STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505530	A. Building B. Wing	02/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington State Walla Walla Veterans Home	92 Wainwright Drive Walla Walla, WA 99362

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify hazards and risks to ensure the resident's environment remained free of accident hazards for 1 of 3 residents (Resident 80) reviewed for hospitalization. The failure to consistently complete a thorough safety assessment of Resident 80's environment with the use of their powered wheelchair (w/c) caused Resident 80 to experience harm when they drove their powered w/c off a curb and sustained an injury that required hospital and surgical intervention. Findings included . Resident 80 Review of the resident's medical records showed they admitted with diagnoses to include bladder cancer (the uncontrolled growth of abnormal cells in the body), wet macular degeneration (an eye condition that causes blurred or reduced central vision, and can cause distortions, such as straight lines that appear to be bent), and myopia (an eye condition that leads to vision loss) of an unidentified eye/eyes. The 11/22/2025 comprehensive assessment showed Resident 80's cognition was intact, had impaired vision, and wore eyeglasses. The assessment showed the resident required one to two staff assistance with activities of daily living and used a motorized (powered) w/c for mobility. Review of a 12/28/2025 incident investigation report at 10:08 AM, showed a call came over the communication radio from the activities department that there was a resident observed outside, in the parking lot, and they had fallen out of their w/c and onto the pavement. The staff found Resident 80 had driven off the end of the sidewalk/curb, causing them to fall out of their w/c. The report showed Resident 80's body was twisted and appeared to be resting on the top of the left leg, and the left leg appeared to be deformed (distorted from the usual shape or form) and could not move on their own. Additionally, Resident 80 received cuts and scrapes on their left knee, hands, fingers and toes. The report showed the resident thought there was a ramp at the end of the sidewalk that that went down into the parking lot, and it was too late to stop when they realized there was not a ramp. Paramedics were called and Resident 80 was sent to the hospital. The report showed the investigation concluded on 01/03/2026 (six days after the incident, and not within the required five days to rule out abuse and neglect) with no updates to the care plan in regard to the fall and the safety awareness of the powered w/c (there was no care plan for the powered w/c prior to or after concluding the incident). The report showed there were no witness statements obtained from the activities staff that observed the fall and called out on the radio, or from the second Nursing Assistant (NA) and Licensed Nurse that were first to find the resident, education provided, or in-services regarding w/c safety and following resident care plans. Review of the 12/28/2025 hospital records showed Resident 80 was admitted to the hospital for surgical repair of a comminuted (a bone that was broken or shattered in three or more pieces), angulated (the bone was slightly bent or angled), and displaced (the bone fragments were moved out of alignment) fracture to their upper left leg. Review of a 01/04/2025 Power-Mobility Indoor Driving Assessment showed the environment Resident 80 was assessed in was SNF [Skilled Nursing Facility] indoor and the resident had five years' experience with the current, personally owned, powered w/c and could not transfer in and out of the w/c without the assistance of two staff and a mechanical lift (a mechanical device used to transfer a person with limited mobility from one surface (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	to the other). The assessment showed Resident 80 requested to use the w/c for appointments only. The assessment showed the resident was unable to open the automatic or regular doors on their own, refused to complete parallel parking or parking under a table, and required staff assistance or supervision going up and down a ramp, going backwards, and with maneuvering unexpected obstacles. The assessment showed the resident was assessed to be hesitant, required several tries, required speed restrictions, and/or bumps walls and objects lightly for manipulating a congested area and maneuverability. The result of the assessment showed, in the opinion of the assessor, Resident 80 was able to drive independently with no restrictions (indoors). Review of Resident 80's 12/11/2025 care plan showed a care plan for Resident 80's impaired visual function with interventions dated 12/23/2024 to remind and ensure resident was wearing their eyeglasses when up and a magnifying glass was used to read fine print. The care plan showed no care plan had been developed for the use and safety of the powered w/c. During an interview on 02/26/2026 at 3:52 PM, Staff M, Director of Rehabilitation Services, stated normal processes were to assess residents in their powered w/c in their indoor and outdoor environments for safety. Staff M stated Resident 80 refused to be assessed outdoors because they had no plans to use the w/c outside independently. Staff M stated Resident 80 was not assessed again after the 01/04/2025 (11 months and 24 days prior to the incident) assessment because they did not get out of bed for what seemed like a year. Staff M stated the resident received a new powered w/c around the middle of summer and the vendor showed the resident how to use the functions on the wheelchair and how to load and offload from the bus for appointments but that was the extent of the assessment. Staff M stated the therapy assessment was not the final decision for the use of the w/c, it was the decision of the Interdisciplinary Team as a whole. Staff M stated they would have expected the same staff supervision and assistance to be provided, per the assessment, whether Resident 80 was inside or outside. During an interview on 02/26/2026 at 4:02 PM, Staff H, Registered Nurse, stated they had given Resident 80 their medication around 8:00 AM to 8:30 AM on the morning of 12/28/2025, and at that time educated the resident how important it was for them to get up and out of bed. Staff H stated it was a constant battle of encouraging the resident to get up and rarely ever did. Staff H stated when they heard the call over the radio that a resident had fallen out of their w/c outside, they were shocked to see that it was Resident 80. Staff H stated they asked the resident what they were doing and the resident told them they had gone outside for some fresh air and didn't realize there was a curb at the end of the sidewalk. Staff H stated Resident 80's eyesight was really bad, and they did not have their eyeglasses on. Staff H stated Resident 80 was not known to get out of bed let alone go outside on their own. During an interview on 02/27/2026 at 10:02 AM, Staff G, Registered Nurse/Resident Care Manager, stated it was a huge challenge to get Resident 80 out of bed and into their powered w/c and that they preferred to stay in bed all the time. Staff G stated Resident 80 had a history of refusing to follow their plan of care (obtaining weights, blood pressures, fluid retention interventions, and getting up for mobility). Staff G stated the only time Resident 80 was up in their powered w/c was for an appointment and they would sit by the front door and wait for the bus to arrive and either a staff member or the bus driver would take them to the bus. Staff G stated a staff member was required to escort the resident to their appointments because the resident was unable to maneuver the w/c by themselves while holding onto appointment packets/paperwork. Staff G stated Resident 80 was not known to be outdoors without someone with them and it was unknown if the resident could open the doors on their own, but if not, staff would have to have opened the door for them if they could not. Staff G stated Resident 80 received a new powered w/c and was very large and top heavy and because the resident was taller, their longer legs unbalanced the w/c, and the w/c had to be tilted in a backward seat position to maneuver the little lip of the ramp on the bus. Staff G stated Resident 80 did have vision issues and was to wear glasses when up but often refused them. Staff G stated they would often see Resident 80 reading, large print, without their glasses. Staff G stated they should have developed a care plan for Resident 80's powered w/c but since the resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	never used the w/c, it was missed. Staff G stated Resident 80's recent visit to the hospital for heart failure (12/08/2025), refusals of care, treatments/medication, refusals to wear their eyeglasses, and to get up and out of bed, and changes in their powered w/c with minimal use and knowledge of it, were not indicative of notifying therapy for a new safety assessment. Staff G stated normal process was to assess use of equipment quarterly and with any change of condition but did not feel there had been any change in the resident since they were alert and oriented and were able to communicate that. During an interview on 02/27/2026 at 11:29 AM, Staff B, Director of Nursing Services, stated there were no other witness statements for Resident 80's incident on 12/28/2025. Staff B stated the process was that every resident with a powered w/c was assessed for safety. Staff B stated they did not know what the assessments entailed or how they were completed because they were completed by therapy. Staff B stated they would have expected the assessments to be completed in any environment that the resident was going to be using the w/c in and then reassessed quarterly and for any changes. Staff B stated they would have expected the powered w/c to be care planned with interventions and realized during the investigation that had not been done. During an interview on 02/27/2026 at 11:43 AM, Staff A, Administrator, stated they did not know whether residents were assessed with the use of their powered w/c inside and outside and did not feel that it would make much of a safety difference if only one or the other environment was assessed. Staff A stated the residents were free to come and go as they please and they could not keep them from doing what they wanted to do even if they were assessed to be unsafe. During an interview on 02/27/2026 at 12:23 PM, Staff U, Activities Assistant, stated on the morning of 12/28/2025, they exited out of the facility door at one end of the building when they observed Resident 80 exiting out the door at the other end of the building. Staff U stated they had to look twice because they could not believe they were seeing Resident 80 out of their bed, in their w/c and outside. Staff U stated Resident 80 continued down the long sidewalk towards the curb to the parking lot, then right before reaching the curb, where the sidewalk ends and splits to the right or the left, the resident slowed down as if they were assessing the area, and then all of a sudden, sped up faster and went straight, off the curb, causing their w/c to flip over forward. Staff U stated they immediately called for assistance on the radio and by the time they reached the resident, other NAs had already come out, and they all met up at the same time. Staff U stated Resident 80 was not wearing glasses at the time and was awake. Staff U stated they thought they completed a witness statement but then again, could not remember if they had or had not. During a telephone interview on 03/04/2026 at 4:00 PM, Staff A, along with Staff B, stated when residents refused a complete and thorough evaluation for safety in their powered w/c then the resident would not have been able to use the equipment or they would have obtained a signed risk and benefit detailing the importance of the assessment and the risks if the resident chose not to follow them. Staff B stated that was not done with Resident 80. Staff B stated their expectation of assessments would be to obtain a new assessment when a new w/c was received or with a change in their condition. Staff A stated in the middle of 2025 (exact date could not be provided), Resident 80 received a new manual w/c because they did not like their powered w/c and the powered w/c was only to be used for appointments. Staff A stated there were no other w/c safety assessments completed for Resident 80 other than the initial w/c assessment dated [DATE], right after admission. Staff A stated the LN staff would have had to request a safety evaluation for the new w/c and that had not been done. Staff B stated direct care nursing staff would have known which w/c to use by following the Kardex (information used by direct care staff when providing the resident with their care needs), but since there was no w/c care plan, they would not have known to transfer the resident to their manual w/c rather than to the powered w/c. Reference: WAC 388-97-1060 (3)(g)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a Preadmission Screening and Resident Review [(PASARR) a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment] accurately reflected residents' mental health conditions for 4 of 8 residents (Resident 5, 12, 13, and 7) reviewed for unnecessary medications. This failure placed the residents at risk for inappropriate nursing home placement and/or not receiving timely and necessary services to meet their mental health needs.Findings included.Resident 5 Review of the medical record showed Resident 5 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder [(PTSD) a mental health condition triggered by witnessing or experiencing terrifying events, such as violence, accidents, or disasters], depression, anxiety, and dementia (a progressive syndrome characterized by severe cognitive decline that interferes with daily life). The 02/09/2026 comprehensive assessment showed Resident 5 was independent with activities of daily living [ADLs) activities related to personal care] and moderate assistance of one staff member for showers. The assessment also showed Resident 5 had an intact cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses). Record review of a PASARR Level I form updated 05/06/2025, showed Resident 5 did not have a diagnosis of dementia, despite the diagnosis listed in their medical record. Resident 12 Review of the medical record showed Resident 12 was admitted to the facility on [DATE] with diagnoses including dementia, depression, anxiety, and PTSD. The 01/17/2026 comprehensive assessment showed Resident 12 required substantial/maximum assistance of one staff member for ADLs. The assessment also showed Resident 12 had a severely impaired cognition. Review of a PASARR Level I form dated 10/28/2025, showed no diagnosis of anxiety listed as a serious mental health indicator and showed they did not have a diagnosis of dementia. The form showed the resident was admitted with an exempted hospital discharge (requiring fewer than 30 days of nursing facility services). There was no updated PASARR Level 1 form in the medical record, despite staying past the 30-day exempted stay. Resident 13 Review of the medical record showed Resident 13 was admitted to the facility on [DATE] with diagnoses including PTSD and depression. Theˆ01/09/2026 comprehensive assessment showed Resident 13 requiredˆsetup/clean upˆassistanceˆof one staff member for activities of daily livingˆ[(ADLs)ˆactivities related to personal care]ˆand was independent with ambulation and transfers.ˆThe assessment also showedˆResident 13 had no memory issues and was able to make independent decisionsˆregardingˆdaily life. Review of a PASARR Level I form dated 10/01/2025, showed Resident 13 had a serious mental illness indicator of a mood disorder. There was no documentation of the resident's diagnosis of PTSD. Resident 7Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses including a system wide infection, Post-Traumatic Stress Disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event), insomnia (difficulty falling or staying or returning back to sleep), Bipolar disorder (a mental illness that causes extreme shifts in an individual's mood, energy, and activity levels), anxiety and substance abuse. The 02/03/2026 comprehensive assessment showed the resident was cognitively intact and able to make their needs (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	known. Review of Resident 7's Level I PASARR form, dated 01/13/2026 showed SMI of PTSD and anxiety were marked down. The SMI did not include the resident diagnosis of bipolar disorder or substance abuse and the resident did not have a Level II referral sent due to being assessed as an exempt hospital discharge (meeting the criteria of the individual likely requiring fewer than 30 days in the facility and a Level II would be completed if not discharged with the 30 days). During an interview on 02/26/2026 at 12:48 PM, Staff C, Social Worker, stated the process for ensuring PASARR's were complete and accurate included screening the referral on admission and assessing for a Level II evaluation (an in-depth, person-centered evaluation triggered by a positive Level 1 screen to determine if an individual required specialized services) if needed. If the resident had a mental health diagnosis, a Level II evaluation would be required prior to admission. If the resident arrived at the facility and there were diagnoses not listed or identified on the admission packet, the facility would complete an accurate Level I PASARR and a Level II evaluation if indicated. When a resident has an exempted hospital discharge status, the facility would need to screen for a referral if they were in the facility longer than the 30 days. Staff C stated they did not have a tracking process for residents that admitted to the facility with the exempted hospital status. Staff C stated they completed an audit of all PASARR's on 02/23/2026 and had identified several inaccurate PASARRs. Staff C stated they did not catch those inaccuracies upon admission. During a continued interview on 02/26/2026 at 1:13 PM, Staff C stated that Resident 7 was an exempted hospital discharge and should have had a Level II referral sent on 02/14/2026 and the resident was currently 12 days over that. Staff C stated the correct process for the facility's PASARR referrals was not being completed. Reference: WAC 388-97-1915(1)(2)(a)(b)(c)

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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, interview, and record review, the facility failed to discard expired foods and complete daily cleaning tasks for 6 of 8 kitchens ([NAME], Umatilla, Palouse, [NAME], [NAME], and [NAME]) and 1 of 1 dry storage area, and the facility failed to consistently monitor cooked food temperatures prior to serving regular and pureed food for 1 of 3 staff (Staff W) observed for safe and sanitary kitchen. This failed practice placed residents at risk for Food borne illness (caused by consuming foods that are contaminated with harmful pathogens [bacteria that reproduce rapidly once entered in the body and can damage tissues and cause illness]). Findings included.Kitchens [NAME] An observation and concurrent interview on 02/25/2026 at 12:07 PM, showed. Three 13.5-ounce (oz., a unit of measure) containers of Strawberry Jello, expired 02/21/2026 one six oz. container of cottage cheese with blueberries, expired 01/26/2026 16 round individual cream cheese, dated 12/19/2025 with no use by date Three 25 oz cartons of concentrated orange juice, expired 02/13/2026 One clear gallon sized baggie with frozen hashbrowns or white cheese, unlabeled and no use by or opened date One clear gallon sized baggie, one quarter full (a unit of measure), of frozen pepperoni slices, unlabeled, dated 11/05/2025, with no use by date. One-clear gallon sized baggie, one quarter full, of frozen beef meat balls, dated 10/29/2025 with no use by date One package of frozen rice, dated 12/23 with no use by date One clear gallon sized baggie of frozen white/tan food with no label or open or used by dates The ice machine was observed to have a vent to the left side that had dried on splatters of food and dust particles and dried brown and white food on the refrigerator doors and handles. Staff AA stated the cooks were to monitor the refrigerators and freezers for expired or old food and discard them. Staff AA stated food is to be labeled and the open/prepared date and the use by date should be on all food. Staff AA stated they did not know how often frozen foods should be kept once opened. Umatilla (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and concurrent interview of the on 02/25/2026 at 12:46 PM showed. Two 25 oz cartons of concentrated orange juice, expired 02/13/2026 One square, clear carton of mixed berries, store bought, expired 02/17/2026 (belonged to resident or staff) Three 13.5 oz cartons of Strawberry Jello, expired 01/24/2026 One eight oz bag of soy protein powder, half used, with no dates One 32 oz bag of slithered almonds, three quarters full-no dates One gallon size clear baggie of walnuts, half full, no dates or label One five-pound (lb., a unit of measure) turkey meat, thawing, with no dates One bag of open and frozen, half used cheese ravioli, not labeled or dated One container of Oikos vanilla yogurt, expired 01/19/2026 One 11 oz can of strawberry milkshake (belonged to resident or staff) unlabeled or dated One clear baggie with 12 oatmeal/chocolate chip cookies, with no label or dates One blue baggie with 12 sausage dogs, no label or dates One gallon size clear baggie, half full, with tater tots, no labels or dates The ice machine was observed to have a vent to the left side that had dried on splatters of food and dust particles. Staff BB stated they were an on-call cook that had been working full-time for the past two months. Staff BB stated they last checked for expired or old food last week. Staff BB stated the fruit and the strawberry milkshake were not products the facility used and should not have been in the refrigerator. Staff BB stated they did not know how long frozen foods should be kept for once they were opened but that all foods should have been dated and labeled. An additional observation and concurrent interview on 02/27/2026 at 9:11 AM, Staff FF, removed the cover to the left side of the ice machine, exposing the coils (condenser). The coils had a thick layer of gray, fuzzy dust. Staff FF stated they had a cleaning cycle with cleaning solutions, they could use a cleaning. Staff FF stated the ice machines were cleaned semi-annually. Palouse During an observation on 02/25/2026 at 1:11 PM showed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A clear bag, one fourth full of raw, fresh mushrooms with no dates One clear bag of shredded cheese, no use by date One clear bag of parmesan cheese, shredded, no use by date One three lb. tub of whipped cream cheese spread with no use by date or expiration date Four 25 oz cartons of orange juice that expired on 02/13/2026 Two eight oz packages of frozen grilled chicken, both opened, with no use by dates One five lb. bag of breaded food with no label or no use by or opened date 16 packages of eight waffles each package, frozen, with no labels, use by date, or date opened One green, one lb. bag, with veggie sausage and a use by date of 09/23. An additional observation and concurrent interview on 02/27/2026 at 9:11 AM, Staff FF removed the vent cover and exposed the coils with a thick layer of gray dust on them. Staff FF stated it was time for them to be cleaned. [NAME] During an observation and concurrent interview on 02/26/2026 at 10:41 AM showed. One two-gallon baggie with whitish colored grainy powder, one fourth full, not labeled or a use by date One bag of egg noodles, opened, one fourth full, no dates One clear baggie of fresh potatoes with a date of 01/14/20266 and no use by date One plastic grocery bag, with 12 0.98 oz packages of instant oatmeal, with no dates on the bag or expiration dates on the individual packages One opened, five lb. box of buttermilk biscuit mix, dated 12/27/2025 with no expiration date on the box itself or a use by date. One opened five lb. box of Spice cake mix, dated 12/31/2025, with no expiration date on the box itself of a use by date. One clear gallon size baggie with two clear bags inside, one labeled half batch of coffee cake mix, dated 09/27/2025 and the second bag labeled coffee cake streusel dated 09/27/2025. Neither bag had an expiration date or a use by date One opened clear bag with six frozen pre-made egg omelets, dated 12/31/2025, no use by date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One opened bag of impossible burger patties unlabeled or undated, half full One bag, half full of pepperoni slices dated 09/17 with a use by date of 10/20/2025 One clear bag of a brownish rectangle meat product, dated 02/19 and no use by date One baggie with ten hot dogs, dated 01/07 with no use by date One plastic container, opened, uncovered because the top did not seal, of two lb. Provolone cheese slices, half full. Three 25 oz cartons of concentrated orange juice, expired 02/13/2026 Seven 13.5 oz containers of strawberry Jello, expired 02/21/2026 The ice machine was observed to have a vent to the left side that had built up dust particles and dried food splatters throughout the vent. Also, the left side of the ice machine had a broken, plastic piece, leaving a hole and sharp edges, the size of a 50-cent piece. The refrigerator and freezer doors had dirty fingerprint smears across the doors and in the handles, there was a shallow area that was filled with dirt and food crumbs. The cupboards in the kitchen, below the sink, were warped and missing the outside laminate covering, exposing the surface of the wood or particle board. Inside of the ovens, one on top of the other, there were dust particles hanging down out of the vents, and the areas beside the oven doors, where they close, were built up dust particles. Staff W stated they did not have a process for checking for expired and old foods, it has been a while.hasn't been done this year yet. Staff W stated maintenance was responsible for cleaning the ice machine vents and the cooks were responsible for nightly cleaning. Staff W stated it was not their process to document nightly cleaning. [NAME] An observation on 02/26/2026 at 1:30 PM showed. Two 25 oz cartons of concentrated orange juice, one expired on 02/13/2026 and the second one expired on 01/15/2026 One opened 12 oz bag of brown gravy mix, no dates Two opened 20 oz bag of country gravy mix, no dates One baggie with different colored cookie decorations, dated 8/17/2025, no use by date One opened 24 oz bag of lime gelatin mix, three quarters full, dated 09/04/2025, no other dates One square, clear, container, filled with a white cream, dated 02/04/2026, unlabeled and no use by date One 32 oz package of roasted turkey sandwich meat, full, undated 12 hardboiled eggs in a clear bag, undated (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Greater than 25 small round white patties in a clear bag, dated 02/01/2026, unlabeled Nine four oz cartons of prune juice, expired 09/14/2025 One 16 oz container of whipped cream topping, thawed, undated A bag of cheese slices, yellow, greater than 25 slices, no dates on the bag or the package One plastic backage of reddish/brown circles, unlabeled and undated The ice machine vent had built up dust particles on the outside and some dried food. The glass stove top had broken, jagged, edges of the glass missing on both sides and a crack in the glass across the bottom about one quarter of the way from the left to the right. [NAME] During an on observation and concurrent interview on 02/23/2026 at 12:29 PM, showed the laminate covering in front of the dishwashing sink had been ripped off and was being held together by clamps. Staff (Amber [NAME], Cook) stated the chemical company accidentally pulled that off when their jacket got caught on it the other day, and the clamps were placed there until it gets fixed. The ice machine vent had dust particles in the vents and splatters of dried food. During an observation on 02/26/2026 at 12:08 PM showed. One 12 oz package gravy mix, one fourth full, opened, not sealed, and no dates One 14 oz package of poultry gravy mix, one fourth full, opened, and no dates. One gallon size clear baggie, one fourth full of parmesan shredded cheese, dated 01/11/2026, and no use by date. One package of mixed shredded cheese, half full, opened, not sealed or in a bag, dated 2/22/2025, and no use by date One 12 oz package, with a yellow substance in it, unlabeled, dated Five lbs. of raw bacon in a box, not sealed, with no use by date One 48 oz container of whipped cream cheese spread, opened, with no date. One gallon of balsamic vinegarette dressing, three fourths full, with no use by date. 22 breakfast wraps 2.50 oz. los Cabos [brand name] in a large clear bag, dated opened 08/01/2025 and a use by date of 12/01/2025. The wraps had egg, cheese, potato, and cooked sausage in them. Dry Storage (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12 Containers of Orange Juice Concentrate-25 oz., expired 02/13/2026 One 28 oz. box-Gluten Free Cream of [NAME] Hot Cereal, expired 09/17/2023 During an interview on 02/27/2026 at 9:30 AM, Staff V, Dietary Manager, stated the food should be labeled with the name, date the food was made or opened, and the date the food was to be used by. Staff V stated the cooks had been given new food labels to use and had been educated on them, but it's a work in progress. Staff V stated their expectation of the cooks was to clean things as they cooked and then to clean daily and as needed. Staff V stated they had floats [additional staff] that came in to clean and organize for a more deep cleaning. Staff V stated they did not document cleaning to keep track of when it had been completed and to track who had completed the cleaning. Staff V stated they used the floats to complete cleaning audits and identify areas that needed worked on. Staff V stated they did not monitor the float/auditor staff or the cooks, to ensure the audits were being done or to ensure the identified areas were being cleaned daily. Staff V stated they had recently put into place a system with a sign that showed how long certain foods should have been kept once opened or used, but the signs were not observed in the kitchens and when asked, the cooks went by how long they thought something should be kept before discarding it. They could not identify a thorough process for discarding foods. Staff V stated they did not know how the cooks would know when individual bulk packages expired because the cooks shared out of a box and they would assume the date would have been on the box. During an interview on 02/27/2026 at 12:16 PM, Staff B, Director of Nursing Services, stated the process for cleaning and maintenance of the ice machines should have been completed according to the schedule and the manufacturer's instructions. Temperatures An observation and concurrent interview on 02/26/2026 11:08 AM, Staff W, Cook, was preparing for lunch in the [NAME] kitchen. The food warmer cart was set to 150 degrees Fahrenheit (F, a unit of temperature) and on the top of the cart were two bowls of fresh pears, two bowls of chocolate pudding, and six cups of freshly baked brownies. The top of the warmer was warm to the touch. At 11:22, Staff W started to prepare pureed textured food and removed cauliflower out of the oven, without checking the temperature, and placed it into the blender. Staff W then added warm water to the blender, blended cauliflower, and then a piece of fish (no temperature check upon removing from the oven), and then added the blended food to the plate and still did not check the temperatures once completed. At 11:36 AM, Staff W began to serve out lunch, Tilapia (a type of fish), potato wedges, cauliflower, chocolate pudding, and brownies. In the bottom of the oven, that was set at 170 F, was holding two baked potatoes, a small pot of mashed potatoes, and the plate of pureed food. Staff W began putting food onto the plates, when the Surveyor stopped them to ask them if they were going to check the temperatures of the food they just cooked. Staff W stated, yes, I can do that, opened the drawer to obtain the thermometer and stated, I need to go get one, mine must have been taken. The temperatures showed. Tilapia, 170.6 F Potato Wedges, 167.5 F (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cauliflower 165.2 Chocolate pudding (sitting on the top of the warmer), 63.5 (was to be a cold food) Mashed potatoes, 150 F Pureed plate of food, 193 F Staff W discarded the pudding and the pears and served a different dessert to replace the warm pudding. Staff W stated the pears were to be a cold dessert as well and they knew they would be warm and discarded them. Staff W placed a metal sheet pan of white rolls onto a three-tiered rolling cart that had food crumbs on all three tiers and was soiled with dried on food. During a follow-up interview at 3:42 PM, Staff W stated they documented food temperatures on a food temperature log. Review of the food temperature log for the lunch meal showed the three temperatures that were logged for the main courses, the fish, cauliflower, and potato wedges, were 160 F, 161 F, and 160 F, none of those were temperatures observed when the food was done cooking. Staff W stated they checked food temperatures once a meal, at the time they started to prepare the pureed food. Staff W stated they did not check the temperatures of the pureed food after it was prepared. During an interview on 02/27/2026 at 9:30 AM, Staff V stated the cooks should have checked temperatures of the food when the food was done cooking and then again before the food was served out but I would need to check the policy to make sure that's correct. During an interview on 02/27/2026 at 12:10 PM, Staff A, Administrator, stated they would have expected Staff V to be monitoring their kitchens for cleanliness, completeness of tasks, and broken equipment or items that needed to be repaired. Staff A stated they were not aware of the cracked ice machine, the broken glass top on the stove, or the missing laminate on the cupboards that exposed non-cleanable surfaces. Reference: WAC 388-97-1100 (2)(3)

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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 ensure, 1) residents on as needed (PRN) psychotropic medications (drugs that affect brain activities associated with mental processes, emotions and behavior) were limited to 14-days or had a documented rationale for the extended use of the PRN psychotropic and, 2) that non-pharmacological interventions (alternative treatment of a resident's symptoms that are directed toward understanding, preventing and relieving a resident's distress or loss of abilities and do not involve the use of medications) were consistently attempted to reflect an adequate need of the medication for 2 of 5 residents (Residents 7 and 35) reviewed for unnecessary medications. This failure placed residents at an increased risk for experiencing medication-related adverse side effects, and unmet care needs. Findings included . Review of the facility's policy titled, Psychotropic Medication Use, dated February 2025, showed that PRN psychotropic medications were limed to 14-days unless the facility's provider documented a clinical rationale for extending the use of the psychotropic medication beyond 14-days. The policy showed that PRN antipsychotic (a type of psychotropic drug used to manage symptoms like hallucinations [a false perception of objects or events involving your senses that seem real, but are not], delusions [a false belief or judgement about external reality, held despite evidence contradicting it]and disordered thoughts) medication could not be renewed unless the provider evaluated the resident and documented the appropriateness of the medication for that resident. The policy showed that residents on psychotropic medications were to be monitored for behavioral and non-pharmacological interventions .to minimize or eradicate (to put an end to) the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction (a steady calculated decrease in dosage to determine if symptoms or conditions can be managed with a lower dose or discontinuation of the medication) which would be documented in the residents medical record. Resident 7Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses including a system wide infection, Post-Traumatic Stress Disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event), insomnia (difficulty falling or staying or returning back to sleep), Bipolar disorder (a mental illness that causes extreme shifts in an individual's mood, energy, and activity levels), anxiety and substance abuse. The medical record showed they returned to the hospital on [DATE] and re-admitted on [DATE] with a diagnosis of an infection within the abdomen. The 02/03/2026 comprehensive assessment showed the resident was cognitively intact, able to make their needs known, and was currently taking an antipsychotic medication. Review of Resident 7's physician orders for medication showed: On 01/28/2026 Prochlorperazine (a specific type of antipsychotic medication, that can also be used for controlling severe nausea and vomiting) was ordered to be administered PRN every six hours for nausea and vomiting. Additionally, the Prochlorperazine order showed indefinite (lasting for an unknown or unstated length of time). On 02/03/2026 monitoring/non-pharmacological interventions were ordered for Resident 7's episodes of nausea/vomiting along with use of the PRN antipsychotic (six days after the PRN antipsychotic Prochlorperazines was ordered). Additionally, the documentation of the non-pharmacological interventions were to include effectiveness, complaints of gas pain/nausea/vomiting, number of episodes occurring each shift and attempts of; offering carbonated soft drinks, encouraging deep breathing, small sips of water and offering a salty snack. Review of Resident 7's medication/treatment administration record (MAR) for January 2026 through February 2026, showed the resident was given the Prochlorperazine medication 10 times from 02/06/2026 to 02/25/2026. Additionally, the MAR showed no documentation of non-pharmacological attempts made for the resident regarding the antipsychotic medication Prochlorperazine. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/26/2026 at 10:23 AM, Staff EE, Registered Nurse/Resident Care Manager, stated that PRN antipsychotic medication were limited to 14-days, could not be renewed unless the provider evaluated/documented the appropriateness of the medication for that resident, and if used beyond the 14-days the provider would document a rationale for extending the use of the medication. Additionally, for PRN psychotropic medications, the non-pharmacological interventions would be implemented and documented in the resident's medical records. During an interview on 02/26/2026 at 1:08 PM, Staff C, Social Services, stated that Resident 7's Prochlorperazine was ordered after the resident had readmitted on [DATE] for nausea/vomiting and should have been limited to 14-days due to the medication being a PRN psychotropic medication or have a documented rationale for the extended use. Staff C stated the Prochlorperazine should have non-pharmacological interventions implemented/attempted regarding Resident 7's PRN psychotropic. After reviewing Resident 7's medical records, Staff C stated, I don't see the extended use justification and it should have been completed 14-days after the order was started. Additionally, Staff C stated they were unable to find non-pharmacological interventions were being attempted and the correct process for Resident 7's 14-day PRN/non-pharmacological interventions was not being completed. During an interview on 02/27/2026 at 10:46 AM, Staff B, Director of Nursing Services, stated that Resident 7's PRN psychotropic medication should have had the required documented rationale for the extended use of the Prochlorperazine and non-pharmacological interventions were being attempted/offered to the resident. Staff B stated the process for Resident 7's PRN Prochlorperazine and non-pharmacological interventions was not completed correctly. Resident 35Review of the medical record showed they were admitted to the facility on [DATE] with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), insomnia (a sleep disorder that may include trouble falling asleep and/or staying asleep) and anxiety (feeling of worry, nervousness or unease). The 12/12/2025 comprehensive assessment showed Resident 35 required substantial/dependent assistance of one to two staff members for activities for daily living and had severe impaired cognition. Review of Resident 35's November 2025, December 2025, January 2026 and February 2026 Medication Administration Record (MAR), showed a, 10/21/2025 physician order for Ativan (anti-anxiety medication) 1 milligram (mg-unit of measure), for end-of-life care (the comprehensive support that focuses on physical, emotional, social, and spiritual needs to manage symptoms of the dying process), agitation, seizure (a loss of consciousness and violent muscle contractions) or intractable (difficult to control) nausea and vomiting to be given by mouth every six hours as needed (PRN) with no end date. Further review of the November 2025 through February 2026 MARs, showed Resident 35 had a total of 10 administrations of Ativan. During an interview on 02/25/2026 at 9:13 AM, Staff D, Registered Nurse (RN), stated Resident 35 was ordered Ativan for air hunger (difficulty in breathing and/or breathing sufficiently) and end-of-life stuff, comfort care only. Staff D stated Resident 35 rarely was provided Ativan. Staff D stated they did not know how long PRN orders were to be prescribed for. During an interview on 02/25/2026 at 9:47 AM, Staff E, Resident Care Manager, stated Resident 35 could be combative and hysterical at times. Staff E stated Resident 35's condition was unique as they would be in bed for a few days, then stay up for three days. Staff E stated the goal was to keep them comfortable and the Ativan was used for sleep. During an interview on 02/27/2026 at 9:13 AM, Staff F, RN, stated Resident 35's Ativan did not work for them. Staff F stated Resident 35 was provided Ativan when they became aggressive with care, including punching, biting, hitting and paranoia with staff. Staff F stated the Ativan was used as a last resort to help decrease the behaviors and the medication hardly worked and would take hours to be effective. During an interview on 02/27/2026 at 10:28 AM, Staff B, Director of Nursing Services, stated Resident 35 did not have a (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis for end of life. Staff B stated the Ativan was for end of life as a PRN medication order. Staff B stated to use a PRN medication for over 14 days, there needed to be a justification to use beyond the 14 days. Staff B stated Resident 35 did not have Staff B stated they believed Resident 35 did not need the order for Ativan as they were not end of life. Reference: WAC 388-97-1060(3)(k)(i)

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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. Based on observation, interview, and record review, the facility failed to recognize a change in condition for 1 of 3 residents (Resident 13) reviewed for hospitalization and follow physician orders as written for 3 of 4 residents (Resident 8, 6, and 80) reviewed accuracy of physician orders related to fluid restrictions and hospitalization. This failure placed all residents at risk for delay in treatment, medical complications, and negative health outcomes. Findings included. Review of a policy titled, Change in a Resident's Condition or Status, revised 12/2016, showed the facility would promptly notify the resident, their attending physician, and representative of changes in the resident's medical/mental condition and/or status. The nurse would notify the resident's attending physician or physician on call when there had been a significant change in the resident's physical/emotional/mental condition. A significant change of condition is a major decline in the resident's status that would not normally resolve itself without intervention by staff or implementing standard disease-related clinical interventions. Review of a policy titled, Encouraging and Restricting Fluids, dated 10/2010, showed the general guidelines included following specific instructions concerning fluid intake or restrictions, accuracy when recording fluid intake, and encouraging the resident's family and visitors to stay within the limits of their intake. Staff should remove the water pitcher and cup from the resident room. If the resident refuses to have the water pitcher removed, the resident's physician would be notified. Change In Condition Resident 13 Review of the medical record showed Resident 13 was admitted to the facility with diagnoses including iron deficiency anemia (a common condition where blood lacks healthy red blood cells due to insufficient iron), heart failure, and kidney disease. The 01/09/2026 comprehensive assessment showed Resident 13 required setup/clean up assistance of one staff member for activities of daily living [(ADLs) activities related to personal care] and was independent with ambulation and transfers. The assessment also showed Resident 13 had no memory issues and was able to make independent decisions regarding daily life. Review of Staff G's, Registered Nurse (RN), nursing progress note (PN) dated 11/21/2025 at 1:33 PM, showed Resident 13 was not eating that day and had stated they were too shaky and refused to work with therapy as they were too short of breath when not using their continuous positive airway pressure [(CPAP) a machine that blows a continuous, steady stream of air through a tube and mask to prevent the airway from collapsing while sleeping]. Review of Staff C's, Social Worker, social services PN dated 11/21/2025 at 5:20 PM, showed Resident 13 had increased anxiety and refused to participate in therapy. The resident was noted to be pale in appearance, lying in bed covered with a blanket with CPAP in place while awake. Resident 13 reported they had no appetite, decreased their therapy participation due to difficulty breathing when not utilizing their CPAP, and were having increased tremors that had worsened. Resident 13 reported they felt they were physically unable to participate at that time and were concerned about their health. The PN showed nursing and primary care provider were notified of Resident 13's concerns. Review of Staff H's, RN, nursing PN dated 11/23/2025 at 1:21 PM, showed Resident 13 was lying in (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed with both hands up in the air attempting to catch something. When asked if they were feeling well, Resident 13 stated they were seeing speckles and dots and was trying to catch them. The note showed Resident 13 did not appear at baseline, was oriented only to self, and thought they were at their brother's house. They did not recall what the year, time, or date was. Resident 13 had mild, slurred speech and their blood pressure was 91/53 mmHg (millimeters of mercury – the standard unit of measurement for blood pressure, with normal readings typically measuring 120/80 mmHg). Resident 13's primary care provider was notified and recommended transfer to the local emergency room for evaluation. Review of Staff I's, RN, nursing PN dated 11/24/2025 at 12:10 AM, showed they had contacted the local emergency room for a status update on Resident 13. Staff I was informed that the resident was not returning to the facility and had been transferred to a regional medical center for further treatment. Review of Staff J's, RN, nursing PN dated 11/24/2025 at 4:24 AM, showed Resident 13 was admitted to the regional medical center and had received a blood transfusion of two units of packed red blood cells (200-300 milliliters of concentrated red blood cells per unit) and a bolus (a rapid infusion of a large volume of intravenous fluid – 500 milliliters or more - to quickly restore blood volume and increase blood pressure) to stabilize the resident's condition. Resident 13 also received a medication to lower their potassium level of 7.0 mmol/L (millimoles per liter – a unit of measurement, with the normal levels between 3.5 – 5.2 mmol/L, levels above 5.2 can cause muscle twitching, shaking, and cramping, along with fatigue and breathing difficulties). During an interview on 02/26/2026 at 8:42 AM, Staff G stated Resident 13 had started to develop a tremor and was not as active as they normally were. They stated they remembered a nurse reporting something didn't look right in regard to the resident's condition. They stated Resident 13 was short of breath and needed to use their CPAP. Staff G stated when they spoke with Resident 13 on 11/21/2025, they were pale and had been in bed a lot and were complaining of being shaky. Staff G stated Resident 13 had a history of frequent health concerns and did not recall them looking as bad as what was noted. Staff G stated if the provider had been contacted regarding the resident's condition, there should have a been a nursing progress note in the record. During an interview on 02/26/2026 at 3:57 PM, Staff C stated when they visited Resident 13 on 11/21/2025, they were gray in color, which was not normal for them. Resident 13 complained of being fatigued and were not feeling well. Staff C stated the resident kept their CPAP on during the entire interaction. They stated they reported Resident 13's condition to the nurse on duty and the resident's primary care physician. During an interview on 02/26/2026 at 3:18 PM, Staff K, RN, stated they worked on 11/21/2026 and did not recall any reports of Resident 13's condition. They stated when they received a concern regarding a resident's condition, their process included completing a full resident assessment and reporting any acute findings (sudden, severe, or rapidly developing symptoms) to the primary care provider, depending on the severity of the symptoms. Staff K stated they did not recall Staff C reporting any concerns regarding Resident 13's condition. During an interview on 02/27/2026 at 8:32 AM, Staff L, Medical Director, stated they were informed of the resident's change in condition (on 11/23/2025) and had informed the nurse at that time, that they would not be able to assess the resident due to time constraints and recommended sending Resident 13 to the emergency room. Staff L stated if the social worker had alerted the nurse to a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change in Resident 13's condition on 11/21/2026, the nurse should have done an evaluation of the resident's condition and notified them of any acute changes at that time. During an interview on 02/27/2026 at 8:46 AM, Staff M, Director of Rehabilitation Services, stated Resident 13 had been participating in therapy services regularly and had progressively complained of a lot of fatigue. They stated Resident 13 was motivated to do therapy but was not doing well health wise and had refused their scheduled sessions on 11/20/2025 and 11/22/2025, the two sessions prior to their transfer to the hospital. During an interview on 02/27/2026 at 9:00 AM, Staff B, Director of Nursing Services, stated the process for addressing and monitoring a resident's change in condition included the licensed nurse completing a thorough assessment, notifying the provider, and placing the resident on alert charting for monitoring. Staff B stated they would have expected the nurse to follow that process once they were notified by Staff C. Fluid Restriction Resident 8 Review of the medical record showed Resident 8 was admitted to the facility with diagnoses including kidney failure, high blood pressure, and heart failure. The 01/08/2026 comprehensive assessment showed Resident 8 required substantial/maximum assistance of one staff member for ADLs. The assessment also showed Resident 8 had a severely impaired cognition. Review of physician orders dated 12/03/2025, showed fluid restriction: 1500mL (milliliter – a unit of measurement)/day (700 day, 700 eve, 100 noc (night). Review of the medical record showed total fluid intake from the licensed nurses and nursing assistants (NA) as follows: 02/14/2026 total: 2580 mL, 1080 mL over the fluid intake allotment (the amount of something given to a person). 02/15/2026 total: 2480 mL, 980 mL over the fluid intake allotment. 02/16/2026 total: 2580 mL, 1080 mL over the fluid intake allotment. 02/17/2026 total: 2460 mL, 960 mL over the fluid intake allotment. 02/18/2026 total: 2520 mL, 1020 mL over the fluid intake allotment. 02/19/2026 total: 2460 mL, 960 mL over the fluid intake allotment. 02/20/2026 total: 2540 mL, 1040 mL over the fluid intake allotment. During a concurrent observation and interview on 02/25/2026 at 8:43 AM, Resident 8 was at the entrance of their room. There was a water tumbler on their beside table that was half full and an empty coffee cup. Resident 8 stated when I see water I drink as much as I want. They stated the staff gave them juice or water whenever they asked for it. Resident 8 stated they did not know that they (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were on a fluid restriction. During an interview on 02/25/2026 at 8:30 AM, N, NA, stated they tried to limit the fluids that Resident 8 consumed. They stated the resident had a water tumbler in their room that staff refilled at 6:00 AM and 2:30 PM every day. Staff N stated the water tumbler held 720 mL of fluid. They stated Resident 8 had an extra cup of coffee in their room that morning that added an extra 240 mL to their intake, but they did not include that in their charting. Staff N stated they did not report the total resident fluid intake to the nurse but charted it in the medical record. They stated Resident 8 asked for extra fluids all the time and the nurses were aware of it. During an interview on 02/25/2026 at 8:49 AM, Staff O, RN, stated they did not know exactly how much fluid Resident 8 was consuming, that it was more of an estimate. They stated Resident 8 went to the multipurpose room during the day and they were unsure of how much fluid was consumed there. Staff O stated the fluid restriction was mostly an encouragement and the probability of exceeding the daily limit was likely. Staff O stated it was assumed that Resident 8 consumed what the kitchen served, the NA's kept track of that, and the licensed nurses kept track of what they gave. Staff O stated there was a good process in place to monitor fluid intake, and they felt, with their current process, they could get very close to an accurate number. During an interview on 02/25/2026 at 9:13 AM, Staff B, Director of Nursing Services, stated the NA's documented what they gave the resident and the licensed nurses documented what they gave, and they total that intake for the day. During a follow up interview at 11:25 AM, Staff B stated the facility had a process in place for monitoring fluid restrictions, but the staff were not following it. Staff B stated the facility needed to ensure residents were willing to follow a fluid restriction, and if not, they should be completing risks and benefits, notify the provider, and possibly discontinue the order. Resident 6 Review of Resident 6's medical record showed diagnoses including End Stage Renal Disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), dependance on dialysis (a procedure to remove waste products and excess fluid from the blood), diabetes (excess sugar in the blood) and heart failure. Review of the 01/15/2026 comprehensive assessment showed Resident 6 was independent with ADLs and had an intact cognition. Review of Resident 6's medication administration record (MAR) for February 2026 showed physician orders for an 1800 ml fluid restriction for kidney failure. The order was written as 240 ml with breakfast, lunch and dinner, other fluids to be divided as 480 ml on day shift, 480 ml on evening shift, and 120 ml of night shift. Document ml consumed on each shift outside of meals and medication pass. A second physician order showed to administer 120 ml of fluid with each medication pass four times a day. The February 2026 MAR showed a third order for Nepro (a high therapeutic nutritional liquid supplement for people on dialysis) one time a day and to document the ml consumed. Review of the February MAR showed from 02/01/2026 through 02/27/2026, 240 ml was consumed every morning. During an observation and concurrent interview on 02/25/2026 at 12:01 PM, showed a 22-ounce water jug on Resident 6's bedside table. Resident 6 stated they monitored their fluid intake themselves and filled the jug with ice three times a day chewed on the ice and drank the melted ice. Resident 6 stated they kept other drinks in their personal refrigerator, and they had not been asked by staff how much they consumed in a day. Resident 6 stated they were unaware of how much fluid they were allowed to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have in a day. During an interview on 02/26/2026 at 9:07 AM, Staff N, NA, stated Resident 6 was provided with an ice pitcher in the morning and chewed on the ice. Staff N stated it was hard to say the definite amount Resident 6 consumed. During an interview on 02/26/2026 at 9:19 AM, Staff P, RN, stated Resident 6 had an 1800 ml fluid restriction. Staff P stated the nurses were to document the fluid intake with their medication administration, the fluid intake for breakfast, lunch and dinner and the nursing assistants were to document how much Resident 6 took with their meals. During an interview on 02/26/2026 at 2:35 PM, Staff T, Licensed Practical Nurse, stated they were unaware if Resident 6 was on a fluid restriction. Staff T stated if they were they would ask the NA's how much fluid was consumed. During an interview on 02/26/2026 at 2:38 PM, Staff Q, RN, stated Resident 6 was on an 1800 ml fluid restriction. Staff Q stated it was hard to know exactly how much fluid Resident 6 consumed, and they just documented what amount of fluid the order showed. During an interview on 02/27/2026 at 10:35 AM, Staff B stated the fluid restriction process needed to be a combined intake of fluids from the nurses, NA's and a discussion with the residents on how much was consumed. Staff B stated the current process for fluid intake needed to be reevaluated and the current process was not working. Accuracy of Physician Orders Resident 80 Review of the resident's medical record showed they admitted with diagnoses to include congestive heart failure (CHF, a condition where the heart cannot pump blood efficiently, which leads to fluid buildup in the body, and respiratory failure (when your lungs cannot get enough oxygen into the blood). The 11/22/2025 comprehensive assessment showed Resident 80's cognition was intact and required one to two staff assistance with ADLs. Review of Resident 80's 12/08/2025 hospital discharge notes showed the resident was admitted to the hospital for fluid retention (when the body accumulates too much fluid in the tissues). The notes showed Resident 80 required 17 pounds (lbs., a unit of measure) of fluid to be removed. Review of the notes showed one new order for Metolazone (a medication used to remove fluid from the body) five milligrams (mg, a unit of measure) to be given every 72 hours as needed for a weight gain of three lbs. or more for two or more days in a row. The notes showed changes to the medication Resident 80 had previously taken, Bumetanide (a medication that helps reduce fluid build-up) one mg twice a day and one additional tablet to be taken for a weight gain of three lbs. or more in a 24-hour period or five lbs. or more in any seven-day period. The baseline weight was to be obtained by the facility upon readmission. Both medications were used for Resident 80's CHF. The notes additionally showed detailed notes of how these two medications should be administered as follows. Weight goes up three lbs. in a 24-hour period from baseline, take the additional bumetanide (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The next day, if the weight is back to baseline, continue as normal, but if weight has gone up three or more pounds from baseline, give additional dose of Bumetanide and the dose of Metolazone. The following day, if weight has returned to baseline, continue as normal, but if the weight has continued to climb after the doses of Bumetanide and Metolazone, then it's time to return to the hospital. Review of Resident 80's weights showed no weight had been obtained on readmission until 12/11/2025 (three days after readmission) at 3:19 PM of 255 lbs., which would be used as the baseline weight. Review of Resident 80's December 2025 Medication Administration Records (MAR), showed an order dated 12/08/2025 for Metolazone as written in the discharge notes on 12/08/2025 and an order dated 11/14/2025 for Bumetanide, one mg twice daily for edema (swelling caused by fluid build-up in the body) with no other details to show there are additional directions or orders for increased weight gain. There is a second 11/14/2025 order that showed Bumetanide one mg every 24 hours as needed for fluid retention, and can give an extra one mg for fluid retention once a day. The orders showed no other orders for the changes of weight parameters ordered on 12/08/2025. There was an order dated 12/12/2025 (four days after readmission) to obtain daily weights. Additionally, the MAR showed. 12/12/2025, weight was 255 lbs., no weights on 12/13/2025 and 12/14/2025 (refused). 12/15/2025, weight was 258 lbs. (three pounds over baseline), dose of Bumetanide should have been given, but was not. 12/16/2025, weight was 261lbs. (six pounds over baseline), dose of Bumetanide should have been given, along with the dose of Metolazone, but only the Metolazone was given. 12/17/2025, weight was still 261 lbs. (six pounds over baseline), no additional doses of medications were given. 12/18/2025, weight was back to baseline, 255lbs. 12/19/2025, weight was 265 lbs. (ten pounds over baseline), no additional medications were given. No weight was obtained on 12/20/2025 (refused). 12/21/2025 and 12/22/2025, weight was four lbs. greater than baseline, 12/23/2025, weight was 11.5 lbs. greater than baseline, 12/25/2025 weight was six lbs. greater than baseline, and no additional medications were given. 12/27/2025, weight was eight lbs. over baseline, Bumetanide was not given, but Metolazone was, and 12/28/2025 weight was seven pounds over baseline, and no additional medications were given. During an interview on 02/27/2026 at 10:19 AM, Staff G, Registered Nurse, stated they were unaware Resident 80 returned with changed orders to their Bumetanide. Staff G reviewed the 12/08/2025 discharge hospital orders and stated it looked as if the old order was brought forward and the changes were not made as ordered. Staff G stated two nurses reviewed discharge orders on return and they both must have missed the new order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2026 at 11:29 AM, Staff B, Director of Nursing Services, stated their expectation was for one Licensed Nurse (LN) to enter the hospital discharge orders on readmission, and then a second LN would verify the orders entered were correct. Staff B stated for Resident 80, that process was not followed correctly, and the Bumetanide order did not get updated. Reference WAC: 388-97-1060(1)(3)(k)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents who were trauma survivors received culturally competent, trauma informed care (TIC), complete with identified experiences and preferences regarding potential triggers (a stimulus that could prompt a recall of a previous traumatic event even if the stimulus itself is not traumatic or frightening) that may cause re-traumatization (occurs when a current situation triggers the emotional and physical responses of past trauma, making it feel as if the original traumatic event was happening again) for 1 of 4 residents (Resident 7) reviewed for TIC. This failure placed the resident at risk for unidentified triggers and re-traumatization.Findings included .Review of the policy titled, Trauma Informed Care and Culturally Competent Care, dated August 2022, showed that TIC was an approach to care delivery that recognized the widespread impact and signs/symptoms of trauma within the facility's residents and incorporating the knowledge of a resident trauma into the care plan to minimize triggers and/or re-traumatization. The policy showed the resident would be screened to identify possible exposure to traumatic events such as trauma history, trauma related symptoms, interpersonal or developmental concerns, history of mental health diagnosis and substance abuse. The policy showed that an in-depth assessment was completed to identify potential triggers and then develop an individualized care plan with modifications to resident care approaches and strategies in order to minimize or decrease a resident's exposure to triggers that may cause re-traumatization.Review of the resident's medical record showed they were admitted to the facility on [DATE] with diagnoses including a system wide infection, Post-Traumatic Stress Disorder (PTSD, a mental health condition that's caused by an extremely stressful or terrifying event), insomnia (difficulty falling or staying or returning back to sleep), Bipolar disorder (a mental illness that causes extreme shifts in an individual's mood, energy, and activity levels), anxiety and substance abuse. The medical record showed the resident had a previous stay with the facility from 03/04/2025 to 07/04/2025. The 02/03/2026 comprehensive assessment showed the resident was cognitively intact and able to make their needs known. During an interview on 02/24/2026 at 11:18 AM, Resident 7 stated they had discussions about their past traumatic experiences/events with the facility staff before, the connections to the PTSD diagnosis and possible triggers. Resident 7 stated they were trigger when someone did not hear the resident when they were talking or when the resident was not getting the whole story from another individual or another person not showing Resident 7 that the resident was being understood in a conversation.Review of Resident 7's medical record showed no TIC screening or assessment had been completed for the resident.Record review of Resident 7's care plan, dated 01/14/2026 through 02/23/2026, showed no documentation of an individualized TIC focus or intervention plan regarding the resident's history of trauma, potential triggers nor modifications of resident care approaches identified to decrease Resident 7's exposure to triggers that may cause re-traumatization.Review of a progress note dated 05/24/2025, showed that social services noted Resident 7's history of trauma from their childhood, time spent in the military, substance abuse, PTSD and night terrors (a sleep disorder characterized by repeated intense nightmares that mostly center on threats to physical safety and security).During an interview on 02/26/2026 at 10:23 AM, Staff EE, Registered Nurse/Resident Care Manager, stated Social Services was charged with screening/assessments of TIC and developing an individualized care plan for trauma history and a resident's PTSD diagnosis.During an interview on 02/26/2026 at 1:08 PM, Staff C, Social Services, stated their process was to complete a TIC screening/assessment on all the facility's residents when admitted to the facility to identify potential triggers from traumatic events. Staff C stated that a lot of residents denied trauma/triggers due to the population of residents being prior military. Staff C stated that even if a resident denied a history of trauma and had a diagnosis of PTSD, an individualized care plan would have been developed, along with collection of records from the Veteran Affairs regarding (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the residents PTSD diagnosis. Staff C stated that Resident 7 had a history of trauma, and they had just spoken to the resident the other day about how changes and not feeling heard triggered the resident and they would become anxious. After reviewing Resident 7's medical record, Staff C stated that a TIC assessment had not been completed on either of the residents stays at the facility nor had the historical records of Resident 7's diagnosis PTSD been collected. Staff C stated that an individualized care plan regarding the resident trauma history, diagnosis of PTSD or potential triggers was not developed. Staff C stated the correct process for TIC was not completed for Resident 7.During an interview on 02/27/2026 at 10:46 AM, Staff B, Director of Nursing Services, stated that Resident 7 should have been assessed for traumatic experiences, potential triggers that could have caused re-traumatization and had an individualized care plan development regarding the TIC assessment/PTSD diagnosis. Staff B stated the correct process for TIC was not followed. Reference: WAC 388-97-1620(2)(b)(i)(ii)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to maintain a Quality Assurance Performance Improvement (QAPI) program that, 1) included the thorough collection of data/feedback and systematic investigations and/or analysis regarding adverse events (an unexpected, undesirable and usually unanticipated event that causes death or serious injury to a resident) within the facility and, 2) showed actions taken towards development of activities regarding, recent adverse events within the facility, problem prone areas, and contributing factors that could impact quality of care, quality of life, and/or resident safety for 1 of 1 QAPI program, reviewed for quality assessment and assurance. This failure placed residents at an increased risk for unidentified complications, prompted corrective action regarding adverse events and unmet care needs.Findings included .Review of the facility's policy titled, Quality Assurance Performance Improvement (QAPI) Plan, dated 05/15/2025 showed, the facility's QAA/QAPI committee members included the Administrator, Director of Nursing Services (DNS), Infection Preventionist (IP)/QAPI coordinator, Medical Director and other management staff. The policy showed the IP/QAPI coordinator and committee staff were responsible/accountable for developing, leading and monitoring the QAPI program. The policy showed that data/feedback monitored through QAPI included adverse events, which were collected from incident reports and clinical review meetings. The policy showed the IP/QAPI staff member attended clinical review meeting and would be informed of adverse events, patterns/trends identified. The policy showed the committee would prioritize/identify .areas of improvement and rank them by factors such as prevalence, risk, cost, relevance, responsiveness, feasibility (have the ability or being capable of completing the task), and continuity. Performance Improvement Projects (PIP's, a concentrated effort on a particular problem and involves gathering information systematically to clarify issues or problems and intervening for improvements) will be determined from this list. Additionally, the policy showed the QAPI program took systematic action/analysis by utilizing processes to identify PIP opportunities such as; plan, do, study, act (PDSA) and a root cause analysis (RCA).Review of the facility incident log for December 2025, showed on 12/28/2025 Resident 80 had a fall outside of the facility, which they obtained substantial fractures from and were sent to the hospital. Record review of the facility's documents for the quarterly QAA/QAPI meeting conducted on 01/15/2026 showed that Staff GG, IP/QAPI, Staff A, Administrator, Staff B, DNS, and the Medical Director attended the meeting. The documents of the meeting showed, .painted curbs for potential safety concern, and no documentation of the data/feedback collection, systematic investigation and/or analysis regarding the adverse event that had taken place on 12/28/2025. Additionally, no documentation showed that a PDSA nor RCA had been completed towards development of activities regarding recent adverse events within the facility, problem prone areas, and possible contributing factors from the adverse event that could impact quality of care, quality of life, and/or resident safety.During an interview on 02/23/2026 at 12:26 PM, Staff A, Administrator and Staff B, DNS, stated that Staff GG was the IP/QAPI coordinator and both the QAA/QAPI committee were in the same meeting. During an interview on 02/27/2026 at 11:51 PM, Staff GG stated they oversaw the QAA/QAPI committee meetings, arranged the quarterly meetings and had the records of the QAPI meeting information/documents. Staff GG stated the QAA/QAPI committee identified/prioritized the patterns and trends for PIP implementation from the facility's quality measures (statistical analysis of facility's resident information, that can show patterns or trends that can result in an actual or potential undesirable resident outcomes) and did not include adverse events or resident safety concerns. After reviewing QAA/QAPI documents from 01/15/2026, Staff GG stated they did not review Resident 80s adverse event in the meeting nor did they complete a PDSA or RCA, because the fall was not a pattern. Staff GG stated that adverse events and/or abuse would be investigated through the specific incident and not brought/reviewed in the QAA/QAPI meetings. Staff GG stated (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that adverse events like Resident 80's fall with major injury would be noted on the incident log and the DNS would bring that into QAPI, but that was not being done. During an interview on 02/27/2026 at 12:57 PM, Staff B stated they were involved in QAA/QAPI, and they brought data/information from the clinical nursing aspect of the facility into the QAA/QAPI meetings. Staff B stated the committee identified/prioritized information from the quality measure to decide what PIP to start. Staff B stated they did not bring in adverse events or potential abuse concerns, which would be identified on the facility's incident logs, into QAPI. Staff B stated they would have expected that Resident 80's adverse event to be reviewed during the QAPI meeting, due to the potential impact on resident safety, but it was not. Staff B stated they did not review the resident incident log for patterns/trends within QAPI. Staff B stated they should be collecting/analyzing information from adverse events, resident safety concerns, potential abuse allegations, and patterns/trends on the incident log within the QAA/QAPI program. Staff B stated the correct process was not followed. During an interview on 02/27/2026 at 1:13 PM, Staff A stated the collection of data/information and analysis of Resident 80's adverse event investigation was reviewed during a safety committee meeting and was not brought into QAA/QAPI. Staff A stated they did not review/analyze the safety committee's adverse events information during the QAPI committee meetings so all the QAA/QAPI committee members would be involved.Reference: WAC 388-97-1760(1)Cross Reference: F868, F689 for more information.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Quality Assessment and Assurance (QAA) committee included the required members that met at least quarterly (once every quarter of the year or every three months) for 2 of 4 quarters (Q3 2025 and Q4 2025) reviewed for QAA. The failure to meet quarterly increased the facility's risk of unrecognized quality deficiencies, the facility's ability to effectively correct identified issues and ongoing unmet care needs regarding residents' quality of life.Findings included .Review of the facility's policy titled, Quality Assurance Performance Improvement (QAPI) Plan, dated 05/15/2025 showed, the facility's QAA/QAPI committee staff would include the Administrator, Director of Nursing Services (DNS), Infection Preventionist (IP)/QAPI coordinator and the Medical Director. The policy showed the committee would meet quarterly and prioritize/identify .areas of improvement and rank them by factors such as prevalence, risk, cost, relevance, responsiveness, feasibility, and continuity. Performance Improvement Projects (PIPs) will be determined from this list. The policy showed the IP/QAPI coordinator and committee staff were responsible/accountable for developing, leading and monitoring the QAPI program. Record review of the quarterly QAPI meeting documents, from the facility's last annual recertification survey on 12/16/2024 through to 02/27/2026, showed the facility conducted quarterly QAA/QAPI meetings for: Q1 (January, February and March 2025), included the required members. Q2 (April, May and June 2025), included the required members. Q3 (July, August and September), showed the Medical Director did not attend the 08/21/2025 and 09/18/2025 QAPI meetings. Q4 (October, November and December 2025), showed the Medical Director did not attend the 10/16/2025 QAPI meeting. During an interview on 02/23/2026 at 12:26 PM, Staff A, Administrator, and Staff B, DNS, stated that Staff GG was the IP/QAPI Coordinator and both the QAA/QAPI were done in the same meeting. During an interview on 02/27/2026 at 11:51 PM, Staff GG stated they oversaw the QAA/QAPI committee meetings, arranged the quarterly meetings and had the records of the QAPI meeting information/documents. Staff GG stated the Medical Director was one of the QAPI committee members that were required to attend quarterly and would try to have meetings more often than one time every three months. After reviewing the quarterly QAPI meeting documents with the surveyor, Staff GG stated the Medical Director did not attend the QAPI meeting in Q3 or Q4, like they were required to. During an interview on 02/27/2026 at 12:57 PM, Staff B stated the facility's process was to have quarterly QAA/QAPI meetings, which included the Medical Director. Staff B stated they would expect the Medical Director to be attending the quarterly QAA/QAPI meetings. During an interview on 02/27/2026 at 1:13 PM, Staff A stated they would expect the Medical Director to attend the QAPI meetings quarterly and if not, then not the right process for the required QAA/QAPI members. Reference: WAC 388-97-1760(1)Cross Reference: F867