STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505236	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edmonds Post Acute	21400 72nd Avenue West Edmonds, WA 98026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure neurological assessments (set of tests nurses do to check how well a person's brain, nerves and muscles are working) were completed post fall and to ensure a physician's order for every 15-minute (observation performed at 15-minute intervals) check was followed for 1 of 3 residents (Resident 1), reviewed for quality of care. This failure placed the resident at risk of potential delay of immediate care and a diminished quality of life. Findings included.Review of the facility's policy and procedure titled, Neurological Assessment, revised in October 2021, showed neurological assessments were indicated following a fall or when indicated by a resident's condition. Review of the facility's policy titled, Falls and Fall Risk, Managing, revised in March 2018, showed The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. It further showed, The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling. Review of hospital nursing progress notes dated 10/25/2025 through 10/29/2025 showed Resident 1's behavior was restless, attempting to get OOB [Out of Bed] multiple times without assistance. It further showed that Resident 1 was assessed to be at risk for fall injury and that a tele sitter (a system used in hospitals where staff can watch patients [residents] remotely through a camera and audio setup) and bed alarm was used for patient safety. It further showed that Resident 1 was impulsive but able to be redirected, and that Resident 1 was relocated to a room to front desk for safety, in addition to the tele sitter and [hospital staff] frequent rounding.Review of a face sheet showed Resident 1 admitted from a hospital to the facility on [DATE] with diagnosis that included dementia (a condition where memory, thinking and performing everyday tasks are impaired), history of falls, and history of venous thrombosis (blood clot forming inside a vein) and embolism (blood clot that blocks the normal flow of blood).NEUROLOGICAL ASSESSMENTSReview of a nursing progress note dated 11/03/2025 showed Resident 1 had an unwitnessed fall, and that Resident 1 was found in their room on the floor by their representative. It further showed that Resident 1 was initiated on neurological checks. Review of a progress note dated 11/05/2025 showed [Resident 1] was transferred to [the Hospital] on 11/05/2025 at 1950 (8:50 PM) due to unresponsiveness, and difficulty to arouse. Further review of the nursing progress notes from 11/04/2025 through 11/05/2025 did not show documentation of Resident 1's status and/or neurological assessments continued post fall on 11/03/2025. Review of Resident 1's Electronic Health Records (EHR) did not show documentation of completed neurological assessments. In an interview on 11/19/2025 at 2:55 PM, Staff D, Registered Nurse (RN), stated neurological checks were completed for a duration of 48-72 hours, and documented on a form. Staff D further stated that completed neurological assessment forms were included in a resident's EHR by medical records. In an interview and joint record review on 11/19/2025 at 3:29 PM, Staff F, Medical Records Director, stated a neurological assessment form was pending for scanning into Resident 1's EHR. A joint record review of Resident 1's neurological assessment form did not show assessments were completed for a duration of 48 and/or 72 hours. Staff F stated the form was not completed or dated beyond 11/03/2025. In an interview and joint record review on 11/19/2025 at 3:37 PM, Staff C, RN, Resident Care Manager, stated it was the facility's protocol to complete neurological assessments for a duration of 72 hours. In a follow up interview and joint record review on 11/24/2025 at 12:52 PM, Staff C stated they expected neurological assessments would be completed according to the facility's protocol for unwitnessed falls. A joint record review of Resident 1's neurological assessment forms dated 11/03/2025 showed neurological assessments were completed starting on 11/03/2025 at 3:02 PM until 11/04/2025 at 6:02 PM (total of 15 hours). Staff C stated No, it was not completed, and that neurological assessments should have continued for Resident 1 until 6:00 PM on 11/04/2025, based on the [neurological assessment] forms. A joint record review and interview on 11/24/2025 at 1:24 PM with Staff B, Director of Nursing, showed Resident 1's incomplete neurological assessment forms dated 11/03/2025. Staff B stated that they expected neurological assessments would be completed in accordance with the instructions on the neurological assessment form and that Whatever our form says, we should be following that. 15-MINUTE CHECKSReview of a nursing progress note dated 10/29/2025, showed Resident 1 was initiated on 15-minute checks. Further review of Resident 1's nursing progress notes showed they were transferred to the hospital on [DATE]. Review of a nursing progress note dated 10/30/2025 at 9:12 PM, showed Resident 1's representative was very upset upon arrival to [Resident 1's] room reports found resident wandering around his side of room unsafe. [Resident 1's representative]