STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505204	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen Anne Healthcare	2717 Dexter Avenue North Seattle, WA 98109

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a self-administration of medication evaluation and a physician order were obtained for 1 of 1 resident (Resident 103), reviewed for self-administration of medication. This failure placed the resident at risk for inaccurate and unsafe medication administration, adverse side effects, and a diminished quality of life.Findings included.Review of the facility's policy titled, Self-Administration of Medications, dated November 2025, showed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.Review of the medical diagnoses sheet printed on 04/30/2026 showed Resident 103 had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - an ongoing lung condition caused by damage to lungs), dyspnea (shortness of breath/not being able to get enough air into the lungs), and obstructive sleep apnea (sleep disorder caused by repeated interruptions in breathing during sleep).Review of Resident 103's Electronic Health Records (EHR) under evaluations tab printed on 04/30/2026 (from 04/22/2026 to 04/29/2026) showed no evaluation or assessment for self-administration of medication for Resident 103.Review of the physician orders printed on 04/30/2026 showed no documentation to indicate that Resident 103 had an order to keep the albuterol sulfate inhaler (medication used to open the airways to increase air flow to the lungs) at bedside.Review of the April 2026 Treatment Administration Record (TAR) showed Resident 103 had an order for SMP [Self-Medication Program] for Albuterol Sulfate and to document the following: can patient [resident] administer [medication] on her own? . does patient ask for inhaler at the right time. does patient know the right dosage. does patient know what medication is for? scheduled for 00:00 AM (midnight), 4:00 AM, 8:00 AM, 12:00 PM (noon), 4:00 PM and 8:00 PM, dated 04/28/2026.Observation on 04/30/2026 at 9:51 AM showed a red canister inhaler on Resident 103's bedside table that was visible and within Resident 103's reach.Observation on 04/30/2026 at 10:26 AM, showed Resident 103 had an albuterol sulfate inhaler that had 160 puffs left in it from 200 total puffs. Resident 103 stated that they brought their albuterol inhaler from home and that they had been using their inhaler since they were admitted to the facility. Resident 103 further stated that they self-administered their home albuterol inhaler two puffs three to four times a day depending on how I'm [I am] feeling.In an interview and joint record review on 04/30/2026 at 10:48 PM, Staff E, Registered Nurse, stated that if residents were on self-medication program, the facility would assess the residents to see if they could take their medications, an evaluation would be completed and get a physician order. A joint record review of Resident 103's April 2026 TAR showed Resident had orders for SMP for albuterol inhaler every four hours. Staff E stated that Resident 103 had an order for self-administration program for albuterol sulfate. When asked where Resident 103 kept their albuterol inhaler, Staff E stated they kept it in the medication cart, and that they did not know if Resident 103 kept their own albuterol inhaler in their room.A joint observation and interview on 04/30/2026 at 10:59 AM with Staff E, showed that Resident 103 had an albuterol sulfate inhaler on top of their bedside (continued on next page)

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

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	table that was within their reach. Staff E took the albuterol inhaler and informed Resident 103 that they could not keep the inhaler in their room. Staff E further stated that Resident 103 was not supposed to keep the albuterol inhaler with them.In an interview and joint record review on 05/05/2026 at 10:21 AM, Staff H, Resident Care Manager (RCM), and Staff D, RCM, stated that residents who wanted to self-administer medications would have a self-administration evaluation completed prior to starting the self-administration of medication program, have an order, and a care plan. Staff H and Staff D stated that residents who could safely self-administer their medications would be allowed to keep their medications in their room in a lockbox. A joint record review of the evaluations tab did not show Resident 103 had a self-administration evaluation prior to 04/30/2026. Staff H and Staff D stated that Resident 103 should not have had an albuterol inhaler at their bedside without having a self-administration of medication evaluation. Staff D further stated that Resident 103 was not safe to keep their albuterol inhaler at bedside.In an interview on 05/05/2026 at 11:27 AM, Staff B, Director of Nursing, stated that residents who wanted to self-administer their medications would have had an evaluation, an order, and a lockbox to keep their medications at bedside. Staff B stated that Resident 103 should have had a self-administration of medication evaluation completed before they could keep their medication at bedside and be able to self-administer their inhaler. Staff B further stated that Resident 103 should not have had their albuterol inhaler in their room.Reference: (WAC) 388-97-0440,1060 (3)(I).

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review, the facility failed to initiate and resolve a grievance for 1 of 2 residents (Resident 68), reviewed for grievances. The failure to initiate, investigate, and resolve grievances for missing personal item placed the resident at risk for feelings of frustration, unmet care needs, and a diminished quality of life.Findings included.Review of the facility's policy titled, Resident Grievance/Complaint Policy and Procedure, updated on 03/20/2026, showed, Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, loss of property, or any other concerns that can not be immediately resolved regarding his or her stay at this facility.In an interview on 05/04/2026 at 8:31 AM, Resident 68 stated that they were missing a blue sweater in January 2026 and that staff did not put their name on it when they took it to laundry. Resident 68 further stated that they did not remember if they spoke to the Social Worker (SW) about it and that their sweater had not been found and/or replaced. Review of Staff L, Nurse Practitioner, progress note dated 01/27/2026 showed that Resident 68 was requesting to speak with the SW to discuss missing items in the laundry.Review of the facility's January 2026 grievance log did not show that a grievance was logged for Resident 68's missing items.In an interview on 05/04/2026 at 11:21 AM, Staff L stated that they could not remember if they told the SW about Resident 68 wanting to speak to them about their missing items in the laundry. When asked if they knew the facility's grievance policy, Staff L stated that they did not know. When Staff L was asked what they would do if a resident informed them of missing personal property, Staff L stated that they would let the SW know and that it was standard practice.In an interview and joint record review on 05/04/2026 at 11:27 AM, Staff I, Social Services Director, stated that they had a new grievance form and that they could be submitted anonymously. Staff I stated that residents could complete it themselves or that staff could help residents complete the grievance form for them. Staff I stated that the grievance box was checked daily and that they had five days to resolve the grievance. A joint record review of Staff L's progress note dated 01/27/2026 showed that Resident 68 was requesting to speak with the SW to discuss missing items in the laundry. Staff I stated that they were not notified in January 2026 that Resident 68 wanted to speak to them regarding their missing item in the laundry. Staff I reviewed Resident 68's progress notes and stated that a SW had met with Resident 68 on 01/30/2026 and that there was no mention of any missing items. When asked if a grievance form was completed for Resident 68, Staff I stated that they could look for it. Staff I further stated that if they were aware of Resident 68's missing items, they would have met with them and if they could not find the missing items, they would complete a grievance form.In a follow up interview on 05/05/2026 at 10:59 AM, Staff I stated that a grievance form had not been completed for Resident 68 in January 2026 and that they were not notified of Resident 68's missing items. In an interview on 05/05/2026 at 11:02 AM, Staff A, Administrator, stated that they would have expected grievances to have been completed if a resident reported to staff that they were missing personal items that staff could not find right away. Staff A stated that they were not aware of Staff L's progress note on 01/27/2026. Staff A stated that they if they knew about it, they would have expected staff to complete a grievance, look for the items and if not found, they would replace them. When asked if they would have expected a grievance to be filed for Resident 68 in January 2026, Staff A stated, If my staff knew about it, yes, but it sounds like they didn't [did not] know about it. When asked if they would have expected Staff L to notify the SW about Resident 68's missing items, Staff A stated that Staff L did not work for them and that logically if a patient [resident] had a concern, I would expect they would tell us.Reference: (WAC) 388-97-0460 (1)(2).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident assessments were completed accurately for 1 of 1 resident (Resident 1), reviewed for pressure ulcers (bedsore). The failure to ensure accurate assessments for turning/repositioning program placed the resident at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included.According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS [Minimum Data Set- an assessment tool] items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. Further review of the RAI manual showed, The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g. [for example], reposition on side, pillows between knees) and frequency (e.g., every 2 [two] hours). Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.Review of the facility's policy titled, Certifying Accuracy of the Resident Assessment, dated in November 2019, showed, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The policy further showed, The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.Review of the admission MDS dated [DATE] showed that Resident 1 readmitted to the facility on [DATE]. Further review showed that Section M1200C (Skin and Ulcer/Injury Treatments) was marked for Turning/repositioning program.Review of Resident 1's Actual skin impairment care plan intervention initiated on 03/12/2026 showed, Turn and position resident REPOSITIONING/ OFF-LOADING PROGRAM: Res. [Resident] to be repositioned Q2 [every two hours] when in bed. When laying supine [flat on their back]- place pillows under the knees for comfort ensuring heels are floated and blanket tented at toes. Turn to right side- placing pillow between the legs (avoiding bone on bone contact and ensuring hips are aligned. Place additional pillow behind the back for support/ avoiding pressure to coccyx [tailbone] area. Turn to left side, same as right side position. Staff to ensure proper alignment.Review of Resident 1's electronic health record (physician orders, progress notes, tasks) did not show documentation that Resident 1 was repositioned every two hours and/or that their turning/repositioning program was monitored/reassessed to determine the effectiveness of the program.In an interview on 05/04/2026 at 1:16 PM, Staff K, Certified Nursing Assistant, was asked if Resident 1 was on a turning/repositioning program, Staff K stated, No, not to my knowledge. In an interview on 05/04/2026 at 1:56 PM, Staff E, Registered Nurse, stated that they were not sure if Resident 1 was on a turning/repositioning program. Staff E stated that Resident 1 had a wound on their back, that they did not move much and that they had to keep repositioning Resident 1 back and forth [from side to side].In an interview and joint record review on 05/04/2026 at 2:03 PM, Staff G, MDS Coordinator, stated that they followed the RAI manual for MDS completion. Staff G stated that to code turning/repositioning program in the MDS, the program had to be followed by a nurse, have specific (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times, instructions on how to do the program and that it had to be evaluated. When asked if Resident 1 was on a turning/repositioning program, Staff G stated, Looks like [Resident 1] was. It didn't [did not] get restarted and was discontinued on 4/3 [04/03/2026]. A joint record review of Resident 1's admission MDS dated [DATE] showed that Section M1200C was marked for Turning/repositioning program. Staff G stated, it [turning/repositioning program] was coded. Staff G reviewed Resident 1's physician orders and stated that it was discontinued on 4/3. Staff G further stated that Resident 1's admission MDS was inaccurate. In an interview on 05/05/2026 at 10:34 AM, Staff B, Director of Nursing Services, stated that they expected the MDS to be completed accurately.Reference: (WAC) 388-97-1000(1)(b).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a care plan for 1 of 1 resident (Resident 2), reviewed for comprehensive care plan. The failure to develop a care plan for diabetes mellitus (a disease where the body cannot properly regulate blood sugar levels) placed the resident at risk for unmet care needs and a diminished quality of life.Findings included.Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, reviewed in June 2025, showed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set -an assessment tool] assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.Review of the admission record printed on 05/05/2026 showed Resident 2 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus.Review of the admission MDS dated [DATE] showed Resident 2 had a diagnosis of diabetes mellitus and was receiving insulin (drug that lowers the level of sugar in the blood) during the assessment period.Review of Resident 2's comprehensive care plan printed on 05/01/2026 showed that there was no care plan developed for Resident 2's diagnosis of diabetes or insulin use.In an interview and joint record review on 05/04/2026 at 11:39 AM, Staff D, Resident Care Manager, stated that if a resident had a diagnosis of diabetes mellitus and receiving insulin, a comprehensive care plan would be developed. A joint record review of Resident 2's comprehensive care plan printed on 05/01/2026 showed that there was no care plan developed for Resident 2's diagnosis of diabetes or insulin use. Staff D stated that there was no care plan initiated for Resident 2's diabetes or insulin use, and it should have been initiated.In an interview on 05/05/2026 at 9:21 AM, Staff B, Director of Nursing, stated that they expected that care plan to be initiated for diagnosis of diabetes mellitus and insulin use.Reference: (WAC) 388-97-1020(1).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure medication was discarded upon reaching its discard date and to properly label and store medications in accordance with current accepted professional standards for 2 of 3 medication carts (Second Floor Medication Cart 1 & First Floor Medication Cart 2), reviewed for medication labeling and storage. These failures placed the residents at risk of receiving compromised and ineffective medications.Findings included .Review of the undated facility's policy titled, Medication Labeling and Storage, showed, Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical [medicine] practices .Multi-dose vials that have been opened or accessed (e.g.[example], needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date.SECOND FLOOR MEDICATION CART 1 A joint observation and interview on 05/01/2026 at 1:25 PM, with Staff F, Licensed Practical Nurse, showed Resident 26's Ozempic pen (a drug used to treat diabetes [disease where the body cannot properly regulate blood sugar levels]) was labeled as first used on 02/14/2026 and stored in the medication cart. Further observation of the pen's instruction showed, Discard 56 days after first use. Staff F stated that the Ozempic pen's first day of use was 02/14/2026 and it should have been discarded after 56 days [on 04/11/2026].FIRST FLOOR MEDICATION CART 2A joint observation and interview on 05/01/2026 at 1:59 PM, with Staff E, Registered Nurse, showed the following medications stored in the First Floor Medication Cart 2:- One opened liquid Ferrous sulfate (iron supplement) date opened sticker field was blank and unlabeled.- Two opened amantadine hydrochloride (used to treat movement disorders) oral solution bottles were not labeled with open date.Staff E stated that these medications should have been labeled with open date.In an interview on 05/04/2026 at 1:10 PM, Staff C, Resident Care Manager, stated that liquid medications would be labeled when opened and medications would be discarded based on the pharmacy's instruction.In an interview on 05/05/2026 at 9:24 AM, Staff B, Director of Nursing, stated that staff were expected to label medications with an open date. Staff B stated that any medication that had a sticker and required an open date must be labeled at the time it was opened. Staff B further stated that they expected the Ozempic pen to have been discarded 56 days after first use.Reference: (WAC) 388-97-1300 (2).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain food safety and services in accordance with professional standards for 2 of 11 staff (Staff O & Staff K), reviewed for food safety. The failure to perform hand hygiene before and after serving food and not covering food items during meal delivery placed the residents at risk for food-borne illness (caused by ingestion of contaminated food or beverages), food contamination and a diminished quality of life.Findings included . Review of the facility's policy titled, Hand washing/ hand hygiene, dated October 2025, showed, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Review of the facility's policy titled, Infection Control for In-Room Dining Meal Service, revised in December 2023, showed, .hand wash prior to distributing meals .if you physically touch .their [residents'] belongings .and/or are assisting with a meal tray set-up . Review of the facility's policy titled, Food Preparation and Service, revised in November 2022, showed, When actively serving residents in a dining room or outside a resident's room where trained staff are serving food/beverage choices directly from a mobile food cart or steam table, there is no need for food to be covered. However, food should be covered when traveling a distance (i.e. [for example], down a hallway, to a different unit or floor). HAND HYGIENESTAFF OObservation on 04/29/2026 at 11:40 AM, showed Staff O, Certified Nursing Assistant (CNA), took a meal tray from the cart and set it up on the table for Resident 66 in the Dynasty Dining Room. Staff O took another meal tray and set it up for Resident 85 at the other table. Staff O then adjusted Resident 85's wheelchair to keep them in an upright position and proceeded to assist Resident 85 with their meal. Staff O did not perform hand hygiene before and after setting up the meals for Resident 66 and Resident 85 and after adjusting Resident 85's wheelchair. In an interview on 04/29/2026 at 12:19 PM, Staff O stated that they were expected to perform hand hygiene before and after setting up the residents' meals and after adjusting their wheelchair/equipment. Staff O stated that they did not perform hand hygiene before and after they set up meals for Resident 66 and Resident 85 and after they adjusted Resident 85's wheelchair and prior to assisting them with their meal. In an interview on 04/29/2026 at 12:24 PM, Staff P, Registered Nurse, stated that staff were expected to perform hand hygiene before and after setting up residents' meals and after touching residents' equipment. In an interview on 05/05/2026 at 10:45 AM, Staff B, Director of Nursing, stated that they expected Staff O to have performed hand hygiene before and after setting up residents' meals and after touching residents' equipment. MEAL TRAY DELIVERYSTAFF KObservation and interview on 05/04/2026 at 12:11 PM, showed Staff J, CNA, took a meal tray with an uncovered fruit crisp from the meal cart labeled Cart # [number] 6 that was parked in front of room [ROOM NUMBER]. Staff J walked down the hallway and stopped in (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	front of room [ROOM NUMBER] and handed the tray to Staff K, CNA. Staff K took the meal tray and walked to the Gardenview Dining Room and delivered the meal tray to Resident 64. A joint observation of Resident 64's meal tray showed that the fruit crisp was uncovered. Staff K stated that the fruit crisp was not covered. In an interview on 05/04/2026 at 1:09 PM, Staff K stated that they were trained not to walk down the hallway to deliver meal trays, perform hand hygiene before/after delivering meal trays and that they had to sit down with the resident when assisting them with their meals. When asked if food items on the meal tray were covered, Staff K stated, sometimes they are, sometimes they aren't [are not] and that it depended on who was working in the kitchen. Staff K stated that the meal tray they delivered in the Gardenview Dining Room was misplaced and that they were trying to give it to them [Resident 64]. When asked if the fruit crisp was covered, Staff K stated that it was not covered and that none of those things were covered in the trays. Staff K stated that they did not realize that it was uncovered until they got to the resident. In an interview on 05/04/2026 at 3:12 PM, Staff H, Resident Care Manager, stated that food items on the meal trays should be covered when walking a distance. In an interview 05/04/2026 at 3:21 PM, Staff N, Kitchen Manager, stated that they expected staff to take the meal cart room to room to deliver the meal trays. Staff N stated that food on the meal trays did not have to be covered if they delivered the meal trays from room to room and that if they carried the meal trays down the hallway, the food had to be covered. When Staff N was informed of observation of a meal tray taken from a meal cart that was parked in front of room [ROOM NUMBER] and delivered to the Gardenview Dining Room, Staff N stated that they would have expected staff to find something to cover it if they were going to walk down the hallway. Staff N further stated, a couple room should be fine, but the Gardenview Dining Room would be a little too far. In an interview on 05/05/2026 at 11:01 AM, Staff A, Administrator, stated that staff should probably cover it [food items] when they delivered the meal tray to the Gardenview Dining Room. Reference: (WAC) 388-97-1100 (3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure clinical records were accurate for 1 of 5 residents (Resident 103), reviewed for unnecessary medications. This failure placed the resident at risk for medical complications and unmet care needs.Findings included.Review of the April 2026 Medication Administration Record (MAR) showed Resident 103 had an order for Albuterol sulfate inhaler (an inhaler used to open the airways to increase air flow to the lungs) three times a day at 8:00 AM, at 2:00 PM and at 9:00 PM that was documented as administered daily from 04/28/2026 to 04/30/2026.Review of the April 2026 Treatment Administration Record (TAR) showed Resident 103 had an order for SMP [Self-Medication Program] for Albuterol Sulfate and to document the following: can patient [resident] administer on her own? . does patient ask for inhaler at the right time. does patient know the right dosage. does patient know what medication is for? The TAR showed that the SMP for the Albuterol was signed as administered for 00:00 AM (midnight), 4:00 AM, 8:00 AM, 12:00 PM (noon), 4:00 PM, and 8:00 PM from 04/28/2026 to 04/30/2026.Review of the May 2026 MAR showed Resident 103 had an order for Albuterol sulfate inhaler three times a day and was documented as administered daily from 05/01/2026 to 05/05/2026.Review of the May 2026 TAR showed Resident 103 had an order for SMP for Albuterol Sulfate to document the following: can patient administer on her own? . does patient ask for inhaler at the right time. does patient know the right dosage. does patient know what medication is for? The TAR was signed as administered for 00:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM from 05/01/2026 to 05/05/2026. Further review of the May 2026 TAR for SMP showed it was marked 6 [six-hospitalized] on 05/03/2026 at 8:00 PM.A joint record review and interview on 05/05/2026 at 10:45 AM with Staff E, Registered Nurse, showed Resident 103 had orders for albuterol sulfate inhaler three times a day. Staff E stated that they provided Resident 103's albuterol inhaler at 8:00 AM and at 2:00 PM during their shift. Further joint record review showed Resident 103's May 2026 TAR had an order for SMP for albuterol inhaler every 4 hours that was signed daily from 05/01/2026 to 05/05/2026. Staff E stated that they documented in Resident 103's TAR for albuterol sulfate inhaler SMP at 8:00 AM and 12:00 PM. Staff E stated that they provided Resident 103 albuterol twice during their shift and that the 12:00 PM was the only second time where they could document that they did Resident 103's SMP daily during their morning shift. Staff E stated that the order was confusing and that the SMP for albuterol sulfate should have been updated to match Resident 103's albuterol inhaler order scheduled for 8:00 AM, 2:00 PM and 9:00 PM.A joint record review and interview on 05/05/2026 at 11:03 AM with Staff D, Resident Care Manager, showed Resident 103's April 2026 MAR and May 2026 MAR had orders for albuterol sulfate inhaler three times a day at 8:00 AM, at 2:00 PM, and at 9:00 PM. Further joint record review showed Resident 103's April 2026 TAR and May 2026 TAR had order for SMP for Albuterol Sulfate every four hours that was signed daily from 04/28/2026 to 05/05/2026. Staff D stated that Resident 103's SMP order should have been updated to reflect the times that Resident 103 was provided their albuterol inhaler for 8:00 AM, 2:00 PM, and 9:00 PM.In an interview and joint record review on 05/05/2026 at 11:39 AM, Staff B, Director of Nursing, stated that Resident 103's SMP for albuterol inhaler should have been updated to reflect Resident 103's albuterol inhaler order for 8:00 AM, 2:00 PM, and 9:00 PM. A joint record review of the May 2026 TAR showed that Resident 103's SMP for albuterol inhaler was marked 6 [six-hospitalized] on 05/03/2026 at 8:00 PM. Staff B stated that Resident 103 was not in the hospital on [DATE] at 8:00 PM, and that they would educate the staff about appropriate documentation.Reference: (WAC) 388-97-1720 (1)(a)(i)(ii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505204	A. Building B. Wing	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen Anne Healthcare	2717 Dexter Avenue North Seattle, WA 98109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow Enhanced Barrier Precautions (EBP- precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections]) for 1 of 7 Staff (Staff E), reviewed for infection control. This failure placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included .Review of the facility's policy titled, Enhanced Barrier Precautions, dated 03/21/2024, showed, .the facility will implement Enhanced Barrier Precautions (EBP mask, Gown, gloves) for residents with colonization of an MDRO during high-contact care activities and for resident with wounds requiring dressing changes or indwelling [residing within or being permanently placed inside the body] medical devices for the duration of the stay or when the wound is resolved and/or the indwelling device is discontinued.Review of the Centers for Disease Control and Prevention (CDC) online document titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2026, showed, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. The document further showed, Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:.Device care or use:.feeding tube [a flexible tube that is inserted into the stomach to deliver nutrition, fluids, and medications when a person cannot eat or swallow safely] .Review of Resident 43's physician orders showed an order for Enhanced Barrier Precautions until resolved dated 04/15/2026.Review of Resident 43' comprehensive care plan printed on 04/30/2026 showed, The resident is on enhanced barrier precautions (EBP) r/t [related to] tube feeding. Further review of the care plan showed interventions for Direct care staff and visitors to follow EBP and Direct care staff to utilize gowns and gloves for all personal care. Observation on 05/01/2026 at 8:23 AM, showed Staff E, Registered Nurse, entered Resident 1's room wearing gloves. Staff E turned off Resident 43's feeding pump and disconnected their feeding tube. Staff E then placed Resident 43's feeding tube inside their shirt and covered their chest with a towel. Staff E removed their gloves and performed hand hygiene. Staff E was not wearing a gown when they provided feeding tube care for Resident 43.In an interview on 05/01/2026 at 8:36 AM, Staff E stated that when caring for residents with a feeding tube, they would wear a mask, gloves and gown. Staff E stated that Resident 43 was on EBP for their feeding tube. Staff E further stated that they should have worn a gown when they provided tube feeding care for Resident 43.In an interview on 05/04/2026 at 3:16 PM, Staff H, Resident Care Manager, stated that staff would wear gown and gloves when providing incontinent care, repositioning, tube feeding care and when changing the residents linens. Staff H further stated that they would have expected staff to wear gown and gloves when providing tube feeding care to Resident 43.In an interview on 05/05/2026 at 10:25 AM, Staff B, Director of Nursing, stated that they followed CDC guidelines for infection prevention. Staff B stated that they expected residents on EBP to have a signage outside their door and for staff to follow recommendations for treatment while trying to keep a home-like environment. Staff B stated that they expected staff to apply PPE when transferring a resident, if they were changing linens in an occupied bed, providing wound care, personal care, and if they were at risk of coming in close contact with the resident. When asked if they would have expected staff to wear PPE when providing feeding tube care, Staff B stated, yes. Staff B stated that if Staff E was not flushing or administering medication via the feeding tube, they would not have expected them to wear a gown. Staff B stated that if they were administering medication via the feeding tube, they would have expected them to wear one. Staff B further stated that this question had not come up before and would have to take a look.Reference: (WAC) 388-97-1320(1)(a).