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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505181	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redmond Care and Rehabilitation Center	7900 Willows Road Northeast Redmond, WA 98052

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 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 ensure physician orders for pain management and/or post-surgery staple removal were carried out for 2 of 4 Residents (Residents 1 & 2), reviewed for quality of care. These failures placed the residents at risk for discomfort and a diminished quality of life.Findings included.Review of the facility's policy titled, Medication and Treatment Orders, revised in April 2014, showed Orders for medications and treatments will be consistent with principles of safe and effective order writing [giving instructions for patient [resident] care in a way that is clear, complete, and impossible to misunderstand].RESIDENT 1Review of Resident 1's face sheet showed she was admitted to the facility on [DATE] with diagnoses that included orthopedic (related to the bones, joints, and muscles) aftercare and left knee osteoarthritis (a type of arthritis - inflammation or damage in the joints).Review of Resident 1's hospital document titled, After Visit Summary, dated 12/09/2025, showed Resident 1 admitted to the facility with a medication list that included Acetaminophen [Over the Counter (OTC- does not require a prescription) pain medication] 500 mg [milligrams - a unit of measurement], take 2 [two] capsules by mouth every 8 [eight] hours.Review of a facility document titled, LN [Licensed Nurse] Pain Management Review, dated 12/09/2025 showed Resident 1 was assessed for pain and that she endorsed having pain or discomfort to her left knee in the past five days. Further review showed, Goal/Recommendations included Initiate plan of care for pain.Review of a facility document titled, Order Summary Report, showed Resident 1 had a physician's order for Acetaminophen Oral Capsule 500 MG - Give 1000 mg by mouth three times a day for pain, with a start date of 12/10/2025 (one day after Resident 1 admitted to the facility).Review of a nursing progress note written on 12/09/2025 at 2:31 PM, showed Resident 1 arrived at the facility. Further review showed Resident 1 had listed allergies of codeine and tramadol (opioid - a class of drugs used to treat pain) medications.Review of Resident 1's Medication Administration Record (MAR) for December 2025 showed Acetaminophen was scheduled for administration at 8:00 AM, 2:00 PM and at 8:00 PM daily, starting on 12/10/2025. It did not show documentation of Resident 2 receiving pain management on 12/09/2025.Review of nursing progress notes showed documentation of Resident 1's initial medical provider encounter on 12/10/2025. It showed, [Resident 1] Seen today for my initial visit with patient [resident] as new admit to SNF [Skilled Nursing Facility] and prior to patient opting to leave AMA [Against Medical Advice]. It further showed, [Resident 1] Says very unhappy with care she has received so far since her admission yesterday afternoon. Says had to wait several hours last night for her pain med [medication] and ice for her knee.In an interview on 02/02/2026 at 8:30 AM, Resident 1 stated she arrived at the facility at 2:00 PM on 12/09/2025 and that I was on [Acetaminophen] every 8 hours because I was allergic to opioid medications. Resident 1 further stated I had no pain medication, no [Acetaminophen].I asked for [Acetaminophen], and that I needed that pain medication, I had a fresh injury.In an interview on 12/13/2026 at 12:45 PM, Staff C, Licensed Practical Nurse, was asked what the facility's (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process was for administering medications to a newly admitted resident and Staff C stated, I refer to the MAR.pain medication, we need to pay attention to and follow the physician orders. Staff C further stated that OTC medication was always available, in the medication carts and medication supply room.In an interview and joint record review on 02/13/2026 at 12:49 PM, Staff B, Resident Care Manager, stated that physician orders for medication and treatment were continued at the facility when a resident admits from a hospital and that We get a discharge summary from the hospital.these orders don't [do not] need to be signed off by the in-house [medical] provider because we are just continuing the orders. When asked about the facility's process for OTC medications for newly admitted residents, Staff B stated, We supply a lot of OTC medication, so there shouldn't [should not] be any lag with those, we could give the next dose. A joint record review of Resident 1's MAR for December 2025 did not show documentation of Resident 1 receiving pain medication upon admission to the facility on [DATE]. Staff C stated, It [Resident 1's Acetaminophen] should have been given.In an interview on 12/13/2026 at 1:20 PM, Staff A, Director of Nursing, stated When there is routine and as needed [orders for pain medication], we follow the doctor's order.RESIDENT 2Review of Resident 2's face sheet showed she was admitted to the facility on [DATE] with diagnoses that included injury of head due to a fall, subsequent encounter.Review of Resident 2's document titled, [Hospital Name] Discharge Summary, dated 12/15/2025, showed SNF [Skilled Nursing Facility] follow-up action items, included Requires staple removal, 4 [four] staples (to be removed from scalp on 12/19 [12/19/2025]).Review of a Resident 2's facility document titled, Order Summary Report, showed a physician's order to Remove 4 staples on scalp, dated 12/15/2025 and to start on 12/19/2025.Review of Resident 2's December 2025 Treatment Administration Record (TAR) showed documentation of Resident 2's scalp staples were marked removed on 12/19/2025. It further showed Staff D, Registered Nurse, documented the removal of Resident 2's scalp staples.Review of a nursing progress note dated 12/23/2025, showed Resident 2 was transferred to the hospital for evaluation of critical laboratory results (abnormal medical test results), diarrhea (watery stools) and vomiting.Review of Resident 2's hospital document titled, Emergency Department Encounter, dated 12/23/2025, showed Right scalp wound with dried blood and staples in place.In an interview and joint record review on 01/07/2026 at 2:35 PM, Staff D was asked if she recalled removing scalp staples for Resident 2 on 12/19/2025, and Staff D stated, I remember her .I had to ask for help because she refused.we had to re-schedule the next day.I think was able to remove a couple before she was like no.I do remember the first time, it was two [staples], she said stop after two [staples]. Staff D further stated that she could not recall the total number of staples removed from Resident 2's scalp. When asked if an additional treatment order would be carried out after Resident 2's initial refusal on 12/19/2025, and Staff D stated Yes, I believe so. A joint record review of Resident 2's December 2025 TAR did not show documentation of additional scheduled scalp removal treatments after 12/19/2025. When asked if it was possible that all four staples were not removed from Resident 2's scalp as ordered, Staff D stated, I remember looking and feeling as much as she would allow us to.A joint record review on 02/13/2026 at 12:53 PM with Staff B showed Resident 2's Hospital Discharge summary, dated [DATE], included the instruction, SNF follow-up action items, included Requires staple removal, 4 staples [to be removed from scalp 12/19/2025]. Staff B stated that the treatment order would be carried out according to Resident 2's hospital discharge summary. A joint record review of Resident 2's document titled, Emergency Department Encounter, dated 12/23/2025, showed Right scalp wound with dried blood and staples in place. Staff B stated, The expectation is for all the staples to be removed, but she did have refusal of care and maybe she didn't [did not] let us remove all of the staples, and that we would try again. Further joint record review of Resident 2's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	December 2025 TAR and December 2025 nursing progress notes did not show documentation of additional scheduled scalp removal treatments after 12/19/2025. Staff B stated, There's [There is] no additional notes about staples.In an interview on 12/13/2026 at 1:20 PM, Staff A stated they expected staff would Assess for pain, assess the site and make sure everything was removed.Reference: (WAC) 388-97-1060 (1)-(3)(k).