STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505182	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure 3 of 10 residents (Residents 94, 24 & 3) and 1 supplemental resident (Resident 47) reviewed for accidents were assessed for the ability to smoke safely and to address storage of smoking materials (Residents 94 & 24), were provided an assistive device to prevent accidents (Resident 3), and were provided an environment free of unsecured chemicals (Resident 47). Additionally, the facility failed to ensure the environment was free of unsecured chemicals and sharps in shower rooms for 2 of 10 units (4 South & 5 North) reviewed. These failures placed residents at risk for burns, accidental removal of implanted devices, exposure to chemicals and sharps, and other negative health outcomes.Findings included .<Facility Policy>Review of the facility's Resident Safety, Accident Prevention, and Supervision policy, revised 04/2025, showed the facility was committed to providing a resident environment that was as free from accident hazards as possible, and to ensure each resident received adequate supervision and assistive support to prevent avoidable accidents.Review of the facility's Non-Smoking Policy, revised 03/2026, showed smoking posed a serious health and safety risk and was prohibited on facility property. Residents were informed of the non-smoking policy and agreed not to smoke or possess smoking material (cigarettes, lighters, matches, etc.) while residing at the facility. Smoking materials were prohibited from being stored in a resident's room. If a resident persisted in smoking, the facility would complete a smoking assessment, a safety plan, and update the Care Plan (CP). Every staff member was responsible for enforcing the non-smoking policy by reporting violations immediately to the Resident's care team or management for follow-up. <SMOKING> <RESIDENT 94> According to a 01/20/2026 Comprehensive Minimum Data Set (MDS – an assessment tool), Resident 94 admitted to the facility on [DATE] with multiple diagnoses including a recent leg amputation and respiratory issues. Resident 94 was able to understand and be understood and had no current tobacco use. Review of a Non-Smoking Policy Acknowledgement, dated 12/22/2025, showed Resident 94 indicated they were a smoker or had a history of smoking, and agreed not to possess cigarettes or smoking materials or to smoke any tobacco products while residing at the facility. The space on the form to write their last day of smoking was left blank. Review of a Care Plan (CP), dated 04/07/2026, showed Resident 94 preferred independence and had reduced supervision during extended outings away from the facility. The CP showed no documentation regarding smoking or smoking materials. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 04/07/2026 at 10:33 AM, Resident 94 stated they were currently a smoker, arranged their own transportation to go out of the facility, and smoked when they got to their destination. Resident 94 declined to say where they kept their smoking materials and said they were not going to let anyone see them. Observation showed Resident 94 laid in their bed wearing a hospital gown, and no smoking materials were within view in their room. Review of a 03/23/2026 provider progress note showed Resident 94 currently smoked cigarettes when they left the facility via wheelchair, with their last cigarette being the previous Friday. In an interview on 04/09/2026 at 12:52 PM, Staff M (Social Worker) stated they were working with Resident 94 on a discharge plan and had suggested a facility that allowed smoking. Staff M stated Resident 94 was extremely independent, arranged their own transportation, and currently smoked when they went out of the facility. Staff M stated they did not know where Resident 94 kept their smoking materials. In an interview on 04/08/2026 at 1:18 PM, Staff E (Long Term Care Registered Nurse - RN) stated there were currently no smokers on their unit (2 North). Staff E stated Resident 94 often made their own arrangements and went out of the facility, but Staff E was not aware they smoked. Staff E stated Resident 94 was not allowed to keep smoking materials there, and Staff E needed to talk to their manager about it. In an interview on 04/09/2026 at 3:00 PM, Staff A (Administrator) stated they were not aware Resident 94 was a current smoker. Staff A stated they needed to talk to Resident 94, complete a smoking assessment, and secure their smoking materials for safety. In an interview on 04/13/2026 at 11:06 AM, Staff B (Director of Nursing) stated staff should have asked Resident 94 upon admission about their smoking materials and date last smoked when Resident 94 indicated they were a smoker. Staff B stated Resident 94 was not on the facility's smoking list, and they expected staff to inform management when they became aware Resident 94 continued to smoke. <Resident 24> According to a 03/23/2026 Quarterly MDS, Resident 24 admitted to the facility on [DATE] with diagnoses including heart conditions and nicotine dependence. The MDS showed that Resident 24 was independent with Activities of Daily Living and was a current tobacco user. Review of a 09/16/2025 smoking assessment showed staff verbally assessed Resident 24, while in their room, for their ability to smoke, with no direct observation of Resident 24's ability to use a lighter or handle lit smoking materials. The assessment showed Resident 24 was no longer planning to smoke. Review of a 04/06/2026 smoking CP showed Resident 24 smoked one cigarette per day after lunch, and smoking materials were not to be kept in Resident 24's room. Review of Resident 24's records showed no further smoking assessment was completed after 09/16/2025, until a 04/06/2026 smoking assessment for Resident 24 showed they could smoke safely. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/10/2026 at 10:43 AM, Staff B stated Resident 24 was assessed for smoking on 04/06/2026. Staff B stated Resident 24 should have been assessed for the ability to smoke safely when it was seen they were continuing to smoke, but that did not happen. Staff B stated it was important to accurately assess the ability to smoke safely due to the risk of fires or burns. <Assistive devices> <Resident 3> According to the 12/07/2025 admission MDS, Resident 3 admitted to the facility on [DATE] with diagnoses including heart conditions and recent stroke. The MDS showed Resident 3 had severely impaired cognition and was dependent on a feeding tube (a tube implanted into the stomach through the abdominal wall for nutrition). Review of a 03/27/2026 tube feeding CP showed Resident 3 had a history of pulling out their feeding tube, and staff were to keep an abdominal binder (an assistive device that could be used to prevent accidental removal of feeding tubes) in place as in intervention to prevent re-occurrence. Review of physician progress notes dated 12/02/25, 12/05/2025, 12/10/2025, 12/17/2025, 12/23/2025, 01/02/2026, 01/13/2026, 01/27/2026, 02/06/2026, 03/03/2026, 03/12/2026, 03/27/2026, and 04/01/2026 showed Resident 3 was dependent on tube feeding to meet nutritional goals and was to wear an abdominal binder to prevent accidental pulling of feeding tube. In an interview on 04/07/2026 at 12:10 PM, Resident 3's responsible party stated Resident 3 was supposed to wear an abdominal binder and received one while in the hospital. Resident 3's responsible party stated Resident 3 recently had to go to the hospital because their feeding tube accidentally came out when they were not wearing the abdominal binder. In an interview on 04/10/2026 at 10:52 AM, Staff B stated there was no physician's order or CP for Resident 3 to wear an abdominal binder at the time the feeding tube was accidentally removed. Staff B stated it was not known by staff that the abdominal binder should have been in place for Resident 3. Staff B stated the facility did not have a process for reviewing physician notes to ensure recommendations were being followed. <Chemicals and Sharps> <Resident 47> Observations on 04/06/2026 at 10:04 AM and 04/08/2026 at 9:25 AM showed a large bottle of 70% isopropyl alcohol (a colorless, flammable chemical commonly used as a solvent, antiseptic, and cleaner) was stored in Resident 47's room on a shelf underneath the sink. The label on the bottle showed it was for external use only, and fumes may be harmful. In an observation and interview on 04/08/2026 at 9:53 AM, Staff E confirmed the bottle of isopropyl alcohol was underneath Resident 47's sink. Staff E stated it was a hazard, especially if someone drank it, and should not be stored in a resident's room. <4 South Shower Room> (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 04/09/2026 at 9:56 AM showed a shower room on the 4 South unit with the door open and cleaning chemicals and a used razor accessible, with no staff members present in the area. In an interview on 04/09/2026 at 9:58 AM, Staff X (Certified Nursing Assistant) stated the door should have been shut and locked for resident safety and the razor should have been disposed of after use. In an interview on 04/09/2026 at 11:23 AM, Staff B stated that the shower room door should have been shut and the razor was a safety concern. <5 North> Observation on 04/07/2026 at 8:52 AM and 04/09/2026 at 11:58 AM showed the 5 North unit spa door open and unlocked. The spa had an unsecured bottle of a chemical disinfectant and some razors. In an interview on 04/07/2026 at 8:54 AM Staff II (RN) stated the spa door should be locked and closed. Staff II stated it was important to keep the door locked for residents' safety since there were chemicals and razors in there. In an interview on 04/09/2026/ at 11:58 AM Staff G (Director Long Term Care RN) stated it was important to keep the door closed and locked because there were multiple chemicals and razors stored in there. Staff G stated it was important to ensure the chemicals and razors were secure for resident safety. Reference: WAC 388-97-1060(3)(g).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure expired medications and expired medical supplies were discarded timely for 2 of 5 medication storage rooms (Saint [NAME] Residence -SJR Medication Storage Room & 2 North Medication Storage Room) and 2 of 6 medication carts (4 South Medication Cart & 5 North Medication Cart B) reviewed for medication storage, and failed to ensure medications were properly secured in 4 of 10 units (4 South, 3 South, 5 Central, and 2 North) reviewed for medications at the bedside. This failure placed residents at risk for receiving incorrect or expired medications, ineffective treatment, and diminished quality of life.<Facility Policy>According to the facility's Medication Administration and Storage policy revised 04/2025, medications must be stored, secured, and managed in a manner that ensure residents safety and decreases the risk of medication error; medication practices must maintain medication integrity and prevent unsafe practices. For residents approved for Self-Administration of Medications (SAM), medications must be stored in a locked container with the resident's room or another approved secure location.<EXPIRED MEDICATIONS AND SUPPLIES> <SJR Medication Storage Room> An observation and interview on 04/08/2026 at 10:52 AM in the SJR Medication Storage Room showed 100 sterile cotton tipped applicators expired on 04/22/2025 and one COVID test expired on 10/04/2025. Staff BB (Licensed Practice Nurse) confirmed the expiration dates and stated the items should have been discarded prior to the expiration dates but were not. <2 North Medication Storage Room> An observation and interview on 04/08/2026 at 11:20 AM in the 2 North Medication Storage Room showed expired medical supplies with expiration dates ranging from 04/2020 to 03/13/2026, including 27 sterile wound dressings, 22 blood collection tubes, 10 specimen collection kits, six colostomy dressings, five sterile intravenous (in the vein) supplies, two tube feeding kits, and two sterile specimen collection kits. Staff E (Long Term Care Registered Nurse) confirmed the expiration dates and stated the items should have been discarded prior to the expiration dates but were not. In an interview on 04/10/2026 at 1:05 PM, Staff B (Director of Nursing) stated they expected staff to discard all medical supplies prior to the expiration date on the packaging. <4 South Medication Cart> Observation on 04/07/2026 at 9:42 AM showed the 4 South medication cart contained two insulin pens (used to control blood sugars), with labeling showing they were opened on 02/2026 with no specific open day specified. In an interview on 04/07/2026 at 9:56 AM, Staff N (Licensed Practical Nurse) stated the insulin pens expired 28 days after opening. Staff N stated the pens should be labeled with the specific date opened, and they were expired and should have been discarded. In an interview on 04/13/2026 at 11:58 AM, Staff B stated expired medications should be disposed of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prior to the expiration date. <5 North Medication Cart B> Observation on 04/07/2026 at 09:36 AM, medication cart on 5 North Medication Cart B contained three packages of pain-relieving suppositories (medication inserted rectally) with an expiration date of 11/2025, and eight packages of laxative suppositories with an expiration date of 03/2026. In an interview on 04/07/2026 at 09:51 AM, Staff H (Registered Nurse) stated expired medications should not be present in the medication cart. Staff H stated administering expired medications could lead to potential adverse reactions and compromise resident safety. <MEDICATIONS AT BEDSIDE> <4 South Unit> <Resident 188> According to the 02/23/2026 admission 5-Day Minimum Data Set (MDS - an assessment tool), Resident 188 had intact memory, clear speech, and was able to understand others. Observations on 04/06/2026 at 10:02 AM, 04/07/2026 at 1:22 PM, and on 04/09/2026 at 10:47 AM showed a bottle of topical powder and a bottle of antiseptic skin cleanser solution on Resident 188's bedside table. In an interview on 04/06/2026 at 10:05 AM, Resident 188 stated these medications were left in their room at bedside table for more than a week. Review of Resident 188's April 2026 Physician Orders showed no order for Resident 188 to keep medications at their bedside. In an interview on 04/09/2026 at 10:56 AM, Staff V (Licensed Practical Nurse) confirmed the medication was unsecured in Resident 188's room and should be secured in the medication cart. <3 South Unit> <Resident 99> Observation on 04/07/2026 at 10:32 AM showed Resident 99 asleep in their bed. A medication cup containing a large, round pink tablet was placed in front of them on the overbed table. Resident 99 did not wake up upon knocking and entering the room. Review of Resident 99's physician orders on 04/07/2026 showed no orders directing staff to leave medications at the resident's bedside. Review of Resident 99's comprehensive care plan at this time showed no interventions that Resident 99 could have their medications left at the bedside, unsupervised. In an observation and interview at 04/07/2026 at 10:37 AM, Staff T (Long Term Care Registered Nurse) confirmed the medication placed in the cup on the overbed table. Staff T stated they did not (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	leave medications at the bedside and Resident 99 must have spit the medication out. Staff T stated they should remain with the resident and ensure the resident took their medications entirely before exiting the room. <5 Central Unit> <Resident 212> According to the 03/30/2026 admission MDS, Resident 212 had decreased memory, clear speech, and an ability to understand others. An observation and interview, on 04/06/2026 at 10:08 AM, showed a sealed package of stool softener powder and a half empty bottle of medicated cream on Resident 212's bedside table. Resident 212 stated they had brought the medications to the facility on admission. Resident 212 stated they had self-administered the medicated cream daily while at the facility. Staff Y (Long Term Care Registered Nurse) stated the medications should have been stored in a secured medication cart but were not. Review of Resident 212's health record on 04/07/2026 showed no physician orders or care plan interventions directing staff to leave medications at the resident's bedside, unsupervised. <2 North Unit> <Resident 66> Observations on 04/06/2026 at 10:41 AM and 04/08/2026 at 9:32 AM showed Resident 66 was not present in their room. Observation showed the overbed table contained a medicated oral spray and a box of medicated vaginal cream pre-filled applicators. Observation showed a container of medicated hemorrhoidal cooling pads stored in Resident 66's bathroom. Review of active physician's orders from 04/01/2026 through 04/30/2026 showed Resident 66 was on the SAM program and was allowed to keep selected medications at their bedside, including the vaginal cream, oral spray, and hemorrhoidal medication. Review of a Care Plan entry, dated 02/05/2026, showed Resident 66 was allowed to keep certain medications at their bedside, utilizing a lock box. In an observation and interview on 04/08/2026 at 9:58 AM, Staff E confirmed the vaginal cream, oral spray, and hemorrhoidal medications were unsecured in Resident 66's room. Observation showed a lock box on Resident 66's nightstand, and Resident 66 was not present in their room. Staff E stated Resident 66 was the SAM program and was supposed to secure their medications in their lock box. Staff E stated they needed to re-assess Resident 66 for appropriateness of the SAM program. <Resident 81> Observations on 04/06/2026 at 9:52 AM and 04/08/2026 at 9:25 AM showed a bin labeled with Resident 81's name near the sink in Resident 81's room, containing a medicated shampoo. Review of Resident 81's active physician's orders from 04/01/2026 through 04/30/2026 showed no order that allowed Resident 81 to keep the medicated shampoo in their room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Care Plan, dated 04/14/2026, showed no evidence that Resident 81 was allowed to store medications in their room. In an observation and interview on 04/08/2026 at 9:50 AM, Staff E confirmed the medicated shampoo was unsecured in Resident 81's room and should have been stored in the nurse's medication cart for safety. <Resident 115> Observations on 04/06/2026 at 10:32 AM and 04/08/2026 at 9:31 AM showed a tube of medicated topical paste on the counter near Resident 115's sink. Review of Resident 115's active physician's orders from 04/01/2026 through 04/30/2026 showed no order that allowed Resident 115 to keep the medicated paste in their room. Review of a Care Plan, dated 04/14/2026, showed no evidence that Resident 115 was allowed to store medications in their room. In an observation and interview on 04/08/2026 at 10:00 AM, Staff E confirmed the medicated paste was unsecured in Resident 115's room and should have been stored in the nurse's medication cart for safety. <Resident 160> Observations on 04/06/226 at 9:25 AM and 04/08/2026 at 9:22 AM showed a tube of medicated topical ointment on Resident 160's bedside table. Review of Resident 160's active physician's orders from 04/01/2026 through 04/30/2026 showed no order that allowed Resident 160 to keep the medicated ointment in their room. Review of a Care Plan, dated 04/14/2026, showed no evidence that Resident 160 was allowed to store medications in their room. In an observation and interview on 04/08/2026 at 9:48 AM, Staff E confirmed the medicated ointment was unsecured in Resident 160's room and should have been stored in the nurse's medication cart for safety. In an interview on 04/13/2026 at 9:55 AM, Staff B stated their expectation was for staff not to leave any medications in resident rooms unless they had physician orders for self-medication program. Staff B stated they expected the medications to be secured in medication cart or in a lock box. REFERENCE: WAC 388-97-1300(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was stored and served under sanitary conditions for 1 of 1 main kitchen and ensure food was prepared and served in a sanitary manner and following residents' dietary needs in 1 of 6 neighborhood kitchens (Saint [NAME] Residence/SJR). The failure to cover refrigerated and frozen food, ensure staff secured their hair and performed hand hygiene, placed residents at risk for cross-contamination, foodborne illness and the spread of infection. Findings included .<Facility Policy>According to the facility's revised 11/2023 Food Storage policy, staff would ensure all containers had tightˆfitting covers and were clearly labeled and dated to prevent contamination.According to the facility's revised 04/2024 Hand Hygiene policy, staff would perform hand hygiene to prevent the spread of infection in all areas of the facility including during meals. <Main Kitchen> <Food Storage> During an observation of the main kitchen refrigerator on 04/06/2026 at 08:35 AM, a large sheet pan containing white sauce and two large sheet pans containing tomato soup were dated 04/05/2026 and not covered. A plastic container with cooked pieces of bacon was undated and not covered. In the main freezer, two muffin pans containing 12 servings of pureed cauliflower in each pan were observed to be undated and not covered. In an observation and interview on 04/06/2026 at 9:05 AM, Staff CC (Interim Dining Services Manager) stated the white sauce and tomato soup should have been covered, but they were not. Staff CC stated the bacon pieces and cauliflower cups should have been dated and covered, but they were not. In an interview on 04/10/2026 at 11:42 AM Staff FF (District Manager) stated hot foods placed in the refrigerator for quick cooling should be labeled and stored in uncovered shallow pans until cool. Staff FF stated this process typically occurs within six hours and, once cool, they expect pans to be covered and stored according to the facility's policy. <SJR Kitchen & Dining Room> <Hand Hygiene & Unsecured Hair) In an observation on 04/06/2026 at 11:40 AM, Staff U (Nutrition Attendant) was plating food and delivering meals to residents seated in the SJR dining room. Staff U returned to the steam table to continue plating food without performing hand hygiene or putting on gloves. Three other dining assistants were observed plating food at the steam table with hair loosely pulled back and not fully secured in a hairnet while serving food. In an observation on 04/06/2026 at 12:10 PM, a volunteer touched residents' clothing to make adjustments and then entered the kitchen area without performing hand hygiene and without wearing a hairnet. The volunteer was observed serving water to a visitor and going through the kitchen to the refrigerator. In an observation on 04/06/2026 at 12:15 PM Staff D (Licensed Practical Nurse) adjusted one (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's clothing while feeding them and used the same hand to feed another resident without performing hand hygiene between residents. In an interview on 04/06/2026 at 12:19 PM, Staff U stated volunteers were available to assist in feeding residents but were not allowed to plate food or enter the kitchen area. In an interview on 04/06/2026 at 12:29 PM Staff D stated volunteers helped with visits and feeding and was not sure if volunteers had food safety cards. Staff D stated they were not aware whether feeding two residents with the same hand required hand hygiene between residents but should be followed for infection control. In an interview on 04/13/2026 at 1:16 PM Staff B (Director of Nursing) stated volunteers should not have been in the kitchen area around food and should not have been serving up water or going through the refrigerator. Staff B stated staff should perform hand hygiene between feeding two residents if they were also touching residents with the same hand as they fed residents for infection control. REFERENCE: WAC 388-97-1100(3).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: ensure Transmission Based Precautions (TBP - a set of infection control practices used to prevent the spread of infectious agents in addition to standard precautions) were implemented or followed for 2 of 2 residents (Resident 212 & 33) and 3 supplemental residents (Residents 12, 156, & 157) reviewed for TBP and/or exposed to respiratory symptoms; failed to ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves and gowns used to prevent exposure to infectious materials) for 1 of 2 residents (Residents 201) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug resistant organisms); ensure staff used appropriate Hand Hygiene (HH) during resident care for 1 resident (Resident 93) who was observed for care; and failed to ensure proper storage of resident hygiene items for 2 of 14 resident rooms (Rooms 220 & 221) on the 2 North unit reviewed for infection control. These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases. Findings included.<Facility Policy>According to the facility policy titled, Transmission Based Precautions, dated April 2025, the facility would implement TBP for residents with documented or suspected to have infections that could be transmitted by airborne or droplet transmission. The policy showed droplets could be generated by the residents coughing, sneezing, talking or during the performance of procedures. The policy showed the facility used different types of precautions to protect residents and staff from different kinds of communicable diseases. The facility would place appropriate signage at the entrance door of resident rooms to alert staff and visitors of necessary measures. The policy showed staff would use PPE as indicated by the identified precaution. <TBP/PPE> <Resident 12> According to the 03/04/2026 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 12 admitted to the facility on [DATE]. The MDS showed Resident 12 had no memory impairment and was able to make themselves understood and understand others. Observation on 04/06/2026 at 1:03 PM showed Resident 12 lying in their bed, eyes closed, and their door was open. There were two signs; a contact precaution sign and a droplet precaution sign were posted on Resident 12's door. A third EBP sign was posted on the wall outside Resident 12's door. In an interview on 04/06/2026 at 1:25 PM, Staff R (Certified Nursing Assistant - CNA) stated Resident 12 was on droplet precautions because they had respiratory infection. Observation on 04/07/2026 at 11:54 AM showed Resident 12 lying in their bed coughing. Resident 12 was receiving oxygen via a nasal tube. Resident 12 had a contact precaution sign posted outside their room. The contact precaution sign directed staff to clean their hands before entering and exiting the room; put on gloves and a gown before entering the room; and directed staff to use dedicated or disposable equipment. In an interview on 04/07/2026 at 11:57 AM, Staff V (Licensed Practical Nurse) stated Resident 12 was on droplet precautions and staff must wear masks and a gown before going into their room. Observation on 04/07/2026 at 12:02 PM showed Staff V enter Resident 12's room without putting on PPE. Staff V exited the room and started talking to another staff member in the hallway. Staff V did (continued on next page)

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	505182	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not wear PPE and did not sanitize their hands. Review of the April 2026 physician orders showed no order directing staff to implement contact/droplet precautions for Resident 12. In an interview on 04/07/2026 at 12:05 PM, Staff V stated they went to see Resident 12 in their room. Staff V was asked if they should follow the sign posted on the door, Staff V read the sign and stated they should follow the directions on the sign to wear PPE, but they did not. <Resident 157> Observation on 04/06/2026 at 11:31 AM showed Resident 157 lying in their bed with their eyes closed, coughing, and gurgling. Gurgling sounds could be heard outside Resident 157's room in hallway. In an interview on 04/06/2026 at 11:35 AM, Staff R stated Resident 157 was receiving end-of-life care and had a respiratory infection. Review of Resident 157's nursing progress notes showed a 04/06/2026 note documented at 12:27 PM that Resident 157 was placed on droplet precautions related to a fever and a cough. Observation on 04/07/2026 at 10:02 AM showed a droplet precaution sign posted on Resident 157's door and an isolation cart was placed outside the room. A droplet precautions sign gave directions for staff to follow: Prior to entering: Visitors check in with nursing; wash/gel hands; wear mask; wear eye protection; and wear gown and gloves if contact with secretions. Review of Resident 157's April 2026 physician orders showed no orders directing staff to implement droplet precautions for Resident 157. Observation on 04/07/2026 at 11:32 AM showed a contract staff member entering Resident 157's room without putting on a mask, eye wear, or gown. The contracted staff talked to Resident 157's representative at Resident 157's bedside and exited the room. In an interview on 04/07/2026 at 11:40 AM, the contract staff stated they should have worn PPE and followed the droplet sign posted on Resident 157's door, but they did not. In an interview on 04/13/2026 at 9:59 AM, Staff B (Director of Nursing) stated the facility staff followed the Centers for Disease Control and Prevention guidelines for TBP. Staff B stated staff should follow the signs posted on residents' doors, but they did not. Staff B stated there should be physician orders for isolation precautions in resident's records according to the diagnoses. Staff B stated the facility staff should wear mask with other PPE when they enter a TBP room with droplet precautions, but they did not. <Resident 33> According to the 03/24/2026 Quarterly MDS, Resident 33 admitted to the facility on [DATE] with a diagnosis of heart disease and diabetes (inability to control blood sugars). The MDS showed Resident 33 had pressure wounds requiring treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 04/06/2026 at 12:29 PM Staff AA (CNA) was observed entering Resident 33's room without wearing PPE. Resident 33's room had a sign taped to the door for contact precautions, indicating that staff must wear a gown and gloves prior to entering the room. Staff AA stated they should have worn a gown and gloves, because the resident could be contagious and they could spread infections to others. In an interview on 04/09/2026 at 10:59 AM Staff P (Infection Preventionist) stated that staff should have worn PPE prior to entering Resident 33's room. Staff P stated that it was important to wear PPE to care for those with contact precautions to avoid spreading infections. <Resident 212> According to the 03/30/2026 admission MDS, Resident 212 had multiple medically complex diagnoses including a multidrug-resistant organism (a germ which antibiotics could not easily treat), wounds, and required intravenous (through the blood) antibiotics. In an observation and interview on 04/06/2026 at 10:08 AM, two precaution signs (EBP and contact) were posted outside Resident 212's room. The contact sign instructed staff to wear an isolation gown and gloves before entering the room. Staff Y (Long Term Care Registered Nurse - LTC RN) entered Resident 212's room without a gown or gloves. Staff Y stated they were expected to wear a gown and gloves prior to entering the room, but they did not. In an interview on 04/10/2026 at 11:54 AM, Staff P stated each room labelled with isolation precautions should have only one sign to communicate the highest level of measures to prevent the spread of infectious organisms. Staff P stated Resident 212's room should have only a contact precaution sign and staff were expected to wear a gown and gloves prior to entering the room. <Resident 156> According to the 03/20/2026 admission MDS, Resident 156 admitted to the facility on [DATE]. The MDS showed Resident 156 had no memory impairment and was able to make themselves understood and understood others. In an observation and interview on 04/08/2026 at 8:13 AM, Resident 156 stated they had developed a cough and runny nose. Resident 156 stated they were tested for a respiratory infection and were waiting to hear the results. Resident 156 stated they felt miserable. There was no TBP signage posted outside of Resident 156's room. In an interview on 04/08/2026 at 11:35 AM Staff P stated they expected staff to initiate TBP as soon as a resident presented with respiratory symptoms. In an interview on 04/09/2026 at 12:21 PM Staff P stated Resident 156 had a pending chest x-ray and was tested for Respiratory Syncytial Virus (RSV – a respiratory infection that could worsen underlying lung conditions and present increased risk in older adults) but those results were also still pending. Staff P stated for suspected respiratory infections, they placed Resident 156 on droplet precautions on 04/09/2026. Staff P stated they expected staff to place Resident 156 on droplet precautions at the time of RSV testing and development of the respiratory symptoms, but staff did not. Staff P stated this was important to prevent the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/13/2026 at 1:55 PM Staff B stated they expected staff to implement TBP for residents with respiratory symptoms and for residents being tested for RSV. Staff B stated it was important to place residents on TBP with respiratory symptoms to prevent spread of infections. <EBP> <Resident 201> According to the 04/02/2026 admission MDS, Resident 201 admitted to the facility with diagnosis of end stage kidney disease and gangrene (death of tissue) to their left foot. Review of a 04/03/2026 infection prevention and control progress note showed Resident 93 was placed on EBP for the gangrene to their foot. Observation on 04/09/2026 at 9:38 AM showed an EBP sign posted at the resident's door. The signage was to be posted for high contact resident care including changing linens, bathing and dressing. Interventions showed staff were to wear a gown and gloves during high contact care for residents. In an observation on 04/09/2026 at 9:38 AM, Staff EE (Environmental Services Technician) removed the dirty bedding from Resident 201's bed without a gown. Staff EE pulled the dirty bedding into a pile, pulled them close to their body, and placed the dirty linens into a trash bag. Staff EE did not change their gloves or perform HH. Staff EE grabbed a spray bottle and a towel, sprayed the bed and wiped it. Staff EE wiped the bedside table and sink with the same gloved hand. While wearing the same gloves, Staff EE grabbed the vacuum and vacuumed the floor. Staff EE went into Resident 201's bathroom and grabbed a towel and wiped and cleaned the bathroom. Staff EE removed their gloves and did not perform HH. Staff EE grabbed new bedding and made up the resident's bed. Staff EE removed their gloves and performed HH. In an interview on 04/09/2026 9:58 AM, Staff G (Director LTC RN) stated they expected all staff to follow the EBP required guidelines. Staff G stated it kept residents safe and allowed additional monitoring to prevent the spread of infection. In an interview 04/09/2026 10:23 AM, Staff P stated they expected staff to wear a gown when changing linens and cleaning beds of residents on EBP. Staff P stated it was important to prevent infection and protect residents and staff who provide care. <Hand Hygiene> <Resident 93>Observation on 04/08/2026 at 9:44 AM showed Staff H (LTC RN) providing colostomy care (a surgical opening in the abdomen allowing stool to pass through to an external pouch) for Resident 93. Staff H wore two pairs of gloves on each hand. Staff H removed the old pouch from the abdominal opening and removed the first layer of gloves leaving the second layer of gloves on. Staff H took a towel and cleansed the skin around the opening of Resident 93's stomach. Staff H removed the second layer gloves. and did not perform HH. Staff H put on two new pairs of gloves, used scissors to cut a hole in the new wafer and placed the wafer over Resident 93's abdominal opening. Staff H removed the first layer of gloves. While wearing the second layer of gloves, Staff H grabbed the wafer pouch and secured it to the wafer. Staff H removed their second layer of gloves and performed HH. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/08/2026 at 9:44 AM, Staff H stated they double gloved because of the resident's diagnosis of a communicable disease. In an interview on 04/09/2026 at 10:23 AM, Staff P stated they expected staff to perform HH and wash their hands if they were visibly soiled to reduce the risk of spreading infections. In an interview on 04/13/2026 at 11:41 AM, Staff B stated double gloving should not occur. Staff B stated they expected staff to perform HH during and after care as double gloving prevented staff from performing HH. <Personal Hygiene Items> <room [ROOM NUMBER]> Observation on 04/06/2026 at 9:58 AM and on 04/08/2026 at 9:25 AM showed a bin full of personal hygiene items stored next to the sink in room [ROOM NUMBER]. The bin contained an uncovered, used toothbrush stored on top of other items, with a hairbrush containing strands of hair stored on top of the toothbrush. <room [ROOM NUMBER]> Observation on 04/06/2026 at 9:37 AM showed two residents shared room [ROOM NUMBER]. An emesis basin (a small kidney-shaped basin often used for oral hygiene) next to the sink contained a used toothbrush, with a second used toothbrush laid across the top of the basin, with nothing to indicate which resident they belonged to. A third used toothbrush was stored vertically in a labeled bin, with the toothbrush bristles touching the wall. In an observation and interview on 04/08/2026 at 9:55 AM, Staff E (LTC RN) and Staff S (CNA) confirmed the toothbrush and hairbrush in room [ROOM NUMBER] were stored together in the same bin. Staff E stated toothbrushes and hairbrushes should be stored separately, and they needed to have a better system to store personal hygiene items, for infection control. In an interview on 04/08/2026 at 12:55 PM, Staff P stated that all personal hygiene equipment and products should be stored separately in separate containers. Staff P stated it was important to keep residents' hygiene products separated for infection control. REFERENCE: WAC 388-97-1320(1)(c),(3),(5)(a)(b).

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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, interview, and record review, the facility failed to ensure residents were provided care and services in a dignified manner for 2 (Residents 202 & 3) of 36 sample residents and 2 supplemental residents. The failure to: ensure catheter bags (bags that collect urine from tubing placed in the body to assist with urinary drainage) were covered to obscure their contents (Resident 202 & 3) and ensure 1 staff (Staff D - Licensed Practical Nurse) sat when providing feeding assistance to residents, placed residents at risk for undignified care and a diminished sense of self-worth.<Facility Policy>According to the facility's revised April 2025 Standards of Care policy, staff would ensure urinary catheters were covered to promote residents' privacy and dignity.According to the facility's revised January 2026 Resident Rights policy, staff would promote dignity, individuality, independence, and quality of life by minimizing institutional characteristics.<Resident 202> According to the 04/10/2026 admission Minimum Data Set (MDS - an assessment tool), Resident 202 admitted to the facility on [DATE] with diagnosis of urinary infection, enlarged prostate, and obstructive uropathy (a blockage in the urinary tract). Record review showed a 03/29/2026 physician order instructing staff to cover Resident 202's catheter bag to ensure dignity. In an observation on 04/06/2026 at 9:08 AM, Resident 202 was sitting in their wheelchair with the catheter bag hanging from it without a cover. In an observation on 04/07/2026 at 9:19 AM, Resident 202 was sitting in bed with the drainage bag hanging on the bedrail without a cover. In an interview on 04/08/2026 at 9:50 AM, Staff H (Long Term Care Registered Nurse) stated Resident 202's catheter bag should have been covered to maintain dignity, but it was not. In an interview on 04/10/2026 at 9:24 AM, Staff B (Director of Nursing) stated they expected staff to use dignity covers for drainage bags to obscure their contents and preserve the resident's dignity and respect. <Resident 3> According to the 12/07/2025 admission MDS, Resident 3 admitted to the facility on [DATE] with diagnoses of stroke, high blood pressure, and kidney disease. The MDS showed Resident 3 had an indwelling urinary catheter. Review of Resident 3's 03/31/2026 care plan showed staff were to keep the urinary catheter drainage bag covered to promote dignity. In observations on 04/06/2026 at 1:01 PM, 04/07/2026 at 8:41 AM, and 04/08/2026 at 9:09 AM showed that Resident 3's catheter bag was not covered and was visible to others in the dining room and from the hallway looking into their room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/08/2026 at 9:19 AM Staff N (Licensed Practical Nurse) stated Resident 3's catheter drainage bag should be covered but was not. In an interview on 04/10/2026 at 11:22 AM with Staff B stated that catheter drainage bags should be covered for residents to provide dignity. <Saint [NAME] Residence (SJR) Dining Room> During an observation on 04/06/2026 at 11:52 AM in the SJR dining room, two female residents were seated at the same table and required assistance with eating. Staff D was observed standing next to the table and feeding both residents by alternating between them. In an interview on 04/06/2026 at 12:29 PM Staff D stated, the facility used teamwork to feed residents and the nurses often interchanged with the nursing assistants to help feed residents. Staff D stated they were not aware that dignity was an issue when standing to feed residents. Staff D stated they were not aware of a policy that staff should sit when assisting residents to eat. In an interview on 04/13/2026 at 10:55 AM, Staff F (Long Term Care Registered Nurse) stated staff should sit down while feeding residents. Staff F stated a resident would have to look up to be fed and that would be demeaning. In an interview on 04/13/2026 at 1:16 PM Staff B stated they expected staff to sit down while assisting residents with feeding for residents' dignity. REFERENCE: WAC 388-97-0180 (1-4).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to implement a system to ensure Advanced Directives (AD) were in place for 3 (Residents 188, 189, & 7) of 8 residents reviewed for ADs. This failure placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care.Findings included.<Facility Policy>Review of the facility's 04/2025 revised Advanced Directives policy showed facility staff would determine on admission whether the resident had an AD and if not, determine if the resident wished to formulate an AD. The policy showed staff would obtain a copy of the resident's AD and maintain the copy for all staff members to access in the resident's record.<Resident 189> According to the 01/23/2026 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 189 had intact cognition and diagnoses including heart failure, difficulty speaking following a brain bleed, and weakness to one side of their body. In an interview on 04/07/2026 at 8:58 AM, Resident 189 stated their sister used to be their Power of Attorney (POA) but was not any longer. Review of an 11/12/2025 Care Plan Conference form showed the resident did not have a POA under the ADs section of the form. Review of an 11/13/2025 social services progress note showed the social work staff contacted Resident 189's POA regarding setting up a care plan conference. Review of Resident 189's comprehensive records on 04/09/2026 at 1:38 PM showed no POA paperwork was available in the record. In a joint interview on 04/10/2026 at 9:13 AM with Staff L (Social Services Manager) and Staff O (Social Worker), Staff O stated the facility process was to ask residents/family on admission if they had a POA and request copies of the paperwork. Staff O reviewed Resident 189's records and confirmed they could not find a copy of the resident's POA paperwork. Staff L stated it was their expectation POA paperwork was available in resident's records. <Resident 7> According to the 01/29/2026 Quarterly MDS, Resident 7 had no impaired memory and no rejection of care during the assessment period. Record review of Resident 7's face sheet showed Resident 7 was their own responsible party. There was no copy of an AD for Resident 7 in their record. There was no documentation showing the facility attempted to offer/assist to complete AD for Resident 7. In an interview on 04/09/2026 at 8:53 AM Staff L reviewed Resident 7's record and stated there was no AD or POA papers in Resident 7's record at that time. Staff L stated they thought the facility was talking to Resident 7's family member for POA paperwork but were unable to provide documentation. In an interview on 04/13/2026 at 9:23 AM, Staff B (Director of Nursing) stated they expected all residents AD/POA paperwork to be available for staff all the time in resident's record. <Resident 188> (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 02/23/2026 admission 5 Day MDS, Resident 188 had intact memory, clear speech, and was able to understand others. The assessment showed Resident 188 had no rejection of care during the assessment period. Record review of Resident 188's face sheet showed Resident 188 was their own responsible party. There was no copy of an AD for Resident 188 in their record. There was no documentation showing the facility offered or/and assisted Resident 188 to complete their AD papers. In an interview on 04/13/2026 at 8:42 AM Staff L reviewed Resident 188's record and stated they did not obtain a copy of Resident 188's ADs. Staff L stated they should have Resident 188's AD copy in the resident's record, but they did not have one. In an interview on 04/13/2026 at 9:23 AM, Staff B stated they expected all residents AD/POA paperwork to be available for staff to access in resident's records. REFERENCE: WAC 388-97-0280(3)(c)(i-ii).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure residents' medication regimens were free of chemical restraints for 1 of 6 residents (Resident 3) reviewed for unnecessary medications. Staff failure to ensure appropriate indication for use, monitor residents for target behaviors, provide nonpharmacological interventions, and obtain consent for psychotropic medications placed residents at risk for receiving unnecessary medications and other negative health outcomes.Findings included .<Policy>According to the facility's 01/2025 Psychotropic Medication (a medication that affects mental processes and behavior) Management policy the facility would utilize behavioral and non-pharmacological approaches to minimize the need for psychotropic medications. This policy showed psychotropic medications would be considered when non-pharmacological approaches were attempted but did not relieve the resident of their medical symptoms. The policy showed prior to initiating the use of psychotropic medication, the staff and the physician would review non-pharmacological alternatives, rationale for the recommendation, potential risks and benefits, and the resident/representative's right to accept or decline the treatment. The policy showed that as needed antipsychotic medications should only be used for 14 days unless the resident is evaluated by a physician for continued use.<Resident 3>According to the 12/07/2025 admission Minimum Data Set (MDS - An assessment tool) Resident 3 admitted the facility on 12/01/2025 with diagnoses of high blood pressure, kidney disease, and a history of a recent stroke. The MDS showed Resident 3 had severely impaired cognition, showed no indicators of psychosis, and had no behaviors in the look back period.Record review of a 12/22/2025 4:00 AM nursing progress note showed Resident 3 had an unwitnessed fall and the physician called a message was left for the on-call provider. There is no documentation in the note regarding predisposing circumstances of Resident 3's fall or behaviors being reported to the on-call provider.Record review of a 12/23/2025 physician progress note showed the physician evaluated Resident 3 and stated more restless with frequent falls. Vitals are stable. Doubt acute illness or other etiology. Suspect this is because (Resident 3) is more alert and strong now. Will start (Resident 3) on (antipsychotic medication) in the evenings routine. Will also have as needed dose available. The physicians note did not specify a medical diagnosis for use of antipsychotics.Record review of a 01/02/2026 physician progress note showed the physician evaluated Resident 3 and did not update the indication for use for the routine use of antipsychotic medication. The physician did not evaluate the use of as needed antipsychotic medication for Resident 3. Resident 3 would not have another physician visit until 01/13/2026.Review of Resident 3's physicians' orders for December 2025 and January 2026 showed a 12/22/2025 order for an anti-psychotic medication to be given once a day in the evening for restlessness. The same anti-psychotic medication was discontinued and restarted for Resident 3 on 01/03/2026 with the same schedule and indication for use and was then discontinued on 01/09/2026. There was no medical diagnosis documented for Resident 3's use of routine antipsychotic medication.Review of Resident 3's physicians' orders for December 2025 and January 2026 showed an antipsychotic medication was ordered on 12/22/2025 to be given as needed for restlessness. Resident 3's as needed antipsychotic medication was discontinued and restarted on 01/09/2026, 18 days later, with the same as needed indication. Resident 3's as needed anti-psychotic medication was discontinued on 01/22/2026. The antipsychotic medication orders do not include a medical diagnosis for use. There was no physician order to monitor adverse side effects or target behaviors.Record review of a 01/08/2026 pharmacy consultation report showed that a consultant pharmacist reviewed Resident 3's medication regimen and recommended the anti-psychotic medication be discontinued. Rationale for the recommendation for Resident 3 stated, CMS requires that (as needed) orders for antipsychotic medications be limited to 14 days. A new order should not be written without the prescriber directly examining the resident and assessing the resident's condition and progress to determine if the (as (continued on next page)

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	505182	A. Building B. Wing	04/13/2026

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed) antipsychotic medications are still needed. Report of the resident's condition from facility staff to the prescriber does not meet criteria for an evaluation. There was no signature or note to indicate the recommendation was seen by the physician for Resident 3.Review of Resident 3's medical records on 04/13/2026 showed no documented abnormal involuntary movement scale assessment. Resident 3's medical records showed no signed or verbal consent for anti-psychotic medications. Resident 3's medical records showed no non-pharmacological interventions used prior to prescribing an anti-psychotic medication.In an interview on 04/10/2026 at 11:07 AM with Staff G, Director of Long-Term Care Registered Nurse, and Staff B, Director of Nursing, Staff B stated that there was no appropriate indication of use for the anti-psychotic medication ordered for Resident 3. Staff G was unable to locate consent for the anti-psychotic medication for Resident 3. Staff G was unable to find documentation of adverse side effect monitoring or behavior monitoring for Resident 3. Staff B stated that a consent should have been in place for Resident 3, and monitoring should have been completed.In an interview on 04/13/2026 at 09:46 AM Staff L, Social Services Manager, stated that there was no appropriate indication of use for the anti-psychotic medication for Resident 3 and that the medication was used as needed for longer than 14 days without a physician evaluation.Refer to F610: Prevent/Investigate/Correct alleged violationREFERENCE: WAC388-97-1060(3)(k)(i), -0620(1)(a)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate, notify provider of changes in condition, implement appropriate fall interventions, and rule out abuse/neglect for 2 of 11 sampled residents (Resident 3 & 27) reviewed for investigations. The failure to conduct thorough investigations left residents at risk for unidentified abuse and/or neglect, recurrence of events, and a decreased quality of life.<Policy>According to the facility's 10/2025 Fall Prevention and Response policy the facility would investigate falls, including interviewing residents, staff, and others about the nature of the falls, and assess the resident for injuries sustained in the event. The policy stated the facility would initiate neurological assessments for residents who sustain an unwitnessed fall to check for potential injury and report to the physician for further assessment and treatment as needed.<Resident 3>According to the 12/07/2025 admission Minimum Data Set (MDS- an assessment tool) Resident 3 admitted to the facility on [DATE] with diagnoses including kidney disease, stroke, and high blood pressure. The MDS showed Resident 3 had recent brain surgery, no history of falls and was dependent on staff for Activities of Daily Living (ADL)Review of a 12/19/2025 Falls Care Plan (CP) showed Resident 3 was at risk for falls. Resident 3's CP showed fall interventions of room close to nursing station and anticipate all needs prior to leaving room. Resident 3's CP did not include when to notify provider of change in condition post fall or fall monitoring interventions.Review of the facility's fall investigation summary for Resident 3's fall on 12/20/2025 showed ADL care was provided an hour and a half prior to the fall and nursing staff had provided care 15 minutes prior to the fall. Documents attached to the summary of Resident 3's fall investigation did not include witness statements or other documented evidence to support when care was provided. Review of a 12/20/2025 nursing progress note showed the fall was unwitnessed and circumstances leading up the fall were unknown. Review of the Neurological Assessment record for Resident 3 following the 12/20/2025 fall showed missing vital signs, observation of signs of neurological changes, and nurses initials on 12/21/2025 at 3:15 PM.Review of the facility's fall investigation summary for Resident 3's fall on 12/22/2025 showed ADL care was provided two hours prior to the fall, and Resident 3 was seen one hour prior to the fall in bed asleep. The facility failed to provide documentation in the fall summary for Resident 3 to support when care was provided or circumstances leading to the fall. A 12/23/2025 physician's note showed Resident 3 was prescribed an anti-psychotic medication (a medication that effects mood and brain processes) as an intervention for falls due to their restlessness.Review of facility's fall investigation for Resident 3's fall on 12/30/2025 showed neurological assessments following the unwitnessed fall were completed at 6:30 AM, 7:30 AM, 9:30 AM, and 11:30 AM, staff had marked yes to indicate new onset of seizures, headaches, vomiting, or paralysis and required physician notification. There was no documentation found in the investigation to show Resident 3's condition was reported to the provider.In an interview on 04/10/2026 at 10:58 AM Staff B (Director of Nursing- DNS) stated a complete and thorough fall investigation would include staff witness statements and accurately completed neurological assessments. Staff B stated there was not an appropriate indication of use for Resident 3's anti-psychotic medication. Staff B stated Resident 3's neurological assessments were inaccurate, and investigations into Resident 3's falls should have included witness statements but did not. <Resident 27> According to the 03/19/2026 Quarterly MDS Resident 27 admitted to the facility on [DATE] with diagnoses of heart failure, an abnormal heart rhythm, and a urinary tract infection. The MDS showed Resident 27 required supervision with ADLs.Review of the facility's fall investigation for Resident 27's fall on 11/12/2025 showed Resident 27 had a fall at home when out of the facility and staff initiated neurological assessments. The neurological assessment within the fall investigation showed staff had marked yes to indicate a new onset of seizures, headache, nausea, or paralysis and required physician notification 11 times between 11/13/2025 and 11/15/2025. There was no documented evidence of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician notification of Resident 27's condition.Review of the facility's fall investigation for Resident 27's fall on 01/21/2026 showed Resident 27 had an unwitnessed fall in their room at 12:01 AM. Staff witness statements for Resident 27's fall showed staff marked NA when asked if the CP was being followed and the last time Resident 27 was toileted. Witness statements for Resident 27's fall were left blank when asked if there was anything different about (Resident 27) during the shift and what the potential cause of the fall was. Neurological assessments attached to the fall investigation showed staff documented in Resident 27's neurological assessments were missed on 01/21/2026 at 8:00 AM and 12:00 PM.In an interview on 04/20/2026 at 11:14 AM Staff B (DNS) stated Resident 27's neurological assessments were inaccurate and not completed. Staff B stated the witness statements should have been further investigated but were not.Refer to F605: Right to be Free from Chemical RestraintsREFERENCE: WAC 388-97-0640(6)(a)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) level 2 referrals were followed up on timely for 1 of 6 residents (Resident 16) whose PASRRs were reviewed. This failure placed residents at risk of not receiving timely and necessary services to meet their mental health needs.Findings included.<Facility Policy>According to the facility's Mood and Behavior Program policy, revised 03/2026, the facility would follow guidance as issued by the State-designated PASRR authority.<Resident 16>According to the 12/05/2025 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 16 had diagnoses including a progressive, irreversible brain disorder that slowly destroyed memory, thinking skills, and the ability to perform simple tasks, anxiety, and depression. The MDS showed Resident 16 received an antipsychotic, antianxiety, and antidepressant medication during the assessment period.Review of a 12/03/2025 social services care conference progress note showed Resident 16's family and facility staff had concerns regarding worsening behaviors of the resident. The note showed Resident 16 was displaying aggressive behavior, was paranoid about their money being stolen, and paranoid about food and drinks. The progress note showed the physician was present, a psychiatric consult was completed, and medication changes were made.Review of Resident 16's physician orders showed a 12/06/2025 physician order directing staff to administer an antipsychotic medication to Resident 16 every day at bedtime.Review of a 01/23/2026 PASRR level 1 showed Resident 16 had serious mental health indicators including mood and anxiety disorders. The PASRR showed staff assessed that a PASRR level 2 evaluation referral was required for Resident 16's identified serious mental illness.Review of Resident 16's comprehensive record and social services progress notes from 01/2026 to 04/10/2026 did not show documentation that a PASRR level 2 determination was received or follow up on the referral by staff was completed.In an interview on 04/10/2026 at 9:38 AM, Staff O (Social Worker) stated their process was to follow up on referrals quarterly. Staff O reviewed Resident 16's records and confirmed the determination was not received and follow-up by staff was not completed but should have been.REFERENCE: WAC 388-97-1975 (2)(3).

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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 observation, interview, and record review the facility failed to ensure Care Plans (CPs) were updated and/or revised as needed for 2 of 35 sample residents (Residents 82 & 18) reviewed, and failed to conduct care conferences for residents with their resident representative and the applicable Interdisciplinary Team (IDT) members for 2 of 7 residents (Resident 58 and 214) reviewed for care planning. Failure to ensure CPs were updated and to offer care conferences to reflect current care needs left residents at risk for unmet care needs, delay in treatments, and a diminished quality of life.Findings included .<Facility Policy>According to the facility's Resident Care Plan Reviews and Care Conferences policy, revised 01/2025, the facility conducted regular CP reviews and care conferences to ensure each resident's needs were met in a timely and effective manner, and were held according to regulatory requirements and as needed, such as with changes of condition or when significant changes to care goals and approaches occurred.<Resident 82> According to the 11/10/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 82 had muscle weakness and a urinary tract infection. The MDS showed Resident 82 was assessed as needing pain management. Review of the 08/20/2024 At risk for pain related to decreased physical mobility CP, staff were to provide nonpharmacological approaches to pain, such as repositioning the resident, and assess the effectiveness of pain medications. The CP did not show Resident 82 had a history of urinary tract infections, what nonpharmacological interventions to do to relieve pain, or when to notify the provider of ongoing pain needs. Review of Resident 82's April 2026 Medication Administration Record (MAR) showed a 12/31/2025 as needed pain medication. The MAR showed the pain medication was administered on 04/04/2026 and 04/05/2026 for pain, on 04/07/2026 for flank pain and on 04/08/2026 for groin pain. No documentation was found in this MAR to show staff assessed Resident 82 for pain medication effectiveness or that nonpharmacological interventions were provided. Review of Resident 82's April 2026 MAR showed an order dated 04/08/2026 for a pain medication to treat pain from a urinary tract infection. Review of the April 2026 MAR showed the medication was administered on 04/08/2026 with no documentation to show the pain medication was effective or what nonpharmacological interventions were provided. Observations and interviews included the following: On 04/07/2026 at 10:02 AM, Resident 82 stated they had pain in their back. On 4/8/2026 at 12:14 PM, Resident 82 yelled from their room that they were in pain. On 4/10/2026 at 10:14 AM, Resident 82 stated they had pain in their stomach. On 4/13/2026 at 9:57 AM, Resident 82 stated they had pain in their head and hurt badly. In an interview on 04/13/2026 at 10:40 AM, Staff F (Long Term Care RN) stated they could not find in Resident 82's medical record that staff assessed resident recently for urinary or general pain or assessed pain medication effectiveness. Staff F stated nursing staff should assess Resident 82's pain to determine the source of pain and notify the provider so necessary pain management could be ordered and added to the CP, but they did not. In an interview on 04/13/2026 at 12:53 PM, Staff B (Director of Nursing) stated nursing staff should (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	check resident's pain every shift and use a pain scale to determine effectiveness of pain management. Staff B stated the source of pain and daily pain monitoring should be stated on the CP to manage Resident 82's pain effectively, but it was not. <Resident 18> According to the 03/15/2026 Annual MDS, Resident 18 received end of life care, had a physical impairment to one side of their body and was dependent on staff for their mobility. Review of the 8/19/2024 Potential for Compromised Psychosocial Wellbeing CP showed staff were to check with Resident 18 and involve them in activities of interest as they were willing and able. Review of the 04/10/2026 Kardex (staff task list), staff were to assist Resident 18 out of bed at least once daily mid-morning and report to the nurse if Resident 18 refused. Observations on 04/06/2026 at 12:49 PM, 4/8/2026 at 12:11 pm, 4/8/2026 at 9:31 AM and 4/9/2026 at 9:11 AM, showed Resident 18 in their room lying in bed. In an interview on 04/07/2026 at 11:22 AM, Resident 18's representative stated Resident 18 was often left in their room instead of being assisted to the dining room for meals or activities. The representative stated it would be good for Resident 18 to be around others at least two to three times per week as the representative was not always available to visit and take Resident 18 out for activities. In an interview on 4/10/2026 at 9:47 AM, Staff Q (Long Term Care RN) stated Resident 18's representative usually took the resident out of their room, and staff waited for the representative because Resident 18 often refused services if the representative was not at the facility. Staff Q stated they were not notified of Resident 18's refusals to leave their room and Resident 18's CP did not include instructions for what to do for refusals. In an interview on 04/13/2026 at 10:32 AM, Staff F (Long term care RN) stated staff waited for the representative to take Resident 18 out because Resident 18 refused to leave their room. Staff F stated staff should document refusals and let the nurses know when residents refused services so adjustments to Resident 18's CP could be made. Staff F stated the CP should be updated to include instructions to staff about resident refusals and interventions on what to do when the representative was not there. In an interview on 04/13/2026 at 12:35 PM, Staff B stated they expected staff to follow what was on the Kardex and the CP and help Resident 18 up in their specialized chair to get out of the room, and to document refusals. Staff B stated they were not aware of refusals documented in Resident 18's record. <Care Conferences> <Resident 58> According to the 01/09/2026 Quarterly MDS, Resident 58 did not speak and rarely/never understood others. The MDS showed Resident 58 had diagnoses including a progressive, incurable brain disorder that caused severe memory loss, cognitive decline, and changes in behavior. The MDS showed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 58 was dependent on staff for eating, personal hygiene, toileting, and dressing. In a telephone interview on 04/07/2026 at 12:34 PM, Resident 58's Power of Attorney (POA) stated the facility used to arrange a care conference once a year. Resident 58's POA stated the last time they were included in a care conference was two years ago. Review of a 03/20/2025 progress note showed the social worker left a voicemail for Resident 58's POA, inviting them to a quarterly care conference. Review of progress notes from 04/2025 to 04/2026 showed no documentation of staff inviting to or providing Resident 58 and their POA with a care conference. Review of a 01/22/2026 Care Plan Conference Interdisciplinary Team (IDT) document showed the facility's IDT met and reviewed Resident 58's plan of care. The document included a section listing Resident 58's POA with checkboxes showing invited, attended, or did not attend. All check boxes were left blank by staff. In a joint interview on 04/10/2026 at 9:22 AM, Staff L (Social Services Manager) and Staff O (Social Worker) stated the facility's process for care conferences was to meet as an IDT and review the resident's record prior to the care conference. Staff L and Staff O stated care conferences were offered quarterly and with significant changes. Staff L and Staff O stated they worked around the resident and/or family's schedule. Staff O reviewed Resident 58's records and confirmed the last documentation regarding a care conference was 03/20/2025. Staff L stated families should be offered care conferences and staff should document whether the resident/family accepted or declined to participate in the care conference. <Resident 214> According to the 04/09/2026 admission MDS, Resident 214 admitted to the facility on [DATE] and had no memory impairment. In an interview on 04/07/2026 at 11:10 AM, Resident 214 stated staff had not offered or discussed a care conference with them. In an interview on 04/10/2026 at 9:28 AM, Resident 214 stated they asked staff about discharge plans on 04/09/2026 but did not get an answer. Resident 214 stated staff did not discuss or offer a care conference to discuss goals and discharge plans. In an interview and record review on 04/10/2026 at 10:32 AM, Staff L (Social Services Manager) reviewed Resident 214's records and stated they had not been offered a care conference and must have been missed because the primary social worker was on leave. Staff L stated they expected staff to offer and provide a care conference within five days of admission to the facility. REFER TO: F697-Pain Management Reference: WAC 388-97-1020 (1), (2)(a-d)(f), (4)(b)(c)(i-ii), (5)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: Ensure Physician's Orders (POs) were clarified and followed, to have parameters for pain medications, and medications given within ordered parameters for 2 of 6 sample residents (Residents 7 & 17), Staff failed to sign for narcotics from the narcotic ledger when given, and count the narcotics effectively each shift for 1 of 5 medication carts reviewed (Four south unit). These failures placed residents at risk for medication errors, unmet care needs, narcotic diversion, and other negative health outcomes.Findings included .<Policy>According to the facility's 02/2026 Pain Management policy the facility would use adequate doses of as needed medications to achieve the residents desired level of pain relief.According to the facility's 02/2025 Bowel Care policy the facility would monitor resident bowel movements and if no bowel movement after 6 shifts staff were to follow the physician ordered bowel care protocol and administer stool softeners and/or laxatives as needed.According to the facility's 02/2026 Controlled Substances Management policy the facility would document in the controlled substance log the date and time a controlled substance was removed and administered to a resident. The policy stated facility staff would count controlled substances at each shift change every day. The policy states staff would count controlled substances by reviewing the controlled substance logbook page by page comparing the documented amount of medication available against the actual amount of medication available in the cart.<Resident 7> According to a 01/29/2026 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 7 had multiple medically complex conditions including chronic kidney disease, arthritis, and high blood pressure. The MDS showed Resident 7 frequently experienced pain, and the resident's pain almost constantly interrupted their sleep and frequently affected their daily activities. This assessment showed Resident 7 required the use of narcotic pain medication during the assessment period. Review of the April 2026 Medication Administration Record (MAR) showed Resident 7 had the following physician orders: A 10/28/2025 order for a narcotic pain medication with directions to staff to administer one tablet two times daily as needed for pain; another 11/17/2025 order for a non-narcotic pain medication with directions to staff to administer one tablet every eight hours as needed for pain. There were no directions to staff to indicate what parameters should be used to identify which pain medication should be administered by staff. In an interview on 04/13/2026 at 9:50 AM, Staff B (Director of Nursing) stated pain medication orders should include parameters according to pain intensity on pain scale for residents. Staff B stated staff should clarify Resident 7's pain medication orders with provider, but they did not. <Resident 17> <Pain medication> According to a 03/05/2026 Quarterly MDS, Resident 17 admitted to the facility on [DATE] with diagnoses of cancer, an anxiety disorder, and constipation. The MDS showed that Resident 17 had occasional pain that limited activities of daily living and made it difficult to sleep at night. Record review of Resident 17's February MAR showed that they had orders for an as needed narcotic pain medication with staff to give one tablet for pain levels four to six out of ten and two tablets for pain levels seven to ten out of ten. Review of the February MAR showed that Resident 17 was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered one tablet of as needed narcotic pain medication for a pain level of seven on 02/23/2026 at 10:35 PM, 02/25/2026 at 10:29 PM, 02/26/2026 at 11:12 PM, and 02/27/2026 at 11:21 PM. In an interview on 04/10/2026 at 11:17 AM Staff B stated Resident 17's pain medication parameters were not being followed but should have been, as the error could have led to under treated pain. <Bowel Care> According to a 03/05/2026 Quarterly MDS Resident 17 admitted to the facility on [DATE] with diagnoses on cancer, an anxiety disorder, and constipation. The MDS showed that Resident 17 was cognitively intact and continent of bowel and bladder with the ability to use the bathroom independently. Record review of February Activity of Daily Living documentation for Resident 17 showed no documented bowel movements from 02/15/2026 through 02/19/2026. Record review of Resident 17's February MAR showed no documentation of the bowel protocol being initiated or as needed stool softeners and/or laxatives being given. In an interview on 04/10/2026 at 11:20 AM Staff B stated that staff caring for Resident 17 should have initiated the bowel protocol and given as needed medications as ordered but did not. <Signing for Narcotics> In an observation on 04/07/2026 at 9:42 AM in the fourth-floor south medication cart showed a narcotic ledger showing one narcotic medication available on page 37, this narcotic medication was not available in the cart. In an interview and observation on 04/07/2026 at 10:02 AM Staff N (Licensed Practical Nurse) stated they reviewed the ledger and the medication administration record for the resident who the medication belonged to and was able to show the medication was given on 04/01/2026 but not signed out of the ledger. Documents seen show the medication was given as ordered, though not signed for in the narcotic ledger. In an interview on 04/13/2026 at 11:56 AM Staff B stated the staff working the fourth-floor medication cart should have signed for the medication when given and counted the cart correctly to identify that the count was not correct but did not. REFRENCE: WAC 388-97-1620(1)(2)(b)(i)(ii). .

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	505182	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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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 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 observation, interview, and record review the facility failed to provide assistance with Activities of Daily Living (ADLs), related to cleanliness and grooming for 3 of 7 sample residents (Residents 39, 189, & 156) reviewed for ADLs. Facility failure to provide residents who were dependent on staff for assistance with nail care (Resident 39 and 189), and bathing (Resident 156) placed the residents at risk for poor hygiene, embarrassment and diminished quality of life.Findings included .<Facility Policy>According to the facility's Activities of Daily Living (ADLs) policy, revised 01/2025, the facility provided residents with care and services for ADLs, including bathing and grooming. <Resident 39> According to a 01/29/2026 admission Minimum Data Set (MDS – an assessment tool), Resident 39 had no memory impairment, had clear speech, and was able to make independent daily decisions. This MDS showed Resident 39 required maximal assistance from staff for transfers, personal hygiene, and bathing, and had no rejection of care during the assessment period. Review of the 12/08/2025 ADL Self-care deficit related to decreased mobility Care Plan (CP) showed a goal for Resident 39 to receive an appropriate level of assistance from staff during ADL care to improve their current level of ADL function. Review of Resident 39's Resident Preference Checklist, signed on 01/21/2026, showed Resident 39 preferred nail care to be provided by staff. Observations on 04/06/2026 at 1:12 PM, on 04/07/2026 at 8:41 AM, on 04/08/2026 at 12:52 PM, and on 04/10/2026 at 12:15 PM showed Resident 39 had long fingernails with black debris underneath. In an interview on 04/07/2026 at 8:42 AM, Resident 39 stated they needed assistance to clip their fingernails. In an interview on 04/10/2026 at 12:19 PM, Staff R (Certified Nursing Assistant) confirmed Resident 39 had long fingernails with black debris underneath. Staff R stated they should clip Resident 39's fingernails on their shower day, but they did not. In an interview on 04/13/2026 at 9:39 AM, Staff B (Director of Nursing) stated their expectation was for staff to perform ADL care daily during morning care. Staff B stated staff should provide nail care to all residents on their shower days and as needed, but they did not. <Resident 189> According to the 01/23/2026 Quarterly MDS, Resident 189 was cognitively intact. The MDS showed Resident 189 had impairment on one of their arms and one of their legs and was dependent on staff for assistance with personal hygiene. The MDS showed Resident 189 had a blood sugar control disorder. In an observation and interview on 04/07/2026 at 8:58 AM, Resident 189 stated they could not use their right hand from the elbow down. Resident 189 used their left hand to open their contracted (rigid or deformed joint) fingers on their right hand. Their fingernails on their right and left hands were long, extending past the nail bed. (continued on next page)

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Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a 04/08/2026 weekly skin check assessment showed the licensed nurse assessed Resident 189's fingernails and documented fingernail length is [within normal limits] per resident preference. Observation on 04/09/2026 at 10:01 AM showed Resident 189's contracted right pinky nail and ring fingernail were over a half inch long. Resident 189 stated they had to ask staff to get their nails clipped, and staff did not offer to clip their fingernails. Resident 189 stated they would like their fingernails to be shorter. In an observation and interview on 04/10/2026 at 11:45 AM, Staff HH (Long Term Care Registered Nurse) stated the facility had a designated nurse who performed nail care. Staff HH stated the nurse aides reported to the nurse anytime a resident needed nail care done. In an observation at this time, Staff HH assessed Resident 189's fingernails and confirmed they needed to be trimmed. Resident 189 stated, Oh, that would be great. In an interview on 04/13/2026 at 10:01 AM, Staff B stated nail care should be offered each week on the resident's shower day and included clipping and cleaning the nails. Staff B stated if the resident had a blood sugar control disorder, the nurse was responsible for checking and trimming their nails. Staff B stated if a resident refused nail care, they expected staff to document the refusal. <Resident 156> According to the 03/20/2026 admission MDS, Resident 156 admitted to the facility on [DATE] with no memory impairment. The MDS showed it was very important for Resident 156 to choose between a tub bath, shower, bed bath, or sponge bath. The MDS showed Resident 156 did not reject care during the assessment period. The MDS showed Resident 156 was occasionally incontinent of urine. Record review of Resident 156's nursing bathing documentation for 03/14/2026 to 04/09/2026 showed no showers were offered or provided. In an interview on 04/06/2026 at 9:21 AM, Resident 156 stated staff told them only Occupational Therapy (OT) could give them showers. Resident 156 stated they preferred showers at least three times a week. Resident 156 stated OT had only assisted them with one or two showers since admission to the facility. In an interview and record review on 04/09/2026 at 1:19 PM, Staff GG (Rehab Director) reviewed Resident 156's OT treatment notes since admission and stated Resident 156 only had showers on 03/18/2026 and 04/08/2026 with OT. Staff GG stated they expected nursing staff to provide bathing per Resident 156's bathing schedule as OT may not always work on bathing with each treatment. Staff GG stated nursing staff were trained to safely transfer residents so there should not be an issue for them to transfer Resident 156 and provide bathing. In an interview and record review on 04/09/2026 at 2:14 PM, Staff G (Director Long Term Care Registered Nurse) reviewed Resident 156's bathing schedule and stated they were scheduled to receive showers every Monday evening. Staff G reviewed nursing bathing documentation and stated there was no documentation to support Resident 156 was offered or provided a shower. Staff G stated they expected nursing to offer and provide residents bathing even when OT was working with the residents on bathing. Staff G stated it was important to offer and provide showers for residents' hygiene. (continued on next page)

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Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	REFERENCE: WAC 388-97-1060(2)(c)

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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 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 observation, interview, and record review the facility: Failed to ensure residents' skin was assessed, documented, monitored, and treated as required for 2 of 4 residents (Residents 188 & 214) reviewed for non-pressure skin. These failures placed all residents at risk for delay in treatment, worsening of condition, and decreased quality of life. Findings included .<Facility Policy>According to the facility policy titled, Skin Integrity Monitoring- Non-Pressure Related Conditions, dated 04/2024, the facility would ensure skin conditions would be assessed and issues would be documented in the resident's records to include location, description, and interventions. The policy showed follow up monitoring would occur to evaluate progression or resolution of the skin condition.<Resident 188> According to the 02/23/2026 5 Day Medicare Minimum Data Set (MDS - an assessment tool), Resident 188 did not have cognitive impairment, was understood, and able to understand others in conversation. This assessment showed Resident 188 did not have any wounds or skin problems and Resident 188 did not receive blood thinner medication during assessment period. Review of Resident 188's record showed Resident 188 was readmitted to the facility from the hospital on [DATE] after a scheduled procedure was performed. Review of a 03/27/2026 Comprehensive Skin Inspection showed staff performed a head-to-toe skin assessment on Resident 188 upon their readmission to the facility. This assessment showed staff did not document bruises on the skin map. Observation on 04/07/2026 at 9:14 AM showed Resident 188 had multiple open scabs on their face, arms, and lower legs, and dark purple bruises on both arms. Resident 188 stated the bruises occurred in the hospital during blood draws and intravenous medication administration during the procedure. Review of Resident 188's April 2026 Physician Orders showed no orders directing staff to monitor the bruising on Resident 188's arms. Review of a 04/06/2026 Weekly Skin Assessment showed no documentation on the skin map that Resident 188 had bruising on both arms. In an interview on 04/09/2026 at 11:01 AM, Staff V (Licensed Practical Nurse) stated they were not a regular staff on this unit, they worked on this unit three days ago (04/06/2026) and noticed bruises on Resident 188's both arms. Staff V stated they did not notify the provider because the bruises were not new and they thought the regular staff on this unit knew about these bruises. In an interview on 04/10/2026 at 9:13 AM, Staff R (Certified Nursing Assistant) stated they did not notice the bruises on Resident 188's arms because Resident 188 was able take care of their upper body independently. In an interview on 04/13/2026 at 9:39 AM Staff B (Director of Nursing) stated it was their expectation staff assessed resident's skin weekly and as needed, document all the issues in the resident's record, notify the clinical manager of any new skin issues, notify the provider, and obtain orders to monitor and/or treat the skin issues. <Resident 214> (continued on next page)

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Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 04/09/2026 admission MDS, Resident 214 admitted to the facility on [DATE] and had no memory impairment. The MDS showed Resident 214 did not have any wounds or skin problems and Resident 214 received blood thinner medication during the assessment period. Observation and interview on 04/07/2026 at 11:25 AM showed Resident 214 had an 8 X 4.5-centimeter dark purple raised bruise to their right arm. Resident 214 stated they received a blood transfusion in the hospital, but it was looking larger and more swollen. Resident 214 stated they took blood thinner medication. In an interview and record review on 04/10/2026 at 9:45 AM Staff G (Director of Long-Term Care Registered Nurse) reviewed Resident 214's skin assessments since admission and stated staff only documented bruise and did not document an assessment of the bruise. Staff G stated they expected staff to do an accurate and thorough skin assessment documenting the appearance to include the size in measurements, color, and any swelling. Staff G stated it was important to document the appearance to have a baseline observation and ensure the skin issue was improving and not worsening. Reference: WAC 388-97-1060(1).

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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 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 observation, interview, and record review the facility failed to ensure pain management was provided to residents consistent with professional standards of practice including the failure to assess pain medication effectiveness for as needed (PRN) pain medications and failure to assess residents pain utilizing pain assessments and pain scales for 2 of 6 residents (Resident 82 & 52) reviewed for pain management. These failures placed residents at risk for experiencing untreated pain, possible side effects, and a decreased quality of life. Findings included <Facility Policy>According to the facility's Pain Management policy, revised 02/2026, the facility assessed residents who had pain using pain assessment tools, including a numeric pain rating scale (a pain severity scale from 0 to 10, with 0 being no pain and 10 being the worst pain imaginable) or a Wong-Baker FACES Pain Rating Scale (a pain assessment tool using six faces ranging from smiling to crying), to ensure consistent and accurate evaluation of resident pain severity and to guide clinical decision-making.<Resident 82> According to the 02/02/2026 Significant Change Minimum Data Set (MDS – an assessment tool), Resident 82 had multiple medically complex conditions, including a bladder infection, cognitive impairment, and muscle weakness. This MDS showed Resident 82 had generalized pain and received pain medications. Review of the 8/20/2024 At risk for pain related to decreased physical mobility Care Plan (CP) showed staff were to assess effectiveness of Resident 82's pain medications, use a pain scale to assess for pain and monitor side effects of pain medications. Review of Resident 82's medical record did not show a recent pain assessment had been completed for Resident 82 and did not show the provider was notified of resident's ongoing pain needs. Review of Resident 82's April 2026 Medication Administration Record (MAR) showed a 12/31/2025 as needed pain medication. The MAR showed the pain medication was administered on 4/4/2026, 4/5/2026, 4/7/2026 and 4/8/2026, no documentation was found in the MAR to show staff reassessed Resident 82's pain medication for effectiveness or used a pain scale to monitor Resident 82's pain. Review of Resident 82's April 2026 MAR showed an order dated 04/08/2026 for a pain medication for a urinary tract infection. Review of the April 2026 MAR showed the medication was administered on 4/8/2026. The MAR did not show documentation the nurses reassess if Resident 82's pain medication was effective and did not show nurses used a pain scale to assess Resident 82's pain level. Observation and interview on 04/07/2026 at 10:02 AM, Resident 82 stated they had pain in their back and always had pain. Observation on 4/8/2026 at 12:14 PM, Resident 82 was observed yelling from their room they were in pain. Observation and interview on 4/10/2026 at 10:14 AM, Resident 82 stated they had pain in their stomach. Observation and interview on 4/13/2026 at 9:57 AM Resident 82 stated they had pain in their head, and it hurt badly. (continued on next page)

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	505182	A. Building B. Wing	04/13/2026

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Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 04/13/2026 at 10:40 AM Staff F (Long Term Care RN) stated they could not find a current pain assessment in Resident 82's record. Staff F reviewed the April 2026 MAR and stated nursing staff should re-assess pain medication for effectiveness every time they administer an as needed pain medication, to provide necessary pain management, but did not. In an interview on 04/13/2026 at 12:53 PM, Staff B (Director of Nursing) stated nursing staff should have assessed Resident 82 for pain on every shift and used a pain scale to determine effectiveness of pain medications but did not. Staff B stated staff should have notified Resident 82's provider to obtain orders for routine pain medications instead of using as needed pain medications. Staff B stated it was important to assess residents for pain so adjustments could be made to manage residents' pain effectively. <Resident 52> According to a 04/09/2026 Comprehensive MDS, Resident 52 re-admitted to the facility on [DATE] after a hospitalization, with diagnoses including heart issues, cancer, wounds, and chronic pain syndrome. The MDS showed Resident 52 reported they frequently had pain, and they rated their worst pain during the last five days at a 5 out of 10 on the numeric pain scale. Resident 52 was able to understand and be understood. Review of a care plan entry, dated 02/26/2026, showed Resident 52 had chronic pain to their lower extremities. Staff were to monitor pain and report to the physician if pain was unresolved after medication administration or if pain worsened. Staff were to utilize the pain scale and follow up assessments per facility protocol. In an observation and interview on 04/07/2026 at 9:18 AM, Resident 52 laid in their hospital bed with the head of bed raised. Resident 52 stated their pain was always an 8 or 9 out of 10, the doctor had not discussed pain management with them, and they were frustrated when nurses told them it was not yet time for their pain medication. Resident 52 stated they had pain in their neck, shoulders, back and leg, and they should be able to get additional medication for breakthrough pain. Review of 03/27/2026 hospital Skilled Nursing Facility Transfer Orders showed Resident 52's principal problem at the hospital was chronic pain syndrome. Physician orders included suboxone (used to treat chronic pain, especially for residents with opioid use disorder) every eight hours routinely, and acetaminophen (an over-the-counter pain reliever) every four hours as needed for pain. Review of Resident 52's MAR dated 04/01/2026 through 04/30/2026, showed a 03/27/2026 physician order for suboxone every eight hours as needed for opioid dependance. Documentation showed suboxone was administered 10 times from 04/01/2026 through 04/07/2026. No pain scale rating was documented for eight of 10 administrations, and no pain scale rating was documented for the results of any of the 10 administrations. Review of interdisciplinary progress notes showed no documentation of Resident 52's pain levels on 03/27/2026, 03/28/2026, or from 03/30/2026 through 04/08/2026 (10 days). Review of a Clients by Vital Parameter report, dated 04/10/2026, showed Resident 52's pain level was 0 out of 10 on 03/27/2026, no pain level entries from 03/28/2026 through 04/08/2026 (12 days), pain level was 8 out of 10 on 04/09/2026 and 9 out of 10 on 04/10/2026. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of physician visit notes dated 03/30/2026, 04/03/2026, and 04/08/2026, showed no documentation of Resident 52's pain level using the numeric pain scale. In an interview on 04/09/2026 at 9:10 AM, Staff DD (Long Term Care RN) stated whenever they went into Resident 52's room, they asked Resident 52 if they were doing well. Staff DD stated if Resident 52 wanted pain medication, they asked for it. When asked, Staff DD stated they typically documented the pain level in progress notes. In an interview on 04/09/2026 at 12:34 PM, Resident 52 stated she just asked Staff DD for a pain pill and was told it was too soon. Resident 52 stated their pain level was currently an 81/2 or 9 out of 10. In an interview on 04/09/2026 at 12:37 PM, Staff DD stated Resident 52 was sleeping and woke up when they went in their room. Staff DD stated Resident 52 told them they were starting to hurt and requested pain medication, but it was too soon, according to physician's orders. Staff DD stated Resident 52 did not say what their pain level was. In an interview on 04/10/2026 at 9:55 AM, Resident 52 stated their pain level was currently an 8 out of 10, down from 91/2 out of 10. Resident 52 stated with good pain control, their pain went down to as low as 6 out of 10. Resident 52 stated Staff DD and some of the other nurses rarely asked what their pain level was, and they had never told anyone their pain was less than 6 out of 10. In an interview on 04/13/2026 at 11:06 AM, Staff B stated because Resident 52 had chronic pain issues, the nurses should provide ongoing pain assessments, including documentation of the location of pain, severity of pain, and the effectiveness of pain medications and other interventions using the numerical pain scale, but they did not. REFER to: F657 Care Planning Timing and Revision Reference WAC 388-97-1060(1).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to ensure a medication error rate of less than 5 percent (%). Failure of 1 of 5 nurses (Staff W - Long Term Care Registered Nurse) to properly administer 2 of 29 medications for 1 (Resident 56) of 6 residents observed during medication pass, resulted in a medication error rate of 6.9%. This failure placed residents at risk for adverse side effects and/or not receiving prescribed medications as ordered.Findings included .<Facility Policy>Review of the facility's Medication Administration policy, revised 04/2025, showed the facility staff administering the medication should be sure to review elements of the medication order including verifying the resident name, name of medication, strength, dosage, time, and route.<Staff W>Observation on 04/08/2026 at 9:04 AM showed Staff W preparing to administer morning medications to Resident 56. Staff W measured 25 milliliters (ml) of a liquid supplement medication into a medication cup and prepared prescription eye drops for Resident 56. Staff W was ready to administer the medication to Resident 56 in their room. Staff W administered 1 drop of the prescribed eye drop to each eye for Resident 56. Resident 56 told Staff W they received two drops in each eye every day from other nurses. Staff W stated Resident 56's physician order directed staff to administer one drop of the eye drops in each eye.On 04/08/2026 at 9:17 AM, Staff W reviewed Resident 56's physician orders, and stated the resident was right. Resident 56's physician orders directed staff to administer two eye drops in each eye and instructed staff to administer 30 ml of the liquid supplement, not 25 ml as Staff W was going to administer. Staff W stated they should check the orders for all residents before they administer medications to the residents.In an interview on 04/13/2026 at 9:44 AM, Staff B (Director of Nursing) stated their expectation was for staff to check the physician orders before they administered medications to residents, but they did not.REFERENCE: WAC 388-97-1060(3)(k)(ii).

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure specialized rehabilitative services were provided as assessed to be required for 3 of 5 sample residents (Residents 188, 189, & 156) reviewed for rehabilitation with skilled therapy services. This failure prevented residents from attaining, maintaining, or restoring their highest practicable level of physical, mental, functional, and psycho-social well-being.Findings included . <Resident 188> According to the 02/23/2026 5 Day Medicare Minimum Data Set (MDS - an assessment tool), Resident 188 did not have cognitive impairment, was understood, and able to understand others in conversation. The assessment showed Resident 188 had diagnoses of kidney stones and bladder infection and required assistance from staff with daily needs including personal hygiene. Review of the facility Census record showed Resident 188 was hospitalized on [DATE] for scheduled procedure to remove kidney stones and came back to the facility on [DATE]. Review of the 03/27/2026 hospital Physician transfer orders showed Resident 188 required Physical Therapy (PT) and Occupational Therapy (OT) evaluation and management to resume previous level of activity. Review of Resident 188's March and April 2026 Physician Orders showed no orders for PT and OT evaluation and treatment. Observations on 04/06/2026 at 10:21 AM and on 04/07/2026 at 9:13 AM showed Resident 188 was lying in bed in their hospital gown. In an interview on 04/06/2026 at 10:25 AM, Resident 188 stated they were in the hospital for more than a week for kidney stone removal procedure and were told therapy staff would work with them to get stronger when they come back to the facility, but no one had worked with them. Resident 188 stated they felt weak and wished they received therapy to help them to sit them on the edge of their bed. In an interview on 04/09/2026 at 12:26 PM, Staff GG (Rehab Director) stated therapy staff was expected to receive hospital transfer orders for new admissions and readmissions, to complete PT/OT evaluations and treatment as required. Staff GG reviewed Resident 188's hospital transfer orders and stated they missed the therapy orders to evaluate Resident 188 for therapy needs. Staff GG stated they should have evaluated Resident 188 for PT and OT services and treated them to resume their previous level of functions, but they did not. <Resident 189> According to the 01/23/2026 Quarterly MDS, Resident 189 was cognitively intact and had diagnoses including weakness to one side of their body. The MDS showed Resident 189 was dependent on staff for oral hygiene, toileting, getting dressed, and personal hygiene. The MDS showed Resident 189 required substantial/maximal assistance from staff to roll left and right in bed and was dependent on staff for getting up in their wheelchair. This assessment showed Resident 189 did not receive OT, PT, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505182	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Mount St Vincent	4831 35th Avenue Southwest Seattle, WA 98126

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	restorative therapy, or splint/brace assistance during the assessment period. Review of Resident 189's 02/07/2026 [activities of daily living] self-care deficit related to decreased mobility. care plan showed an intervention of therapy as ordered/needed to increase the resident's strength and independence. Review of Resident 189's OT certification notes showed the last time OT assessed and provided therapy services to Resident 189 for their hand contracture was from 02/16/2024 to 04/24/2024, nearly two years prior. The OT discharge summary showed the therapist discharged Resident 189 due to the resident declining to wear the recommended hand splint. There was no documentation showing why the resident declined the splint, if alternate therapies were offered, or if a restorative nursing program was offered/recommended. In an interview and observation on 04/07/2026 at 8:58 AM, Resident 189 was lying in bed. Resident 189 stated they could not use their right hand due to having a stroke (brain bleed). Observation at this time showed their right hand was contracted, with their fingers forming a fist; there was no brace or splint in place. Resident 189 used their left hand to pry open their fingers on their right hand. Observation at this time showed Resident 189's left leg was amputated above their knee. Resident 189 stated [the staff] have been talking about therapy recently but no one has started therapy with them. Observation on 04/08/2026 at 9:47 AM and 1:40 PM showed Resident 189 in bed, no brace was present on their right hand. In an interview on 04/09/2026 at 9:58 AM, Resident 189 stated they wanted to use their hand and staff were not working with them to stretch or provide range of motion. In a joint interview on 04/13/2026 at 1:23 PM with Staff GG and Staff A (Administrator), Staff GG stated their process for refusals during therapy was to find out the reason for refusal and attempt to address barriers to promote compliance with therapy services. Staff GG stated it was the therapy department's process to screen residents for restorative nursing programs every six months to a year if the resident was not evaluated in that time. Staff GG stated therapy also performed quarterly therapy screenings on residents and confirmed there was no quarterly screenings for Resident 189, but there should be. Staff A stated the importance of the quarterly screenings was to determine if there were any changes in the resident's functional abilities and to prevent functional decline if able. Staff GG stated they spoke to Resident 189 in 2025 regarding their hand contracture and confirmed they did not have documentation regarding the conversation with Resident 189. Staff GG and Staff A confirmed there should be documentation to show what was offered and discussed with Resident 189 but there was not. <Resident 156> According to the 03/20/2026 admission MDS Resident 156 admitted to the facility on [DATE] with no memory impairment. The MDS showed Resident 156 worked with OT services. The MDS showed Resident 156 did not reject care during the assessment period. Record review of Resident 156's 03/16/2026 OT evaluation showed OT would work with Resident 156 three to six times a week for four weeks. Review of the OT treatment sessions only showed two OT sessions for the week of 03/16/2026 to 03/21/2026. In an interview and record review on 04/09/2026 at 1:19 PM Staff GG reviewed Resident 156's OT (continued on next page)

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	505182	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment sessions and stated they only received OT service twice the first week (03/16/2026 to 03/21/2026) they were admitted to the facility. Staff GG stated they used a Sunday to Saturday week when scheduling rehab treatment sessions. Staff GG stated Resident 156 only received OT on 03/16/2026 and 03/18/2026 but should have received at least three sessions that week per the OT evaluation and plan. Staff GG stated rehab services were important to get residents stronger, independent, and back home. Reference: WAC 388-97-1280(1)(a).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure nurses aides completed required annual training for 2 of 5 nurses aides (Staff J, Certified Nursing Assistant - CNA, and Staff K, CNA) reviewed for annual training. The failure to ensure CNAs completed 12 hours of annual training placed residents at risk for care deficits and other negative health outcomes. Findings included . <Facility Policy>According the facility's 06/2025 Mandatory Education/Training Requirements policy, the facility would establish a system to ensure all caregivers completed mandatory education and training in accordance with certification and regulatory requirements. The policy showed CNAs must complete a minimum of 12 hours training annually. Review of Staff J's annual training documentation from their last full year of employment from 9/9/2024 through 09/09/2025 showed Staff J completed 4.3 hours of education/training. Staff J did not meet the 12 hour requirement. In an interview on 04/13/2026 at 11:47 AM, Staff B (Director of Nursing) stated the facility had difficulty encouraging CNAs to complete the required training that required creativity because of the size of the facility and the format of the education modules provided by ownership/foundation. Staff B stated Staff J and K did not but should have completed a minimum of 12 hours of annual training. REFERENCE: WAC 388-97-1680(2)(a-c).