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	02/06/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was evaluated, assessed, and a physician order was obtained for safe administration of a medication for 1 of 1 resident (Resident 1), reviewed for self-medication administration. This failure placed the resident at risk for medication errors, adverse medication interactions, and complications. Findings included .Review of the facility's policy titled, Administering Medications, revised in April 2019, showed, Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.Review of Resident 1's admission Minimum Data Set (MDS-an assessment tool) dated 01/20/2026 showed that they were admitted to the facility on [DATE] and that they were cognitively intact. Further review of the admission MDS showed that they had a diagnosis of Gastroesophageal Reflux Disease (GERD- a chronic digestive disorder where stomach acid or contents flow back into the esophagus [tube connecting to your stomach to your mouth], causing irritation and symptoms like heartburn (burning pain in the chest).Observation on 02/03/2026 at 2:00 PM showed Resident 1 had a stack of medication cups on their bedside table and the medication cup on top of the stack had three round tablets and the medication cup below had one round tablet. Resident 1 stated that they were TUMS [brand name for Calcium Carbonate chewable tablet-medication used to relieve occasional heartburn and acid indigestion] and that they did not need to take it all the time and took them when they needed it. When asked if the nurses observed them take their medications, Resident 1 stated, some do and some don't [do not]. Observation on 02/04/2026 at 1:59 PM showed Resident 1 had a medication cup with three round tablets on their bedside table.Review of Resident 1's physician orders printed on 02/04/2026 showed an order for Calcium Carbonate chewable tablet give 1,500 milligrams (a unit of measurement) by mouth before meals for GERD. Further review of the physician orders did not show an order that Resident 1 could self-administer their medications and/or keep their medications at their bedside table.In an interview and joint observation on 02/04/2026 at 4:05 PM, Staff D, Licensed Vocational Nurse, stated that if residents requested to leave their medications at bedside, the resident would need to be assessed if they could take their medications safely. Staff D stated that Resident 1's physician orders did not show an order that they could self-administer and keep their medications at bedside. A joint observation showed a medication cup with three round tablets on Resident 1's bedside table. Staff D stated that Resident 1's medication should not have been at their bedside table. In an interview and joint record review on 02/06/2026 at 11:06 AM, Staff C, Charge Nurse/Registered Nurse, stated that residents were not allowed to have medications at their bedside table unless they had a physician's order and an assessment completed to evaluate if the resident could safely administer their own medications. A joint record review of Resident 1's physician orders did not show an order that they could self-administer their medications and/or keep their medications at bedside. Staff C stated that they could not find (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	an order.In an interview on 02/06/2026 at 12:25 PM, Staff B, Director of Nursing, stated that if a resident wanted to self-administer their medications, they would expect staff to complete an evaluation to ensure the resident could swallow/administer their medications safely and obtain a physician's order that they could safely leave the medications at the resident's bedside.Reference: (WAC) 388-97-1060 (3)(l), 0440.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an appropriately sized bed for 1 of 1 resident (Resident 1), reviewed for accommodation of needs. This failure placed the resident at risk for discomfort, skin issues and a diminished quality of life.Findings included .Review of the facility's policy titled, Bed Safety and Bed Rails, revised in August 2022, showed, Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. The policy further showed, Bed dimensions are appropriate for the resident's size.Review of the admission Minimum Data Set (MDS-an assessment tool) dated 01/20/2026, showed that Resident 1 was admitted to the facility on [DATE] and that they were cognitively intact. Further review of the admission MDS showed that Resident 1's height was 78 inches (unit of measurement) and that they were dependent on staff with their bed mobility (rolling left and right, sitting to lying, and lying to sitting on one side of bed).Observation on 02/03/2026 at 2:00 PM, showed Resident 1 wore pressure relieving boots on both feet and they were pressed against the footboard.Observation on 02/04/2026 at 2:07 PM showed Resident 1 wore pressure relieving boots on their feet and they were pressed against the footboard. Resident 1 stated that their feet were touching the footboard and that it would cause their knees to hurt. Resident 1 stated that staff were aware that their feet were touching the footboard and that staff would have to scoot them up in bed.In an interview and joint observation on 02/04/2026 at 3:49 PM, Staff F, Certified Nursing Assistant, stated that they would notify maintenance to change the resident's bed if they appeared too small for them. When asked if Resident 1's bed appeared too small, Staff F stated, It's [it is] small but not too small. Staff F stated that Resident 1 required two-person assistance to scoot them up in bed when they slid down. When asked if they requested a longer bed for Resident 1, Staff F stated that they did not. A joint observation showed that Resident 1 was wearing pressure-relieving boots on their feet and they were pressed against the footboard. When Resident 1 raised the head of their bed up, Resident 1's toes touched the footboard. Staff F stated that Resident 1's toes were touching the footboard and asked an unknown staff to assist them to scoot Resident 1 up in bed.In an interview on 02/05/2026 at 2:59 PM, Staff E, Maintenance Director, stated that if a resident needed a longer bed, the request had to come from the nurse manager and that it had to be care planned. Staff E stated that if they knew that a resident admitting to the facility was a tall person, admissions would let them know and that they would check if they had the appropriate bed. If they did not, they would rent one. When asked if Resident 1 needed a longer bed, Staff E stated that there was a work order that was put in yesterday [02/04/2026]. Staff E further stated that they expected staff to let the nurse manager know so they can let maintenance know about [Resident 1] needing a longer bed.In an interview on 02/06/2026 at 12:25 PM, Staff B, Director of Nursing, stated that admissions alerted the nursing team regarding the resident's height/weight and maintenance ensured that the bed was appropriate for the incoming resident. When asked what they expected staff to do if a resident requested a longer bed or if staff observed a resident's bed was too small, Staff B stated that staff should notify maintenance.In an interview on 02/06/2026 at 12:55 PM, Staff A, Administrator, stated that they expected resident beds to be functional and working and that residents had the appropriate bed size.Reference: (WAC) 388-97-0860 (2).

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident had reasonable access to a telephone and a place where calls could be made without being overheard by others for 1 of 3 residents (Resident 1), reviewed for telephone access. In addition, the facility failed to ensure mail was delivered unopened for 1 of 3 residents (Resident 2), reviewed for resident rights. These failures placed the residents at risk for decreased communication with others inside and outside of the facility, lack of privacy and a diminished quality of life.Findings included .Review of the facility's policy titled, Telephones, Resident Use of, revised in May 2017, showed, Residents shall have easy access to telephones. The policy showed, Telephones are available to residents to make and receive private telephone calls. The telephones at the nursing stations should ordinarily be reserved for staff use, unless no other alternative is available. Residents should use telephones at the nursing stations for as brief a period as possible. The policy further showed, Telephones will be in areas that offer privacy and accommodate the hearing impaired and wheelchair bound residents.Review of the facility's policy titled, Mail and Electronic Communication, revised in May 2017, showed, Residents are allowed to communicate privately with individuals of their choice and may send and receive personal mail, email and other electronic forms of communication confidentially. The policy further showed, Mail will be delivered to the resident unopened and Staff members of this facility will not open mail for the resident unless the resident requests them to do so. (Such request will be documented in the resident's plan of care).TELEPHONE ACCESSRESIDENT 1Review of Resident 1's admission Minimum Data Set (MDS-an assessment tool) dated 01/20/2026, showed that they were admitted to the facility on [DATE] and that they were cognitively intact. Further review of the admission MDS showed that Resident 1 was dependent with their mobility.On 02/03/2026 at 2:00 PM, Resident 1 stated that they did not have a telephone since they were admitted to the facility and that they had talked to several nurses about wanting one. Observation showed that Resident 1 did not have a telephone in their room.Observation on 02/04/2026 at 2:07 PM showed that Resident 1 did not have a telephone in their room and that the telephone wall jack did not have a telephone plugged in.In an interview and joint observation on 02/04/2026 at 3:49 PM, Staff F, Certified Nursing Assistant, stated that all the residents had telephones in their rooms and that the telephone were by the residents' bed. A joint observation of Resident 1's room showed that the telephone wall jack did not have a telephone plugged in. Staff F searched Resident 1's room and could not find a telephone. Staff F stated that there was no telephone plugged in the telephone wall jack.In an interview and joint observation on 02/04/2026 at 4:05 PM, Staff D, Licensed Vocational Nurse, stated that residents had telephones in their rooms. When asked what if a resident did not have one, Staff D stated, As far as I know, they have phones [telephones] and that they had not seen a resident that did not have a telephone. Staff D stated that if a resident did not have one and requested for one, they would let maintenance know and put a portable one in there. A joint observation showed that Resident 1 did not have a telephone in their room. Staff D stated that Resident 1 should have one.In an interview on 02/05/2026 at 3:04 PM, Staff E, Maintenance Director, stated that before new residents admitted , they would check the phone, ensured the television and call light worked and ensured that the bed was functioning properly. Staff E stated that some telephone lines were not working and that they would let the resident know before they were admitted . Staff E further stated that they expected Resident 1 to have had a phone in their room.In a follow-up interview on 02/06/2026 at 9:51 AM, Staff E was asked if there was an area in the facility where residents could use the phone in private, Staff E stated that if the resident needed to use the phone and (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they did not need privacy, they could use the nurse's station and that if they wanted a private area, they could use the Nurse Manager's office or the Social Services' office to use the phone. When asked if there was an area that was not an office, Staff E stated, not that I'm aware of. Staff E stated that there were no telephones in common areas. When asked if they had cordless telephones residents could use, Staff E stated that they currently did not have one and that the cordless telephones they ordered should be here soon.OPENED MAILRESIDENT 2Review of Resident 2's admission MDS dated [DATE] showed that they were admitted to the facility on [DATE] and that they were cognitively intact.On 02/03/2026 at 12:50 PM, Resident 2 stated that several of their delivered packages were opened and that they were told that Social Services staff opened them. Resident 2 further stated that their delivered packages were opened because Social Services wanted to make sure that they were not getting pills or liquids in their packages.In an interview on 02/05/2026 at 9:51 AM, Staff H, Administrative Assistant, stated that Life Enrichment staff delivered the residents' packages and that if the package contained medication pills, Social Services made sure it was given to the nurse and made sure it went to the right resident. Staff H stated that Resident 2 got a lot of packages and some were delivered damaged. Staff H stated that Resident 2 had complained about their packages being opened and that they had talked to the Administrator in Training about it. Staff H stated that they informed Resident 2 that if a package sounded like pills, they would notify Social Services and that it would go to the nursing station.In an interview on 02/05/2026 at 10:45 AM, Staff G, Social Services Assistant, stated that sometimes they delivered the resident's mail and that if packages sounded like pills, they would give it to the nurse or charge nurse. Staff G stated that Staff H had asked them to deliver packages to the residents and that they had delivered an opened package to Resident 2. Staff G stated that Resident 2 did not say anything to them about the opened package that day and that two to three days later, Resident 2 had reported that staff were opening their mail. Staff G stated that the package that they had delivered to Resident 2 was already opened when it was given to them to deliver. Staff G further stated that the package did not appear damaged, it was opened and that they were not sure who opened Resident 2's package.On 02/06/2026 at 11:55 AM, Resident 2 stated that they had five or six packages delivered that were opened. Resident 2 stated that some of their packages did come damaged and had tears on them. Resident 2 stated that the packages that they received opened, were cut opened or had used something to cut it open. Resident 2 stated that they spoke to the Administrator in Training and that they were told that staff should not have opened their packages. Resident 2 stated that they had taken pictures of their damaged and opened packages. Review of the pictures that Resident 2 took of the damaged packages showed a package that was torn on the corners and had holes in them. Review of the picture that Resident 2 took of their opened package showed a large plastic package with a straight line opening with a smaller package inside the bag and one smaller package outside the bag that was opened. Resident 2 stated that the large plastic package contained two other packages inside that were opened.In an interview on 02/06/2026 at 12:55 PM, Staff A, Administrator, stated that they expected residents to receive their mail unopened. Staff A stated that there were residents who order their own medications and that they want to make sure that those medications were given to the nurses. Staff A further stated that they would expect that staff would open the packages with the residents' presence.Reference: (WAC) 388-97-0500 (1); 2300 (1-4).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to make needed repairs to maintain a homelike environment for 2 of 3 resident rooms (Rooms 14 & 15) and failed to maintain a clean and comfortable environment for 1 of 3 resident rooms (room [ROOM NUMBER]), reviewed for environment. These failures placed residents at risk for unmet care needs, a less than homelike environment, and potential infection control issues.Findings included .Review of the facility's policy titled, Homelike Environment, revised in February 2021, showed, The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment.REPAIRSroom [ROOM NUMBER]Observations on 02/03/2026 at 11:26 AM showed that the baseboard below the sink in room [ROOM NUMBER] was coming off the wall. Resident 2 stated that housekeeping was aware of the baseboards coming off the wall.Observation on 02/05/2026 at 9:40 AM showed that the baseboard below the sink in room [ROOM NUMBER] was coming off the wall.In an interview and joint observation on 02/05/2026 at 1:52 PM, Staff J, Housekeeper, stated that they had cleaned room [ROOM NUMBER] and that they did not notice the baseboard was coming off the wall. Staff J stated, a lot of work needs to be done, it's [it is] old. A joint observation showed that the baseboard below the sink in room [ROOM NUMBER] was coming off the wall. Staff J stated that they did not recall seeing the baseboard coming off the wall and that if they observed it, they would have notified maintenance.room [ROOM NUMBER]Review of the facility provided document titled, Work Orders, from 08/01/2025 through 02/04/2026, showed a work order for room [ROOM NUMBER]A with the description Water dripping from [the] ceiling in [the] bathroom with a completed date of 10/25/2025.Observation on 02/04/2026 at 12:44 PM showed the bathroom in room [ROOM NUMBER] had a hole in the ceiling above the toilet seat with a black colored piping exposed. Resident 3 stated that the ceiling had been leaking since last year. Resident 4 (Resident 3's roommate) stated that water had dripped on them a couple times and that maintenance was aware.In an interview and joint observation on 02/05/2026 at 1:28 PM, Staff K, Certified Nursing Assistant, stated that if the facility environment was in disrepair or if a resident complained that something needed to be repaired, they would report it to the nurse and maintenance. A joint observation showed that the bathroom in room [ROOM NUMBER] had a hole in the ceiling above the toilet seat with black colored piping exposed. Staff K stated that they did not see the hole in the ceiling and that if they did, they would have reported it.In an interview on 02/05/2026 at 2:14 PM, Staff L, Registered Nurse, stated that they would put in a maintenance request on TELS [a tool used to create, track and complete works orders] if something needed to be repaired. Staff L stated that the hole in the bathroom ceiling in room [ROOM NUMBER] had been reported to maintenance and that they were aware of it. Staff L further stated that they were not aware of the baseboard below the sink were coming off the wall in room [ROOM NUMBER] and that if they had observed it, they would have reported it to maintenance.In an interview and joint observation on 02/05/2026 at 2:48 PM, Staff E, Maintenance Director, stated that if something needed to be repaired, staff would put in a work order request in TELS. Staff E stated that they were aware of the hole in the bathroom ceiling in room [ROOM NUMBER], that there was a slow drip and that their plan was to patch the ceiling tomorrow [02/06/2026]. Staff E stated that they expected a work order to be completed within 72 hours. When asked if there had been a hole in the bathroom ceiling in room [ROOM NUMBER] since October 2025, Staff E stated, yes. A joint observation showed that the baseboard below the sink was coming off the wall in room [ROOM NUMBER]. Staff E stated that they were not aware of it and that if staff (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed it, they would have expected staff to have put in a work order request in TELS.HOUSEKEEPINGroom [ROOM NUMBER]On 02/03/2026 at 11:26 AM, Resident 2 stated that there were feces in the closet and that they had notified housekeeping staff and the Administrator in Training about it. Observation showed an empty closet near the wall in room [ROOM NUMBER] had a smear of brown matter on the inside of the closet door and on the edge of the shelf. Resident 2 stated that their wound supplies were stored in that closet and were concerned for infections. Resident 2 stated that there were cobwebs on the fire sprinkler above the bed next to them and that their previous roommate had left the facility because of how uncleaned it was.Observation on 02/05/2026 at 9:40 AM showed that room [ROOM NUMBER] had a cobweb on the fire sprinkler by the bed next to Resident 2 and on the ceiling above Resident 2's television. Further observation showed an empty closet near the wall had a smear of brown matter on the inside of the closet door and on the edge of the shelf.In a joint observation and interview on 02/05/2026 at 1:52 PM with Staff J showed that the empty closet near the wall in room [ROOM NUMBER] had a smear of brown matter on the inside of the closet door and on the edge of the shelf. Staff J stated that they cleaned the closets and deep-cleaned the rooms when the residents were discharged . When asked what they thought the brown matter was, Staff J stated, hot chocolate. I don't know. Staff J further stated that they were not aware of the brown matter in the closet. When asked if they cleaned the dust or cobwebs in the resident's room, Staff J stated, We're [we are] supposed to. Staff J stated that before a resident was admitted , they were supposed to clean the cobwebs and wipe them. A joint observation of room [ROOM NUMBER] showed cobwebs on the fire sprinkler, on the ceiling above Resident 2's television and on the ceiling by the closets. Staff J stated that it should have been cleaned and that Staff I, Housekeeping Supervisor, had told them to clean the cobwebs.In an interview and joint observation on 02/05/2026 at 2:23 PM, Staff I stated that resident rooms were cleaned daily and that they expected housekeeping staff to clean the cobwebs. When asked what they would do if a resident complained of having feces in their room, Staff I stated that they would take care of it immediately. Staff I stated that they were not aware of complaints of feces in the closet in room [ROOM NUMBER]. A joint observation showed an empty closet near the wall in room [ROOM NUMBER] had a smear of brown matter on the inside of the closet door and on the edge of the shelf. Staff I took a rag, applied gloves and wiped the brown matter off the closet door and shelf. Staff I stated that they expected the closet doors, outside and inside to be disinfected daily. A joint observation of room [ROOM NUMBER] showed cobwebs on the fire sprinkler, on the ceiling above Resident 2's television and by the closets. Staff I stated that resident rooms should have been dusted at least once a week.In an interview on 02/06/2026 at 12:55 PM, Staff A, Administrator, stated that if the facility was in disrepair, they expected staff to put in a work order request in TELS. Staff A stated that depending on the priority of the work order, they expected it to be done quickly as possible. Staff A stated that they expected maintenance to have fixed the hole in the bathroom ceiling in room [ROOM NUMBER] as soon as he was able to and that they expected staff to have put in a work order request for the baseboard in room [ROOM NUMBER] if they observed it. Staff A stated that they expected the housekeepers to clean the residents' rooms daily, keeping a clean environment. Staff A stated that they expected staff to notice the cobwebs, the brown matter and that they would clean it. Staff A further stated that if they could not clean it, they would notify Staff I or them to ensure it was cleaned.Reference: WAC 388-97-0880 (1)(2).