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	04/10/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services in a manner that promoted dignity related to uncovered indwelling urinary catheter (a tube inserted into the bladder that drains urine into a bag outside of the body) bags for 1 of 2 sampled residents (Resident 21) reviewed for dignity. This failure placed residents at risk for embarrassment, diminished self-worth, and a decreased quality of life.Findings included. Record Review of the facility's policy titled, Indwelling Urinary Catheters, date revised April 2018, documented, .8. Residents with catheter bags will have them covered or use of bags that provided dignity while in bed with visibility from hallway, out of their room or in community. Resident 21 was admitted to the facility on [DATE]. The Modification of Admission/Medicare - 5 day Minimum Data Set, an assessment tool, dated 01/13/2026, documented Resident 21 was moderately cognitively impaired and had an indwelling catheter. Record review of Resident 21's physician orders, dated 01/09/2026, documented, LN [licensed nurse] to ensure, catheter system is secured, catheter strap in place, covered appropriately (privacy bag). Record review of Resident 21's Indwelling Urinary Catheter care plan, date revised, 03/06/2026, documented an Intervention, Maintain dignity at all times (leg strap, bag cover). In an observation on 04/06/2026 at 10:54 AM, Resident 21 was observed sitting in his wheelchair in the dining room with the catheter drainage bag hanging under the wheelchair, uncovered, with urine visible in the bag. In an observation on 04/06/2026 at 11:04 AM, Resident 21 was observed sitting in his wheelchair in the living room near the fireplace with the catheter drainage bag hanging under the wheelchair, uncovered, with urine visible in the bag. In an interview on 04/06/2026 at 2:37 PM, Staff G, Certified Nursing Assistant, said urinary catheter bags were supposed to be covered for privacy. In an interview and observation on 04/06/2026 at 2:43 PM, Staff E, Licensed Practical Nurse, said urinary catheter bags should be covered with a blue bag cover when residents were in bed and anytime in the facility. When asked to look at Resident 21's catheter drainage bag, hanging under his wheelchair uncovered in the hallway, Staff E said Resident 21 did not have a cover on the catheter bag and there should have been. In an observation on 04/07/2026 at 8:46 AM, Resident 21 was observed sitting in his wheelchair in the hallway outside the dining room. A blue privacy bag was hanging under the wheelchair bunched up. Resident 21's catheter drainage bag was observed hanging under the wheelchair, uncovered with urine visible in the bag, not placed in the blue privacy bag. In an interview on 04/07/2026 at 2:05 PM, Staff B, Director of Nursing/Registered Nurse, said it was her expectation urinary catheter bags were covered for privacy. Reference WAC 388-97-0180 (2)

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents and/or resident representatives were informed and provided consent before administering psychotropic medications (a medication capable of affecting the mind, emotions, and/or behaviors) for 2 of 6 sampled residents (Residents 5 & 4) reviewed for unnecessary medications and/or medication consent. This failure placed residents and/or resident representatives at risk of not being fully informed of the risks and benefits before making decisions about medications, and a diminished quality of life.Findings included. Record Review of the facility's policy titled, Behavior Management/Psychotropic Medication Overview, date revised July 2025, documented, .10. Resident or representative must be fully informed, and consent will be obtained when psychotropic medications are initiated or dosage increased. Resident 5 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 03/19/2026, showed Resident 5 was severely cognitively impaired and was taking an antipsychotic (a class of psychotropic medications used to treat symptoms of various mental disorders) medication. Record review of Resident 5's physician orders, dated 09/18/2025, showed Resident 5 was prescribed Seroquel (an antipsychotic medication) oral tablet 25 mg (milligrams), give 0.5 (one half) tablet two times a day, which was increased from 25 mg tablet, give 0.5 tablet once daily at bedtime. The September 2025 Electronic Medication Administration Record (EMAR) showed Resident 5 received an increased dose of Seroquel beginning 09/19/2025. Review of Resident 5's Electronic Health Record (EHR), did not show documentation of an informed consent completed for the increased dose of Seroquel. In an interview on 04/08/2026 at 3:15 PM, Staff H, Registered Nurse (RN), said they needed to obtain consent from a resident's responsible party to give psychotropic medications. Staff H said consent was also needed for a change in dose of psychotropic medication. In an interview on 04/08/2026 at 3:33 PM, Staff D, Resident Care Manager/Licensed Practical Nurse, said consent was needed for new psychotropic medications. Staff D said if there was a change in dose of psychotropic medications, a new consent was not needed. In an interview on 04/08/2026 at 3:43 PM, Staff B, Director of Nursing/RN, said consent was needed for psychotropic medications. Staff B said if changes were made to the medication, they should notify the responsible party, get consent and document a progress note for any changes. In a joint interview on 04/09/2026 at 10:25 AM, Staff B and Staff I, Regional Nurse/RN, said there was no documentation of consent for the increased dose of Seroquel for Resident 5 in September 2025 and there should have been. Resident 4 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 4 was moderately cognitively impaired. Record review of Resident 4's physician orders, dated 04/06/2026, showed Resident 4 was prescribed Seroquel oral tablet 25 mg, give 0.5 tablet every 12 hours as needed. The April 2026 EMAR showed Resident 4 received Seroquel on 04/06/2026. Review of Resident 4's EHR did not show documentation of an informed consent completed for administration of Seroquel. In a joint interview on 04/09/2026 at 1:10 PM, Staff B and Staff I said Resident 4 should have had an informed consent completed prior to starting the Seroquel and did not. Reference WAC 388-97-0260 (1)(a)(b)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor for adverse side effects (ASE) of antianxiety medication (a class of drugs used to treat anxiety [a mental health condition that causes fear, a constant feeling of being overwhelmed, and excessive worry about everyday things]) and/or failed to complete an AIMS (Abnormal Involuntary Movement Scale) test (a rating scale used to assess the severity of involuntary movements that sometimes develop as a side effect of treatment with antipsychotic medications [a class of drugs primarily used to treat mental health conditions such as hallucinations and delusions]) and/or failed to place a stop date order of 14 days for PRN (as needed) psychotropic medication (a medication capable of affecting the mind, emotions, and/or behaviors), and failed to ensure resident specific target behaviors were monitored prior to administering antianxiety medication for 3 of 6 sampled residents (Residents 3, 4, and 25) reviewed for unnecessary medications. This failure placed residents at risk for adverse medication side-effects, medical complications, and a diminished quality of life.Findings included . Record review of the facility policy, titled, Behavior Management/Psychotropic Medication Overview, revised July 2025, documented, .11. Adequate monitoring and reevaluation of psychotropic medications for side effects and adverse consequences will be implemented upon initiation of the medication and the need for tapering as indicated, to include: .Documentation in the eMAR [electronic medication administration record] every shift for a minimum of 14 days and then as needed. The AIMS test will be used to monitor for specific side effects associated with antipsychotic medication. Resident 3 was admitted to the facility on [DATE]. The 5-day Minimum Data Set (MDS), an assessment tool, dated 03/13/2026, indicated Resident 3 was alert and oriented and had a diagnosis of anxiety disorder. Record review of Resident 3's electronic health record (EHR) showed a Physician's order, dated 03/27/2026, for clonazepam (an antianxiety medication) oral tablet 1 MG (milligram) to give 0.5 (one half) tablet orally three times a day for anxiety. Record review of Resident 3's March and April 2026 EMAR did not show documentation of facility monitoring ASE while Resident 3 was receiving clonazepam. In an interview and record review on 04/10/2026 at 9:19 AM, Staff B, Director of Nursing/Registered Nurse (RN), reviewed Resident 3's EHR and said there was no monitoring in place. Staff B said it was the expectation that Resident 3 was monitored for ASE while she was receiving clonazepam. Resident 4 was admitted to the facility on [DATE]. The Significant Change MDS, dated [DATE], showed Resident 4 was moderately cognitively impaired. Record review of Resident 4's physician orders, dated 04/06/2026, showed Resident 4 was prescribed Seroquel (an antipsychotic medication) oral tablet 25 mg, give 0.5 (one half) tablet every 12 hours as needed. The April 2026 EMAR showed Resident 4 received Seroquel on 04/06/2026. Review of Resident 4's EHR did not show documentation of an AIMS test completed for the administration of Seroquel. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 4's physician orders, dated, 04/07/2026, documented, LORazepam [an antianxiety medication] Concentrate 2 MG/ML [two milligrams per milliliter] Give 0.5 ml by mouth every 6 hours as needed for Anxiety. The April 2026 EMAR showed resident 4 received Lorazepam on 04/08/2026. Further review of Resident 4's physician orders did not document a stop date of 14 days for PRN Lorazepam. In an interview on 04/08/2026 at 3:33 PM, Staff D, Resident Care Manager/Licensed Practical Nurse (LPN), said an AIMS test should be completed when there was a new order for Seroquel. In a joint interview on 04/09/2026 at 1:10 PM with Staff B and Staff I, Regional Nurse/RN, Staff B and Staff I said Resident 4 should have had an AIMS test prior to starting Seroquel and she did not. Staff B and Staff I said Resident 4 should have had a stop date for the PRN Lorazepam and there was not. Resident 25 was admitted to the facility on [DATE] with multiple diagnoses to include anxiety disorder. The Quarterly MDS, dated [DATE], documented Resident 25 was alert and oriented. Record review of Resident 25's physician orders, dated 03/24/2026, documented, LORazepam Oral Tablet 1 MG (Lorazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety, and LORazepam Oral Tablet 1 MG (Lorazepam) Give 2 tablet by mouth every 6 hours as needed for anxiety. Record review of Resident 25's April 2026 EMAR showed Resident 25 received 2 tablets of Lorazepam, three times per day, on 04/02/2026, 04/03/2026, 04/04/2026, and 04/07/2026. Record Review of Resident 25's EHR did not show documentation that Resident 25 exhibited symptoms or behaviors, warranting the administration of 2 tablets as opposed to 1 for all four dates. In an interview on 04/09/2026 at 09:18 AM, Staff E, LPN, stated He is prescribed lorazepam every 6 hours, but can take two. Staff E said the amount of medication had been effective when resident exhibited symptoms of hitting himself, or when Resident 25 reported increased mental anguish. Staff E said symptoms should have been documented on the EMAR, but was unable to provide such documentation for the dates requested. In an interview on 04/09/2026 at 10:12 AM, Staff D said Resident 25 was administered 2 tablets instead of 1 due to his verbal outburst and history of hitting himself. Staff D said nurses used their judgment and clinical observations when deciding whether to administer 1 tablet or 2 tablets. Staff D was unable to provide documentation of Resident 25's behaviors warranting the administration of 2 tablets opposed to 1, and stated, I would trust the nurses make good judgement without writing it out. In a joint interview on 04/09/2026 at 2:15 PM, Staff I and Staff B said the facility's current anxiety monitor for Resident 25 was insufficient and did not capture all of Resident 25's behaviors indicating when and when not to administer 2 tables. Staff I stated, the best practice is to document rationale. Reference WAC 388-97-1060 (3)(k)(i)(4)

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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 interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I, a screening tool used to identify mental health needs, was requested upon a significant change of condition for 1 of 6 residents (Resident 7) reviewed for PASRR. This failure placed the residents at risk of unidentified mental health needs, and a diminished quality of life.Findings included . Record Review of the facility's policy titled, Pre-admission Screening and Resident Review WA (PASRR), revised June/2024, documented, .6. The PASRR will be reviewed and updated as indicated with significant changes in resident's physical or mental condition. The state mental health authority will be notified of the changes affecting the resident's physical or mental condition. Resident 7 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set (MDS, an assessment tool), dated 01/28/2026, showed Resident 7 was moderately cognitively impaired and was exhibiting signs of physical and mental decline. Record review of Resident 7's Level I PASRR, dated 01/28/2026, documented Resident 7 did not require a Level II PASRR. Record review of Resident 7's EHR (Electronic Health Record), documented Resident 7 was assessed for change of condition on 01/28/2026. Record review of Resident 7's EHR did not show documentation that a new Level I PASRR was completed upon Resident 7's significant change of condition. In an interview on 04/09/2026 at 2:31 PM, Staff J, MDS Coordinator, said Resident 7 started to experience overall decline in the areas of food intake, cognition, mood, participation in activities and ADL care, and behaviors to include hallucinations and delusions. In an interview on 04/09/2026 at 2:37 PM, Staff I, Regional Nurse/Registered Nurse, said it was the facility's practice to send new PASRR referrals following a significant change in condition. Staff I said Resident 7's condition had changed significantly, but a new PASRR referral was not completed. Staff I stated, new PASRR should have been done, with a new referral. Reference WAC 388-97-1915 (4)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to fully address lab results as reported by laboratory services for 1 of 1 resident (Resident 31) reviewed for death. This failure placed residents at risk for adverse side effects and a diminished quality of life. Findings included .Resident 31 was admitted to the facility on [DATE] and passed away on 03/08/2026. The admission /Medicare - 5 Day minimum data set, an assessment tool, dated 02/27/2026, documented Resident 31 was severely cognitively impaired. Record review of Resident 31's electronic health record showed a physician's order, dated 03/05/2026, for CBC (complete blood count) with Platelets, BMP (Basic metabolic panel, a blood test measuring kidney health, electrolyte balance; essential minerals including sodium, potassium, calcium, magnesium, chloride, and phosphate, fluid status, and blood sugar levels).Record review of Resident 31's laboratory results, dated 03/07/2026, indicated, Mild Hemolysis [blood sample destruction] Present; Some results may be affected Interference present; unable to result BMP panel. BUN [Blood Urine Nitrogen measure in the blood]/ CREAT [creatinine, waste product in the blood] resulted only.In an interview and record review on 04/09/2026 at 1:04 PM, Staff E, Licensed Practical Nurse, said when lab (laboratory) results were received, nurses were expected to review the results and report them to the provider. Staff E reviewed Resident 31's Lab report dated 03/07/2026 and said it was the expectation that the report of mild hemolysis should have been reported to the provider but wasn't. In an interview and record review on 04/10/2026 at 9:36 AM, Staff B, Director of Nursing/Registered Nurse, reviewed Resident 31's lab report dated 03/07/2026 and said it was the expectation that the lab report indicating blood sample hemolysis should have been reported to the provider and the BMP should have been re-drawn. Reference WAC 388-97-1060(1)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately monitor residents' heart rate (HR) for 1 of 5 residents (Resident 3) reviewed for unnecessary medications. This failure placed residents at risk for adverse side effects and a diminished quality of life. Findings included.Resident 3 was admitted to the facility on [DATE]. The 5-day Minimum Data Set, an assessment tool, dated 03/13/2026, indicated Resident 3 was alert and oriented and had a diagnosis of chronic atrial fibrillation (irregular heart rhythms that do not revert to normal rhythm on their own).Record review of Resident 3's electronic health record (EHR) showed a Physician's order, dated 03/09/2026, for Digoxin (medication used to manage irregular heart rhythms) Oral Tablet 125 MCG (micrograms) to give 1 tablet orally in the morning for atrial fibrillation.Record review of Resident 3's EHR showed Resident 3's HR was 58 bpm (beats per minute) on 03/13/2026, 56 bpm on 03/20/2026, 59 bpm on 03/23/2026, 57 bpm on 03/27/2026 and 51 bpm on 04/09/2026. Record review of Resident 3's electronic medication administration record (EMAR) showed Resident 3 received Digoxin on 03/13/2026, 03/20/2026, 03/23/2026, 03/27/2026 and 04/09/2026 despite a HR of below 60 bpm.In a joint interview and record review on 04/10/2026 at 9:32 AM, Staff B, Director of Nursing/Registered Nurse (RN) and Staff I, [NAME] Nurse/RN, said nurses assessed Resident 3's HR prior to administering Digoxin. Staff B said it was the expectation that licensed nurses would assess Resident 3's HR prior to administering Digoxin, hold the medication if Resident 3's HR was below 60 bpm and notify the provider. Staff B and Staff I reviewed Resident 3's EHR and EMAR and said Resident 3 had received Digoxin on 03/13/2026, 03/20/2026, 03/23/2026, 03/27/2026 and 04/09/2026 while her HR was below 60 bpm. Staff B said Digoxin should not have been administered with the HR below 60 and provider should have been made aware. Reference WAC 388-97-1060 (3)(k)(i)