STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505516	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Soldiers Home	1301 Orting-Kapowsin Hwy E Orting, WA 98360

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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 0686 Level of Harm - 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 interview and record review, the facility failed to address identified risk factors for the development of pressure ulcers and implement preventative interventions timely for 1 of 4 sampled residents (Resident 3) reviewed for pressure related wounds. Resident 3 experienced harm when they developed two facility acquired pressure injuries after identified pressure prevention strategies, air mattress and heel protection boots, were not implemented timely as recommended. This failure placed residents at risk of development for pressure injury, medical complications, and diminished quality of life.Findings included . The National Pressure Ulcer Advisory Panel (NPUAP) describes/defines a suspected deep tissue injury as: Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This injury can result from prolonged pressure and may either resolve or develop into further tissue loss. Review of the facility's policy and procedure titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated March 2014, showed The nursing staff and Attending Physician/Wound Care Provider will assess and document an individual's significant risk factors for developing pressure sores and identify factors contributing or predisposing residents to skin breakdown. Review of the electronic health record (EHR) showed Resident 3 readmitted to the facility on [DATE] following a hip surgery with diagnoses that included high blood pressure, diabetes (too much sugar in the blood) and dementia (a decline in mental ability that interferes with daily life). Resident 3 was able to make their needs known. Review of the July 2025 incident log showed Resident 3 fell out of their wheelchair and fractured their left hip which required surgery. Review of a progress note dated 07/28/2025 showed Resident 3 readmitted from the hospital with complaints of pain at the surgical site upon movement. Review of the Significant Change Minimum Data Set (an assessment tool) dated 08/04/2025 showed Resident 3 was at risk for pressure ulcer/injuries and did not have any unhealed pressure ulcer/ injuries at the time of re-admittance. Review of a progress note dated 08/01/2025 from the wound nurse showed a recommendation for a low air loss or alternating pressure air mattress and bilateral heel lift boots on at all times for skin integrity/prevention. Review of a progress note, dated 08/04/2025, showed Staff J, Registered Nurse/Resident Care Manager (RN/RCM), Followed up on the request to have a specialty mattress installed related to left hip fracture and non-movement and Custodial supervisor confirms that they are aware of the request and are waiting for proper support as the resident is being resistive and combative about trying to move them to install specialty mattress to prevent skin breakdown. Will continue to monitor and follow up. Review of a progress noted dated 8/13/2025 showed during routine care staff observed Resident 3 had an open sore on the left buttock approximately 1.6 centimeters (cm) x 2.5 cm and a right heel diabetic foot ulcer (DFU) approximately 1.5 cm x 1.5 cm. The progress note showed, Resident has stayed in bed after surgery. Review of a progress note, dated 08/14/2025, showed Resident 3 was enrolled with an outside wound provider for wound #1 left heel (Deep Tissue Pressure Injury) & wound #2 sacrum (lower back) unstageable pressure injury. Review of a progress note, dated 08/15/2025, showed Resident 3's power of attorney (legal representative) was notified of alternating air mattress in place and boots to prevent skin breakdown. Review of the August 2025 (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 0686 Level of Harm - Actual harm Residents Affected - Few	treatment administration record (TAR) showed alternating air mattress with a start date of 08/15/2025 and heel lift boots with a start date of 08/14/2025. During an interview on 08/27/2025 at 2:36 PM, Staff J, Registered Nurse/Resident Care Manager (RN/RCM), stated staff should have consistently followed up on the status of the alternating air mattress and the heel lift boots for Resident 3. During an interview on 08/29/2025 at 11:52 AM, Staff B, Director of Nursing Services (DNS), stated staff should have reapproached Resident 3 about implementation of the alternating air mattress and documented the outcome. Staff B stated when a resident refused care or preventative measures the expectation was for staff to document, educate the resident, and contact the provider. Reference WAC 388-97-1060 (3)(b)

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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 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure podiatry (the treatment of feet and their ailments) care and services were provided timely to avoid podiatric complications in residents with diabetes (elevated blood sugar) for 1 of 3 sampled residents (Resident 39) reviewed for foot care. Resident 39 experienced harm when they developed an avoidable foot wound and pain due to wearing ill-fitting shoes that prevented the resident from participating in therapy resulting in a decrease in strength from baseline and a slight functional decline when there was a delay in scheduling a podiatric shoe fitting. This failure placed residents at risk of discomfort, reduced ambulation and reduced participation in activities of daily life. Findings included . Review of the electronic health record (EHR) showed Resident 39 admitted to the facility on [DATE] with diagnoses that included quadriplegia (medical condition characterized by the complete or partial loss of motor function in all four limbs [arms and legs]), diabetes, and kidney disease (impaired kidney function). Resident 39 was able to make needs known. During an interview on 08/21/2025 at 10:01 AM, Resident 39 stated, They never get things done here. I've been waiting on new shoes for over a month now. Resident 39 stated their current shoes were not wide enough and caused a painful blister on their foot. Resident 39 stated they had not been able to participate in restorative or other activities because they did not have any shoes. Review of a progress note, dated 07/15/2025, showed during routine care Resident 39 was noted with a tender diabetic foot ulcer (DFU) on the bottom of the right foot/sole approximately 1.8 centimeters (cm) x 2.7 cm. Resident 39 stated their shoes were tight. Review of the EHR showed Resident 39 was enrolled with an outside wound provider on 07/16/2025. During an interview on 08/27/2025 at 9:30 AM, Staff J, Registered Nurse/Resident Care Manager (RN/RCM), stated Resident 39 informed them that their shoes were not wide enough and requested a podiatry appointment in June 2025. Staff J stated they did not have any information on the status of the appointment. During an interview on 08/29/2025 at 9:22 AM, Staff K, Facility Truck Driver, stated the podiatry referral went in on 07/01/2025 and was approved on 07/02/2025. Staff K stated they did not follow up with scheduling the appointment until 08/27/2025, 56 days later. Review of Resident 39's Resident attended/participated in Restorative Therapy Task for August 2025 showed Not available was marked daily from 08/07/2025-08/28/2025. No documentation for participation was located for 08/01/2025-08/06/2025. Review of the PT evaluation, dated 08/29/2025, showed Resident 39's transfer prior level of functioning was Total A (76-99% assistance) on 06/26/2025 and was assessed to be Dependent (100% assistance) on 08/29/2025. During an interview on 08/29/2025 at 10:57 AM, Staff O, Director of Rehabilitation Services, stated Resident 39's 08/29/2025 physical therapy evaluation showed a decrease in strength and had slight functional decline since discharge from Physical Therapy. Staff O stated they were surprised to hear Resident 39 had not been participating in the restorative program as exercise was something they enjoyed and was previously self-motivated. Staff O stated Resident 39 stated they were hopeful and willing to participate in therapy. During an interview on 08/29/2025 at 11:44 AM, Staff B, Director of Nursing Services, stated Resident 39's podiatry appointment was needed to get a fitting for shoes, and the expectation was for staff to follow up on appointments that needed to be scheduled for residents during the weekly transportation meeting. Refer to F688 for additional information.Reference WAC 388-97 -1060 (3)(j)(viii).

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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 have psychotropic medication (medications that affect a person's mental state) informed consents accurately completed prior to administering the medication for 1 of 5 sampled residents (Resident 8) reviewed for unnecessary medication use. This failure placed the resident and/or their legal representatives at risk for lack of knowledge to make an informed decision regarding the use of the medications and a diminished quality of life. Findings included . Review of the electronic health record (EHR) showed Resident 8 readmitted to the facility on [DATE] and was able to make needs known. The quarterly minimum data set (MDS, assessment tool) dated 08/06/2025 showed Resident 8 had diagnoses to include schizoaffective disorder (a mental health condition that affects a person's ability to think, feel, and behave clearly), bipolar disorder (episodes of mood swings ranging from depressive lows to manic highs), anxiety disorder, depression, psychotic disorder (a mental disorder characterized by a disconnection from reality), and post-traumatic stress disorder (difficulty recovering after experiencing or witnessing a terrifying event). Review of the medication administration record (MAR) dated August 2025 from 08/01/2025 - 08/22/2025 showed Resident 8 received Aripiprazole (an antipsychotic medication) 20 milligrams (mg) once a day for schizoaffective disorder with hallucination and received quetiapine fumarate (an antipsychotic medication) 50 mg in the morning and 100 mg at bedtime for schizoaffective disorder. Review of Resident 8's consent for Aripiprazole, dated 03/18/2025, showed the medication dosage was for 15 mg by mouth, one time a day for schizoaffective disorder, bipolar type. However, the current provider order was for 20 mg via a gastrostomy tube (G-tube, a tube placed directly into the stomach to deliver nutrition, fluid, and medications) one time a day. Review of Resident 8's consent for quetiapine fumarate, dated 03/18/2025, showed the medication was for 100 mg via a G-tube at bedtime for schizoaffective disorder, bipolar type. However, it did not include the current order for 50 mg via a G-tube, once a day in the morning. During an interview on 08/25/2025 at 12:09 PM, Staff C, Registered Nurse/Resident Care Manager (RN/RCM), stated Resident 8's informed consents for Aripiprazole, dated 03/18/2025, dose and route was different from the current providers medication order. Staff C stated Resident 8's informed consents for quetiapine fumarate, dated 03/18/2025, was missing the morning dosage of 50 mg and it should have been included in the informed consent. Staff C stated this did not meet expectations. During an interview on 08/25/2025 at 12:46 PM, Staff B, Director of Nursing Services, stated Resident 8's informed consent for Aripiprazole, dated 03/18/2025, did not meet expectations because it was inaccurate for the current medication orders for dosage and route. Staff B stated Resident 8's informed consent for quetiapine fumarate, dated 03/18/2025, did not meet expectations because the dosage of 50 mg to be provided in the morning was missing. Reference WAC 388-97-0260

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personal privacy was protected for 1 of 3 sampled residents (Resident 50) when reviewed for resident rights. This failure placed the resident at risk for embarrassment, a violation of their privacy, and a diminished quality of life.Findings included . Review of the electronic health record (EHR) showed Resident 50 admitted to the facility on [DATE] with diagnoses that included high blood pressure, diabetes (too much sugar in the blood) and dementia (a decline in mental ability that interferes with daily life). Resident 50 was able to make needs known. Observation on 08/22/2025 at 9:27 AM showed a Monitoring in Progress sign on the exterior of Resident 50's room door. Review of Resident 50's EHR showed no documentation of consent to the recording device in their room. During an interview on 08/25/2025 at 10:57 AM, Staff J, Registered Nurse/Resident Care Manager (RN/RCM), stated Resident 50's roommate used an [NAME] (a smart device capable of playing music or recording). Staff J stated all residents who resided in the room with a recording device should have consent in the EHR, and Staff J was unable to locate a consent for Resident 50. During an interview on 08/29/2025 at 11:35 AM, Staff B, Director of Nursing Services, stated the expectation was for a consent to be signed by the resident or resident representative prior to the use of the recording device. Reference WAC 388-97-0360, 0500(1)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a sanitary and homelike environment for 1 of 4 halls (100 hall) when reviewed for environment. Failure to ensure Resident 19's wheelchair left armrest was in good repair placed the resident at risk for unsanitary conditions and a diminished quality of life.Findings included. Review of the electronic health records (EHR) showed the Resident 19 admitted to the facility on [DATE] with diagnoses to include stroke (blood supply to a part of the brain is suddenly cut off), hemiplegia (total or partial inability to move one side of the body) affecting the right side of the body, and utilized a wheelchair for mobility. Resident 19 was able to make needs known. Multiple observations on 08/21/2025 at 12:27 PM, 08/22/2025 at 12:48 PM, 08/25/2025 at 10:03 AM, 08/26/2025 at 10:56 AM, and 08/27/2025 at 12:54 PM showed Resident 19's wheelchair left armrest's black vinyl covering missing/torn off towards the back of the armrest with exposed cream material/padding. It was not a cleanable surface or a homelike environment. During an interview on 08/21/2025 at 12:27 PM, Resident 19 stated the left armrest of their wheelchair with exposed padding started out small and got bigger. Resident 19 stated the left armrest had been that way for about 10 months or so and staff were aware. During an interview on 08/27/2025 at 12:56 AM, Staff B, Director of Nursing Services, stated Resident 19's wheelchair left armrest was peeling and missing black [NAME] with exposed padding underneath. Staff B stated this was not a cleanable surface and did not meet expectations. Resident 19 told Staff B they had been provided with an armrest a while ago, but it was the wrong kind and had told staff they wanted it replaced with the one they had with an attached cup holder. Staff B was able to locate a document that showed an armrest was replaced on 02/13/2025 for Resident 19; however, no other documentation was found after that date. During an interview on 08/27/2025 at 1:54 PM, Staff A, Administrator, stated Resident 19's wheelchair left armrest condition with exposed substructure cloth which was not addressed prior to now did not meet their expectations. Reference WAC 388-97-0880

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide written bed hold notice at the time of transfer to the hospital for 2 of 4 sampled residents (Residents 93 and 5) when reviewed for hospitalization. This failure placed the residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life.Findings included . Resident 93 Review of the electronic health record (EHR) showed Resident 93 admitted to the facility on [DATE] with diagnoses that included chronic pain, anxiety (emotional state characterized by feelings of fear or worry) and diabetes (too much sugar in the blood). Resident 50 was able to make needs known. Review of Resident 93's EHR showed hospitalization on 06/01/2025 and there was no documentation the resident or resident representative was provided with written copies of the bed hold notice or transfer form. During an interview on 08/26/2025 at 1:30 PM, Staff B, Director of Nursing Services (DNS), stated residents were provided with written copies of the bed hold and transfer form upon request. During an interview on 08/26/2025 at 3:20 PM, Staff A, Administrator, stated the expectation was for bed hold and transfer forms to be provided to residents when transferred to the hospital. Resident 5 Review of the EHR showed Resident 5 was admitted to the facility on [DATE] with diagnoses that included diabetes, depression, heart failure and Charcot's joint (progressive musculoskeletal condition that causes joint instability and destruction in foot and ankle). Resident 5 was able to make needs known. During an observation and interview on 08/27/2025 at 10:06 AM, Resident 5 sat in their wheelchair in the room and stated they were in the hospital for six days and did not know about a bed hold. Review of the EHR showed Resident 5 had a signed bed hold form for leave on pass with family in August 2025, but no signed form for bed hold when they were in the hospital in June 2025. Review of progress notes showed Resident 5's spouse was notified about hospitalization, but there was no documentation about a bed hold, either verbally or in writing. Reference WAC 388-97-0120(4)

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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 interview and record review, the facility failed to ensure the minimum data set (MDS, an assessment tool) accurately reflected the status for 3 of 19 sampled residents (Residents 6, 5, and 1) when reviewed for accuracy of assessments. This failure placed the residents at risk for unmet care needs, inaccurate medical record information, and a diminished quality of life. Findings included .Resident 1 Review of the electronic health record (EHR) showed Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis following cerebral infarction (paralysis that affects only one side of the body after blood flow to the brain was interrupted), heart failure, dysphagia (difficulty swallowing food or liquids) and dementia (thinking and social symptoms that interferes with daily functioning). Resident 1 was able to communicate their needs. During an observation and interview on 08/21/2025 at 12:24 PM, Resident 1 sat on their bed with an uneaten lunch tray in front of them. Resident 1 stated they did not have an appetite, had lost weight, and were shrinking away. Review of the significant change MDS, dated [DATE], showed Resident 1 was on a prescribed weight loss program. Review of the providers' orders showed Resident 1 had Prostat (nutritional supplement) for decreased muscle mass, dated 08/01/2025, and high calorie shake three times a day for weight loss, dated 07/21/2025. Review of the care plan dated, 02/06/2024, showed Resident 1 had potential for weight loss and multiple interventions to maintain weight. There were no instructions about a planned weight loss. Resident 5 Review of the EHR showed Resident 5 was admitted to the facility on [DATE] with diagnoses that included diabetes mellites (too much sugar in blood), depression, heart failure and Charcot's joint (progressive musculoskeletal condition that causes joint instability and destruction in foot and ankle). Resident 5 was able to make needs known. During an interview on 08/27/2025 at 10:50 AM, Resident 5 stated they lost a lot of weight because they could not eat the food provided by the facility and they were drinking four shakes a day to help with weight gain. Review of the quarterly MDS, dated [DATE], showed Resident 5 was on prescribed weight loss program. Review of providers' orders showed Resident 5 was ordered Glucerna (supplemental shake) three times a day, dated 07/21/2025. Review of care plan, dated 03/21/2025, showed Resident 5 has a nutritional problem. There were no instructions about a planned weight loss. During an interview on 08/29/2025 at 8:56 AM, Staff B, Director of Nursing Services, stated the MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on Residents 1 and 5 were coded in error, and the assessments did not meet expectations. Resident 6 Review of the EHR showed Resident 6 readmitted to the facility on [DATE] with diagnoses to include depression and post-traumatic stress disorder (difficulty recovering after experiencing or witnessing a terrifying event). Resident 6 was able to communicate needs. Review of the level I Preadmission Screening and Resident Review (PASSAR, a mental health screening tool), dated 01/07/2025, showed Resident 6 required a level II evaluation referral for serious mental illness. Review of the level II PASSAR Initial Psychiatric Evaluation Summary, dated 02/13/2025, showed Resident 6 was referred on 01/08/2025 and the evaluation was completed on 02/13/2025. Review of Resident 6's admission MDS, dated [DATE], showed section A1500 was coded No for being considered for the level II PASSAR process for having a serious mental illness and/or intellectual disability or a related condition. During an interview on 08/26/2025 at 11:01 AM, Staff G, Registered Nurse/MDS Coordinator (RN/MDSC), stated Resident 6's admission MDS dated [DATE] section A1500 should have been coded Yes and the MDS needed to be modified. During an interview on 08/26/2025 at 11:16 AM, Staff B, Director of Nursing Services, stated their expectation was that nurses followed the guidelines of the Resident Assessment Instrument Manual (detailed instructions on using the MDS assessment form along with care area assessments to develop a comprehensive plan that tracks resident status and aims to improve their well-being) when completing the MDS. Staff B stated Resident 6's admission MDS, dated [DATE], section A1500 was coded No and should have been coded Yes and needed to be modified. 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 screen for mental health services on admission for 1 of 7 sampled residents (Resident 30) when reviewed for Pre-admission Screening and Resident Review (PASSAR, a mental health services screening tool). This failure placed the resident at risk for lack of mental health support, increase in adverse behaviors, decrease in mood, and diminished quality of life. Findings included.Review of the electronic health record showed Resident 30 admitted to the facility on [DATE] with diagnoses to include anxiety disorder, diabetes, and chronic kidney disease. The resident was able to make needs known. Review of the PASSAR level one, dated 05/09/2025, showed the Resident 30 required a level two PASSAR assessment. Review of the care plan, initiated 04/18/2025, showed Resident 30 had a level one PASSAR and a level two PASSAR was requested on 05/09/2025. During an interview on 08/27/2025 at 11:51 AM, Staff M, Social Worker, stated residents who admitted from the community would be considered a respite stay and the PASSAR would be completed within the first month of admission to the facility. Staff M stated Resident 30 admitted to the facility on [DATE] without a PASSAR and their PASSAR level one was completed on 05/09/2025. During an interview on 08/27/2025 at 1:46 PM, Staff N, Admissions, stated residents who admitted from the community would not have a level one PASSAR completed before admitting to the facility and the facility social workers would complete the PASSAR level one if it was determined the resident would stay at the facility greater than 30 days. Staff N stated the provider did not determine if the PASSAR level one should be completed or not due to a hospital exempted stay. During an interview on 08/27/2025 at 1:59 PM, Staff A, Administrator, stated the PASSAR level one should be completed prior to admission. Reference WAC 388-97-1915 (1)(2)(a-c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure license nurses followed orders for applying a splint (device used to immobilize or stabilize a joint or protected body part) and prevalon boots (boots used to relieve pressure on heels) for 1 of 3 sampled residents (Resident 1) when reviewed for positioning. This failure placed the resident at risk for worsening mobility, medical complications, and diminished quality of life.Finding Included.Review of the EHR showed Resident 1 was admitted to the facility on [DATE] with diagnoses that include hemiplegia and hemiparesis following cerebral infarction (paralysis that affects only one side of the body after blood flow to the brain was interrupted), heart failure, dysphagia (difficulty swallowing food or liquids) and dementia (thinking and social symptoms that interfered with daily functioning). Resident 1 was able to communicate their needs. Observation on 08/21/2025 at 11:28 AM showed Resident 1 laid in bed with no boots or splint on. There was a splint on their nightstand. Observation and interview on 08/22/2025 at 11:26 AM showed Resident 1 had no splint or boots on in bed and Resident 1 stated the staff placed the right-hand splint on them a couple of days ago. Observations on 08/25/2025 at 1:03 PM and 08/26/2025 at 9:09 AM showed Resident 1 did not use their splint or boots. Review of the care plan showed Resident 1 had interventions for right wrist extension splint, dated 04/02/2025, and prevalon boots, dated 04/04/2025. Review of the provider's orders showed Resident 1 had order for Apply right wrist extension splint to right wrist, dated 04/02/2025 and prevalon heel lift boot (or equivalent) to bilateral [both sides] feet/lower legs while in bed, dated 04/02/2025. Review of the treatment administration record for August 2025 showed licensed nurses had initialed the splint and boots were on during the same timeframe of observations on the dates of 08/21/2025, 08/22/2025, and 08/25/2025. During an interview on 08/26/2025 at 9:53 AM, Staff F, Registered Nurse, stated Resident 1 refused the splint in the morning, and the documentation should reflect that. During an interview on 08/29/2025 at 8:56 AM, Staff B, Director of Nursing Services, stated the expectation was for licensed nurses to follow orders and document accurately. Documentation for Resident 1 splint and boots did not meet expectations. Reference WAC 388-97-1060(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505516	A. Building B. Wing	08/29/2025

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and services to increase and/or prevent further decline for 1 of 3 sampled residents (Resident 39) reviewed for limited range of motion (ROM). This failure placed residents at risk for a functional decline, increased dependence on staff, and diminished quality of life.Findings included . Review of the electronic health record (EHR) showed Resident 39 admitted to the facility on [DATE] with diagnoses that included quadriplegia (medical condition characterized by the complete or partial loss of motor function in all four limbs [arms and legs]), diabetes (too much sugar in the blood), and kidney disease (impaired kidney function). Resident 39 was able to make needs known. During an interview on 08/21/2025 at 10:01 AM, Resident 39 stated they had not participated in restorative because they had been waiting for wider shoes to be ordered. Resident 39 stated they felt increased weakness in their legs and could not recall the last time they participated in restorative. Review of Resident 39's 06/26/2025 Physical Therapy (PT) Discharge Summary showed the therapist documented Discharge Recommendations; Restorative Nursing Program for maintenance/build strength. Review of Resident 39's care plan, initiated 05/27/2025, showed the following Nursing Restorative Programs. Level 2 Lower extremity program with 3 pound weights. Vertical/Horizontal bar sit-to stand. Progress as tolerates. Encourage 6 times a week. Chart when participates. Initiated 06/26/2025 Modified Upper extremity program, rickshaw #25. Progress as tolerates. Encourage 6 times a week. Chart when participates. Initiated 07/16/2025 Sci-fit bike 15-20 minutes. Progress as tolerates. Encourage 6 times a week. Chart when participates. Initiated 06/26/2025 Trunk reaching exercises on each side. Progress as tolerated. Encourage 6 times a week. Chart when participates. Initiated 08/01/2025. Review of Resident 39's care plan, initiated on 05/27/2025, showed to Document any care refused by resident, reason for refusal and notify licensed nurse. Review of Resident 39's Resident attended/participated in Restorative Therapy Task for August 2025 showed Not available was marked daily from 08/07/2025-08/28/2025. No documentation for participation was located for 08/01/2025-08/06/2025. During an interview on 08/27/2025 at 8:24 AM, Staff L, Nursing Assistant (NA), stated they did not know why Resident 39 had not been participating in the restorative program. Resident 39 reported to Staff L that they had lost all their strength due to lack of participation in the restorative program and did not know if or when they would participate again. Staff L stated Resident 39 was supposed to be encouraged to participate six time per week but was offered the program approximately three times per week since they had stopped participating. Staff L stated they staffed residents who were not participating weekly but was unable to provide any further information on Resident 39's status with restorative. Review of the PT evaluation, dated 08/29/2025, showed Resident 39's transfer prior level of functioning was Total A (76-99% assistance) on 06/26/2025 and was assessed to be Dependent (100% assistance) on 08/29/2025. During an interview on 08/29/2025 at 10:57 AM, Staff O, Director of Rehabilitation Services, stated Resident 39's 08/29/2025 physical therapy evaluation showed a decrease in strength and had slight functional decline since discharge from Physical Therapy. Staff O stated they were surprised to hear Resident 39 had not been participating in the restorative program as exercise was something they enjoyed and was previously self-motivated. Staff O stated Resident 39 stated they were hopeful and willing to participate in therapy. During an interview on 08/29/2025 at 11:44 AM, Staff B, Director of Nursing Services, stated when Resident 39 expressed to Staff L that they lost their strength, a referral should have been made to physical therapy for evaluation. Staff B stated the lack of documentation, communication, and referral did not meet their expectations. Reference WAC 388-97-1060 (3)(d)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor and accurately document fluid restrictions or failed to follow up on a speech therapy referral for 2 of 6 sampled residents (Residents 2 and 3) when reviewed for nutrition and/or dialysis.These failures placed residents at potential risk for medical complications and a diminished quality of life. Findings included.Resident 2 Review of the electronic health records (EHR) showed Resident 2 readmitted to the facility on [DATE] with diagnoses to include kidney failure with dependence on dialysis (the process of removing waste products and excess fluid from the blood due to kidney failure), diabetes (too much sugar in the blood), and heart failure. Resident 2 was able to make needs known. During an interview and observation on 08/25/2025 at 1:01 PM, Resident 2 stated they used to be on a fluid restriction but was no longer on a fluid restriction. There was a sign on the wall that showed, No Water Pitcher Fluid Restriction and Resident 2 stated it was an old sign. Resident 2 did not have a water pitcher in the room. Review of the current provider diet order, dated 03/31/2025, showed Resident 2 was prescribed a regular diet with regular texture and thin fluid consistency. It showed Resident 2 was to have smaller portions of starches and vegetables and had a fluid restriction of 1000 milliliters (ml) per 24 hours. The kitchen was to provide 200 ml each meal and nursing was to provide 150 ml during the day and evening shifts and 100 ml during the night shift, and to exclude Boost supplement from the restriction. Review of the current provider order, dated 07/29/2025, showed Resident 2 was prescribed a fluid restriction of 1000 ml in a 24-hour period. The dietary department was to provide 760 ml; breakfast = 280 ml, lunch = 240 ml, and dinner = 240 ml. Nursing was to provide 240 ml; each shift = 80 ml, and to document the amount of all fluids consumed during each shift in ml. This order did not match the fluid restrictions documented in the current dietary order. Review of Resident 2's Kardex (directions and information to provide care), dated 08/27/2025, showed, Fluid Restriction 1000 ml/day. 760ml - DIETARY - (280ml breakfast) - (240ml lunch)- (240ml dinner). 240ml - NURSING -(80ml/shift). It showed to document the amount of all fluids consumed during shift in ml. This matched the current fluid restriction order. Review of Resident 2's EHR in Tasks for Nutrition: amount eaten from 07/29/2025 – 08/26/2025 regarding the follow up question response to How much did the resident drink? (in mls?) showed the resident was provided over 760 ml on the following dates: 07/30/2025 = 1,200 ml, 08/03/2025 = 960 ml, 08/04/2025 = 793 ml, 08/13/2025 = 960 ml, 08/17/2025 = 900 ml, 08/19/2025 = 960 ml, 08/23/2025 = 880 ml, and 08/25/2025 = 880 ml. Review of the July and August 2025 medication administration records (MAR) from 07/29/2025 – 08/26/2025 showed the total amount of fluids documented in ml were lower when compared to what was documented in Tasks for 20 out of 29 dates. During an interview on 08/29/2025 at 10:49 AM, Staff D, Food Service Supervisor (FSS), stated their system showed Resident 2 was on a regular diet, regular texture, thin liquids, and a fluid restriction of 1000 ml per 24 hours. Resident 2's diet order showed the kitchen was to provide 200 ml each meal (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and nursing was to provide 150 ml on day and evening shift and 100 ml on the night shift. Staff D stated the dietary order and fluid restriction orders should match and the dietary department relied on nursing and/or speech therapy to communicate any changes related to a resident's diet and fluid restrictions by using a dietary communication form. During an interview on 08/29/2025 at 11:18 AM, Staff H, Nursing Assistant (NA), stated a resident's Kardex informed them who was on fluid restrictions, and they could also ask the nurse if they were not sure. Staff H stated the nursing assistants documented what fluids the residents drank in the computer system during meals and would have to ask the nurse first if the resident could have extra fluids before being able to provide. Staff H stated Resident 2 was on fluid restrictions and had a sign posted on the wall in their room. During an interview on 08/29/2025 at 11:25 AM, Staff C, Registered Nurse/Resident Care Manager (RN/RCM), stated when Resident 2's fluid restriction order dated 07/29/2025 was obtained their dietary order dated 03/31/2025 should have been updated/revised to reflect the current fluid restriction order. Staff C stated the aids/nursing assistants documented what fluids they gave to the residents in the computer system in tasks and nurses documented in the MAR. Staff C stated Resident 2's EHR tasks for amount of fluids consumed at meals compared to their July and August 2025 MAR fluids consumed showed the aids provided over the parameters for fluid restrictions and the MARs showed lower amounts consumed the majority of the time and this did not meet expectations. During an interview on 08/29/2025 at 11:56 AM, Staff B, Director of Nursing Services (DNS), stated residents on fluid restriction were to have all fluids consumed including during meals, during the shift, and documented by the licensed nurses in the MAR. Staff B stated the nursing assistants documented what fluids they provide and were consumed in the computer system (in tasks). Staff B stated Resident 2's dietary order should have been updated with the fluid restriction order, dated 07/29/2025, when it was obtained. Staff B stated what was documented in the computer system by the aids did not look like it was included in Resident 2's July and August 2025 MARs and this did not meet expectations. Resident 3 Review of the EHR showed Resident 3 readmitted to the facility on [DATE] following a hip surgery with diagnoses that included high blood pressure, diabetes, and dementia (a decline in mental ability that interferes with daily life). Resident 3 was able to make needs known. Review of Resident 3's progress note, dated 08/06/2025 at 9:55 PM, showed Resident 3 was starting to have a problem with a regular texture diet and could not eat. Resident 3 was given a supplement to drink, and staff referred to speech therapy for an evaluation to be completed. During an interview on 08/27/2025 at 2:36 PM, Staff J, RN/RCM, stated there had been no follow up on Resident 3's speech referral. During an interview on 08/29/2025 at 11:35 AM, Staff B, DNS, stated the expectation was referrals were followed up on and completed timely. Staff B stated if there was immediate concern related to the texture of a resident's diet nursing staff had the ability to assess the resident and downgrade the diet if necessary, in the interim. Reference WAC 388-97-1060 (3)(h)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act on the consultant pharmacist's medication regimen review (MRR) recommendations and to have clearly documented rationale for not following the recommendation for 1 of 5 sampled residents (Residents 8) when reviewed for unnecessary medication use. This failure placed the resident at potential risk for medical complications and a decreased quality of life.:Findings included . Review of the electronic health record (EHR) showed Resident 8 readmitted to the facility on [DATE] with diagnoses to include diabetes (too much sugar in the blood), schizoaffective disorder (a mental health condition that affects a person's ability to think, feel, and behave clearly), and depression. Resident 8 was able to make needs known. Review of the form titled, Pharmacist Report of Irregularity, dated 06/09/2025 showed the pharmacist recommended Resident 8 be offered the shingles vaccination (a series of two shots that protects against shingles, a painful rash). The form's Facility Response section was left blank and did not show a clinical justification and/or rationale for not following the pharmacist recommendation. Review of the form titled, Pharmacist Report of Irregularity, dated 06/09/2025 showed the pharmacist recommended Resident 8 be offered the Respiratory Syncytial Virus (RSV, a severe respiratory illness) vaccination (used to prevent RSV infection). The form's Facility Response section was left blank and did not show a clinical justification and/or rationale for not following the pharmacist recommendation. Review of a progress note, dated 07/08/2025, showed the facility contacted Resident 8's power of attorney (POA, legal authority to act for another person's behalf) to obtain consent for the shingles and the RSV vaccination. The POA stated it was up to Resident 8 to decide, and staff should ask Resident 8 for their consent. There was no other documentation found in the EHR related to the pharmacist's recommendations. During an interview on 08/25/2025 at 11:40 AM, Staff C, Registered Nurse/Resident Care Manager, stated they tried to follow up on any pharmacist's recommendations within a week depending on the recommendation. Staff C stated they would contact the provider to see if they agreed or disagreed with the pharmacist's recommendations. Staff C stated there was a progress note dated 07/08/2025 that showed Resident 8's POA stated to ask Resident 8 if they wanted the vaccinations and they did not see any other progress note related to any follow up at this time. Staff C stated Resident 8 did not have documentation to show they had received the vaccinations, and the 06/09/2025 pharmacist's vaccination recommendations should have been followed up on by now and this did not meet expectations. During an interview on 08/25/2025 at 12:34 PM, Staff B, Director of Nursing Services, stated Resident 8's 06/09/2025 pharmacist's recommendations for shingles and RSV vaccinations should have been followed up on prior to now and this did not meet their expectations. Reference WAC 388-97-1300(4)(c)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to schedule a follow up dental appointment and provide prompt dental services for 1 of 3 sampled residents (Resident 19) when reviewed for dental. This failure placed the resident at risk for continued dental problems and a diminished quality of life. Findings included. Review of the electronic health records (EHR) showed the Resident 19 admitted to the facility on [DATE] with diagnoses to include stroke (blood supply to a part of the brain is suddenly cut off), hemiplegia (total or partial inability to move one side of the body) affecting the right side of the body, and diabetes (too much sugar in the blood). Resident 19 was able to make needs known. During an interview and observation on 08/21/2025 at 12:42 PM, Resident 19 stated they had oral pain at times in their left upper back molar and told staff three or four weeks ago that they wanted to see a dentist to have the tooth pulled out. Resident 19 stated they still had not seen a dentist. Resident 19 had missing upper and lower teeth. Review of the focused care plan, initiated on 07/01/2020, showed Resident 19 had an oral/dental health problem related to natural teeth, cracked/broken tooth/teeth/fillings, heavy build up and needed encouragement for daily brushing. It showed an intervention initiated on 07/01/2020 to coordinate arrangements for dental care and transportation as needed. Review of the Patient Information Exchange form dated 04/22/2025 for Resident 19's dental appointment on 04/22/2025 showed Observation, Evaluation & Recommendations, included tooth number 15 was on a root canal watch (identified issue, that could lead to a root canal, a dental procedure that treats infected or inflamed tooth pulp/nerve and blood vessels of the soft tissue). It showed tooth number 15 needed a built-up/crown (materials to rebuild the damaged portion of the tooth), and silver diamine fluoride (SDF, an antimicrobial liquid used to treat cavities) to be placed everywhere. Review of a progress note dated 04/22/2025 showed, Resident went to Dental appointment this morning, a note stated [Resident 19] will need buildup crown for #15, however [Resident 19], must pay from [their] own pocket due to not being covered by the insurance. Resident said that [they] will not do it. During a follow-up interview on 08/26/2025 at 1:13 PM Resident 19 stated that after their dental appointment in April 2025 they had told staff they did not want to pay for a root canal, and they just wanted the tooth pulled out to prevent further occasional oral pain. Review of the progress note dated 08/07/2025 showed Resident 19 was on alert for reports of pain of the left upper molar at times. During an interview on 08/26/2025 at 1:42 PM, Staff C, Registered Nurse/Resident Care Manager, stated when Resident 19 complained of tooth pain they should have been assessed, provider notified, and a dental appointment scheduled to have the tooth pulled to prevent further oral pain. Staff C stated this should have been addressed prior to now. During an interview on 08/26/2025 at 2:50 PM, Staff B, Director of Nursing Services, stated Resident 19 needed to have an oral assessment, provider notified, and a dental appointment scheduled to have the tooth extracted. Staff B stated Resident 19's dental issues were not addressed timely and did not meet their expectations. Reference WAC 388-97-1060(1)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the actual hours worked in the nursing staffing postings for 5 of 5 observed days during the survey period (08/21/2025, 08/22/2025, 08/25/2025, 08/26/2025, and 08/27/2025) when reviewed for nursing staff postings. This failure prevented the residents, family members, and visitors from exercising their rights to know the actual numbers of available nursing staff in the facility. Findings included . Observations on 08/21/2025 at 9:48 AM, 08/22/2025 at 10:36 AM, 08/25/2025 at 1:47 PM, 08/26/2025 at 2:00 PM, and 08/27/2025 at 9:30 AM of the nursing staffing postings showed, Number of hours; however, did not indicate if those hours were actual or scheduled hours documented for each discipline on each shift. During an interview on 08/27/2025 at 11:09 AM, Staff E, Administrative Assistant 3 (AA3), stated the night nurse made up the nursing staff postings and posted them daily. Staff E stated the postings showed scheduled hours worked for each discipline on each shift and not the actual hours worked. During an interview on 08/27/2025 at 12:08 PM, Staff B, Director of Nursing Services, stated the scheduled hours worked were what was being posted for the nursing staffing postings; however, they should have also reflected the actual hours worked. Staff B stated this did not meet expectations and the form needed to be updated to reflect/include actual hours worked for each discipline. No Associated WAC