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	01/09/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure expired and/or BUE (beyond-use date) medications were discarded when expired from 2 of 5 medication carts (Cart B & Cart E) reviewed. The facility also failed to store medication in residents' room in a locked container for 1 of 1 resident reviewed (Resident 80). This failure placed residents at risk of not receiving the full benefits of the medication, equipment, supplies, and at risk for accessing unsecured medication. Findings included . Expired medications During an observation and review of the E Wing medication cart on 01/09/2026 at 10:22 AM, the cart had two pill packs with expired medication packs. Torsemide (diuretic, or water pill, used primarily to treat fluid retention) 20 mg (milligrams) expiration date 09/21/2025 and Hydralazine (used to treat high blood pressure) 10 mg expiration date 10/11/2025. The cart also had one Ondansetron (used to prevent and treat nausea and vomiting) 4 mg BUE 10/13/2025. During an observation and review of the B Wing medication cart, on 01/09/2026 at 10:58 PM, the cart had two packages of Ondansetron 4 mg's one BUE date 10/30/2025 and the other 12/05/2025. In an interview on 01/09/2026 at 10:22 AM, Staff P, Licensed Practical Nurse (LPN), said expired medication should not be kept in the cart. Staff P said the pharmacist would go through the cart once a month to get rid of the expired medications. In an interview on 01/09/2026 at 10:58 PM, Staff C, Assistant Director of Nursing/Registered Nurse (RN), said expired medications should be removed from the medication cart and destroyed. Unsecured medications Resident 80 was admitted to the facility on [DATE] with diagnosis including unspecified visual field defects. The Annual Minimum Data Set (MDS), an assessment tool, dated 10/13/2025, documented Resident 80 was alert and oriented. Record review of facility's policy, titled, Self-Administration of Medications and Treatments undated, documented . 8. Self-administered medications and/or treatment supplies will be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room.Nursing will transfer the unopened medication to the (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident when the resident requests them. Record review of Resident 80's electronic health record did not show a care plan or assessment for medication self-administration and/or storage. In an observation on 01/06/2026 at 12:14 PM, Resident 80 was observed to have a plastic basin with medication bottles on the shelves near the front of his bed. Resident 80 showed the medications that were in the plastic basin which included bottles of: Super Enzymes for digestion, Alpha lipoic 100mg (milligrams) (anti-oxidant), Multivitamin pure food capsules, Melatonin 3mg (sleep aid), Niacin 500mg (Vitamin), Cranberry capsules 500mg (Vitamin), and Vitamin d3 gummies. In an interview on 01/06/2026 at 12:19, Resident 80 said he occasionally took the medications in his room. When asked where he typically kept his medications, Resident 80 said he kept them in the plastic basin on the shelves. In an observation and interview on 01/06/2026 at 12:28 PM, Staff N, Unit Manager/LPN, observed the basin of medications on Resident 80's shelf and said Resident 80's medications should have been kept in a lockbox that could only be accessed by Resident 80 and licensed staff. In an interview on 01/08/2026 at 12:44 PM, Staff B, Director of Nursing/RN, said it was the expectation that Resident 80 received education on having his own medications in his room and the facility provided Resident 80 with a lock box to store his medications. Reference WAC 388-97-1300(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure staff performed hand hygiene during the lunch hallway meal pass for 1 of 5 hallways (C-Wing) reviewed for lunch meal pass. This failure to perform proper hand hygiene placed residents at risk of cross-contamination, food borne illness and a diminished quality of life. Findings included.During the lunch time dining observation on 01/06/2026 at 1:03 PM, Staff Q, Nursing Assistant (NA), took a meal tray into room [ROOM NUMBER]-B put the tray on the bedside table and pulled the table up to the resident. Staff Q left the room but did not wash or sanitize her hands.In an observation on 01/06/2026 at 1:04 PM, Staff Q grabbed another tray from the cart and took it into room [ROOM NUMBER]. Staff Q placed the tray on the bedside table and pulled the table closer to the resident. Staff Q left the room but did not wash or sanitize her hands.In an observation on 01/06/2026 at 1:06 PM, Staff Q grabbed another tray from the cart and took it into room [ROOM NUMBER]. Staff Q placed the tray on the bedside table. Staff Q left the room but did not wash or sanitize her hands.In an observation on 01/06/2026 at 1:08 PM, Staff Q grabbed another tray from the cart. Staff Q placed the tray on the bedside table and asked another NA for assistance to reposition the resident. Staff Q washed her hands.In an observation on 01/06/2026 at 1:10 PM, Staff Q grabbed another tray from the cart and took it into room [ROOM NUMBER]. Staff Q placed the tray on the bedside table. Staff Q left the room but did not wash or sanitize her hands.In an observation on 01/06/2026 at 1:14 PM, Staff Q grabbed another tray and delivered it to room [ROOM NUMBER].During an interview on 01/06/2026 at 1:15PM, Staff Q stated she was supposed to wash her hands before delivering trays. Staff Q said if she took a tray to a room and touched the bedside table or anything not clean, she was supposed to sanitize or wash her hand. When asked about moving the bedside table in several rooms she stated she was supposed to sanitize her hands. Staff Q said she realized she did not perform hand hygiene.During an interview on 01/08/2026 at 12:29 PM, Staff K, Infection Preventionist/Licensed Practical Nurse, said staff were supposed to wash or sanitize their hands after delivering trays to resident rooms.Reference WAC 388-97-2980

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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 obtain a signed consent before administering a psychotropic medication (medications capable of affecting the mind, emotions, and behaviors) for 1 of 5 residents (Resident 6) reviewed for unnecessary medications. This failure placed the resident 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 Resident 6's Annual Minimum Data Set (an assessment tool), dated 12/18/2025, documented Resident 6 was admitted on [DATE], alert and oriented, and was treated for multiple diagnoses to include anxiety disorder (excessive and persistent fears or worries that interfere with daily life) and bipolar disorder (a mental health condition with significant mood swings of extreme highs and lows that affect the ability to function in daily life). Record review of Resident 6's Order Summary Report documented the following medication ordered on 11/27/2025: Sertraline (an antidepressant and psychotropic medication) 25 MG (milligrams). Give 2 tablet by mouth one time a day for MDD [Major Depressive Disorder, a persistent sadness, irritability, and a loss of interest in activities that once brought joy].Record review of Resident 6's Electronic Medical Records did not show documentation of an informed consent completed for the administration of Sertraline.In a joint interview on 01/08/2026 at 2:27 PM, Staff B, Director of Nursing and Registered Nurse (RN) and Staff E, Regional Nurse Consultant and RN, said Resident 6 did not have a consent for Sertraline in their records. In a joint interview on 01/09/2026 at 11:04 AM, Staff B and Staff E said it was their expectation residents on psychotropic medications had consents signed prior to administration of the medication. Reference WAC 388-97-0260

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, the facility failed to ensure residents who had personal fund accounts established, received accrued interest on those accounts for 3 of 3 sampled residents (Residents 16, 76, and 98) reviewed for Trust Funds interest accrued. This failure placed residents at risk not to receive or have access to monies owed to them.Findings included .Record review of Resident 16's Resident Fund Statement, quarterly statement for the period of 10/01/2025 thru 12/31/2025, showed four credits totaling $7,140.40, four debits totaling $6,801.64, and an ending balance of $381.58. The Statement further showed, YEAR-TO DATE INTEREST PAID. 0.00.Record review of Resident 76's Resident Fund Statement, quarterly statement for the period of 10/01/2025 thru 12/31/2025, showed four credits totaling $2,761.00, three debits totaling $2,343.66, and an ending balance of $852.02. The Statement further showed, YEAR-TO DATE INTEREST PAID. 0.00.Record review of Resident 98's Resident Fund Statement, quarterly statement for the period of 10/01/2025 thru 12/31/2025, showed three credits totaling $6,789.00, five debits totaling $6,671.66, and an ending balance of $123.12. The Statement further showed, YEAR-TO DATE INTEREST PAID. 0.00.In an interview on 01/09/2026 at 2:40 PM, Staff L, Business Office Manager (BOM), said Resident 16, Resident 76, and Resident 98 had their money in an interest-bearing account. When asked why it did not show any interest paid to Residents 16, 76, and 98 on their last quarterly statement, Staff L said over the last quarter they were not dispersing the interest accrued properly.In an interview on 01/09/2026 at 3:23 PM with Staff A, Administrator, Staff D, Regional Director, and Staff M, Regional BOM, Staff M said the interest was not divided correctly to the residents and they needed to fix it. Staff M said every resident account that had over fifty dollars in it accrued interest. Staff M said they did it wrong at the facility, stating, .I've already told them they need to fix it.Reference WAC 388-97-0340 (a)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a Medicare Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN - a notice of Medicare non-coverage and residents assumption of financial responsibility) to 1 of 3 residents (Resident 16) reviewed for beneficiary notification. This failure placed residents at risk of not being informed of services and related changesFindings included.Resident 16 was re-admitted to the facility on [DATE]. The Annual Minimum Data Set, an assessment tool, dated 12/31/2025, documented Resident 16 was severely cognitively impaired.Record review of Resident 16's Notice of Medicare Non-Coverage (NOMNC) form, dated 09/03/2025, showed Resident 16's representative received a call on 09/03/2025, informing them that Resident 16's Medicare Part A coverage would end on 09/05/2025. Record review of Resident 16's electronic health record did not show a SNF ABN was issued.In an interview on 01/09/2026 at 2:36 PM, Staff I, Social Services Director, said Resident 16 was not issued a SNF ABN because staff were unclear about which facility department was responsible for addressing Medicare Part A services which included issuing SNF ABNs. In an interview on 01/09/2026 at 2:47 PM, Staff D, [NAME] Director, said social services was responsible for issuing SNF ABNs and said Resident 16 should have received a SNF ABN notice but did not.Reference WAC 388-97-0300(1)(e)(5)(6)

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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 interview, observation and record review, the facility failed to maintain a clean homelike environment by not ensuring resident rooms were cleaned for 1 of 11 rooms (C Wing, room [ROOM NUMBER]) reviewed for environment. This failure placed residents at risk for a diminished quality of life.Findings included. Review of the Environmental Services Department. In-Services: Daily Resident Room Cleaning, dated 03/09/2015, showed 7. Dust Mop. The entire floor is to be dust mopped; especially behind, under beds and behind dressers.During an observation on 01/06/2026, in room [ROOM NUMBER] a hospital wristband was on the right side of the bed and on the left side of the bed next to the dresser was a tied-up plastic bag with trash in it on the floor.During an observation on 01/07/2026 at 10:03 AM, in room [ROOM NUMBER] the wristband and the bag were in the same location as the day before on the floor.During an observation on 01/08/2026 at 8:40 AM, in room [ROOM NUMBER] the wristband and the bag were in the same location as the day before on the floor.During an interview and observation on 01/08/2026 at 8:49 AM, Staff R, Housekeeping Aide (HA), said she cleaned all rooms daily. Staff R said part of her cleaning included sweeping and mopping the floors. When we went to room [ROOM NUMBER] Staff R was shown and observed the wristband and plastic bag on the floor, Staff R said HA was supposed to sweep and pick up the stuff around and under the bed.During an interview on 01/08/2026 8:56 AM, Staff S, Housekeeping Supervisor Director, said trash should be picked up and the floor should be dust mopped daily. Staff S said the HAs had a guidance checklist to follow.Reference WAC 388-97-0880 (2)

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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 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 [drugs used primarily to treat symptoms such as hallucinations and delusions]) for 2 of 5 sampled residents (Resident 4 &118) 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 . Resident 4 was admitted to the facility on [DATE] with multiple diagnoses to include a psychotic disorder ([other than schizophrenia] a severe mental illness where a person loses touch with reality). The 5-Day Minimum Data Set (MDS, an assessment tool), dated 12/08/2025, showed Resident 4 was alert and oriented. Review of Resident 4's physician order, dated 12/19/2025, showed Resident 4 was prescribed quetiapine fumarate 25 mg (milligrams) at bedtime. The December 2025 and January 2026 electronic medication administration record (EMAR) showed Resident 4 was receiving quetiapine fumarate at bedtime. Review of Resident 4's care plan, dated 12/13/2025, showed the focus Antipsychotics: the resident is at risk of adverse reactions related to the use of antipsychotics. The care plan's intervention AIMS (abnormal involuntary movement scale) assessment as indicated. Review of the Consultant Pharmacist's Medication Regimen Review dated 12/01/2025 and 12/20/2025, Pt's [patient] on quetiapine (Seroquel), an antipsychotic. I was unable to locate a Current AIMS test in chart. Review of Resident 4's electronic health record (EHR) did not show documentation of an AIMS test completed for the administration of quetiapine fumarate. During an interview on 01/09/2026 at 8:34 AM, Staff H, Unit Manager/Licensed Practical Nurse, said an AIMS assessment was needed for a resident on an antipsychotic medication. While reviewing Resident 4's electronic records, Staff H said she could not find an AIMS for Resident 4 but one should have been completed. Resident 118 was admitted to the facility on [DATE] with multiple diagnoses to include depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities). The admission MDS, dated [DATE], showed Resident 118 was severely cognitively impaired and was taking antipsychotic medication. Record review of Resident 118's physician orders, dated 12/31/2025, showed Resident 118 was prescribed quetiapine fumarate (an antipsychotic medication) 37.5 mg at bedtime. The December 2025 and January 2026 EMAR showed Resident 118 was receiving quetiapine fumarate at bedtime. Review of Resident 118's EHR did not show documentation of an AIMS test completed for the administration of quetiapine fumarate. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/09/2026 at 10:34 AM, Staff E, Regional Nurse Consultant/Registered Nurse (RN), said there was not an AIMS test done for Resident 118 and there should have been. In an interview on 01/09/2026 at 12:44 PM, Staff B, Director of Nursing/RN, said an AIMS test should be done upon admission for a resident taking an antipsychotic medication, or when a new antipsychotic medication was started. Reference WAC 388-97-1060 (3)(k)(i)

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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 ensure a written transfer/discharge notice was provided to the resident or the resident representative in a language and manner they understood for 1 of 1 residents (Resident 115) reviewed for hospitalization. This failure placed the resident at risk for not knowing the reason for their transfer or have the opportunity to make decisions about their transfer/discharge rights.Findings included .Record Review of the facility's undated Bed Hold Policy, documented, .Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: .The details of the transfer (per the notice of transfer).Record review of Resident 115's admission Minimum Data Set (MDS, an assessment tool), dated 12/05/2025, documented Resident 115 was admitted on [DATE] and had moderate cognitive impairment.Record review of Resident 115's Nursing Note, dated 12/03/2025, stated, .At 0002 [12:02 am], the patient's granddaughter, present in the room, spoke with the patient's daughter, who requested the patient be transferred to a hospital for evaluation of potential sepsis [the body's extreme response to an infection. It is a life-threatening medical emergency]. Emergency services were called at 0005 [12:05 am], and the patient was subsequently transferred to Legacy Hospital. The on-call provider was notified.Record Review of Resident 115's Electronic Medical Records showed no documentation of a written transfer/discharge notice.Record Review of Resident 115's Nursing Home Discharge MDS, dated [DATE], documented Resident 115 had an unplanned discharge on [DATE].In a joint interview on 01/08/2026 at 2:27 PM, Staff B, Director of Nursing and Registered Nurse (RN) and Staff E, Regional Nurse Consultant and RN, said they were unable to find a Discharge/Transfer notice form for Resident 115. In a joint interview on 01/09/2026 at 11:04 AM, Staff B and Staff E said when a resident was transferred to the hospital they should be sent with an Interact SNF/NF [Skilled Nursing Facility/Nursing Facility] to Hospital Transfer Form. When asked if a resident was transferred emergently how they notified the resident or their representative in writing of the reason for their transfer, they stated it's done verbally over the phone and sent in writing the next business day. Staff B and Staff E confirmed Resident 115 did not have a Hospital Transfer Form filled out, given in person, or mailed to them or their representative. Reference WAC 388-97-0140 (1)(a)(b)(c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, an assessment tool) was completed accurately to reflect a resident's health status and/or care needs for 2 of 2 sampled residents (Residents 39 and 22) reviewed for resident assessment. This failure placed residents at risk for unidentified and/or unmet care needs and a diminished quality of life. Findings included . Dialysis Resident 39 was admitted to the facility on [DATE] with multiple diagnosis to include acute kidney failure (the sudden loss of the kidneys' ability to filter waste and balance fluids in your body) and chronic kidney disease, stage 4 (severe kidney damage). The Quarterly MDS, dated [DATE], showed Resident 7 was cognitively intact, had acute kidney failure, and was not on dialysis (a life sustaining medical treatment that filters waste products and excess fluid from your body when your kidneys fail). Record review of Resident 39's physician orders, dated 07/01/2025, showed Resident 39 was ordered to have dialysis every Tuesday, Thursday, and Saturday at 3:30 PM at a dialysis center. Record review of Resident 39's care plan, dated 07/01/2025, documented a Focus area, COMMUNITY DIALYSIS: [Resident 39] is at increased risk for complications secondary to requiring hemodialysis [dialysis using an external machine that requires a pathway into the bloodstream] secondary to ESRD [End Stage Renal Disease, the final permanent stage of chronic kidney disease]. Record review of Resident 39's progress notes, dated 10/23/2025, showed Resident 39 went to her dialysis appointment on 10/23/2025. Record review of Resident 39's October 2025 Electronic Treatment Administration Record (ETAR), showed Resident 39 went to dialysis on October 23rd and October 25th, 2025. In an interview on 01/09/2026 at 9:53 AM with Staff F, MDS Nurse/Registered Nurse (RN), and Staff G, MDS Nurse/Licensed Practical Nurse, Staff F said they gathered information for completing the MDS through interviews with the resident and Electronic Health Record (EHR) review. When asked about how Resident 39's dialysis was coded on the Quarterly MDS, dated [DATE], Staff G looked at Resident 39's EHR and said Resident 39 went out to dialysis on October 23, 2025. Staff F said dialysis should have been captured on the MDS and it was not. In an interview on 01/09/2026 at 11:19 AM, Staff B, Director of Nursing/RN, said it was her expectation the MDS was completed to accurately reflect the resident and their care needs. Hospice Resident 22 was admitted to the facility on [DATE] with multiple diagnosis to include Alzheimer's disease (brain disorder). The Annual MDS dated [DATE], documented Resident 22 was severely cognitively declined. (continued on next page)

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Salmon Creek Post Acute & Rehabilitation	2811 NE 139th Street Vancouver, WA 98686

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 22's physician order, dated 08/06/2025, showed Resident 22 was admitted to hospice services. Record review of Resident 22's care plan, dated 01/26/2025, documented Resident is admitted to hospice services .with expected decline in condition due to terminal progressive disease related to advanced age, debility and failure to thrive. Record review of Resident 22's Annual MDS, dated [DATE], showed Resident 22 was not receiving hospice care. In an interview on 01/08/2026 at 12:55 PM, Staff F and Staff G said Resident 22 was receiving hospice services. When asked if hospice was coded in the Annual MDS, dated [DATE], Staff G said hospice was not captured on the MDS and it should have been. Reference WAC 388-97-1000 (2)(n)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 develop a comprehensive care plan for 1 of 1 sampled resident (Resident 116) reviewed for comfort care (medical focus shifts from curing an illness to providing relief from pain and symptoms).This failure placed residents at risk of unmet care needs and a diminished quality of life.Findings included.Resident 116 was admitted to the facility on [DATE]. The Significant Change Minimum Data Set, an assessment tool, dated 11/18/2025, documented Resident 116 was moderately cognitively impaired. Record review of Resident 116's Portable Orders for Life-Sustaining Treatment, dated 11/11/2025, documented Resident 116 was on comfort care. Record review of Resident 116's care plan, dated 12/11/2025, showed a care plan for comfort care was developed a month after Resident 116 was placed on comfort care.In an interview on 01/08/2026 at 12:50 PM, Staff B, Director of Nursing/Registered Nurse, said it was the expectation that Resident 116's care plan was updated when Resident 116 level of care changed to comfort care. Reference WAC 388-97-1020(1)(2)(a)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance with grooming for 1 of 4 residents (Resident 80) reviewed for activities of daily living. This failure placed residents at risk of unmet care needs and a diminished quality of life. Findings included.Resident 80 was admitted to the facility on [DATE] with diagnosis including unspecified visual field defects. The Annual Minimum Data Set (MDS), an assessment tool, dated 10/13/2025, documented Resident 80 was alert and oriented. Record review of Resident 80's electronic health record, showed resident was scheduled for and received showers on Tuesday, Friday and Sunday. In an interview on 01/06/2026 at 12:45 PM, Resident 80 said the facility staff did not help him shave his facial hair. Resident 80 was observed with unkempt facial hair during the interview. Resident 80 said he was unable to shave himself and needed assistance from staff. In an observation on 01/08/2026 at 1:59 PM, Resident 80 was observed with unkempt facial hair. Resident 80 said staff did not assist him with shaving. He stated, they keep saying I have an electric shaver, it has never worked.In an interview on 01/08/2026 at 2:14 PM, Staff O, Certified Nurse Assistant, said Resident 80 received showers in the evening and the staff were to assist him with shaving. Staff O said Resident 80 required assistance with shaving due to his visual impairment. Staff O said Resident 80 used to have an electric shaver, but it might have broken. In an observation on 01/09/2026 at 9:20 AM, Resident 80 was observed with unkempt facial hair.In an interview on 01/09/2026 at 10:09 AM, Staff B, Director of Nursing/Registered Nurse said it was the expectation that staff were to assist residents with shaving. Reference WAC 388-97-1060(2)(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 interviews and record reviews, the facility failed to ensure bowel interventions were initiated for 1 of 8 sampled residents (Resident 74) reviewed for quality of care and failed to perform ordered weights for 1 of 5 residents (Resident 13) reviewed for weights. This failure placed residents at risk for discomfort, health complications and a diminished quality of life.Findings included . Resident 74 was admitted to the facility on [DATE]. The Modification of Quarterly Minimum Data Set (MDS, assessment tool), dated 12/16/2025, documented the resident was alert and oriented. Review of Resident 74's Electronic Health Record (EHR) order, dated 06/04/2025, documented, Polyethylene Glycol Powder [laxative]. Give 17 grams by mouth as needed for Constipation. Dissolve in 8oz [ounce] fluid and drink daily as needed. Review of Resident 74's EHR order, dated 06/29/2025, documented, Bisacodyl [laxative] Rectal Suppository 10 MG [milligrams]. Insert 1 suppository rectally every 24 hours as needed for constipation. The Bowel and Bladder Elimination task sheet showed Resident 74 had a Bowel Movement (BM) on 01/01/2026 at 08:33 PM, and did not show another BM until 01/06/2026 at 06:00 PM, over 117 hours (five days) since his previous documented BM.Review of Resident 74's January 2026 Medication Administration Record (MAR) showed the bowel protocol was not initiated between the dates of 01/01/2026 and 01/06/2026.In an interview on 01/09/2026 at 10:57 AM, Staff H, Unit Manager/ Licensed Practical Nurse, said nursing staff received daily BM reports in the morning, and administer bowel medications per orders. Staff H said the administration of bowel interventions should be documented, including refusals, and stated, I would expect something administered on the 4th.In an interview on 01/06/2026 at 02:33 PM, Staff E, Regional Nurse Consultant/ Registered Nurse, said the BM protocol should have been initiated and documented as ordered. Staff E said Resident 74 routinely refused care, including BM medications. Staff E was unable to produce documentation of bowel interventions for Resident 74. Resident 13 was admitted to the facility on [DATE]. The 5-day MDS, dated [DATE], indicated that Resident 13 was renal insufficient and required dialysis treatment (a life sustaining medical treatment that filters waste products and excess fluid from your body when your kidneys fail). Resident 13 was alert and oriented Review of Resident 13's EHR order, weight one time a day. Review of Resident 13's Medication Administration Record (MAR), dated December 2025, had no documented weights for 12/01/2025, 12/02/2025, 12/06/2025, 12/09/2025, 12/11/2025, 12/13/2025, 12/15/2025, 12/18/2025, 12/20/2025, 12/21/2025, 12/29/2025 and 12/30/2025. Review of Resident 13's MAR, dated January 2026, had no documented weights for 01/01/2026, 01/02/2026, 01/04/2026, 01/05/2026 and 01/07/2026. Review of Resident 13's dialysis communication log had no documentation for 12/01/2025, 12/02/2025, 12/06/2025, 12/11/2025, 12/13/2025, 12/15/2025, 12/18/2025, 12/20/2025, 12/21/2025, 12/29/2025, 12/30/2025, 01/01/2026, 01/02/2026, 01/04/2026, 01/05/2026, and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/07/2026. During an interview on 01/08/2026 at 10:57 AM, Staff K, Unit Manager/Licensed Practical Nurse, said weights should be documented in the EHR. Staff K said if the resident refused the refusal should be documented. While reviewing the EHR, Staff K said she could see several weights were not completed. Reference WAC 388-97-1060 (1), (3)(c)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain physician orders for oxygen use for 1 of 2 sampled residents (Resident 83) reviewed for respiratory care. This failure placed residents at risk for worsening health complications, unmet care needs, and a diminished quality of life.Findings Included. Record review of the facility's policy titled, Oxygen Administration, undated, documented .1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Resident 83 was admitted to the facility on [DATE], discharged return anticipated on 12/19/2025, and re-admitted on [DATE] on hospice. The admission Minimum Data Set, (an assessment tool) dated 11/11/2025, showed Resident 83 was cognitively intact and was on oxygen therapy. In an observation on 01/06/2026 at 10:52 AM, Resident 83 was observed lying in bed with oxygen on per nasal cannula (NC) running at 3 liters per minute (lpm). In an observation on 01/07/2026 at 10:01 AM, Resident 83 was observed lying in bed with oxygen on per NC running at 3 lpm. Record review of Resident 83's care plan, dated 12/24/2025, documented a Focus, RESPIRATORY DISEASE: [Resident 83] is at risk for respiratory complications secondary to supplementary oxygen requirement.Oxygen 2L [2 liters] via NC for comfort. Record review of Resident 83's readmission progress note, dated 12/23/2025, documented, .on oxygen. Record review of Resident 83's progress note, dated 01/06/2026, documented, .Resident uses continuous oxygen via nasal canula. Record review of Resident 83's progress note, dated 01/07/2026, documented, .Resident uses continuous oxygen via nasal canula. Review of Resident 83's Electronic Health Record (EHR) showed no physician's order related to use of oxygen. In an interview on 01/09/2026 at 11:01 AM, Staff H, Unit Manager/Licensed Practical Nurse, said a physician's order was needed for residents using oxygen. After looking at Resident 83's EHR, Staff H said she did not see an order for oxygen use after the readmission to the facility and there should have been. In an interview on 01/09/2026 at 11:10 AM, Staff B, Director of Nursing/Registered nurse, said it was her expectation residents using oxygen had physician's orders in place for oxygen use. Reference WAC 388-97-1060 (1)(3)(vi)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on interview and record review, the facility failed to ensure resident census and nursing hours were accurately posted and/or updated daily for 30 of 30 days reviewed for nurse staff postings. This failure placed residents, resident representatives, and visitors at risk of not being fully informed of the current staffing levels and resident census information.Findings included.Record review of facility's policy titled, Posting Nursing Staffing Information Policy dated 10/06/2022, documented, I. The facility will post the following information daily, at the beginning of each shift. The posting shall include:. d. The information should reflect staff absence on each shift due to call-outs and illness.e. Resident Census.Record review of the daily nursing staffing information postings, from 12/07/2025 to 01/06/2026 did not show resident census posted daily.In an interview on 01/09/2026 at 11:05 AM, Staff H, Staffing, reviewed the Daily Nursing Staffing Information postings from 12/07/2025 to 01/06/2026 and said they did not include resident census on them. Staff H said the nurse staffing data reflecting staff absence or changes at the beginning of each shift was updated the next day and not on the actual date/shift the changes occurred. In an interview on 01/09/2026 at 1:08 PM, Staff B, Director of Nursing/Registered Nurse, said it was the expectation that staffing changes were adjusted every shift and the resident census was updated daily on the Daily Nursing Staffing Information postings.Reference WAC 388-97-1620(2)(b)(i)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff properly donned (putting on) personal protective equipment (PPE) for 1 of 3 sampled resident rooms (room [ROOM NUMBER]) reviewed for infection prevention and control. This failure placed residents at risk for the spread of infection transmission in the facility and a diminished quality of life.Findings included. Record review of the facility's policy titled, Transmission-Based Precautions [TBP, extra infection control measures used in healthcare settings for people with known or suspected infections that spread easily], dated 02/01/2022, documented: .Contact Precautions [infection control measures used to prevent the spread of infections that are transmitted through direct contact with an infected person or their environment]. 2. Personal Protective Equipment (PPE)A. Glovesa. Staff and visitors will wear gloves when entering the room for all interactions that may involve contact with the resident and/or the resident's environment.b. Staff and visitors will remove gloves and perform hand hygiene prior to leaving the resident's room.B. Gownsa. Staff and visitors will wear a gown when entering the room for all interactions that may involve contact with the resident and/or the resident's environmentb. Staff and visitors will remove the gown and perform hand hygiene prior to leaving the resident's room. In an observation on 01/08/2026 at 12:46 PM, a sign was observed posted on the wall to the left of the door entrance to room [ROOM NUMBER] that showed: Contact PrecautionsEVERYONE MUST: clean their hands, including before entering and when leaving roomPROVIDERS AND STAFF MUST ALSO Put on gloves before room entry.Discard gloves before room exit.Put on gown before room entry.Discard gown before room exit . In an observation on 01/08/2026 at 12:50 PM, Staff J, Certified Nursing Assistant, entered room [ROOM NUMBER] with a lunch tray. Staff J did not don gloves or a gown prior to entering room [ROOM NUMBER]. Staff J set the lunch tray down on the bedside table placed over the bed and talked to the resident lying in bed. A visitor was observed in room [ROOM NUMBER] sitting next to the bed with a gown and mask on. Staff J then picked the lunch tray up off the bedside table, exited the room without cleaning her hands, and placed the lunch tray back in the food cart. In an interview on 01/08/2026 at 12:53 PM, when asked Staff J what the process was for entering and exiting a room for a resident on contact precautions, Staff J said she would put on gloves or a gown when providing one on one care or changing a resident. Staff J then looked at the contact precautions sign on the wall outside of room [ROOM NUMBER] and said they should have gowned and gloved whenever they went into the room. In an interview on 01/08/2026 at 12:50 PM, Staff K, Infection Preventionist (IP)/Licensed Practical Nurse, said she expected staff to put on a gown and gloves when they entered the room for a resident on contact precautions, even when delivering a food tray. Staff K said Staff J should have put on a gown and gloves when she entered room [ROOM NUMBER]. In an interview on 01/08/2026 at 3:06 PM, Staff B, Director of Nursing/Registered Nurse, said she expected staff followed the TBP, such as contact precautions, indicated for a resident and room per the IP's directions and directions posted at the door. Reference WAC 388-97-1320 (1)(a)