

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Edmonds Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written transfer/discharge notice to the residents and/or their representatives with the required information for 4 of 4 residents (Residents 30, 25, 52 & 14) and failed to provide a bed hold notice for 2 of 4 residents (Residents 52 & 14), reviewed for hospitalizations. These failures placed the residents at risk for not having opportunities to make informed decisions about transfer/discharge. Findings included.</p> <p>Review of the facility's policy titled, Transfer or Discharge Notice, revised in March 2021, showed that Residents and/or representatives are notified in writing, and in a language and format they understand. It showed that the resident and/or representative are notified of the specific reason for the transfer or discharge, date of the transfer or discharge, the location of where they are being transferred or discharged, and an explanation of the resident's rights to appeal the transfer or discharge.</p> <p>TRANSFER/DISCHARGE NOTICE RESIDENT 30 Review of the discharge Minimum Data Set (MDS-an assessment tool), dated 02/15/2026, showed that Resident 30 admitted to the facility on [DATE] and discharged to an acute hospital on [DATE].</p> <p>Review of the Electronic Health Record (EHR-progress notes, assessments, and attachments) showed that Resident 30 was discharged from the facility on 02/15/2026. Further review of Resident 30's EHR showed no documentation that a written transfer/discharge notice was provided to Resident 30 and/or their representative.</p> <p>In an interview on 03/03/2026 at 9:05 AM, Staff I, Resident Care Manager (RCM), stated that when a resident discharged to the hospital they would usually call the family. Staff I further stated that they were unsure if a written transfer/discharge notice was provided to the resident and/or their representative.</p> <p>In an interview and joint record review on 03/04/2026 at 9:44 AM, Staff A, Executive Director, stated that we should be providing a written [transfer/discharge] notice. Staff A stated that Resident 30 went to the hospital. A joint record review of Resident 30's EHR showed no documentation that a written transfer/discharge notice was provided to Resident 30 and/or their representative. Staff A stated that I don't [do not] see anything, nothing like that for Resident 30.</p> <p>RESIDENT 25 Review of the quarterly/discharge MDS dated [DATE] showed that Resident 25 was admitted to a Short-Term General Hospital.</p> <p>Review of the facility's Transfer Form dated 08/09/2025 showed that Resident 25 was transferred to (continued on next page)</p>

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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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>the hospital related to abnormal laboratory results. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the EHR showed no documentation that a written transfer/discharge notice was provided to Resident 25 and/or their representative.</p> <p>RESIDENT 52 Review of the discharge MDS dated [DATE] showed that Resident 52 was admitted to a Short-Term General Hospital.</p> <p>Review of the discharge MDS dated [DATE] showed that Resident 52 was admitted to a Short-Term General Hospital.</p> <p>Review of the discharge MDS dated [DATE] showed that Resident 52 was admitted to a Short-Term General Hospital.</p> <p>Review of the facility's Transfer Form dated 09/07/2025 showed that Resident 52 was transferred to the hospital for chest pain. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the facility's Transfer Form dated 10/31/2025 showed that Resident 52 was transferred to the hospital for uncontrolled pain. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the facility's Transfer Form dated 01/26/2026 showed that Resident 52 was transferred to the hospital for shortness of breath. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the EHR showed no documentation that a written transfer/discharge notice was provided to Resident 52 and/or their representative.</p> <p>RESIDENT 14 Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital.</p> <p>Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital.</p> <p>Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital.</p> <p>Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital.</p> <p>Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital.</p> <p>Review of the discharge MDS dated [DATE] showed that Resident 14 was admitted to a Short-Term General Hospital.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's Transfer Form dated 06/09/2025 showed that Resident 14 was transferred to the hospital for surgery. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the facility's Transfer Form dated 08/08/2025 showed that Resident 14 was transferred to the hospital for abnormal vital signs (essential body functions) and no urinary [urine] output in their left nephrostomy (a thin plastic tube inserted through the back to drain urine directly from the kidney into a bag outside the body). Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the facility's Transfer Form dated 10/23/2025 showed that Resident 14 was transferred to the hospital for increase temperature and increase heart rate. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the facility's Transfer Form dated 11/17/2025 showed that Resident 14 was transferred to the hospital for increase temperature and increase heart rate. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the facility's Transfer Form dated 01/05/2026 showed that Resident 14 was transferred to the hospital for suspected kidney infection. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the facility's Transfer Form dated 02/02/2026 showed that Resident 14 was transferred to the hospital for unresponsiveness. Further review of the Transfer Form did not show that it included a statement of the resident's appeal rights and Ombudsman contact information as required.</p> <p>Review of the EHR showed no documentation that a written transfer/discharge notice was provided to Resident 14 and/or their representative.</p> <p>In an interview on 03/03/2026 at 9:18 AM, Staff L, Registered Nurse, stated that when a resident was transferred to the hospital, they completed the transfer form/packet and would make and give a copy to the resident. Staff L further stated that if the resident was alert, they would notify them of the bed hold, if they were not, they would notify their representative.</p> <p>In an interview and joint record review on 03/03/2026 at 3:10 PM, Staff I was asked if they provided the resident or their representative with a transfer/discharge notice that informed them of appeal rights/Ombudsman contact information when they were transferred to the hospital, Staff I stated that they have never done that. A joint record review of Resident 25's Transfer Form dated 08/09/2026, did no show that it contained appeal rights and Ombudsman contact information as required. Staff I stated that there were no appeal rights and Ombudsman contact information on the transfer form. Staff I stated that all the forms they completed when a resident transferred to the hospital was the transfer form, bed hold notice and paperwork that were provided to the paramedics. Staff I further stated that they did not provide any documents to the resident and/or their representative. In an interview on 03/04/2026 at 11:56 AM, Staff A stated that they expected residents and their representative to receive a written transfer/discharge notice. Staff A stated that the facility used the transfer form and that when they reviewed the form, it did not contain the appeal rights and ombudsman notification as required. When Staff A was requested to do a record review for Resident (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident assessments were completed accurately for 6 of 29 residents (Residents 4, 7, 103, 11,14, & 133), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments were marked on the MDS regarding indwelling catheter (a flexible, hollow tube inserted into the bladder to continuously drain urine into an external collection bag), insulin injections (medication used to manage blood sugar levels), ostomy (surgically created opening on the abdomen that allows waste to leave the body), turning/repositioning program, hospice (specialized care for people with a terminal illness) and prognosis placed the residents at risk for unidentified and/or unmet care needs, and a diminished quality of life. Findings included .</p> <p>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 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.</p> <p>The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period).INDWELLING CATHETERRESIDENT 4Observation and interview on 02/24/2026 at 10:38 AM, showed Resident 4 did not have an indwelling catheter. Resident 4 stated they did not have an indwelling catheter and that it was removed last year in July.</p> <p>Review of the quarterly MDS dated [DATE], showed Resident 4 was marked for indwelling catheter in Section H (Bladder and Bowel - under H0100A).</p> <p>Review of Resident 4's January 2026 progress notes and physician orders printed on 02/24/2026 showed Resident 4's indwelling catheter was discontinued on 07/24/2025.</p> <p>In an interview and joint record review on 03/03/2026 at 11:30 AM with Staff K, MDS Coordinator, stated that they follow the RAI manual for MDS accuracy. A joint record review of Resident 4's quarterly MDS dated [DATE] showed indwelling catheter was marked in Section H. Further joint record review of the January 2026 progress notes and physician orders showed Resident 4's indwelling catheter was discontinued on 07/24/2025. Staff K stated that Resident 4's indwelling (continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>catheter was discontinued before the quarterly MDS look back period, the MDS was not marked accurately, and the indwelling catheter should not have been marked.</p> <p>In an interview on 03/04/2026 at 9:08 AM, Staff B, Director of Nursing, stated that they expected MDS assessments to be completed accurately. Staff B further stated that Resident 4's quarterly MDS should not have been marked for indwelling catheter and that Resident 4's MDS was inaccurate.</p> <p>INSULINRESIDENT 7Review of Resident 7's admission MDS dated [DATE] showed that Resident 7 was marked seven days for injections in Section N (Medications &ndash; under N0300) and seven days for insulin injections in Section N (under N0350A).</p> <p>Review of Resident 7's January 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) printed on 03/04/2026 showed that Resident 7 was given insulin injection for two days (01/21/2026 and 01/23/2026) during the look back period.</p> <p>A joint record review and interview on 03/03/2026 at 11:30 AM with Staff K, showed Resident 7's admission MDS dated [DATE] was marked seven days for injections and seven days for insulin injections in Section N. Further joint record review of January 2026 MAR and TAR showed that Resident 7 was given insulin injections for two days (01/21/2026 and 01/23/2026) during the look back period. Staff K stated that Resident 7 was given insulin injections for two days, the MDS was not marked accurately, and the insulin injections should have been marked according to the days it was given during the look back period.</p> <p>RESIDENT 103Review of Resident 103's admission MDS dated [DATE] showed that Resident 103 was marked zero days of insulin injections in Section N (under N0350).</p> <p>Review of Resident 103's February MAR and TAR printed on 02/27/2026 showed that Resident 103 was given insulin injections for seven days (02/03/2026 through 02/09/2026) during the look back period.</p> <p>A joint record review and interview on 03/03/2026 at 11:30 AM with Staff K, showed Resident 103's admission MDS dated [DATE] was marked zero days for insulin injections in Section N. Further joint record review of the February 2026 MAR and TAR showed that Resident 103 was given insulin injection for seven days (02/03/2026 through 02/09/2026) during the look back period. Staff K stated that Resident 103 was given insulin injections for seven days and that the MDS was not marked accurately.</p> <p>In an interview on 03/04/2026 at 9:08 AM, Staff B stated that they expected MDS assessments to be completed accurately. Staff B further stated that Resident 7's and Resident 103's admission MDS were inaccurate and that the insulin injections should have been marked according to what was given during the look back period.</p> <p>OSTOMYRESIDENT 11Review of Resident 11's admission MDS dated [DATE] showed that Resident 11 was marked for ostomy in Section H (Bladder and Bowel &ndash; H0100C).</p> <p>Review of Resident 11's provider orders printed on 02/27/2026 showed no ostomy device.</p> <p>Review of Resident 11's December 2025 progress notes printed on 03/03/2026 showed no ostomy device.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A joint record review and interview on 03/03/2026 at 11:30 AM with Staff K, showed Resident 11's admission MDS dated [DATE] was marked for ostomy in Section H. Staff K stated Resident 11 never had an ostomy. Further joint record review of the December 2025 progress notes and December 2025 MAR and TAR showed that Resident 11 did not have an ostomy. Staff K stated that Resident 11 did not have an ostomy and that the MDS was not marked accurately.</p> <p>In an interview on 03/04/2026 at 9:08 AM, Staff B stated that they expected MDS assessments to be completed accurately. Staff B further stated that Resident 11's admission MDS should not have been marked for ostomy and that Resident 11's MDS was inaccurate.</p> <p>TURNING/REPOSITIONING PROGRAM RESIDENT 14 Review of Resident 14's quarterly MDS dated [DATE] showed that Section M (Skin Conditions) was marked for Turning/repositioning program.</p> <p>Review of Resident 14's annual MDS dated [DATE], showed that Section M was marked for Turning/repositioning program.</p> <p>Review of Resident 14's comprehensive care plan printed on 02/25/2026 showed a care plan for Pressure ulcer [bed sore] of left buttock [bottom] and sacrum [tailbone] r/t [related to] Dermal [skin] Frailty, Decreased mobility, noncompliance with repositioning. Further review of the care plan did not show a turning/reposition intervention or a care plan to address a turning/repositioning program.</p> <p>Review of Resident 14's Electronic Health Record (EHR-progress notes, evaluations, miscellaneous files) showed no documentation to support that their turning/repositioning program was monitored and reassessed to determine the effectiveness of the program.</p> <p>In an interview and joint record review on 03/04/2026 at 10:15 AM, Staff K stated that they followed the RAI manual for MDS completion. Staff K stated that residents were placed on a turning/repositioning program if the resident could not do it themselves and that if it was care planned, it would be a program. Staff K stated that if a resident was on the turning/repositioning program, they would monitor and assess the program's effectiveness. A joint record review of Resident 14's quarterly MDS dated [DATE] and annual MDS dated [DATE] showed that Section M was marked for Turning/repositioning program. Staff K stated that Section M was marked for Turning/repositioning program. A joint record review of Resident 14's care plan showed an intervention to Offer to turn/reposition at least every two hours and as needed or requested with a resolved date of 03/07/2025. A joint record review of Resident 14's progress notes showed no documentation that Resident 14's turning/repositioning program was assessed and monitored to determine its effectiveness. Staff K stated that they did not see any documentations to support the turning/repositioning program marked for Section M on Resident 14's quarterly MDS dated [DATE] and annual MDS dated [DATE]. Staff K further stated that Section M was not accurate.</p> <p>In an interview on 03/04/2026 at 11:39 AM, Staff B stated that they expected MDS assessments to be completed accurately and timely. Staff B further stated that Resident 14's MDS should have been accurate.</p> <p>HOSPICE and PROGNOSIS RESIDENT 133 Review of Resident 133's EHR showed that Resident 133 was admitted to hospice services on 11/14/2025.</p> <p>Review of hospice physician note dated 11/14/2025, showed that the physician certifies that the (continued on next page)</p>		

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