STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505515	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Olympia Rehabilitation and Nursing Center	1811 East 22nd Avenue Olympia, WA 98501

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. . Based on interview and record review, the facility failed to identify and report potential allegations of abuse and/or neglect to the State Survey Agency as required for 2 of 3 sampled residents (Resident 5 and X). This failure placed residents at risk for further abuse and/or neglect and a diminished quality of life. Findings included . Review of the facility's policy entitled Abuse/Neglect/Misappropriation/Exploitation, revised 10/2022, showed the facility would ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials [including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities] in accordance with State law through established procedures. RESIDENT 5 Review of Resident 5's quarterly Minimum Data Set (MDS) assessment, dated 02/26/2025, showed Resident 5 was admitted with diagnoses including stroke (a medical emergency that occurs when blood flow to the brain is disrupted) and depression. The MDS showed the resident had limited movement on both sides of the upper and lower body, requiring up to maximum assistance with Activities of Daily Living (ADLs) and the resident was able to make needs known. Review of the facility grievance log, dated December 2024 through May 2025, showed on 01/16/2025, Resident 5 filed a grievance. Review of the facility's Grievance Form, dated 01/16/2025, showed Resident 5 reported A male CNA [Certified Nursing Assistant] was helping me get ready in the morning and he was really rough getting me dressed. He left a bruise on my arm. The allegation of abuse was investigated as a grievance. Review of the facility reporting incident log, dated December 2024 through May 2025, showed Resident 5's allegation of potential abuse had not been logged or called in to the State Survey Agency. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RESIDENT X Review of Resident X's MDS assessment, dated 12/06/2024, showed Resident X was admitted with diagnoses including a spinal fracture and depression. The MDS showed the resident had limited movement on both sides of his body, was incontinent of bowel and bladder, was totally dependent on staff for toileting care, and was able to make needs known. Review of the facility's Grievance Form, dated 02/25/2025, showed Resident X reported he was incontinent of bowel. He asked a family member to get the Nursing Assistant (NA) to assist. A NA came in and told the resident they would have to wait to be changed because their NA was on break and this was not the NA's section. The NA left the room without providing toileting care. The resident remained in his soiled brief until his assigned aid returned from break. The allegation of neglect was investigated as a grievance. Review of the facility reporting incident log, dated February 2025, showed Resident X's allegation of potential neglect had not been logged or called in to the State Survey Agency. On 05/22/2025 at 11:44 AM, Staff B, Director of Nursing Services, said the allegations had not been logged or call in to the State Survey Agency as required. Reference WAC 388-97-0640 (5)(a), (6)(a)(c) .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, the facility failed to accurately assess the dental status on the Minimum Data Set (MDS) assessment for 1 of 3 sampled residents (Resident 17) reviewed for assessment accuracy. This failure placed residents at risk for unmet dental and nutritional needs and a diminished quality of life. Findings included . Record review of Resident 17's admission Record document, undated, showed she was admitted to the facility on [DATE] with diagnoses of failure to thrive, poor calorie intake and malnutrition. On 05/19/2025 at 10:33 AM, Resident 17 said her dentures were outdated. The resident was observed pointing to her front top dentures and said her two front teeth were missing. The resident said she needed to have her dentures fixed and then she might be able to eat and chew better. Record review of Resident 17's care plan, dated 03/18/2025, showed the resident had an oral hygiene performance deficit due to full upper and lower dentures. The MDS, dated [DATE], showed Resident 17's dental section coded as no broken or loosely fitting full or partial dentures. On 05/23/2025 at 3:22 PM, Staff N, MDS Coordinator, said she did not recall if Resident 17 had missing teeth or dentures. Reference WAC 388-97-1000 (1)(b) .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness (SMI), Intellectual Disabilities (ID), and related conditions are not inappropriately placed in nursing homes for long-term care) Level I form was completed accurately and Level II PASARR referrals were made for 2 of 5 sampled residents (Residents 8 & 9) reviewed PASARR screening. These failures placed residents at risk of not receiving specialized mental health services and a diminished quality of care. Findings included . Review of the facility's policy entitled Pre-admission Screening and Resident Review WA [PASARR], revised June 2024, showed, Level II PASRR evaluations are required for all nursing facility residents identified to have indicators of SMI/ID during the Level I screening or at any time during residency in the nursing facility, and for any resident with confirmed SMI or ID who presents with significant changes in their cognitive or physical conditions. RESIDENT 8 Review of Resident 8's admission Record, undated, showed the resident was admitted to the facility on [DATE] with diagnoses including depression (feeling of loneliness, sadness), anxiety disorder (having excessive/persistent worry and fear), and insomnia (having trouble sleeping at night and/or staying asleep). Review of Resident 8's Level I PASARR, dated 02/20/2025, showed the diagnoses of depression and anxiety disorder. There was no documentation in the resident's electronic health record that a referral for a Level II evaluation was made. RESIDENT 9 Review of Resident 9's admission Record, undated, showed the resident was admitted to the facility on [DATE] with diagnoses including depression and insomnia. Review of Resident 9's Level I PASARR, dated 02/20/2025, showed the diagnosis of depression. There was no documentation in the resident's electronic health record that a referral for a Level II evaluation was made. On 05/22/2025 at 9:23 AM, after review of the medical record for Resident 8 and Resident 9, Staff A, Administrator, said referral for a Level II evaluation should have been made for Residents 8 and Resident 9. Reference WAC 388-97-1975 (1) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** RESIDENT 14 Review of the admission Record, undated, showed Resident 14 was admitted to the facility on [DATE], with diagnoses including a sudden interruption of blood flow to the brain, muscle weakness affecting one side of the body and/or paralysis of one side of the body, and language disorder caused by brain damage. Review of Resident 14's Skin Integrity/Pressure Injury Care Plan, dated 05/18/2025, showed interventions included, Encourage resident to offload/reposition frequently for ongoing pressure relief. On 05/27/2025 at 2:38 PM, Staff B, Registered Nurse and Director of Nursing Services, said this would not be something Resident 14 could do entirely on her own. Reference WAC 388-97-1020 (1)(2)(d) Based on observation, interview and record review, the facility failed to ensure person centered care plans were completed to address all aspects of care including individualized goals and approaches for eating and for assistance with turning and repositioning for 2 of 14 sampled residents (Resident 4 & 14) reviewed for care plans addressing resident needs. These failures placed residents at risk for inconsistent and/or inadequate care and treatment and diminished quality of care. Findings included . RESIDENT 4 Review of the admission Record, undated, showed Resident 4 was admitted to the facility on [DATE] with diagnoses including dysphasia (difficulty swallowing food or liquids) and cerebral vascular disease (stroke). The quarterly Minimum Data Set (MDS) assessment, dated 02/28/2025, showed the resident required a mechanically altered diet (thickened liquids). On 05/19/2025 at 11:00 AM, Resident's 4 room was observed with signs giving the following instructions to caregivers: --[Resident 4's] get up Schedule: Monday, Wednesday, Friday: Please ensure that [Resident 4] is getting up into a wheelchair on the following days. These are the minimum days patient should be getting up and if they would like to get up on other days, please encourage this. Thank you. --No Straws --Knobbed Cup Only Please On 05/21/2025 at 8:55 AM, Staff K, Nursing Assistant, said the information on the signs posted in the room directing resident care were not in the Kardex (a computer program developed from a resident's care plan with instructions for nursing assistants to follow and document resident care). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/22/2025 at 1:30 PM, Staff I, Nursing Assistant, said there were no instructions for nursing assistants to follow in the Kardex regarding Resident 4 using a knobbed cup, not using straws and nothing about Resident 4's preferred schedule for getting in and out of bed. On 05/23/2025 at 2:30 PM, Staff E, Corporate Regional Nurse, said the directives for nursing assistants to follow posted on the walls in Resident 4's room were not on the care plan or Kardex and needed to be updated.

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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, record review and interview, the facility failed to implement physician's orders for a heart and a breathing medication during medication administration for 1 of 6 sampled residents (Resident 11) reviewed for services provided meet professional standards. This failure placed residents at risk for adverse outcomes for a heart rate below 60, mouth irritation, and a diminished quality of care. Findings included . <Heart Medication> On 05/22/2025 at 8:06 AM, during a medication administration observation, Resident 11's physician's order showed to administer a heart medication, give one tablet orally in the morning for heart failure. Check apical pulse (pulse at the heart) prior to administering medication. If below 60 hold medication and call the physician. Staff F, Registered Nurse, said she would hold the medication because the resident's pulse was 45 beats per minute this morning. Record review of Resident 11's April 2025 Medication Administration Record (MAR) showed on 16 out of the 30 days the pulse was below 60 and one day was documented X. Record review of Resident 11's May 2025 MAR showed on 7 out of the 22 days the pulse was below 60. On 05/22/2025 at 3:10 PM, when asked if the physician was notified regarding the pulse below 60 beats per minute, Staff F stated, No, and reviewed the physician's order. <Breathing Medication> On 05/22/2025 at 8:21 AM, Resident 11 was observed during another medication administration. The physician's order showed to administer 2 puffs of an inhaler for better breathing, two times a day. Then rinse mouth with water after use. Do not swallow. Staff F did not have the resident rinse their mouth with water as ordered. At 8:23 AM, Staff F said she should have had Resident 11 rinse their mouth with water and spit it out. At 2:42 PM, Staff B, Director of Nursing Services, said the expectation for administering medications was to follow the physician's orders. After reviewing the April 2025 and May 2025 physician orders and MAR for Resident 11's heart medication and asked how many times Resident 11's pulse was under 60 for each of these two months, Staff B said there were several days the resident's pulse was under 60 and there was no documentation the physician was notified. Reference WAC 388-97-1060 (3)(a)(k) .

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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 interview and record review, the facility failed to provide restorative nursing services including a restorative stretching program for 1 of 2 sampled residents (Resident 10) reviewed for maintaining activities of daily living. This failure placed residents at risk for avoidable decline in function and a diminished quality of life. Findings included . The admission record, undated, showed Resident 10 was admitted to the facility on [DATE]. The quarterly Minimum Data Set assessment, dated 03/11/2025, showed the resident was cognitively impaired and required substantial to maximum assistance with bed mobility and transfers. A Restorative Program Referral Form, dated 05/12/2025, documented, Stretching program-while in chair, straighten left lower leg (LLE) extremity as far as tolerable. Hold for 45 seconds-1 minute. Repeat X5 [five times] or to a maximum tolerance. On 05/22/2025 at 11:39 AM, Staff B, Director of Nursing Services, said one resident in the facility, Resident 10, was on a restorative program. Staff B said Nursing Assistants (NAs) were responsible for the restorative program and the charge nurse oversaw the care and services. On 05/23/2025 at 9:24 AM, Staff F, Registered Nurse, stated, We do not have a restorative nursing program here. No one I know is on a restorative nursing program . At 9:57 AM, Staff G, Rehab Director, said referrals from therapy were given to nursing. Staff G stated, I let them know what we recommend. [Resident 10] is on a restorative nursing program for her left leg. At 10:15 AM, Staff H, Nursing Assistant (NA), said for Resident 10 a brace was used on her left arm. At 11:13 AM, Staff I, NA, said for Resident 10 on her weak left arm, we wash and dry her arm and hand, and we put lotion on her hands making sure the hand is clean and dry. Staff I stated, I do apply a splint to her left arm. At 11:37 AM, Staff E, Corporate Regional Nurse, was unable to provide documentation for a restorative nursing program for Resident 10's left lower leg. Staff E stated, We need to clean this up a little bit. Reference WAC 388-97-1060(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 toileting, repositioning, and pressure relieving devices for 1 of 4 sampled residents (Resident 14) reviewed for activities of daily living for dependent residents. This failure placed residents at risk for skin impairment including developing a pressure injury (PI) and a diminished quality of life. Findings included . Per the admission Record, undated, Resident 14 admitted to the facility on [DATE], with diagnoses including a stroke (a sudden interruption of blood flow to the brain). Review of Resident 14's Braden Scale (an assessment tool that measures risk for pressure injury), dated 04/25/2025, scored the resident as 14, moderate risk for PI development. The Braden Scale noted the resident had redness in the peri area and buttocks and required staff assistance with all locomotion and bed mobility. Resident 14's Skin Integrity Care Plan, dated 04/25/2025, included a goal of, The resident will not have avoidable skin impairment through the next review date, and an intervention of, Provide pressure relieving devices in bed and/or wheelchair. Review of Resident 14's admission Minimum Data Set (a standardized assessment tool measuring health status in nursing home residents), dated 04/29/2025, showed the resident required assistance from staff for activities of daily living including bed mobility, transfers, eating and toileting. A Skilled Charting Evaluation form, dated 05/18/2025, documented Resident 14 required staff assistance with bed mobility, transfers, eating, and toileting (Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.}. On 05/19/2025 at 10:13 AM, Resident 14 was observed laying on her back in bed. An air mattress or other pressure relieving device was not observed on the bed. A provider order, dated 05/19/2025 (24 days after being identified as a moderate risk for developing a pressure ulcer on the Braden Scale), requested an Air Mattress be placed on Resident 14's bed between 2:00 PM and 10:00 PM that day to promote skin integrity. On 05/20/25 at 11:43 AM, Resident 14 and her Resident Representative (RR) were observed in the facility gathering room. Resident was on her back in her partially reclined wheelchair (WC). At 12:14 PM, Resident 14 was observed in the same position as previously observed with the RR at her side. The RR said no staff had come to take Resident 14 to the bathroom or reposition her in the previous half hour. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:15 PM through 3:30 PM, Resident 14 was continuously observed with her WC in the same location and the resident in the same position as previously observed. No toileting or repositioning was offered by staff during this period of time. At 3:30 PM, Staff L, Nursing Assistant (NA), and Staff M, NA, were observed taking Resident 14 to her room and placing the resident in bed. At 3:35 PM, Staff L and Staff M were observed providing personal care for Resident 14 showing a red, blotchy, non-raised rash that covered Resident 14's lower abdomen and mid-to-lower back area. On 05/27/2025 at 2:38 PM, Staff B, Director of Nursing Services, said Resident 14 was not on a turning or toileting check and change schedule. Staff B said she would expect staff to perform a check and change and reposition Resident 14 at least every two hours. 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 provide an ongoing activity program of meaningful engagement to meet individual resident needs for 1 of 2 sampled residents (Resident 14) reviewed for activities. This failure placed residents at risk of boredom and a diminished quality of life. Findings included . Resident 14 was admitted to the facility on [DATE] with diagnoses including stroke (a sudden interruption of blood flow to the brain), muscle weakness affecting one side of the body and/or paralysis of one side of the body, aphasia (neurological condition that affects ability to communicate) and other reduced mobility. Review of Resident 14's Minimum Data Set assessment, dated 04/29/2025, showed the resident's family or significant other was interviewed regarding Resident 14's activity preferences, and indicated the resident liked listening to music and it was not important for the resident to keep up with the news. On 05/19/2025 at 9:12 AM, 11:44 AM, 1:22 PM and 3:14 PM, Resident 14 was observed in bed without the television, radio or music on. On 05/20/2025 at 8:54 AM, 10:12 AM, 11:57 AM, and 2:59 PM, Resident 14 was observed in bed in her room without the television, radio or music on. At 9:07 AM, Resident 14's Resident Representative (RR) said the resident liked to listen to music and watch certain television shows. The RR said no one from the facility asked about what activities Resident 14 might like, or what she might like to watch on the television. On 05/21/2025 at 9:17 AM, Resident 14 was observed in her room in bed without music, radio or television on. On 05/22/2025 at 9:09 AM, Resident was observed in bed without television, radio or music on. On 05/23/2025 at 12:05 PM, Staff O, Activity Assistant, said she was not aware Resident 14 liked music and watching TV. Staff O said the Resident's Representative or Guardian should have been contacted regarding the resident's activity preferences. Reference WAC 388-97-0940 (1) .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to provide pressure reducing measures and repositioning to prevent and/or contribute to the development of a pressure injury for 1 of 3 sampled residents (Resident 14) reviewed for pressure injury (areas of damaged skin and tissue caused by sustained pressure). This failure placed residents at risk for developing pressure ulcers, pain and a diminished quality of life. Findings included . REVISED NATIONAL PRESSURE ULCER ADVISORY PANEL PRESSURE INJURY STAGING SYSTEM -Stage 2 Pressure Injury (PI) - Partial thickness with exposed middle layer of skin. Resident 14 was admitted to the facility on [DATE] with diagnoses including diabetes (abnormal processing of sugar), a stroke (a sudden interruption of blood flow to the brain) and decreased mobility in both arms and legs. Review of Resident 14's Braden Scale (an assessment tool that measures risk for pressure injury), dated 04/25/2025, scored the resident as 14, moderate risk for PI development. This form noted the resident had redness in the peri area and buttocks and required staff assistance with all locomotion and bed mobility. Reviews of Resident 14's admission Minimum Data Set (MDS--a standardized assessment tool that measures health status in nursing home residents), dated 04/29/2025, indicated the resident required assistance from staff for activities of daily living including bed mobility, transfers, and positioning. The MDS documented the resident was at risk of developing a PI and did not have a PI at the time of admission. A Skilled Charting Evaluation form, dated 05/18/2025, documented Resident 14 was incontinent of bowel and bladder and required total assistance from two staff for bed mobility, transfers, and positioning. Review of a facility Incident Note, dated 05/18/2025 at 5:31 PM, showed documentation of, Licensed Nurse and Certified Nursing Assistant observed an open area on resident's coccyx (small, triangular bone at the base of the spine) . MD notified . Review of Resident 14's Initial Skin Ulcer/Injury Measurement and Evaluation form, dated 05/18/2025, showed the resident had developed a facility acquired Stage II pressure injury on the coccyx. On 05/19/2025 at 10:13 AM, Resident 14 was observed laying on her back, in bed. No air mattress or other pressure relieving device was observed on the bed. A provider order, dated 05/19/2025 (24 days after being identified as a moderate risk for developing a pressure ulcer), requested an air mattress be placed on Resident 14's bed between 2:00 PM and 10:00 PM that day, to promote skin integrity. (continued on next page)

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	505515	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Olympia Rehabilitation and Nursing Center	1811 East 22nd Avenue Olympia, WA 98501

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/25 at 11:43 AM, Resident 14 and her Resident Representative (RR) were observed in the facility gathering room. Resident 14 was on her back in her partially reclined wheelchair (WC). At 12:14 PM, Resident 14 was observed in the same position as previously observed with the RR at her side. The RR said no staff had come to take Resident 14 to the bathroom or reposition her in the previous half hour. On 05/20/2025 at 12:15 PM through 3:30 PM, Resident 14 was continuously observed in her WC in the same location and in the same position as previously observed. No bathroom or repositioning was offered by staff. Refer to F677 Reference WAC 388-97-1060 (3)(b) .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview, and record review, the facility failed to secure electronic smoking (involves using battery-powered devices called e-cigarettes or vapes) materials for 1 of 1 sampled resident (Resident 8); and failed to implement a system for securing and storing potentially toxic chemicals in 1 of 1 shower room (shower room [ROOM NUMBER]) reviewed for accident hazards. These failures placed residents at risk for accidents, injury and a diminished quality of life. Findings included . ELECTRONIC SMOKING Review of the facility's policy entitled Smoking/E-Cigarette Safety Program, revised 04/2024, showed smoking supplies were to be stored at the nurses station. The resident's admission Record, undated, showed the resident was admitted to the facility on [DATE] with diagnoses including a stroke (a medical condition that occurs when blood flow to the brain is interrupted or reduced, causing brain cells to die) which resulted in limited movement in his right arm and leg. A review of Resident 8's care plan, dated 02/28/2024, showed the resident required supervision while vaping and smoking supplies are stored at the nurses station. On 05/19/2025 at 9:46 AM, during the entrance conference, Staff A, Administrator, said there was only one resident in the facility, Resident 8, who smoked. Staff A said the resident used a vape pen. On 05/20/2025 at 12:40 PM, Resident 8 was observed vaping outside in the designated smoking area with Staff O, Activities Assistant. At 12:58 PM, Staff O said resident smoking supplies were kept at the nurse's station. When Staff O went to show the smoking supplies located at the nurse's station, they were not there. Staff O said the resident still had the vape pen with him. On 05/22/2025 at 9:29 AM, Staff O was observed walking toward Resident 8's room, without any smoking supplies. Then Staff O and the resident went outside. The resident took the vape pen from his shirt pocket and began to smoke. At 11:45 AM, Staff A, Administrator and Staff B, Director of Nursing Services, said all smoking materials were to be kept secured at the nurse's station. CHEMICAL HAZARDS On 05/19/2025 at 11:07 AM, the shower room door was observed to be unlocked and open. Inside the shower room, to the left, was an unlocked cabinet affixed to the wall. The cabinet contained a bottle with chemicals used for disinfection and sanitation. The bottle was labeled potentially hazardous. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:31 AM, the shower room door was observed opened and accessible to residents. At 11:35 AM, Staff I, Nursing Assistant, said the shower room door was left unlocked and open. At 11:43 AM, Staff P, Housekeeping Assistant, said the shower room door was left unlocked and open. At 11:57 AM, after observing the shower room door unlocked and open, Staff B, Director of Nursing Services, said the shower room door was to remain closed and locked. Reference WAC 388-97-1060 (3)(g) .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to develop a trauma trigger (a psychological stimulus that prompts recall of a previous traumatic event) assessment for 2 of 2 sampled residents (Residents 17 and 12) reviewed trauma informed care. This failure placed residents at risk for unidentified trauma triggers, behaviors, re-traumatization and a diminished quality of life. Findings included . <Resident 17> Record review of Resident 17's admission record, undated, showed she was admitted to the facility on [DATE]. The facility matrix (documented used to identify pertinent care categories), undated, showed Resident 17 had a diagnosis of Post Traumatic Stress Disorder/Trauma (PTSD). Resident 17's care plan, dated 03/16/2025, showed a focus problem, Potential alteration in psychosocial well-being related to survivor of traumatic event . The care plan had a goal that, Triggers of traumatic event will be minimized . Record review of Resident 17's Psychosocial History and Discharge Plan, effective 03/21/2025, showed the resident had a history of trauma, and documented a trauma informed care plan was developed with a goal to minimize the triggers of the traumatic event. On 05/21/2025 at 11:04 AM, Staff C, Resident Care Manager, said she was unable to find a list of triggers. On 05/22/2025 at 2:00 PM, Staff B, Director of Nursing Services, said trauma triggers would be listed on the [NAME] (a computer program developed from a resident's care plan with instructions for nursing assistants to follow and document resident care) under the Behavior and Mood section. Staff B said she did not see any specific triggers listed. <Resident 12> Record review of Resident 12's admission Record, undated, showed an original admission date to the facility of 12/20/2024 with diagnoses including depression (feeling of loneliness, sadness), and hallucinations (seeing or hearing things that are not there). Record Review of Resident 12's Psychosocial History and Discharge Plan, effective 04/08/2025, showed the resident had a history of trauma. Record review of Resident 12's care plan, revised 04/18/2025, showed a focused problem, Potential alteration in psychosocial well-being r/t [related to] survivor of traumatic event (specify). The care plan showed a goal, Triggers of traumatic event will be minimized . (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/2025 at 2:15 PM, Staff B said the trauma triggers for this resident were not listed. Reference WAC 388-97-1060 (1)(3)(e) .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to ensure adequate indication for medication was provided for 1 of 5 sampled residents (Resident 223) reviewed for unnecessary medications. This failure placed residents at risk for adverse side effects and a diminished quality of care. Findings included . Per the admission Record, undated, Resident 223 was admitted to the facility on [DATE] and showed she was alert, oriented and able to make needs known. A physician's order, dated 05/16/2025, showed upon admission Resident 223 was prescribed Diclofenac (pain medication) and Eliquis (blood thinner used to prevent and treat blood clots). The facility's Potential Drug Interaction report, dated 05/16/2025, from the facility's long-term care pharmacy, documented receiving both Diclofenac and Eliquis may be Concurrent therapy and approach use with caution. A nursing progress note, dated 05/17/2025, documented Resident 223 had Concerns about medication interactions between Eliquis and Diclofenac. Refused to take Diclofenac today. On 05/19/2025 at 11:36 AM, Resident 223 said there was a mistake made on one of the medications prescribed for her on admission. Resident 223 stated, Not everyone is on the same page. On 05/20/2025 at 3:04 PM, after reviewing Resident 223's Medication Administration Record, Staff J, Licensed Nurse (LN), stated, Resident 223 had taken Diclofenac 75 milligrams (mg) on 05/16/2025 at bedtime. Staff J said since then the resident had refused the medication. At 3:37 PM, Staff B, Director of Nursing Services, said when medications were ordered, they go through the facility's long term care pharmacy, and the pharmacy reviews the medications and lets us know if there are any concerns. Staff B said the pharmacy did send the contraindication notices to us on the same day the resident was admitted . When we receive these notifications, we should be notifying either the on-call provider or our Medical Director. When asked what was done for Resident 223's situation, Staff B stated, We should have notified the on-call doctor to see if we need to change, put on hold or discontinue the order based on the recommendations. Reference WAC 388-97-1060 (3)(k)(i)(4)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observations and interviews, the facility failed to ensure treatment carts were locked for 1 of 1 treatment carts (Treatment Cart 1), and failed to ensure medication dosages were accurately labeled for 1 of 6 sampled residents (Resident 14) reviewed for medication storage. This failure placed residents at risk for having access to treatment supplies not prescribed and receiving incorrect doses of medications. Findings included . <Unlocked Treatment Cart> On 05/19/2025 at 9:25 AM and 9:57 AM, Treatment Cart 1 was observed to be unlocked. The treatment cart contained a total of 18 containers of antifungal powder and creams (treatment for fungal skin problems), 2 tubes of hydrocortisone 1 percent (%) cream (treats skin problems), 3 tubes of lidocaine ointment 5% (treatment for skin pain), 2 tubes of zinc oxide paste (protects the skin from moisture), 3 tubes of estradiol vaginal cream 0.01% (treats vaginal dryness, and irritation), 2 containers of clobetasol propionate 0.05% (treats severe skin irritations), and 5 containers of Thera-Honey gel (provides moisture for wound healing). The cart also contained wound care supplies. On 05/20/2025 at 1:22 PM and 1:33 PM, Treatment Cart 1 was observed to unlocked and contained the above mentioned medications and medical supplies. On 05/20/2025 at 1:35 PM, Staff F, Registered Nurse, said medications ought to be locked up. Staff F observed that Treatment Cart 1 was unlocked. On 05/21/2025 at 12:33 PM, Treatment Cart 1 was observed to be unlocked and contained the above mentioned medications and medical supplies. On 05/22/2025 at 2:47 PM, Staff B, Director of Nursing Services and Registered Nurse, said the expectation was for the treatment cart to be locked. <Medication Labeling> The admission Record, undated, showed Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's May 2025 Medication Administration Record (MAR) showed an order for Lisinopril Oral Tablet 20 milligrams (mg), Give 0.5 tablet via PEG Tube (a feeding tube inserted through the skin, directly into the stomach) two times a day. Review of Resident 14's Lisinopril Bubble Pack Medication Card, stored in the medication cart, showed an order for Lisinopril 10 mg tablet, give 1 tablet via tube twice daily. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/22/2025 at 10:23 AM, after removing Resident 14's AM dose of Lisinopril from the medication bubble pack, Staff F, Licensed Practical Nurse, was asked to review the provider order and the medication card order. Staff F said the orders should match and did not. Staff F said there was a potential for a dose error because one indicated to give ½ a pill and the other indicated to give a whole pill. On 05/23/2025 at 11:03 AM, Staff A, Administrator and covering for Staff B, said the MAR order and Medication dispensing card orders should match. Reference WAC 388-97-1300 (2) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** <Resident 12> On 05/20/2025 at 12:41 PM, Resident 12 was observed standing in the bathroom holding onto the safety bar. Without performing hand hygiene, Staff F applied gloves and removed the dirty dressing on the resident's buttocks. Staff F then changed gloves without performing hand hygiene. Staff F cleansed the buttocks area, patting it dry, then said she forgot the wound treatment as she removed her dirty gloves leaving the room without completing hand hygiene. Upon returning to the room, Staff F applied clean gloves without performing hand hygiene, applied the wound treatment and clean dressing. Staff F then removed the dirty gloves and left the room without completing hand hygiene. At 1:10 PM, when asked about performing hand hygiene during a dressing change with wound care, Staff F said to do hand hygiene when changing gloves. Staff F said she might have forgotten to do so each time during Resident 12's dressing change. Reference WAC 388-97-1320 (1)(a)(c)(3) Based on observation, interview, and record review, the facility failed to ensure appropriate Personal Protective Equipment (PPE) use was implemented during linen sorting and washing machine cleaning in 1 of 1 facility laundry areas, failed to ensure PPE was used during personal care for 1 of 1 sampled resident (Resident 14), failed to ensure safe hand hygiene practices were implemented during dressing changes for 2 of 3 sampled residents (Residents 12 and 124), failed to develop a complete Water Management Program to reduce the risk of Legionella (a family of micro-organisms which are naturally found in water bodies) growth and spread in the facility, and failed to create an Infection Prevention and Control Program based on a facility and community-based infection control (IC) risk assessment. These failures placed residents at risk of potential contaminants being passed from staff to residents, worsening wound infections, and developing Legionnaires disease (a severe form of pneumonia, a lung infection, caused by a bacterium known as Legionella), and diminished quality of life. Findings included . <Laundry Area> On 05/23/2025 at 11:12 AM, Staff P, Housekeeping Assistant, said they wear gloves and a mask when sorting dirty laundry and loading laundry into the washing machine. At 11:18 AM, Staff P was observed while demonstrating and verbalizing areas of the facility washing machine to sanitize prior to removing clean laundry from the washing machine. Staff P did not demonstrate or verbalize the need to clean the interior rim of the washing machine door. At 11:36 AM, Staff Q, Maintenance Director, said staff were not currently required to wear a clothing protector device when sorting or loading dirty linens into the washing machine. When asked how laundry staff protect their clothing from potential contamination, Staff Q said it would make sense for staff to wear some kind of cover when sorting dirty laundry and placing it into the washing machine to reduce the risk of exposure. Staff Q said he would expect staff to sanitize the interior rim and the washing machine door before staff unload clean clothes from the washer to reduce risk of potential contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<PPE Use During Direct Contact Care> Review of Resident 14's Minimum Data Set assessment, dated 04/29/2025, showed the resident was admitted to the facility on [DATE] with an existing feeding tube (a medical device used to provide nutrition to people directly into the stomach). On 05/20/2025 at 3:30 PM, Resident 14 was observed with a roommate and a sign for Enhanced Barrier Precautions (EBP-an intervention designed to reduce transmission of multi-drug resistant organisms in nursing homes) attached to the room door. The sign directed staff to wear a mask, gown and gloves when providing direct contact care for the resident(s) on EBP. At 3:32 PM, Staff L, Nursing Assistant (NA) and Staff M, NA, were observed not wearing gowns while turning Resident 14 onto her left side. Staff M's uniform pants and top were observed to come into direct contact with Resident 14 as Staff M supported the resident, who had been turned onto the left side so staff could provide personal care. When asked if Resident 14 was on EBP, Staff L and Staff M both said they did not know what EBP was. Staff L removed her gloves, performed HH, went to the door, read the EBP sign, and told Staff M they should have been wearing gowns. At 4:41 PM, Staff B, Registered Nurse (RN) and Director of Nursing Services, said she would expect staff to put on gown and gloves prior to entering Resident 14's room to provide personal care and when a resident was on EBP. <Infection Control Program> Review of the facility Infection Control Program, provided by Staff B, did not show documentation supporting the completion of a required facility and community-based IC risk assessment. On 05/23/2025 at 10:14 AM, Staff B said they could not provide the requested IC facility and community-based risk assessment. Staff B said they were not involved in making an IC risk assessment and would check with the corporate office to see if they could provide one. At 4:05 PM, the facility provided documents did not include the IC facility and community-based risk assessment. <Water Management Program> Review of the facility's Water Management Program showed the following incomplete or missing required components: --Specific control measures or acceptable ranges for each of the program identified areas where hazardous conditions could exist. --What specific corrective actions the facility would take to get conditions back to within the facility's program identified control measure acceptable ranges. --Contingency responses for how the facility would respond to unexpected problems or corrective actions to take to bring control measures into the determined acceptable range for that control measure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Procedures to show how the facility would confirm their water management program was effectively controlling the hazardous conditions throughout the building water systems. --Identification of type of sample collection, specimen transport methods and which lab the facility would use to perform stated Legionella testing. -- How the facility would communicate information on the water management program to staff. On 05/23/2025 at 11:36 AM, Staff Q said he would review the Center for Disease Control's Legionella Water Management Toolkit and complete items that were missing from their program. At 4:55 PM, Staff A, Administrator, asked for clarification on what concerns were identified with the facility water management program. Staff A said they would check with the corporate office and see if they could provide an existing completed plan. <Lack of Hand Hygiene During Wound Care> RESIDENT 124 On 05/19/2025 at 8:52 AM, Resident 124's wound dressing change was observed. Staff C, Resident Care Manager, cleansed Resident 124's wound area and did not change gloves or perform hand hygiene (HH) prior to working with clean dressing material. Staff F, RN, cleansed around the resident's wound area and did not perform HH prior to cutting the packing foam to be inserted into the resident's wound. The end of one piece of foam was observed to have touched an area of the resident's bottom sheet, which had four light brown nickel-sized areas from unknown substance on it. This piece of foam was then packed into the resident's wound. Scissors used to cut the clean dressing packing and other materials were laid directly on the resident's bottom sheet three times and directly on the resident's bedspread twice during the dressing change process. Staff F then changed gloves and did not perform HH prior to applying the clear dressing over Resident 124's packed wound. At 12:46 PM, Staff F said when doing a wound dressing change HH should be done between dirty and clean processes. Whenever gloves are changed, HH should be done. When asked where clean dressing supplies should be placed, Staff F said there was supposed to be a barrier used and they were set on the bed during this dressing change. At 12:59 PM, Staff C said gloves should be changed when you go from a dirty to a clean process and HH should be done before and after the dressing changes. On 05/20/2025 at 4:52 PM, Staff B said she expected nurses to perform HH and change gloves, anytime they go from a dirty to a clean processes. Staff B said there should be a clean area to lay dressing supplies and scissors on and equipment should be cleaned in between dirty and clean processes and/or before moving to a different area or wound.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. . Based on interview and record review, the facility failed to ensure urinary tract infection related antibiotic initiation practices were based on Center for Disease Control and Prevention (CDC) approved criteria. This failure placed residents at risk of receiving or not receiving necessary antibiotics and a diminished quality of care. Findings included . The facility's Antibiotic Stewardship Policy, revised 04/2023, did not identify what urinary tract infection qualifying symptom criteria was to be used to assist providers in determining if resident symptom presentation met criteria threshold to initiate use of an antibiotic. On 05/23/2025 at 10:14 AM, Staff B, Registered Nurse and Director of Nurses Services, said the facility created an SBAR (a structured communication tool used to facilitate clear and concise communication) tool the nurses used to report urinary tract infection related symptoms and concerns to a resident's provider. When asked what antibiotic initiating criteria the SBAR contained, Staff B stated, McGeer's criteria. Review of CFR 483.80(a)(3) showed the facility's Antibiotic Stewardship Program shall assess residents for any infection using standardized tools and criteria (e.g. SBAR tool for urinary tract infection assessment using Loeb minimum criteria for initiation of antibiotics). Review of CFR 483.80(a)(2)(i) Showed McGeer criteria was used to count true case events (diagnosed infections) and to estimate the actual incidence/prevalence of disease. No Associated WAC .