STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505513	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puget Sound Transitional Care	2800 South 224th Street, Des Moines, WA 98198

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure one (Resident 9) of five sampled residents reviewed for unnecessary medications had completed consents for psychoactive medications. Additionally, the facility failed to obtain consents for safety devices including bed against the wall and floor mats both sides of bed for 2 (Resident 2 & 3) of 7 residents reviewed for safety devices. These failures did not ensure residents were notified about their medications, safety devices, and facility policies. Findings included <Resident 9> According to the 07/27/2025 admission Medicare 5 Day Minimum Data Set (MDS- an assessment tool) Resident 9 had clear speech and was able to make themselves understood. The MDS showed Resident 9 had memory issues and demonstrated no behavior of rejection of care during the assessment period. Review of August 2025 Medication Administration Record on 08/26/2025 showed Resident 9 received an antianxiety medication on 08/22/2025, 08/23/2025, 08/24/2025, and on 08/26/2025. Review of Resident 9’s record showed no resident/representative approval for the medication. In an interview on 08/26/2025 at 11:00 AM, Staff F (Resident Care Manager - RCM) reviewed Resident 9’s record and stated the facility did not receive a consent for an administration of an antianxiety medication. Staff F stated they expected staff to obtain consent from the residents/representatives before starting any medications, but they did not. <Resident 2> According to the 05/14/2025 Quarterly MDS Resident 2 had a history of falls with fractures. The MDS showed Resident 2 had memory issues and no rejection of care during the assessment period. Observations on 08/20/2025 at 3:27 PM, on 08/21/2025 at 10:49 AM, and 08/25/2025 at 12:21 PM showed Resident 2 was lying in their bed and had fall mats on the floor both sides of the bed. Review of Resident 2’s record showed no resident/representative approval for the fall mats on the floor as a safety device. In an interview on 08/26/2025 at 11:01 AM, Staff F stated they expected staff to assess the resident for any safety devices, receive a Physician order and obtain a consent from the resident/representative prior to implementing the interventions. Staff F reviewed Resident 2’s record and stated they did not have a consent for the fall mats on the floor for Resident 2. (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 3> According to a 05/22/2025 Quarterly MDS Resident 3 had no memory impairment. The MDS showed Resident 3 had no restraints in place. Review of Resident 3’s health records showed a 03/22/2025 Activities of Daily Living Performance Deficit Care Plan with an intervention to have the bed against the wall. Observation on 08/21/2025 at 9:36 AM showed Resident 3’s right side of bed against the wall. In an interview on 08/26/2025 at 9:21 AM Staff J (RCM) stated they did not obtain a signed consent from Resident 3 for the bed against the wall. Staff J stated they were expected to obtain a consent for the bed against the wall because it would be a form of a restraint, and the facility should ensure the resident consented to it. Reference: WAC 388-97-0300(3)(a), -0260, -1020(4) (a-b). .

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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 observation, interview, and record review the facility failed to provide information and assistance to formulate an Advance Directive (a document describing a resident's wishes for care if they became incapacitated) for 2 of 4 residents (Resident 11 & 8) reviewed for advanced directives. This failure left residents at risk for losing the right to have their preferences and choices honored during emergent and end of life care. Findings included .<Policy>According to a facility policy titled, Advanced Directives and Associated Documentation, date 04/2025, showed the facility would provide written information to formulate an advance directive prior to, upon, or immediately after admission to all residents or their representative. The policy showed staff would document in the resident's record at the time of admission, the resident or representative had been provided written information regarding advance directives. The policy showed if a resident already had an advance directive staff would obtain a copy and place in the resident's records. <Resident 11>According to 08/07/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 11 readmitted to the facility on [DATE] and was rarely/never understood and their memory was severely impaired. The MDS showed Resident 11 was dependent on staff for all care. The MDS showed Resident 11 had dementia related to a stroke, altered mental status, and other disorders of the brain. Review of Resident 11's health records showed a 03/13/2025 I am interested in formulating an Advance Directive Care Plan (CP). Resident 11's records showed a 05/01/2025 Advanced Directives information form documenting Resident 11 did not have an advanced directive formulated but was interested in receiving information and assistance to formulate one. The form showed no information was provided to Resident 11. Observations on 08/22/2025 7:55 AM and 08/25/2025 8:35 AM showed Resident 11 did not verbally respond. In an interview on 08/26/2025 9:21 AM Staff J (Resident Care Manager) stated Resident 11 had a stroke and was unable to verbally communicate or make needs known. Staff J stated Resident 11's needs were anticipated by staff. Staff J stated Resident 11 did not have an advanced directive. <Resident 8>According to 07/22/2025 Quarterly MDS Resident 8 readmitted to the facility on [DATE]. The MDS showed Resident 8 would understand others and make self-understood. The MDS showed Resident 8 had severe memory impairment. The MDS showed Resident 8 had diagnoses of, but not limited to, non-Alzheimer's dementia and a progress neurological condition. Review of Resident 8's health records showed a I have an advance directive: I have a Guardian who is my decision maker CP. Resident 8's records showed an undated advance directive information form uploaded to their records on 04/16/2025 showing Resident 8 reported they had advance directive paperwork completed but also showed Resident 8 requested information on how to formulate an advance directive. In an interview on 08/26/2025 at 11:51 AM Staff H (Social Service) reviewed Resident 11s health records and was unable to provide documentation that Advanced Directive information or assistance was provided to Resident 11 or their family at the time of the 05/01/2025 request. Staff H reviewed Resident 8's records and was unable to provide documentation of an advance directive or that information and/or assistance was provided to Resident 8 to formulate an advance directive if they did not have one. In an interview on 08/27/2025 at 10:48 AM Staff B (Director of Nursing) stated they expected staff to provide information and assistance with formulating advanced directives at the time of the resident's request. Staff B stated if a resident had an advance directive, they expected staff to attempt to obtain a copy and document attempts. Reference: WAC 388-97-0280(3) (c) (i-ii), -0300 (1) (b. (3) (a-c)

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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 a system by which residents received required written notices and Long Term Care Ombudsman (LTCO) notifications at the time of transfer/discharge for 6 of 7 residents (Residents 1, 7, 9, 3, 11, & 53) and report to receiving hospital for 2 of 7 residents (Residents 3 & 11) reviewed for hospitalization. Failure to ensure a written notification was provided to the resident and/or representative in a language and manner the resident and/or representative understood, notify the LTCO as required of the reasons for the discharge, and give a report to the receiving hospital on resident's condition placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care/preferences, and a break in communication and continuity of care. Findings included . <Facility Policy>According to the facility's revised 04/2025 Criteria for Discharge policy, the facility would provide the resident or their representative with the reason for the discharge in writing and send a copy to the State LTCO office within 30 days. The policy showed this should happen prior to transfer or as soon as practicable and should include the reason for transfer.<Resident 1> According to the 06/17/2025 and 08/10/2025 Discharge Return Anticipated Minimum Data (MDS - an assessment tool) Resident 1 discharged to the hospital on [DATE] and again on 08/10/2025 related to a change in the resident's condition. The MDS showed Resident 1 had medical conditions including stroke (a medical condition prevents the brain from getting enough blood supply) and kidney failure. Record review of Resident 1's clinical record showed no copy of any written transfer notice provided to the resident or their representative describing the reason for transfer for either hospitalization as required scanned into the record. for either hospitalization. <Resident 7> According to the 06/17/2025 and 08/15/2025 Discharge Return Anticipated MDS, Resident 7 discharged to the hospital on [DATE] and again on 08/15/2025 related to a change in the resident's condition. The MDS showed Resident 7 had medical conditions including kidney failure and high blood sugars. Record review of Resident 7’s clinical record showed no copy of any written transfer notice provided to the resident or their representative describing the reason for transfer for either hospitalization as required scanned into the record. <Resident 9> According to the 07/15/2025 Discharge Return Anticipated MDS, Resident 9 discharged to the hospital on [DATE] related to abdominal pain. The MDS showed Resident 9 had medical conditions including high blood sugars and inflammation of the pancreas. Record review of Resident 9’s clinical record showed no copy of any written transfer notice provided to the resident or their representative describing the reason for transfer for either hospitalization as required scanned into the record for either hospitalization as required. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/26/2025 at 10:45 AM, Staff F (Resident Care Manager - RCM) stated they notified residents families by phone about residents’ hospital transfers and sent an “e-interact” (emergency transfer) form to the hospital with residents. Staff F stated they were not aware of the requirement to provide written notifications to residents and/or their representatives for discharge and hospitalizations. In an interview on 08/26/2025 at 10:50 AM, Staff L (Admissions Director) stated they were not responsible for the written notice providing to residents or their representatives during discharge or hospitalizations. In an interview on 08/26/2025 at 12:50 PM, Staff M (Corporate Clinical Consultant) stated they only sent the e-interact form with residents to the hospital. Staff M stated the facility should have, but did not provide Resident 1, Resident 7, and Resident 9 the required written transfer/discharge notice during hospitalizations. <Resident 3> According to the 02/13/2025 Discharge Return Not Anticipated MDS Resident 3 discharged to the hospital on [DATE]. The MDS showed Resident 3 had medical conditions including a terminal illness. Review of Resident 3’s records showed no written transfer notification was provided to Resident 3 for the 02/13/2025 hospitalization. Resident 3’s records showed they stayed in the hospital from [DATE] and returned to the facility on [DATE]. Review of Resident 3’s “Nursing Home to Hospital Transfer Form” showed the report was not communicated to the receiving hospital. In an interview on 08/21/2025 at 9:30 AM Resident 3 stated they “threw up blood and were sent to the hospital on their birthday,” on 02/13/2025. In an interview on 08/26/2025 at 11:51 AM Staff H (Social Services) stated the LTCO was not notified of Resident 3's transfer to the hospital on [DATE]. <Resident 11> According to the 04/01/2025 Discharge Return Anticipated MDS Resident 11 was transferred to an acute care hospital on [DATE]. The MDS showed Resident 11 had medical conditions including a stroke (a medical emergency occurring when blood flow to the brain is interrupted or reduced causing brain cell loss). According to the 04/24/2025 Discharge Return Anticipated MDS Resident 11 was transferred to an acute care hospital on [DATE]. The MDS showed Resident 11 had medical conditions including a stroke. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 11’s records showed no written transfer notification was provided to Resident 11 or their representative for the 04/01/2025 or 04/24/2025 hospitalizations. Resident 11’s records showed they stayed at the hospital from [DATE] and returned to the facility on [DATE] and were transferred to the hospital again on 04/24/2025 and returned to the facility on [DATE]. Review of Resident 11’s “Nursing Home to Hospital Transfer Form” showed report was not communicated to the receiving hospital for either transfer. In an interview on 08/26/2025 at 9:21 AM Staff J (RCM) stated they did not provide written transfer notifications to Resident 3 or Resident 11 at the time of the transfers. Staff J stated they were never instructed that nursing was to provide written transfer notifications to residents at time of transfers. Staff J reviewed Resident 3 and Resident 11’s records and stated report was not called to the receiving hospital for Resident 3’s 02/13/2025 transfer or for Resident s 11’s 04/01/2025 and 04/24/2025 transfers. Staff J stated it was important to provide residents with a written transfer notification, so they understood their rights regarding the transfer and report to the receiving facilities for continuity of care. In an interview on 08/26/2025 at 11:51 AM Staff H (Social Services) stated the LTCO was not notified of Resident 11's transfers to the hospital on [DATE] or 04/24/2025. <Resident 53> According to the 08/09/2025 Discharge Return Anticipated MDS, Resident 53 discharged to the hospital on that date. Record review showed no written transfer notification was provided to Resident 53 explaining the reason for their 08/09/2025 hospitalization as required. According to the 07/12/2025 Discharge Return Anticipated MDS, Resident 53 discharged to the hospital on that date. Record review showed no written transfer notification was provided to Resident 53 explaining the reason for their 07/12/2025 hospitalization as required. In an interview on 08/26/2025 at 12:52 PM Staff J stated they did not see in Resident 53’s chart that the resident was provided written notification for the basis of their transfer to the hospital on [DATE] or 07/12/2025. REFERENCE: WAC 388-97-0120 (2)(a-d), -0140 (1)(a)(b)(c)(i-iii).

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the comprehensive assessments within the regulatory timeframes for 1 of 2 (Residents 64) supplemental residents, and 2 of 3 resident (Resident 18 & 93) reviewed as closed records for assessments and timing. The failure to ensure comprehensive admission Minimum Data Set (MDS - an assessment tool) assessments were completed timely hindered the care planning process necessary to provide the appropriate resident care and services, and placed residents at risk for unidentified care needs, delayed services, and a decreased quality of life. Findings included. <Resident Assessment Instrument (RAI - instructional guidelines for MDS completion) Manual>The October 2019 RAI Manual outlined an admission MDS was a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1. The manual outlined an Annual MDS was a comprehensive assessment for a resident that must be completed on an annual basis and the completion date must be no later than 14 days after the Assessment Reference Date (ARD).<Resident 64>According to the 07/16/2025 admission 5 Day Minimum Data Set (MDS- an assessment tool), Resident 64 was admitted to the facility on [DATE] with multiple medical conditions including heart failure. Review of the MDS with ARD date 07/16/2025 and the completion date by the MDS Coordinator showed 07/31/2025, 15 days past the regulatory time frame as required. <Resident 18>According to the 07/15/2025 admission MDS, Resident 18 was admitted to the facility on [DATE]. Review of the date of MDS completion by the RN Coordinator showed 07/31/2025, five days past the regulatory timeframe as required. <Resident 93>According to the 07/16/2025 admission MDS, Resident 93 was admitted to the facility on [DATE]. Review of the MDS completion date by the RN Coordinator showed 07/31/2025, 15 days past the regulatory timeframe as required. In an interview on 08/26/2025 at 2:20 PM, Staff I (MDS Coordinator) stated it was important for comprehensive assessments to be completed timely for resident care and for the purposes of facility reimbursement. Staff I stated if the MDS was not completed timely, then the residents care plans will not be initiated to provide appropriate care. Staff I stated they started working in this facility for a month and when they started working here, facility had no MDS Coordinator. Staff I stated they were aware the facility was behind with the completion of their residents' MDS assessments. REFERENCE: WAC 388-97-1000(b)(c)(ii), (3)(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review the facility failed to ensure the Minimum Data Set (MDS - an assessment tool) accurately reflected the status of the resident for 2 of 19 sampled residents (Residents 53 and 71). This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included .<Resident 53>According to the 05/08/2025 Quarterly MDS Resident 53 had a condition where the bladder muscles and nerves did not function properly due to damage to the nervous system. The MDS showed Resident 53 used an indwelling catheter (tubing to assist with bladder drainage). The MDS showed Resident 53 was always incontinent of bladder.Observation on 08/20/2025 at 9:28 AM showed Resident 53 lying in bed. Resident 53's catheter was attached to the bed frame below the resident.In an interview on 08/27/2025 Staff I (MDS Coordinator) stated it was important for MDS assessments to be accurate as they were the basis for care planning for residents. Staff I stated because Resident 53 used an indwelling catheter, his incontinence status should have been coded as not rated rather than always incontinent.<Resident 71>According to the 07/17/2025 Quarterly MDS, Resident 71 was assessed with a mood score of 16 out of a possible 27 (with higher numbers indicating a worsening mood.) This assessment showed Resident 71 had a poor appetite, felt bad about themselves, and had difficulty concentrating nearly every day of the assessment's two-week lookback period. The MDS showed Resident 71 took an antidepressant medication but showed Resident 71 did not have a diagnosis of depression. Review of the physician's orders showed Resident 71 had a 10/16/2024 order of an antidepressant. The order showed to give 300 milligrams in the morning for depression.In an interview on 08/27/2025 Staff I stated as Resident 71 was actively treated for depression during the MDS assessment, Resident 71 should have been identified with a depression diagnosis on the MDS assessment.REFERENCE: WAC 388-97-1000 (1)(b).

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR) level 2 comprehensive evaluation (a process to determine what mental health services residents required after a level 1 PASRR identified potential indicators of Serious Mental Illness - SMI) were obtained for 2 of 5 residents (Residents 1 & 3) whose PASRRs were reviewed. This failure placed residents at risk for not receiving the necessary mental health care and services they needed, frustration, and unmet mental health needs. Findings included. <Policy>According to the facility's revised 09/2018 PASRR policy, a PASRR would be completed upon admission rather than prior to admission as required. The policy showed based on assessment, residents would be referred to the state PASRR office for evaluation for specialized mental health services. The policy showed the facility's social services office was responsible for communication with the PASRR office.<Resident 1> According to the 06/25/2025 Admission/5-Day Minimum Data Set (MDS – an assessment tool) Resident 1 originally admitted to the facility on [DATE] with a diagnosis of depression. The MDS showed Resident 1 received an antidepressant medication every day of the assessment period. Review of Resident 1’s record showed the facility started a course of antidepressant medication for Resident 1 on 12/31/2024 to treat the resident’s depression. Review of Resident record showed a 04/01/2025 PASRR level 1 with “level 2 evaluation required for serious mental illness” and was completed four months after Resident 1 was diagnosed with depression. Review of Resident 1’s record on 08/26/2025 showed no follow up on the level 2 PASRR. In an interview on 08/26/2025 at 12:07 PM, Staff G (Corporate Social Service Resource) stated they were aware Resident 1 started antidepressant treatment on 12/31/2024 and the facility did not update the level 1 PASRR until 04/01/2025, four months late. Staff G stated the facility needed to update the level 1 PASRR as soon as the resident started the treatment for depression and the facility should request the State PASRR office complete a level 2 PASRR evaluation. Staff G stated the facility’s Social Services Director worked by themselves in the facility and could not follow up on all the PASRRs. <Resident 3> According to the 05/22/2025 Quarterly MDS, Resident 3 had a diagnosis of a psychiatric mood disorder. The MDS showed Resident 3 had no rejection of care. Review of Resident 3’s health records showed a 05/06/2024 PASSR level 1 with “level 2 evaluation required for serious mental illness. Resident 3’s records did not include a level 2 PASRR. In an interview on 08/26/2025 at 9:21 AM Staff J (Resident Care Manager) stated Resident 3 had behaviors often. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/26/2025 at 11:51 AM Staff G stated they sent the referral for a level 2 evaluation on 05/06/2024 and followed up on 08/11/2025, over one year and three months after the referral was initially made. Staff G stated it was the state PASRR office’s fault for not doing the evaluation. When Staff G was asked if the facility should follow up to ensure their residents are receiving necessary mental health services, Staff G stated the regulation only said “timely” and declined to provide a timeframe for what timely meant or say whether a delay of over a year and three months was timely or not. In an interview on 08/27/2025 at 8:44 AM Staff A (Administrator) stated they expected staff to follow up on PASRR level II reviews timely. Staff A stated follow up one year and three months later was not timely. REFERENCE: WAC 388-97 -1915 (4).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review the facility failed to ensure Care Plans (CPs) were updated and revised periodically and as needed for 5 of 19 sample residents whose CPs were reviewed (Residents 57, 28, 2, & 11). This failure placed residents at risk for unmet care needs, unnecessary care, and frustration.Findings included.<Facility Policy>According to the facility's revised 04/2025 Comprehensive Care Planning policy, the facility's Interdisciplinary Team (IDT) would develop a comprehensive, person-centered CP including measurable goals and timeframes. The policy showed CPs would be reviewed and revised quarterly, and as needed to meet the resident's ongoing needs. <Resident 57> According to the 07/18/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 57 used hearing aids. Review of the revised 07/30/2023 “impaired communication…” CP showed Resident 57 required hearing aids. Resident 57’s “alteration in sensory…” CP showed staff should provide Resident 57 with hearing aids daily. Observation on 08/25/2025 at 8:18 AM, 08/22/2025 at 7:52 AM, 08/22/2025 at 7:57 AM, 08/26/2025 at 10:36 AM, and 08/26/2025 on 11:52 AM showed Resident 57 in bed with no hearing aids. In an interview on 08/26/2025 at 1:16 PM Staff J (Resident Care Manager - RCM) stated Resident 57 did not wear the hearing aids for a long time. Staff J stated the CP should be updated to reflect the resident’s preference. <Resident 28> Review of the 06/11/2025 Quarterly MDS showed Resident 28 had a mental health diagnosis. The MDS showed Resident 28 received an antipsychotic medication to treat this condition. Review of the physician’s orders showed a 05/07/2025 order for an antipsychotic medication to treat Resident 28’s mental health condition. Review of Resident 28’s comprehensive CP showed a revised 07/09/2024 psychotropic medication CP was developed. There was no CP developed to address Resident 28’s mental health diagnosis. In an interview on 08/26/2025 at 10:39 AM Staff J reviewed Resident 28’s CP and stated no CP was developed to address Resident 28’s mental health diagnosis, only their medication. Staff J stated a CP should have been developed to address the diagnosis but was not. <Resident 2> (continued on next page)

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	505513	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Puget Sound Transitional Care	2800 South 224th Street, Des Moines, WA 98198

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 08/14/2025 Quarterly MDS, Resident 2 had multiple medical complex conditions including kidney failure and heart failure. The MDS showed Resident 2 had no impairment in functional range of motion on both arms and legs. The MDS showed Resident 2 had no swallowing issues and had an order for soft food. The MDS showed Resident 2 did not use a feeding tube during the assessment period. Review of the August 2025 Physician Order showed a 03/05/2025 order directed staff to provide regular diet, soft texture with thin liquid to Resident 2 each meal. Observations on 08/20/2025 at 12:02 PM, 08/21/2025 at 8:06 AM, and 08/25/2025 at 12:13 PM showed Resident 2 was eating breakfast and lunch meals with staff assistance without any swallowing problem. In an interview on 08/20/2025 at 3:31 PM, Resident 2’s representative stated Resident 2 had not used a feeding tube for food since May 2025 because they were eating soft food with no difficulty. Review of Resident 2’s 02/07/2025 Nutritional Care Plan showed Resident 2 required a tube feeding and the interventions directed staff to keep Resident 2’s head of bed up. The CP showed Resident 2 was dependent on the feeding tube for nutrition and staff to obtain and monitor labs as ordered. In an interview on 08/26/2025 at 11:52 AM, Staff F (RCM) stated Resident 2 was not using the feeding tube anymore. Staff F stated staff should update the CPs, but they did not. <Resident 11> According to the 08/07/2025 Quarterly MDS Resident 11 had diagnoses of a Stroke (poor blood flow to the brain causing cell death) and non- Alzheimer’s Dementia. The MDS showed Resident 11 was dependent on staff for bathing, dressing, toileting, and all hygiene needs. Review of Resident 11’s health records showed an ADL Self-Performance Deficit CP with an intervention of shower/bathe self twice weekly and as needed, two days a week not specified on the CP. Observation on 08/21/2025 at 11:50 AM showed Resident 11 dependent on staff for all mobility and care. Resident 11 was lying in bed wearing a gown. In an interview on 08/26/2025 at 9:21 AM Staff J stated the CP should show bed baths twice a week on Mondays and Fridays and as needed. Staff J stated it was important to update the CP, so staff knew how to care for and assist Resident 11. Staff J stated physical therapy completed an assessment on Resident 11 and recommended getting them up in their wheelchair daily for mobility purposes with pillows to prop them from falling toward their weak side, but the CP did not reflect positioning or instruct staff to get Resident 11 up daily in their wheelchair. Refer to F677 - ADL Care for Dependent Residents. Reference: WAC 388-97-1020(2)(c)(d).

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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. Based on observation, interview, and record review the facility: failed to ensure physician's orders were followed for 3 of 19 (Residents 11, 62, & 5) sampled residents; failed to ensure nurses only signed for treatment once provided for 1 of 19 (Resident 1) sampled residents; failed to ensure physician's orders were clarified as needed for 1 of 19 (Resident 1) sampled residents; ensure physician's orders were in place prior to care for 2 of 19 (Residents 1 & 53) sampled residents. These failures placed residents at risk for unmet needs, and ineffective and/or delayed treatments. Findings included.<Following Orders> <Resident 11> According to the 08/07/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 11 was at risk of pressure ulcers. The MDS showed Resident 11 had a pressure reducing device for their bed. Review of Resident 11’s 08/19/2025 Pressure Ulcer Development related to Impaired Functional Abilities Care Plan (CP) showed an intervention of a pressure relieving/reducing device for the resident’s bed. The CP also included an intervention of an air mattress with a weight setting of 170-180 pounds for Resident 11. Review of Resident 11’s physician’s orders showed an order for air mattress with a weight setting 160-180 pounds, check function and inflation every shift. Observations on 08/21/2025 at 9:58 AM, 08/22/2025 at 7:55 AM, and 08/25/2025 at 8:35 AM showed Resident 11’s air mattress setting was 300 pounds. Observation on 08/25/2025 at 8:35 AM showed Resident 11 restless, sweaty, agitated, and unable to verbally express discomfort. In an interview on 08/25/2025 at 8:35 AM Staff J (Resident Care Manager - RCM) stated Resident 11’s air mattress settings should not be at 300 pounds. Staff J reviewed Resident 11’s physician orders and stated the air mattress should be set at 160-180 pounds but the air mattress Resident 11 had was unable to accommodate those settings. Staff J stated Resident 11’s air mattress could only be set at 50-pound increments, so the order needed to be clarified with the physician to allow a setting of 150 pounds since Resident 11 weighed 168 pounds. Staff J stated it was important to follow physician’s orders and set the air mattress at an appropriate weight for the residents to relieve pressure and reduce the risk of pressure ulcer development. <Resident 62> According to the 08/1/2025 Quarterly MDS, Resident 62 had multiple medically complex diagnoses including heart failure, high blood pressure (BP), atrial fibrillation (irregular electrical signals of the heart) and used blood thinning medications. (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 Resident 62's physician’s orders showed the resident received a medication to lower their BP with instructions to hold the medication if the resident’s Systolic BP (the pressure in your arteries when your heart beats, the larger BP value) was less than 100. Review of the August 2024 MAR showed this medication was administered on two occasions when Resident 62's SBP was less than 100: on 08/03/2025 at 10:48 AM for a value of 99 and on 08/10/2025 at 9:21 AM for a value of 98. Review of Resident 62's physician’s orders showed the resident received a diuretic medication (used to increase urinary output) with instructions to hold the dose when the resident’s SBP was less than 100 or their pulse less than 60. Review of the August 2024 MAR showed medication was administered on one occasion when Resident 62's SBP was less than 100 on 08/10/2025. In an interview on 08/22/2025 at 1:30 PM, Staff J reviewed Resident 62’s August 2025 MAR and confirmed the blood pressure and diuretic medications were administered outside parameters on 3 occasions. Staff J stated they expected staff to hold medications as ordered. <Resident 5> According to the 06/20/2025 Quarterly MDS Resident 5 had two stage 2 pressure ulcers at the time of their 06/17/2023 admission and was at risk of developing additional pressure ulcers. The MDS showed Resident 5 had a pressure-reducing device for their bed. Review of Resident 5’s record showed a physician’s order for an air mattress to be set to 100-110 lbs. The order showed staff should monitor the mattress for functionality every shift. Review of Resident 5’s August 2025 MAR showed staff documented the air mattress was monitored every shift. Observations on 08/20/2025 at 8:47 AM, 08/21/2025 at 9:32 AM, and 08/22/2025 at 7:55 AM showed Resident 5’s air mattress weight indicator was set at 200 pounds. In an interview on 08/21/2025 at 09:38 AM, Resident 5 stated the bed was not particularly comfortable and explained that was why they asked for so many pillows. In an interview on 08/22/2025 at 8:16 AM Staff Q (Licensed Practical Nurse) confirmed Resident 5’s air mattress was set at 200 pounds and should have been set at 100 pounds per the physician’s orders. Staff Q stated it is important to follow the physician’s orders to provide therapeutic benefit and comfort for the residents. <Signing for Medications Administered> According to the 06/25/2025 admission MDS, Resident 1 had medically complex conditions including a stroke with left arm weakness and difficulty swallowing. The MDS showed Resident 1 received nutrition via a feeding tube during assessment period. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/22/2025 at 9:13 AM, Staff K (Registered Nurse) stated they administered all morning medications to Resident 1 that morning. Staff K opened Resident 1’s August 2024 Medication Administration Record (MAR) and showed none of the morning medications were signed for that day to indicate staff administered morning medications to Resident 1. In an interview on 08/22/2025 at 9:25 AM, Staff K stated they were supposed to sign the MAR as soon as the morning medications were administered to Resident 1, but they did not. <Clarifying Orders> <Resident 1> Observations on 08/20/2025 at 11:50 AM, on 08/21/2025 at 2:01 PM, and on 08/22/2025 at 10:18 AM showed Resident 1 lying in bed with a feeding tube providing artificial nutrition at 45 Milliliter per Hour (ML/hour). Review of Resident 1’s physician’s orders showed a 08/14/2025 order directing staff to administer artificial nutrition at 45 ML/hour via a feeding tube. There was no order showing what type of artificial nutrition to administer for Resident 1. In an interview on 08/22/2025 at 11:10 AM, Staff F (RCM) stated their expectation was for staff to administer medications and artificial nutrition to residents as ordered. Staff F reviewed Resident 1’s physician orders and stated there was no order showing what artificial nutrition to administer for Resident 1. Staff F stated staff should have clarified the orders with a provider but did not. <Obtaining Orders Prior to Care> <Resident 1> Observations on 08/21/2025 at 11:52 AM and on 08/22/2025 at 10:18 AM showed Resident 1 was lying in their bed receiving oxygen on at 2 liter per minute via nasal cannula (tubing providing supplemental oxygen directly to the nostrils). Resident 1 was observed removing the cannula from their nose and throwing it on the floor. Review of Resident 1’s physician’s orders showed no order for oxygen for Resident 1. In an interview on 08/22/2025 at 11:06 AM, Staff F reviewed Resident 1’s physician’s orders and confirmed there was no oxygen order. Staff F stated it was important to have physician’s orders in place prior to providing the resident care. Staff F stated the facility should have obtained an order from the provider to administer Oxygen for Resident 1 but did not. <Resident 53>According to the 05/08/2025 Quarterly MDS, Resident 53 had diagnoses including lower body paralysis, a spinal cord injury, and deep tissue damage at the base of spine caused by pressure. The MDS showed Resident 53 was at risk for pressure injuries and had moisture associated skin damage. The MDS did not show Resident 53 had a pressure-reducing device for their bed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/20/2025 at 2:09 PM showed Resident 53 lying in bed. The mattress on the bed was a low air loss mattress used to reduce pressure when there is a risk of pressure injury. According to a 08/13/2025 physician’s orders, Resident 53 “may have pressure relieving/reducing device on bed.” There were no more specific orders directing staff to use a low-air-loss mattress. In an interview on 08/26/2025 at 12:57 PM, Staff J stated they did not see an order for a low air loss mattress in Resident 53’s record. Staff J stated there should be an order. Staff J stated there was a low air loss mattress order in place prior to Resident 53’s recent hospitalization. In an interview on 08/27/2025 at 9:52 AM, Staff B (Director of Nursing) stated it was important for physician's orders to be clarified when they were not specific. REFERENCE: WAC 388-97-1000 (1)(b).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 (Resident 1) of 1 sample residents reviewed for communication was provided with a functional communication system. Failure to identify and provide services to maintain effective communication placed residents at risk for unmet care needs, social isolation, and a diminished sense of well-being. Findings included . <Facility Policy>On 08/25/2025 at 1:13 PM, Staff A (Executive Director) stated they did not have language and communication policy for residents with English as a second language. <Resident 1>According to the 06/25/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 1 admitted to the facility on [DATE] with multiple medical conditions and had no memory issues. The MDS showed Resident 1 was Asian, had clear speech and made self-understood and able to understand others. The MDS showed Resident 1's preferred language was not English and needed interpreter to speak with health care staff. Observations on 08/20/2025 at 2:27 PM, and 08/22/2025 at 9:19 AM showed Resident 1 lying in their bed in their room and mumbling in their language. A note was posted on a wall for a language line phone number in Resident 1's room. In an interview on 08/22/2025 at 9:20 AM, Resident 1 opened their eyes, mumbled, and was unable to make themselves understood to the surveyor. Resident 1 was observed tapping on their right leg multiple times. Observations on 08/22/2025 at 10:33 AM and on 08/25/2025 at 11:23 AM showed staff F (Resident Care Manager) assisting with Resident's feeding tube (a soft, flexible tube inserted in stomach for individual unable to swallow to meet their nutritional needs) and oxygen (the process of adding oxygen to body's tissues to maintain cellular function and life, involving the lungs for gas exchange and circulation). Resident 1 mumbled but Staff F could not understand the resident. Staff F was not observed to use the language line phone number to assist with communication to provide better care to Resident 1.Review of the revised 10/28/2024 Communication Care Plan (CP) showed Resident 1 had a communication problem related to a language barrier. The CP had nursing interventions instructing staff to anticipate and meet Resident 1's needs. The CP showed Resident 1 only understood and spoke preferred language and instructed staff to call the resident's family or to use the language line whenever needed to communicate with the resident. In an interview on 08/25/2025 at 10:52 AM, Resident 1's representative at bed side in Resident 1's room stated Resident 1 did not speak English at all. Resident 1's representative stated they visited the resident this morning and noticed the resident with shortness of breath but the resident was not able to explain that to staff. Resident 1 was observed with oxygen in their nose and lying in their bed comfortably at that time. In an interview on 08/26/2025 at 11:26 AM, Staff F stated Resident 1 could not speak English and communicated with staff by facial expressions. Staff F stated they posted the language line phone number in Resident 1's room for when staff needed an interpreter to communicate with the resident. When asked how facility staff communicated with the resident while providing care during day and night shifts, Staff F stated they should have a communication binder with everyday words and pictures in Resident 1's room for better communication with the resident, but they did not have one. REFERENCE: WAC 388-97-1620 (2)(a)(v).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 - bathing, grooming, getting up, oral hygiene etc.) to residents dependent on staff assistance for ADL for 4 of 6 (Residents 10, 2, 11, & 13) residents reviewed for ADLs and 1 supplemental resident (Resident 53). The failure to provide assistance with showers, dressing, oral hygiene, and getting out of bed left residents at risk for frustration, poor hygiene, embarrassment, and diminished quality of life. Findings included. <Facility Policy>According to the facility's revised 07/2015 ADL policy, Certified Nursing Assistants (CNAs) would provide ADL assistance to residents according to their individualized Care Plans (CPs). The policy showed CNAs would document the ADL assistance provided in the residents' medical records<Resident 10> According to the 07/22/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 10 admitted to the facility on [DATE] with medically complex conditions including respiratory failure and kidney issues. The MDS showed Resident 10 had no functional limitations in their arms or legs. The MDS showed Resident 10 was dependent on staff for lower body dressing and toileting needs and required one-person assistance from staff with personal hygiene, transfers, and showers. The MDS showed Resident 10 had no behavior of refusing care during the assessment period. According to the revised 08/19/2025 ADL Self-Care Performance Deficit Care CP, Resident 10 required one-to-two-person assistance from staff with toileting, transferring, and personal hygiene including showering and oral care, and dressing. Observations on 08/20/2025 at 10:47 AM, on 08/21/2025 at 11:22 AM, and on 08/22/2025 at 10:34 AM showed Resident 10 lying in bed in a hospital gown, not shaved, with greasy hair, and their teeth not brushed. On each occasion Resident 10’s toothbrush was noted to be dry and placed in a wash basin near their closet In an interview on 08/22/2025 at 12:53 PM, Resident 10 stated no one helped them to brush their teeth. Resident 10 was seated in their wheelchair wearing a hospital gown, with greasy, uncombed hair and unbrushed teeth. In an interview on 08/22/2025 at 1:03 PM, Staff S (Certified Nursing Assistant - CNA) stated Resident 10 was asleep this morning so they only assisted to change them. Staff S stated they did not help the resident to brush their teeth. Staff S looked for Resident 10’s toothbrush in their room and it took a while for the staff to find the toothbrush. Staff S stated they should provide oral care to assigned residents in the morning, dress them, and brush their hair before helping them into their wheelchair, but they did not. In an interview on 08/26/2025 at 10:18 AM, Staff F (Resident Care Manager - RCM) stated they expected staff to check all assigned resident’s preferences related to ADLs and provide the assistance they needed every morning. Staff F stated staff should provide morning care including oral care, hair care, dressing, and assistance to get up per the residents’ preferences. Staff F stated if the resident refused care, staff should document the refusals. Staff F stated staff should provide oral care, hair care, shaving, dressing, and assistance to get up for meals to Resident 10, but they did not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 2> According to the 05/14/2025 Quarterly MDS, Resident 2 admitted to the facility on [DATE], had impaired memory, and required maximal assistance with personal hygiene, toileting, and transferring. The MDS showed Resident 2 had no behavior of refusing care during the assessment period. According to the 02/07/2025 revised ADL Self-Care Performance Deficit CP, Resident 2 required two-person assistance with a mechanical lift (a machine to assist with transferring) to transfer from their bed to their wheelchair. Review of Resident 2’s Kardex (care instructions for CNAs) on 08/22/2025 showed CNAs should offer and assist the resident to get out of bed every day before lunch and help them back to bed after lunch. Observations on 08/20/2025 at 10:22 AM, on 08/21/2025 at 1:39 PM, and on 08/22/2025 at 12:20 PM showed Resident 2 lying in bed in a hospital gown. Staff were observed assisting the resident with lunch while the resident remained in their bed. In an interview on 08/26/2025 at 11:52 AM, Staff F stated they expected staff to follow the CP and Kardex regarding Resident 2’s daily routine and preferences. Staff F stated if the resident refused, staff should document the refusals. Staff F stated staff should dress the resident per their preferences and get them up for lunch and activities as needed, but they did not. <Resident 11> According to the 08/07/2025 Quarterly MDS Resident 11 was dependent for all cares. The MDS showed Resident 11 had medical conditions including stroke and non-Alzheimer’s Dementia. Review of a 06/08/2025 ADL Self Care Performance Deficit related to impaired functional mobilities CP showed an intervention to get Resident 11 out of bed from 11:00 AM until 3:00 PM. The CP showed Resident 11 required assistance from staff for transfers, bed mobility, and dressing. Review of Resident 11’s health records showed no bathing was offered or provided for June, July, or August of 2025. Observations on 08/21/2025 at 9:58 AM, 11:50 AM, and 12:58 PM, 08/22/2025 at 7:55 AM, 9:38 AM, 11:11 AM, and 1:21 PM, and 08/25/2025 at 8:35 AM, 12:01 PM until 1:12PM, 08/26/2025 at 8:20 AM until 9:16 AM showed Resident 11 lying in bed in a gown. In an interview on 08/26/2025 at 9:21 AM Staff J (RCM) stated Resident 11 was dependent on staff for all mobility and cares. Staff J stated Resident 11 should be offered bed baths every Monday, Friday, and as needed. Staff J was unable to provide documentation that bathing was offered for June, July, or August 2025. Staff J stated bathing was important for good hygiene and good health. Staff J stated the last time Resident 11 was assisted out of bed was for an eye examination in June 2025. Staff J stated Resident 11 should be getting up, dressed, and out of bed daily for quality of life. Staff J stated Resident 11 was nonverbal, so staff had to anticipate all the residents’ needs. <Resident 13> (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 06/04/2025 Quarterly MDS Resident 13 was dependent on staff for toileting hygiene and bathing. The MDS showed Resident 13 required substantial assistance from staff for dressing. The MDS showed Resident 13 had medical conditions including stroke and non-Alzheimer’s Dementia. Review of Resident 13’s health records showed a 07/29/2023 ADL Self Care Performance Deficit related to weakness and decreased mobility CP with bathing twice weekly, per the resident’s preference, and as needed. The CP showed Resident 13 required staff assistance with bathing and dressing. In an interview on 08/20/2025 at 10:09 AM Resident 13 stated staff always left them in bed and never got them dressed. Resident 13 stated they were incontinent of bowel and bladder, and staff cleaned them up once a day. Observation on 08/22/2025 at 9:31 AM showed Resident 13 received a shower, was placed back into a hospital gown, and returned to bed. In an interview on 08/26/2025 at 8:58 AM Staff W (CNA) stated they were expected to check on Resident 13 at least every two hours and provide incontinent care when needed. Staff W stated they were expected to offer and provide assistance with morning ADL cares to all residents needing help which included washing up, incontinence or toileting assistance, dressing, and oral hygiene. In an interview on 08/26/2025 at 9:21 AM Staff J stated they expected staff to offer Resident 13 bathing twice weekly on Sundays and Fridays per the schedule, and as needed. Staff J reviewed Resident 13’s records and stated Resident 13 was not offered bathing twice weekly for June, July, or August 2025. Staff J stated they expected staff to assist Resident 13 with dressing and getting out of bed daily, but Resident 13 would refuse sometimes. Staff J reviewed Resident 13’s records and was unable to provide documentation of refusals. Staff J stated they expected staff to document refusals to show they were offering the resident cares per CP. <Resident 53> According to the 05/08/2025 Quarterly MDS, Resident 53 had diagnoses including a spinal cord injury, lower body paralysis, and muscle weakness. The MDS showed Resident 53 was dependent on staff for transferring from their bed to a chair and required partial/moderate assistance with bathing themselves. The MDS showed Resident 53 had intact memory. In an interview on 08/20/2025 at 2:05 PM Resident 53 stated they were frustrated because they were supposed to get two showers a week on Mondays and Fridays, but they did not receive showers per the schedule in their CP. Resident 53 stated they felt “cheated.” Resident 53 was in bed at the time. According to the 12/16/2024 ADL CP, Resident 53 required 1-person assistance with showering. This CP showed Resident 53 should receive bathing/showering twice a week and as needed. Review of the CNA shower documentation showed from 07/25/2025 through 08/22/25 Resident 53 showered on only three occasions out of eight scheduled shower days (Resident 53 was out of the facility from 08/09/2025 to 08/13/2025): 07/28/2025, 08/04/2025, and 08/18/2025. There were no documented refusals of bathing assistance. (continued on next page)

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Puget Sound Transitional Care	2800 South 224th Street, Des Moines, WA 98198

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/26/2025 at 1:05 PM, Staff J (Resident Care Manager) stated they knew showers were important to Resident 53 and felt the resident was provided showers as care planned. Staff J reviewed the CNA shower documentation and stated there could also be showers documented in the unit shower book. Review of the 300 Unit shower book showed documentation Resident 53 was also provided with a shower on 08/22/2025. This meant Resident 53 received a total of four showers out of eight scheduled shower days. In an interview on 08/26/2025 at 1:02 PM, Staff J stated they would provide any additional documentation showing Resident 53 received showering assistance as required. No additional documentation was provided. REFERENCE: WAC 388-97-1060 (2)(c).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to offer and provide individualized activities plans and to document the refusals for 2 of 3 residents (Resident 11 & 2) reviewed for activities. Failure to consistently offer and provide meaningful individual activity plans left residents at risk of boredom, frustration, isolation, and a diminished quality of life.Findings included. According to the facility's 04/2025 Activities Programming policy, the facility would ensure activities were available for all residents to meet resident's needs and interest that would support the physical, mental, and psychosocial well being of the resident. The policy showed the facility would conduct an activity evaluation at admission time to determine resident's preferences and interests including cultural preferences and spiritual preferences. The facility staff would make efforts to accommodate resident's preferences according to activity calendar. The policy showed the facility would provide assistance to transfer residents in wheelchair for activities, provide proper seating and positioning and placements of supplies for residents with physical limitations.<Resident 11> According to the 08/07/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 11 was readmitted to the facility on [DATE]. The MDS showed Resident 11’s activity preferences for customary routine were not assessed. Review of the 08/08/2025 Dependent on Staff for Activities Care Plan (CP) showed activities staff would provide 1:1 room visits for music, hand massage, and hair care. The CP showed Resident 11 required escort by staff to group activities and staff would provide assistance during group activities. Observations on 08/21/2025 at 9:58 AM, 11:50 AM, and 12:58 PM, 08/22/2025 at 7:55 AM, 9:38 AM, 11:11 AM, and 1:21 PM, and 08/25/2025 at 8:35 AM, 12:01 PM until 1:12PM, 08/26/2025 at 8:20 AM until 9:16 AM showed Resident 11 lying in bed in a gown. These observations showed no music was playing and Resident 11’s television was turned off. These observations showed Resident 11 was dependent on staff for all mobility and care. During the 08/25/2025 at 8:35 AM Resident 11 was restless, sweaty, and agitated, and unable to verbally express discomfort or utilize call light. In an interview on 08/26/2025 at 9:21 AM Staff J (Resident Care Manager -RCM) stated Resident 11 was dependent on staff for all mobility and care. Staff J stated Resident 11 “really lit up when staff would play music for them and they could tell the resident really enjoyed music.” Staff J stated staff should turn music or the TV on for Resident 11 during the day when they’re in their room. Staff J stated Resident 11 was nonverbal, so staff had to anticipate all the residents’ needs. Staff J stated they expected staff to get Resident out of bed daily per their CP. In an interview on 08/26/2025 at 10:27 Staff Y (Activities Director) stated they have requested staff to get Resident 11 out of bed so they could attend group activities, but it hasn’t happened. Staff Y stated when Resident 11 was sleeping they would document “Not Applicable” in their records for activities offered. Staff Y stated they expected activities offered and refused to be documented in the residents’ records, but they were not. Staff Y was unable to provide documentation for activities offered for Resident 11. Staff Y stated it was important to offer and provide activities to residents for quality of life and because they looked forward to socialization and entertainment. <Resident 2> (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 05/14/2025 Quarterly MDS, Resident 2 was assessed with medically complex conditions including depression. The MDS showed activity preferences including listening to music, participating in favorite activities, and in religious services were very important to Resident 2. The MDS showed Resident 2 was dependent on staff to get out of bed and had no rejection of care during the assessment period. Record review showed the 02/19/2025 revised Activities CP showed Resident 2 had impaired vision and could not see TV images or read the captions. The CP included goals for Resident 2 to participate in one-to-one visits as much as possible from staff and attend activities of choice. The CP showed Resident 2 required escort by staff to group activities and staff would provide assistance during activities such as; religious services, music/entertainment, exercise, and basic word games. Observations on 08/20/2025 at 10:33 AM and 1:57 PM, on 08/21/2025 at 8:02 AM, 10:45 AM, and 2:32 PM, on 08/22/2025 at 9:20 AM and 2:43 PM, and on 08/25/2025 at 7:53 AM, 9:46 AM, and 1:32 PM showed Resident 2 lying in their bed awake, in hospital gown. These observations showed no music was playing in Resident 2’s room and television was turned off. In an interview on 08/25/2025 at 11:02 AM, Resident 2 stated they could not see the television because their one eye was bad. Resident 2 stated they would like to attend activities such as listening to music and going outside for fresh air and church services but needed assistance from staff for all mobility and care. In an interview on 08/25/2025 at 11:02 AM, Staff F (RCM) stated Resident 2 required assistance from staff with transferring from bed to wheelchair and Resident 2 refused care at times. When asked about activities for Resident 2, Staff F stated Resident 2 would like to stay in their room most of the time. Staff F stated staff should check with the resident and get them up in a wheelchair for activities per Resident 2’s preferences. In an interview on 08/27/2025 at 9:00 AM, Staff Y stated activities were important to help take people's minds off problems, as it gives residents meaning for life, and to give them something to look forward to. Staff Y stated Resident 2 was sleeping in their room most of the time and activity staff would not bother them. Staff Y stated Resident 2 could not see but staff turned the television on at times. When asked Staff Y about Resident’s preferences according to assessment and CP, Staff Y stated they did not have a radio to play music in Resident 2’s room and they would ask Resident 2’s daughter to bring a radio or music player to play music in Resident 2’s room. Staff Y did not provide documentation for activities offered or refusals for Resident 2 including religious services and fresh air outside. Staff Y stated staff should get Resident 2 up in a wheelchair for activities as CP, but they did not. REFERENCE: WAC 388-97- 0940(1).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, interview, and record review the facility: Failed to ensure residents' skin was assessed weekly as ordered, monitored, and treated as required for 2 (Residents 9 & 10) of 4 residents reviewed for non-pressure skin. These failures placed all residents at risk for delay in treatment, worsening condition, unmet care needs, and a decreased quality of life. Findings included . <Facility Policy>Review of the facility's 04/2025 Skin and Wound Monitoring and Management revised policy showed the facility would provide care and services to prevent the development of new skin issues. The policy showed staff would perform weekly head-to-toe checks for all residents, document the findings in resident's record, and notify the provider to obtain treatment orders as needed. The policy showed nursing staff would implement the ordered interventions and develop a Care Plan (CP) for staff to consistently implement the care. <Resident 9> According to the 07/27/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 9 had memory impairment, was understood, and able to understand others in conversation. This assessment showed Resident 9 did not have any wounds or skin problems. Observations on 08/20/2025 at 11:45 AM, 08/21/2025 at 9:21 AM, on 08/22/2025 at 2:12 PM, and on 08/26/2025 at 9:00 AM showed Resident 9 had multiple bruises on both their arms. Review of Resident 9’s August 2025 physician’s orders showed no orders directing staff to monitor the bruising on Resident 9’s arms. Review of the 06/23/2025 Skin CP showed instructions to staff to perform weekly head-to-toe skin assessments and notify the nurse supervisor immediately of any skin breakdown including redness, blisters, and bruises. Review of Resident 9’s weekly skin assessments on 08/26/2025 showed staff performed head-to-toe skin assessment for Resident 9 on 08/04/2025 and 08/25/2025. These assessments showed staff did not identify any skin impairments for Resident 9. In an interview on 08/26/2025 at 9:05 AM, Staff F (Resident Care Manager) stated the facility’s process for monitoring skin issues was for staff to perform head-to-toe skin assessments for residents upon admission, weekly, and as needed, and to document any new issues in the resident’s record. Staff F stated if staff noticed any new skin issues for any resident, they should notify the nursing supervisor, to provider and resident’s families. Staff F reviewed Resident 9’s weekly skin assessments and stated staff did not complete weekly skin checks as ordered and did not document any skin problems. On 08/26/2025 at 9:15 AM, Staff F assessed Resident 9’s skin with this surveyor and stated Resident 9 had multiple bruises on both arms that staff did not report to them. Staff F stated the 08/25/2025 weekly skin assessment was not accurate. Staff F stated staff should document all skin issues in the resident’s record and notify the provider, but they did not. <Resident 10> (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 07/22/2025 admission MDS, Resident 10 had memory impairment, was understood, and able to understand others in conversation. This assessment showed Resident 10 did not have any wounds or skin problems. The MDS showed Resident 10 had no behavior of refusing care during the assessment period. Observations on 08/20/2025 at 10:00 AM, on 08/21/2025 at 11:21 AM, and on 08/22/2025 at 2:12 PM showed Resident 10 had a one-centimeter by one-centimeter scab with light, bloody drainage on their left cheek. Review of Resident 10’s physician’s orders showed a 07/18/2025 order directing staff to perform weekly skin checks. There was no order for treatment of Resident 10’s left cheek scab in the record. Review of Resident 10’s weekly skin assessments on 08/26/2025 showed staff last performed and documented a head-to-toe assessment for Resident 10 on 08/09/2025 and did not identify any skin impairments for Resident 10. There were no weekly skin assessments completed after 08/09/2025. In an interview on 08/26/2025 at 9:45 AM, Staff F reviewed Resident 10’s record and stated the facility staff did not perform weekly skin assessments as ordered and there was no documentation showing Resident 10 had a scab on their left cheek. Staff F stated staff should perform weekly skin assessment as ordered, document any skin impairments in Resident 10’s record, and notify the physician to obtain treatment orders, but did not. In an interview on 08/26/2025 at 9:39 AM, Staff B (Director of Nursing) stated it was their expectation staff follow the facility policy and the physician’s order to complete weekly skin assessments, notify the RCM of any new skin issues, evaluate and document the newly identified skin issue, and notify and obtain orders from the physician. REFERENCE: WAC 388-97-1060(1).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents admitted with Indwelling Catheters (I/C - a flexible tube inserted into the bladder) were assessed for the continued need for a I/C, attempted to remove the I/C as soon as possible for 1 (Resident 9) of 3 residents reviewed for the I/C. These failures placed residents at risk for urinary tract infections, decreased bladder tone (muscle strength), urethral erosion (gradual destruction of the tissues), and dignity issues. Findings included .According to the facility's 01/2025 Indwelling Catheter Care policy, Staff would provide catheter care to each resident with an I/C every day and as needed to promote hygiene, comfort and decrease the risk of infection.<Resident 9>According to the 07/27/2025 admission 5-day Minimum Data Set (MDS - an assessment tool), Resident 9 admitted to the facility on [DATE] and was assessed as cognitively impaired and had the indwelling catheter during the assessment period. In an interview on 08/20/2025 at 1:23 PM, Resident 9's representative stated Resident 9 went to the hospital in June 2025 and they inserted this catheter in her bladder. Resident 9 came to this facility on 06/23/2025 from the hospital and no one talk to them about the catheter. Review of the 08/18/2025 bowl and bladder assessment in Resident 9's record showed Resident 9 was incontinent of bowel and bladder. Resident 9's record showed no I/C assessment showing the reason Resident 9 had a catheter in their bladder. Observations on 08/20/2025 at 11:21 AM and 08/22/2025 at 9:02 AM showed Resident was lying in bed and an I/C was hanging on the bed frame. Observation on 08/25/2025 at 10:39 AM showed Resident 9 was up in a wheelchair in their room and I/C bag was resting on the floor under their wheelchair in their room. Review of the 06/24/2025 Physician Order showed Resident 9 had an I/C, and staff were to provide catheter care every shift. Review of the 06/24/2025 Indwelling Catheter Care Plan showed interventions instructing staff to provide I/C care every shift for Resident 9. In an interview on 08/26/2025 at 10:44 AM, Staff F (Resident Care Manager) stated the facility process for I/C care was ; when a resident got admitted to the facility from the hospital with an I/C, staff would complete bowel and bladder assessment, why a resident needed I/C, would consult with a provider and attempt a trial to remove a catheter and would complete post void residual (PVR - amount of urine remaining in bladder after a voluntary urination). If a resident had difficulty voiding independently and had PVR more than 200 milli liters, staff would consult with the provider. Staff F reviewed Resident 9's record and said they did not assess Resident 9 for an I/C. Staff F did not provide documentation about why Resident 9 needed an I/C in bladder. Staff F stated the facility did not attempt a trial to remove the catheter. Staff F stated staff should assess the resident for need of I/C, attempt a trial to remove the catheter and complete PVR, but they did not. REFERENCE: WAC 388-97-1060 (2)(a)(iii).

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete safety assessments for a bed against the wall and fall mats on the floor for 2 of 7 residents (Residents 3 & 2) and a tilt-in-space wheelchair for 1 of 8 residents (Resident 77) reviewed for accident hazards. This failure placed residents at risk for injury, entrapment, and other negative health outcomes.Findings included.<Facility Policy>According to the facility's revised 03/2016 Physical Restraints policy, placing a resident's bed close enough to the wall to prevent the resident from getting out of bed was considered a restraint. The policy showed when a restraint was assessed to be necessary, a physician's order should be in place and the risks and benefits explained to the resident and/or their representative (the Informed Consent process).<Resident 3> According to a 05/22/2025 Quarterly MDS Resident 3 had no memory impairment. The MDS showed Resident 3 had no restraints in place. Review of Resident 3’s health records showed a 03/22/2025 Activities of Daily Living Performance Deficit Care Plan (CP) with an intervention to have the bed against the wall. Resident 3’s records did not show a safety assessment for the bed against the wall. Observation on 08/21/2025 at 9:36 AM showed Resident 3’s right side of the bed against the wall. In an interview on 08/26/2025 at 9:21 AM Staff J (Resident Care Manager - RCM) stated they expected staff to complete a safety assessment for beds against the wall. Staff J was unable to provide documentation for a safety assessment for Resident 3’s bed against the wall. Staff J stated it was important to do a safety assessment for the bed against the wall because it could be a form of restraint, and they needed to ensure the resident did not get injured. <Resident 2> According to the 05/14/2025 Quarterly MDS, Resident 2 admitted to the facility on [DATE] and had impaired memory. The MDS showed Resident 2 had no falls in the facility and had no restraints in place. Observations on 08/20/2025 at 10:43 AM, on 08/21/2025 at 11:29 AM, and on 08/25/2025 at 2:04 PM showed Resident 2 lying in their bed with fall mats on the floor on both sides of their bed. Review of the 02/05/2025 Fall CP showed Resident 2 was at risk for falls related to a history of falls with fracture. The CP instructed staff to keep Resident 2’s bed in the lower position. Review of Resident 2’s record did not show any physician’s order, informed consent, or safety device assessment for the floor mats. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/26/2025 at 11:02 AM, Staff F (RCM) stated they expected staff to obtain a physician’s order for a safety device, informed consent from the resident or their representative, and a safety device assessment and to document these actions in the resident’s CP. Staff F reviewed Resident 2’s record and stated there was no physician’s order, no informed consent, and no safety device assessment for floor mats for Resident 2, but there should be. <Resident 77> According to the 06/25/2025 Quarterly MDS, Resident 77 had diagnoses including stroke, impaired memory, seizures, anxiety, a history of falls, and an abnormal gait. The MDS showed Resident 77 had one fall with injury since admission and had no restraints in place. Review of the 06/01/2025 Safety Device Evaluation recommended use of a tilt-in-space wheelchair (a specialized wheelchair where the angle of the seat can be adjusted that has the potential to limit the ability of the resident to ambulate) for trunk support and comfort related to impaired cognition, weakness, and seizures. The evaluation stated the tilt-in-space wheelchair would not restrain resident’s movement. Review of the 06/25/2025 Interdisciplinary Team (IDT – a group of senior facility staff representing different disciplines) Care Plan Review showed no safety assessment was reviewed and showed Resident 77 was able to self-propel down the hallway. Observation on 08/20/2025 at 12:53 PM showed Resident 77 placed outside their room with the wall on their right side, tilted 45 degrees backwards with their wheels locked and the lock levers out of reach of the resident. Resident 77 was observed to repeatedly slap their legs with their hands, rock from side to side, and moved consistently with attempting to exit the left side of the wheelchair. Resident 77 requested to return to their room to take a nap. In an observation on 08/21/2025 at 12:02 PM, Resident 77 was placed in the activity room, tilted 45 degrees backwards with their wheels locked. Resident 77 repeatedly slapped their legs with their hands and requested they were returned to their room. Observation on 08/22/2025 8:55 AM showed Resident 77 placed outside their room with the wall on their right side, sitting in an upright position with the wheels locked. Resident 77 was finished with breakfast and repeatedly slapped their legs with their hands and rocked from side to side. In an interview on 08/22/2025 at 11:32 AM, Staff O (Certified Nurse Assistant) stated they provided care for Resident 77 since their hire date in April 2025. Staff O stated the purpose of tilting Resident 77 backwards in their chair was for safety due to the resident’s history of falls. Staff O stated Resident 77 was positioned in the hallway with their wheelchair breaks locked, so staff could monitor them. Staff O stated they observed occasions when Resident 77 appeared frustrated with waiting for staff to unlock their brakes and return them to their room after meals and activities. In an interview on 08/22/2025 at 1:23 PM, Staff R (Therapy Program Manager) reviewed Resident 77’s record and was unable to provide a therapy evaluation to assess the safety and necessity of the tilt-in-space wheelchair. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/27/2025 at 9:59 AM, Staff J stated Resident 77 was able to self-propel in their wheelchair. Staff J stated Resident 77 could not independently unlock the brakes of the tilt-in-space wheelchair, because they were located behind the resident and out of reach. Staff J stated they expected staff to complete a therapy evaluation to ensure devices used by residents provided the least restrictive and highest practicable well-being. Staff J reviewed Resident 77’s record and stated there was no therapy evaluation for the tilt-in-space wheelchair, but there should be. REFERENCE: WAC 388-97-0230.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 percent (%). Failure of 2 of 4 nurses (Staff U & V - Registered Nurses) to properly administer 2 of 32 medications for 1 (Resident 38) of 4 residents observed during medication pass resulted in a medication error rate of 6.25%. This failure placed residents at risk for adverse side effects and/or not receiving prescribed medications as ordered. Findings included . <Facility Policy>According to the facility's revised 01/2025 Medication Administration policy, Medications would be accurately prepared, administered, and documented per physician order. The policy showed staff would check the medication label with the Medication Administration Record (MAR) to verify resident name, medication name, form, dosage, route, and time.<Resident 38>Observations on 08/20/2025 at 8:59 AM showed Staff U administered a blood thinner medication enteric coated (protective coated delays pills dissolution) to Resident 38 related to heart issues. Review of Resident 38's August 2025 Physician Orders showed an 07/22/2025 order for staff to administer a chewable blood thinner for heart issues. In an interview on 08/20/2025 at 10:00 AM, Staff U confirmed they administered the wrong medication to Resident 38. Staff U stated they should check the physician order before administering the medication to the resident, but they did not. In an observation on 08/22/2025 at 8:03 AM, Staff V administered artificial tear eye drops in both eyes to Resident 38 for dry eyes. Review of Resident 38's August 2025 Physician orders showed an 08/14/2025 order for staff to administer medicated eye drops in both eyes for eye irritation. In an interview on 08/22/2025 at 10:02 AM, Staff V stated they thought the physician order was for dry eyes, and they used artificial tears. Staff V stated it was very important to administer the right medications to all residents. Staff V stated they should follow the physician orders, but they did not. In an interview on 08/26/2025 at 12:32 PM, Staff B stated according to the facility process medications were expected to be administered timely as ordered by the physician. Staff should follow the physician orders, but they did not. REFERENCE: WAC 388-97-1060(3)(k)(ii).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were returned or discarded when expired or when residents discharged for 1 of 1 medication rooms (200 Unit Medication Room) and 2 of 2 medication carts (200 North and 300 North medication carts) observed. The failure to ensure unneeded medications were returned to the pharmacy or destroyed upon resident discharge or expiration placed the residents at risk for receiving unauthorized, compromised, and/or ineffective medications. Findings included . <Facility Policy>According to the facility's revised [DATE] Storage and Expiration of Medications and Biologicals policy, the facility would ensure all medications and biologicals were stored in an organized manner in cabinets, drawers, carts, and refrigerators with sufficient space to prevent crowding and inaccessible to visitors and residents. The policy showed medicines and biologicals that exceeded their use by date must be stored separately and returned to the pharmacy or supplier. The policy showed facility staff must follow manufacturer guidelines for opened medication containers.<200 Unit Medication Room>Observation of the 200 Unit medication room on [DATE] at 8:59 AM showed:-A bottle of an antifungal medication for a resident who discharged on [DATE]-A bottle of an oral antibiotic medication and four bags of an intravenous (through the veins) antibiotic for a resident who discharged on [DATE]-An injectable diabetic medication for a resident who discharged on [DATE]-An injectable diabetic medication for a resident who discharged on [DATE]-An injectable diabetic medication for a resident who discharged on [DATE]-Two bottles of medicated eyedrops for a resident who discharged on [DATE]-A box with various medications for a resident who discharged on [DATE]-Four packets of a medicated eyedrop for a resident who discharged on [DATE]-An inhaled respiratory medication for a resident who discharged [DATE]- An intravenous antibiotic medication for a resident who discharged on [DATE] In an interview on [DATE] at 9:26 AM Staff X (Registered Nurse - RN) stated they were one of the staff responsible for destroying or returning medications when required. Staff X explained they did this as needed rather than on a particular schedule. Staff X stated it was important to discard medications no longer needed to avoid medication errors and potential misuse.In an interview on [DATE] at 9:29 AM Staff F (Resident Care Manager) stated they knew the facility had a policy regarding discarding or returning medications but were unsure of the timeframe and said they thought it was 30 days. Staff F stated handling discharged residents' medications appropriately was important.In an interview on [DATE] at 10:25 AM Staff F stated they asked facility management about the timeline for handling discharged residents' medications and was told there was no specific timeframe, but best practice was to return such medications as soon as possible.In an interview on [DATE] at 9:23 AM Staff B (Director of Nursing) stated they expected medications to be returned or destroyed with a couple days of discharge. <200 Unit North Medication Cart>Observation of the 200 Unit North medication cart on [DATE] at 10:18 AM with Staff U (RN) showed the following:-An opened container of an eye medication. This medication had a handwritten label showing it was opened on [DATE] and should be used by [DATE].In an interview at this time Staff U stated the eye medication should have been discarded on [DATE].Further observations of this medication cart on [DATE] at 10:37 AM showed:-Eyedrops with a partially legible open date that read 07/ and a partially legible use by date of 08/.In an interview at this time Staff U stated the eye drops should be discarded. <300 Unit North Medication Cart>Observation on [DATE] from 11:47 AM to 12:09 PM with Staff T (RN) at the 300 north medication cart - north showed:-An opened injectable diabetic medication with no open date and a pharmacy date of [DATE].-An opened injectable diabetic medication which expired on [DATE] and an open date of [DATE].-An opened injectable diabetic medication with no open date and a pharmacy date of [DATE].-An opened injectable diabetic medication with a pharmacy date of [DATE] and no open date.-A bubble pack of Resident 35's narcotic pain medications with six doses remaining. The corresponding page in the cart's narcotic book (a place where nurses document narcotic counts to minimize the risk of drug diversion) showed there were seven doses remaining.In an interview on [DATE] at 12:12 PM Staff T stated they gave the narcotic to Resident 35 at 7:12 AM that morning but did not yet document that in the narcotic book. Staff T stated it was important to document the administration of the narcotic both on the resident's Medication Administration Record and in the narcotic book timely.Review of the [DATE] MAR showed the medication was documented to be provided to Resident 35 that morning as stated by Staff T.In an interview on [DATE] at 2:36 PM Staff B (Director of Nursing) stated they expected medications to be removed from storage areas and either returned to the pharmacy or destroyed promptly

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure the Dietary Manager met the minimum qualifications required in the absence of a full-time Registered Dietician for 1 of 1 facility kitchens. This failure placed residents at risk for unmet nutritional needs and other negative health outcomes. Findings included. Review of the facility's Key Personnel list showed Staff D was the facility's Dietary Manager for the facility. The list did not identify who worked as the facility's Registered Dietician.In an interview on 08/22/2025 at 9:33 AM Staff A (Interim Administrator) stated they would provide contact information for Staff C (Dietary Manager). Staff A wrote Staff C's phone number and email address on a sticky note and added on the note that Staff C worked three times a week and as needed at the facility, and that Staff D was currently enrolled in a dietary manager certification class.In an interview on 08/26/2025 at 9:42 AM, Staff D stated they worked as dietary manager for thirteen months. Staff D stated Staff C was on site at the facility on Thursdays.In an interview on 08/27/2025 9:41 AM, Staff A stated they did not know if Staff D's experience or qualifications were sufficient to meet the regulatory requirements for a dietary manager as they did not complete their certification. Staff A stated they were unsure if Staff C also worked elsewhere. Staff A stated they would provide any documentation that demonstrated Staff D's experience or qualifications were sufficient. No further information was provided.In an interview on 08/27/2025 at 10:21 AM, Staff C confirmed they were only on site at the facility on Thursdays and remotely two other days. Staff C stated they also provided dietician services at another facility. REFERENCE: WAC 388-97 -1160 (1).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure food was stored under sanitary conditions for 2 of 2 unit refrigerators (200 & 300 unit refrigerators), and meal trays were distributed in a way that promoted food safety for 1 of 2 units (300 unit). These failures placed residents at risk for spoiled food, foodborne illness, injury, and infections. Findings included .<Policy>According to the facility's revised July 2014 Food Receiving and Storage Statement, food service or other designated staff would ensure food storage areas were always clean. The policy showed all food items stored in refrigerators on the unit would be kept below 41 degrees Fahrenheit (F) and must be labeled with a use-by date, and all food belonging to residents must be labeled with the resident's name, the name of the item, and a use-by date. The policy did not identify a temperature below which frozen food must be stored.<Unit Snack Fridges> Observation of the 200 Unit snack refrigerator on 08/25/2025 at 8:59 AM showed no temperature log was maintained for the freezer party of the combination refrigerator/freezer. The freezer contained a frozen meal that did not identify to which resident it belonged, a frozen bottle of iced tea that did not identify to whom it belonged, and an open water bottle half full of a brown frozen liquid. There were large orange liquid stains, now dry, splattered inside the refrigerator. A sign posted on the refrigerator door showed no non-resident food should be stored in the refrigerator and all food must have a resident name, room, and date. The sign showed all perishable food could be stored for a maximum of three days. Observation of the 300 Unit snack refrigerator on 08/25/2025 at 9:06 AM showed the refrigerator contained outside food for rooms [ROOM NUMBERS] that were not dated. The log for the freezer dates showed no temperatures documented from 08/01/2025 through 08/14/2025. There was an unopened bottle of a blue fruit beverage that did identify to whom it belonged and an open, half-consumed bottle of green soda. There was a container that once contained store-bought macaroni salad that now contained a brown substance with a texture consistent with cooked ground beef. This container had a label that read “1-31st-2025”. In the bottom right drawer of the refrigerator was a disposable soup bowl container with a lid. This bowl contained a moldy substance and the liquid inside was now spilled over the bottom of the drawer. The container did not indicate when it was brought in, when it should be discarded, to whom it belonged, or what it contained. In an interview at this time Staff JJ (Corporate Resource Nurse) observed the state of the refrigerator and its contents and declined to comment on whether the food inside was stored appropriately. Staff E (Dietary Aide) appeared and stated the nurse’s aides were responsible for maintaining the cleanliness of the snack fridges and the labeling of food brought in for residents. Staff E stated the freezer temperature should be monitored, and the refrigerator was not but should be clean. In an interview on 08/26/2025 at 9:42 AM, Staff D (Dietary Manager) stated the nursing department was responsible for the upkeep of the snack fridges. Staff D stated they expected the unit fridges to be kept clean, and all food stored to be labeled with a name and a use-by date. <300 Unit> (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 08/20/2025 at 1:09 PM showed Staff AA (Certified Nursing Assistant) carrying two lunch trays to room [ROOM NUMBER]. Staff AA set a tray in front of the resident in bed A and the other tray in front of the resident in bed B. At this time, both residents in room [ROOM NUMBER] started calling for Staff AA to come back because their lunch trays were swapped. In an interview at this time Staff AA stated they were expected to bring residents their meal trays one at a time. Staff AA stated it was important to bring meal trays one at a time so they wouldn’t give a resident the wrong meal which could present a risk of injury, or incorrect diet. In an interview on 08/27/2025 at 10:47 AM Staff B (Director of Nursing) stated they expected staff to deliver one tray at time to residents to ensure they did not give a resident an incorrect meal. Staff B stated it was important for residents’ safety and infection prevention. REFERENCE: WAC 388-97 -1100 (3), -2980.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 complete Antibiotic (ABO) Stewardship to promote appropriate use of ABOs and reduce the risk of unnecessary ABO use for 2 of 4 residents (Residents 10 & 93) reviewed for unnecessary ABOs. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate/unnecessary use of ABOs.Findings included.<Policy>According to the facility policy titled, Infection Prevention and Control Program - ABO Stewardship, dated 03/2023, the Infection Preventionist (IP) or designee would be responsible for infection surveillance and multidrug resistant organism tracking. The policy showed the IP would collect and review all supporting labs and tests for ABO usage.<Resident 10>Review of Resident 10's health records showed they were admitted to the facility on [DATE] with an ABO prescribed for Sepsis (a life-threatening response to an infection). Review of Resident 10's records showed no supporting labs or test results for the ABO treatment.<Resident 93>Review of Resident 93's health records showed they were admitted to the facility on [DATE] with an ABO prescribed for a bone infection. Review of Resident 93's records showed no supporting labs or test results for the ABO treatment.In an interview on 08/25/2025 at 10:00 AM Staff BB (Resource Infection Preventionist) stated the facility used McGeers criteria (a tool used for infection surveillance activities and management of ABO usage). Staff BB stated when a resident admitted to the facility with an infection, staff were expected to obtain, from the hospital, the appropriate diagnosis for the prescribed ABO, start and stop date of ABOs, lab results, and data to ensure the residents condition met the McGeers criteria. Staff BB stated when a resident acquired an infection in house, staff were expected to ensure the residents symptoms met the McGeers criteria, the prescribed ABO was appropriate and necessary, lab results were communicated to the prescriber to ensure the least invasive ABO was prescribed, and the order was complete with the ABO name, dose, length of course, and had an appropriate diagnosis. Staff BB stated they reviewed resident's orders with new ABOs, indications, doses, labs and supporting tests, and followed up with the prescriber regarding any concerns. Review of Resident 10 and 93's ABO stewardship documentation with Staff BB showed no supporting lab results to support the prescribed ABO treatment in their records.In an interview on 08/25/2025 at 12:27 PM Staff BB stated they completed a thorough review of Resident 10 and 93's records and they were unable to provide documentation to support the ABO treatment. Staff BB stated staff were expected to obtain the lab results at time of admission to the facility but did not. Reference: WAC 388-97-1060(3)(k)(i)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to educate and offer staff the Covid 19 (C19) vaccination for all staff when reviewed for vaccinations. This failure placed staff and residents at a higher risk of contracting C19 infections.Findings included .<Policy>According to the facility policy titled, Infection Prevention and Control Program - C19 vaccine for staff, dated 01/12/20222, the facility would educate staff on the risks and benefits of the C19 vaccines and offer to administer the vaccine to staff.In an interview on 08/25/2025 at 10:00 AM with Staff BB (Resource Infection Preventionist) and HH (Human Resource), Staff HH stated they do not keep records of staff C19 vaccinations or education of the vaccinations. Staff HH stated they understood that the Infection Preventionist (Staff BB) would keep employee records of the C19 vaccinations. Staff BB reviewed the infection preventionist records and stated they did not educate or offer any staff the C19 vaccine. Staff BB was unable to provide any staff C19 vaccination education or documentation staff were offered the C19 vaccination. Reference: WAC 388-97-1320

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure toilets were functioning properly on 2 of 3 floors (Second and Third Floor) and failed to ensure call lights were functioning on 1 of 2 floors where residents lived (Third Floor). These failures placed residents at risk for a less-than-homelike environment, skin tears, the inability to call for help when needed, and frustration.Findings included. <Facility Policy>According to the facility's 10/04/2016 Resident Rights policy, residents had the right to a safe, clean, comfortable, and homelike environment.<Second Floor Family Room Bathroom> Observations on 08/25/2025 at 10:30 AM, 08/26/2025 at 11:13 AM, and 08/27/2025 at 9:30 AM showed the second-floor family room bathroom broken and not flushing adequately to clear its contents. <Sensory Room Bathroom> Observations on 08/20/2025 at 8:38 AM, and 11:14 AM showed the toilet in the sensory room broken and not thoroughly flushing adequately to clear its contents. In an interview on 08/20/2025 at 11:14 AM Staff II (Medical Records) stated “the sensory room toilet had always been that way because it was an old building, so the plumbing doesn’t work well.” Staff II stated, “you need to flush the toilet 15-20 times, and it would mostly clear.” Staff II stated maintenance was aware of the sensory room plumbing issue. <room [ROOM NUMBER]/311 Bathroom> In an interview and observation on 08/20/2025 at 10:06 AM Resident 27 stated they reported their broken shared toilet several times and “maintenance came in and did some cosmetic touch ups to their walls but did not repair the toilet.” Resident 27 stated they “used a commode instead of the shared toilet because it was always filled with urine and feces and it was disgusting.” Observation at this time showed room [ROOM NUMBER]/311 shared toilet full of urine and feces. Observation showed the toilet would not flush all the way down after multiple flushes, the urine and feces remained in the toilet bowl. In an interview on 08/27/2025 at 9:11 AM Staff Z (Maintenance Director) stated they were not notified that the 2nd floor family room toilet, the sensory room toilet, or the room [ROOM NUMBER]/311 shared toilet were broken. In a confidential interview on 08/27/2025 at 9:27 AM, an employee that worked with residents on the floor stated “many staff had made multiple notifications of the all the toilets not flushing thoroughly. We have notified Maintenance many, many times and maintenance come to the floor but does not work on toilet. Maintenance did just come up and worked on the toilet for room [ROOM NUMBER]/311 but it still does not flush, it is a bigger plumbing issue that needs to be resolved”. Observation at this time showed room [ROOM NUMBER]/311 shared toilet did not thoroughly flush after several flushes. <200 Unit Bathroom> (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 08/21/2025 at 10:06 AM showed an unlocked bathroom in the short hall behind the 200 Unit’s nurse’s station. The hot water faucet on the left side of the sink had a large crack on it, leaving jagged metal on the handle. There was a ring of rust around the sink where the enamel was lifted. An area of laminate over two inches wide was lifted at the edge of the counter. There were brown stains at the bottom of the mirror. In an interview at that time Staff F (Resident Care Manager) stated the restroom was not safe to use because a resident could cut their finger on the jagged metal. Staff F stated residents could cut themselves on the faucet handle and the bathroom should be locked until made safe. <Bathroom Call Light Cords> Observation on 08/20/2023 at 9:23 AM of the call lights in shared bathrooms on the 300 Unit showed in the bathroom shared by rooms [ROOM NUMBERS], the call light cord was hung over the safety rail next to the doorknob and not reachable from the floor if a resident fell. In the bathrooms shared by rooms [ROOM NUMBERS] and by rooms [ROOM NUMBERS], the call light cords were tied/wound shorter and rested on the toilet paper dispenser towards the back wall of the rooms, causing the cord to be out of reach if a resident fell. In the bathroom shared by 308 rooms and 309, the call light cord was missing, giving the residents no way to alert the nurse’s station if they fell or needed assistance. In an interview on 08/22/2025 at 10:20 AM, Staff N (Certified Nurse Assistant) stated the call lights would be out of reach if a resident fell to the floor from the toilet. Staff N stated that if the call light cord needed to be replaced, they used the portable intercom system to report the problem to maintenance staff. Review of the maintenance log from March 2025 to August 2025 showed no repairs initiated for call lights in the shared bathrooms for rooms [ROOM NUMBERS], 302 and 303, 304 and 305, 306 and 307, or 308 and 309. In an interview on 08/22/2025 at 12:22, Staff Z stated the bathroom missing the string should be repaired right away and by not having a string was a safety risk for the residents. No additional documentation was provided regarding repairs to bathroom call lights. REFERENCE: WAC 388-97-2100.