STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER Salmon Creek Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 NE 139th Street Vancouver, WA 98686	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive individualized care plan was developed with specific information for that resident for 4 of 7 sampled residents (1, 4, 5, and 6) reviewed for care plans. This failure placed residents at risk for unmet care needs and a diminished quality of life.Findings included . Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses including spinal stenosis (narrowing of the spaces within the spinal canal), osteoarthritis (a chronic, degenerative joint disease leading to pain, stiffness, and reduced mobility), and presence of an artificial knee joint. Review of Resident 1's 5-Day Minimum Data Set (MDS, an assessment tool), dated 02/11/2026, showed Resident 1 was cognitively intact.Review of Resident 1's Care Plan, initiated 02/05/2026, showed the following segments were incomplete and/or not individualized:--Focus: Communication: the resident has risk for complications related to communication impairment due to (Areas to fill in were left blank.)-- Focus: Risk for Falls: the resident is at risk for falls related to: (Areas to fill in were left blank.)-- Focus: Anticoagulants: the resident is at risk for bleeding and bruising related to use of an anticoagulant for diagnosis of (Areas to fill in were left blank.) Resident 4Resident 4 was admitted to the facility on [DATE] with diagnoses including hypertension (a condition where pressure in the blood vessels is too high, potentially leading to heart failure) and chronic heart failure (a chronic condition where the heart cannot pump enough blood to meet the body's needs leading to fluid buildup in the lungs and legs). The admission MDS assessment, dated 01/27/2026, showed Resident 4 had severe cognitive impairment. Review of Resident 4's Care Plan, initiated 01/21/2026, showed the following segments were incomplete and/or not individualized:--Focus: Diuretics: the resident is at risk for complications secondary to diuretic use due to diagnosis of (areas to fill in were left blank.)--Focus: Opioids: the resident is at risk for complications related to the use of opioid secondary to (areas to fill in were left blank.) Resident 5Resident 5 was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus (a chronic metabolic leading to high blood glucose levels which can cause significant vision changes). The admission MDS assessment, dated 01/27/2026, showed Resident 5 had moderate cognitive impairment and required moderate assistance with ambulation. Review of Resident 5's Care Plan, initiated 01/21/2026, showed the following segments were incomplete and/or not individualized:--Focus: [Resident 5] has vision impairment related to (areas to fill in were left blank.) RESIDENT 6Resident 6 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage (bleeding inside the brain, usually caused by a head injury, potentially leading to dizziness, confusion, and weakness). The admission MDS assessment, dated 02/28/2026, showed Resident 6 was cognitively intact. Review of Resident 6's Care Plan, initiated 01/21/2026, showed the following segments were incomplete and/or not individualized:--Focus: the resident is at risk for falls related to (areas to fill in were left blank.)--Focus: the resident has been admitted to the facility to rehabilitation and requires assistance with their activities of daily living due to (areas to fill in were left blank.)--Focus: the resident is at risk for constipation related to (areas to fill in were left blank.)On 04/02/2026, Staff B, Director of Nursing Services and Registered Nurse, said the Unit (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

Printed: 06/25/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505522	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Managers are tasked with writing the comprehensive care plans pertaining to nursing services. After reviewing the segments of incomplete care plans for Residents 1, 4, 5, and 6, Staff B said they each should have been completed and stated, We recognized that was an issue and we have been working on hiring and positions being filled, so our team is really coming together and now we are looking at systems. Reference WAC 388-97-1020 (1), (2)(a)(c)

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently conduct and document pre and post dialysis (a life sustaining treatment for kidney failure) assessments designed to ensure consistent ongoing communication and collaboration with the dialysis facility and failed to follow physicians' orders pertaining to dialysis treatment, for 1 of 1 resident (Resident 3) reviewed for dialysis. This failure had the potential to place residents who receive dialysis at risk for unmet care needs and dialysis related complications.Findings included .Review of the facility service agreement with the dialysis service provider, dated 01/05/2026, showed the dialysis service provider would, provide services to designated residents and will provide no other services, medical or otherwise, except as such services relate to or are an integral part of the provision of dialysis service.facility [Skilled Nursing Facility, SNF] shall ensure all appropriate medical, social, administrative, and other information accompany all designated residents at the time of transfer.facility [SNF] will provide for the interchange of information useful or necessary for the care of the designated resident.RESIDENT 3Resident 3 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease (ESRD, the final, permanent stage of chronic kidney disease signifying fatal kidney failure necessitating regular dialysis.) and dependence on renal dialysis (signifies that a resident requires dialysis for survival.). Review of the 5-Day Minimum Data Set (an assessment tool), dated 01/29/2026, showed Resident 3 had severe cognitive impairment, the resident had a diagnosis of ESRD, and dependence on renal dialysis.Review of Resident 3's physician orders, dated 01/31/2026, showed an order for the Pre HD (hemodialysis) Assessment form to be completed before transporting the resident to dialysis, stating, Complete under Pre/Post HD [hemodialysis] Assessment in PCC [Point Click Care, An Electronic Medical Record, EMR] and provide a copy of HD paper form to transport upon arrival for center [dialysis service provider] to complete and return.Review of Resident 3's physician orders, dated 01/29/2026, showed an order for the Post HD Assessment form to be completed upon resident return from dialysis, stating, Complete under pre/post HD assessment in PCC and place a copy of HD paper form into HD [binder] after each session and update weight on return.Review of Resident 3's physicians' orders, dated 02/05/2026, showed an order to premedicate with Norco (A prescription medication used to treat moderate to severe pain.) prior to dialysis, ensure dentures were in, and to send a donut seat and a blanket with the resident to dialysis.Review of Resident 3's physicians' orders, dated 01/29/2026, showed an order to obtain the residents' weight daily.Review of the EMR for Resident 3 showed the following omissions on the Pre/Post HD Assessment:01/31/2026 Incomplete Pre HD Assessment.01/31/2026 Incomplete Post HD Assessment.02/03/2026 Incomplete Post HD Assessment.02/05/2026 Incomplete Pre HD Assessment.02/10/2026 Incomplete Pre HD Assessment.02/14/2026 Incomplete Pre HD Assessment.03/26/2026 Incomplete Post HD Assessment. Review of Resident 3's Comprehensive Care Plan, initiated 01/28/2026, showed the resident required hemodialysis related to their diagnosis of ESRD, interventions included dialysis at every Tuesday, Thursday, and Saturday. The Care Plan did not address Pre and/or Post Dialysis Assessments or documentation and did not address communication and coordination with the dialysis service provider after each dialysis visit.Review of Resident 3's Medication Administration Record (MAR), dated February 2026, showed Resident 3 did not consistently receive Norco prior to dialysis, as ordered by the physician. The MAR had the following entries for administration of Norco on the following dates the resident was scheduled to attend dialysis:02/07/2026 9 indicating see Progress Notes.02/10/2026 Blank/ no documentation.02/12/2026 9 indicating see Progress Notes.02/17/2026 Blank/ no documentation.Review of Resident 3's Progress Notes for the dates of 02/07/2026, 02/10/2026, 02/12/2026, and 02/17/2026 show no documentation pertaining to the physicians' order for Norco to be administered prior to dialysis treatment.Review of Resident 3's Nursing: Hemodialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Communication Observation/Assessment, dated 02/05/2026, a recommendation from the dialysis center states, Pt. [patient] needs to come with snack/lunch, blanket, donut cushion, dentures in. He [Resident 3] states he isn't getting pain meds there [at the SNF] but complains of severe pain.Review of Resident 3's dialysis facility Patient Note, dated 02/05/2026, stated, Pt. [patient] expressed frustration.regarding care at [SNF]. Called facility and spoke with RN [registered nurse]. Pt. is given Tylenol TID [three times per day] and pain medication is available but not being given. Discussed pt. being in pain at tx [treatment] and on ride to dialysis. RN reported often dialysis pt.'s are premedicated to help with this and she was unsure why this was not happening but would discuss with her team. Requested there additionally be a note that says pt. should always have teeth put in and donut sent.Review of Resident 3's dialysis facility Patient Note, dated 02/10/2026, states, .Pt. was visibly cold and had been sent from SNF without a blanket, jacket or shoes.told pt. he seemed confused. Pt. agreed and said he has been for a few days.Called RN at SNF again and reviewed importance of sending warm clothes, blanket, shoes.Spoke with pt.'s [family member-name redacted] by phone and reported above concerns. She also felt pt was more confused and felt this was d/t [due to] missed tx [treatment] on Saturday [02/07/2026] . this is the second time [dialysis staff member] has called the facility to alert them to need for having warm clothes and having his teeth put in.Review of Resident 3's EMR showed Resident 3 did not attend their scheduled dialysis appointment on 02/07/2026.In an interview on 03/05/2026 at 3:40PM, Collateral Contact 1, dialysis staff member, said Resident 3 often arrived for dialysis in pain, without their communication binder, not properly clothed, and they were often sent without food, their dentures, or a blanket.In an interview on 04/02/2026 at 11:00AM, Staff B, Director of Nursing Services and Registered Nurse said a blank spot on the MAR indicated a medication omission or lack of charting. After review of the Pre and Post Dialysis Assessments that were blank and/or incomplete, Staff B said, That information should have been in the communication binder and then entered in the Pre and Post Assessments. Reference WAC 388-97-1900 (1)(6)(a-c)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from significant medication errors when medications were not administered in accordance with provider orders and/or within the standard practice administration parameters for 3 of 7 sampled residents (Resident 1, 2, and 6) reviewed for significant medication errors. This failure placed residents at risk of adverse medical conditions, a change in health conditions, and a diminished quality of life.Findings included.Review of the facility policy, Medication Administration Section 7.1, General Guidelines, dated January 2023, showed, Medications are administered in accordance with written orders of the prescriber . The individual who administers the medication dose records the administration on the resident's MAR [Medication Administration Record, comprehensive records of physicians' orders and the medications and treatments administered to a resident] immediately following the medication being given.medications are administered within 60 minutes of the scheduled time. Resident 1Resident 1 was admitted to the facility on [DATE] with diagnoses including spinal stenosis (narrowing of the spaces within the spinal canal), post-traumatic stress disorder (PTSD, a mental health condition caused by an extremely stressful or terrifying event), and chronic kidney disease (a long-term condition where the kidneys are damaged). Review of Resident 1's 5-Day Minimum Data Set (MDS, an assessment tool), dated 02/11/2026, showed Resident 1 was cognitively intact.Review of Resident 1s' February 2026 MAR and Treatment Administration Record (TAR, comprehensive records of physicians' orders and the medications and treatments administered to a resident), showed the following medications or treatments were omitted/not administered:-02/10/2026 at 8:00PM Ketoconazole (medicated cream to treat skin), for wound care.-02/10/2026 Evening. Monitoring bruising area; arms bilateral, knees, abdomen.-02/10/2026 Evening. Sedative/Hypnotic. Monitor for insomnia.-02/10/2026 Evening. Anticoagulant (blood thinning medication) medication monitoring.Review of Resident 1's Medication Administration Audit Report, dated 02/05/2026 through 02/16/2026, showed the following medications were not administered within the nursing standard of practice window of one hour prior to the ordered administration time to one hour after the ordered administration time (a two-hour timeframe):-Acetaminophen, for pain, was administered outside of the two-hour parameters four times out of 12 opportunities. -Estradiol, for hormone regulation, was administered outside of the two-hour parameters one time out of 12 opportunities. -Fluticasone propionate, for allergies, was administered outside of the two-hour parameters six times out of 12 opportunities. -Furosemide, for fluid retention, was administered outside of the two-hour parameters four times out of 12 opportunities. -Heparin (blood thinner) was administered outside of the two-hour parameters five times out of 12 opportunities. -Hydromorphone, for pain, was administered outside of the two-hour parameters four times out of 12 opportunities. -Ketoconazole, for wound care, was administered outside of the two-hour parameters 10 times out of 12 opportunities. -Losartan potassium, for hypertension (high blood pressure), was administered outside of the two-hour parameters four times out of 12 opportunities. -Phentermine, for weight loss, was administered outside of the two-hour parameters four times out of 12 opportunities. -Prazosin, for anxiety (feelings of fear, tension or uneasiness) and PTSD nightmares, was administered outside of the two-hour parameters two times out of 12 opportunities. -Rosuvastatin calcium, for hyperlipidemia (high cholesterol), was administered outside of the two-hour parameters five times out of 12 opportunities. -Senna, for constipation, was administered outside of the two-hour parameters six times out of 12 opportunities. -Sertraline, for depression (persistent feelings of sadness, hopelessness, and loss of interest), was administered outside of the two-hour parameters 10 times out of 12 opportunities. -Topiramate, for weight loss, was administered outside of the two-hour parameters one time out of 12 opportunities. Resident 2Resident 2 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD, a lung and airway disease), chronic pain syndrome (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(pain lasting longer than three months), type 2 diabetes mellitus (a chronic metabolic disorder leading to high blood sugar), and a psychotic disorder (a severe mental disorder causing abnormal thinking and perceptions). The quarterly Minimum Data Set (MDS) assessment, dated 12/31/2025, showed Resident 2 was cognitively intact.Review of Resident 2's January 2026 MAR and TAR showed the following medications or treatments were omitted/not administered:-01/04/2026 at 8:00PM Arnuity ellipta (mediation for asthma), for wheezing.-01/04/2026 at 8:00PM Cymbalta, for chronic pain syndrome.-01/04/2026 at 8:00PM Melatonin (sleep aid), for supplement.-01/04/2026 at 8:00PM Olanzapine, for psychotic disorder.-01/04/2026 at 8:00PM Omega-3, for supplement.-01/04/2026 at 8:00PM Vitamin C, for supplement.-01/04/2026 at 8:00PM Zetia, type 2 diabetes mellitus.-01/04/2026 at 8:00PM Zinc, for supplement.-01/04/2026 at 8:00PM Potassium chloride, for supplement.Review of Resident 2's Medication Administration Audit Report, dated 01/13/2026 through 01/28/2026, showed the following medications were not administered within the nursing standard of practice window of one hour prior to the ordered administration time to one hour after the ordered administration time (a two-hour timeframe):-Arnuity ellipta, for wheezing, was administered outside of the two-hour parameters two times out of 16 opportunities. -Cymbalta, for chronic pain syndrome (CPS), was administered outside of the two-hour parameters six times out of 16 opportunities. -Furosemide, for fluid retention, was administered outside of the two-hour parameters six times out of 16 opportunities. -Incruse ellipta, for COPD, was administered outside of the two-hour parameters three times out of 16 opportunities. -Insulin glargine, for Diabetes mellitus type II, was administered outside of the two-hour parameters six times out of 16 opportunities. -Levothyroxine sodium, for autoimmune thyroiditis (inflammation of the thyroid), was administered outside of the two-hour parameters six times out of 16 opportunities.-Melatonin, for supplement, was administered outside of the two-hour parameters one time out of 16 opportunities. -Olanzapine, for psychotic disorder, was administered outside of the two-hour parameters one time out of 16 opportunities. -Omega-3, for supplement, was administered outside of the two-hour parameters one time out of 16 opportunities. -Potassium Chloride, for supplement, was administered outside of the two-hour parameters four times out of 16 opportunities. -Vitamin C, for supplement, was administered outside of the two-hour parameters one time out of 16 opportunities. -Zetia, for type 2 Diabetes Mellitus, was administered outside of the two-hour parameters one time out of 16 opportunities. -Zinc, for supplement, was administered outside of the two-hour parameters one time out of 16 opportunities. Resident 6Resident 6 was admitted to the facility on [DATE] with diagnoses including traumatic subdural hemorrhage (bleeding inside the brain, usually caused by a head injury, potentially leading to dizziness, confusion, and weakness). The admission MDS assessment, dated 02/28/2026, showed Resident 6 was cognitively intact.Review of Resident 6's Medication Administration Audit Report, dated 02/24/2026 through 03/11/2026, showed the following medications were not administered within the nursing standard of practice window of one hour prior to the ordered administration time to one hour after the ordered administration time (a two-hour timeframe):-Acetaminophen, for pain, was administered outside of the two-hour parameters one time out of 16 opportunities. -Amlodipine, for hypertension, was administered outside of the two-hour parameters three times out of 16 opportunities. -Aspirin, for Cerebral Vascular Accident (stroke) prevention, was administered outside of the two-hour parameters one time out of 16 opportunities. -Atorvastatin, for Hyperlipidemia (high levels of fat in the blood), was administered outside of the two-hour parameters three times out of 16 opportunities. -Donepezil, for Alzheimer's disease (a brain disorder that affects memory, thinking, and behavior), was administered outside of the two-hour parameters three times out of 16 opportunities. -Levetiracetam, for spasms, was administered outside of the two-hour parameters two times out of 16 opportunities. -Lisinopril, for hypertension, was administered outside of the two-hour parameters three times out of 16 opportunities. -Multi-Vitamins, for supplement, was administered outside of the two-hour parameters two times out of 16 opportunities. -Senna, for constipation, was administered outside of the two-hour parameters three times out of 16 opportunities. -Zinc, for supplement, was administered outside of (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the two-hour parameters three times out of 16 opportunities. On 04/02/2026 at 11:00AM, Staff B, Registered Nurse and Director of Resident Services, said if there was a blank spot on the MAR or TAR, it meant the medication or treatment was omitted or not charted. While reviewing the January 2026 and February 2026 MAR and TAR for Residents 1 and 2, Staff B noted the blank spots and said those should not be blank. In an interview on 04/06/2026 at 2:00PM with Staff B, after review of the omissions and medication administration times of concern, they stated the administration times were outside of the permitted two hour timeframe and stated, We are making a change to the scheduling of medication administration but there is a lot that goes into it so we have not been able to do it yet. Reference WAC 388.97.1060 (3)(k)(iii)This is a recurring deficiency previously cited on 01/05/2026, 11/18/2025, and 07/31/2025.