1 was able to be present for care conferences, as it would help the family understand the dementia diagnosis and any decline. When asked about the past few care conferences, CC2 said they were not sure CC1 was invited but that they were always welcome. CC2 said it was okay for CC1 to know about upcoming appointments, such as dental or podiatry appointments. During an interview on 03/25/2026 at 2:40 PM, Staff H, Social Services Director, said CC1 has had approval for information since admission, and she can get whatever information the guardian was okay with. When asked what the guardian had specified for CC1 to get information on, Staff H said they had only been in this role since 02/16/2026. Staff H said that if CC1 requested information today, they would call the guardian and get information from them on what they could provide to CC1. Staff H said they were in the process of setting up a care conference for Resident 54 and had not emailed the guardian for permission to invite CC1. During a follow-up interview on 03/27/2026 at 10:03 AM, Staff H said CC1 was allowed to have general information on care, activities and appointments, and could call to check on them. Staff H said this should be care planned, and confirmed it was not. During an interview on 03/27/2026 at 10:09 AM, Staff J, Licensed Practical Nurse, reviewed Resident 54's electronic profile and said they would not give CC1 any information. Staff J said it would be helpful, to have a care plan with information on who could be involved and what kind of contact they could have. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/27/2026 at 10:45 AM, Staff B, DNS, was told about Resident 54's family being unable to get information/updates. Staff B reviewed the past couple of care conferences and said they did not list the family as being present. Staff B said this probably should have been care planned, for staff communication. Staff B said their expectation was for it to have been communicated correctly to staff, so that they would pass information on to those that were allowed to have the information. Resident 6Resident 6 was admitted to the facility on [DATE]. Review of the Quarterly MDS, dated [DATE], showed the resident had moderate cognitive impairment, a diagnosis of anxiety disorder, and received antidepressant and antianxiety medication during the assessment period. Review of the electronic health record showed Resident 6 had the following psychotropic medication (drugs that alter brain chemistry to treat mental health conditions) orders:a) A 03/19/2026 order for alprazolam (an antianxiety medication) every eight hours as needed for 120 days for anxiety disorder.b) A 02/18/2026 order for duloxetine (an antidepressant) daily for dysthymic disorder (a chronic, long-term form of mild-to-moderate depression that lasts for at least two years).c) A 02/11/2026 order for escitalopram (an antidepressant) daily for depression. An impaired psychosocial wellbeing related to depression and anxiety disorders care plan, initiated 01/21/2026, directed staff to monitor for Anxious, Panic, self-isolation and refusal of care, as well as for adverse side effects associated with antipsychotic, antidepressant, anxiolytic and anticonvulsant medications. The care plan did not identify what psychotropic medications Resident 6 was receiving or what target behavior(s) each medication was initiated to treat. Additionally, Resident 6 was not prescribed a anticonvulsant or antipsychotic medication. Resident 50Resident 50 was admitted to the facility on [DATE]. Review of the admission MDS, dated [DATE], showed the resident was cognitively impaired, had diagnoses of depressive disorder (a serious, common mood disorder causing persistent sadness, loss of interest, and low energy that interferes with daily life), psychotic disorder (a mental health condition characterized by a loss of contact with reality, where individuals struggle to distinguish what is real from what is not) and received antipsychotic and antidepressant medication during the assessment period. Record review showed Resident 50 had a 03/05/2026 order for aripiprazole (an antipsychotic) once a day for psychosis, and a 02/10/2026 order for escitalopram (an antidepressant) once a day for depression. An impaired psychosocial well-being related to depression and psychosis care plan, initiated 02/10/2026, showed staff were instructed to monitor for refusals and self-isolation, as well as for adverse side effects associated with antipsychotic, antidepressant, anxiolytic and anticonvulsant medications use. The care plan did not identify which medications Resident 50 was received or the target behaviors they were initiated to treat. Additionally, Resident 50 was not prescribed an anticonvulsant medication. During an interview on 03/27/2026 at 10:44 AM, Staff H, Director of Social Services, said the psychotropic medications a resident received and the specific behavior(s) each medication was initiated to target/treat should be identified/addressed in the care plan. When asked if the care plans should be specific/personalized to the needs of each resident (e.g., only monitor for adverse side effects of medications a resident receives) Staff H stated, yes. Resident 9 Resident 9 was admitted to the facility on [DATE] with diagnoses of depressive disorder (mental health condition characterized by persistent feeling of sadness or loss of interest) and post-traumatic stress disorder (mental health condition that can develop after a person experiences or witnesses a traumatic event). According to the Quarterly MDS, dated [DATE], Resident 9 was moderately (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively impaired. Resident 9 had a provider order, dated 03/17/2026, for Seroquel (antipsychotic medication that affects brain chemicals and may stabilize mood, thinking and behavior) to be given daily for post-traumatic stress disorder. Resident 9 had another provider order, dated 02/24/2026, for Venlafaxine, (an antidepressant medication), to be given daily for major depressive disorder. Review of Resident 9's impaired psychosocial well-being care plan, revised 02/22/2026, documented the behaviors requiring intervention and psychotropic drug utilization were related to diagnoses of delirium due to known physiological condition, major depressive disorder, PTSD and chronic pain. The target behaviors listed under the diagnoses were sad/tearful. The care plan went on to document that the antidepressant target behaviors were sad/tearful, but did not have any specific target behaviors for the antipsychotic medication. On 03/26/2026 at 12:22 PM, Staff C, Resident Care Manager, Registered Nurse, regarding the lack of differentiation between the target behaviors for the antidepressant and antipsychotic medications on the care plan, Staff C said they did not see that it had been differentiated between the medication classes. Reference F605 Reference WAC 388-97-1020(1), (2)(a)(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an effective antibiotic stewardship program to promote appropriate use of antibiotics, reduce the risk of unnecessary antibiotic use and decrease the development of adverse side effects and antibiotic resistance for 3 of 5 entries or 2 of 4 residents (Resident 80 & 39) reviewed for antibiotic stewardship. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics.Findings included .Resident 801) Resident 80 was admitted to the facility on [DATE]. Review of the December 2025 infection control (IC) log showed Resident 80 was started on Bactrim DS times seven days for an urinary tract infection (UTI) on 12/24/2025. The line listing showed a urine sample was collected on 12/17/2025 and sent out for a urinalysis with culture and sensitivity (UA with C&S). The UA C&S results, dated 12/17/2025, showed there were greater than three organisms identified, which was consistent with contamination. Recollection of a urine sample was recommended. A Resident Infection Report dated 12/28/2025, showed the residents 12/17/2025 UA was contaminted and needed to be recollected and documented Resident 80 denied symptoms of a UTI. The report determined McGeer's criteria for UTI was not met. The section of the report that asked if the provider was notified and consulted regarding the resident's condition and infection criteria, was left blank. Review of the electronic health record (EHR) showed Resident 80 completed the full seven days course of Bactrim DS despite denying symptoms of a UTI and the infection criteria not being met. During an interview on 03/27/2026 at 12:50 PM, when asked if they could provide documentation to show staff recollected Resident 80's urine sample as recommended, and the provider was notified (prior to completion of the antibiotics) that McGeer's criteria for a UTI was not met, Staff H, Infection Preventionist, said no. When asked if they knew what the causative organism was and whether it was susceptable to Bactrim Staff H said no. 2) Review of the January 2026 IC log showed Resident 80 was started on levofloxacin for seven days for a UTI on 01/14/2026. The line listing showed a UA with C&S was sent on 01/12/2026. The UA C&S results, dated 01/12/2026, showed greater than three organisms were identified, which was consistent with contamination. Recollection of a urine sample was recommended. A Resident Infection Report dated 01/15/2026, showed resident 80 had complained of pain/discomfort with urination but had no further urinary symptoms and documented McGeer's criteria for UTI was not met. The report showed Resident 80 was receiving levofloxacin (an antibiotic) for seven days and documented that another UA was needed. Review of the EHR showed no documentation that staff recollected a urine sample as recommended but did show Resident 80 completed the full seven days of levofloxacin therapy, even though the residents symptoms did not meet the criteria of UTI. During an interview on 03/27/2026 at 12:50 PM, when asked if they could provide documentation that staff recollected Resident 80's urine sample as recommended, and the provider was notified prior to completion of the antibiotics) that McGeer's criteria for a UTI was not met, Staff H, Infection Preventionist said, no. When asked if they knew what the causative organism was and whether it was susceptable to levofloxacin Staff H said no.3) Resident 39 was admitted to the facility on [DATE]. Review of the February 2026 IC log showed Resident 39 was started on Augmentin times seven days on 02/16/2026 for a UTI. The line listing showed a urine sample was collected on 02/08/2026 and sent for a UA with C&S. The UA C&S results, dated 02/08/2026, showed greater than three organisms were identified, which was consistent with contamination. Recollection of a urine sample was recommended. The provider noted the lab result on 02/13/2026 and wrote on the lab re-collect. Progress notes dated 02/05/2026 and 02/08/2026 showed Resident 39 complained of dysuria (pain/discomfort with urination). A urine sample was obtained on 02/08/2026, but the results were contaminated and a urine sample needed to be recollected. Subsequent progress notes dated 02/11/2026, 02/15/2026 and 02/19/2026 all documented Resident 39 denied dysuria. A Resident Infection Report dated 02/19/2026, showed (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident 39 had complained of pain/discomfort with urination, no further signs or symptoms of a UTI were noted. The report identified that the 02/08/2026 UA was contaminated and needed to be recollected but attempts to obtain a urine sample via straight catheterization were unsuccessful. The report determined McGeer's criteria for a UTI were not met, but the Loeb criteria was and Resident 39 was treated with a seven-day course of Augmentin.During an interview on 03/27/2026 at 12:50 PM, Staff H explained that the facility used Loeb's criteria in situations of an expected UTI so treatment could be initiated pending UA C&S results. When asked how they knew what the causative organism was and whether is was susceptible to Augmentin, Staff H indicated they didn't and acknowledged in this case there was not a UA with C&S pending.Reference WAC 388-97-1620(2)(b)(i)(ii)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a system that ensured a copy of a residents advanced directives (AD, written instruction for the provision of health care when the individual is incapacitated, such as a living will or durable power of attorney for health care) were requested/obtained upon admission and residents without ADs were provided written information about and informed of their right to formulate one, for 2 of 4 residents (Resident 11 & 8) reviewed for ADs. This failure placed residents at risk of not having their health care goals and treatment choices honored in the event they were incapacitated.Findings included . Resident 11Resident 11 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/18/2026, showed the resident was cognitively intact. Review of the electronic health record (EHR) showed a document titled Advanced Directive was scanned into the miscellaneous section. Review of the document showed it was a Portable Order for Life-Sustaining Treatment (POLST) form, not an advanced directive for healthcare. A Care Conference note, dated 12/24/2025, showed under paperwork reviewed staff placed a checkmark next to Advance Directive. Further review showed staff failed to document whether Resident 11 had an AD for health care or not, or if Resident 11 was informed and provided written information about their right to formulate one.Resident 8Resident 8 was admitted to the facility on [DATE]. Review of the Significant Change MDS, dated [DATE], showed the resident was cognitively impaired. Review of the EHR showed a document titled Advanced Directive was scanned into the miscellaneous section. Review of the document showed it was a Portable Order for Life-Sustaining Treatment (POLST) form, not an advanced directive for healthcare. A Care Conference note, dated 12/08/2025 (greater than 10 months after admission), showed under paperwork reviewed staff placed a checkmark next to advanced directive. Further review of the Care Conference note showed staff documented Power of Attorney (POA) paperwork was discussed with the daughter who indicated her sister previously started the POA for healthcare process and may have the paperwork.Review of the EHR showed no documented attempts to contact the other daughter to determine if POA for healthcare paperwork had been completed and/or to request a copy of the document.On 03/23/2026 at 10:44 AM, Staff H, Social Services Director, said it appeared some staff were not aware of the difference between a POLST form and an AD for healthcare, noting that both above referenced residents had their POLST forms scanned into the EHR and labeled as ADs. Staff H also said when staff check that ADs were reviewed on the care conference form, their documentation should identify if the resident had one, if so, whether a copy was provided/requested, and if not, whether the resident was informed of their right to formulate one. Reference WAC 388-97-0300 (1)(b), (3) (a-c).

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure potential restraints were assessed for safety, risks versus benefits associated with the device were discussed with the resident and/or representative and consent was obtained prior to device implementation for 1 of 2 residents (Resident 6) reviewed for physical restraints. This failure placed residents at risk for feelings of powerlessness, restrained or inhibited movement, physical injury, psychosocial harm and diminished quality of life. Findings included .Review of the facility's Physical Restraint and Enablers/Devices policy, updated January 2025, showed a restraint was defined as any manual method, physical or mechanical device, equipment or material attached or adjacent to the resident's body that meets all of the following: is attached to or adjacent to the resident's body; cannot be removed easily by the resident; restricts the resident's freedom of movement or normal access to his or her body. Prior to implementation of a physical or mechanical device a device evaluation would be completed and the risks and benefits of the restraint or enabler device would be discussed with the resident and/or the resident's representative and consent obtained. If the device was assessed to be a restraint the provider would be contacted to obtain an order for the specific device, and the reason and duration of use. If not considered a restraint a physician order was not required. Resident 6Resident 6 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS, an assessment tool), dated 02/09/2026, showed the resident was cognitively impaired, had a diagnosis of multiple sclerosis (MS, a chronic, often disabling autoimmune disease of the central nervous system where the immune system attacks the myelin sheath protecting nerve fibers), required partial/moderate assistance to roll left and right in bed, and to move from lying to sitting on the edge of the bed. On 03/23/2026 at 9:29 AM, Resident 6 reported that recently, while she was out of her room, staff removed the mattress on her bed and replaced it with a new one without discussing it with her or obtaining her consent. Observation of Resident 6's mattress showed it was a perimeter mattress (a mattress with firm elevated foam bolsters around the edges that encourage centered positioning and designed to prevent falls). Resident 6 explained with the standard mattress, she was able to roll to the edge of the bed and reach items on the dresser that she needed. Resident 6 said since the perimeter mattress was placed, she could no longer reach those items and had to call staff whenever she wanted to grab an item or put one back. Resident 6 reported the perimeter mattress made her feel like she was stuck in a hole in the middle of the bed and insisted that it be removed. Review of the electronic health record showed facility staff did not complete a device evaluation, explain the risks and benefits of perimeter mattress use to the resident or obtain their consent for its use prior to implementation. On 03/26/2026 at 3:30 PM, Staff B, Director of Nursing Services, said facility staff should have completed a device evaluation to determine if it restrained Resident 6's movement, explained the risks and benefits of perimeter mattress use and obtained the resident's consent prior to implementation. When asked if there was documentation to show staff completed any of those Staff B stated, No. Reference WAC 388-97-0620(1).

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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 residents were free from unnecessary medication related to excessive duration for 1 of 6 residents (Resident 19) reviewed for medications. This failure placed residents at risk of medication complications and a diminished quality of life.Findings included.Resident 19 was admitted to the facility on [DATE]. The admission Minimum Data Set assessment, dated 03/05/2026, showed Resident 19 was cognitively moderately impaired.Resident 19 had a current order for a lidocaine patch (topical numbing medication), ordered on 03/05/2026. Starting on 03/08/2026, the order was to remove the patch at 8:59 AM and to apply at 9:00 AM. The lidocaine patch was applied from 03/08/2026 to 03/21/2026 (13 total administrations of 24 hours of duration) with the patch applied and removed the following day before a new application. During an interview on 03/23/2026 at 2:36 PM, Resident 19 said that staff put their lidocaine patch on for 24 hours at a time, and would take it off and put one right back on. Resident 19 said that is not how it should be done. During an interview on 03/23/2026 at 10:28 AM, Staff D, Registered Nurse (RN), said lidocaine patches should only be on for about 12 hours at a time, and normally would not be worn for 24 hours at a time. During an interview on 03/26/2026 at 10:32 AM, Staff C, Resident Care Manager/ RN, said lidocaine patches should be worn for 12 hours and then off for 12 hours. Staff C said Resident 19's lidocaine order was transcribed incorrectly by nursing and should have been on in the morning and off in the evening per the provider's notes. During an interview on 03/27/2026 at 10:43 AM, Staff B, Director of Nursing Services, said the standard amount of time lidocaine patches should be worn continuously for was 12 hours, and acknowledged the provider's intent was for only 12 hours of use. Reference WAC 388-97-1060 (3)(k)(i)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess food preferences and provide food that met preferences for 3 of 7 residents (Residents 75, 76, and 11) reviewed for food. These failures placed residents at risk for hunger, nutrient deficiency and diminished quality of life.Findings included.Resident 75 & 76 On 03/24/2026 at 8:36 AM, Resident 75 said they had recently been admitted to the facility, no one had talked to them about their food preferences yet (neither the Dietary Manager or the Registered Dietitian) and they had not been able to eat most of the food because they were supposed to be a on a diabetic diet. Observation of Resident 75's meal ticket documented CCHO [consistent carbohydrate diet], diet is eating the same amount of carbohydrates every day. This helps keep your blood sugar, or glucose, levels stable], NAS [no added salt] thin liquids. Observation of Residents 75's breakfast meal tray showed, Resident 75 was served pancakes with packaged syrup, sausage and packaged brown sugar. Resident 75 ate one pancake with no syrup (packages still closed), half of the sausage and did not open the brown sugar. Resident 75 said they did not like pancakes or sausage, but they had to eat something. Resident 75 said they asked for sugar free syrup and was told by staff the facility did not carry that. Resident 75 said they never opened the brown sugar because they do not eat brown sugar. On 03/24/2026 at 9:13 AM, Resident 76 said they had recently been admitted to the facility and already had concerns with the food. Resident 76 said the food was always cold and half the time they did not eat the food because they did not know what it was and no alternatives had been provided. On 03/25/2026 at 8:17 AM, Resident 75 said Staff E, the Dietary Manager, finally came to interview them and their roommate the previous night about food preferences and had documented their likes and dislikes. Resident 75 said Staff E had told them about an alternative menu and was supposed to bring them a copy of the alternative menu, but Staff E had never returned last night. Observation of Resident 75's meal ticket documented Regular CCHO, NAS, thin liquids; Dislikes milk, pancakes, French toast, pork, eggs, canned fruit, hot cereal and cold cereal. Observation of Resident 75's meal tray included one English muffin (cut in half) with two sugar based jellies (one grape and one orange), no other foods or condiments were on the plate (to include butter). Resident 75 said they needed some type of protein like a piece of cheese or cottage cheese to have the strength to complete physical therapy today, this was all carbs and sugar and they could not go without eating. On 03/25/2026 at 8:23 AM, Resident 76 said Staff E came in the previous night and spoke with them about the likes and dislikes. Observation of Resident 76's meal ticket documented Regular diet, regular texture, thin liquids; Dislikes: eggs, milk, yogurt, pancakes, French toast, hot cereal. Resident 76 said they did like eggs but not every day and sometimes not in the AM. Observation of Resident 76's meal tray included one English muffin (cut in half) and one piece of bacon; no other foods or condiments were on the plate (including butter or jellies). Resident 76 said they had eaten one piece of bacon. On 03/25/2026 at 8:29 AM, Staff L, Certified Nursing Assistant (CNA), was asked to make an observation of the meal trays delivered this morning. Staff L confirmed they had delivered breakfast meal trays this morning. Staff L said when they delivered meal trays, they would take the tops off the plates, offer assistance with set up and help reposition residents who needed it. When asked what (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was offered to residents, Staff L [NAME] they would offer drinks and condiments like mayo, mustard, ketchup, salt, pepper, jelly, syrup. When asked specifically about butter, Staff L said yes, they offered butter, for like pancakes, toast or rolls. Staff L was shown both Resident 75' and Resident 76's meal tray. Staff L confirmed neither resident had butter on their plates and said it should have been offered. Staff L then exited the room. On 03/25/2026 at 8:45 AM, Resident 75 said they could no longer wait for staff to return with butter, then took three bites of what they described as a cold, dry English muffin. Resident 75 said they were not going to eat the rest. Resident 76 said they were not going to eat their cold dry English muffin. Staff L never returned or offered an alternative or condiments. On 03/25/2026 at 12:44 PM, observation of Resident 75's lunch meal with pasta taking up 50% of plate, 25% of plate a breadstick, and less than 25% of plate cauliflower (a small helping) and a banana on the side of tray. Resident 75 said they did not eat bananas and it was too many carbohydrates for them. Resident 75 said they needed some protein, they would have preferred the alternative but were never asked. At 2:05 PM, observation of the banana, bread stick and a large pile of pasta remained on Resident 75's plate, only the cauliflower had been consumed. On 03/25/2026 at 10:51 AM, Staff E said when staff deliver meal trays, they should ask the residents what they want to drink and offer condiments, like salt or pepper to go with their meals. Staff E said the facility offered different types of condiments, like if the resident wanted jelly or syrup for their pancakes or ketchup for other meals. When asked if floor staff delivered those items, Staff E said no, kitchen staff would primarily plate those items when tray line was completed, but residents could ask floor staff for more or if it was missing. When asked about diabetic options for residents, Staff E said the facility carried sugar free jellies, for residents who were diabetic. Staff E said those options were also put on the delivery cart with the drinks, so staff did not have to run back and forth to the kitchen, but if they were out of that item on the carts, then staff could come back to the kitchen to get more. Staff E pointed and showed a box of sugar free jellies sitting on the drink cart. The observation of the English muffins were explained, Staff E said the expectation was the residents should have had butter on their plates for the English muffins. When it was explained that both residents waited 15 minutes for the staff (after the interview) to bring them butter and then finally decided not to eat, because it was cold and dry, Staff E apologized and said that was not acceptable. On 03/25/2026 at 1:21 PM, Staff F, Registered Dietitian (RD), said when a new resident was admitted to the facility, they have 14 days to complete the assessments regarding the residents' diet/nutritional requirements. When asked about residents who were diabetic and meeting their nutritional requirements when admitted (during the assessment period), Staff F said if there were concerns regarding a resident's diet, staff would notify the RD and the provider. When asked if a resident was not eating due to being served too many carbohydrates, or items outside of a diabetic diet, Staff F stated, diabetics need a certain amount of sugar in their diet. When the observation of the English muffin was explained for two different residents and asked if that was acceptable, Staff F did not answer. When asked if the resident should have been offered an alternative meal when not eating the pasta, Staff F did not answer. When asked how the facility was meeting the residents' nutrition needs and preferences, Staff F said we need to do a food preference evaluation with the residents. Resident 11 Resident 11 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with a (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis of chronic kidney disease. According to the Discharge Return Anticipated Minimum Data Set (MDS, and assessment tool), dated 02/19/2026, Resident 11 was independently able to make decisions regarding tasks of daily life. On 03/23/2026 at 12:13 PM, Resident 11 said they had issues with food due to their kidney disease which changed the food flavors and consistency, food would taste like mud. Resident 11 said they could have soft food but the facility was pureeing their food, they did not recognize the food served and they did not want to eat it. On 03/23/2026 at 12:27 PM, Resident 11 received their lunch and told staff they disliked pureed food and nobody had asked them if they wanted pureed food. Review of Resident 11's food meal ticket showed they were to have soft and bite sized food. Observation of Resident 11's meal showed some diced potatoes, with the rest of the food present being pureed. On 03/24/2026 at 12:41 PM, Resident 11 had a lunch meal that had mashed potatoes, beef that had some texture to it and the rest of the food on the plate was pureed. Resident 11 said the food had just showed up pureed one day and they hated pureed food. Resident 11 said they had told staff from day one that they were not going to eat pureed food and they did not know where the orders for pureed food came from, the changes were made without their knowledge, and it was annoying. Resident 11 had an order, dated 03/13/2026, for CCHO (consistent carbohydrate), Renal diet (therapeutic diet designed for individuals with kidney disease), soft and bite sized texture, and thin liquid consistency. Review of the electronic health record showed the last food preference evaluation for Resident 11 was dated 12/01/2025, during a previous stay at the facility. On 03/25/2026 at 1:51 PM, Staff E said options for soft bite sized food included meat cut up, mashed vegetables, mashed potatoes, cottage cheese, diced fruit and other soft types of foods. Staff E said residents with soft and bite sized diet orders would also get pureed items depending on the type of food it was, giving the example of green beans saying they were stringy and it could get lodged in the throat and a resident could choke on it. When asked if substituting a different soft vegetable for the day rather than pureeing the vegetable was possible, Staff E said yes, and residents could also have a vegetable juice if they preferred. During this interview, regarding Resident 11, Staff E said their diet was soft and bite size. When asked if Resident 11 required pureed food, Staff E said, it would depend and gave the example of bread saying it was a choking hazard. Staff E said she had talked to Resident 11 quite a few times as they had been in and out of the facility, but this was the first time they had a soft and bite sized diet. When asked if there was a reason Resident 11 was getting pureed food instead of soft and bite sized as ordered Staff E said it depended on the vegetable some could not be mashed. Regarding Resident 11 having a diet for soft and bite sized and receiving pureed foods, Staff E said a lot of times if the food for that day was too crunchy, they would have to give it to the residents pureed. On 03/25/2026 at 1:58 PM, Staff F, Registered Dietician, when asked if there was any reason Resident 11 would be served pureed food rather than their ordered diet of soft and bite sized, said they did not know. Staff F said pureed food was a downgraded diet texture from soft/bite sized diet, and the two textures were different. Staff F said that Resident 11 was supposed to receive a soft and bite sized meal from the kitchen vs a pureed meal, but she was not sure if Resident 11 could tell the difference. When asked when Resident 11 had a diet order for soft and bite sized diet should they be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505507	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelton Health and Rehabilitation	153 Johns Court Shelton, WA 98584

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving pureed food, Staff F said, no and if the resident could tell the difference between soft and bite sized and pureed, they should have received what was ordered. Staff F said Resident 11's food preferences should have been updated, it was last done on their previous admission on [DATE], and food preferences should have been obtained on admission. Reference WAC 388-97-1120 (2)(a), -1100(1), -1140 (6)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to designate a member of their inter-disciplinary team (IDT) who would be responsible for working with the hospice representatives to ensure effective coordination of care between the facility and hospice staff and to have documentation in residents' Electronic Health Records (EHR) that showed when hospice disciplines (e.g. registered nurse, chaplain, certified nursing assistant, massage therapist) participated with care and what care was provided for 1 of 1 sampled resident (Resident 3) reviewed for hospice services. These failures detracted from staffs' ability to effectively collaborate, communicate and coordinate care with the hospice provider and placed residents at risk for not receiving necessary care and services and/or unmet care needs. Findings included .Resident 3 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, (MDS, an assessment tool), dated 02/23/2026, documented Resident 3 was severely cognitively impaired and was receiving hospice services. A [name of hospice provider] Home Coordinated Task Plan of Care, dated 01/13/2026, documented Resident 3 was to have a hospice nurse visit two times a week (Tuesdays and Fridays), a hospice aide visit two times a week (Tuesdays and Fridays), a social worker visit and Chaplin visit per resident preference and wound care each visit, all starting 12/26/2025. Resident 3's EHR documented no hospice nurse, hospice aide, social worker or Chaplin visit notes or updates. On 03/26/2026 at 8:38 AM, Staff N, Licensed Practical Nurse (LPN), was asked where the hospice binders were located. Staff N said hospice binders were located at the nurses' station based on what hall the resident resided on. Staff N looked for Hospice binder for Resident 3 but was unable to locate the binder at nurses' station across from Sunshine/dining room. When asked where they would find hospice information about a resident, Staff N said in the EHR. On 03/26/2026 at 8:46 AM, Staff D, Registered Nurse (RN), was asked to located Resident 3's hospice binder. Staff D said the binder would be located at the nurse's station by the dining room. When it was explained the hospice binder was not there, Staff D looked at main nurses' station and was unable to locate Resident 3's hospice binder. When asked if there was any other locations hospice information could be, Staff D said that one of the Resident Care Managers (RCM) may have the binder. Staff D said they did not know where to locate hospice information in the EHR. On 03/26/2026 at 8:50 AM, Staff B, Director of Nursing Services, Staff O, LPN, and Staff C, RN/RCM, were asked about Resident 3's hospice binder. All three staff said the hospice agency did not have binders. When asked where to find Resident 3's hospice information, including nurses' and aides' notes Staff B said they would get the information. On 03/26/2026 at 10:08 AM, Collateral Contact 3 (CC3), Hospice Aide, said they come to the facility twice a week to provide shower and care to Resident 3. CC3 said today Resident 3 had a rough morning, but were about to change the residents' sheets, did pericare, gave Resident 3 a quick bed bath and changed them. CC3 said whenever they complete any type of care, they document it on shower sheet and place it in the binder located at the nurse's station. CC3 was asked to show the binder located at the nurses' station. CC3 walked to nurses' station (across from Sunshine/dining room) and pulled the shower binder. CC3 showed the shower sheet dated 03/26/2026. The shower binder was reviewed for further documentation of Resident 3's previous hospice nurse and aide visits. No other documentation was found. CC3 said they had always placed the showers sheet in the binder but did not know what the facility does with the shower sheets. When asked about hospice nursing notes, CC3 said they did not know what the process was for nurses' notes. On 03/26/2026 at 11:08 AM, when asked about the updated hospice paperwork, Staff C, RN/RCM, stated I just got off the phone with the hospice agency. They are sending the paperwork. On 03/26/2026 at 11:57 AM, Staff B, DNS, confirmed the facility did not have the hospice documentation and Staff C had contacted the facility to obtain the updated information/documentation. When asked how staff would know about hospice changes for Resident 3, (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B said the hospice staff would check in with the floor nurses and provide any necessary information when needed. When asked who was the facility's point of contact for the hospice agency (s), who should have requested this information, Staff B said no one was currently assigned, but it used to be Staff O, LPN. No associated WAC.