STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505092	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Park Health and Rehab of Cascadia	2726 Alderwood Avenue Bellingham, WA 98225

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to ensure thorough investigation and resolution of grievances for one of one resident facility groups. This failure resulted in continued dissatisfaction among residents regarding how their grievances are being addressed and had the potential to impact residents quality of life. Findings included .Review of the facility policy titled: Grievance Process, with a revised date of 08/2025, documented that the Nursing Home Administrator or Designee was responsible for the grievance process including tracking and conclusion. The policy stated grievances would include the date received, summary of the resident grievance, steps to investigate the grievance, statement whether the grievance was confirmed or not confirmed, communication with the individual making the grievance to determine if resolution was satisfactory and maintained. Review of the facility grievance logs for the prior six months showed: August 2025 there were a total of 14 grievances logged. 5 of the total grievances were from the facility resident council and included concerns regarding communication, care, missing items and dietary grievances. September 2025 there were a total of 16 grievances logged. 8 of the total grievances were dietary grievances and 4 of those were from the resident council. October 2025 there were 11 total grievances logged November 2025 there were 4 grievances logged. An ongoing grievance form was found to have been created for dietary grievances from the resident council and were no longer being individually logged. December 2025 there were 3 grievances logged. In a group resident council interview on 01/13/2026 at 2:09 PM the following concerns were voiced: Resident 65 stated they used to come talk to you and get a written summation of what was done when you wrote a grievance and that has not happened for several years. The resident stated they were aware this was written in the regulation. Resident 65 stated Staff C, Social Services Manager was the grievance official but did not talk to us and stated, I never even get interviewed about my concerns. Resident 62 stated ?I don't even know that they have seen my grievances. There was no follow up for my grievances. No one comes to even talk to me about it, so nothing changes. Resident 62 stated they have repeatedly asked for less carbohydrates on their trays and less repetition. Resident 57 stated I never hear back about my grievances. No one talks to me about them.nothing happens. Review of a sample of resident grievances for the prior six months showed that the facility grievance investigations were incomplete. The facility failed to consistently identify the summary of the resident grievance, steps to investigate the grievance, statement whether the grievance was confirmed or not confirmed, providing written resolution and communication with the individual making the grievance to determine if resolution was satisfactory and maintained. In an interview on 01/15/2026 at 11:31 AM, Staff C stated the grievances come to social services, directly from residents or sometimes staff will help residents fill them out. There was also a mailbox outside the social service office so people can drop forms in. Staff C stated the issues are routed to the department that was involved but keeps the forms. Staff C stated the forms needed to be redone and we talk about the issues as a team and make a plan. Staff C stated there was follow up with the residents, and for the resident council specifically, they made the ongoing form and were meeting every month. Staff C acknowledged that the current grievance forms were not showing that the process was being followed. In an interview on 01/16/2026 at 10:44 (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM, Staff A, Executive Director stated grievances were reviewed in the facility stand up meeting and assignments made to address them and the paperwork remained with social services. Staff A stated they had not been following up regarding completion of the forms and had not been providing residents with a copy of the resolution of their grievances. Staff C was aware of the ongoing grievance concerns from the resident council group and stated the facility was working to address those concerns, acknowledging the documentation was not clear with respect to what was being done. Reference WAC 388-97-0460, 0920 (5)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 5 of 5 residents (3, 4, 9, 16, and 26) reviewed for limited Range of Motion (ROM) received necessary care and services. The facility failed to ensure residents received appropriate restorative nursing services programs as ordered. This failure placed residents at risk for decline in mobility and function, increased dependence on staff, and a decreased quality of life.Findings included . Review of the facility policy titled, Restorative Nursing, revised 09/10/2025, stated to promote the residents optimum function, a program will be developed by identifying, care planning and monitoring of a residents assessment and indicators.the program must be supervised by a licensed nurse. the licensed nurse will conduct an evaluation on a routine basis, including progress towards goals, and response to the program. <RESDIENT 3>Resident 3 was admitted to the facility on [DATE] with diagnoses that include hemiplegia (paralysis affecting one entire side of the body) to dominant right side of body, and end stage renal disease with dependence on renal dialysis (life-sustaining treatment that removes waste products and excess fluid from the blood). The Quarterly Minimum Data Set (MDS – an assessment tool) dated 12/14/2025, documented no refusal of care, substantial to maximum assist for assistance with personal hygiene, bed mobility and transfers. There was no restorative nursing or therapy coded on the assessment. Review of Resident 3's care plan focus dated 11/07/2025, documented that the resident required restorative nursing program related to decline in mobility, range of motion (ROM), physical weakness, and was at risk for contractures (permanent tightening of muscles, tendons, or skin that limit joint movement). The interventions included the following:- if resident refuses, see refusal care plan and follow directives as indicated, - monitor for decline in function, - monitor for pain, and report, - passive/active assist with ROM to elbow, shoulder, wrist, 1-2 sets with 5-10 repetitions 3-6 times a week,- Sit to stand with sit to stand lifts ten times, (Hold standing 1- 3minutes) 1 set with 10 repetitions 3-6 times a week,- review the restorative program routinely to validate the effectiveness and adjust as needed. Review of Resident 3's entire care plan, print date 01/12/2026, showed there was no refusal of care plan as directed in the restorative interventions. Review of Resident 3's restorative documentation for November 2025, December 2025 and January 1st – 12th of 2026 had the following documentation of the restorative program:- November 2025 the program was offered three times, the resident declined twice and accepted once with 5 minutes of exercise, - December 2025 the program was offered once with 5 minutes of exercise, and two documentations that the resident was out of the facility, - January 2026 (1st – 12th) the program was offered once with 10 minutes documented. Review of Resident 3's progress notes 11/01/2025 – 01/12/2026, there was no documentation of any monitoring, refusal, or assessment of the restorative program. In an observation and interview on 01/13/2026 at 8:31 AM, Resident 3 was observed sitting in their wheelchair in their room. The resident's right arm and hand were dangling between their legs; the limb was a discolored reddish/purplish tone. Resident 3 stated they are unable to feel or move their right upper limb after they had a motorcycle accident. Resident 3 stated when they first arrived at the facility, they worked with the therapy department and were working on standing on their own or with (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a transfer pole. Resident 3 stated they cannot do that anymore. They stated they are not getting any therapy currently and would prefer to, as their goal was to be able to care for themselves. In an observation on 01/14/2026 at 7:58 AM, Resident 3 was sitting on the side of their bed, feet on the floor, their right arm hanging between legs, dangling. In an interview on 01/14/2026 at 9:04 AM, Staff G, Director of Rehabilitation, stated that Staff B, Director of Nursing (DNS) has been responsible for the restorative nursing program at the facility. In an observation and interview on 01/14/2026 at 9:50 AM, Resident 3 was sitting on the side of the bed, feet on the floor. Their right arm was dangling, their fingers on their right hand were partially curved closed. Resident 3 was asked if they were able to straighten their fingers out, they used their left hand to pry fingers out, then placed the right hand on the mattress so the fingers to the right hand would be straight out. Resident 3 was asked if that was painful, and they responded yes, it is. In an interview on 01/15/2026 at 1:04 PM, Staff H, Restorative Aid (RA)/Nursing Assistant Certified (NAC) stated they are responsible for completing restorative nursing programs Sunday – Thursday, then another aid will work Friday and Saturday. Staff H stated they have roughly 34 residents on restorative nursing programs, around 17 on the [NAME] Hall, and 17 on the Central Hall. Staff H was asked if they can complete the restorative programs for all individuals throughout the week and they responded, most of the time. Staff H stated they are not asked to work at NACs on the floor but are pulled to assist with two person transfers often. Staff H stated that if a resident refused, they were to document in the electronic medical record. Staff H stated if a resident continued to refuse, they would notify the licensed nurse responsible for the restorative nursing program. Staff H was asked how Resident 3 was participating in their restorative nursing program. Staff H stated they are tricky due to a room move, and that they are out of the facility three times a week for dialysis, and so therefore they have not really got around to offering them the program. Staff H was asked who the licensed nurse was that they report to, and they responded that Staff B, DNS had been entering the new program into the medical record, and that the MDS nurse that was out on leave was working on the programs, but they were not sure when that person was to return. In a joint interview on 01/16/2026 at 8:15 AM, Staff I, Resident Care Manager (RCM)/Licensed Practical Nurse (LPN), and Staff B, DNS, were asked if they were aware of the discoloration to Resident 3's right arm, and the potential contraction of their right fingers. Staff I stated, I think I mentioned to the provider that their arm was off color, I do not believe I documented that though. Staff B stated they were unaware of the discoloration or potential contraction of the right fingers, they were made aware of the resident observation, and that they had reported pain. <RESIDENT 9> Resident 9 was admitted to the facility on [DATE], with diagnoses to include spinal stenosis, muscle wasting and atrophy. Review of the physical therapy notes on 08/09/2025 showed the Physical Therapist (PT) established an restorative program for Resident 9 which included bilateral lower extremity ([NAME]) exercises both lying down and while seated in the wheelchair. The note included that PT communicated with the RA personnel and provided education/training. Resident 9 verbalized understanding that they had been discharged from therapy and would begin a restorative program for [NAME] exercise per recommendation. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly MDS assessment, dated 11/25/2025, showed Resident 9 utilized a wheelchair and had limited range of motion to one side of their upper extremity. The resident did not reject care. Review of Resident 9's current care plan directed staff to provide a restorative nursing program (RNP) related to muscle weakness, low activity tolerance and maintain strength beginning 08/13/2025. The care plan goal showed the resident would tolerate hip ROM, knee ROM, and ankle ROM for 2 sets of 10 repetitions, three to six times a week. The interventions included to monitor for decline in function, refer to therapy as needed and review the restorative program routinely to validate effectiveness and adjust the program as indicated. In an observation and interview on 01/12/2026 at 8:59 AM, Resident 9 was lying in bed with a left arm brace on and stated the staff doesn't move them around enough or turn them. Resident 9 stated their back pain would be improved with more exercise. The resident stated therapy cut them off and they did not get restorative. The resident stated they did not know why they were not getting therapy. In an interview on 01/16/2026 at 9:46 AM, Resident 9 stated they didn't get exercise after they were taken off PT related to money and they felt they were in a state of decline. Observations on all dates of the survey (01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026 and 01/16/2026), showed Resident 9 was not observed to receive RNP services. Review of Resident 9's clinical record showed the resident did not receive an RNP as recommended by PT and care planned. In an interview on 01/16/2026 at 10:14 AM, Staff H, Restorative Aide, stated Resident 9 did not have a restorative program. In an interview on 01/16/2026 at 11:11 AM, Staff B, DNS, stated Resident 9 was to have an RNP three to six times a week. Staff B reviewed the clinical record and stated the order had been incorrectly placed under the goal portion of the care plan so Resident 9 had not received any restorative services yet. In an interview on 01/16/2026 at 11:32 AM, Staff L, Restorative Aide stated Resident 9 did not have an RNP. <RESIDENT 4> Resident 4 was admitted to the facility on [DATE], with diagnoses to include pelvic fracture, kyphosis (excessive outward curvature of the spine), muscle weakness and pain in the left leg, and difficulty walking. Review of the physical therapy notes on 12/09/2025 showed the PT established an RNP for Resident 4 which included bed mobility exercises, sit to stand with their front wheeled walker (FWW) five times, lying to sitting at edge of bed once for functional maintenance to improve their functional mobility. Review of Resident 4's current care plan directed staff to provide a RNP related to prevention of a decline in activities of daily living (ADL's) beginning 12/22/2025. The care plan goal directed staff to work on bed mobility lying to sitting for one set and transfers sit to stand with FWW one set for 5 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reps, three to six times per week. The interventions included to monitor for decline in function and review the restorative program routinely to validate effectiveness and adjust the program as indicated. In an interview on 01/13/2026 at 8:47 AM, Resident 4 stated they fell at the facility and broke their pelvis. The resident stated they used to get therapy daily on the other unit, and not on this unit. Resident 4 stated they chalked that up to their insurance running out. The resident stated they had to ask for exercise, and they were only getting it maybe twice a week. In an interview on 01/14/2026 at 8:12 AM, Resident 4 was resting in bed and stated, They don't do anything with me. (Staff L, RA) took me to the gym once this week and did not know what to do with me. I can't get there (gym,) myself. I need exercise. In an interview on 01/16/2026 at 10:14 AM, Staff H, RA, stated Resident 4 was on their caseload for standing with a walker, sitting on the edge of the bed. Staff H stated they had only got to their RNP twice this week. Staff H stated they were supposed to get RNP three times a week and they did not refuse their restorative program. In an interview on 01/16/2026 at 11:11 AM, Staff B, DNS stated Resident 4's RNP was implemented on 01/09/2026. In an interview on 01/16/2026 at 11:32 AM, Staff L, RA, stated they just started working with Resident 4 two weeks ago. <RESIDENT 16> Resident 16 re-admitted on [DATE] with diagnosis to include reduced mobility with quadriplegic cerebral palsy (most severe form of cerebral palsy with entire body impairment), muscle weakness, osteoarthritis. Review of Resident 16's quarterly MDS assessment, dated 12/10/2025, showed Resident 16 utilized a wheelchair and had limited range of motion both sides of their lower extremities. The resident did not reject care. Review of Resident 16's current care plan directed staff to provide a RNP related to cerebral palsy and muscle weakness beginning 08/30/2022. The care plan goal showed the resident would tolerate upper and lower extremity passive range of motion (PROM - staff completes the movement for the resident) times 5-10 reps, three to six times a week. The interventions included to monitor for decline in function, refer to therapy as needed and review the restorative program routinely to validate effectiveness and adjust the program as indicated. In an interview on 01/16/2026 at 10:29 AM, Resident 16 stated they received their RNP sporadically and were supposed to get their RNP on Monday, Wednesdays and Fridays. Review of the clinical record did not show an RNP. In an interview on 01/16/2026 at 11:11 AM, Staff B, DNS stated Resident 16 was getting their RNP once a week and received it twice this week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 01/16/2026 at 11:32 AM, Staff L, RA, stated they do resistance bands and ROM with their legs. Staff L stated Resident 16 did not refuse their RNP. <RESIDENT 26> Resident 26 admitted on [DATE] with diagnoses to include spinal stenosis (narrowing of spaces in the spine causing pain, numbness, weakness), spondylosis (wear and tear on the vertebrae and discs), weakness and muscle wasting. Review of Resident 26's quarterly MDS assessment, submitted 01/02/2026, showed Resident 26 utilized a wheelchair and had limited range of motion both sides of their lower extremities. The resident did not reject care. Review of Resident 26's current care plan directed staff to provide a RNP related to quadriplegia beginning 09/02/2022. The care plan goal showed the resident would tolerate the restorative program. The RNP was for PROM lying, left upper extremity active assist to PROM to the shoulder 3-6 times a week, and PROM to bilateral hips 2 sets for 10 reps, three to six times a week. The interventions included to monitor for decline in function, refer to therapy as needed and review the restorative program routinely to validate effectiveness and adjust the program as indicated. In an interview on 01/16/2026 at 10:29 AM, Resident 26 stated they received their RNP sporadically, once or twice a week rather than three times a week. Review of the clinical record did not show an RNP. In an interview on 01/16/2026 at 11:11 AM, Staff B, DNS stated Resident 26 received RNP on 01/07/2026, 01/09/2026 and 01/14/2026 and was getting their RNP two to three times a week. In an interview on 01/16/2026 at 11:32 AM, Staff L, RA stated they do exercises with Resident 26. Staff L stated Resident 26 did not refuse their RNP. In a follow up interview on 01/16/2026 at 11:33 AM, Staff B was asked how the restorative nursing program worked here that the facility. Staff B stated as therapy recommended programs, they were initiating them in the electronic medical records for the aids to complete. Staff B stated that since the primary restorative aid was a family member, they were unable to directly supervise the program. Staff B stated previously the MDS nurse was the primary responsible party to manage the programs, assess if they were effective and document and update as needed. Staff B stated the MDS nurse who was responsible has been out on leave since mid-October 2025. The other MDS nurse worked remotely and was unable to supervise. Staff B confirmed they have only been discontinuing, or changing the program, and that was all they had done. Reference: (WAC) 388-97-1060 (3)(d)(j)(ix)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that 1 of 6 residents (Resident 3) reviewed for the Preadmission Screening and Resident Review (PASRR - a federally required screening of all individuals for Intellectual Disability (ID) or Related Condition and a Serious Mental Illness (SMI) prior to admission) process. The facility failed to ensure a resident with a positive Level 1 PASRR had a Level 2 evaluation completed for a resident that qualified with ID for services. This failure placed residents at risk for unidentified health care needs, lack of services and diminished quality of life.Findings included .Review of the facility policy titled, Pre-admission Screening & Resident Review Process, revised 08/29/2025 stated the facility would necessitate any positive level 1 screens for an in-depth evaluation, and recommendations would be incorporated into a resident's plan of care.Resident 3 was admitted to the facility on [DATE] with diagnoses that include hemiplegia (paralysis affecting one entire side of the body) to dominant right side of body, and end stage renal disease with dependence on renal dialysis (life-sustaining treatment that removes waste products and excess fluid from the blood). The Quarterly Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], documented the resident had intact cognition, moderate depression, and no refusal of care. Review of Resident 3's Level 1 PASRR dated 08/21/2025, showed Resident 3 required a Level 2 evaluation for ID.Review of Resident 3's PASRR Level 2 determination letter dated 08/14/2025, showed the resident did have an intellectual disability or related condition, did meet the requirements for nursing facility, and did require new specialized services in order to acquire skills and behaviors that would enable the resident to function with as much self-determination and independence as possible, and/or in order to prevent or slow the loss of current functional status. Review of Resident 3's medical record showed no evaluation of what services the resident qualified for or required based on the positive Level 2 determination. Review of Resident 3's care plan focus dated 09/19/2025 stated the resident had impaired cognitive function/dementia or impaired thought process related to developmental delay. Interventions were not specific to Resident 3; there was no mention of the positive PASRR Level 2 and did not include any individualized services that the resident qualified for. Review of Resident 3's progress notes from admission date 08/29/2025 to 01/12/2026 showed no documentation the facility had reviewed or inquired about what specialized services Resident 3 qualified for with the positive Level 2 PASRR determination. In observation and interview on 01/13/2026 at 8:31 AM, Resident 3 was observed to have disheveled hair, facial hair was unkempt and appeared scraggly, clothes were dirty and unbuttoned. The residents' breakfast tray was sitting on the bed, there were stains of yogurt, and crumbs on blankets. The residents' conversation was depressive, they would talk about their mother that passed away, it was difficult to keep the resident focused on a question or to get a clear answer. In observation on 01/14/2026 at 9:50 AM, Resident 3 was wearing same clothes as day before, hair was disheveled, facial hair unkempt and scraggly, clothes are stained with food. In observation on 01/15/2026 at 7:48 AM, Resident 3 was wearing same clothes as the last two days before, hair was disheveled, facial hair unkempt and scraggly, clothes are stained with food. In an interview on 01/15/2026 at 10:19 AM, Staff M, Nursing Assistant Certified (NAC) stated they relied on the care plan to ensure they have had the most accurate level of care each resident required. Staff M stated if they noticed something inaccurate, they notified the licensed nurse. Staff M stated when residents refused care they would reapproach and notify the nurse. Staff M stated that Resident 3 liked to stay up in their wheelchair and not be bothered so they just took that as a refusal of care and didn't approach. Staff M was unaware of Resident 3's intellectual delay or related condition. In an interview on 01/15/2026 at 11:24 AM, Staff N, NAC stated they used the care plan as guidance on what level of care each resident required. Staff N stated Resident 3 would refuse care all the time and would just stay in their wheelchair. Staff N (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that Resident 3 was in a lot of pain and would be grumpy so they would not push too hard if they refused to change clothes, or bathe. Staff N was unaware of Resident 3's intellectual delay or related condition. In an interview on 01/15/2026 at 12:28 PM, Staff O, Registered Nurse (RN) stated that Resident 3 would not follow their own care plan, or the fluid restriction they were on. Staff O was unaware of Resident 3's intellectual delay or related condition. In an interview on 01/15/2026 at 1:55 PM, Staff C, Social Services Manager, stated the social services department was responsible for managing the PASRR evaluations, and ensure the care plan was up to date. Staff C stated another social services department employee was working with Resident 3 and was unavailable for questions. Staff C stated they reviewed the medical record and emails and stated the facility had been trying to get services for Resident 3 but was not clear on the progress that had been made since admission. Staff C did confirm there was no documentation in the medical record to reflect the Level 2 evaluation was received, or if there were any recommendations for care. In a joint interview on 01/16/2026 at 11:33 AM, Staff A, Administrator and Staff B, Director of Nursing Services, Staff A stated they thought social services had been trying to get services for Resident 3. Staff A and Staff B were unaware of the lack of information in the residents' medical record, lack of evaluation in the medical record, and lack of individual care plan for Resident 3. Staff A and Staff B were not aware that the staff had not provided appropriate care to Resident 3 due to lack of guidance in the care plan related to the resident's intellectual delay or related condition. Reference WAC 388-97-1975

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure comprehensive care planning and implementation for 1 of 4 residents (Resident 66) reviewed for impaired range of motion. This failure placed residents at risk for impaired skin integrity and decreased quality of care. Findings included .Review of the facility policy titled, Comprehensive Care Plans and Conferences, with a revision date of 09/2025, stated the facility care plans would reflect the residents' individual conditions, risks, needs, behaviors, cultural values and preferences, and would include measurable goals, interventions and realistic timeframes. Resident 66 admitted [DATE] with diagnosis which included cognitive impairment and a fall with nerve injury and paralysis of the left arm and subsequent severe contracture (fixed shortening and hardening of muscles and other tissues) of the left hand. In an observation on 01/12/2026 at 10:55 AM, Resident 66 was in the hallway in their wheelchair, self propelling by pulling with their feet and using their right hand. The resident's left hand was visible, observed to be severely contracted in a fisted position with thick calloused overgrown appearance of the skin and nails grown in a curved long manner. In an interview on 01/13/2026 at 8:39 AM, Resident 66 was conversational and was asked about their left hand and what kind of care was being done for it. Resident 66 stated I fell about 5 years ago and after that it just started to curl up like this.I have to either get it amputated or just go along like this.they don't touch it, only the doctor can touch it. I just put a sock on it. Review of Resident 66's annual Minimum Data Set (MDS- a required assessment tool) assessment, dated 12/15/2026, showed no behaviors or rejections of care. In an interview on 01/15/2026 at 9:43 AM, Staff Q, Nursing Assistant Certified, stated they normally do nail care for residents while in the shower, after they check if the nurses need to do it, such as diabetic residents. Staff Q stated they (the nursing assistants) do not do anything with Resident 66's hand. In an interview on 01/15/2026 at 9:48 AM, Staff E, Registered Nurse, stated the only thing Resident 66 allowed them to do was cover the hand. Staff E stated they were supposed to offer when they do a skin check and attempt to cut the nails and document if there was a refusal. Review of the care plan related to skin integrity dated 07/25/2022 stated the resident was at risk for alteration in skin integrity due to impaired mobility and left hand contracture. The listed goal of intact skin did not include specific goals related to the contracture or specific risk associated. The interventions included nail care but did not include any contracture care or care related to the resident's left hand. Further record review of the weekly skin audit in the Treatment Administration Record showed only direction to document Y if there was new skin issue or N if none; however, that documentation was not found, only initials of the nurse and a checkmark with no corresponding progress note documentation of the condition of the left hand or any documentation that the resident accepted or refused cares of the hand. In an interview on 01/15/2026 at 11:08 AM, Staff B, Director of Nursing Services, stated Resident 66 became agitated or aggressive when staff attempted hand care, and was resistant. Staff B stated the nurses were supposed to be offering nail care and attempting to clean inside the hand, monitor and document appropriately. In a follow-up written communication on 01/15/2025 (time not documented) Staff B documented they had identified that Resident 66 does allow care of the hand at times by certain staff. Reference WAC 388-97-1020 (1)(2)(a), (4)(b)

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	505092	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Park Health and Rehab of Cascadia	2726 Alderwood Avenue Bellingham, WA 98225

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to consistently provide supervision, verbal cues or assistance with meals per the individualized assessments and plan of care and did not develop a process to document if supplements, alternative meals, or snacks were offered for 1 of 3 residents (Resident 58) reviewed for nutrition. Resident 58 experienced a severe weight loss of 18 pounds (lbs.), a 8.73 percent (%) of body weight in less than a month. This failure placed residents at risk of further weight loss, decline in nutritional status and decreased quality of life. Findings included . Review of the facility provided policy, Nutrition and Hydration, last revised 09/09/2025, showed the facility shall ensure each resident receives adequate nutrition to support their overall health and maintain clinically acceptable parameters. Care and services shall be based on the resident's comprehensive assessment. Serve at least three meals daily, if a resident declines a meal or specific item, offer a nutritionally similar alternative. Provide snacks between meals and at bedtime based on resident preference and/or clinical need. Ongoing visual observations of the resident's ability to consume and benefit from food and fluids, including the resident's self-feeding ability.Review of the State Operations Manual (SOM), Appendix PP- Guidance to Surveyors for Long Term Care Facilities, revised/issued on 07/23/2025 defined severe weight loss as greater than 5% in one month.Resident 58 was admitted to the facility on [DATE] with diagnoses to include Parkinson's (progressive brain disorder that primarily affects movement), unspecified protein-calorie malnutrition (form of undernutrition characterized by insufficient intake of protein and calories necessary for maintaining health), need for assistance with personal care and dementia (loss of cognitive function that interferes with daily life and activities) .Review of Resident 58's admission Minimum Data Set (MDS- an assessment tool) assessment, dated 12/21/2025, documented the resident had a Brief Interview for Mental Status (BIMS - a structured cognitive interview) score of 03 which indicated the resident had significant cognitive impairment. The assessment also showed Resident 58 required partial to moderate assistance with eating which indicated the resident needed physical assistance.Review of Resident 58's Mini Nutritional assessment, dated 12/10/2025, documented the resident had a score of 07 and indicated they were malnourished, with a moderate decrease in food intake, and had difficulties feeding themselves and preferred finger foods.Review of Resident 58's nutrition care plan, dated 12/10/2025, documented that they were at risk for nutritional decline with decreased ability to use utensils, and the Mini Nutritional assessment indicated they were malnourished. Nutritional interventions were to encourage family to visit at mealtimes, and if they consumed less than 50% of a meal, a snack or alternative would be offered. The care plan included interventions to monitor weight/weight changes, monitor/evaluate meal percentage intake via intake records and observation, update the resident advocate as indicated and provide feeding/dining assistance as needed. Review of Resident 58's Activities of Daily Living (ADL) care plan, dated 12/10/2025, documented they required supervision or touch assistance for eating finger foods, with verbal cues. There were no interventions in place to address what assistance the resident needed if they were not provided or served finger foods. Review of Resident 58's Kardex (a guide the care staff use to help direct the resident care), dated 01/13/2026, documented they required supervision or touch assistance for eating finger foods with verbal cues. There were no instructions for assistance needed if the meal provided was not finger foods or for snacks, or an alternative to be provided if they ate less than 50% of their meal. Review of Resident 58's weights documented on 12/10/2025, the resident weighed 207.4 lbs. and on 01/03/2026, the resident weighed 189.3 lbs. This was an 8.73% decrease in body weight in 24 days. In a continuous observation on 01/13/2026 from 8:37 AM until their breakfast tray was removed, Resident 58 was observed sitting up in their wheelchair, trunk and upper body leaning to the right, with their breakfast on the table in front of them. Staff entered the room, set up the resident's meal and then left the room, observation showed no supervision, verbal cues or assistance (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were provided to the resident. In an interview on 01/13/2026 at 10:12 AM, Collateral Contact (CC) 1, Resident 58's spouse/Power of Attorney (POA), stated the resident needed assistance to eat and had told facility staff they required assistance, but were unsure if the staff had assisted the resident to eat when they were not there at mealtimes. CC1 stated they felt the facility staff put pressure on them to come in at mealtimes to assist the resident. CC1 stated the resident did not like to eat in the dining room and preferred to eat in their room and would need assistance. CC1 stated they believed the resident had lost weight. CC1 stated they were unaware if Resident 58 had been weighed since they were admitted to the facility. CC1 stated they had not been informed of any information related to their weight status. In a continuous observation on 01/14/2026 from 8:29 AM until 8:47 AM, Resident 58 was observed sitting up in their wheelchair, trunk and upper body leaning to the right, with their breakfast tray in front of them. Observation showed no staff supervision, verbal cues or assistance was provided to the resident.In an interview on 01/16/2026 at 10:13 AM, Staff S, Nursing Assistant Certified (NAC)/Staffing Coordinator, stated they reviewed care plans to know what assistance and care a resident required. Staff S stated they had cared for Resident 58 and was aware they had trouble with their hand motor skills during meals. Staff S stated the resident preferred to eat in their room and they would set up the meal and stop by to give verbal cues if needed. Staff S stated if the spouse was not there at mealtimes, they would try to take them to the dining room. Staff S stated they were unsure if any snacks or alternatives were to be given and would document any snacks or alternatives given into their meal monitor included in the meal documentation. Staff S stated they would not document snacks or alternatives separately and were unable to explain how to tell if a resident had eaten a meal, was provided a snack, or an alternative. Staff S stated they obtain the resident weight, gave the information to the nurse, and the nurse documented the resident's weight in their medical record. Staff S stated they were unable to see if a resident had lost weight since they do not input the information into the medical record.In an interview on 01/16/2026 at 10:25 AM, Staff T, Licensed Practical Nurse/Resident Care Manager (LPN/RCM), stated Resident 58 needed extensive assist and was very forgetful. Staff T stated staff were to set up Resident 58's meal and supervise to see if they required verbal cues and provide assistance if needed. Staff T stated they review meal monitor documentation to know how much a resident was eating. Staff T stated they thought the Registered Dietitian (RD) would inform the resident representative of their weight loss or tell the RCM to do it but was unsure of the facility process. Staff T stated they thought they could look at the meal monitor to see if a snack or alternative was offered but were unsure about specific documentation related to whether a snack or alternative been offered or consumed. Staff T stated they were unsure if the care plan had an intervention to offer snacks or alternative if less than 50% of the meal was consumed. Staff T stated they were unsure about what assistance was needed if the food provided to Resident 58 was not finger foods.In an interview on 01/16/2026 at 10:37 AM, Staff B, Chief Nursing Officer (CNO), stated their expectation for staff was to follow the standards of care, make sure resident needs were being met, and the care plan was followed. Staff B stated Resident 58 usually ate in their room and was encouraged to eat in the dining room. Staff B stated supervision and light touching assistance with meals meant staff were to set up the meal, check in and give verbal cues or assist the resident if needed. Staff B stated the spouse would come in to assist the resident with meals. Staff B stated the MDS assessment should have been followed, which indicated partial to moderate assist with eating, and the information did not make it to the care plan. Staff B stated if the RD had an intervention in the care plan to offer snacks or alternatives for a resident if they ate less than 50% of their meal, there should have been a separate task set up for staff to be able to document information related to supplements, snacks or alternatives. Staff B stated there was no way to know if the resident was offered snacks or alternatives with the current documentation. Staff B confirmed the care plan was unclear related to the assistance Resident 58 required if not provided finger foods for meals. Staff B stated their expectation was the resident's POA would have been notified of their weight loss and the notification information would be (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented in their medical record. Staff B confirmed they were unable to locate documentation of weight loss notification to Resident 58's POA. Staff B stated they were aware the resident had experienced weight loss but was unaware it was severe. Staff B stated the resident had not triggered on their weekly weight loss report. Reference WAC: 388-97-1060(3)(h)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that 3 of 3 residents (Residents 9,16 and 26) reviewed for respiratory care, were provided care consistent with professional standards of practice. Failure of the facility to ensure oxygen (O2) delivery per physician's order, monitor, assess and address resident responses to O2 therapy (Resident 9), and ensure ordered Continuous Positive Airway Pressure (CPAP, non-invasive ventilation machine that involves the administration of air usually through the nose by an external device at a predetermined level of pressure) equipment was in place when ordered, and to ensure CPAPs were cleaned and parts replaced per manufacturers recommendations. These failures placed residents at risk of respiratory infection, respiratory distress, lack of restful sleep and diminished lung condition.Findings included .According to the facility policy titled, BiPap/CPAP Administration, dated 09/12/2025, showed the facility would provide non-invasive ventilation using BiPap or CPAP therapy in accordance with physician orders and professional standards of practice. The procedure directed the nurses to obtain a physician's order specifying, mode, pressure settings, mask type and size, oxygen flow rate if applicable, frequency of use. The nurses were directed to document therapy initiation and resident response and any adjustments made. The policy directed staff to clean equipment per manufacturer guidelines.<RESIDENT 9> Resident 9 was admitted to the facility on [DATE], with diagnoses to include chronic obstructive pulmonary disease (COPD-group of diseases that cause airflow blockage and breathing problems), obstructive sleep apnea (OSA - residents repeatedly stop and start breathing while they sleep) and chronic respiratory failure with hypercapnia (buildup of carbon dioxide in the blood from poor ventilation treated with oxygen and CPAP) . Review of a progress note dated 07/24/2025 at 2:20 PM, Staff B, Director of Nursing Services, (DNS) documented Resident 9 expressed interest in attempting to get another CPAP as theirs was taken a long time ago. Provider was notified and ordered to refer the resident to pulmonology to obtain a new sleep study. Review of a progress note written by Staff K, Admissions Coordinator dated 07/25/2025 at 8:26 AM showed a referral was sent to pulmonology for history of BiPap (device that has two different pressure levels) /CPAP use and resident's request to use one again. Staff K documented they would follow up with the clinic regarding referral and schedule an appointment once received. Review of the clinical record showed no further progress notes regarding follow up to obtaining the CPAP. Review of the July, August, September and October Treatment Administration Record's (TAR's) showed an alert at the top of each page that showed referral to pulmonology related to resident wanting a CPAP. Review of a progress note dated 11/21/2025 at 3:03 PM showed Resident 9 was on supplemental oxygen use via nasal canula on 2 liters per minute (L/min) and a local vendor dropped off a BiPap machine. Review of the admission Minimum Data Set (MDS - an assessment tool) assessment dated [DATE] showed Resident 9 did not use oxygen, BiPAP or CPAP and did not refuse care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician's orders dated 11/21/2025 included Oxygen at 2 liters per minute (LPM) continuously per nasal cannula via 02 concentrator and document if the resident was anxious or in distress every shift for Chronic Respiratory Disease and BiPAP at 18 cm H20 Inspiration; 8cmH20 expiration for tidal volume of oxygen at 2L/min. BIPAP scheduled start at 2200 and discontinued at 0600 to meet goal of 8 hours each night, every shift for OSA. Review of Resident 9's care plan did not address the residents' BiPap supply vendor, contact information, brand of BiPap, manufacturers guidelines and when the equipment was required to be replaced. The care plan did not address cleaning the humidifier chamber. In an interview and observation on 01/12/2026 at 9:05 AM, Resident 9 was resting in bed without oxygen on. An oxygen concentrator was at the foot of the bed in the off position. The resident had BiPAP at bedside with no filter in it. Resident 9 stated they had sleep apnea, and the staff had never cleaned their machine. The resident stated they got on the staff about the cleaning last week and they did not understand why the nurses did not check the water level. Resident 9 stated that staff must expect them to put their oxygen and CPAP (resident referred to the BiPAP as CPAP) on because they don't help them. The resident stated they cannot get to their oxygen or CPAP as they were weak, and the machines were located out of their reach at the end of their bed. In an interview on 01/15/2026 at 8:25 AM, Resident 9 was in bed on their right side without oxygen on. The resident stated they were not happy with what was going on at the facility and they did not get their CPAP on again last night. The resident stated the last time the CPAP was on, was a week ago. The resident stated the CPAP machine was a few weeks old and they did not have one here before this despite asking the nurses for one for months. The resident stated they had very bad sleep apnea and they were afraid they would be found dead in bed. The resident said they had required a CPAP for many years and they must wear it. They said the staff would check in and ask them what time they wanted their CPAP on, but then they would not come back to put it on them. The resident said they had instructed the nurses that if they came in and saw them asleep, to still put it on them. Resident 9 stated they had not observed cleaning of the water reservoir, tubing, mask or headgear. The CPAP remained located at the foot of the bed, out of their reach with no filter in place. In an observation on 01/16/2026 at 9:46 AM Resident 9 was lying in bed on their right side, without oxygen on. The resident stated they were really upset that the staff don't put their CPAP on or clean it. The resident stated, the staff rarely check their oxygen saturations and they could die. Resident 9 was observed without oxygen on for all observations on 01/12/2026, 01/13/2026, 01/14/2026, 01/15/2026, and 01/16/2026. Review of the clinical record showed oxygen saturations were not routinely monitored to assess response to oxygen therapy. Oxygen saturations were checked 7 days in November, 4 days in December and 3 days in January as of 01/16/2026 at 12:27 PM. In an interview on 01/16/2026 at 11:11 AM, Staff B, DNS, was asked about conflicting BiPAP cleaning orders and the care plan lacked BiPap parts replacement schedule. Staff B was informed Resident 9 was concerned about the lack of oxygen saturation monitoring and the last documented 02 sat was 01/10/2026. Staff B was made aware the resident was observed without oxygen on 01/12/2026 although nurses documented they were on 2 liters of oxygen. The documentation on 01/13/2026, 01/14/2026 and 01/15/2026 day shift showed NA which reflected medication not available. Staff B stated they would need to look into that. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/16/2026 at 1:15 PM, Staff K, Admissions Coordinator stated they called to order a CPAP for Resident 9 in July, but the prior settings were outdated, and the vendor would not send a CPAP. Staff K stated there were no pulmonary appointments available for months. <RESIDENT 16> Resident 16 re-admitted on [DATE] with diagnosis to include OSA. Review of Resident 16's physician orders dated 03/01/2024, showed CPAP/BiPAP Machine Non-Disposable Tubing Care and headset frame, Soak CPAP tubing and headset frame in warm soapy water x 20 minutes, rinse with clean water, and then let air dry one time a day every Sat for CPAP tubing care. Review of Resident 16's care plan dated 03/05/2024 did not address the residents' CPAP supply vendor, contact information, brand of CPAP, settings, manufacturers guidelines and when the equipment was required to be replaced. The care plan did not address cleaning the humidifier chamber. <RESIDENT 26> Resident 26 admitted on [DATE] with diagnosis to include OSA. Review of the physician order dated 03/01/2024 directed nurses to place Resident 26's CPAP at 16-20 centimeters (cm) H2O on room air with humidification. The nurse was to empty and rinse reservoir tank prior to filling it with fresh distilled water and turning on CPAP at bedtime and discontinue at 8:00 AM. Review of a physician order dated 12/09/2025 showed CPAP/BiPAP machine daily care was to remove mask from head gear. Clean mask and cushion with warm soapy water or with a CPAP wipe one time a day. Review of a physician's order dated 10/03/2025 showed CPAP/BiPAP machine non-disposable tubing care to be completed Sunday morning and nurse to wash tubing, reservoir, mask in warm soapy water rinse items thoroughly with cold water and let air dry. CPAP tubing should be hung up while drying every Sunday day shift. Review of Resident 26's care plan dated 07/05/2022 did not address the residents' CPAP supply vendor, contact information, brand of CPAP, settings, manufacturer's guidelines and when the equipment was required to be replaced. The care plan did not address cleaning the humidifier chamber. In an interview on 01/15/2026 at 1:48 PM, Staff D, Infection Preventionist stated the Nurses are to follow manufacturer's instructions and orders for CPAP cleaning and part replacement. They stated CPAP directions should be on the orders and care plans. In an interview on 01/15/2026 at 2:59 PM Staff J, Registered Nurse, stated orders regarding CPAP cleaning and equipment changes should be in the TAR. Staff J stated they were unsure of when the parts are to be replaced. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/15/2026 at 3:02 PM, Staff F, Licensed Practical Nurse (LPN) stated they did not know who changes the CPAP tubing as they just clean the water reservoir. Staff F stated they would go ask for clarification. Staff F came back and stated CPAP tubing was supposed to be cleaned daily. Staff F said they did not know when headgear and mask were to be cleaned or when supplies were to be changed/replaced. In an interview on 01/16/2026 at 11:00 AM, Staff R, LPN stated CPAP tubing was cleaned once a week on days and evenings. Staff R further stated the tubing was washed on Sundays and head gear was washed once a week. Staff R stated the mask was to be wiped down with warm water only, once a day. Staff R stated there were days they had missed their cleaning. In an interview on 01/16/2026 at 11:56 AM, Staff I, LPN/Resident Care Manager stated nurses wash the CPAP's weekly and it goes on the TAR. Staff I stated the facility was not responsible for changing the tubing or other parts and the vendor was. Staff I stated the vendors come in and change the equipment out and the nurses just needed to wash the tubing with soap and water. In a follow up interview on 01/16/2025 at 1:11 PM, Staff B, DNS stated they had taken pictures of the CPAP's and would obtain the device manuals then revise the care plans and orders to include the manufacturer's recommendations and instructions. No additional information was received. This is a repeat deficiency from 01/07/2025. Reference: WAC 388-97-1060 (3)(j)(vi)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection prevention practices were followed for 1 of 2 residents (Resident 7) reviewed for wounds, and for 1 of 4 residents (Resident 68) reviewed for transmission-based precautions. These failures placed residents at risk for infection due to cross contamination. Findings included .Review of the facility policy titled: Hand Hygiene, with a revised date of 09/2025 stated all healthcare workers perform hand hygiene at critical moments during resident care which included moving from soiled to clean tasks, contact with objects in the resident environment and following Personal Protective Equipment removal. Resident 7 admitted [DATE] with diagnoses which included pressure ulcers requiring wound care and enhanced barrier precautions. Review of Resident 7's wound care orders on 01/13/2025 documented the wound was dressed with a wound vacuum dressing changed three times per week (and as needed) which included cleansing with a prescribed wound cleanser, applying skin sealant and protective dressing around the wound, inserting a pre-cut foam to the wound bed and attaching suction at a prescribed strength with tubing connected to a cannister that collects wound drainage. An observation of wound vacuum dressing change was conducted on 01/13/2026 at 11:48 AM, Staff E, Registered Nurse and Staff F, Licensed Practical Nurse, were observed to enter Resident 66's room wearing appropriate personal protective equipment (gown, gloves, surgical mask) and prepared supplies for wound care. Staff E was observed to ask the resident roommate for permission to borrow their overbed table, and then picked up the roommates personal water pitcher, moved it to another table, and then rolled the table over to Resident 66's side of the room and began to place clean dressing supplies on top of the overbed table without disinfecting the surface. In a continued observation, at 11:55 AM, Staff F was observed to drop a package of gauze pads on the floor, pick it up, and place it back on the overbed table. Staff E was observed to remove the soiled vacuum dressing and foam and change gloves without performing hand hygiene between glove change. There was a smaller upper wound. Staff E sprayed wound cleanser into the wound and used their gloved right hand and gauze to cleanse inside the wound bed. Staff F opened a package of wound treatment and handed to Staff E, who placed the wound treatment into the wound with the same glove used during the wound cleansing, then applied the outer dressing to cover. Staff E changed gloves again without performing hand hygiene. Staff E applied wound cleanser to wound and inserted gloved hands into the wound to cleanse and then moved to applying the clean dressing without changing gloves. Staff E applied the exterior dressing pieces around the wound and then changed gloves without performing hand hygiene. Staff F was observed to respond to a walkie talkie inside of their uniform pocket, replace it, and did not change gloves and perform hand hygiene before resuming assistance with clean packages for Staff E. Staff E did not perform hand hygiene until removing gloves just prior to exiting the room. In an interview on 01/13/2026 at 1:50 PM, Staff E and Staff F acknowledged, but had not been aware of their breaks in infection control during the wound care. Staff E stated they should have cleaned the overbed table with disinfectant wipe prior to use. Staff E stated they believed they had changed gloves when required and had not been aware of need for hand hygiene between glove changes. Staff F verbalized that the outside of the package of gauze touched the floor, but the gauze inside did not. Staff F acknowledged that they should have changed gloves after touching an item from their pocket. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505092	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Park Health and Rehab of Cascadia	2726 Alderwood Avenue Bellingham, WA 98225

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 01/15/2026 at 1:15 PM, Staff B, Director of Nursing Services stated the facility conducted infection control in-services and wound training and would be reviewing with nurses. <RESIDENT 68> Resident 68 was admitted to the facility on [DATE] with diagnoses to include abscess (collection of pus that has built up within the tissue of the body) of right lower limb, surgical aftercare following surgery on the skin, urinary tract infection (infection of any part of the urinary system) and protein calorie malnutrition (insufficient intake of protein and calories). Review of Resident 68's Physician's orders showed Enhanced Barrier Precautions (EBP) were to be used every shift related to chronic wounds, initiated on 12/19/2025. EBP precautions meant staff would need to wear a gown and gloves when assisting with dressing, bathing, wound care, incontinence or toileting care and changing linens. Review of Resident 68's care plan showed EBP were to be used to reduce the risk of Multi Drug Resistant Organism (MDRO) transmission related to their right thigh wound, initiated on 12/15/2025. Review of Resident 68's Kardex (a guide the care staff use to help direct the resident care) dated 01/14/2026 showed their care was to include EBP. Review of Resident 68's Treatment Administration Record (TAR) dated December of 2025 showed EBP were documented as being followed every shift. Review of Resident 68's Treatment Administration Record (TAR) dated January of 2026 showed EBP were documented as being followed every shift. During all observations on 01/12/2026, 01/13/2026, 01/14/2026, and 01/15/2026, Resident 68's room did not have EBP signage present or a Personal Protective Equipment (PPE) bin available. No staff were observed to obtain or use PPE for the care of Resident 68. In an interview on 1/14/2026 at 10:07 AM, Staff P, NAC stated they reviewed the Kardex to know what assistance a resident requires. Staff P stated Resident 68 was incontinent of bowel and bladder and required brief changes and incontinent care. Staff P stated they had not noticed if Resident 68 had any wounds and had not used EBP precautions during provided cares. In an interview on 01/15/2026 at 11:09 AM, Staff E, Registered Nurse (RN), stated they knew if a resident required EBP there would be specific precaution signage on the room door, and it would be in their care plan. Staff E confirmed they had signed Resident 68's TAR dated 01/15/2026 that they had followed EBP. Staff E confirmed there was no EBP signage or PPE bin present for Resident 68's room and had not followed precautions. In an interview on 01/16/2026 at 11:17 AM, Staff D, Staff Development Coordinator/Infection Preventionist (SDC/IP), stated they update orders and care plans for resident's who require EBP. Staff D stated there would be EBP signage outside of the door, PPE bin present and a trash bin inside the room to dispose of PPE used. Staff D stated staff should review the Kardex and care plan to know if a resident required any kind of precautions. Staff D stated their expectation was when staff enter an EBP room they would follow the signage and wear gown and gloves when needed. Staff D verified Resident 68 had orders for EBP related to their chronic wounds and confirmed they were responsible (continued on next page)

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	505092	A. Building B. Wing	01/16/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to complete audits to ensure precautions are being followed. Reference WAC 388-97-1320 (1),(2)(b),(5)