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	11/26/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure resident dignity was maintained related to urinary catheter (a semi-flexible tube inserted into the bladder to drain urine) use for 1 of 3 residents (Resident 88), reviewed for dignity. This failure placed the resident at risk for decreased self-worth and a diminished quality of life. Findings included . Review of the facility's policy titled, Resident Rights, dated August 2022, showed the purpose was to treat each resident with respect and dignity. Review of the admission minimum data set (an assessment tool), dated 11/01/2024, showed Resident 88 admitted to the facility on [DATE], and had an indwelling catheter. Review of Resident 88's catheter care plan, revised on 11/06/2024, showed to check catheter system every shift for patency and integrity. Observations on 11/21/2024 at 8:04 AM and 11/22/2024 at 9:18 AM, showed Resident 88 had an uncovered urinary catheter drainage bag (collects urine from the catheter) with yellow urine. Resident 88's catheter bag was visible from the hallway and had no privacy bag covering the drainage bag. In an interview and joint observation on 11/22/2024 at 9:21 AM, Staff AA, Certified Nursing Assistant, stated that the catheter bag should have a privacy bag on it and to make sure it is covered. Joint observation showed Resident 88's drainage bag did not have a privacy bag. Staff AA stated that the drainage bag could be seen from the hallway and should be in a bag for dignity. In an interview on 11/22/2024 at 10:34 AM, Staff J, Resident Care Manager, stated that catheter drainage bags should be covered and should not be visible from the hallway. In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated they expected catheter drainage bags to be covered with a privacy bag and should not be visible from the hallway. Reference: (WAC) 388-97-0180 (1)(2)

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to inform the resident and/or their designated representative before administering a psychotropic (mind altering) medication for 1 of 5 residents (Resident 78), reviewed for unnecessary medications. This failure placed the resident and/or their representatives at risk of not being fully informed of the risks and benefits before making decisions about their medications. Findings included . Review of the facility's undated document titled, Notification and Consent Form, showed that the Resident has the right to refuse any medical treatment, to the extent permitted by law, and to be informed of the consequences of refusing the treatment. Review of Resident 78's admission record showed Resident 78 admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder (a mental disorder that causes people to experience excessive worry about everyday things) and major depressive disorder (a mood disorder that can affect how a person feels, thinks, and acts). Review of the quarterly minimum data set (an assessment tool) dated 11/01/2024, showed Resident 78 readmitted to the facility on [DATE]. Review of the October 2024 Medication Administration Record (MAR) showed an order for Mirtazapine (a psychotropic medication to treat depression) to be given daily at bedtime that started on 10/25/2024. Review of the facility's document titled, Psychopharmacologic Medication Informed Consent, dated 11/15/2024, showed that Resident 78 was informed of the risks and benefits of Mirtazapine on 11/15/2024, 22 days after starting Mirtazapine. In an interview on 11/21/2024 at 9:32 AM, Staff J, Resident Care Manager, stated that before a resident started a psychotropic medication they would inform and give risks and benefits to the resident and/or their representative. In an interview and joint record review on 11/21/2024 at 9:40 AM, Staff B, Director of Nursing Services, stated that they expected risks and benefits to be provided to residents before starting a psychotropic medication. Staff B stated that when a resident re-admits to the facility, they would provide risks and benefits prior to starting a psychotropic medication. A joint record review of Resident 78's electronic health record showed that Resident 78 readmitted to the facility on [DATE]. A joint record review of the October 2024 MAR showed that Resident 78 started Mirtazapine on 10/25/2024. A joint record review of the Psychopharmacologic Medication Informed Consent, showed that risks and benefits were provided to Resident 78 on 11/15/2024. Staff B stated, we should have [provided risks and benefits] on 10/25 [10/25/2024], and Mirtazapine was given for 22 days before informing Resident 78 about the risks and benefits of the medication. Reference: (WAC) 388-97-0260 (2) (a-d)(3)(c)

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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. 47218 Based on observation, interview, and record review, the facility failed to ensure safe self-administration of medication was clinically appropriate and/or an assessment or evaluation was done for 1 of 1 resident (Resident 56), reviewed for self-medication administration. This failure placed the resident at risk for inaccurate/unsafe medication administration, adverse side effects, and related medical complications. Findings included . A review of the facility's policy titled, Self-Medication Program and Evaluation, revised in September 2024, showed the facility would complete a Self-Medication Evaluation, determine if the resident was able to safely self-administer medications, discuss with physician any medications that may not be self- administered, determine location to store medications to ensure that the location is secure and clean (i.e., in resident room in locked cupboard/drawer), discuss with resident how medication will be tracked and monitored, and to document in nursing notes that the resident is self-medicating. Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 09/13/2024 showed Resident 56 was cognitively intact. During an observation on 11/18/2024 at 11:48 AM, Resident 56 had a bottle of folic acid (vitamin B-9) 1000 micrograms (mcg - unit of measurement) capsules on their left nightstand. Resident 56 stated that they started taking them [folic acid capsules] about a week or so ago and that they were taking the medication on their own. Further observations on 11/21/2024 at 10:07 AM and at 10:32 AM showed the bottle of folic acid capsules was on top of Resident 56's left nightstand. In a joint observation and interview on 11/26/2024 at 11:43 AM with Staff K, Licensed Practical Nurse, showed Resident 56 had a bottle of folic acid 1000 mcg capsules on top of Resident 56's left nightstand. Staff K stated that Resident 56 had orders for self-medication administration. Joint record review and interview with Staff K did not show orders for Resident 56's folic acid and/or an order for self-medication administration of folic acid. Staff K stated that Resident 56 should have had an order for self-medication administration for folic acid. A joint record review and interview on 11/26/2024 at 11:54 AM with Staff E, Resident Care Manager, showed Resident 56 did not have a self-medication administration evaluation for folic acid, orders for folic acid, and/or orders for self-administration of folic acid. Staff E stated that Resident 56 should have had a self-medication administration evaluation for folic acid and an order prior to start taking the medication. On 11/26/2024 at 2:54 PM, Staff B, Director of Nursing, stated that they expected residents' self-medication administration evaluations was completed and that residents were provided with a secure storage for their medication. Staff B further stated that Resident 56 should have had a self-medication evaluation completed and an order for folic acid. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: (WAC) 388-97-0440, 1060 (3)(k)(l)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care-a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so) was obtained from the resident and/or their representative and ensure a copy was readily available in the medical records for 2 of 5 residents (Residents 76 & 73), reviewed for advance directives. This failure placed the residents and/or their representatives at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice. Findings included . Review of the facility policy titled, Advance Directives, revised in May 2023, showed to Determine upon admission whether the resident has an Advance Directives .document in the resident's medical record whether or not an Advance Directive has been executed by the resident. It further showed, Place a copy of such Advance Directive in the permanent medical record. This may include living will, durable power of attorney for health care . RESIDENT 76 Resident 76 admitted to the facility on [DATE]. Review of Resident 76's Advance Directives Policy and Record form dated and signed on 04/22/2024, showed Resident 76's collateral contact was their POA for health care. In an interview and joint record review on 11/25/2024 at 1:22 PM, Staff I, Social Services Director, stated that Resident 76 had a DPOA for health care. Joint record review of Resident 76's Advance Directives Policy and Record form showed Resident 76's collateral contact was their POA and that it was electronically signed by Resident 76 on 04/22/2024. When asked if a copy of Resident 76's Advance Directive was in their medical record, Staff I stated No and further stated, It (Advance Directive) should have been placed in [Resident 76's] medical record. In an interview on 11/26/2024 at 11:43 AM, Staff A, Administrator, stated that residents' Advance Directives should be in their medical record and readily accessible by staff. 47218 RESIDENT 73 Resident 73 admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS - an assessment tool) dated 10/29/2024 showed Resident 73 had moderate impaired cognition. Review of the Electronic Health Record under the miscellaneous tab showed no advance directives documentation for Resident 73. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Advance Directive Policy and Record form dated 01/23/2024 showed it was blank, and did not show whether Resident 73 had an advance directive or that advance directives were discussed with Resident 73 and/or their representative. On 11/19/2024 at 1:56 PM, Resident 73's representative stated that they were Resident 73's POA. A joint record review and interview on 11/25/2024 at 2:06 PM with Staff I, showed Resident 73's Advance Directive Policy and Record form dated 01/23/2024 was blank. Staff I stated that Resident 73's representative was their POA and that there was no advance directive document in Resident 73's EHR. Staff I further stated that they have asked Resident 73's POA for advance directive document. Staff I did not provide a copy of Resident 73's advance directives and/or documentation that it was requested/discussed with Resident 73's POA. On 11/26/2024 at 3:24 PM, Staff A stated they expected advance directives were discussed with residents and/or their representatives on admission and during care conferences. Staff A further stated they expected the Advance Directive Policy and Record form given to residents and/or their representatives were not blank and that they were completed. Reference: WAC 388-97-0280 (3)(c) (i-ii), -0300 (1)(b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50891 Based on observation, interview, and record review, the facility failed to ensure appropriate water temperature used for showers/bathing were maintained for 3 of 3 residents (Residents 4, 25 & 73), failed to ensure blinds in resident's rooms were maintained or replaced when broken for 2 of 2 rooms (Rooms 63 & 64), and failed to ensure oxygen equipment was stored appropriately for 1 of 1 resident (Resident 88), reviewed for environment. These failures placed the residents at risk for a less than homelike environment, unmet care needs, and a diminished quality of life. Findings included . WATER TEMPERATURE A review of the Resident Council Meeting minutes, dated 10/31/2024, showed that water temperature issues, lukewarm too cold at times. A review of the facility's grievance log from 10/26/2024 to 11/25/2024 showed no complaints regarding residents having to take cold showers/bed baths. In an interview on 11/18/2024 at 1:00 PM, Resident 4 stated that it took the facility three weeks to get the hot water fixed and was taking cold showers. In an interview on 11/19/2024 at 11:25 AM, Resident 25 stated that the facility was without hot water until this last week for about two months [October 2024 & November 2024]. Resident 25 further stated that they were told that the water heater was broken. During a resident council meeting on 11/20/2024 at 10:56 AM, the residents reported that the facility was out of hot water for three weeks and had to take cold showers. In an interview on 11/21/2024 at 10:24 AM, Resident 73 stated that they received two cold showers about two weeks ago because there was no hot water in the facility. In an interview on 11/22/2024 at 11:03 AM, Staff Z, Certified Nursing Assistant (CNA)/Shower Aid, stated that it took one to two weeks to get the hot water back for the residents and that there were residents that declined showers and wanted to wait until the water was warmer. In an interview on 11/22/2024 at 11:12 AM, Staff H, Maintenance Director, stated that the water temperature had been fluctuating and when the temperatures would not go over 100 degrees, they reported it to the Administrator. Staff H stated the water temperature had gone down to 97 degrees for one week and residents were unable to take hot showers. Staff H stated that it took two days for plumbers to come to the facility and was told they needed to replace the water heater's mixing valve, a part they obtained a week later. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/26/2024 at 9:27 AM, Staff A, Administrator, stated that they received report that residents felt the water wasn't [was not] getting hot enough. Staff A stated that they expedited the order for the part they needed to repair the water heater. 46912 BROKEN BLINDS Observation and interview on 11/19/2024 at 7:56 AM, showed room [ROOM NUMBER] had broken blinds with a blanket covering up the hole in the blinds. Resident 78 stated, someone put up a blanket because there's a light that shines through the broken blinds. Observation on 11/20/2024 at 8:42 AM, showed broken blinds in room [ROOM NUMBER]. Observation and interview on 11/20/2024 at 8:46 AM, showed broken blinds in room [ROOM NUMBER] and the blanket had been taken down. Resident 78 stated, the light is in my eyes since they took the blanket down. Additional observation at 1:42 PM showed staff putting up new blinds in room [ROOM NUMBER]. In an interview and joint observation on 11/22/2024 at 11:19 AM, Staff CC, CNA, stated that if they noticed anything broken or in disrepair in the building, they would report it to the maintenance department. Staff CC stated they would report if there were broken blinds. A joint observation of room [ROOM NUMBER], showed broken blinds, Staff CC stated that the blinds were broken. In an interview on 11/22/2024 at 3:05 PM, Staff H stated that they do monthly checks on the resident rooms and they depend highly on nursing staff to report anything that needed repair. When asked about the broken blinds, Staff H stated that their assistant had made measurements two or three weeks ago and they have not been ordered yet. Staff H showed a list of rooms that had broken blinds including room [ROOM NUMBER] and 64. Staff H stated that for room [ROOM NUMBER], they went and got the blinds myself because [Resident 78] was using a sheet [blanket]. OXYGEN EQUIPMENT Observation and interview on 11/19/2024 at 11:53 AM, showed an oxygen concentrator (a device that provides oxygen therapy) with oxygen tubing and a nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) in Resident 88's room. Resident 88 stated that they did not use oxygen. Observation on 11/20/2024 at 8:49 AM, showed an oxygen concentrator with tubing and nasal cannula in Resident 88's room. In an interview and joint record review on 11/20/2024 at 2:05 PM, Staff L, Registered Nurse, stated they would not expect a resident to have oxygen equipment in their room unless they used oxygen. A joint record review of Resident 88's physician orders showed no oxygen order, Staff L stated that Resident 88 was not on oxygen and hasn't [has not] been. Staff L further stated that Resident 88 should not have oxygen equipment in their room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 11/26/2024 at 9:41 AM, Staff A stated that Staff H was responsible for routine maintenance of the building. Staff A stated that they expected staff to put in work orders for the maintenance department. When asked if they would expect there to be broken blinds in resident's rooms, Staff A stated, It's been a work in progress, [Staff H] has a second person to help now. Staff A stated they would not expect a blanket to be used to cover up broken blinds. Staff A further stated they would not expect oxygen equipment to be in a resident's room if they were not on oxygen therapy. Reference: (WAC) 388-97-0880 (1)(2)

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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. 48298 Based on observation, interview, and record review, the facility failed to initiate, investigate, log, and promptly resolve a grievance for 1 of 3 residents (Resident 76), reviewed for grievances. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Grievances, revised in February 2024, showed, The center strives to complete the review of the grievance within five business days of receipt. The policy further showed, Initiate the Resident Grievance Report for all concerns . the employee . should assist the resident/resident representative as needed to complete the form. Immediately provide the completed Resident Grievance Report to the Grievance Officer/Executive Director and/or his or her designee . Review of the quarterly minimum data set (an assessment tool) dated 10/31/2024 showed Resident 76 had intact cognition. In an interview on 11/18/2024 at 9:43 AM, Resident 76 stated, I got [a] missing cell phone, Samsung [a brand name]. I reported it about three weeks ago. I don't [do not] have any updates yet. Review of the facility's Grievance log dated 05/19/2024 to 11/18/2024 showed no documentation of Resident 76's missing cell phone. Observation on 11/20/2024 at 8:04 AM, showed Resident 76 was displaying sleep pattern. Further observation showed a cell phone was on top of their bedside drawer. A follow-up interview at 12:49 PM with Resident 76 stated, I have two cell phones, one personal phone and one business phone. That's my business phone [pointing to the cell phone on top of their bedside drawer]. The one that was missing was my personal phone and I have all my contacts in there. I need to call a few people. Resident 76 further stated that they spoke with [Staff H] from maintenance about two or three weeks ago and one staff from laundry. In an interview on 11/20/2024 at 1:32 PM, Staff H, Maintenance Director, stated that Resident 76 reported to them about their missing cell phone about a few weeks ago, around Halloween. Staff H stated that they told Staff I [Social Services Director] about it, that same day [when Resident 76 reported to them]. In an interview and joint observation on 11/20/2024 at 1:36 PM, Staff S, Laundry Aide, stated that they got a report about Resident 76's missing cell phone. When asked, Staff S did not remember when they got the report about the missing cell phone. Staff S further stated that they had checked their laundry for Resident 76's missing cell phone. Staff S then showed a cell phone bearing an M [Motorola-a brand name] symbol with a cracked screen. Staff S stated, It has broken screen and does not turn on. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/20/2024 at 1:43 PM, Staff I stated they received a report about Resident 76's missing cell phone and that it was found on top of Resident 76's bedside drawer. When informed that Resident 76 stated they had two cell phones, Staff I stated they had Resident 76's inventory list in a binder in their office. At 1:48 PM, a joint record review and follow-up interviewed with Staff I, showed Resident 76 had two cellphones on their admission inventory list. Staff I stated they had not written and/or completed a grievance report about Resident 76's missing cell phone. Staff I stated that they should have completed a grievance report. Staff I further stated, Apparently, we only knew about the two cell phones, and we will work on it. On 11/21/2024 at 8:34 AM, Staff I gave a verbal update that Resident 76's missing cell phone had been found in Resident 76's closet. Observation and interview on 11/21/2024 at 2:30 PM, showed Resident 76 had two cell phones. Resident 76 stated that their missing personal cell phone had been found inside their closet by a staff. In an interview on 11/26/2024 at 11:43 AM, Staff A, Administrator, stated that they should have had completed a grievance report about Resident 76's missing property and followed it through. Staff A further stated, We did not follow our process. Reference: (WAC) 388-97-0460(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to ensure allegation of abuse was thoroughly investigated for 2 of 2 residents (Residents 92 & 25), reviewed for abuse investigations. This failure placed the residents at risk for repeated incidents, unidentified abuse, and inappropriate corrective actions. Findings included . Review of the facility's policy titled, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source, and Misappropriation of Resident Property, updated in August 2022, showed that the facility would review and investigate all allegations of abuse, neglect, exploitation, mistreatment, injuries, of an unknown source, and misappropriation of resident property using the risk management electronic incident report. The policy further showed that the components of a thorough investigation were to include resident interview, resident observation, staff interviews, and other resident interviews. RESIDENT 92 Review of the admission Minimum Data Set (MDS-an assessment tool) dated 11/07/2024, showed Resident 92 was cognitively intact. Review of Resident 92's incident investigation dated 11/19/2024 showed the facility did not thoroughly collect evidence related to other possible witnesses or other residents related to the investigation. RESIDENT 25 Review of the quarterly MDS dated [DATE] showed Resident 25 was cognitively intact. Review of Resident 25's incident investigation dated 11/19/2024 showed the facility did not thoroughly collect evidence related to other possible witnesses or other residents related to the investigation. A joint record review and interview on 11/26/2024 at 2:58 PM with Staff B, Director of Nursing, showed other residents' interviews were to be included as part abuse and/or neglect allegation investigation policy. Staff B stated that they interviewed the affected resident, staff, and other residents when completing abuse and/or neglect allegation investigations. Staff B further stated that if other residents' interviews were not included in the abuse and/or neglect investigations for Resident 92 & 25, they were not done. Reference: (WAC) 388-97-0640 (6)(a)(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	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to provide a written transfer/discharge notice to the resident and/or their representative for 2 of 4 residents (Residents 76 & 61), reviewed for hospitalization . This failure placed the residents and/or their representatives at risk for not having an opportunity to make informed decisions about transfers/discharges. Findings included . Review of the facility policy titled, Bed-Hold: Notification Notice of Bed Hold Policy and Return (Voluntary Transfer to Hospital and Therapeutic Leave, updated in September 2022, showed, The center requires that when a resident is transferred to a hospital or for a therapeutic leave all federal and state laws, rules and regulations will be followed. The policy further stated that at the time of transfer of a resident for hospitalization or therapeutic leave, the center must provide to the resident and the resident's representative written notice which specifies the . reasons for transfer or discharge. RESIDENT 76 Resident 76 admitted to the facility on [DATE]. Review of the discharge Minimum Data Set (MDS-an assessment tool) dated 09/04/2024, showed Resident 76 was discharged to an acute hospital on 09/04/2024. Review of the nursing progress notes dated 09/04/2024 showed Resident 76 had a change in condition and was transferred to the emergency room . Review of Resident 76's Electronic Health Record (EHR-under evaluations, nursing progress notes and miscellaneous) did not show documentation that a written notice of transfer/discharge was provided to Resident 76 and/or their representative. In an interview and joint record review on 11/25/2024 at 3:07 PM, Staff F, Resident Care Manager (RCM), stated that Resident 76 had been provided a written notice of transfer/discharge. Joint review of Resident 76's EHR titled, WA [[NAME]] Nursing Home Transfer or Discharge Notice/Notice of Voluntary Transfer (Bed Hold), dated 09/04/2024, did not show it was provided to Resident 76 and/or their representative. Interview and joint record review on 11/26/2024 at 10:55 AM, Staff B, Director of Nursing Services, stated that Resident 76 had a document in their EHR that showed details about their transfer to the hospital on 09/04/2024. Joint review of Resident 76's EHR titled, WA [[NAME]] Nursing Home Transfer or Discharge Notice/Notice of Voluntary Transfer (Bed Hold), dated 09/04/2024, showed item 5b (Notice provided to Resident or Resident Representative) was blank and did not have Resident 76 or their representative's signature. Staff B stated, item 5b had no signature. We cannot tell whether a written copy was provided to the resident [Resident 76] or their family. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RESIDENT 61 Resident 61 admitted to the facility on [DATE]. Review of the discharge MDS dated [DATE], showed Resident 61 was discharged to the hospital on 11/11/2024. Review of the nursing progress notes dated 11/11/2024 showed Resident 61 had a change in condition and was transferred to the emergency room . Review of Resident 61's Electronic Health Record (EHR-under evaluations, nursing progress notes, and miscellaneous) did not show documentation that a written notice of transfer/discharge was provided to Resident 61 and/or their representative. In an interview and joint record review on 11/25/2024 at 2:50 PM, Staff E, RCM, stated that Resident 61 was expected to return to the facility and that there was no written notice of transfer/discharge was provided to them or their representative. In an interview and joint record review on 11/26/2024 at 3:10 PM, Staff B stated that Resident 61 was discharged to the hospital on 11/11/2024. Joint review of Resident 61's EHR showed no documentation that a written notice of transfer/discharge was provided to the resident and/or their representative. Staff B stated that there should have been a written notice of transfer/discharge completed and provided to Resident 61 considering there was a change in condition documented on the 11th [11/11/2024]. In an interview on 11/26/2024 at 3:36 PM, Staff A, Administrator, stated that residents should be provided with a copy of the written notice of transfer/discharge. Reference: (WAC) 388-97-0120 (1)(b), (2)(a-d)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to ensure bed hold (the opportunity to reserve a resident's current occupied bed while out of the facility to ensure their room was available when ready to return) notice was offered for 1 of 4 residents (Resident 61), reviewed for hospitalization . This failure placed the resident or their representative at risk for lack of knowledge regarding the right to hold their bed while in the hospital. Findings included . Review of the facility policy titled, Bed-Hold: Notification Notice of Bed Hold Policy and Return (Voluntary Transfer to Hospital and Therapeutic Leave, updated in September 2022, showed, The center requires that when a resident is transferred to a hospital or for a therapeutic leave, a written notice will be provided to the resident, family member or responsible party regarding the resident's bed hold rights and the center's bed hold policy. Resident 61 admitted to the facility on [DATE]. Review of the discharge Minimum Data Set (MDS- an assessment tool) dated 11/11/2024, showed Resident 61 discharged to the hospital on 11/11/2024. A review of the entry MDS dated [DATE], showed Resident 61 returned to the facility on [DATE]. Review of the nursing progress notes dated 11/11/2024 showed Resident 61 had a change in condition and was transferred to the hospital. Review of Resident 61's Electronic Health Record (EHR-under evaluations, nursing progress notes, and miscellaneous) did not show documentation that Resident 61 and/or their representative were provided a bed hold notice for their transfer to the hospital. In an interview and joint record review on 11/25/2024 at 2:50 PM, Staff E, Resident Care Manager, stated that Resident 61 was expected to return to the facility and that there was no notice of bed hold provided to them or their representative. In an interview and joint record review on 11/26/2024 at 3:10 PM, Staff B, Director of Nursing Services, stated that Resident 61 was discharged to the hospital on 11/11/2024. Joint review of Resident 61's EHR showed no documentation that a notice of bed hold had been provided to the resident and/or their representative. Staff B stated that there should have been a notice of bed hold provided to Resident 61 and/or their representative. In an interview on 11/26/2024 at 3:36 PM, Staff A, Administrator, stated that a notice of bed hold should have been provided to Resident 61 and/or their representative. Reference: (WAC) 388-97-0120 (1)(b), (4)(a-c)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed timely for 1 of 1 resident (Resident 16), reviewed for significant change in condition. The failure to complete a SCSA timely placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of 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 1.19.1, dated October 2024, showed that a SCSA is required to be performed when a terminally ill resident enrolls in a hospice program or changes hospice providers and remains a resident at the nursing home. The RAI manual further showed that the assessment should be completed no later than 14 days after the determination was made (determination date plus 14 calendar days). Review of the SCSA MDS Care Area assessment dated [DATE] showed Resident 16 admitted to hospice services on 04/29/2024. Review of the SCSA MDS dated [DATE] showed it was completed on 05/16/2024, three days late. A joint record review and interview on 11/26/2024 at 10:00 AM with Staff G, MDS Specialist, showed the clinical records (Electronic Health Records) for Resident 16 revealed they started hospice services on 04/29/2024. Staff G stated they scheduled a significant change MDS seven to (10) days after residents started on hospice services. Staff G further stated that Resident 16's MDS dated [DATE] was completed on 05/16/2024. Joint record review the October 2024 MDS Manual showed a significant change MDS should be completed on the 14th (fourteenth) calendar day after the determination that significant change in resident's status occurred (determination date plus 14 calendar days). Staff G stated that Resident 16's determination date was 04/29/2024 and that their SCSA MDS was completed late. On 11/26/2024 at 2:49 PM, Staff B, Director of Nursing Services, stated they expected MDS assessments were completed timely. Reference: (WAC) 388-97-1000 (3)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to accurately assess 5 of 21 residents (Residents 61, 76, 62, 16 & 95), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding pressure ulcer/injury (wounds that occur from prolonged pressure on the skin), diagnosis, behavior, use of insulin (medication/hormone that regulates blood sugar levels) injections, hypoglycemic medication (drug that lowers blood sugar level) and discharge status placed the residents 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 1.19.1, dated October 2024, 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. 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). PRESSURE ULCER/INJURY RESIDENT 61 Review of a wound care progress notes dated 11/07/2024, showed Resident 61 had a stage 2 (shallow open wound) pressure ulcer to their left buttock. A joint record review and interview on 11/26/2024 at 10:22 AM with Staff G, MDS coordinator, showed Resident 61's annual MDS dated [DATE] was not coded for pressure ulcer under Section M (Skin Conditions). Joint record review of the wound care progress notes dated 11/07/2024, showed Resident 61 had a stage 2 pressure ulcer to their left buttock. Staff G stated that Resident 61's annual MDS was not accurate, and that pressure ulcer should have been coded. RESIDENT 76 Review of Resident 76's quarterly MDS assessment dated [DATE], showed a stage 1 (intact skin with non-blanchable redness) and stage 2 pressure ulcers were coded. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Electronic Health Record (EHR-progress notes, evaluations and miscellaneous, showed Resident 76's EHR had no documentation of stage 1 and stage 2 pressure ulcers during the seven day look-back period. A joint record review and interview on 11/26/2024 at 10:22 AM with Staff G, showed Resident 76's quarterly MDS was coded for pressure ulcer in Section M. A joint record review of the EHR showed no documentation of pressure ulcer during the look-back period. Staff G stated that Resident 76 had no pressure ulcer within the look-back period (10/25/2024 to 10/31/2024). Staff G stated that it was inaccurate coding, and that pressure ulcer should not have been coded in Resident 76's quarterly MDS. DIAGNOSIS Review of Resident 76's significant change MDS assessment dated [DATE], showed depression (feeling of sadness) was not coded under Section I (Active Diagnoses). Review of the physician's note dated 07/29/2024, showed Resident 76 had an antidepressant prescribed for depression and poor appetite. A joint record review and interview on 11/26/2024 at 2:29 PM with Staff G, showed Resident 76's significant change MDS had no depression coded in Section I. A joint record review of the physician's note dated 07/29/2024, showed Resident 76 had an antidepressant prescribed for depression and poor appetite. Staff G stated that depression should have been coded in Resident 76's significant change MDS. RESIDENT 62 Review of Resident 62's admission MDS dated [DATE], showed a change in behavior was marked zero [0-same (from prior MDS assessment)] under Section E (Behavior). Further review of the MDS assessment look up page showed Resident 62 had no prior MDS assessment done. A joint record review and interview on 11/26/2024 at 10:22 AM with Staff G, showed Resident 62's admission MDS was marked zero. Staff G stated that it was a wrong coding and that [Resident 62] had no prior assessment, and that Section E1100 (Change in Behavior or Other Symptoms) should have been marked as N/A (because of no prior MDS assessment). In an interview on 11/26/2024 at 3:10 PM, Staff B, Director of Nursing Services, stated that they expected MDS assessments to be coded accurately. 47218 INSULIN USE RESIDENT 16 Review of the July 2024 and August 2024 Medication Administration Record (MAR) showed Resident 16 was administered insulin on 07/31/2024 to 08/06/2024, for a total of seven days during the seven-day look back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the October 2024 and November 2024 MAR showed Resident 16 was administered insulin on 10/31/2024 to 11/06/2024, for a total of seven-day during the look back period. Review of the quarterly MDSs dated 08/06/2024 and 11/06/2024 showed Resident 16's injections, insulin injections, and hypoglycemic medications were not marked in Section N (Medications). A joint record review and interview on 11/26/2024 at 10:13 AM with Staff G, showed Resident 16's quarterly MDS dated [DATE] did not have injections, insulin injections, and hypoglycemic medications marked in Section N. Staff G stated that Resident 16 did not receive insulin according to the MDS. Joint record review of the August 2024 MAR showed Resident 16 received insulin daily. Staff G stated that Resident 16 received insulin every day and that the quarterly MDS should have been coded for 7 (seven) days of injections, 7 (seven) days of insulin injections, and for hypoglycemic medications in Section N. Another joint record review and interview on 11/26/2024 at 10:17 AM with Staff G, showed Resident 16's quarterly MDS dated [DATE] did not have injections, insulin injections, and hypoglycemic medications marked in Section N. Staff G stated that Resident 16 did not receive insulin according to the MDS. Joint record review and interview of the November 2024 MAR showed Resident 16 received insulin daily. Staff G stated that Resident 16 received insulin every day and that the quarterly MDS should have been coded for 7 days of injections, 7 days of insulin injections, and for hypoglycemic medications in Section N. In an interview on 11/26/2024 at 10:18 AM, Staff G stated that Resident 16's quarterly MDSs dated 08/06/2024 and 11/06/2024 were inaccurate. On 11/26/2024 at 2:49 PM, Staff B stated they expected MDS assessments were completed accurately. 46912 DISCHARGE STATUS RESIDENT 95 Review of the discharge MDS dated [DATE], showed Resident 95 admitted to the facility on [DATE]. Further record review showed Resident 95's MDS was coded for discharge status to acute hospital. Review of the social services progress notes dated 09/24/2024, showed that stated Resident 95 will d/c [discharge] home on 09/25/2024. A joint record review and interview on 11/25/2024 at 11:16 AM with Staff G, showed that Resident 95's EHR revealed they discharged to home. A joint record review of Resident 95's discharge MDS showed that that it was coded for discharge to acute hospital. Staff G stated that Resident 95's discharge MDS should have been coded as discharge to the community. In an interview on 11/25/2024 at 2:16 PM, Staff B stated that they expected the MDS to be accurate. Reference: (WAC) 388-97-1000 (1)(b)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview and record review, the facility failed to complete a new Level I Preadmission Screening and Resident Review (PASARR- an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], intellectual disabilities, or related conditions) and referral for Level II evaluation (a comprehensive evaluation for positive Level I screening) when a significant change in status occurred and new diagnoses of mental illness were identified for 2 of 7 residents (Residents 76 & 38), reviewed for PASRR. This failure placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, PASRR Requirements, dated 04/26/2023, showed that Following admission of a resident, the nursing facility must review all level I am screening forms for accuracy. If at any time the facility finds that the previous level 1 screening was incomplete, erroneous, or is no longer accurate, the facility must immediately complete a new screening using the department's standardized level I form . The policy showed to complete a new level I screening for residents with significant change in physical or mental condition. The policy further showed, Immediately complete a new level I screening using the department's standardized form if the facility finds that a resident, not previously determined to have a [SMI], develops symptoms of [SMI], and refer the resident to the mental health PASRR evaluator for further evaluation. RESIDENT 76 Resident 76 admitted to the facility on [DATE] with diagnosis that included left hemiplegia (left-side weakness) due to a stroke (a medical condition where the blood supply to the brain is blocked or reduced). Review of Resident 76's Level I PASARR dated April 2024 showed no SMI and a referral for level II was marked. Review of Resident 76's discharge summary dated 04/16/2024 showed no SMI diagnosis. Review of the physician's note dated 07/29/2024 showed Resident 76 had an antidepressant medication indicated for depression (feeling of sadness). Review of Resident 76's Minimum Data Set (MDS-an assessment tool) showed a completed significant change MDS dated [DATE]. Review of Resident 76's Electronic Health Record (EHR-under evaluations and miscellaneous, showed no new Level I PASARR was completed nor referral for Level II evaluation was made. (continued on next page)

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	505236	A. Building B. Wing	11/26/2024

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and a joint record review on 11/25/2024 at 1:22 PM, Staff I stated that they reviewed Level I PASARR for residents admitted to the facility. Joint review of Resident 76's EHR (PASARR, diagnoses list, and MDS) showed Resident 76's Level I PASARR dated April 2024 did not have SMI and was marked for Level II referral. Staff I stated that they were not aware of any Level II referral for Resident 76. Staff I stated that Resident 76 had a significant change assessment dated [DATE] and that there was no new Level I PASARR completed for Resident 76. Staff I further stated that they expected that a new Level I PASARR and a referral for Level II evaluation should have been completed for Resident 76. RESIDENT 38 Resident 38 admitted to the facility on [DATE] with diagnoses that included end stage renal disease (a condition in which the kidneys have lost their function) and diabetes mellitus (a condition affecting blood sugar levels). Review of Resident 38's Level I PASARR dated 12/20/2022 showed Resident 38 did not have SMI. Review of Resident 38's admission record printed on 11/19/2024 showed a diagnosis of depression dated 12/27/2022. Review of Resident 38's antidepressant comprehensive care plan initiated on 12/29/2022 showed Resident 38 started on antidepressant for depression and for appetite stimulation. Review of Resident 38's Minimum Data Set (MDS-an assessment tool) showed Resident 38 had a significant change MDS completed on 12/29/2022 and the most recent completed significant change MDS was dated 12/30/2023. Review of Resident 38's EHR showed no new Level I PASARR was completed nor a referral for Level II evaluation was made. In an interview and joint record review on 11/25/2024 at 1:44 PM, Staff I stated that a new Level I PASARR should be completed for residents that had newly diagnosed SMI and who had significant change in their condition. Joint review of Resident 38's EHR (PASARR, diagnoses list, and MDS) showed Resident 38 had a diagnosis of depression and had a recent significant change MDS assessment. Staff I stated that there was no new Level I PASARR completed for Resident 38 and that they expected that a new Level I PASARR and a referral for Level II evaluation should have been completed. In an interview on 11/26/2024 at 3:36 PM, Staff A, Administrator, stated that a new Level I PASARR should have been completed and a referral for level II should have been made for residents that had newly diagnosed SMI and had significant change in their condition. Reference: (WAC) 388-97-1975 (1)(7)(9)

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	11/26/2024

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASARR - a federally required screening of all individuals who have an Intellectual Disability [ID], Related Condition [RC], or Serious Mental Illness [SMI] prior to admission to a Medicaid-certified nursing facility or a significant change of condition) form for 3 of 7 residents (Residents 50, 78 & 62), reviewed for PASARR. This failure placed the residents at risk for not receiving the care and services appropriate for their needs. Findings included . Review of the facility's policy titled, PASRR Requirements, dated 04/23/2024, showed the nursing facility would review all Level I PASRR screening forms for accuracy. The policy further showed that if at any time the facility found that the previous Level I PASRR screening was incomplete, erroneous, or was no longer accurate, the facility would immediately complete a new screening using the department's standardized level I form, following the directions provided by the department's PASRR program. The policy further showed, If the corrected Level I screening identified a possible serious mental illness or intellectual disability or related condition, the facility must notify DDA [Developmental Disabilities Association] and/or the mental health PASRR evaluator so a level II evaluation can be conducted. RESIDENT 50 Resident 50 admitted to the facility on [DATE] with diagnoses that included bipolar disorder (a mental health condition that causes extreme mood swings), anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation), and depression (persistent feeling of sadness and loss of interest). Review of Resident 50's Level I PASARR dated 08/08/2022 showed mood disorders and anxiety disorders were marked in Section I (SMI/ID/RC). Further review of the Level I PASARR showed that referral for Level II evaluation was not marked. In an interview and joint record review on 11/25/2024 at 1:22 PM, Staff I, Social Services Director, stated that PASARRs were reviewed before residents were admitted to the facility. Joint record review with Staff I showed Resident 50's Level I PASARR dated 08/08/2022 was marked for mood disorders, anxiety disorders, and marked that Level II evaluation was not required. Staff I stated that Resident 50's PASARR should have been referred for Level II PASARR evaluation. On 11/26/2024 at 3:26 PM, Staff A, Administrator, stated they expected Level I PASARR forms that were marked for SMIs were sent to the PASARR coordinator for Level II PASARR evaluation. 46912 RESIDENT 78 (continued on next page)

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	505236	A. Building B. Wing	11/26/2024

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 78's admission record showed that Resident 78 admitted to the facility on [DATE] with diagnoses that included anxiety disorder and depression. Review of Resident 78's Level I PASARR dated 05/14/2024, showed that Resident 78 met the requirements for an exempted hospital discharge which included, the individual is likely to require fewer than 30 days of nursing facility services. It further showed that because Resident 78 met the requirement for an exempted hospital discharge, they could be referred to a nursing facility without a Level II PASARR. Review of Resident 78's Electronic Health Record (EHR) showed that Resident 78 was admitted to the facility for more than 30 days. In an interview and joint record review on 11/25/2024 at 9:09 AM, Staff I stated that a resident would have an exempted PASARR if the hospital determines that a resident will be here less than 30 days. Staff I stated that if a resident stayed longer than 30 days, then I fill out a new Level I [PASRR] and if it needs to be referred for Level II [PASARR] then they would send to the PASARR coordinator. A joint record review of Resident 78's EHR showed Resident 78 was admitted to the facility more than 30 days. Staff I stated, [Resident 78] stayed longer than we thought. In a joint record review of Resident 78's Level I PASARR, dated 05/14/2024, under Section IV, showed it was marked for no Level II evaluation indicated at this time due to exempted hospital discharge. Staff I stated that, they checked it as exempt and I didn't [did not] do what I should do, I should have followed up. Staff I further stated that yes, [Resident 78] should have had new Level I PASARR done, and based on Resident 78's diagnoses, I need to refer [Resident 78] for Level II evaluation. In an interview and joint record review on 11/26/2024 at 9:41 AM, Staff A stated that if a resident stayed longer than 30 days, we contact the PASARR coordinator, they would determine if the resident needed a Level II [PASARR]. In a joint record review of Resident 78's Level I PASARR, Staff A stated, we should have contacted the PASARR coordinator. In a joint record review of a social services note, dated 11/25/2024, showed that Staff I, updated and sent to PASARR Coordinator for Level 2 review. Staff A stated, based on what [Staff I] wrote, Resident 78's Level 1 PASARR was sent to the PASARR coordinator yesterday. 48298 RESIDENT 62 Resident 62 admitted to the facility on [DATE] with diagnoses that included depressive type schizoaffective disorder (a type of schizophrenia- mental health condition that is marked with symptoms of hallucinations [an experience in which one sees, hears, feels, or smells something that does not exist], delusions [fixed, false beliefs in something that is not real or shared by other people] and mood disorders [mental health condition that primarily affects one's emotional state] such as depression). Review of Resident 62's Level I PASARR dated 09/12/2024, showed schizophrenic disorders and mood disorders were marked. Further review of Resident 62's Level I PASARR showed the referral for Level II evaluation was marked. Review of Resident 62's EHR (evaluations and miscellaneous) showed no Level II PASARR evaluation. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 11/25/2024 at 1:33 PM, Staff I stated that they reviewed Level I PASARR for residents admitted to the facility. A joint review of Resident 62's Level I PASARR showed SMI and referral for Level II evaluation was marked. When asked about Resident 62's Level II evaluation, Staff I stated Resident 62 had no Level II PASARR evaluation in their EHR. Staff I stated they will follow up Resident 62's referral for Level II PASARR evaluation. In an interview on 11/26/2024 at 11:43 AM, Staff A stated that they expected a referral for Level II PASARR evaluation was completed for Resident 62. Reference: (WAC) 388-97-1975(1-5)

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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** 46912 Based on observation, interview, and record review, the facility failed to develop and implement care plans for 3 of 18 residents (Residents 78, 46 & 77), reviewed for comprehensive care plans. The failure to implement care plans for diuretic (medications that help move extra fluid out of the body) use, resident preferences, and antibiotic (medications to treat infections) use, put the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Planning Process, revised on 05/19/2023, showed that the care plan provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being. RESIDENT 78 Review of the physician progress note on 11/01/2024, showed that Resident 78 was on torsemide (a diuretic) for edema (swelling). Review of the November 2024 Medication Administration Record (MAR) showed that Resident 78 was on torsemide for edema. Review of Resident 78's comprehensive care plan printed on 11/19/2024 showed no care plan for diuretic use. In an interview and joint record review on 11/22/2024 at 9:45 AM, Staff W, Licensed Practical Nurse, stated that they expected there to be a care plan for a resident who was taking a diuretic. In a joint record review of Resident 78's comprehensive care plan, showed no care plan for diuretic use. Staff W stated, I don't know if there should be a care plan. In an interview and joint record review on 11/22/2024 at 10:20 AM, Staff J, Resident Care Manager (RCM), stated that they expected there to be a care plan for diuretic use. In a joint record review of Resident 78's comprehensive care plan, showed no diuretic care plan. Staff J stated, there is not one, I will add one. In an interview and joint record review on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated that they expected there to be a care plan for diuretic use. In a joint record review of the comprehensive care plan, Staff B stated, I see the one activated on 11/22/2024 and that there should have been one prior to that. 48298 RESIDENT 46 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 11/19/2024 at 9:55 AM, showed Resident 46 had no clothes on and laying on their bed uncovered. Resident 46's room door was opened, and Resident 46 could be seen from the hallway. Further observation showed Resident 46 was wearing disposable incontinent brief and had no pants on. When asked, Resident 46 stated they did not like to wear clothes and did not want to be covered. Resident 46 further stated that they did not care much about having the privacy curtain drawn or their room door opened. In an interview on 11/20/2024 at 1:04 PM, Staff X, Certified Nursing Assistant, stated, [Resident 46] does not want to wear clothes and [Resident 46] removes the blanket. Does not want [themselves] covered. In an interview and joint observation on 11/20/2024 at 2:12 PM, Staff M, Registered Nurse, stated that Resident 46 never wanted to wear clothes. Staff M stated, I have never seen [Resident 46] wear clothes. A joint observation with Staff M, showed Resident 46's upper body covered by the privacy curtain and their lower body can be seen from the hallway. Staff M went in Resident 46's room and pulled the curtain all the way to Resident 46's foot board. Resident 46 refused to have privacy curtain drawn. Staff M stated that Resident 46 liked to see people in the hallway. In an interview and joint record review on 11/21/2024 at 2:52 PM with Staff E, RCM, stated that they maintained residents' privacy and dignity and respect their desire. Staff E stated that they were familiar with Resident 46's behavior and preferences. Staff E stated, [Resident 46] likes to see people. [They] like [their] curtain open to see people in the hallway. Staff E stated that residents' behaviors and preferences were care planned. A joint record review of Resident 46's comprehensive care plan did not show documentation about Resident 46's preferences not to wear clothes/pants, to keep their privacy curtain open, to remain uncovered and to wear disposable incontinent briefs. Staff E stated that Resident 46's preferences should have been care planned. A joint record review and Interview on 11/26/2024 at 10 :55 AM with Staff B, showed Resident 46's comprehensive care plan did not show their preferences not to wear clothes/pants, to keep their privacy curtain open, to remain uncovered and to wear disposable incontinent briefs. Staff B stated that Resident 46's preferences should have been care planned. 50891 RESIDENT 77 A review of the face sheet showed Resident 77 admitted to the facility on [DATE]. A review of the November 2024 MAR showed Resident 77 had an order for Vancomycin (an antibiotic) 125 milligrams (mg-a unit of measurement) 1 capsule by mouth every 6 hours for 10 days. In a joint record review and interview on 11/26/2024 at 10:24 AM with Staff W, did not show antibiotic use was included in the comprehensive care plan that would indicate what adverse side effects (ASE) to watch for. Staff W stated that when residents were prescribed antibiotics, they would monitor ASE by placing them on alert charting for three days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint record review on 11/26/2024 at 11:14 AM with Staff U, RCM, stated that when an antibiotic was initiated, the resident would be placed on alert charting for three days and their comprehensive care plan would be updated. A joint record review with Staff U showed no mention of antibiotics in the care plan. Staff U did not comment about the use of antibiotic that was not in Resident 77's care plan, and stated they monitor ASE on alert charting. In an interview on 11/26/2024 at 1:24 PM, Staff B stated that they expected the comprehensive care plans to be updated when a resident was placed on antibiotics. References: (WAC) 388-97-1020(1), (2)(a)(b) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48298 Based on interview, and record review, the facility failed to revise comprehensive care plan for 1 of 18 residents (Resident 38), reviewed for care plan revision. The failure to revise the care plan to include current dialysis (a treatment to remove extra fluid and waste when kidneys fail) services placed the resident at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Care Planning Process, revised on 05/19/2023, showed, The care plan must be reviewed and revised according to the RAI [Resident Assessment Instrument- a guide directing staff on how to accurately assess the status of residents] process at a minimum upon admission, quarterly and with significant change in condition and services provided or arranged must be consistent with each resident's written Care Plan. Review of the facility policy titled, Dialysis Management, dated August 2022, showed, Review and revise the appropriate Dialysis care plan as needed. Resident 38 admitted to the facility on [DATE] with a diagnosis of end stage renal disease (a medical condition in which kidneys lost their function). Review of Resident 38's active physician orders printed on 11/19/2024, showed Resident 38 had dialysis at Puget Sound Kidney Center, Mill Creek .[at] 11:00 [AM], Phone: 425.744.1095 in the morning every Mon [Monday], Wed [Wednesday], Fri [Friday]. Review of Resident 38's dialysis comprehensive care plan printed on 11/19/2024, showed, [NAME] [DaVita-name of a dialysis center] 8130 Evergreen Way [PHONE NUMBER] [phone number]. Review of the facility document titled, Dialysis Communication Record, dated 11/15/2024, showed Resident 38 went to Puget Sound Kidney Center. Interview on 11/20/2024 at 10:50 AM, Staff P, Licensed Practical Nurse (LPN) stated that Resident 38 had dialysis schedule of three times a week [Monday, Wednesday and Friday] at Puget Sound Kidney Center. A joint record review and follow-up interview at 2:04 PM, showed Resident 38's dialysis comprehensive care plan was initiated on 03/30/2021. Further joint review of Resident 38's dialysis comprehensive care plan showed, [NAME] [DaVita-name of a dialysis center] 8130 Evergreen Way [PHONE NUMBER] [phone number]. When asked, Staff P stated that Resident 38's dialysis CP was not updated or revised. During a joint record review and interview on 11/21/2024 at 7:58 AM with Staff E, Resident Care Manager, showed Resident 38's dialysis comprehensive care plan did not include the current dialysis center where Resident 38 received their dialysis services. Staff E stated that Resident 38 goes to Puget Sound Kidney center three times per week and that [Resident 38] is very strict with [their] dialysis appointment. Staff E stated that Resident 38's dialysis care plan was not updated and should have been revised to reflect Resident 38's current plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/26/2024 at 10:55 AM, Staff B, Director of Nursing, stated that Resident 38's dialysis comprehensive care plan did not have the current dialysis center information. Staff B stated, We have updated the PCC (a software application) dashboard, but we did not update [Resident 38's] care plan. Staff B further stated that they have updated Resident 38's care plan since Staff E informed them about it. Reference: (WAC) 388-97-1020 (5)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47218 Based on interview and record review, the facility failed to ensure professional standards of practice were followed when administering medications for 1 of 5 residents (Resident 26) and failed to ensure physician orders were followed for 3 of 5 residents (Residents 50, 38 & 61), reviewed for medication and treatment management. The failure to administer the right dosage form of medication for Resident 26, hold medication as ordered for Residents 50 & 38, and provide wound care treatment for Resident 61 placed the residents at risk for adverse side effects, worsening of pressure ulcer, and diminished quality of life. Findings included . Review of the facility's policy titled, Medication Administration, updated in October 2022, showed that the licensed nurse would check the following prior to administering the medication: right medication, right dose, right dosage form, right route, right resident, and right time. The policy further showed that the nurse would read the Medication Administration Record (MAR) for the ordered medication, dose, dose form, route, and time; verify correct medication, expiration date, dose, dosage form, route, and time again by comparing MAR before administering; and would document administration of medication in the MAR as soon as medications were given. Review of the facility's undated policy titled, Wound Prevention and Management, showed, A resident with pressure ulcers will receive continued preventive interventions and necessary treatment and services to promote healing and prevent infection. RESIDENT 26 Review of the November 2024 MAR showed Resident 26 had orders for aspirin (medication used to reduce pain, fever and inflammation) 81 milligrams (mg - unit of measurement) tablet chewable every morning. During a medication administration observation on 11/21/2024 at 7:39 AM, Staff L, Registered Nurse (RN), was observed pouring one aspirin 81 mg enteric coated (special coating to protect medication from stomach acids) tablet in a medication cup and administered it to Resident 26. A joint record review and interview on 11/21/2024 at 8:33 AM, showed Resident 26 had orders for aspirin 81 mg chewable tablet. Staff L, checked the bottle of aspirin 81 mg tablets enteric coated and stated that they were not sure what enteric coated means and that they would have to look it up. Staff L further stated that they did not know that the medication they gave to Resident 26 was not the right aspirin. In an interview on 11/21/2024 at 2:27 PM, Staff J, Resident Care Manager (RCM), stated that Staff L should have given Resident 26 a chewable aspirin tablet. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 11/26/2024 at 10:10 AM with Staff B, Director of Nursing Services, showed Resident 26's November 2024 MAR had orders for chewable aspirin. Staff B stated that they expected nurses to follow the orders for right medication and right dose. Staff B further stated that Staff L should have given Resident 26 a chewable aspirin tablet instead of the enteric coated aspirin. RESIDENT 50 Review of the face sheet printed on 11/19/2024 showed Resident 50 had diagnosis that included diabetes mellitus type 2 [a disease that occurs when blood sugar level is too high]. Review of the physician orders printed on 11/19/2024 showed that Resident 50 had an order for Insulin [medication/hormone that regulates blood sugar levels] Lispro [type of insulin] Solution Inject 3 [three] unit subcutaneously [under the skin] two times a day for Diabetes HOLD if CBG [capillary blood glucose - level of sugar circulating in the blood] is < [less than] 110 [mg/dl - milligram per deciliter-a unit of measurement] and if resident is not eating for 8:00 AM and 4:30 PM that started on 10/18/2024. Review of the November 2024 MAR showed that Resident 50 received insulin when their CBG readings were below 110. The following records showed Resident 50's insulin was held when they had their CBG below 110 mg/dl and had eaten their meals: - On 11/09/2024 at 5:20 PM, CBG was 108 mg/dl, Resident 50 ate 75%-100% of their dinner. - On 11/11/2024 at 8:59 AM, CBG was 97 mg/dl, Resident 50 ate 75%-100% of their breakfast. - On 11/11/2024 at 5:38 PM, CBG was 74 mg/dl, Resident 50 ate 51% to 75% of their dinner. A joint record review and interview on 11/26/2024 at 1:42 PM with Staff B showed Resident 50 had an order for insulin lispro with parameters to hold if blood sugar < 110 and if resident is not eating. Staff B stated that for the insulin to be held, Resident 50's blood sugar had to be less than 110 and that resident had not eaten. Further record review showed Resident 50's insulin was held when their CBG was less than 110 on 11/09/2024 and on 11/11/2024 and Resident 50 consumed their meals. Staff B stated that Resident 50's insulin should have been given. 48298 RESIDENT 38 Resident 38 admitted to the facility on [DATE] with diagnosis that included type 2 diabetes mellitus. Review of Resident 38's physician orders showed, Novolog [a brand name of insulin . Inject 5 units [unit of measurement] subcutaneously [under the skin] with meals . hold for cbg [capillary blood glucose-concentration of blood sugar] < 100 mg/dl. Review of Resident 38's blood sugar level taken on 11/04/2024 at 5:48 PM, showed Resident 38 had a blood sugar level of 99 mg/dl. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 38's November 2024 MAR showed Resident 38 was administered with five units of Novolog on 11/04/2024 at 6:11 PM. In an interview on 11/25/2024 at 2:14 PM, Staff K, LPN, stated that they followed the prescribed parameters when giving insulin to residents. Staff K stated that they would hold insulin if a resident's blood sugar level was below the prescribed parameter, let the provider know and watch for hypoglycemia (a condition when the blood sugar level drops below the specified limit). A joint record review and interview on 11/25/2024 at 2:21 PM with Staff F, RCM, showed Resident 38 had a physician order for Novolog injection of five units and to hold [insulin] if cbg was < 100. A joint record review of Resident 38's blood sugar taken on 11/04/2024 at 5:48 PM, showed Resident 38 had a blood sugar level of 99 mg/dl. A joint record review of Resident 38's November 2024 MAR showed Resident 38 was administered with five units of Novolog on 11/04/2024 at 6:11 PM. Staff F stated that staff should have held and not have administered the insulin. On 11/26/2024 at 11:24 AM, Staff B stated that they expected staff to have followed the prescribed parameters and not have administered the insulin. RESIDENT 61 Review of the annual Minimum Data Set (an assessment tool) dated 11/07/2024, showed Resident 61 had an intact cognition. In an interview on 11/19/2024 at 9:41 AM, Resident 61 stated that they had pressure ulcer to their left buttock. When asked if they had received wound care to their left buttock, Resident 61 stated, No. It [wound care to their left buttock] should be done daily. Resident 61 further stated that they had wound care to their left buttock about two weeks ago [from today's date of interview]. Review of a wound care progress note dated 11/07/2024, showed Resident 61 had one stage 2 (shallow open wound) pressure ulcer to their left buttock. Review of Resident 61's physician's order dated 11/07/2024 showed a treatment to Resident 61's left buttock wound to . apply Medihoney [brand name-wound ointment made of honey] to the wound bed. Cover with bordered gauze. Change daily and as needed .every evening shift for open area. Review of Resident 61's November 2024 MAR dated 11/14/2024 showed wound treatment to left buttock wound, [apply] with NS [normal saline-type of water solution] pat dry, apply foam dressing, change daily in evening .every evening shift. Another interview on 11/20/2024 at 9:55 AM and on 11/21/2024 at 7:49 AM, Resident 61 stated that they did not receive wound care to their left buttock pressure ulcer the night of 11/19/2024 and 11/20/2024. A joint observation on 11/21/2024 at 9:08 AM with Staff R, Certified Nursing Assistant, showed Resident 61 had an uncovered left buttock wound. Further observation showed no wound dressing on Resident 61's left buttock pressure ulcer. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint observation on 11/21/2024 at 9:56 AM with Staff E, RCM, and Staff M, RN, showed Resident 61 had no wound dressing to their left buttock pressure ulcer. Further joint observation showed Resident 61's left buttock had red-pink wound bed with shearing on the edges. Staff M then provided wound care and covered the wound to Resident 61's left buttock per physician's order. A joint record review and interview on 11/21/2024 at 10:12 AM with Staff E and Staff M, showed Resident 61's November 2024 MAR had a daily wound care to their left buttock pressure ulcer scheduled for evening shift and PRN (as needed). When asked if they had provided PRN or other scheduled wound care to Resident 61's left buttock for the month of November 2024, Staff M stated, No. In an interview on 11/21/2024 at 10:44 AM, Staff E stated that wound rounds are on Thursdays. Staff E stated that Staff W, Licensed Practical Nurse (LPN), was in the facility on 11/14/2024 to help with wound care. Staff E stated, [Staff W] did wound measurement for all residents that have wounds. [They] provided wound treatment. When asked if Staff W provided wound treatment to Resident 61's left buttock pressure ulcer on 11/14/2024, Staff E stated, I did not actually see [Staff W] doing the treatment on [Resident 61]. An interview and joint record review on 11/21/2024 at 11:04 AM with Staff E and Staff W, stated that they were in the facility on 11/14/2024 and that they performed wound measurement and treatment on residents with wounds. Staff W were asked if they had provided wound care treatment to Resident 61's left buttock pressure ulcer at any other time after 11/14/2024, Staff W stated, No. A joint review of the November 2024 MAR dated 11/18/2024 and 11/19/2024, showed Resident 61's wound treatment order scheduled for the evening shift had been administered and signed with an initial BB11 [Staff W's initial in the MAR]. When asked, Staff W stated that BB11 was their initial/signature. Staff W stated that they did not provide the treatment to Resident 61's left buttock pressure ulcer on 11/18/2024 and 11/19/2024. Staff W further stated, I verified with [Staff M] and [Staff M] did the wound care .and I signed it [MAR]. When asked if signing for another person was considered a good standard of practice, Staff W stated, I don't [do not] see anything wrong with that. Another interview on 11/21/2024 at 11:27 AM, Staff E stated they did not expect staff to sign the MAR if they did not provide the treatment themself. A joint interview on 11/21/2024 at 1:15 PM, with Staff C, Regional Director of Clinical Operations, and Staff B, stated that they expected staff to follow the doctor's order [wound treatment] and to follow the professional standard of practice. Staff B further stated that they did not expect the MAR to be signed by another person (staff) other than the person who administered the treatment. Reference: (WAC) 388-97-1620 (2)(b)(i)(ii)

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	505236	A. Building B. Wing	11/26/2024

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

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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. 47218 Based on interview and record review, the facility failed to ensure skin assessments were consistently evaluated for 1of 1 Resident (Resident 73), reviewed for quality of care. This failure placed the resident 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, Documentation-Skin Conditions, updated in February 2023, showed that weekly skin assessments would be documented weekly using the Total Body Skin Evaluation or PCC [Point Click Care - facility's electronic documentation software] Skin & Wound - Total Body Skin Assessment. Review of the skin assessment for November 2024 in the electronic clinical records under the evaluations tab, showed Resident 73 had one skin evaluation dated 11/18/2024. There were no other skin evaluations done for November 2024. In an interview on 11/26/2024 at 11:35 AM, Staff K, Licensed Practical Nurse, stated that residents' skin check evaluations were part or the physician orders for them to appear in the treatment administration records. Joint review of Resident 73's physician orders showed a diabetic nail care scheduled for every Friday. Staff K stated that Resident 73 had a diabetic nail care on Friday, skin assessment should have been done on Fridays. In an interview on 11/26/2024 at 11:47 AM, Staff E, Resident Care Manager, stated that they expected skin checks/evaluations were done weekly, documented in the resident's electronic skin evaluation form, and that staff documented the resident's skin check refusal in the clinical record. A joint record review with Staff E showed Resident 73 had one skin evaluation done for November 2024 [on 11/18/2024]. Staff E stated that no other skin evaluations completed for Resident 73 before and/or after 11/18/2024. Staff E further stated that Resident 73 should have had skin evaluations completed weekly. On 11/26/2024 at 2:50 PM, Staff B, Director of Nursing Services, stated they expected residents had weekly skin evaluations completed, and that staff documented skin check refusals in the resident's clinical records. Reference: (WAC) 388-97-1060 (1)(3)(b)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48298 Based on observation, interview, and record review, the facility failed to ensure pressure ulcer/pressure injury (wound that occur due to prolonged pressure on the skin) was provided the necessary treatment and services consistent with professional standards of practice for 1 of 2 residents (Resident 61), reviewed for pressure ulcer care. This failure placed the resident at risk for deterioration of their pressure ulcer and a diminished quality of life. Findings included . Review of the facility undated policy titled, Wound Prevention and Management, showed, A resident with pressure ulcers will receive continued preventive interventions and necessary treatment and services to promote healing and prevent infection. Review of Resident 61's annual Minimum Data Set (an assessment tool) dated 11/07/2024, showed Resident 61 had an intact cognition. In an interview on 11/19/2024 at 9:41 AM, Resident 61 stated that they had pressure ulcer to their left buttock. When asked if they had received wound care to their left buttock, Resident 61 stated, No. It [wound care to their left buttock] should be done daily. Resident 61 further stated that they had wound care to their left buttock about two weeks ago [from today's date of interview]. Review of a wound care progress note dated 11/07/2024, showed Resident 61 had one stage 2 (shallow open wound) pressure ulcer to their left buttock. Review of Resident 61's physician's order dated 11/07/2024 showed a treatment to Resident 61's left buttock wound to . apply Medihoney [brand name-wound ointment made of honey] to the wound bed. Cover with bordered gauze. Change daily and as needed . every evening shift for open area. Review of Resident 61's November 2024 Medication Administration Record (MAR) dated 11/14/2024 showed wound treatment to left buttock wound, [apply] with NS [normal saline-type of water solution] pat dry, apply foam dressing, change daily in evening .every evening shift. Another interview on 11/20/2024 at 9:55 AM and on 11/21/2024 at 7:49 AM, Resident 61 stated that they did not receive wound care to their left buttock pressure ulcer the night of 11/19/2024 and 11/20/2024. A joint observation on 11/21/2024 at 9:08 AM with Staff R, Certified Nursing Assistant, showed Resident 61 had an uncovered left buttock wound. Further observation showed no wound dressing on Resident 61's left buttock pressure ulcer. A joint observation on 11/21/2024 at 9:56 AM with Staff E, RCM, and Staff M, RN, showed Resident 61 had no wound dressing to their left buttock pressure ulcer. Further joint observation showed Resident 61's left buttock had red-pink wound bed with shearing on the edges. Staff M then provided wound care and covered the wound to Resident 61's left buttock per physician's order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 11/21/2024 at 10:20 AM with Staff E and Staff M, showed Resident 61's November 2024 MAR had a daily wound care to their left buttock pressure ulcer scheduled for evening shift and PRN (as needed). When asked if they had provided PRN and other scheduled wound care to Resident 61's left buttock pressure ulcer on other days during the month of November 2024, Staff M stated, No. During a joint interview and joint record review on 11/21/2024 at 11:04 AM with Staff E and Staff W, stated that they were in the facility on 11/14/2024 and that they were not sure if they had seen or provided wound care to Resident 61's left buttock that day. Staff W was asked if they had provided wound care treatment to Resident 61's left buttock pressure injury at any time after 11/14/2024, Staff W responded, No. A joint record review of the November 2024 MAR dated 11/18/2024 and 11/19/2024, showed Resident 61's wound treatment order scheduled for evening shift was signed and initialed BB11. When asked, Staff W stated that BB11 was their initial/signature. Staff W stated that they did not provide the treatment to Resident 61's left buttock pressure ulcer on 11/18/2024 and on 11/19/2024. Staff W further stated that Staff M provided the treatment and I signed it [in the MAR]. Staff W was notified that Staff M clarified that they did not provide a wound treatment to Resident 61's left buttock pressure ulcer other than a PRN treatment dated 11/21/2024. Another joint record review and interview on 11/21/2024 at 11:27 AM, showed Resident 61's November 2024 MAR did not show Staff M provided treatment to Resident 61's left buttock pressure ulcer on 11/18/2024 and on 11/19/2024. Staff E stated they did not expect staff to sign the MAR if they did not provide the treatment themselves. A joint interview on 11/21/2024 at 1:15 PM with Staff C, Regional Director of Clinical Operations, and Staff B, Director of Nursing, stated that they expected staff to follow the doctor's order [wound treatment] and to follow the professional standard of practice. Staff B further stated that they did not expect the MAR to be signed by another person (staff) other than the person who administered the treatment. Reference: (WAC) 388-97-1060(3)(b)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure appropriate oxygen storage and use of respiratory equipment were maintained to include care of oxygen tubing and nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) in accordance with professional standards of practice for 2 of 3 residents (Residents 36 & 18), reviewed for respiratory care. This failure placed the residents at risk for respiratory infections and complications due to improper oxygen storage. Findings included . Review of the facility's policy titled, Oxygen Management, revised in August 2023, showed to place oxygen delivery device in plastic bag when not in use. OXYGEN TUBING/NASAL CANNULA CARE Review of the admission Minimum Data Set (MDS-an assessment tool), dated 10/22/2024, showed that Resident 36 admitted to the facility on [DATE]. It further showed that Resident 36 was on oxygen therapy. Observations on 11/18/2024 at 9:52 AM and on 11/20/2024 at 8:28 AM, showed Resident 36's oxygen tubing was not labeled. In an interview and joint observation on 11/20/2024 at 2:05 PM, Staff L, Registered Nurse, stated that when the nasal cannula was not in use it should be in a bag. Staff L stated that the oxygen tubing should be labeled. A joint observation showed that Resident 36's oxygen tubing was not labeled, and their nasal cannula was not in use and not properly stored. Staff L stated that the oxygen tubing should be labeled and the nasal cannula should be in a bag. In an interview on 11/22/2024 at 10:34 AM, Staff J, Resident Care Manager, stated that oxygen tubing, should be labeled. Staff J further stated that the nasal cannula should be put in a bag, so it doesn't get contaminated. In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated that they expected the oxygen tubing to be changed weekly and that the date should be on there. Staff B further stated that they expected the nasal cannula to be in a bag when it was not in use. PORTABLE OXYGEN TANK STORAGE Observations on 11/19/2024 at 8:25 AM, showed Resident 36's portable oxygen tank was not secured and was near the baseboard heater. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview and joint observation on 11/19/2024 at 9:48 AM, Staff DD, Licensed Practical Nurse (LPN), stated that if a resident was not using a portable oxygen tank it should be stored in the oxygen storage room. Staff DD stated that the portable oxygen needs to be secured. A joint observation of Resident 36's room showed the oxygen tank was not secured. Staff DD stated the [oxygen tank] should not be there and it's not secured and it's close to the heat, and it should not be. In an interview on 11/22/2024 at 10:34 AM, Staff J stated that portable oxygen tanks should not be free standing and should not be close to heaters. In an interview on 11/25/2024 at 2:16 PM, Staff B stated that they expected portable oxygen tanks to be stored in a carrier and should be secured. Staff B further stated that the portable oxygen tanks should be stored away from the heater. In an interview on 11/26/2024 at 9:41 AM, Staff A, Administrator, stated that they expected portable oxygen tanks to be stored properly, in the holder, secured. Staff A further stated that oxygen tanks should not be stored by a heater. 47218 RESIDENT 18 Resident 18 admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (ongoing lung condition caused by damage to the lungs) and respiratory disorder. The quarterly MDS dated [DATE] showed Resident 18 was cognitively intact. Observation on 11/18/2024 at 10:45 AM, showed Resident 18 had one oxygen tank laying on the floor on its side between Resident 18's wheelchair and the wall in their room. Resident 18 stated, I knocked it [the oxygen tank] down on accident last night [11/17/2024]. Another observation on 11/19/2024 at 9:39 AM, showed Resident 18's oxygen tank was laying on the floor on its side between their wheelchair and the wall. On 11/19/2024 at 11:30 AM, Resident 18 stated that their oxygen tank that was laying on the floor was removed from their room and taken to a storage room. On 11/20/2024 at 1:14 PM, Staff P, LPN, stated that Resident 18's oxygen tank should have not been laying on the floor. On 11/22/2024 at 11:38 AM, Staff B stated that oxygen tanks should be in upright position stored in the oxygen tank rack/cradle when not in use. Staff B further stated that Resident 18's oxygen tank should have not been laying on the floor. Reference: (WAC) 388-97-1060 (3)(j)(vi)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 46912 Based on interview and record review, the facility failed to provide the required Registered Nurse (RN) coverage for 1 of 31 days (10/08/2024), reviewed for staffing. This failure placed the residents at risk for inadequate assessments, delay in care services by an RN, unmet care needs, and a diminished quality of life. Findings included . Review of the facility's document titled, Daily Nursing Staffing Report, dated 10/08/2024 showed that no RN worked on 10/08/2024. In an interview on 11/21/2024 at 3:28 PM, Staff BB, Medical Records/Staffing Coordinator, stated, I assume there should be one [RN] every shift, every day of the week. Staff BB further stated that on 10/08/2024, there was no RN coverage for that that day and there should have been. In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated that they were unsure about the RN coverage requirement and will look into that. In an interview on 11/26/2024 at 2:32 PM, Staff A, Administrator, stated, that's the expectation, to have at least 8 hours [of RN coverage] a day. Reference: (WAC) 388-97-1080 (3)

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	505236	A. Building B. Wing	11/26/2024

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. 46912 Based on interview and record review, the facility failed to ensure the daily nurse staffing form was accurately completed for the number of staff worked and actual hours worked for 6 of 31 days, reviewed for posted nurse staffing information. The failure to post a complete and accurate form daily placed the residents, family members, and visitors, at risk of not being fully informed of the current staffing levels. Findings included . Review of the facility's policy titled, Daily Nurse Staffing Posting, revised in June 2024, showed that the Daily Nurse Staffing is completed at the beginning of each shift to post nurse-staffing data for the licensed and unlicensed staff directly responsible for resident care in the facility. It further showed that the Daily Nurse Staffing Posting will include the following .Enter the actual number and shift (including split shifts) of licensed and unlicensed nursing staff directly responsible for the care of residents for that particular day on each shift . post each shift staff number very close to the beginning of the shift in order to ensure that the posted numbers are actual staff working the shift .if any changes to the information posted are needed, they must be made as soon as possible. Review of the daily nurse staffing posting from 10/01/2024 to 10/31/2024, showed the following: - 10/09/2024 - showed an adjustment was made for the Certified Nursing Assistant (CNA) staffing total on day shift, no adjustment made for actual hours worked. - 10/13/2024 - showed no data in the columns for actual hours worked or staffing total for evening shift. - 10/14/2024 - showed an adjustment was made for the CNAs on day and evening shift, no adjustment made for actual hours worked. - 10/20/2024 - showed an adjustment was made for the CNAs on evening shift, no adjustment made for actual hours worked. - 10/30/2024 - showed an adjustment was made for the CNAs on night shift, no adjustment made for actual hours worked. - 10/31/2024 - showed an adjustment was made for the CNAs on evening shift, no adjustment made for actual hours worked. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 11/21/2024 at 2:46 PM, Staff BB, Medical Records/Staffing Coordinator, stated their process was to post the daily nurse staffing posting every morning. Staff BB stated, if there's a call out and [I am] unable to replace [staff], I don't adjust the hours worked on the staff posting. Staff BB stated, I will modify the staff posting the next day if there are changes. A joint record review of the daily nurse staffing posting for the dates 10/09/2024, 10/14/2024, 10/20/2024, 10/30/2024 and 10/31/2024, Staff BB stated, I didn't adjust the hours worked. Joint record review of the daily nurse staffing posting for 10/13/2024 showed no data for evening shift. Staff BB stated, It's blank and it shouldn't [should not] be. In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated that they expected the nurse staff posting to be updated by Staff BB in the mornings and if there's any changes, [Staff BB] should be making the changes. Staff B further stated if there were call offs then it should be adjusted on the nurse staff posting for the staffing total as well as the actual hours worked. In an interview on 11/26/2024 at 2:32 PM, Staff A, Administrator, stated they expected the daily nurse staffing posting to be updated as needed. Staff A further stated that Staff BB should update both the actual hours worked and the total staff as needed through the day. No associated WAC

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50891 Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 3 of 6 residents (Resident 77, 78 & 38), reviewed for unnecessary medications. The failure to monitor for adverse side effects for use of antibiotics (a medication to treat infections) and diuretics (a medication to move extra fluid out of the body) and follow insulin (medication/hormone that regulates blood sugar levels) parameters placed the residents at risk for unmet care needs, adverse side effects, and related complications. Findings included . Review of the facility's policy titled, Medication Administration, updated in October 2022, showed that the licensed nurse would check the following prior to administering the medication: right medication, right dose, right dosage form, right route, right resident, and right time. The policy further showed that the nurse would read the Medication Administration Record (MAR) for the ordered medication, dose, dose form, route, and time; verify correct medication, expiration date, dose, dosage form, route, and time again by comparing MAR before administering; and would document administration of medication in the MAR as soon as medications were given. Review of the facility's policy titled, Insulin Injection, revised on 12/22/2022, showed that administration of insulin should be documented on the Medication Administration Record (MAR). The policy further showed that staff would document pertinent information including assessments, observations, and interventions in the progress notes. RESIDENT 77 A review of the November 2024 MAR showed Resident 77 had an order for Vancomycin (an antibiotic) 125 milligrams (a unit of measurement) 1 capsule by mouth every six hours for 10 days. The MAR did not show any type of monitoring for adverse side effects (ASE) related to use of this antibiotic. A joint record review and interview on 11/26/2024 at 10:24 AM with Staff W, Licensed Practical Nurse (LPN), did not show ASE monitoring for antibiotics in Resident 77's November 2024 MAR. Staff W stated that they monitored ASE for antibiotics by placing them on alert charting for three days. A joint record review and interview on 11/26/2024 at 11:14 AM with Staff F, Resident Care Manager (RCM), showed Resident 77's November 2024 MAR did not show ASE for antibiotic use was monitored. Staff F stated that when residents started antibiotics, they were placed on alert charting for three days. Staff F further stated that ASE should be monitored on the MAR while on antibiotics. In an interview on 11/26/2024 at 1:24 PM, Staff B, Director of Nursing Services, stated that if the antibiotic order included instructions to monitor for ASE, then they would include it in the MAR. 46912 RESIDENT 78 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician progress note dated 11/01/2024, showed Resident 78 was on torsemide (a diuretic) for edema (swelling). Review of the November 2024 MAR showed Resident 78 was on torsemide for edema. In an interview and joint record review on 11/22/2024 at 9:45 AM, Staff W stated that typically there's an order to monitor residents that were taking a diuretic for edema, laboratory, and maybe intake and output. A joint record review of Resident 78's physician orders showed Resident 78 was on a diuretic for edema. Staff W stated I don't see any orders for monitoring Resident 78's diuretic use. In an interview and joint record review on 11/22/2024 at 10:20 AM, Staff J, RCM, stated that they expected there to be an order for monitoring edema, shortness of breath, weights, if a resident was on a diuretic. A joint record review of Resident 78's physician orders showed an order for diuretic monitoring with start date 11/22/2024, Staff J stated, I just put in [an order for monitoring], just got started today, I'm going to get a weight on her. In an interview and joint record review on 11/25/2024 at 2:16 PM, Staff B stated they expected an order to monitor for edema if a resident was taking a diuretic for edema. In a joint record review of Resident 78's physician orders, showed that there had been no monitoring for Resident 78's diuretic use and Staff B stated it was added starting 11/23/2024. Staff B further stated that there should have been monitoring before 11/23/2024. 48298 RESIDENT 38 Resident 38 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a medical condition that affects blood sugar levels in the body). Review of Resident 38's November 2024 MAR showed, Novolog [a brand name of insulin] Injection .Inject 5 [five] units [unit of measurement] subcutaneously [under the skin] with meals . hold for cbg [capillary blood glucose-concentration of blood sugar in the body] < [less than] 100 [mg/dl (milligram per deciliter-a unit of measurement)]. Review of Resident 38's blood sugar level taken on 11/04/2024 at 5:48 PM, showed Resident 38 had a blood sugar level of 99 mg/dl. Review of Resident 38's November 2024 MAR showed Resident 38 was administered with five units of Novolog on 11/04/2024 at 6:11 PM. In an interview on 11/25/2024 at 2:14 PM, Staff K, LPN, stated that they followed the prescribed parameters when giving insulin to residents. Staff K stated that they would hold insulin if a resident's blood sugar level was below the prescribed parameters, let the provider know and watch for hypoglycemia (a condition when the blood sugar level drops below the specified limit). (continued on next page)

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	505236	A. Building B. Wing	11/26/2024

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A joint record review and interview on 11/25/2024 at 2:21 PM with Staff F, showed Resident 38 had a physician order for Novolog injection of five units and to hold [insulin] if cbg was < 100. A joint record review of Resident 38's blood sugar taken on 11/04/2024 at 5:48 PM, showed Resident 38 had a blood sugar level of 99 mg/dl. A joint record review of Resident 38's November 2024 MAR showed Resident 38 was administered with five units of Novolog on 11/04/2024 at 6:11 PM. Staff F stated that staff should have not administered the insulin. In an interview on 11/26/2024 at 11:24 AM, Staff B stated that staff should have followed the prescribed parameters and not have administered the insulin. Reference: (WAC) 388-97-1060 (3)(k)(i)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 47218 Based on interview and record review, the facility failed to ensure residents received the ordered medication dosage for residents receiving psychotropic medications (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) for 1 of 5 residents (Residents 50), reviewed for unnecessary medications. This failure placed the resident at risk for receiving unnecessary medications, adverse side effects, and a diminished quality of life. Findings included . Review of the facility's policy titled, Physician Orders, revised on 02/24/2024, showed that discontinue the original physician's order when the physician changes an order that is currently in place and ensure the new order is in place and reflects the change. Confirm accuracy of orders by leaving new or changed orders in the queue for a second licensed to verify; the second nurse would review transcription errors and errors of omission. Review of the facility's policy titled, Medication Administration, updated in October 2022, showed that the licensed nurse would check the following prior to administering the medication: right medication, right dose, right dosage form, right route, right resident, and right time. The policy further showed that the nurse would read the Medication Administration Record (MAR) for the ordered medication, dose, dose form, route, and time; verify correct medication, expiration date, dose, dosage form, route, and time again by comparing MAR before administering; and would document administration of medication in the MAR as soon as medications were given. RESIDENT 50 Review of the August 2024 medication regimen review showed the pharmacist recommended for facility to discontinue one of the duplicate trazodone (an antidepressant medication) orders for Resident 50. Review of the August 2024 Medication Administration Record (MAR) showed Resident 50 received two doses a day for Trazodone 50 mg at bedtime from 08/08/2024 to 08/15/2024 for a total of 8 days. A joint record review and interview on 11/26/2024 at 11:26 AM with Staff E, Resident Care Manager, showed Resident 50's August 2024 MAR had two orders that read Trazadone 50 mg tablet at HS [bedtime] and that Resident 50 received two doses a day of Trazodone 50 mg for a total of 100 mg per day from 08/08/2024 to 08/15/2024. Staff E stated that Resident 50 should have had one order of Trazodone 50 mg and not two. In a joint record review and interview on 11/26/2024 at 2:35 PM with Staff B, Director of Nursing Services, showed Resident 50's was administered Trazodone 50mg twice a day from 08/08/2024 to 08/15/2024 when the order was for one time a day at bedtime. Staff B stated that one of the trazodone orders should have been discontinued before the other one was started. Reference: (WAC) 388-97-1060(3)(k)(i) (continued on next page)

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	505236	A. Building B. Wing	11/26/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47218 Based on observation, interview, and record review, the facility failed to appropriately label and store drugs and/or biologicals (diverse group of medicines made from natural sources) for 1 of 2 refrigerators (East Medication Room Refrigerator), reviewed for medication storage. This failure placed the residents at risk for receiving compromised and ineffective medications. Findings included . Review of the facility's provided document titled, Omnicare Medication Storage Guidance, dated 2022, showed that tuberculin (purified protein derivative, is a combination of proteins that are used in the diagnosis of tuberculosis [a serious illness caused by a type of bacteria that mainly affects the lungs]) vials should be dated when opened and discarded after 30 days. In a joint observation and interview on 11/20/2024 at 3:34 PM with Staff O, Licensed Practical Nurse, showed the refrigerator in the East Medication Room had one opened and undated multi-dose vial of tuberculin. Staff O stated that the tuberculin vial should have been dated when it was first opened. In an interview on 11/21/2024 at 2:24 PM, Staff J, Resident Care Manager, stated that tuberculin vials are good for 28 days after they were opened and expected multi-dose vials were dated and initialed when they were first opened. Staff J further stated that the tuberculin vial should have been dated when it was first opened. On 11/22/2024 at 11:56 AM, Staff B, Director of Nursing Services, stated that tuberculin vials were good for 30 days after they were opened, and that the tuberculin vial in the East Medication Room refrigerator should have been dated when it was first opened. Reference: (WAC) 388-97-1300 (2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48298 Based on observation, interview, and record review, the facility failed to ensure food items were dated and discarded in accordance with professional standards for food safety for 1 of 2 unit refrigerators (West Nursing Station Unit Refrigerator and failed to ensure refrigerators' temperature were maintained for 2 of 2 unit refrigerators (West Nursing Station and East Nursing Station Refrigerators), reviewed for food services. In addition, the facility failed to ensure the dishwasher chemical solution was tested routinely in the Kitchen's dishwasher. These failures placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages) and a diminished quality of life. Findings included . Review of the facility policy titled, Preventing Foodborne Illness, revised in December 2022, showed that food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. The policy further showed that Functioning of the refrigeration and food temperatures will be monitored .Federal standards require that refrigerated food be stored below 41 [degrees Fahrenheit] . Review of facility policy titled, Dish Machine Temperature Log, revised in November 2022 showed, The center promotes the use of the Dish Machine Temperature Log for high temperature and low temperatures to provide record of dish machine temperatures and chemical sanitation (parts per million) taken at each meal prior to dishwashing. The policy further showed to document chemical saturation level using appropriate litmus paper required for low temperature/chemical sanitizing dish machines. WEST NURSING STATION UNIT REFRIGERATOR Observation on 11/20/2024 at 8:12 AM, showed a double-door refrigerator with a separate freezer and a refrigeration compartment. The refrigeration compartment showed a covered cup of cottage cheese without a label/date and a covered cup of vanilla pudding dated 11/17[2024]. Further observation showed the refrigeration compartment had a thermometer that read 48 degrees Fahrenheit (F). Interview and a joint observation on 11/20/2024 at 8:26 AM with Staff F, Resident Care Manager, stated that the unit refrigerator was for residents' food. Staff F stated that residents' food must be labeled with their name and dated. Staff F stated that food inside the unit refrigerator could be kept for three days then it had to be discarded. A joint observation with Staff F, showed an undated covered cup of cottage cheese and a covered cup of vanilla pudding dated 11/17/2024. Staff F stated that the covered cup of cottage cheese should have been dated. Staff F further stated that the cup of vanilla pudding should have been discarded because it's [it has] been more than three days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation and interview on 11/20/2024 at 9:03 AM, showed the thermometer read 58 degrees F. Staff M, Registered Nurse, stated, the kitchen staff [had] just cleaned the refrigerator about five minutes ago and it was opened. At 9:13 AM, another joint observation with Staff M showed the thermometer read 54 degrees F. Staff M stated, five minutes ago the kitchen staff cleaned the refrigerator. Staff B, Director of Nursing Services and Staff C, Regional Nurse Consultant were both at the nursing station and saw the refrigerator thermometer reading of 54 degrees F. Staff B stated, this [thermometer] is not working. I will tell maintenance. EAST NURSING STATION UNIT REFRIGERATOR A joint observation and interview on 11/20/2024 at 8:47 AM with Staff B, showed a double-door refrigerator with a separate freezer and a refrigeration compartment that had a thermometer that read 48 degrees F. Staff B stated, I expect it to be 41 [degrees F] and not lower than 36 [degrees F]. I will call maintenance. On 11/26/2024 at 11:24 AM, Staff B stated that food in the refrigerator must be labeled/dated and discarded after 72 hours. Staff B further stated that the refrigerator thermometers must be in working condition and that appropriate temperature must be maintained to keep food safe. On 11/26/2024 at 3:36 PM, Staff A, Administrator, stated that they expected refrigerators' temperatures were within normal range and the thermometers were functioning properly. DISHWASHER CHEMICAL TESTING Observation and interview on 11/22/2024 at 9:43 AM with Staff Y, Dietary Manager, showed dishwashing temperature at 124 degrees Fahrenheit. Staff Y stated that they had low-temperature dishwasher and uses chemical solution to sanitize. Another interview on 11/22/2024 at 12:15 PM, Staff Y stated, Ecolab (a company that specializes in treatment, purification, cleaning and hygiene of water in a wide variety of applications) comes here once a month and they are the one that tests the dishwasher. When asked if they were performing chemical test themselves to monitor chemical sanitation, Staff Y stated, I did not know we have to do that. In an interview on 11/26/2024 at 11:43 AM, Staff A, stated, we actually have not done any chemical test, and we just learned it from you. Staff A stated that they bought test strips and started testing this morning. Staff A further stated that they were not following the process of testing the chemicals used for dishwashing. Reference: (WAC)388-97-1100(3)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 46912 Based on interview and record review, the facility failed to ensure the facility assessment (document describing resident population and needs to determine staff and other resources necessary to competently care for residents) was updated to accurately determine and identify the resources needed for the facility's resident care needs. This failure placed the residents at risk for unmet care needs. Findings included . Review of the facility assessment, updated on 05/22/2024, showed the assessment did not address or consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. In an interview on 11/26/2024 at 9:41 AM, Staff A, Administrator, stated that they updated the facility assessment once a year, it's a work in progress and if there were changes, I would update it. When asked where in the facility assessment was it documented that the facility considered specific staffing needs for each unit and each shift (day, evening, night and weekends), Staff A stated, I don't [do not] think it is in there. In a follow up interview at 2:32 PM, Staff A stated, it will be something that we bring up with corporate to see if they want to add the staffing info [information] into the facility assessment. No associated WAC

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on observation, interview, and record review, the facility failed to ensure the facility's water management program included a written description and a flow diagram that assessed the potential growth of Legionella (a water-borne bacteria that can cause pneumonia [a lung infection]) or other waterborne pathogens (an organism that can cause disease), failed to ensure appropriate catheter (a semi-flexible tube inserted into the bladder to drain urine) care was followed for Resident 36, and failed to ensure hand hygiene was performed during dining services for Resident 9, reviewed for infection control. In addition, the facility failed to ensure proper use of gloves and/or gown were followed for 2 of 5 residents (Residents 61 & 76) who were on Enhanced Barrier Precautions (EBP- precaution to protect residents from Multidrug-Resistant Organism [MDRO-a germ that is resistant to medications that treat infections]), and failed to ensure sharp containers were replaced when full for 1 of 2 shower rooms (Southeast Shower Room). These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included . WATER MANAGEMENT PROGRAM Review of the CDC online toolkit titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings, Version 1.1, dated 06/24/2021, showed that there are seven elements of a Water Management Program, which includes to describe the building water systems using text and flow diagrams. It further showed, In addition to developing a written description of your building water systems, you should develop a process flow diagram and Once you have developed your process flow diagram, identify where potentially hazardous conditions could occur in your building water systems. Review of the facility's policy titled, Legionella Water Management Program, revised in July 2017, showed that the water management program includes the following elements .a detailed description and diagram of the water system in the facility and the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria. In an interview on 11/20/2024 at 9:51 AM with Staff H, Maintenance Director, when asked if there was written description of the building that identified areas where waterborne bacteria could grow, Staff H stated, not that I know of. Staff H further stated that there was no diagram of the facility's water system that showed potential risk areas where waterborne bacteria could grow. In an interview on 11/26/2024 at 9:41 AM, Staff A, Administrator, stated that Staff H oversaw the water management program and that they were doing monthly water testing. When asked if there was a written description and a diagram of the facility's water system that showed areas where Legionella and waterborne bacteria could grow, Staff A stated, not since I've [I have] been here. Not that I know of. CATHETER CARE RESIDENT 36 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission minimum data set (an assessment tool) dated 10/22/2024, showed Resident 36 had an indwelling catheter. Observations on 11/18/2024 at 9:52 AM, on 11/19/2024 at 1:23 PM, and on 11/20/2024 at 12:48 PM, showed Resident 36's catheter tubing on the floor. In an interview and joint observation on 11/20/2024 at 2:05 PM, Staff L, Registered Nurse (RN), stated that catheter tubing should absolutely not be on the floor. A joint observation showed that Resident 36's catheter tubing was on the floor. Staff L stated, it should not be like that. In an interview on 11/22/2024 at 10:34 AM, Staff J, Resident Care Manager (RCM), stated that they expected catheter to be off the floor. In an interview on 11/25/2024 at 11:49 AM, Staff D, Infection Preventionist, stated that the catheter bag and tubing should not be on the floor. In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated that they expected catheter to not be on the floor. 48298 DINING OBSERVATION RESIDENT 9 Observation on 11/18/2024 at 11:52 AM, showed Staff T, Certified Nursing Assistant (CNA), was providing meals to Resident 9 in the dining room. Staff T had a surgical mask on and was seen touching their facemask. Staff T did not perform hand hygiene and continued to assist Resident 9 with their meals. There were three occurrences that Staff T touched their facemask and did not perform hand hygiene while providing meals to Resident 9. In an interview on 11/18/2024 at 12:04 PM, Staff T stated they performed hand hygiene before setting up meal trays for the residents in the dining room. When asked if they need to perform hand hygiene after they had touched their facemask before assisting the resident with their meals, Staff T stated, yes, you need to wash your hands after touching your face or hair or mask. When asked if they were aware that they touched their facemask while providing meals to Resident 9, Staff T stated, I should have sanitized my hands after I touched my mask. ENHANCED BARRIER PRECAUTIONS RESIDENT 61 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 11/21/2024 at 9:05 AM, showed Staff R, CNA, donned a disposable gown, a pair of gloves and entered Resident 61's room (an EBP room). Staff R placed a transparent plastic bag underneath Resident 61's ileostomy bag (a plastic pouch that collects stool when someone has an ileostomy [a surgical procedure that involves creating an opening in the abdomen to connect the last portion of the small intestine to the outside of the body] and drained contents (liquid stools) into the transparent plastic bag. Staff R then removed their gloves, placed the gloves in the trash bin and donned a new pair of gloves. Staff R removed the transparent plastic bag from underneath Resident 61's ileostomy bag, then Staff R removed their gloves and donned a new pair of gloves. Staff R did not perform hand hygiene. Staff R then twisted and tied the top portion of the transparent plastic bag and placed it in the trash bin. Staff R then removed their gloves and donned a new pair of gloves. Staff R did not perform hand hygiene after removing their soiled gloves in between tasks. Staff R proceeded to assist in repositioning Resident 61 in bed. In an interview on 11/21/2024 at 9:16 AM, Staff R stated that hand hygiene should be performed before and after glove use. When asked if they need to perform hand hygiene between glove use, Staff R stated, I made sure that I don't [do not] touch the side of my hand. When asked how they can be sure that their hands were not contaminated with bodily wastes, Staff R stated, It was an oversight on my part. I usually used these [showing two containers of hand sanitizers]in my pocket. Staff R further stated that they should have performed hand hygiene in between glove use. In an interview on 11/21/2024 at 2:42 PM, Staff E, RCM, stated that they expected staff to perform hand hygiene before, after, and between glove use when providing care to the residents. In a follow up interview on 11/25/2024 at 2:43 PM, Staff E stated that they expected staff to perform hand hygiene after they touched their face or hair when handling foods or assisting residents with their meals. In an interview on 11/26/2024 at 10:55 AM, Staff B stated that they expected staff to perform hand hygiene before, after and between glove use and to follow hand hygiene protocols as required. 47218 RESIDENT 76 Review of the undated facility provided signage titled, Enhanced Barrier Precautions, showed that providers and staff must wear gloves and a gown for high contact resident care activities that included feeding tube care or use. Resident 76 admitted to the facility on [DATE] with diagnosis that included dysphagia (difficulty with swallowing) and had a feeding tube (flexible tube that provides nutrients directly into the stomach). Observation on 11/21/2024 at 11:21 AM, showed an EBP signage outside Resident 76's room. Further observation showed Staff M, RN, was entering Resident 76's room with their medications without wearing gloves and/or gown. Staff M wore gloves while they gave Resident 76 their medications via their feeding tube. Staff M did not wear a gown prior to giving Resident 76's medications via their feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Joint observation and interview on 11/21/2024 at 11:30 AM with Staff M showed an EBP signage outside Resident 76's room that showed staff must wear gown and gloves before entering the room prior to providing feeding tube care. Staff M stated they did not wear a gown prior to providing Resident 76's their medications via feeding tube and that they should have. On 11/25/2024 at 9:31 AM, Staff D stated that EBP precautions were in place for residents who had a feeding tube and that they expected staff wore gowns and gloves prior to providing medication via feeding tube. Staff D further stated that Staff M should have worn gown and gloves prior to providing Resident 76's medications via feeding tube. On 11/25/2024 at 10:00 AM, Staff B stated that they expected staff to read and follow the EBP signage directions. Staff B further stated that Staff M should have worn gown and gloves before providing Resident 76's medications via feeding tube. SHARPS CONTAINER IN THE SOUTHEAST SHOWER ROOM Review of the undated facility's policy titled, Sharps Handling and Disposal, showed that to provide safe handling and disposal of sharps safely to reduce the risk of healthcare acquired infections, staff would collect sharps container before the contents go over the fill line (3/4 full) and close lid firmly. Observation on 11/21/2024 at 11:24 AM, showed the Southeast shower room had a sharp container in it that was filled past the full line and had three used razors sticking out. On 11/21/2024 at 1:35 PM, Staff L stated that sharp containers should be replaced after reaching the full line. Joint observation and interview on 11/21/2024 at 1:40 PM with Staff J showed the Southeast shower room had a sharp container that had sharp items past the full line with three used razors sticking out. Staff J stated that they expected sharp containers were replaced once they reached full line. On 11/26/2024 at 8:47 AM, Staff D stated that they did not expect staff to place sharp items in the sharp's container past the full line. Staff D further stated that the sharp container from the Southeast shower room should have been replaced when the sharps reached the full line. On 11/26/2024 at 9:40 AM, Staff B stated they expected sharp containers were replaced when they reached the full line and did not expect sharp items to be forced in. Reference: (WAC) 388-97-1320 (1)(a)(c)

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	505236	A. Building B. Wing	11/26/2024

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

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 46912 Based on interview and record review, the facility failed to designate a qualified staff person to serve as an Infection Preventionist (IP) to oversee the facility's infection prevention and control program. This failure placed the residents, staff, and visitors at risk for unmet infection control issues and lack of oversite of infection control practices. Findings included . Review of the facility's policy titled, Infection Preventionist, revised in September 2022, showed that the infection preventionist has obtained specialized IPC [Infection Prevention and Control] training beyond initial professional training or education prior to assuming the role and evidence of training is provided through a certificate of completion. It further stated that the infection preventionist is employed on site and at least part time. In an interview on 11/25/2024 at 11:49 AM, Staff D, Infection Preventionist, stated that they had not competed the test for their specialized training in infection prevention and control, so [I am] not certified yet. Staff D stated that there was a corporate infection preventionist that comes to the facility on ce or twice a month and who was available on the phone for guidance. In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated that Staff D was responsible for the facility's infection prevention and control program. Staff B stated that Staff D was not certified and that they had a corporate IP that was certified. When asked how often the corporate IP was in the building, Staff B stated, depends on the needs of the facility. In an interview on 11/26/2024 at 9:41 AM, Staff A, Administrator, stated that Staff D was responsible for the facility's infection prevention and control program and was not certified at this time. Staff A stated that Staff D worked closely with the corporate IP and that they come once a month to the facility and could contact them by phone. No associated WAC .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure residents and/or their representatives were provided information about the influenza vaccine (used to prevent influenza [an infection of the nose, throat, and lungs]), including risks, benefits, potential side effects, documented if the vaccine was accepted and/or refused in the medical record, and as to why the vaccine was refused for 2 of 5 residents (Residents 22 and 78), reviewed for immunizations and infection control. This failure placed the residents at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from influenza disease and denied the residents and/or their representative of the right to make informed decisions. Findings included . Review of the facility's policy titled, Vaccination of Residents, revised in October 2019, showed that all residents will be offered vaccines that aid in preventing infectious disease unless the vaccine is medically contraindicated, or the resident has already been vaccinated. It showed, prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations and provision of such education shall be documented in the resident's medical record. It further showed that if vaccines are refused, the refusal shall be documented in the resident's medical record. RESIDENT 22 Review of the admission record showed Resident 22 admitted to the facility on [DATE]. Review of the Electronic Health Record (EHR) showed no documentation that Resident 22 was offered the current influenza vaccine or was informed about the risks and benefits. In an interview on 11/22/2024 at 10:14 AM, Staff D, Infection Preventionist, stated that Resident 22 had been offered the influenza vaccine this year, but [Resident 22] refused. Staff D further stated that there was no documentation of refusal or that risks and benefits were given to Resident 22 and I should have documented that. In a follow-up interview on 11/25/2024 at 3:01 PM, Staff D stated that the influenza vaccine was available in the facility the week of 10/1 [10/01/2024]. RESIDENT 78 Review of Resident 78's admission record showed Resident 78 admitted to the facility on [DATE]. Review of the EHR showed no documentation that Resident 78 was offered the current influenza vaccine. In an interview on 11/26/2024 at 12:49 PM, Staff D stated that there is no documentation the flu [influenza] vaccine was offered to [Resident 78] when it was available and we missed it. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing Services, stated that they expected everyone who does not have a contraindication to be offered the influenza vaccine when it was available. Staff B further stated that they expected there to be documentation that a resident was offered the influenza vaccine, if they accepted or refused, and that they were provided risks and benefits of the influenza vaccine. Reference: (WAC)388-97-1340 (1)(2)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46912 Based on interview and record review, the facility failed to ensure residents and/or their representative were provided information about COVID-19 (an infectious disease-causing respiratory illness) vaccinations, including risks, benefits, potential side effects, documented if the vaccine was accepted and/or refused in the medical record, and as to why the vaccine was refused for 2 of 5 residents (Residents 22 and 78), reviewed for COVID-19 immunizations. This failure placed the residents at risk for a COVID-19 infection and denied the residents and/or their representative of the right to make informed decisions. Findings included . Review of the Centers for Disease Control and Prevention online document titled, Staying Up to Date with COVID-19 Vaccines, dated 10/03/2024, showed that everyone ages 6 months and older should get a 2024-2025 COVID-19 vaccine. It showed that for people ages 12-[AGE] years are up to date when they have received one dose of the 2024-2025 COVID-19 vaccine. It further showed that for people ages [AGE] years and older are up to date when they have received two doses of any 2024-2025 COVID-19 vaccine 6 months apart. Review of the facility's policy titled, COVID-19 Vaccination P&P, revised in June 2023, showed, this facility follows current guidelines and recommendations to prevent transmission of [COVID-19] by ensuring staff and residents are educated about, offered, and provided COVID-19 vaccines. It further showed that the facility must maintain the following information, at a minimum that supports .residents and/or POA [Power of Attorney] were provided education regarding the risks and benefits associated with COVID-19 vaccines and that residents were offered a COVID-19 vaccine. RESIDENT 22 Review of Resident 22's admission record, printed on 11/22/2024, showed Resident 22 admitted to the facility on [DATE]. Review of the Electronic Health Record (EHR) showed no documentation that Resident 22 had been offered, had accepted or refused, and been provided education about the 2024-2025 COVID-19 vaccine. In an interview on 11/22/2024 at 10:14 AM, Staff D, Infection Preventionist, stated that Resident 22 had been offered the 2024-2025 COVID-19 vaccine and had refused. Staff D stated that there was no documentation of Resident 22's refusal or that they had been provided education about the risks and benefits of the COVID-19 vaccine. RESIDENT 78 Review of Resident 78's admission record, printed on 11/25/2024, showed Resident 78 admitted to the facility on [DATE]. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 78's EHR showed no documentation that Resident 78 had been offered, had accepted or refused, or been provided education about the 2024-2025 COVID-19 vaccine. In an interview on 11/25/2024 at 11:49 AM, Staff D stated that the COVID-19 vaccine was offered to residents when a new vaccine was available. Staff D stated that there should be documentation that a resident was offered the COVID-19 vaccine and was provided education about the risks and benefits. In a follow up interview on 11/26/2024 at 12:49 PM, Staff D stated that there was no documentation that the 2024-2025 COVID-19 vaccine was offered to Resident 78 when it was available. Staff D stated that the 2024-2025 vaccine COVID-19 vaccine was available in October 2024. Staff D further stated that for Resident 78, we missed it. In an interview on 11/25/2024 at 2:16 PM, Staff B, Director of Nursing, stated that they expected everyone who does not have a contraindication, to be offered the COVID-19 vaccine. Staff B further stated that they expected there to be documentation that the COVID-19 vaccine was offered, accepted or refused, and that they were provided education about the risks and benefits of the COVID-19 vaccine. No reference WAC