STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505534	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Transitional Care Center of Seattle	2611 S Dearborn Street Seattle, WA 98144

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review the facility failed to provide a comfortable, appropriately sized bed for 1 of 1 resident (Resident 64) reviewed for accommodation of needs. This failed practice placed the resident at risk for discomfort and skin issues.Findings included .<Resident 64>According to a 06/24/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 64 had multiple medically complex diagnoses including partial paralysis and a pain syndrome. The MDS showed staff assessed Resident 64 to have a functional limitation in their range of motion to both their arms and legs and was dependent on staff for their mobility with rolling side to side. In an interview on 09/18/2025 at 10:11 AM, Resident 64 was observed lying in their bed with their feet propped up on pillows over the top of the footboard and their head positioned higher than the top of their mattress. Resident 64 stated they were always uncomfortable when trying to sleep or eat in their bed and described their bed as too small. Resident 64 stated their mattress bowed like a banana with the foot and the head of the bed always raised compared to the middle. Resident 64 stated they asked staff multiple times to help with their mattress because they felt crunched up in bed. Resident 64 stated they were told by maintenance staff their bed was extended to make their bed longer, but the mattress was too small, and a foam spacer was used between the mattress and footboard to fill the extra space. Resident 64 stated the spacer sometimes fell out of place and slid under their mattress. Resident 64 stated they told several staff about this and were told there was nothing else they could do to fix the bed for them.At that time, the foot of the mattress was observed to tilt up and was placed on top of the foam spacer instead of in between the mattress and bed frame. Resident 64 demonstrated how they used the bed remote control to lower the foot of their bed so they could reposition themselves and demonstrated the foot of their bed could not go down to a fully flat position. The foam spacer was under Resident 64's mattress and prevented the mattress from lying flat. Resident 64 stated their bed was very uncomfortable because it was small and the foot of the bed being positioned upwards made it more difficult for the resident to position themself on the side of their bed.Observations on 09/18/2025 at 10:11 AM and 1:29 PM and on 09/19/2025 at 8:52 AM showed the foot of Resident 64's mattress was in an inclined position on top of the foam spacer instead of the spacer being between the mattress and the bed frame.In an observation and interview on 09/19/2025 at 8:52 AM Staff P (Certified Nursing Assistant) stated they were not aware of issues with Resident 64's bed. At this time, Resident 64 told Staff P they could only partially sit up because the foot of the mattress could not fully go down, making it harder for the resident to sit comfortably to eat. Staff P observed Resident 64's foot of bed was tilted upwards and stated there was nothing they could do to adjust the bed, and they would call maintenance to fix it. In an interview on 09/19/2025 at 9:12 AM Staff Q (Resident Care Manager) stated they knew Resident 64's bed mattress moved when they sat along the side of their bed. Staff Q stated the bed was extended as far as it could to accommodate Resident 64's height. Staff Q stated Resident 64's mattress was too small for the extended bed, and a spacer was used between the shorter mattress and the extended footboard. Staff Q stated they were not aware the spacer could slide under Resident 64's mattress making the foot of the bed elevated, and stated Resident 64 would have to call staff to fix the bed each time they were uncomfortable so they could adjust their bed. Staff Q stated there was nothing else they could do to fix Resident 64's bed as their bed was a standard facility bed. Staff Q stated even though Resident 64 was taller than the bed they should still be made comfortable. In an interview on 9/22/2025 at 12:14 PM Staff B (Director of Nursing) stated the facility changed the bed mattress several times and was not aware the bed could not be completely lowered with the foam spacer configuration. Staff B stated the spacer should not have caused problems for Resident 64 and stated the resident needed a longer, more comfortable bed without having to use a spacer. Staff B stated the facility had longer beds to accommodate residents who were taller, and Resident 64 should be provided with a longer bed for comfort and to accommodate their needs but was not. REFERENCE: WAC 388-97-0860(2).

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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. Based on observation and interview, the facility failed to ensure a safe, sanitary, and homelike environment was maintained for 1 (Resident 5) of 1 sampled resident. These failures left the resident at risk for a diminished quality of life and a less than homelike environment.Findings included .<Resident 5> Observation on 09/17/2025 at 9:07 AM showed Resident 5 lying in bed watching television. A 3-drawer cabinet was observed under the television with numerous packages of personal care items and medical supplies on top of the cabinet. Next to the cabinet was a bedside table with several boxes of medical dressing supplies. Underneath the bedside table was an open cardboard box with numerous supplies inside. Between the cabinet and the bedside table were two baskets with disposable medical supplies. The extra bed in the room had a green lift harness draped across the end of the bed with more supplies scattered across the bed. In an interview on 09/17/2025 at 9:33 AM, Resident 5 stated they felt the room was not orderly like they would expect to see at home. Resident 5 stated they would prefer the items remained easily available but not as disorganized and visible. In an observation on 09/18/2025 at 10:24 AM, Resident 5's room appeared unchanged with disorganized medical supplies and personal items. In an interview on 09/18/2025 at 10:42 AM, Staff H (Resident Care Manager) observed Resident 5's room and stated items had begun to pile up, but they thought Resident 5 preferred it that way. Staff H stated Resident 5's room appeared cluttered and disorderly with the lack of storage for supplies. Staff H stated they agreed there was room for improvement to achieve a homelike environment. REFERENCE: WAC 388-97-0880.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and record review, the facility failed to ensure thorough investigations were completed timely for 1 of 2 residents (Resident 6) reviewed for abuse and 1 of 1 (Resident 8) reviewed for falls. Failure to ensure investigations were thorough and completed timely placed residents at risk for further injuries, potential abuse/neglect, and other negative health outcomes.Findings included .<Facility Policy>According to the facility's updated October 2022 Abuse Investigation policy, the facility would complete a thorough investigation of any potential/suspected instances or allegations of abuse, neglect, or exploitation in accordance with state laws. <Resident 6> According to a 08/15/2025 re-entry Minimum Data Set (MDS - an assessment tool) Resident 6 had clear speech, could understand, and was understood by others. In an interview on 09/16/2025 at 1:19 PM Resident 6 stated a staff member was not very nice to them and took their charging power bank with a flashlight. Resident 6 stated they won the power bank in a facility activity, and they wanted the power bank back. Resident 6 stated they talked to Staff JJ (Activity Assistant) about this, and Staff JJ asked them why they kept bothering them about the power bank as the facility provided them with an cell phone with a flashlight and they should be happy about this. Resident 6 stated other staff and residents were in the activity room when the incident occurred and stated they felt Staff JJ was verbally abusive to them when they spoke to them in this manner. Resident 6 stated no one had talked to them about the incident again and they were still upset the power bank was not returned to them. In an interview on 9/18/2025 at 1:17 PM Resident 6 stated no one talked to them again about this incident and they feared retaliation by the staff. Review of investigation notes dated 09/17/2025 showed an investigation was started and called into the state per regulation. The completed investigation notes did not include a full investigation that included other resident interviews or interventions. The investigation did not include a staff background check for the staff involved. Review of the investigation did not show the care plan was updated or that staff was provided with education on reporting verbal abuse. The facility did not provide a full investigation of the incident upon request. <Resident 8> According to the 06/29/2025 Quarterly MDS, Resident 8 had diagnoses including heart failure and a progressive neurological disorder affecting movement, balance, and coordination. The MDS showed Resident 8 had intact hearing, vision, and memory. The MDS showed Resident 8 had no history of falling. According to 09/14/2025 progress notes, Resident 8 was overheard calling for help that afternoon and was found on the floor. Resident 8 stated they slid from their bed trying to get up and did not bump their head. The notes showed around 6:25 PM, Resident 8 reported shortness of breath and was noted to be unable to rise from their bed. Resident 8 was transferred to the hospital at that time. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/23/2025 at 9:29 AM, Staff Z (Registered Nurse) stated the facility did not complete an investigation into Resident 8's fall on 09/14/2025, nine days prior. Staff Z stated they returned from vacation the prior day and the facility had an unusually large number of incidents to investigate in their absence. Staff Z stated adequate arrangements were in place to manage their workload in their absence. REFERENCE: WAC 388-97-0640 (6)(a)(b).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 system by which residents received required written notices at the time of transfer/discharge for 4 of 10 residents (Residents 3, 13, 8, & 60) and report to receiving hospital for 2 of 10 residents (Residents 13 & 60) reviewed for hospitalization. Failure to ensure a written notification was provided to the resident and/or representative in a language and manner the resident and/or representative understood, notify the LTCO as required of the reasons for the discharge, and give a report to the receiving hospital on resident's condition placed residents at risk for a discharge that was not in alignment with the resident's stated goals for care/preferences, and a break in communication and continuity of care.Findings included .<Facility Policy>Review of an updated May 2025 Transfer and Discharge policy showed when the facility transferred or discharged a resident they would document the transfer or discharge in the medical record and appropriate information would be communicated to the receiving care institution or provider. This policy showed when the transfer or discharge was initiated, the resident would receive written notice using the Resident Notice of Transfer or Discharge form. <Resident 3> According to a 07/03/2025 Discharge Minimum Data Set (MDS – an assessment tool), Resident 3 was transferred to an acute care hospital on [DATE] with their “return anticipated.” Review of a 07/03/2025 Nursing Home Transfer or Discharge Notice showed Resident 3 was being transferred to the hospital and was signed by Staff FF (Social Services) for the notice being provided to Resident 3. In an interview on 09/19/2025 at 1:35 PM, Staff FF stated they complete the Transfer/Discharge notice and fax it to the LTCO within 30 days of the transfer. Staff FF stated they did not provide the form to Resident 3 and/or their representative. <Resident 13> According to a 02/15/2025 Discharge MDS, Resident 13 was transferred to an acute care hospital on [DATE] with their “return anticipated.” Review of a 02/15/2025 progress note showed staff documented Resident 13 was having chest pain and was being sent to the hospital by emergency services. Staff did not document they called the hospital to give report of Resident 13’s status. Review of a 02/15/2025 facility hospital transfer form in Resident 13’s records was blank and not filled out by staff, including the section to document report was called to the hospital. In an interview on 09/23/2025 at 4:34 PM, Staff B (Director of Nursing) stated it was their expectation report be given to the receiving hospital to help prepare the hospital for a resident’s condition and background. Staff B stated staff should document the report was given in a resident’s records. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 02/15/2025 Nursing Home Transfer or Discharge Notice showed Resident 13 was being transferred to the hospital and was signed by Staff FF for the notice being provided to Resident 13. In an interview on 09/19/2025 at 1:35 PM, Staff FF stated they complete the Transfer/Discharge notice and fax them to the LTCO within 30 days of the transfer. Staff FF stated they did not provide the form to Resident 13 and/or their representative. Staff FF stated they do not provide the forms to the residents and/or their representatives unless they were being discharged to the community. <Resident 8> According to a 09/14/2025 progress notes, Resident 8 was hospitalized after an unwitnessed fall. The note showed Resident 8 became short of breath and weak and was sent out by ambulance at 6:40 PM. Record review showed a 09/14/2025 Nursing Home Transfer/Discharge Notice showing Resident 8 transferred to the hospital because their needs could not be met at the facility, signed by Staff FF. In an interview on 09/19/2025 at 1:26 PM, Staff R (Social Services Director) stated when residents transferred emergently to the hospital, the facility's business office notified the State Long Term Care Ombudsman (LTCO) office of the transfer by sending out a batch of Nursing Home Transfer/Discharge Notices monthly. In an interview on 09/23/2025 at 3:09 PM, Staff FF stated they sent notification of Resident 8's transfer to the LTCO but did not notify the resident as required. <Resident 60> According to a 05/15/2025 progress note, Resident 60 was transferred emergently to the hospital that day after a change in their condition. Record review showed 05/15/2025 Nursing Home Transfer/Discharge Notice showing Resident 60 transferred to the hospital because their needs could not be met at the facility, signed by Staff FF. In an interview on 09/19/2025 at 1:35 PM, Staff FF stated they sent notification of Resident 60's transfer to the LTCO but did not notify the resident as required. Record review showed a 05/15/2025 Nursing Home to Hospital Transfer Form. This form had an area for nurses to document and sign off that a report was called in to the hospital. This section did not indicate who, if anyone notified the hospital of the resident's condition. In an interview on 09/23/2025 at 5:09 PM, Staff B reviewed the e-interact form and stated someone should have notified the hospital but there was no indication someone did. REFERENCE: WAC 388-97-0120 (2)(a-d) -0140, (1)(a)(b)(c)(i-iii).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to reassess the resident after a significant change in function lasting more than 14 days occurred for 1 (Resident 60) of 19 sample residents. The failure to identify the need for a Significant Change in Status Assessment (SCSA - an assessment tool) after Resident 60 had a decline in their condition placed the resident at risk for unmet care needs and a diminished quality of life. Findings included .<Resident 60>In an interview on 09/16/2025 at 12:56 PM Resident 60 stated they went to the hospital emergently because of bleeding. Resident 60 stated they used to get up and go outside to smoke but since returning from the hospital they could no longer get out of bed. Resident 60 was observed to be in bed at this time.Record review showed Resident 60 was hospitalized from [DATE] and returned to facility on 05/24/2025.According to the 08/07/2025 Annual Minimum Data Set (MDS - an assessment tool) Resident 60 was scored at 00 out of a possible 27 points on a scale indicating no current mood/depression concerns. This MDS showed Resident 60 rejected care one-to-three times during the assessment's lookback period. This MDS showed Resident 60 was totally dependent on staff assistance with upper body dressing, moving from lying to sitting/lying to sitting, and required partial/moderate assistance with rolling from side to side in bed.Review of the 03/31/2025 Quarterly MDS (the last MDS assessment completed prior to the 05/15/2025 hospitalization) showed this was the last MDS assessment completed prior to Resident 60's hospitalization. This MDS showed Resident 60 was scored at 10 out of a possible 27 points on a scale indicating the presence of mood/depression concerns. This MDS showed Resident 60 did not reject care during the assessment's lookback period. This MDS showed Resident 60 required partial/moderate assistance with upper body dressing, was independent with rolling from side to side in bed, moving from lying to sitting/lying to sitting.In an interview on 09/23/2025 at 10:08 AM Staff B (Director of Nursing) compared the information on the 03/31/2025 and 08/07/2025 MDSs and stated they believed Resident 60's declines in three care areas represented a significant change required a SCSA assessment.In an interview on 09/25/2025 1:47 PM Staff N (Corporate MDS Consultant) stated because Resident 60 had sustained declines in their mood, rejection of care, and functional abilities, a SCSA assessment should have been completed after 14 days, but was not.REFERENCE: WAC 388-97 -1000 (3)(b).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Pre-admission Screening and Resident Review (PASRR) assessments were accurately completed prior to or upon admission to the facility or updated with changes with appropriate follow up with the State PASRR office for 3 of 6 (Residents 67, 60, & 68) reviewed for PASRRs. This failure placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health care needs.Findings included . <Facility Policy>According to the facility's 01/01/2025 PASRR Process Policy, if a Level 2 evaluation was indicated on a Level 1 PASSR screening, the social worker would validate within a timely period that an evaluation should occur. This policy showed if there was a significant change affecting a resident's mental health needs, staff would complete and submit a new Level 1 screening.<Resident 67> According to a 09/05/2025 Annual Minimum Data Set (MDS - an assessment tool) Resident 67 had diagnoses including depression and anxiety. Review of Resident 67's record showed a 10/30/2024 Level 1 screening showing the presence of Serious Mental Illness (SMI) indicators including mood disorders and anxiety. The level I PASSR indicated a PASSR Level II referral was required due to the SMI. Resident 67's records did not show a referral for a PASRR Level II was made until 05/08/2025, seven months after the initial assessment. In an interview on 09/23/2025 at 2:06 PM Staff R (Social Services Director) stated a Level 2 PASSR evaluation was important so residents could receive the help they needed with their mental health. Staff R stated they did not make a referral until May 2025 for Resident 67 and did not demonstrate that a Level II referral was made prior to May 2025. <Resident 60> According to the 08/072025 Annual MDS, Resident 60 had medically complex diagnoses including anxiety and a mood disorder characterized by large changes in mood. The MDS showed Resident 60 took an antipsychotic medication. Review of the 04/16/2025 Level 1 PASRR showed Resident 60 was noted with an anxiety disorder and a mood disorder characterized by large changes in mood. This PASRR showed Resident 60 used an antipsychotic medication. Record review showed a 04/29/2025 email to the facility from the State PASRR office thanking the facility for submitting Resident 60's Level 1 screening. This email was a response to the facility's submission of a Level 1 evaluation. Nothing in the resident's record indicated the facility clarified with the State PASRR office that they already submitted the Level 1 or made further follow up regarding obtaining Level 2 services for Resident 60. In an interview on 09/23/2025 2:52 PM, Staff B (Director of Nursing) stated they would provide any information they could provide showing follow up on Resident 60's PASRR. No further documentation was provided. <Resident 68> (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to a 07/11/2025 Quarterly MDS, Resident 68 admitted to the facility on [DATE] and had medically complex diagnoses including an anxiety disorder and required the use of an antidepressant medication during the assessment period. Review of a 04/01/2025 Level 1 PASRR showed hospital staff identified Resident 68 had a SMI indicator but did not identify on the form which SMI as required. This form showed Resident 68 required a Level 2 PASSR referral for having SMI indicators. According to the 04/02/2025 Level 2 PASRR evaluation, Resident 68 was determined not to have any SMI, including an anxiety disorder, due to “no known diagnoses of mental health per chart review” at the hospital. Review of Resident 68’s physician orders showed on 05/20/2025 an antidepressant medication was prescribed to treat an anxiety disorder. Resident 68 continued to receive medications for anxiety and a diagnosis of generalized anxiety disorder was added to the resident’s diagnosis list in the resident’s records. Review of Resident 68’s September 2025 Medication Administration Record (MAR) showed the resident still received an antidepressant medication twice daily for their anxiety disorder. In an interview on 09/23/2025 at 1:43 PM, Staff R stated it was their expectation Level 1 PASRRs were updated with any changes in diagnoses or SMI changes. Staff R stated accurate PASRRs were important to ensure a resident’s mental health needs were addressed. Staff R reviewed Resident 68’s records and stated a new Level 1 PASRR was required. REFERENCE: WAC 388-97-1915(1)(2)(a-c)(4).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to facilitate quarterly care conferences for 2 of 3 residents (Resident 6 & 33) reviewed for care conferences. This failure placed residents at risk for unmet care needs, unnecessary care, frustration, and other negative health outcomes.<Resident 6>According to a 08/15/2025 re-entry Minimum Data Set (MDS-an assessment tool), Resident 6 had clear speech, understands, and was understood by others.In an interview on 09/16/2025 at 1:30 PM, Resident 6 stated no one at the facility talked to them about their care and stated they did not have a care conference recently. Review of Resident 6's records showed the last care conference was on 03/28/2025. A progress note dated 05/08/2025 showed the resident refused a care conference on that day. The progress notes did not show any further care conferences were scheduled.In an interview on 09/25/25 at 10:47 AM Staff GG (Social Services Director) stated care conferences were important to make sure everybody including staff and residents were on the same page. Staff GG stated during care conferences discussion were made about any updates to the care plan or discharge plan, and advanced directives were reviewed. Staff GG stated the care conference also provides an opportunity for the resident to ask questions about their care. Staff GG stated the facility conducted quarterly care conferences on all residents. Staff GG stated the last conference for Resident 6 was in March 2025 and no other conferences were scheduled for Resident 6. Staff GG stated they attempted a care conference in May 2025. Staff GG stated there was no upcoming care conferences scheduled at this time for Resident 6 but there should be. <Resident 33>According to the 07/10/2025 Quarterly MDS, Resident 33 had clear speech, understands, and was understood by others. The MDS showed Resident 33 had medically complex conditions.Review of the revised 01/30/2024 Depression Care Plan (CP) showed staff were to discuss with the resident, family, caregivers any concerns, fears, or issues regarding health or other subjects.In an interview on 09/18/2025 at 10:22 AM, Resident 33 stated they had many concerns about the food at the facility, was unsure if the facility had their family member listed as an emergency contact, and stated they would like to speak with a mental health specialist. Resident 33 stated the facility did not talk to them about their concerns.In an interview on 09/22/2025 at 1:46 PM, Resident 33 stated they did not talk with staff about their care. Resident 33 stated they only talked with the facility's physician assistant because the staff do not talk to them. Resident 33 stated the staff did not understand their panic and fear and wished they did.In an interview on 09/25/25 at 10:47 AM Staff GG stated Resident 33's last care conference was in February 2025, and the social services team missed scheduling a quarterly care conference since then. Staff GG stated they were not aware of any mental health behaviors Resident 33 was experiencing and were not aware of mental health providers following Resident 33 for their anxiety and panic behaviors, but there should be. REFERENCE: WAC 388-97-1020(2)(d-e),(4)(c-f),(5)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure physician orders were followed for 4 residents (Residents 64, 67, 2, & 3), failed to ensure physician orders were clarified for 2 residents (Resident 68 & 3), and failed to obtain physician orders prior to providing treatment for 1 resident (Resident 32) of 19 residents reviewed. These failures placed residents at risk for medication errors, delayed treatment, and adverse outcomes.Findings included .<Clarification of Orders> <Resident 68> Review of Resident 68’s September 2025 Medication Administration Records (MAR) showed two separate orders for a laxative suppository to be given as needed for constipation and two separate orders for a laxative enema (rectal administration of a medication) for constipation. There were no directions to staff to indicate which orders should be given over the other orders. In an interview on 09/23/2025 at 10:42 AM, Staff C (Resident Care Manager) stated duplicate orders should be clarified due to the risk of medication errors if administered together. <Resident 3> Review of Resident 3’s physician orders showed a 07/22/2025 order that the resident was to receive nothing by mouth and had a feeding tube (a tube which entered the stomach through a small opening in the abdomen to provide nutrition, fluids, and medications) for their route of medication administration. Review of Resident 3’s September 2025 MAR showed several medications were ordered to be administered by mouth. In an interview on 09/23/2025 at 10:42 AM, Staff C stated Resident 9 should not receive any medications by mouth and stated the orders should have been clarified. <Obtaining Orders> <Resident 32> According to a 07/16/2025 admission Minimum Data Set (an assessment tool), Resident 32 was at risk for pressure ulcers and had a pressure ulcer and a surgical wound. Observations of wound care on 09/18/2025 at 11:12 AM showed Staff EE (Licensed Practical Nurse) provided wound care to Resident 32’s left outer hip and buttocks. During the observation a bordered dressing, dated “9/16”, was observed to Resident 32’s left lower leg. When asked about the dressing to the left lower leg, Staff EE stated there used to be a wound but now the dressing was used only as precaution and for protection. Staff EE removed the dressing to the left lower leg and stated, “it looks like your leg opened again.” Observation showed a small amount of bleeding and superficial skin tear. Staff EE repositioned Resident 32 and two other undated dressings were observed on Resident 32’s right inner knee and right outer calf. Staff EE stated the dressings on the knee and calf were used for protection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 32’s physician orders showed no orders directing staff to apply, change, or monitor the dressings to the resident’s left and right lower legs or their right knee. In an interview on 09/23/2025 at 4:34 PM, Staff B (Director of Nursing) stated nurse staff were expected to obtain orders from a physician prior to applying dressings on residents. Staff B stated obtaining orders and monitoring skin areas under protective dressings routinely was important to ensure no skin breakdown occurred. <Following Physician Orders> <Resident 64> According to the 06/24/2025 Quarterly Minimum Data Set (MDS-an assessment tool) Resident 64 had medically complex conditions including central pain syndrome and partial paralysis. Review of a 12/16/2024 physician order, showed a pain medication film to be administered every 8 hours as needed for pain ranging from 6 to 10 on the pain scale. (1 being the least amount of pain to 10 being the highest level of pain. Review of the September 2025 Medication Administration Record (MAR) showed on, 09/5/2025, 09/16/2025, 09/18/2025, 09/21/2025, 09/22/2025,09/24/2025,09/25/2025, 09/26/2025 and 09/29/2025, staff gave Resident 64 the as needed pain film medication without documentation of their pain level. On 09/9/2025 and 09/12/2025 Resident 64’s was administered the pain film medication and pain level 5 was documented which was lower than the parameters shown on the physician order. Review of an 01/24/2025 physician order showed a pain medication was to be administered every 8 hours as needed for a pain level of 1 to 5 out of 10. Review of the September 2025 MAR, showed on 09/03/2025, 09/04/2025, 09/06/2025, 09/10/2025, 09/11/2025, 09/13/2025, 09/15/2025, 09/17/2025, 09/18/2025, 09/19/2025 and 9/28/2025, Resident 64 was administered the pain medication with a documented pain level above 5; which was above the parameters listed on the physician order. <Resident 67> According to the 09/05/2025 Annual MDS, Resident 67 had medically complex conditions including respiratory failure, heart failure and hypertension. Review of a 03/03/2025 physician order showed an order for pain medication to administer every 4 hours as needed for a pain level of 6 to 10 on a pain scale of 1 to 10. Review of September 2025 MAR showed the pain medication was given on day shifts on 09/15/2025, 09/17/2025, 09/18/2025 and on the evening shifts on 09/16/2025, 09/17/2025, 09/18/2025, when Resident 67 pain level was documented less than 6. In an interview on 9/22/2025 at 12:14 PM, Staff B (Director of Nursing) stated staff was expected to follow the physician order and administer medications within the prescribed parameters. <Resident 2> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 08/28/2025 Quarterly MDS Resident 2 was dependent on staff for toileting and was always incontinent of bowel. Record review showed Resident 2 had three different medications to treat constipation: a 02/13/2025 order for rectal medication every 24 hours as needed to treat constipation, a 07/17/2025 order for a soluble powder, give 17 grams every 12 hours as needed for constipation, and a 11/19/2024 order for an oral medication every 24 hours as needed for constipation. The three orders did not instruct staff which medication to give first, what order the medications should be given, how long to wait before determining whether the medication was effective, or when to try another treatment. In an interview on 09/23/2025 at 2:52 PM, Staff B stated that because of Resident 2’s refusals of medications, routine administrations were changed to “as needed.” Staff B stated staff should have clarified directions when new orders were received, but clarification was not done. <Resident 73> According to the 09/10/2025 admission Nursing Evaluation, Resident 73 was admitted to the facility on [DATE]. The evaluation showed Resident 73 required dialysis (a treatment for kidney disease). In an interview on 09/17/2025 at 10:37 AM Resident 73 stated they did not receive dialysis for 7 days, since admission on [DATE]. Review of Resident 73’s admission physician orders showed a 09/10/2025 order for “Dialysis Days: ___ Pick Up Time: ___ Dialysis Location: [Emergency Department] *Notify dialysis provider of refusal or missed treatment to determine orders needed.” A 09/17/2025 physician order showed “Dialysis PRN [as needed] at … Emergency Department” According to a 09/11/2025 nursing progress note, the facility received a call from a hospital inpatient dialysis department explaining Resident 73 was not an established patient at the hospital and could not be treated. The progress note showed the hospital only provided inpatient dialysis, not outpatient. In interview on 09/22/2025 at 12:36 PM, Staff B stated Resident 73’s dialysis orders were incomplete and should have been clarified by staff. Staff B stated the incomplete dialysis orders did not meet Resident 73’s dialysis needs. REFERENCE: WAC 388-97 -1900 (1), (6)(a-c).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, activity, and record review the facility failed to ensure residents were provided a program of meaningful, life enriching activities for 2 (Residents 60 & 3) of 6 residents reviewed for activities. This failure placed residents at risk for boredom, frustration, a diminished quality of life, and social isolation. Findings included .<Facility Policy>According to the facility's July 2015 Activity Program policy, the facility would provide an ongoing program of activities designed to meet the interests of, as well as the physical, mental, and psychosocial needs of each resident. The policy showed the Activity Director was responsible for program implementation and showed the program should promote residents' physical, mental, and emotional wellbeing.<Resident 60> According to the 08/07/2025 A Minimum Data Set (MDS - an assessment tool) Resident 60 had moderate memory impairment and reported they felt down, depressed, or hopeless on 12-14 days of the assessment's 14-day lookback period. The MDS showed participating in their favorite activities was very important to Resident 60, and participating in group activities was somewhat important. The MDS showed Resident 60 was totally dependent on staff assistance to get out of bed. According to the revised 06/25/2025 Resident has stated a preference for independent activity in her own room. Enjoys going outside with group for socialization . Care Plan (CP), Resident 60 had a goal to socialize in a group setting at least 3 times per week . Review of the activity program charting showed from showed activities staff charted Resident 60 only participated in one-to-one visits and group activities from 08/24/2025 and 09/20/2025. There were no instances documented of Resident 60 participating in or refusing to attend group activities. According to an 08/26/2025 activity progress note Resident 60's favorite activities were watching movies, listening to music, using their tablet, watching television, and online shopping. In an interview on 09/16/2025 at 12:39 PM Resident 60 expressed dissatisfaction with the activities programs they were offered. Resident 60 stated when they used to smoke, they had more social interactions with other residents but since they returned from the hospital, they did not get out of bed anymore and needed more to do. Resident 60 stated all the Activities department did for them was deliver their mail and packages. Resident 60 stated it was really depressing. In an interview on 09/22/2025 at 12:13 PM, Staff M (Activity Director) stated the purpose of the activity program was to ensure residents had meaningful activities while at the facility as it was their home at the time. Staff M stated the activity program was a way to provide socialization, and ensure residents' leisure needs met, were especially for the residents confined to their room. Staff M stated group activities were important as they provided opportunities to socialize and engage with peers. Staff M stated for resident with mobility issues they coordinated with nurses' aides who helped get the residents to their activity of their preference. Staff M stated it was important to encourage and assist residents with barriers to activity participation, including shyness. Staff N stated all activities charting was done in the electronic chart and would include documentation of refusals to participate. Staff M reviewed Resident 60's activity charting and stated it was time to reassess Resident 60's activity needs. Staff M stated Resident 60 showed less interest in group activities lately, but they did not document any refusals for Resident 60. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 3>According to 07/16/2025 admission MDS, Resident 3 had intact hearing and a severe memory problem. The MDS showed listening to music and participating in their favorite activities was very important to Resident 3. The MDS showed Resident 3 was unable to get out of bed at the time of the assessment due to safety concerns. According to the 07/17/2025 Activities CP, Resident 3 preferred in-room activities and had supplies for independent activities. This CP showed Resident 3 preferred classical, instrumental, piano, orchestral/symphonies, and religious music. Observation on 09/17/2025 at 9:21 AM showed Resident 3 lying in bed, sleeping, with no activity supplies available within reach. There was a rolled-up musical keyboard noted in a box out of reach of the resident on another bed. In an interview on 09/19/2025 at 10:36 AM Resident 3 stated they liked to play piano and would love to play every day. Resident 3 stated it had been some time since anyone offered them their keyboard to play. Resident 3 stated they wished to keep busier. At that time Resident 3’s keyboard was observed to remain rolled up inside the box it came in on the other bed. In an interview on 09/19/2025 at 1:10 PM Resident 3 expressed they had little to do. Resident 3 was observed staring at their ceiling with no stimulation. In an interview on 09/18/2025 at 9:51 AM, Resident 3’s spouse stated Resident 3 was a pianist prior to their change in medical status. Resident 3’s spouse stated the resident had a piano that fit on the overbed table and lit up when played. Resident 3’s spouse stated they hoped facility staff would help set it up for Resident 3 and wanted the resident to have more to do to keep their mind active. In an interview on 09/23/2025 at 2:12 PM Staff M stated they rounded with residents once a week and verbally checked in with them to see if they were satisfied with the activities available to them. Staff M stated they did not document these discussions with residents. Staff M stated Resident 3 was last provided access to their keyboard the prior week and was usually offered in-room activity assistance once a week. Staff M stated for residents unable to leave their room, once a week was not sufficient and more engagement would be appropriate. REFERENCE: WAC 388-97-0940 (1).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent avoidable accidents for 1 of 3 residents (Residents 9) reviewed for falls. This failure placed residents at risk for additional falls, discomfort, and substantial injuries.Findings included .<Resident 9> According to a 07/14/2025 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 9 had clear speech, was understood, and was able to understand others. The MDS showed Resident 9 had multiple medically complex diagnoses including obesity and muscle weakness, required substantial assistance from staff to roll side to side in bed, and was dependent on staff for transfers from their chair to bed. Observation on 09/17/2025 at 9:04 AM showed Resident 9 lying in bed. In an interview at this time, Resident 9 stated they had previous falls but was unsure when the falls occurred. In an interview on 09/19/2025 at 8:00 AM, Resident 9 stated they had a fall the previous night when two staff members were transferring them to bed. Resident 9 stated staff were using a slide board for the transfer when the resident started slipping, and staff assisted them to the floor. Observation at this time showed a slide board in Resident 9’s room. Review of the revised 12/19/2022 fall Care Plan (CP) showed Resident 9 was at risk for falls and directed staff with an identified goal the resident would be free of falls through the next review. Review of a 10/20/2023 baseline CP showed directions to staff that Resident 9 was dependent on staff for transfers and used a mechanical lift for transfers. In an interview on 09/23/2025 at 10:28 AM, Staff AA (Certified Nursing Assistant - CNA) stated they review resident CPs to determine what care a resident required. Staff AA stated they transfer Resident 9 using a mechanical lift and stated the resident only transfers using a slide board when working with therapy. In an interview on 09/23/2025 at 10:42 AM, Staff C (Resident Care Manager) stated it was their expectation staff followed a resident’s CP and staff should be trained with a resident prior to performing transfers using a slide board. In an interview on 09/23/2025 at 2:22 PM, Staff Y (CNA) stated they were asked to assist another CNA with a transfer for Resident 9 on 09/19/2025. Staff Y stated Resident 9 was usually transferred using a mechanical lift but was told by the other CNA the resident used a slide board for transfers now. Staff Y stated Resident 9 began to slide during the transfer, so they assisted the resident, using a gait belt, to the floor and got a nurse. Staff Y stated they were not trained to use a slide board with Resident 9 for transfers. In an interview on 09/23/2025 at 2:28 PM, Staff BB (Director of Therapy) stated therapy was currently working with Resident 9 on slide board transfers and nursing was still using mechanical lifts for transfers. Staff BB stated therapy did not train nursing staff to use the slide board and they did not clear nursing staff to use the slide board for Resident 9 yet. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on 09/23/2025 at 3:39 PM, Staff U (CNA) stated they were assisting with Resident 9’s transfer on 09/19/2025 using a slide board. Staff U stated Resident 9 told staff they used a slide board for transfers and there was a slide board in the resident’s room. Staff U stated Resident 9 started to slide during the transfer and was assisted to the floor. Staff U stated they did not receive training for slide board transfers from the facility but had used one previously. In an interview on 09/23/2025 at 4:34 PM, Staff B (Director of Nursing) stated it was their expectation staff follow a resident’s CP interventions, update and revise them as needed, and that staff were adequately trained to decrease the risks of injuries and accidents. REFERENCE: WAC 388-97-1060(3)(g). Refer to 726 Competent Nursing Staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, and record review the facility failed to assess the resident for bowel and bladder needs or provide the necessary care and services to ensure bowel and bladder continence was improved or maintained for 1 of 1 residents (Resident 9) reviewed for bowel and bladder needs. This failure left the resident at risk for unmet care needs, avoidable incontinence, and decreased quality of life.Findings included .<Facility Policy>Requested policy on 09/22/2025 and 09/25/2025 regarding bowel and bladder assessments. Facility was unable to provide a policy as requested.<Resident 9>According to a 07/14/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 9 had clear speech, understands, and was understood by others. This MDS showed Resident 9 required substantial assistance from staff to roll side to side in bed, was dependent on staff for bed to chair transfers and toileting hygiene, had no rejection of care, and was always incontinent with bowel and bladder.Review of a 10/18/2025 urinary incontinence Care Area Assessment (CAA) showed Resident 9's CAA was triggered due to the resident always being incontinent of bladder and being dependent on staff for assistance with toileting. The type of incontinence section was left blank by staff.Review of a10/20/2023 baseline Care Plan (CP) showed the goal for Resident 9 was to have their toileting needs met. Interventions identified showed Resident 9 was incontinent for toileting and required substantial assistance from staff with toileting transfers. Review of a 01/18/2024 potential for development of incontinence CP showed interventions to manage Resident 9's incontinence with adult incontinence products.Observations on 09/17/2025 at 9:09 AM showed Resident 9 lying in bed. In an interview at this time, Resident 9 stated they had a hard time sleeping at night because they wore incontinence briefs. Resident 9 stated they could feel when they needed to use the bathroom and stated they have worn incontinence briefs since admission because the staff wanted the resident to wear them. Resident 9 stated the facility did not attempt a toilet training program with the resident.Review of Resident 9's 12/01/2022 admission evaluation showed the resident was continent of bowel and had regular urinary frequency. Review of the quarterly nursing review evaluations from 03/01/2023, 06/01/2023, 09/04/2023, 12/04/2023, 03/04/2024, 06/06/2024, 09/06/2024, and 12/06/2024 showed staff documented there were no changes noted for Resident 9's bowel and bladder since the past review.In an interview on 09/23/2025 at 10:28 AM, Staff AA (Certified Nursing Assistant) stated Resident 9 always used an incontinence brief and was incontinent of both bowel and bladder. Staff AA stated they never saw Resident 9 use a toilet or bedpan and were unsure if they were tried on a toileting program. Staff AA stated they offer to brief changes to Resident 9 and their brief was usually wet.In an interview on 09/23/2025 at 10:42 AM, Staff C (Resident Care Manager) stated the facility did not have bowel and bladder assessments and they relied on the CP to review a resident's bowel and bladder status. Staff C stated Resident 9 was incontinent and therefore was not tried on a toileting program. Staff C reviewed Resident 9's records and was unable to provide a bowel and bladder assessment or toileting plan.In a joint interview with Resident 9 and Staff C on 09/23/2025 at 11:00 AM, Resident 9 reported to Staff C they did not like wearing the incontinence briefs and had difficulty sleeping because they were uncomfortable. Resident 9 stated they were able to feel when they needed to use the toilet. When Staff C asked Resident 9 if they would be willing to try a toileting plan and/or use a bed pain, Resident 9 stated, yes and smiled.In an interview on 09/23/2025 at 4:34 PM, Staff B (Director of Nursing) stated the facility did not currently have a bowel and bladder assessment process in place. Staff B stated the assessments were important in order to put a proper CP in place and set a resident up for success. Staff B stated it was their expectation a bowel and bladder assessment was completed on admission and quarterly with their MDS.REFERENCE: WAC 388-97-1060(3)(c).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure 4 (Residents 5, 67, 53, & 32) of 4 residents reviewed for respiratory care were provided care and services consistent with professional standards of practice. The facility's failure to implement stoma suctioning according to physician orders (Resident 5), obtain physician order prior to administering oxygen therapy (Resident 5), deliver oxygen therapy according to physician ordered flow rates (Resident 67 & 53), and maintain oxygen equipment (Residents 67, 53 & 32) placed residents at risk for potential negative outcomes such as over or under oxygenation, respiratory discomfort, infections, and a decreased quality of life.Findings included .<Facility Policy>Review of a December 2017 Respiratory Care; Oxygen Administration facility policy showed staff would provide oxygen therapy and respiratory care in accordance with physician's orders, state and federal regulation, and standards of practice, and replace cannulas when visibly soiled, and as needed.<Resident 5> According to a 06/25/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 5 had multiple medically complex diagnoses including cancer, required suctioning and stoma care (a surgical opening in the neck into the windpipe). The MDS showed Resident 5 was not assessed to require oxygen therapy. A review of the 09/16/2025 hospital discharge orders showed an order for a sterile triflow catheter and glove kit (a sterile kit used for gentle suctioning and to keep procedure germ-free) for stoma suctioning. In an interview and observation on 09/17/2025 at 9:07 AM Resident #5 stated they received 5 liters per minute (lpm) oxygen therapy via nasal cannula (a tube in the nose that delivers oxygen). Resident 5 stated they were not sure if they really needed oxygen. An observation on 09/17/2025 at 10:14 AM showed Resident 5’s oxygen set at 5 lpm and the nasal cannula was draped over Resident 5’s bedrail. Resident 5 stated they removed the oxygen therapy because they felt fine breathing on room air. A portable suction device was observed on the bedside cabinet with extension tubing connected to oral suction (a hard plastic tube with a rounded end used to remove secretions in the mouth). Observations on 09/18/2025 at 10:24 AM and 1:50 PM showed Resident 5 in bed receiving 5 liters of oxygen therapy via nasal canula. A portable suction device was on the bedside cabinet with extension tubing connected to oral suction. The suction container was observed to be full of dark pink suctioned fluids. An observation on 09/22/2025 at 8:33 AM showed Staff I (Registered Nurse) perform stoma suctioning with the oral suction setup. In an interview on 09/17/2025 at 12:47 PM, Staff H (Resident Care Manager) reviewed Resident 5's physician orders and stated no oxygen therapy was ordered. Staff H stated Resident 5 received oxygen not prescribed by the physician. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/23/2025 at 1:24 PM, Staff B (Director of Nursing) stated Resident 5 requested on admission that oral suctioning be available to them at bedside. Staff B stated they were unaware nurses were using oral suction for stoma suctioning. Staff B stated they expected nurses to clarify orders with providers prior to performing care. Staff B stated oral suction should only be used for mouth secretions and not stoma secretions. In an interview on 09/23/2025 at 1:30 PM, Staff CC (Physician Assistant-Certified) stated they implemented orders for Resident 5’s stoma care and suctioning in accordance with the hospital discharge orders. Staff CC stated they expected staff to clarify suctioning orders. In an interview on 09/23/2025 at 4:34 PM, Staff H reviewed Resident 5's physician order for suctioning and stated the orders lacked specific instructions including method and route. Staff H stated the hospital discharge instructions should have been followed. Staff H stated they were unaware Oral suction suctioning was for oral suctioning only. Staff H stated the hospital discharge orders should have been clarified by nursing and Resident 5’s care plan (CP) should reflect accurate physician orders. <Resident 67> According to the 09/05/2025 Annual MDS, Resident 67 had multiple medically complex diagnoses including heart and respiratory failure. Review of the 02/13/2025 altered respiratory status CP showed nurses were to ensure Resident 67’s oxygen setting was set to 2 lpm. Review of the September 2025 medication administration record (MAR) showed a 03/04/2025 order for the nurses to check oxygen was set to 2 lpm every shift and an order dated 04/09/2025 instructed to change the oxygen tubing as needed and change when visibly soiled. An observation on 09/17/2025 at 9:45 AM showed Resident 67’s oxygen setting was less than 2 lpm. There was no date on the oxygen tubing that showed when the last tubing was changed. In an observation and interview on 09/18/25 at 9:54 AM, the nasal cannula was observed unclean and with debris, the oxygen level was set less than 2 lpm, and the filter on the oxygen machine was covered in dust. Resident 67 stated the nasal cannula had debris on it for the last few days and did not recall when the oxygen tubing was changed. In an interview on 09/19/2025 at 11:06 AM Staff T (Licensed Practical Nurse) stated the oxygen setting was incorrect and was required to be set to 2 lpm. Staff T stated the filter was and they were not aware the filter needed to be cleaned. Staff T stated it was important to check resident’s oxygen settings as the resident may not have enough oxygen. Staff T stated the nasal cannula should not be soiled because there could be a risk of contamination. Staff T stated staff only replaced oxygen tubing when the resident asked and stated they were not aware Resident 67 had debris on their nasal tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/22/2025 at 11:43, Staff B stated staff were required to follow physician orders, check oxygen settings every shift, and change the nasal cannula when soiled. Staff B stated there was no training provided to staff to clean the filters on the oxygen machine. Staff B stated the vendor cleaned the filters annually. <Resident 53> According to a Quarterly MDS Resident 53 had multiple medically complex diagnoses including lung disease, heart failure, and respiratory failure. An observation on 09/16/2025 at 12:30 PM showed Resident 53 lying in bed with an oxygen nasal cannula in their nose. The oxygen concentrator machine was running with the oxygen level set at 3 lpm. The humidifier water bottle was attached to the machine and was almost empty. An observation on 09/19/2025 at 7:54 AM showed Resident 53 with oxygen on running at 3 lpm and an empty humidifier water bottle attached to the machine. Review of an 08/07/2024 physician order showed Resident 53 was to be on continuous oxygen at 2 lpm for heart failure, not 3 lpm as observed on 09/16/2025 and 09/19/2025. There was a 12/12/2024 physician order to change the humidifier bottle as needed. In an interview on 09/19/2025 at 10:30 AM, Staff C stated staff was expected to follow physician orders for oxygen settings and was required to replace the humidifier water bottle when empty. In an observation and interview on 09/19/2025 at 10:52 AM, Staff C observed the oxygen level setting on Resident 53’s machine was set to 3 lpm and the humidifier bottle was empty. Staff C stated Resident 53’s oxygen physician orders needed to be clarified and the humidifier water bottle needed to be replaced. <Resident 32> According to a 06/16/2025 admission MDS, Resident 32 was cognitively intact and had multiple medically complex diagnoses including heart and respiratory failure. This MDS showed Resident 32 required the use of oxygen. An observation on 09/17/2025 at 9:44 AM showed Resident 32 was lying in bed with a nasal cannula in their nose that was brown-orange in color. There was no date on the nasal cannula to indicate when it was last changed. Resident 32’s oxygen concentrator machine had a filter on the back which had a layer of light grey debris covering the entire filter. In an interview on 09/19/2025 at 1:23 PM, Resident 32 stated the nasal cannula was dirty because they got tomato soup on it last week. Resident 32 stated the nasal cannula was changed “a month or two ago. ” Review of a 06/12/2025 physician order showed directions to staff to change Resident 32’s oxygen tubing if it becomes damaged or visibly soiled as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/19/2025 at 10:56 AM, Staff C observed the layer of debris on Resident 32’s oxygen concentrator filter. Staff C stated it needed to be cleaned. In an interview and observation on 09/19/2025 at 1:51 PM, Staff O (Resident Care Manager) confirmed Resident 32’s oxygen tubing was visibly soiled and needed to be changed. In an interview on 09/22/2025 at 1:02 PM, Staff B stated, after doing some research, it was their expectation the oxygen concentrator filters should be washed and dried as needed when dirty, and staff should do spot checking every two weeks to assure the filters are clean. REFERENCE: WAC 388-97-1060(3)(j)((iv)(v)(vi). .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to develop and implement a system to evaluate staff competencies in skills and techniques to ensure staff provided necessary care and responded to each resident's individualized needs for 7 of 7 sampled staff (Staff I [Registered Nurse - RN] Staff U [Certified Nursing Assistant - CNA], Staff V [CNA], Staff K [CNA], Staff L [CNA], Staff X [RN], & Staff Y [CNA]) reviewed for nursing competency. This failure placed residents at risk of receiving care from under-trained and/or under-qualified care staff, unmet care needs, and diminished quality of life.Findings included . <Facility Policy>The facility was unable to provide a nursing competency policy.<Staff I> According to a 06/25/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 5 had multiple medically complex diagnoses including cancer and required stoma care (a surgical opening). An observation and interview on 09/22/2025 at 8:33 AM showed Staff I (Registered Nurse) administer a toxic cancer therapy medication to Resident 5 without wearing two sets of gloves. Staff I stated they did not receive special instructions on handling toxic cancer treatments. Staff I performed stoma suctioning (a process to remove mucus). Staff I stated they did not receive specific training regarding stoma care or suctioning. Staff I stated they were unaware of any difference between oral and stoma suction techniques. In an interview on 09/23/2025 at 1:24 PM, Staff B (Director of Nursing) stated staff were trained on the proper handling of cancer treatment therapies but did not provide documentation to demonstrate Staff I attended. Staff B stated they expected nurses to understand the basic concepts of oral and stoma suctioning. Staff B stated staff were expected to utilize available training resources, if they were unsure of the requirements for stoma suctioning. <Staff U> Review of the facility’s employee list showed Staff U was hired on 04/11/2025. Review of Staff U’s training records showed a 04/11/2025 “Inservice Education Summary” form signed by Staff U. The form showed the curriculum was General Orientation and the content or summary of the in-service included: Dementia (a group of brain disorders causing a gradual decline in memory, thinking, language, and problem solving), Abuse and Neglect, Bloodborne pathogens (diseases spread through contaminated blood) training, effective communication, hand hygiene, and putting on and taking off Personal Protective Equipment (specialized clothing or equipment worn to protect a person from hazards and prevent exposure to harmful substances or conditions). Review of Staff U’s online training records showed no training regarding safe resident transfers and no documentation of Staff U’s CNA competencies on file. <Staff V> Review of the facility’s employee list showed Staff V was hired on 02/20/2025. Review of Staff V’s training records showed no documentation of CNA competencies on file. <Staff K> (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility’s employee list showed Staff K was hired on 05/22/2025. Review of Staff K’s training records showed no documentation of CNA competencies on file. <Staff L> Review of the facility’s employee list showed Staff L was hired on 04/04/2025. Review of Staff L’s training records showed no documentation of CNA competencies on file. <Staff X> Review of the facility’s employee list showed Staff X was hired on 07/29/2025. Review of Staff X’s training records showed no documentation of nurse competencies on file. <Staff Y> Review of the facility’s employee list showed Staff Y was hired on 08/31/2023. Review of Staff Y’s training records showed no documentation of CNA competencies on file. In an interview on 09/23/2025 at 2:55 PM, Staff W (Staff Development) stated they provided new staff with an orientation checklist upon hire but did not collect them back from employees. Staff W stated they did not yet offer a skills workshop for new hires, but would “in the future.” In an interview on 09/22/2025 at 12:12 PM, Staff W stated assessing the competency of staff was important to make sure staff remained up to date on procedures and to provide safety for the residents by ensuring the facility had competent staff. Staff W stated their expectation was for yearly competencies to be completed. Staff W stated the last skills workshop for staff was held in July 2024, over a year prior. Staff W stated they did not have any documentation showing each staff’s competencies from July 2024 and only had a staff attendance record. Staff W stated they were unable to demonstrate how staff were assessed to be competent with their current process. Staff W opened a binder showing the last time staff competency checklists were completed was February 2023. In an interview on 09/23/2025 at 4:34 PM, Staff B stated having competent staff was important to ensure facility staff followed facility protocols and procedures, and were set up for success. Staff B stated the facility did not want nursing staff to be assigned to care they were not adequately trained for and competent with. Staff B stated they expected staff competency to be assessed on hire and annually thereafter with documentation available in the staff’s employee files. REFERENCE: WAC 388-97-1680. Refer to F689 Free of Accident Hazards/Supervision/Devices.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure meals were prepared to maintain the palatability of the food served for 6 (Residents 16, 2, 60, 33, 53, & 9) of 9 residents reviewed for food. The failure to ensure the food provided looked and tasted palatable placed residents at risk for weight loss, frustration, and a diminished quality of life. Findings included .<Facility Policy>According to the facility's updated November 2018 Preparation and Service of Foods policy, foods should be prepared and served in a manner to provide food safety. <Resident Interviews> <Resident 16> In an interview on 09/16/2025 at 10:40 AM, Resident 16 stated they could not stomach the food the facility served. Resident 16 stated they needed to buy outside food to augment the diet provided at the facility to feel satisfied. Observation at this time showed cans of tuna, instant noodles, puffed corn snacks, and cans of condensed soup. <Resident 2> In an interview on 09/16/2025 at 2:00 PM, when asked about the food Resident 2 stated they complained so many times about the kitchen. Resident 2 stated some of the food served was unidentifiable. Resident 2 stated the menu was repetitive and the food served was bland, often lacking standard condiments such as toast with no butter. Resident Observation on 09/18/2025 at 1:20 PM showed Resident 2 eating taco salad, chips, beans, salsa, sour cream, and lettuce. The taco salad was visually unappealing with the layers of the salad added in a way that appeared spattered and haphazard, with no attention paid to presentation. <Resident 60> In an interview on 09/16/2025 at 12:37 PM Resident 60 stated they were dissatisfied with the food served and spoke with the kitchen but felt there was little dietary staff could do to improve the food. Resident 60 stated they were served the same meals repeatedly. <Resident 33> In an interview on 09/18/2025 at 10:22 AM, Resident 33 stated their main concern at the facility was the taste of the food served. Resident 33 stated the vegetables, especially the zucchini, were consistently mushy. In an observation and interview on 09/22/2025 at 1:46 PM, Resident 33 took their lunch meal apart in an effort to create a better tasting salad because their lunch was not good. Resident 33 stated they tried to put something together that would make the food taste better as the food at the facility did not taste good and neither did the alternative options on the menu. <Resident 53> (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 09/16/2025 at 12:34 PM, Resident 53 stated they felt the food was lousy and “terribly disgusting.” Resident 53 stated they often turned away the food when offered. <Resident 9> In an interview on 09/17/2025 at 8:44 AM, Resident 9 stated they were unhappy with the food and stated, “the eggs are fake.” <Facility Kitchen> Review of the posted menu on 09/23/2025 showed the primary choice for lunch that day was roast turkey, bread dressing, and herbed green beans with wheat bread, and a dessert of baked apple slices. In an interview on 09/23/2025 at 11:12 AM, Staff S (Food and Nutrition Service Manager) stated the facility used a menu with a 35-day cycle. Staff S stated the facility still used the same seasonal menu started in02/18/2025 and was awaiting new menus from corporate. Staff S said the facility had two seasonal menus a year, spring/summer and fall/winter menus. <Test Tray> Observations of a test tray representing regular lunch service for the date on 09/23/2025 at 12:32 PM showed the tray included: -a slice of roast turkey. This slice had two distinct colors, half the slice was the color of standard turkey breast meat, and the other half was a much darker with a gray/brown/pinkish hue that was not appealing. This slice had a temperature of 102 degrees Fahrenheit (F). The turkey slice tasted very salty. - herbed green beans. These beans were [NAME] green in color and had a temperature of 121 F. These beans retained no bean flavor and had a strong, unpleasant garlic/onion/herb aftertaste. - a scoop of bread dressing. This dressing was gelatinous in texture and wobbled as the plate shook. The dressing was not easily identifiable as a particular dish and held the shape of the scoop it was served with on the plate. - a bread roll. - a glass of milk with a temperature of 55 F, too warm to be palatable. - a dessert of apple slices. These apples were brown/yellow in color white, retaining some crispness as if they were not cooked. The apples had a temperature of 59 F. - an unidentified blue cold drink. This drink tasted of sugar and had no other flavor. In total, the lunch tray both looked and tasted unappetizing as observed by four surveyors, confirming residents’ concerns. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In interviews on 09/23/2025 from 2:14 PM to 2:20 PM Resident 16 and Resident 2 stated they did not enjoy the lunch they were served that day. In an interview on 09/23/2025 at 2:40 PM, Staff S stated it was important to serve residents meals they enjoyed. Staff S stated the budget they had for procuring ingredients affected the quality of the food they were able to provide. REFERENCE: WAC 388-97-1100 (1), (2).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain an infection prevention and control program designed to provide a clean environment to help prevent the transmission of communicable diseases for 2 of 2 residents (Resident 2 & 5) and failed to follow enhanced barrier precautions (EBP) for 1 for of 1 residents (Residents 58) and failed to follow standard precautions and wear protective eye covering for 1 of 1 resident (Resident 5) reviewed for Transmission-Based Precautions (TBP - airborne, contact, droplet and enhanced barrier precautions used to prevent the spread of transmissible diseases. The failure to wear PPE (Personal Protective Equipment - gowns, gloves etc.) when caring for resident on TBP and the failure to maintain a clean environment placed residents at risk for facility-acquired/healthcare-associated infections and related complications. Findings included <Facility Policy>According to the facility's updated March 2025 Transmission Based Precautions (TBP) policy, TBP was used in addition to standard precautions (use of personal protective equipment (PPE) such as gloves, gowns, masks, and proper handling of equipment and the resident's environment). The policy showed TBP included residents on contact, droplet, airborne or enhanced barrier precautions (EBP.) When residents were on EBP, staff were required to use gown and gloves during high-contact resident core activities. <Resident 2> According to the 08/28/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 2 used a urinary catheter (a device to assist draining the bladder of urine.) The MDS showed Resident 2 had a kidney condition. Observation on 09/16/2025 at 2:06 PM showed Resident 2's catheter bag hanging from their bedframe. The catheter bag had a slow, steady drip and small puddle of urine pooled in the floor beneath. In an interview on 09/23/2025 at 9:14 AM Staff F (Infection Preventionist) stated they expected both nurses and nurses' aides to prevent, identify, and address leaking catheters timely. <Resident 58> According to a 06/22/2025 annual MDS assessment, Resident 58 had diagnoses that included chronic congestive heart failure, localized edema (swelling) and history of bladder infections. Review of the 06/16/2025 Enhanced Barrier CP showed EBP signage was posted at the resident’s door related to a history of bacteria resistance to antibiotics. The signage was to be posted for high contact resident care such as dressing, bathing, changing linen and providing hygiene. Interventions showed staff were to use gown and gloves during high contact resident care. Observation on 09/18/2025 at 8:52 AM showed EBP signage on Resident 58’s door. Staff P (Certified Nursing Assistant) was observed to provide Resident 58 assistance with putting on their leg wraps to both legs. Staff P did not have a gown on while providing direct care to Resident 58. In an interview on 09/18/2025 at 11:13 AM Staff F stated whenever residents had a history of multidrug resistance, or had any lines or wounds, they would be on EBP. Staff F stated staff were to wear a gown and gloves when providing high contact care for infection control. Staff F stated staff were educated on EBP and should be following the instructions provided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 5> <Failure to wear eye protection> According to a 06/25/2025 Quarterly Minimum Data Set MDS, Resident 5 had multiple medically complex diagnoses and required stoma care (the cleaning and suctioning of mucus in a surgical opening in the neck) to clear out fluids and protect the airway. During an observation on 09/22/2025 at 8:33 AM, Staff I (Registered Nurse) performed stoma care wearing a gown, gloves, and a face mask, but no eye protection to protect from splashes of mucus during suctioning. In an interview on 09/22/2025 at 9:02 AM, Staff I stated they understood wearing eye protection was expected per facility policy for suctioning, but they had forgotten to wear them when suctioning Resident 5. In an interview on 09/23/2025 at 4:34 PM, Staff H (Resident Care Manager) stated they expected all staff to wear eye protection during the suctioning procedure <Mattress Cover> In an observation on 09/19/2025 at 1:20 PM, a large piece of Resident 5’s protective mattress cover was missing. In an interview on 09/19/2025 at 1:22 PM, Staff II (Certified Nursing Assistant) stated the mattress could not be disinfected due to the missing piece and should be reported to maintenance staff by entering a request into the logbook at the nursing station. Review of the maintenance logbook showed Resident 5’s mattress cover issue was not added. In an interview on 09/19/2025 at 1:23 PM, Staff H (Resident Care Manager) stated the mattress should not be missing the protective fabric because it could not be disinfected. Staff H stated the mattress would need to be replaced. Staff H stated staff were expected to report issues to maintenance when mattresses were torn. REFERENCE: WAC 388-97-1320 (1)(a), (2)(b).