

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Montesano Health-Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 N Medcalf Lane Montesano, WA 98563	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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 interview and record review, the facility failed to conduct real time analysis of their infection control program for 10 of 10 months (August 2025 to May 2026) reviewed for monthly line listings and monthly maps summaries for the facility's surveillance program. These failures placed the facility at risk for failing to identify infection trends and implementing interventions that would prevent residents from acquiring facility related infections. Finding included. Record review of the facility's policy titled, Infection Prevention and Control Program [IPCP], dated 09/18/2023, documented 4. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. 7. Surveillance a. Process surveillance (adherence to infection prevention and control practices) and outcome surveillance (incident and prevalence of healthcare acquired infections) are used as measures of the IPCP effectiveness. b. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infection, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. c. The information obtained from infection control surveillance activities is compared with that from other facilities and with acknowledged standards (for example, acceptable rates of new infections), and used to assess the effectiveness of established infection prevention and control practices. d. Standard criteria are used to distinguish community-acquired from facility-acquired infections. 9. Data Analysis a. Data gathered during surveillance is used to oversee infections and spot trends. b. One method of data analysis is by manually calculating number of infections per 1000 resident days as follows: (1) The infection preventionist collects data from the nursing units, categorizes each infection by site (these can also be categorized by organism or according to whether they are facility- or community-acquired), and records the absolute number of infections; (2) To adjust for differences in bed capacity or occupancy on each unit, and to provide a uniform basis for comparison, infection rates can be calculated as the number of infections per 1000 patient days (a patient day refers to one patient in one bed for one day), both for each unit and for the entire facility; (3) Monthly rates can then be plotted graphically or otherwise compared side-by-side to allow for trend comparison; (4) Finally, calculating means and standard deviations (using computer software) allows for screening of potentially clinically significant rates of infections (greater than two standard deviations above the mean). During an interview on 06/18/2026 at 10:42 AM, Staff J, [NAME] President of Clinical Services, said the facility could not find documentation from August 20, 2025, to December 31, 2026, that showed (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505537	Facility ID: 505537 If continuation sheet Page 1 of 14

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they maintained an infection surveillance program to include preventing, identifying, reporting, investigating and controlling infections. Staff J stated there were some gaps in the program due to personnel issues. During an interview on 06/18/2026 at 3:12 PM, when asked about facility's infection surveillance from January 2026 to June 2026, Staff J said there were gaps identified from February 2026 to June 2026. Staff J provided surveillance reports that were generated retrospectively but were not completed monthly in real time. Reference WAC 388-97-1320 (1)(a) (2)(a)(c)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide care and services in a manner that maintained and promoted dignity when staff stood next to the resident while assisting with meals for 1 of 4 sampled residents (Resident 3) reviewed for resident rights. This failure placed residents at risk for diminished self-worth, self-esteem, and feelings of embarrassment. Finding included . Resident 3 was admitted to the facility on [DATE] with multiple diagnoses, to include paraplegia (medical condition characterized by the loss of motor and sensory function in the lower half of the body). Record review of The Quarterly Minimum Data Set, an assessment tool, dated 03/11/2026, indicated the Resident 3 was severely cognitively impaired, and required extensive assistance with eating. In an observation on 06/15/2026 at 12:50 PM, Staff N, Certified Nursing Assistant (CNA) was observed standing on right side of Resident 3, while providing him feeding assistance. In an observation on 06/15/2026 at 12:54 PM, Staff N proceeded to provide feeding assistance to Resident 3 while standing over him on his left side. In an interview on 06/15/2026 at 12:58 PM, Staff N said staff providing feeding assistance to residents typically sat with residents during meals. Staff N was asked why she stood to assist Resident 3 today. Staff N stated, today, we have three feeders here, and I needed to be available for the others. In an interview on 06/17/2026 at 2:37 PM, Staff B, Director of Nursing Services/Registered Nurse, said staff should be seated while providing feeding assistance. Reference WAC 388-97-0180 (2)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to include resident's representative in the care planning conference for 1 of 6 residents (Resident 51) who was moderately cognitively impaired and reviewed for care conferences. This failure placed residents at risk of unmet care needs and a diminished quality of life. Findings included. Resident 51 was admitted to the facility on [DATE]. The admission Minimum Data Set, an assessment tool, dated 04/28/2026, documented Resident 51 was moderately cognitively impaired. Record review of Resident 51's Brief Interview for Mental Status (BIMS, a 0-15 standardized cognitive screening tool to assess attention, orientation, and memory, with higher scores indicating better cognitive health) completed on 04/23/2026 documented Resident 51's BIMS score was 9, indicating moderate cognitive impairment. In a telephone interview on 06/16/2026 at 10:07 AM, Resident 51's representative said they had not participated in a care conference with the facility staff to discuss Resident 51's plan of care and discharge. Resident 51's representative stated, no one has talked to me at all. Even the financial part. I have not had a family meeting to learn about his progress. In an interview on 06/17/2026 at 9:52 AM, Staff H, Social Services Director, said care conferences were held on admission and quarterly. Staff H said care conference were held with resident representative if the resident had a low BIMS score. In an interview on 06/18/2026 at 10:24 AM, Staff H said the facility failed to have a care conference with Resident 51's representative considering Resident 51 had a low BIMS score. Reference WAC 388-97-1020(2)(e)(f)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care with activities of daily living (ADL) for dependent residents to include bed baths and/or showers for 1 of 3 residents (Resident 36), reviewed for ADLs. This failure placed residents at risk of unmet care needs and a diminished quality of life. Findings included. Resident 36 was admitted to the facility on [DATE]. The 5-day Minimum Data Set, and assessment tool, dated 05/31/2026, indicated Resident 36 was alert and oriented. Record review, on 06/17/2026, of Resident 36's bathing task, dated 05/21/2026 through 06/17/2026, documented Resident 36 had not had a bed bath and/or shower since 06/09/2026, eight days since the last bed bath and/or shower. Record review of the shower log showed Resident 36's shower schedule was Mondays & Thursdays. During an interview on 06/17/2026 at 11:24 AM, Staff M, Nursing Assistant, said resident shower day assignments were based on resident room assignments. Staff M said if a resident refused a shower During the week they would make it up on Sunday. During an interview and record review on 06/17/2026 at 2:05 PM, Staff B, Director of Nursing, said resident showers were given twice a week based on a schedule. Staff B said nursing assistants document in the electronic health record (EHR) and/or on paper. After reviewing Resident 36's EHR, Staff B said she would check to see if they had written documentation. Record review of a noted provided by Staff B on 06/17/2026 at 2:27 PM, documented for Resident 36's showers no further documentation was located. Reference WAC 388-97-1060 (2)(c)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate bowel interventions for 1 of 5 residents (Resident 34) reviewed for constipation. This failure placed residents at risk of discomfort, experiencing health complications and a diminished quality of life.Finding included. Record review of the facility's policy titled, Bowel Care, Undated, documented,Bowel care protocol will be indicated for residents who have not had a bowel movement in the past three days as follows (per physician order):1. The Licensed Nurse will administer 30cc [cubic centimeters] of Milk of Magnesia [laxative-medication to stimulate bowel movement] per M.D. [doctor] Order. (Recommend P.M. Shift initiates based on routine checking of bowel sheet)2. If no results from Milk of Magnesia by the end of the suggested shift, (i.e., NOC Shift), the Licensed Nurse will administer a Dulcolax Suppository [laxative- medication to stimulate bowel movement] per M.D. Order. 3. If no results from a suppository by suggested shift, (i.e., AM. Shift) the Licensed Nurse will give resident a fleet enema [laxative- medication to stimulate bowel movement], per M.D. order. If no results from fleet enema by the end of the same shift, the Licensed Nurse will check the resident for a possible fecal impaction. Resident 34 was admitted to the facility on [DATE]. The Quarterly Minimum Data Set, an assessment tool, dated 07/06/2026, indicated Resident 34 was alert and oriented. Record review of Resident 34's electronic health record (EHR) Bowel Task sheet documented Resident 34 had a BM [bowel movement] on 06/01/2026 at 1:59 PM. The next documented BM was on 06/07/2026 at 10:59 PM, over 153 hours since the last BM. Record review of Resident 34's physician's orders, dated 9/29/2025, documented to administer, Milk of Magnesia Suspension 400 MG [milligrams]/5ML [milliliter] (Magnesium Hydroxide). Give 30 ml by mouth as needed for Constipation give at bedtime if no BM in 3 days . MiraLax Powder (Polyethylene Glycol 3350). Give 17 gram by mouth as needed for Constipation in 4 to 8 ounces of fluid-if resident has not had a bowel movement in past 72 hours.Record review of Resident 34's Medication Administration Record (MAR), dated June 2026, did not show a bowel intervention was initiated. In an interview on 06/17/2026 at 9:25 AM, Staff D, Infection Preventionist/ Registered Nurse (RN), said the bowel protocol was typically initiated after 72 hours of no BM. Staff D stated, we get an alert after three days. In an interview on 06/17/2026 at 9:30 AM, Staff E, Resident Care Manager/Licensed Practical Nurse, said no bowel intervention was started for Resident 34. Staff E was unable to provide documented bowel intervention and stated, there should be something in the record, even if residents refused. In an interview on 06/17/2026 2:37 PM, Staff B, Director of Nursing/RN, said she expected bowel interventions to be initiated per physician's orders but was unable to find any documentation showing administration or a refusal from Resident 34. Staff B stated, we need to be documenting that. Reference WAC 388-97-1060(1)(3)(c)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 of 2 sampled residents (Resident 42) reviewed for Pressure Ulcers (PUs), received appropriate pressure reducing measures and repositioning on a consistent basis. This failure placed residents at risk for PU development, and a diminished quality of life. Findings included . Record review of the facility policy, titled, Skin Integrity, undated, documented: 4. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated- .4.4 Turning and repositioning based on resident needs. Resident 42 was admitted to the facility on [DATE]. The Medicare 5-Day Minimum Data Set, an assessment tool, dated 04/08/2026, documented the Resident 42 was moderately cognitively impaired, and was dependent on staff for bed mobility. In an interview on 06/15/ 2026 at 11:33 AM, when asked about repositioning, Resident 42 stated, they say 'we should reposition you,' but they never do. Record review of Resident 42's Electronic Health Record (EHR) documented, Wound Healing Report, dated 06/03/2026, outlined the following recommendations: Aggressive offloading is recommended and medically necessary: repositioning schedule. Facility should document offloading compliance and any barriers to adherence at each nursing assessment. Record Review of Resident 42's EHR showed no documentation of repositioning taking place. During an observation on 06/15/2026 at 1:42 PM, Resident 42 was observed awake in bed, lying on his back. During an observation of 06/17/2026 at 10:13 AM, Resident 42 was observed lying in bed, on his back. During an observation of 06/17/2026 at 2:31 PM, Resident 42 was observed lying in bed, on his back in the same position as in the previous observations. During an interview 06/17/2026 at 2:38 PM, Staff O, Registered Nurse (RN), said staff documented repositioning care on the Treatment Administration Record (TAR). Staff O said Resident 42 was repositioned very frequently throughout the day but was not able to produce documentation of his repositioning. In an interview on 06/17/2026 at 2:45 PM, Staff B, Director of Nursing/ RN said Resident 42 was repositioned every two hours, during Resident 42's care tasks. Staff B said repositioning should be documented in the Resident care record but was not. Staff B stated, This is an issue with documentation. That's something we need to improve on. Reference WAC 388-97-1060 (3)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure physician orders were followed for 1 of 1 sampled resident (Resident 30) reviewed for pain medication. This failure placed residents risk of receiving unnecessary medications and a diminished quality of life. Findings included. Record review of the facility's policy titled, Administering Pain Medications, dated April 2025, showed, 6. Administer pain medications as ordered. Resident 36 was admitted to the facility on [DATE]. The 5-day Minimum Data Set, and assessment tool, dated 05/31/2026, indicated Resident 36 was alert and oriented. Record review of Resident 36's physician's order, dated 05/22/2026, showed Resident 36 was prescribed Oxycodone (a narcotic pain medication) tablet, give 2 tablet [sic] by mouth every 4 hours as needed for severe pain 7-10. Record review of Resident 36's medication administration record (MAR), dated May 2026, showed Resident 36 received two oxycodone tablets for pain levels less than seven on two separate occasions both were for pain levels of six. Record review of Resident 36's MAR, dated June 2026, showed Resident 36 received two oxycodone tablets for pain levels less than seven on eight different occasions, seven times was for pain level of six and one time for pain level of five. During an interview on 06/17/2026 at 1:34 PM, Staff K, Unit Manager/Registered Nurse (RN), said nursing should attempt non-pharmacological interventions before the use of Oxycodone. If the non-pharmacological interventions don't work, then the nurse could give the Oxycodone as ordered. During an interview and record review on 06/17/2026 at 2:05 PM, Staff B, Director of Nursing/RN, after reviewing the June 2026 MAR said she saw several sixes. Staff B said the oxycodone should not have been given. Reference WAC 388-97-1060 (1), (3)(k)(i)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document/monitor targeted behaviors for 1 of 5 residents (Resident 49) reviewed for mood and behavior. This failure placed residents at risk for unmet psychosocial needs and a decreased quality of life. Findings included . Resident 49 was admitted to the facility on [DATE], with multiple diagnoses to include Dementia (group of symptoms affecting memory, thinking and social abilities) with mood disturbance, Major Depressive Disorder (mental health condition defined by a persistent feeling of sadness, emptiness, and loss of interest in activities), and Generalized Anxiety Disorder (mental health condition characterized by excessive, and uncontrollable worry about everyday events and activities). Record review of The Quarterly Minimum Data Set, an assessment tool, dated 05/18/2026, indicated Resident 49 was severely cognitively impaired. In an interview with Resident 49's roommate (Resident 27), on 06/15/2026 at 3:03 PM, Resident 27 reported Resident 49 had been getting up in the middle of the night, walked over to Resident 49's bed and shook it repeatedly. Resident 27 said this happened daily, and stated, I asked her to stop and told nurses several times, but nothing. Record review of Resident 49's Neurological Status Evaluation, dated 06/06/2026, documented the following recommendations: The resident's behavior warrant's further evaluation of condition. The resident's elopement behavior warrants a wander guard placed to the back Velcro fold of her w/c [wheel chair].Record review of Resident 49's Electronic Health Record (EHR) showed no documentation of mental health consult, evaluation for behaviors, and/or elopement.Record review of Resident 49's care plan, dated 03/24/2026, did not document a focus area addressing dementia behavior monitoring. In an interview on 06/17/2026 at 10:41 AM, Staff O, Registered Nurse, said Resident 49's behaviors had increased due to a Urinary Tract Infection (UTI) [infection caused by bacteria entering the urinary tract], but the behaviors had since subsided. Staff O stated, she was looking for her husband, and walking around. With the exception of a single documented behavioral episode, dated 06/06/2026, no other documents were available. In an interview on 06/17/2026 at 10:35 AM, Staff E, Resident Care Manager/Licensed Practical Nurse, said if residents were exhibiting behaviors, they should be documented. Staff E stated, her behaviors had actually gotten better, and she is not disturbing at night. Staff E was unable to produce additional documentation of Resident 49's behaviors. In an interview on 06/17/2026 at 2:35 PM, Staff B, Director of Nursing/ Registered Nurse, said Resident 49's behavior should have been monitored and documented. Reference WAC 388-97-1060 (1)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered by professional standards of practice for 1 of 2 sampled residents (Resident 36) reviewed for medication administration. This failure placed residents at risk for medication errors, negative outcomes, and a diminished quality of life. Findings included. Resident 36 was admitted to the facility on [DATE]. The 5-day Minimum Data Set, and assessment tool, dated 05/31/2026, indicated Resident 36 was alert and oriented. Record review of Resident 36's Medication Self-Administration Evaluation, dated 05/24/2026, indicated Resident 36 was not granted approval to self-administer medication. During an observation on 06/15/2026 at 12:33 PM, an unidentified nursing assistant (NA) took Resident 36's lunch tray into the room. The NA was observed moving a small pill cup from the bedside table and placing it on the tray. After the NA left the room, it was observed that there were three pills in the pill cup. ~ During an interview and observation on 06/15/2026 at 12:41 PM, Staff L, Licensed Practical Nurse, when asked about Resident 36 being able to self-administer medications, Staff L said Resident 36 was not approved. Staff L walked over to Resident 36's room and observed the pill cup on Resident 36's tray containing three pills: oxybutynin (an antispasmodic medication to treat overactive bladder and neurological bladder conditions), baclofen (an antispasmodic medication) & oxycodone (a narcotic pain medication). Staff L asked Resident 36 to take his medication before leaving the room. Staff L said she was supposed to observe residents' taking their medications before leaving the room. During an interview on 06/17/2026 at 10:16 AM, Staff B, Director of Nursing/Registered Nurse said nurses should witness residents taking medications before leaving the room. Reference WAC 388-97-1300 (1)(b)(ii)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure food items were labeled and dated when opened in 1 of 1 Resident Food Refrigerators. This failure placed residents at risk for food borne illness, and a diminished quality of life. Findings included . Record review of the facility policy, titled, Safe Handling of Foods from Visitors, dated 08/25/2025, documented: 4. When food items are intended for later consumption, the responsible staff member will: Ensure that the food is stored separate or easily distinguishable from the facility food. Ensure that foods are in a sealed container to prevent cross contamination. Label foods with the resident's name, and the current date and use by date (2 days from date when the food was brought in). Example: day 1 is the date of food was brought in = 2/1/21. Use by date is 2/2/21. During an observation on 06/17/2026 at 2:15 PM, the resident food refrigerator, was observed with the following expired, opened items: One unsealed/ loose pancake in the back of the refrigerator without a use by date. One white paper bag containing a plastic cup of clam chowder soup with a use by date of 06/15/2026. One plastic jar containing cottage cheese with a use by date of 6/11/2026. One blue plastic shopping bag containing apples- with multiple of them spoiled and mushy with a use by date of 06/04/2026. One black plastic shopping bag containing yogurts with a use by date of 06/07/2026. One Ziplock bag containing 3 hardboiled eggs with a use by date of 06/14/2026. One resealable bag of TruFru chocolate strawberries, with a use by date of 01/25/2026. In an interview on 06/17/2026 at 2:12 PM, Staff C, Dietary Manager, said the resident food refrigerator was maintained by the nursing staff, and not the kitchen. In a joint interview and observation on 06/17/2026 at 2:21 PM, Staff E, Resident Care Manager/Licensed Practical Nurse, said it was the responsibility of the nursing staff to maintain the refrigerator, label all items and dispose of expired items. After assessing the contents of the refrigerator, Staff E proceeded to throw out the expired and unlabeled food items. In an interview on 06/17/2026 2:37 PM Staff B, Director of Nursing/Registered Nurse, said she expected food items in the refrigerators to be labeled accurately per policy and to be discarded by the use by date. Reference WAC 388-97-1100 (3) & 2980		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Montesano Health-Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 N Medcalf Lane Montesano, WA 98563	
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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure arbitration (a procedure used to settle a dispute using an independent person mutually agreed upon by both parties) agreements were explained in a form and manner understood by the resident and/or their representative for 1 of 3 residents (Resident 51) reviewed for arbitration. This failure placed residents at risk of lacking understanding of the legal document signed and a diminished quality of life. Findings included. Resident 51 was admitted to the facility on [DATE]. The admission Minimum Data Set, an assessment tool, dated 04/28/2026, documented Resident 51 was moderately cognitively impaired. Record review showed Resident 51 signed an arbitration agreement on 04/22/2026. Record review of Resident 51's Brief Interview for Mental Status (BIMS, a 0-15 standardized cognitive screening tool to assess attention, orientation, and memory, with higher scores indicating better cognitive health) completed on 04/23/2026 documented Resident 51's BIMS score was 9, indicating moderate cognitive impairment. In an interview on 06/18/2026 at 12:09 PM, Resident 51's representative said she signed many documents on Resident 51's admission but did not recall signing an arbitration agreement. In an interview on 06/18/2026 at 1:07 PM, Staff I, Admissions Coordinator, said residents whose BIMS were 12 or lower were not given the arbitration agreement but it was offered to their representatives. When asked if Resident 51 signed the arbitration agreement, Staff I said Resident 51's representative asked Staff I to have Resident 51 sign the agreement. Staff I was unable to provide documentation of the directive given by Resident 51's representative. No associated WAC		

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NAME OF PROVIDER OR SUPPLIER Montesano Health-Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 N Medcalf Lane Montesano, WA 98563	
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 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a Medicare Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN - provides information about services that may not be paid for by Medicare, making the resident financially responsible) for 2 of 3 sampled residents (Residents 39 & 40) reviewed for Beneficiary Notification. This failure deprived residents of their right to make an informed financial decision about continuing their care and the related charges. Findings included. Resident 39 was re-admitted to the facility on [DATE]. The Quarterly Minimum Data Set (MDS, an assessment tool), dated 04/24/2026, documented Resident 39 was moderately cognitively impaired. Resident 39 did not discharge from the facility immediately following the last covered day of Part A Service. Record Review of Resident 39's SNF Beneficiary Notification Review Form, received on 06/17/2026, showed the following: Medicare Part A Skilled Services Episode Start Date: 04/14/2026 Last covered day of Part A Service: 05/18/2026 How was the Medicare Part A Service Termination determined?: The facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Was a SNF ABN Form provided to the resident: no Resident 40 was re-admitted to the facility on [DATE]. The Quarterly MDS, dated [DATE], documented Resident 40 was alert and oriented. Resident 40 did not discharge from the facility immediately following the last covered day of Part A Service. Record Review of Resident 40's SNF Beneficiary Notification Review Form, received on 06/17/2026, showed the following: Medicare Part A Skilled Services Episode Start Date: 12/01/2025 Last covered day of Part A Service: 02/15/2026 How was the Medicare Part A Service Termination determined?: The facility initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Was a SNF ABN Form provided to the resident: no In an interview on 06/17/2026 at 11:40 am, Staff A, Administrator, said the facility did not provide the residents with SNF ABN Forms, and that there had been confusion between departments regarding the responsibility for SNF ABN Form issuance and signature collection. Reference WAC 388-97-0300(1)(e)(5)(6)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Montesano Health-Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 N Medcalf Lane Montesano, WA 98563	
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 0646 Level of Harm - Potential for minimal harm Residents Affected - Some	Notify the appropriate authorities when residents with MD or ID services has 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 notify the state mental health authority coordinator of a significant change in physical condition, for 1 of 5 residents (Resident 25) reviewed for PASRR process (Preadmission Screening and Resident Review, a screening tool used to identify mental health needs). This failure placed the residents at risk for unmet care and a diminished quality of life. Findings included. Resident 25 was admitted to the facility on [DATE], with multiple diagnosis to include Depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in daily activities). The Significant Change Minimum Data Set (MDS), an assessment tool, dated 05/27/2026, documented Resident 25 was severely cognitively impaired and had a significant change in condition. Record review of Resident 25's electronic health record did not show a new Level I PASRR was completed when Resident 25 was determined to have had a significant change in condition on 05/27/2026. In an interview on 06/18/2026 at 9:44 AM, Staff F, MDS Coordinator/Registered Nurse, said Resident 25 was coded as a significant change on 05/27/2026, after having had a significant weight loss of 7.5% (percent). In an interview on 06/18/2026 at 10:09 AM, Staff H, Social Services Director, said a new PASRR was completed when a resident had a new diagnosis of serious mental illness or dementia. When asked whether Resident 25 had a new PASRR completed with the significant change MDS on 05/27/2026, Staff H said it was not, because Resident 25 had not had a new mental health diagnosis. Reference WAC 388-97-1975(7)		