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	06/25/2026

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 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. Based on observation, interview, and record review, the facility failed to ensure a clean, safe, and homelike environment for 1 of 3 residents (Resident 5), reviewed for environment. This failure placed the residents at risk of injury, a less than homelike environment, and a diminished quality of life.Findings included.Review of the facility's policy titled, Homelike Environment, revised in February 2021, showed that Residents are provided with a safe, clean, comfortable and homelike environment.Observation and interview on 06/23/2026 at 10:25 AM, showed an oxygen concentrator (a medical device used to deliver oxygen) and a bedside commode (a moveable toilet) on Resident 5's side of the curtain that belonged to their roommate (Resident 4). Further observation showed that the oxygen concentrator was near Resident 5's bed. Resident 5 stated, that [oxygen concentrator] is for [Resident 4] and it makes it cramped, hard to get into bed.Additional observations on 06/23/2026 at 2:45 PM, on 06/24/2026 at 11:35 AM and on 06/25/2026 at 9:56 AM, showed an oxygen concentrator and bedside commode on Resident 5's side of the curtain that belonged to their roommate (Resident 4).In an interview and joint observation on 06/25/2026 at 9:59 AM, Staff H, Certified Nursing Assistant, stated that they usually have a curtain in between [resident beds] so there would be space in-between them. Joint observation showed an oxygen concentrator and bedside commode on Resident 5's side of the curtain that belonged to their roommate (Resident 4). Staff H stated, this is the space we have for [Resident 5].In an interview and joint observation on 06/25/2026 at 10:11 AM, Staff I, Charge Nurse, stated that they expected residents to have their own belongings on their side of their room and not be in their roommates' space. Staff I stated that it included bedside commodes and oxygen concentrators. Staff I stated that the curtain between resident spaces divides the space and they would not expect one resident's bedside commode and oxygen concentrator to be on the other side of the curtain and in their roommate's space. Joint observation showed Resident 4's bedside commode and oxygen concentrator on Resident 5's side of the curtain. Staff I stated that the oxygen concentrator and bedside commode were on Resident 5's side and should be on Resident 4's side and it shouldn't [should not] be like that.In an interview on 06/25/2026 at 11:59 AM, Staff B, Director of Nursing, stated it's [it is] my expectation that every resident has their own space. Staff B stated that the room is divided by the curtain line between residents' beds. Staff B stated that the concentrator and bedside commode for Resident 4 should be on their side of the curtain, not on Resident 5's side. Staff B further stated, it's [it is] my expectation that every resident has their own space.Reference: WAC 388-97-0880 (1).

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

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	06/25/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician orders were implemented and followed in accordance with professional standards of practice for 1 of 1 resident (Resident 1), reviewed for quality of care. This failure placed residents at risk for not receiving necessary care services, unmet care needs, and a diminished quality of life.Findings included .Review of the facility's policy titled, Wound Care, revised in October 2021, showed, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.Review of the facility's policy titled, Medication and Treatment Orders, revised in July 2016, showed, Orders for medications and treatments will be consistent with principles of safe and effective order writing.Review of a face sheet printed on 06/11/2026 showed Resident 1 admitted to the facility on [DATE].Review of the hospital document titled, Discharge Summary, dated 05/14/2026, showed, Will need dressing changes of leg incisions every other day, under Outpatient Follow-up Issues.Review of the hospital document titled, Skilled Nursing Facility [SNF] Transfer Orders, dated 05/14/2026, showed Resident 1 had femoral-tibial bypass procedure on 05/06/2026 and right trans metatarsal amputation on 05/08/2026. The document further showed surgical care orders for:- Surgical wound care R (right) groin w (with)/ Medipore (a soft, breathable, and stretchable medical tape used to secure dressings and medical devices while minimizing skin irritation) until discontinued. comments: wrap right lower extremity with ACE wrap (an elastic bandage used to provide compression, support, and swelling control for injuries and rehabilitation). R groin w/ Medipore. change dressing. do not change-reinforce if saturated. 1st (first) change. by surgeon.- Surgical wound care right foot until discontinued. right foot. change dressing. do not change-reinforce if saturated.Review of the hospital document titled, Vascular Surgery, dated 05/13/2026, showed the following under Plan:- Elevate leg when not ambulating- Dressing change of leg incisions every other day- Wrap leg in ACE for the next week- OOB (Out of Bed) and on chair 2 (two) to 3 (three) times dailyReview of the May 2026 Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 05/14/2026 to 05/31/2026 showed no orders and/or documentation to indicate that Resident 1 had dressing changes to their leg incisions every other day and/or ACE wraps done to their right lower extremity.Review of June 2026 MAR/TAR showed no orders and/or documentation to indicate that Resident 1 had dressing changes to their leg incisions every other day and/or ACE wraps done to their right lower extremity.On 06/11/2026 at 2:38 PM, Resident 1 stated that their hospital discharge orders included changing their right leg incision dressings every other day, having their right leg wrapped with ACE wrap for one week, and to be out of bed 2 to 3 times a day. Resident 1 stated that these orders were not followed since they were admitted to the facility on [DATE]. Resident 1 stated that their right foot amputation dressing was changed on 06/03/2026 during their follow-up post-operative appointment outside the facility. Resident 1 further stated that the facility staff did not provide wound care to their right incisions and/or right leg since they admitted to the facility.In an interview and joint record review on 06/22/2026 at 3:27 PM, Staff C, Charge Nurse, stated that wound care for residents would be done following treatment orders. A joint record review of May 2026 and June 2026 MAR/TAR did not show that Resident 1 had a treatment order for their right leg incisions. Staff C stated that there were orders to not remove Resident 1's right groin wound dressing and right foot amputation dressing and to reinforce if soiled. A joint record review of the hospital Discharge summary dated [DATE] showed, will need dressing changes of leg incisions every other day. A joint record review of the hospital skilled nursing facility transfers orders showed, wrap right lower extremity with ACE wrap, under the right groin dressing orders. Staff C stated the orders should have been clarified with the hospital during admission, both treatment orders are not complete and are unclear. Staff C stated that there was no documentation to show that Resident 1 had right incision dressing changes or right leg ACE wrap treatments done since the resident was admitted to the (continued on next page)

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	06/25/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE].In an interview and joint record review on 06/25/2026 at 12:46 PM, Staff B, Director of Nursing, stated that during the admission process the facility followed the skilled nursing transfer orders from the hospital as new admission orders. A joint record review of the hospital skilled nursing facility transfers orders showed, wrap right lower extremity with ACE wrap, under the right groin dressing orders. A joint record review of the hospital Discharge summary dated [DATE] showed, will need dressing changes of leg incisions every other day. Staff B stated that the facility used the hospital skilled nursing facility transfers orders as the official orders for new admits. A joint record review of May 2026 MAR/TAR and June 2026 MAR/TAR did not show documentation to indicate that Resident 1 received wound care/treatment to their right leg incisions or ACE wrap to their right leg. Staff B stated that the wound/treatment orders should have been clarified during Resident 1's admission time and that the hospital SNF transfer orders were the orders followed for newly admitted residents.Reference: (WAC) 388-97-1060 (1)(3)(b).

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	06/25/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide necessary/adequate supervision for 1 of 1 resident (Resident 2), reviewed for elopement. This failure allowed Resident 2 to exit the facility unnoticed and placed the resident at risk for serious injury and a diminished quality of life.Findings included .Review of the facility policy titled, Elopements, revised in April 2021, showed, Staff shall investigate and report all cases of missing residents.Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. If an employee discovers that a resident is missing from the facility, he/she shall: a. Determine if the resident is out on authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; c. If the resident is not located, notify the Administrator and the Director of Nursing Services, the resident's legal representative (sponsor), the Attending Physician, law enforcement officials, and (a necessary) volunteer agencies i.e., Emergency Management, Rescue Squads, etc.); d. Provide search teams with resident identification information; and e. Initiate an extensive search of the surrounding area.Review of a face sheet printed on 06/16/2026 showed Resident 2 admitted to the facility on [DATE] with diagnoses that included dementia (a progressive condition that causes a decline in cognitive abilities, such as thinking, remembering, and reasoning, that interferes with daily life) and secondary parkinsonism (group of disorders that produce movement symptoms similar to Parkinson's disease [a condition where parts of the brain slowly stop working properly, causing movement and other body functions to become harder over time] such as tremor, slowness of movement, and rigidity, but arise from different underlying causes).Review of the admission Minimum Data Set (MDS-an assessment tool) assessment, dated 05/19/2026 showed Resident 2 had severe cognitive impairment.Review of the elopement evaluation dated 05/14/2026, showed Resident 2 was disoriented all the time, agitated, ambulatory, independent with mobility, and was taking medications for verbal, physical, or emotional outbursts. Further review of the elopement evaluations showed that Resident 2 was at risk for elopement, wanders through facility.wanders into other rooms exit seeking.Review of the elopement care plan initiated on 05/26/2026 showed Resident 2 had a goal of, will not leave center unattended . Further review of the care plan showed an intervention for Assure resident is wearing their wander guard bracelet. distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. document wandering behavior and attempted diversional interventions.Review of another elopement care plan initiated on 05/14/2026 showed Resident 2 had a goal of, will not elope. Further review of the care plan showed an intervention for wander guard on right ankle.Review of the facility document titled, 15 Minute Check, dated 06/13/2026, showed Resident 2 was last seen in the dining room at 2:15 PM. Further review showed there was no documentation of 15 Minute Checks being completed between 2:30 PM and 9:45 PM (when resident returned from the Emergency Room) on 06/13/2026.Review of a police incident report dated 06/13/2026 showed that a report was received by the police on 06/13/2026 at 4:04 PM of Resident 2 walking and disoriented. Further review of the police report showed that the police were with Resident 2 at 4:05 PM near [NAME] dealership (on 212th SW and 99 interstate).Review of a google online map showed that the distance between facility and 212th & 99 interstate (where resident was found) was approximately 0.4 miles and that it took eight minutes walking to get there.Review of the investigation report dated 06/13/2026 showed Resident 2 was last seen in the facility on 06/13/2026 at 4:05 PM. Observation on 06/16/2026 at 3:33 PM showed Resident 2 was sitting on a chair next to the medication cart across their room. Further observation showed Resident 2 had a wander-guard on their right ankle.Observation on 06/16/2026 at 4:31 PM showed Resident 2 was sitting on a chair outside their room.In an interview on 06/16/2026 at 4:43 PM Resident 2's representative stated that (continued on next page)

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	06/25/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2 had their wander guard on their right ankle after the resident was found outside the facility by local police on 06/13/2026.In an interview on 06/22/2026 at 2:17 PM, Staff E, Certified Nursing Assistant, stated they noticed Resident 2 was not in their room at around 2:40 PM. Staff E further stated that Resident 2 was not in the dining room. Staff E stated that Resident 2 walked independently and refused to use a walker. Staff E stated that they notified an unnamed nurse that Resident 2 was not in their room, and Staff E was told that Resident 2 was last seen in the dining room, then Staff E looked for Resident 2 in the dining and did not find them. Staff E stated that Resident 2 wore a wander guard on their leg.In an interview and joint record review on 06/22/2026 at 2:45 PM, Staff C, Charge Nurse, stated that they expected staff to check the facility when a resident was missing. Staff C stated they expected staff to look for a missing resident in the facility, call 911, notify resident's family, doctor, law enforcement, director of nursing, and administrator. Staff C stated that Resident 2 wandered around the hallways and dining room across the [NAME] nurse station. Staff C stated that Resident 2 was at risk for elopement and that they had a wander guard since admission. A joint record review of the elopements care plan showed that Resident 2 had the following goals: will not leave center unattended. will not elope. Staff C stated, well that did not happen, because [Resident 2] left the facility. A joint record review showed an elopement risk assessment dated [DATE] indicating that Resident 2 was disoriented all of the time; was agitated; was ambulatory; independent with mobility; was taking medications for verbal, physical, or emotional outbursts; wanders through facility.wanders into other rooms exit seeking. Staff C stated that Resident 2 wore a wander guard on their right ankle due to that they were exit seeking and wandered into other residents' rooms. A joint record review of a 15 Minute Check document dated 06/13/2026 showed that Resident 2 was seen in the dining room at 2:15 PM. Staff C stated, they documented seeing [Resident 2] in the dining room at that time, and then at 10:00 PM after [Resident 2] came back from the hospital. Staff C stated that there was no documentation of 15-minute checks on 06/13/2026 between 2:30 PM and 9:45 PM. Staff C further stated that Resident 2 should not have left the facility unattended.In an interview and joint record review on 06/25/2026 at 1:17 PM, Staff B, Director of Nursing, stated that residents at risk for elopement were evaluated during admission and that if they were exit seeking, a wander guard would be in place after a consent was obtained. Staff B stated that Resident 2 was pleasantly confused, wandered around, went into other residents' rooms, staff redirected them and that Resident 2 wore a wander guard. A joint record review of an elopement care plan showed Resident 2 would not leave the facility unattended. A joint record review of the elopement risk evaluation showed the resident was at risk for elopement due to exit seeking and wandering into other resident's rooms. Staff B stated that Resident 2 had a wander guard on their right ankle due to being at risk for elopement. A joint record review of the incident investigation dated 06/13/2026 showed Resident 2 was last seen in the facility on 06/13/2026 at 4:05 PM. A joint record review of the police report showed the resident was found by the police at 4:05 PM near [NAME] dealership (0.4 miles away from the facility), the same time the facility was reporting last seeing the resident. Staff B stated that Resident 2 should not have left the facility unattended.In an interview on 06/25/2026 at 2:40 PM, Staff A, Administrator, stated that Resident 2 should not have left the facility unattended. Staff A provided no further information.Reference WAC 388-97-1060(3)(g).

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	06/25/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pharmacy services were provided to meet the needs of 2 of 7 residents (Residents 3 and 4), reviewed for medication administration. The failure to administer and/or document medication administration in accordance with professional standards of practice placed the residents at risk for negative outcomes and a diminished quality of life. Findings included .Review of the facility policy titled, Pharmacy Services Overview, revised in April 2019, showed, the facility shall accurately and safely provide or obtain pharmaceutical services, including the provision of routine and emergency medications and biologicals, and the services of a licensed consultant pharmacist. the facility shall contact with a licensed consultant pharmacist to help it obtain and maintain timely and appropriate pharmacy services that supports the resident's needs, are consistent with current standards of practice. And meet state and federal requirements. Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner.Review of the manufacturer's recommendations titled, Biktarvy [Bictegravir-Emtricitab-Tenofov - an antiviral medication], revised in July 2025, showed, It is important to take Biktarvy on a regular dosing schedule with or without food and to avoid missing doses as it can result in development of resistance.Review of an online medication drug information titled, Medline Plus - Emtricitabine-Tenofovir Alafenamide Fumarate (an antiviral medication), revised on 07/15/2025, showed, Continue to take emtricitabine and tenofovir AF even if you feel well. Do not stop taking emtricitabine and tenofovir AF without talking to your doctor. If you stop taking emtricitabine and tenofovir AF even for a short time, or if you skip doses, the virus may become resistant to medications and may be harder to treat.<RESIDENT 3>Review of the face sheet showed Resident 3 admitted to the facility on [DATE] with diagnoses that included Human Immunodeficiency Virus (HIV-virus that attacks the body's immune system that can lead to Acquired Immunodeficiency Syndrome [AIDS - advance stage of HIV infection where the immune system is severely damaged making the body vulnerable to infections]).Review of the May 2026 Medication Administration Record (MAR) showed Resident 3 had an order for Emtricitabine-Tenofovir Alafenamide Fumarate (an antiviral medication) Oral Tablet 200-25 milligrams (MG- unit of measurement) Give 1 tablet by mouth in the morning for HIV. Further review of the May 2026 MAR showed Resident 3 did not receive their Emtricitabine-Tenofovir AF on the following dates: - 05/24/2026- 05/25/2026- 05/26/2026- 05/27/2026- 05/28/2026- 05/29/2026- 05/30/2026, and- 05/31/2026, a total of eight days for May 2026.Review of the June 2026 MAR showed Resident 3 had an order for Emtricitabine-Tenofovir AF Oral Tablet 200-25 MG. Give 1 tablet by mouth in the morning for HIV. Further review of the June 2026 MAR showed Resident 3 did not receive their Emtricitabine-Tenofovir AF on the following dates: - 06/01/2026- 06/02/2026- 06/03/2026- 06/04/2026- 06/05/2026- 06/07/2026- 06/08/2026- 06/10/2026, and- 06/11/2026, a total of nine days for June 2026.The June 2026 MAR also showed that Resident 3 had an order for Azithromycin (antibiotic - treats bacterial infections) tablet 500 mg. 1 tablet scheduled for 12:00 PM. Further review of the MAR showed Resident 3 did not receive their medication on 06/02/2026, as indicated by a blank on the MAR. On 06/16/2026 at 3:57 PM, Resident 3 stated that they had not received their Emtricitabine-Tenofovir AF since they admitted to the facility and were told that the pharmacy was not delivering the medication. Resident 3 stated they just started [taking the medication] last Friday [06/12/2026] or this week. Resident 3 stated that their doctor told them it was important for them to take both of their medications for HIV. Resident 3 stated they were afraid their illness would get worse or cause them to go back to the hospital.On 06/17/2026 at 10:59 AM, Resident 3 stated that they were discharging home today. Resident 3 showed their medication discharge orders included dolutegravir, bottle and Emtricitabine-Tenofovir (continued on next page)

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	06/25/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AF bottle. Resident 3's medication order did not include the amount of tablets both of their medications had in each bottle. A joint record review and joint observation on 06/17/2026 at 11:14 AM with Staff J, Registered Nurse (RN), showed Resident 3's discharge medication orders showed dolutegravir, bottle and Emtricitabine-Tenofovir AF bottle. A joint observation of the dolutegravir bottle showed there were 11 tablets in it and the Emtricitabine-Tenofovir AF bottle had 24 tablets. Staff J stated that Resident 3's discharge medication orders should have included the number of tablets each bottle had.In an interview and joint record review on 06/22/2026 at 4:00 PM, Staff F, RN, stated that their medication administration process consisted of checking residents' orders, checking medication carts for the medications. Staff F stated that when medications were not available, staff would notify the provider and call the pharmacy until medications were obtained. A joint record review of May 2026 MAR and June 2026 MAR Resident 3's showed Resident 3 did not receive their Emtricitabine-Tenofovir AF on 05/24/2026, 05/25/2026, 05/26/2026, 05/27/2026, 05/28/2026, 05/29/2026, 05/30/2026, 05/31/2026, 06/01/2026, 06/02/2026, 06/03/2026, 06/04/2026, 06/05/2026, 06/07/2026, 06/08/2026, 06/10/2026, and 06/11/2026 a total of 17 days. Staff F stated that Resident 3's medication was not delivered by the pharmacy due to that their insurance did not cover it. Staff F further stated that Resident 3 was not provided with their medication from 05/31/2026 to 06/11/2026, for a total of 19 days. Staff F stated that the June 2026 MAR for 06/06/2026 and 06/09/2026 showing that Resident 3 was given their Emtricitabine-Tenofovir AF was documented by mistake, Staff F stated that on 06/11/2026 the pharmacy overnighted the medication and that Staff F provided Resident 3 their first dose on 06/12/2026. When asked Staff F if Resident 3 was not given their medication from 05/24/2026 to 06/11/2026 for a total of 19 days, Staff F stated Yes.In an interview on 06/23/2026 at 2:43 PM, Staff L, Pharmacist, stated that HIV medications should be administered as prescribed or following manufacturer's recommendations. Staff L further stated, residents should not be without their medications.In an interview and joint record review on 06/25/2026 at 11:39 AM, Staff D, Charge Nurse, stated they expected staff administered medications to residents as prescribed. A joint record review of May 2026 Mar and June 2026 MAR showed Resident 3 was not given their Emtricitabine-Tenofovir AF tablets on the above dates for a total of 17 days. Further review of the June 2026 MAR showed Resident 3 was not given their Azithromycin on 06/02/2026, it was blank. Staff D stated that Resident 3 should have been given their medications as prescribed and that if it was not documented it was not done.In an interview and joint record review on 06/25/2026 at 1:58 PM, Staff B, Director of Nursing, stated that medications for HIV were important. A joint record review of May 2026 MAR and June 2026 MAR showed Resident 3 was not given their Emtricitabine-Tenofovir AF and Azithromycin tablets on he above dates. Staff B stated that Resident 3 should have been given their medications as prescribed. <RESIDENT 4>Review of the face sheet showed Resident 4 admitted to the facility on [DATE] and was readmitted on [DATE]Review of May 2026 MAR showed Resident 4 had an order for Bictegravir-Emtricitab-Tenofov Oral Tablet 50-200-25 MG Give 1 tablet by mouth one time a day for HIV. Further review of the May 2026 MAR showed Resident 4 was not given this medication on 05/20/2026.Review of the June 2026 MAR showed Resident 4 was not given their Bictegravir-Emtricitab-Tenofov on the following dates:- 06/07/2026- 06/10/2026- 06/11/2026- 06/12/2026- 06/13/2026- 06/14/2026- 06/15/2026- 06/16/2026- 06/17/2026- 06/18/2026, and - 06/19/2026, for a total of 11 days.On 06/16/2026 at 3:31 PM, Resident 4 stated that they were told that their Biktarvy was not available and that their insurance did not cover it. Resident 4 stated, My doctor said I need to take my antiviral medication, I have been hospitalized for 6 [six] months, so it is important I get those medications, so I don't [do not] get too sick and go to the hospital again. An observation and joint record review on 06/17/2026 at 3:17 PM, showed Staff G was preparing Resident 4's medications that included Bictegravir. Staff G stated, let me check if this medication [Biktarvy] is here or not; I'm not sure. This medication is not available. Staff G stated that Resident 4 did not have this medication since last week. A joint observation of the June 2026 MAR showed Resident 4 was not given their Biktarvy from 06/10/2026 (continued on next page)

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	06/25/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to 06/17/2026. Staff G stated, I think [Resident 4's] insurance hasn't [has not] covered it.A joint record review and interview on 06/22/2026 at 4:27 PM with Staff F showed the May 2026 MAR and June 2026 MAR indicated Resident 4 was not given their Biktarvy on 05/20/2026, 06/07/2026, 06/10/2026, 06/11/2026, 06/12/2026, 06/13/2026, 06/14/2026, 06/15/2026, 06/15/2026, 06/16/2026, 06/17/2026, 06/18/2026, and 06/19/2026, for a total of 11 days. Staff F stated that Resident 4's medication was not available in the facility pending pharmacy delivery. Staff F stated that Resident 4 should have been administered their medications as prescribed and the medications should have been available for Resident 4.In an interview on 06/23/2026 at 11:05 AM, Staff K, Medical Doctor, stated that they were aware Resident 3 & 4's medications for HIV were not available at the facility due to their medications not being covered by their insurance. Staff K stated that residents were being monitored. Staff K stated that HIV medications were important and that missing doses for prolonged time could cause flare ups of the disease symptoms. A joint record review and interview on 06/25/2026 at 11:39 AM with Staff D, showed May 2026 MAR and June 2026 MAR indicated that Resident 4 was not administered their Biktarvy on the above dates for a total of 11 days. Staff D stated that Resident 4 should have been administered their medications as prescribed. In an interview on 06/25/2026 at 1:58 PM, Staff B stated that Resident 4 should have been administered their Biktarvy as prescribed.In an interview on 06/25/2026 at 3:00 PM, Staff A, Administrator, stated that the facility should have had Resident 3 & 4's medications readily available.Reference: (WAC) 388-97-1300 (1)(b)(i-ii)(3)(a).