STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505262	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Health and Rehabilitation	2818 Northeast 145th Street Seattle, WA 98155

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities for 3 of 4 residents (Residents 8, 55 & 71), reviewed for activities. This failure placed the residents at risk for dissatisfaction with their activity choices, poor psychosocial well-being, and boredom.Findings included . Review of the facility's policy titled, Activities Programming, revised in April 2025 showed, it is the policy of this facility to ensure that activities are available to meet resident needs and interests that support the physical, mental, and psychosocial well-being of the resident. The policy further showed that activities were intended to enhance [residents'] well-being and to promote or enhance physical, cognitive, and emotional health. RESIDENT 8Review of a face sheet printed on 03/23/2026 showed Resident 8 admitted to the facility on [DATE] with diagnoses that included walking difficulty and need for assistance with personal care. Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 02/20/2026 showed that Resident 8 was mildly impaired with cognition. The assessment showed it was somewhat important for Resident 8 to do things with groups of people and to do their favorite activities. Further review of the assessment showed that Resident 8 required substantial/maximal assistant (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with transfers and dressing. Review of Resident 8's comprehensive care plan printed on 03/23/2026 showed, Invite to and encourage activities with a low stimulation environment when available. [Resident 8] has an updated activity calendar in [their] room. On 03/18/2026 at 10:49 AM, Resident 8 was in bed and expressed a desire to participate in activities, stating they were not offered to them. Observation showed an activity program was concurrently in progress in the second-floor dining room. Observation on 03/19/2026 at 9:58 AM showed that Staff F, Activity Director, was inviting residents to the activity program scheduled at 10:00 AM. Further observation showed Resident 8 was in bed and stated they were not offered a chance to participate in the activity. Observation on 03/20/2026 at 10:11 AM, showed there was an exercise activity going on in the second-floor dining room. There were few residents participating but Resident 8 was not attending the exercise program. (continued on next page)

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

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/20/2026 at 10:18 AM showed Resident 8 was resting in bed wearing their nightgown with their television off. Resident 8 stated that their TV remote was missing, requiring them to ask staff for assistance whenever they wanted to watch TV. Further observation of Resident 8's bedside table, nightstand and nightstand drawer showed there was no TV remote. Additionally, no activity calendar was posted in the resident's room. Review of the January 2026 documentation survey report showed one recorded activity for Resident 8, with no documentation of activity refusals during that month. Review of the February 2026 documentation survey report showed six recorded activities for Resident 8, with no documentation of activity refusals during that month. Review of the March 2026 documentation survey report showed six recorded activities for Resident 8, with no documentation of activity refusals during that month. RESIDENT 55Review of a face sheet printed on 03/20/2026 showed Resident 55 was admitted to the facility on [DATE] with diagnoses that included difficulty walking and need for assistance with personal care. Review of the quarterly MDS dated [DATE] showed that Resident 55 was mildly impaired with cognition. Further review of the assessment showed Resident 55 was dependent on staff with transfers and dressing. Review the quarterly activity evaluation dated 01/07/2026 showed, Activities will continue to meet with [Resident 55] on regular basis to ensure that [their] activity needs are being met. [Resident 55] has an updated activity calendar in [their] room. On 03/18/2026 at 12:30 PM, Resident 55 was in bed and expressed a desire to participate in activities, stating they were not offered to them. Observations on 03/19/2026 at 2:01 PM showed an activity program was underway in the second-floor dining room, however, Resident 55 was in bed with their nightgown on. Further observations on 03/20/2026 at 10:29 AM, on 03/21/2026 at 10:24 AM, and on 03/23/2026 at 9:12 AM showed Resident 55 was in bed with their nightgown on. Review of the January 2026 documentation survey report showed one recorded activity for Resident 55, with no documentation of activity refusals during that month. Review of the February 2026 documentation survey report showed no recorded activities for Resident 55, with no documentation of activity refusals during that month. Review of the March 2026 documentation survey report showed one recorded activity for Resident 55, with no documentation of activity refusals during that month. In an interview on 03/21/2026 at 12:44 PM, Staff R, Restorative Nurse Assistant, stated that Resident 8 and Resident 55 required one to two staff assistance for transfers and dressing. Staff R stated that the facility's activity calendar would be posted in each resident's room to offer and prepare them for upcoming activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint observation on 03/21/2026 at 2:23 PM, Staff F stated that the facility's monthly calendars were posted in each resident's room. Staff F stated that certified nursing assistants would get ready residents for activities, and once a resident was dressed and ready, the activity personnel would transport them to the activity room. A joint observation of Resident 8's room showed no activity calendar was posted in the room. Staff F stated they would post the calendar. In an interview on 03/23/2026 at 9:42 AM, Staff F stated that any resident refusal of an activity would be documented in their medical record. In an interview on 03/23/2026 at 1:52 PM, Staff A, Administrator, stated that activity staff were expected to follow each resident's care plan, provide scheduled activities, and document participation. Staff A further stated that they expected activity staff to follow the facility's activity policies and regulatory requirements. RESIDENT 71 Review of a face sheet printed on 03/20/2026 showed Resident 71 was admitted to the facility on [DATE]. Review of the admission activity evaluation dated 02/04/2026 showed Resident 71 enjoys listening to classical music. Review of Resident 71's activity care plan dated 02/09/2026 showed, It is very/somewhat important to [Resident 71] to listen to music.Offer a personal stereo. In an interview on 03/19/2026 at 9:44 AM, Resident 71 stated that they did not remember if they were offered or provided activities by staff. Multiple observations on 03/20/2026 at 8:43 AM, at 2:50 PM and on 03/21/2026 at 8:21 AM, showed that Resident 71 was awake, lying in bed and did not have a personal stereo in their room. An observation and interview on 03/21/2026 at 8:29 AM showed Staff F was distributing reading materials to residents. When asked how they determine residents' activity preference, Staff F stated that they would complete an activity evaluation upon admission of the resident and that they offered/provided activities based on residents' interests. When asked about Resident 71's activity preference and their care plan, Staff F stated that Resident 71 liked music and that we should offer a portable [personal] stereo. Staff F stated that Resident 71 had no personal stereo in their room. A follow-up observation on 03/21/2026 at 8:51 AM showed Staff F brought a portable stereo to Resident 71. Resident 71 was heard asking Staff F, What is it for? Staff F stated that they brought the portable stereo so that Resident 71 could listen to music. Another observation and interview on 03/22/2026 at 8:35 AM showed a portable stereo on Resident 71's bedside table. Resident 71 stated, It was not plugged [in]. And last night it (portable stereo) was over there (pointed to where their wheelchair was located, about four feet away from Resident 71's bed). What's the use of it? I can't even reach it. Would love to listen to music. Further observation showed the portable stereo was not plugged into the electrical outlet. In an interview and a joint observation on 03/22/2026 at 8:51 AM, Staff Q, Activity Assistant, stated (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that they were made aware of Resident 71 having a portable stereo. A joint observation with Staff Q showed Resident 71's portable stereo was not plugged into the electrical outlet. Staff Q proceeded to plug the portable stereo into the wall outlet. Resident 71 was heard telling Staff Q that they have told maintenance that the radio may need an adapter to work. In an interview on 03/23/2026 at 3:07 PM, Staff A stated that they were overseeing implementation of activities for residents and that they expected staff to provide residents their preferred activities. Staff A further stated, I expect staff to meet their [residents'] needs related to their [interests] or activity. Reference: (WAC) 388-97-0940(1)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food stored were handled appropriately in accordance with professional standards of food safety for 1 of 1 kitchen refrigerator (Kitchen Walk-in refrigerator) and 1 of 8 staff (Staff T), reviewed for food services. The failure to discard food items and perform hand hygiene when assisting residents with their meals, placed the residents at risk for food borne illness (caused by the ingestion of contaminated food or beverages), cross-contamination, and a diminished quality of life.Findings included.Review of the facility's policy titled, Food Procurement, Storage and Distribution, updated on 07/08/2022, showed, The facility, store, prepare, distribute and serve food in accordance with professional standards for food service safety.Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes.KITCHEN'S WALK-IN REFRIGERATORIn a joint observation and interview on 03/18/2026 at 6:31 AM with Staff D, Dietary Supervisor, showed one clear bag of purple seedless grapes stored inside the kitchen walk-in refrigerator shelf with white hairy/fuzzy substance on the grapes. Staff D stated that the white fuzzy substance on the grapes looks like mold and that it should not have been there.In an interview on 03/24/2026 at 11:31 AM, Staff A, Administrator, stated that they expected staff to follow their policy for food storage and procurement of purple seedless grapes.HAND HYGIENE DURING ROOM TRAY DELIVERYAn observation on 03/18/2026 at 7:51 AM showed Staff T, Director of Rehabilitation, was pushing the meal cart from East 1 nurses' station to outside of room [ROOM NUMBER]. Staff T took out the meal tray and delivered it to room [ROOM NUMBER]. Staff T then exited room [ROOM NUMBER] with the plate warmer lid and placed it on top of the meal cart. Staff T did not perform hand hygiene. Further observation showed Staff T opened the meal cart and took out the meal tray and delivered it to room [ROOM NUMBER]. Staff T placed the meal tray on the bedside table, removed the lid, and exited room [ROOM NUMBER]. Staff T did not perform hand hygiene before and after they delivered meal trays to room [ROOM NUMBER] and room [ROOM NUMBER].In an interview on 03/18/2026 at 08:05 AM, Staff T stated that they would perform hand hygiene before they go into a resident's room and when they go out of resident's room. Staff T further stated that they should have performed hand hygiene between meal tray delivery to room [ROOM NUMBER] and room [ROOM NUMBER].In an interview on 03/24/2026 at 10:56 AM, Staff B, Director of Nursing, stated that they would expect staff to perform hand hygiene before and after delivering meal trays to residents.Reference: (WAC) 388-97-1100 (3).

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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** Based on observation, interview, and record review, the facility failed to ensure the water management program included an Infection Preventionist and an appropriate agency to report an outbreak. Additionally, the facility failed to follow infection control practices for disinfection of shared medical equipment and/or hand hygiene by 2 of 8 staff (Staff I and Staff S) and ensure hand hygiene products and supplies were readily available and accessible for 1 of 1 medication room (Second Floor Medication Room), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included. WATER MANAGEMENTReview of the undated facility's document titled, Water Management Program, showed, Contact the Snohomish County Health Department to report any outbreak or cases of Legionellosis [or Legionella - bacteria found in water that can cause pneumonia [a lung infection] or other water-borne illnesses [diseases caused by contaminated water] . Further review showed, Healthcare facilities water management team should include someone who understands accreditation of licensing requirements, someone with expertise in infection control, a clinician with expertise in infectious diseases, and risk/quality management staff. The document further showed that the Infection Preventionist was not part of the risk management team. A joint record review and interview on 03/23/2026 at 11:03 AM with Staff C, Maintenance Supervisor, showed the water management should include someone who understands accreditation of licensing requirements, someone with expertise in infection control, a clinician with expertise in infection diseases, and risk/quality management staff. Staff C stated that the risk water management team consisted of Staff A, Administrator, Staff B, Director of Nursing, Staff C, and a Regional Maintenance Director. When asked if an Infection Preventionist staff member was part of the water risk management team, Staff C stated that Staff B was part of the water risk management team. In an interview on 03/23/2026 at 2:56 PM, Staff N, Registered Nurse Practitioner, stated they previously worked at the facility as an Infection Preventionist. When asked if an Infection Preventionist staff member was part of the water risk management team, Staff N stated that Staff B was a member of the water management risk team. A joint record review and interview on 03/24/2026 at 12:53 PM with Staff A, the water management plan showed that legionella outbreaks would be reported to the Snohomish County Department of Health. Staff A stated that it should have been King County Department of Health. A joint record review of the water risk management team showed that the Infection Preventionist was not part of the water risk management team. Staff A stated that Staff B was part of the risk management team. When asked if Staff B was a certified infection preventionist, Staff A stated no. DISINFECTING MEDICAL EQUIPMENT Review of the facility's policy titled, Infection Prevention and Control Program, revised in October 2022, showed, The facility will provide areas, equipment. to implement its Infection Control Program with the goal of.effective cleaning and disinfecting equipment as needed. STAFF I An observation on 03/22/2026 at 12:51 PM showed Staff I, Certified Nurse Assistant, pushed a Hoyer (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lift (a mechanical lift used for transfer) out of room [ROOM NUMBER]. Staff I continued to push the Hoyer lift down the unit hallway and parked it at a corner. Staff I then walked back to room [ROOM NUMBER]. No disinfecting or sanitizing of the Hoyer lift was observed. In an interview on 03/22/2026 at 12:55 PM, Staff I stated that they were expected to disinfect residents' equipment after use. When asked if they had disinfected the Hoyer lift used in room [ROOM NUMBER], Staff I stated, No. I should have sanitized it right away after using it. In an interview on 03/22/2026 at 1:12 PM, Staff J, Licensed Practical Nurse, stated that staff were expected to wipe down the machine [Hoyer lift] before and after use, using the sanitizing wipes. HAND HYGIENE Review of the facility's policy titled, Handwashing/Hand Hygiene, revised in October 2023, showed, Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc. [etcetera]) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. Alcohol based hand-rub (ABHR) dispensers are placed in areas of high visibility and consistent with workflow throughout the facility. STAFF I An observation on 03/22/2026 at 12:54 PM showed Staff I went out of room [ROOM NUMBER] carrying a clear plastic bag with soiled linens and went to the soiled utility room. With the soiled utility door halfway opened, Staff I dropped the plastic bag in the bin then went towards the end of the hallway and walked back towards the nursing station and stood there. Staff I did not perform hand hygiene. Further observation showed a hand sanitizer attached to a wall about four feet away from the soiled utility room was not accessed by Staff I. In an interview on 03/22/2026 at 12:56 PM, when asked if they were expected to perform hand hygiene after handling soiled linens, Staff I stated, Yes. I should have done hand hygiene and I did not. In an interview on 03/22/2026 at 1:12 PM, Staff J stated that staff were expected to perform hand hygiene after handling soiled linens. In an interview on 03/22/2026 at 1:26 PM, Staff G, Resident Care Manager (RCM), was asked if a staff needed to wait before disinfecting or sanitizing an equipment used for a resident, Staff G stated, No, you have to sanitize it right away because somebody else might use it. Staff G further stated that they expected staff to sanitize before and after using the Hoyer lift and to perform hand hygiene after handling soiled linens. In an interview on 03/23/2026 at 2:30 PM, Staff N stated that they expected staff to disinfect resident's equipment after use and to perform hand hygiene after handling soiled linens. In an interview on 03/24/2026 at 10:12 AM, Staff B stated that they expected staff to disinfect the Hoyer lift before and after use and that they should use the sanitizing wipes with a purple top to wipe down the equipment. Staff B further stated that they expected staff to perform hand hygiene after handling soiled linens. STAFF SObservation on 03/21/2026 at 7:51 AM, showed Staff S, Registered Nurse, was opening the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication cart and started preparing Resident 30's morning medication. Staff S did not perform hand hygiene prior to preparing Resident 30's medication. After preparing the resident's medication, Staff S entered Resident 30's room, gave Resident 30 their medication, and touched and moved the resident's bedside table. After medication administration, Staff S left Resident 30's room without performing hand hygiene. Further observation showed Staff S started documenting medication administration and continued working on their medication cart without performing hand hygiene. Observation on 03/21/2026 at 8:04 AM, showed Staff S opened the medication cart started preparing Resident 11's morning medication. Staff S did not perform hand hygiene prior to preparing Resident 11's medication. After preparing the resident's medication, Staff S entered Resident 11's room and administered their medication without performing hand hygiene. In an interview on 03/21/2026 at 8:24 AM, Staff S stated that hand hygiene would be performed before and after each medication administration. Staff S stated that hand hygiene should have been performed before Resident 30's and Resident 11's medication preparation and after medication administration. HAND HYGIENE SUPPLIES-SECOND FLOOR MEDICATION ROOMDuring a joint observation and interview on 03/21/2026 at 2:49 PM, with Staff H, RCM, showed that the Second-Floor Medication room hand-washing station's soap dispenser was blocked by a small over-the-counter refrigerator, making it difficult to access. Additionally, the medication room lacked paper towels, a wastebasket, and/or an ABHR dispenser. Staff H stated that there should be paper towels and wastebasket available in the room and the soap dispenser should be accessible. In an interview on 03/23/2026 at 11:07 AM, Staff N stated that hand hygiene should be performed both before and after administering medications to residents. Staff N stated that hand hygiene supplies should have been readily available in the medication room. On 03/23/2026 at 11:47 AM, Staff B stated that staff were expected to perform hand hygiene before and after medication administration. Staff B stated that there should have been hand sanitizers available in the medication room. Reference: (WAC) 388-97-1320 (1)(a)(c)(2)(b)(5)(a)(c) .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident environment were maintained for 2 of 2 rooms (Rooms 218 & 223), reviewed for environment. The failure to ensure resident rooms were maintained in good repair placed the residents at risk for less than homelike environment and a diminished quality of life.Findings included.Review of the facility's undated policy titled, Preventative Maintenance Policy (Using TELS System [a digital maintenance management system], showed, This policy ensures that all building systems, equipment, and physical structures are maintained in safe working condition through a structured preventive maintenance program. The facility uses the TELS system to meet CMS [Centers for Medicare & Medicaid Services], Life Safety Code, and state regulatory requirements.room [ROOM NUMBER]Observations on 03/18/2026 at 7:58 AM, on 03/19/2026 at 2:20 PM, on 03/20/2026 at 8:07 AM, and on 03/23/2026 at 9:16 AM showed the room wall by the sink was painted reddish-brown. Further observation showed that multiple areas of the wall had multiple white patches from previous repairs that remained unpainted.In an interview on 03/20/2026 at 10:31 AM, Resident 79 in room [ROOM NUMBER] stated that the wall had been like that since they moved in and that someone forgot to finish the job after patching it. Resident 79 further stated they would try not to look at the wall and It would be nice if it was repaired.room [ROOM NUMBER]Observations on 03/18/2026 at 12:41 PM, on 03/19/2026 at 8:32 AM, on 03/19/2026 at 2:06 PM, and on 03/20/2026 at 8:05 AM showed the room's laminate flooring by the resident's bed was cracked and chipped, had missing pieces and part of the flooring was lifting off the subfloor. In an interview and joint observation on 03/22/2026 at 11:16 AM, Staff C, Maintenance Supervisor, and Staff K, Maintenance Staff, stated that most of the facility's repairs would be completed immediately. When asked if there were any pending maintenance needs for rooms [ROOM NUMBERS], Staff K stated that they were notified about room [ROOM NUMBER]'s flooring repair needs on yesterday [03/21/2025] and they repaired it. Staff C and Staff K stated that they were unaware of the necessary repair needs in room [ROOM NUMBER]. A joint observation of room [ROOM NUMBER] showed multiple areas of the wall had multiple white patches from previous repairs that remained unpainted. Staff C stated that they were waiting for another repair need the room had and the sanding of the patched wall and repainting job would be completed. A joint observation of room [ROOM NUMBER] showed that the sections of laminate flooring previously lifted from the subfloor had been glued down while the floor repair remained incomplete with sections of the floor still missing. Staff C stated that the missing section of the floor should have been repaired.In an interview on 03/23/2026 at 1:52 PM, Staff A, Administrator, stated that they expected all resident rooms to be maintained in good repair. Staff A further stated that they were unaware of the floor issues in room [ROOM NUMBER], and that the facility had a plan to replace the flooring.Reference: (WAC) 388-97-0880 (1)(2).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident assessments were completed accurately for 1 of 13 residents (Resident 6), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessment was marked on the MDS regarding weights placed the resident 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 1.20.1, dated October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. Further review of the RAI showed, The measurement of weight is one guide for determining nutritional status. check the medical record and enter the weight taken within 30 days of the Assessment Reference Date (ARD or assessment period) of this assessment. If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (- [dash]) and document rationale on the resident's medical record.Review of an annual MDS dated [DATE] showed Resident 6's weight was recorded in Section K - Weight (K0200B) as 219 pounds (lbs. - unit of measurement).Review of a quarterly MDS dated [DATE] showed Resident 6's weight was recorded in K0200B as 219 lbs.Review of Resident 6's weight records from May 2025 to January 2026 showed the following weights:- 05/16/2025 - 219 lbs.- 01/09/2026 - 232 lbs.In an interview and joint record review on 03/22/2026 at 2:02 PM, Staff L, MDS Coordinator, stated they used the RAI manual to complete MDS assessments. Staff L stated they used the facility weight records to document weights in MDS and that they used a weight within 30 days prior to the ARD. A joint record review of Resident 6's MDSs dated 08/06/2025 and 11/05/2025 showed a weight of 219 lbs. Staff L stated that Resident 6's weight of 219 lbs. was recorded in both MDSs. A joint record review of Resident 6's weight records showed 219 lbs. for May 2025 and 232 lbs. for January 2026. Staff L stated that there were no other weights recorded between May 2025 to January 2026. Staff L stated that Resident 6's May 2025 weight of 219 lbs. was used for both MDSs dated 08/06/2025 and 11/05/2025 and that the weight recorded in both MDSs was not within 30 days from the ARD. Staff L further stated the MDSs weights section should have been dashed and that Resident 6's MDSs were not accurate.In an interview on 03/24/2026 at 10:29 AM, Staff B, Director of Nursing, stated they expected MDSs to be completed timely and accurately.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. Based on interview and record review, the facility failed to ensure the Preadmission Screen and Resident Review (PASRR or PASARR) Level II (refers to the evaluation process conducted after a Level I screening indicates a possible serious mental illness or intellectual disability to ensure that individuals receive appropriate care and support based on their specific needs and conditions) was obtained for 1 of 7 residents (Resident 6), reviewed for PASRR coordination. This failure placed the resident at risk of not receiving the necessary behavioral health services and a diminished quality of life.Findings included .Review of the facility's policy titled, PASRR, revised in September 2018, showed It is the policy of this facility to ensure that each resident is properly screened using PASRR specified by the State. 1. A PASRR shall be completed on every resident upon admission. 2. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with MI [Mental Illness] . 3. Social services shall contact the appropriate State Agency for referral of specialized care and services the resident may require.Review of a diagnosis list printed on 03/20/2026 showed Resident 6 had diagnosis that included bipolar disorder (mental health condition that causes extreme mood swings).Review of a document titled, PASRR Notice of Determination, dated 08/26/2025, showed that Resident 6 had a mental health diagnosis, met the requirements for nursing facility level of care due to current mental health needs, and that Resident 6 may benefit from specialized behavioral health services. Further review of the document showed, The full PASRR [Level II] report will be sent to the nursing facility where you are staying and will become part of your medical record within 30 days.Review of the Electronic Health Record (EHR - document tab and progress notes from 08/01/2025 to 03/18/2026) showed no documentation of Resident 6's Level II PASRR full report.In an interview and joint record review on 03/23/2026 at 1:46 PM, Staff E, Social Services Supervisor, stated if Level I PASARR was referred for Level II PASRR evaluation, they would send it to the PASRR coordinator, then they would follow up for the results of the evaluation. A joint record review of the PASRR Notice of Determination dated 08/26/2025 showed Resident 6 met requirements for nursing facility level of care and may benefit from specialized services. A joint record review of the progress notes and documents tab did not show Resident 6's Level II PASRR report. Staff E stated that there was no Level II PASRR for Resident 6 in their clinical record.In an interview on 03/24/2026 at 10:54 AM, Staff E stated that if residents had a Level II PASRR report, they would review the Level II PASRR recommendations, follow them up, and develop a care plan. Staff E further stated that they should have requested the Level II PASRR report after 30 days of receiving Resident 6's PASRR notice of determination.In an interview on 03/24/2026 at 1:10 PM, Staff A, Administrator, stated they expected staff to follow their PASRR policy and that they expected the facility to follow up/obtain the Level II PASRR reports to carry forward with the recommendations.Reference: (WAC) 388-97-1975(8)(10).

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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** Based on interview and record review, the facility failed to ensure Level II Preadmission Screening and Resident Review (PASRR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or Related Conditions are not inappropriately placed in nursing homes for long-term care) referral was made for 1 of 7 residents (Resident 4), reviewed for PASRR screening. This failure placed the resident at risk of not receiving the care and services appropriate for their needs.Findings included.Review of the facility's policy titled, PASRR, revised in September 2018, showed, It is the policy of this facility to ensure that each resident is properly screened using the PASRR specified by the State. 1. A PASRR shall be completed on every resident upon admission. 2. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to residents with MI [Mental Illness] . 3. Social Services shall contact the appropriate State Agency for referral of specialized care and services the resident may require.Resident 4 admitted to the facility on [DATE] with diagnoses that included depression (persistent, intense sadness or a loss of interest in activities).Review of Resident 4's PASRR level I form dated 12/24/2025, showed that they were marked yes for SMI for mood disorder depression and that the individual's attending physician certifies that the individual is likely to require fewer than 30 days of nursing facility services. The form further showed, No Level II evaluation indicated at this time due to exempted hospital discharge: Level II must be completed if scheduled discharge does not occur.In an interview and joint record review on 03/23/2026 at 1:46 PM, Staff E, Social Services Supervisor, stated that they were responsible for PASRR follow up and that they would follow up with the PASRR coordinator by phone, email, or fax depending on what was marked on the PASRR level I form. A joint record review of Resident 4's level I PASRR showed that they were marked yes for SMI and that no Level II evaluation was indicated at that time due to exempted hospital discharge and that Level II must be completed if scheduled discharge did not occur.In a follow up interview on 03/24/2026 at 8:31 AM, Staff E stated that they contacted the PASRR office yesterday [03/23/2026], and that there were no Level II PASRR referrals made for Resident 4. Staff E stated that a PASRR Level I with PASRR Level II evaluation indication should have been completed for Resident 4 no later than 30 days from admission.In an interview on 03/24/2026 at 11:31 AM, Staff A, Administrator, stated that they expected Resident 4's PASRR to be completed accurately and for staff to follow their PASRR policy.Reference: (WAC) 388-97-1975 (5).

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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** Based on observation, interview, and record review, the facility failed to ensure that the comprehensive care plan was reviewed and revised based on the resident's assessment for 1 of 13 residents (Resident 43), reviewed for care planning. This failure placed the resident at risk for unidentified and unmet care needs, and a diminished quality of life.Findings included.Review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised in April 2025, showed, The resident's comprehensive plan of care will be reviewed and/or revised by the IDT [Interdisciplinary Team] after each assessment, including both the comprehensive and quarterly review assessments.Review of a face sheet printed on 03/20/2026 showed Resident 43 was admitted to the facility on [DATE] and had a diagnosis of drug induced subacute dyskinesia (movement disorder characterized by involuntary, erratic, and uncontrollable muscle movements).Review of a quarterly AIMS (Abnormal Involuntary Movement Scale) assessment dated [DATE] showed Resident 43 scored 6 [six] indicating they had involuntary movement disorder.Review of the quarterly AIMS assessments dated 07/25/2025, 10/23/2025, and 01/23/2026 showed Resident 43 scored 11 (significantly increased compared to the 04/24/2025 assessment).Review of the March 2026 Medication Administration Record showed Resident 43 was on antipsychotic (medications to manage severe mental health symptoms and carry a risk of involuntary movement disorders).Review of the comprehensive care plan printed on 03/20/2026 showed Resident 43 had Positive AIMS 6.0 moderate to severe movement Disorder 4/24/25 [04/24/2025] Date Initiated: 01/24/2024 Revision on 04/24/2025.Observations on 03/18/2026 at 1:02 PM, on 03/21/2026 at 1:05 AM, and on 03/23/2026 at 9:03 AM showed Resident 43 had abnormal involuntary movements to their mouth and hands.In an interview and joint record review on 03/22/2026 at 2:13 PM, Staff H, Resident Care Manager (RCM), stated that residents AIMS assessment was completed by RCMs quarterly with Minimum Data Set (an assessment tool) and the resident's care plan would be updated based on the assessment. A joint record review of the AIMS assessments dated 07/25/2025, 10/23/2025, and 01/23/2026 showed Resident 43 scored 11. A joint record review of the comprehensive care plan printed on 03/20/2026 showed Resident 43's AIMS score was 6. Staff H stated that Resident 43's care plan should have been updated.In an interview on 03/23/2026 at 11:35 AM, Staff B, Director of Nursing, stated that the facility would review and revise resident care plans upon change in status, as well as on a quarterly and annual basis. Staff B further stated Resident 43's care plan should have been revised based on the resident's AIMS assessment.Reference: (WAC) 388-97-1020 (5)(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** Based on interview and record review, the facility failed to ensure physician order was in place for continuous positive airway pressure (CPAP- a device used to treat sleep apnea [a condition where breathing repeatedly stops and starts during sleep]) settings and develop/implement care plan for CPAP for 1 of 1 (Resident 30), reviewed for respiratory care. This failure placed the resident at risk for respiratory related complications, respiratory infection, and a diminished quality of life.Findings included.Review of the facility's policy title, Comprehensive Person-Centered Care planning, revised in April 2025, stated that, It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.Resident 30 was admitted to the facility on [DATE] with diagnoses that included sleep apnea.Review of Resident 30's physician orders printed on 03/19/2026 showed C1-Patient [Resident] wears C-PAP while sleeping with 2 [two] liters [a unit of measurement] of oxygen for sleep apnea. Further review showed no CPAP pressure settings were included in the order.Review of Resident 30's comprehensive care plan printed on 03/19/2026 showed no care plan for CPAP usage for sleep apnea.In an interview and joint record review on 03/20/2026 at 10:40 AM, Staff P, Licensed Practical Nurse, stated that for residents who use CPAP, they would check the physician's orders, assist residents with applying the CPAP mask, and fill the CPAP machine with distilled water if required. Staff P further stated that the physician's order would include the prescribed pressure settings for the CPAP. A joint record review of Resident 30's physician's orders showed, C1-Patient wears C-PAP while sleeping with 2 liters of oxygen for sleep apnea. Staff P stated they did not see CPAP pressure settings in the physician order. A joint record review of the comprehensive care plan showed no care plan for CPAP for sleep apnea. Staff P stated they do not see a care plan for CPAP.In an interview and joint record review on 03/22/2026 at 10:39 AM, Staff O, Resident Care Manager, stated that staff would know a resident's CPAP pressure settings and how to manage them from the physician's order. Staff O further stated that if the resident's CPAP were set to their home settings, it would be stated on the physician orders. A joint record review of Resident 30's physician's orders showed no order with CPAP pressure settings. Staff O stated there should have been an order with the CPAP pressure settings on admission. A joint record review of Resident 30's comprehensive care plan showed no care plan for CPAP usage for sleep apnea. Staff O stated they expected there to be a care plan for CPAP usage for sleep apnea.In an interview and joint record review on 03/24/2026 at 10:56 AM, Staff B, Director of Nursing, stated they expected there to be physician orders for CPAP pressure settings. A joint record review of Resident 30's physician's orders showed no order with CPAP pressure settings. Staff B stated the order should have been completed when the resident started CPAP on admission. A joint record review of Resident 30's comprehensive care plan showed no care plan for CPAP usage for sleep apnea. Staff B stated that the care plan should have been created when the resident started CPAP on admission.Reference: (WAC) 388-97-1060 (3)(j)(vi).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure controlled drugs were accurately accounted for 1 of 2 medication carts (East 2 Medication Cart), reviewed for controlled drugs management. This failure placed the facility at risk for potential loss and/or drug diversion of the controlled medications.Findings included.Review of the facility's policy titled, Controlled Substances, revised in November 2022, showed, Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.During an interview and joint record review on 03/22/2026 at 8:39 AM, Staff M, Licensed Practical Nurse, stated that they had counted the controlled drugs in the East 2 Medication Cart at the start of their shift. A joint record review of the controlled drug logbook (page 49) indicated that Resident 56 had one 5 (five) mg (milligram-a unit measurement) oxycodone (prescription opioid painkiller) tablet remaining. A joint observation of the controlled drug box showed that one tablet of the 5 mg oxycodone was missing. When asked about the discrepancy between the controlled drug book and the controlled drug box, Staff M stated that they signed the shift-change log without verifying the drug book's balance against the physical stock in the box. Staff M stated that the night shift nurse may have administered the missing tablet without documenting it. Staff M further stated that they should have cross-referenced the physical inventory with the controlled drug book during the shift change count.On 03/22/2026 at 9:11 AM, Staff B, Director of Nursing, stated that they would investigate the missing oxycodone 5 mg tablet.In an interview on 03/23/2026 at 11:52 AM, Staff B stated that administered controlled drugs must be recorded in the logbook and validated during shift-change counts. Staff B further stated that their expectation was that all controlled medication records be accurate and regularly reconciled.Reference: (WAC) 388-97-1300 (3)(a).

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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. Based on interview and record review, the facility failed to ensure a physician's order was followed when administering medication for 1 of 5 residents (Resident 6), reviewed for unnecessary medications. This failure placed the resident at risk for side effects related to the medications, medical complications, and a diminished quality of life.Findings included.Review of the facility's policy titled, Administering Medications, revised in March 2022, showed, Medications will be accurately prepared, administered, and documented per physician order .follow the special directions for administering such as blood pressures .Review of Resident 6's physician orders printed on 03/19/2026 showed an order for metoprolol (medication for high blood pressure [measurement that shows how hard the heart is pumping to move blood through the body]) once a day, with an instruction to hold it if their systolic blood pressure (the first or top number in a blood pressure reading, showing the pressure in the arteries [muscular and elastic tubes that carry blood from the heart to the tissues and organs of the body] when the heart beats) was less than 110.Review of the March 2025 to March 2026 Medication Administration Record (MAR) showed metoprolol were given when Resident 6's systolic blood pressure were below 110:- 03/19/2025: systolic blood pressure - 108- 09/01/2025: systolic blood pressure - 106- 10/03/2025: systolic blood pressure - 108- 10/14/2025: systolic blood pressure - 108- 10/15/2025: systolic blood pressure - 108- 01/01/2026: systolic blood pressure - 102- 01/09/2026: systolic blood pressure - 103In an interview and joint record review on 03/22/2026 at 1:49 PM, Staff M, Licensed Practical Nurse, stated that they would follow parameters for blood pressure medications. Staff M stated that if blood pressures were outside parameters, they would hold the medication. A joint record review of Resident 6's MAR for March 2025, September 2025, October 2025 and January 2026 showed that metoprolol was given to Resident 6 when their systolic blood pressure was below 110 on the above dates. Staff M stated that metoprolol was given and it should have been held when the systolic blood pressure was below 110, it [metoprolol] should not have been given.In an interview on 03/24/2026 at 11:56 AM, Staff B, Director of Nursing, stated they expected staff to follow physician orders. Staff B stated that if medications had parameters, they expected staff to follow [blood pressure] parameters, to recheck, and notify the provider [doctor]. Staff B stated that metoprolol should have been held on the above dates when Resident 6's systolic blood pressure was below 110.Reference: (WAC) 388-97-1060 (3)(k)(i).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure medication was stored in accordance with professional standards and manufacturer specifications for 1 of 2 medication carts (East 2 Medication Cart), reviewed for medication storage and labeling. This failure placed the residents at risk for receiving compromised and ineffective medications.Findings included .Review of the Amneal Pharmaceutical (manufacturer) prescribing information titled, Lorazepam [a drug used to quickly calm severe anxiety] Oral Concentrate USP, 2 mg [milligram - a unit measurement] per mL, [milliliter - a unit measurement] revised in December 2015 showed, Store at Cold Temperature-Refrigerate 2 [two degrees] to 8 C [eight degrees Celsius- a unit measurement] (36 to 46 F [Fahrenheit - a unit measurement]) . Discard opened bottle after 90 days.During a joint observation and interview on 03/22/2026 at 8:39 AM with Staff M, Licensed Practical Nurse, showed the East 2 Medication Cart had one unopened bottle of Lorazepam 30 ml oral concentrate USP (2 mg/mL) for Resident 76 was found stored at room temperature inside the cart. Further observation showed the lorazepam was received on 02/13/2026. When questioned regarding storage protocols, Staff M stated that lorazepam would require refrigeration after opening. After review of the packaging, Staff M further stated that the instructions specified storage at a 'cold temperature' and stated, it [the instruction] did not show store it in fridge after opening. Staff M stated they would need to consult with their supervisor.On 03/22/2026 at 9:11 AM, Staff B, Director of Nursing, stated that unopened bottle of lorazepam liquid concentrate could be stored in room temperature for 90 days. Staff B further stated they would provide the manufacturer's instructions.On 03/22/2026 at 9:59 AM, Staff B stated that they confirmed with their pharmacist that the Lorazepam Oral Concentrate could be stored at room temperature and discarded within 42 days. Staff B provided a 9-page printout of Amneal Pharmaceutical prescribing information titled, Lorazepam Oral Concentrate USP, 2 per mL, revised in December 2015.Review of the facility provided instruction and the actual manufacturer's instructions for Lorazepam Oral Concentrate, revised in December 2015, revealed a discrepancy. Further review of the facility's version of the document included an added instruction stating, Once left at room temperature, discard within 42 days.In an interview and joint record review on 03/23/2026 at 11:52 AM, Staff B stated that they personally printed the manufacturer's instructions for lorazepam concentrate from the manufacturer's website on 03/22/2026 and provided to the surveyor. A joint record review of the facility's version of the document included an added instruction stating, Once left at room temperature, discard within 42 days which was not found on the actual manufacturer's document. Staff B could not explain how the document was altered before they provided it and further stated that staff were expected to follow the manufacturer's medication storage guidelines.Reference: (WAC) 388-97-1300 (2).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently maintain an established Antibiotic (medication to treat infection) Stewardship Program to promote the appropriate use of antibiotics for 2 of 6 residents (Residents 63 & 95) and failed to ensure standardized tools and criteria were utilized for Antibiotic Stewardship Program (such as Loeb Minimum Criteria [minimum set of signs symptoms used to determine whether to treat an infection with antibiotic]). These failures placed the residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of antibiotics and an increased risk for multi-drug-resistant organisms (microscopic organisms that are resistant to many antibiotics).Findings included.Review of the facility's policy titled, Antibiotic Stewardship, revised in March 2023, showed, This policy is aligned with the CDC [Centers for Disease Control and Prevention] Core Elements of Antibiotic Stewardship for Nursing Homes. It is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs.Antibiotic Stewardship: refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This can be accomplished through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use to ensure that residents receive the right antibiotic for the right indication, dose, and duration. The team will. Assess residents for any infection using McGeer's criteria.Review of the facility's policy titled, Infection Control, revised in September 2025, showed, The facility uses McGeer criteria as the nationally recognized surveillance criteria to define infections.Review of a Revised McGeer Criteria for Infection Surveillance Checklist, revised on 11/05/2024, showed that residents with Urinary Tract Infection (UTI - infection of the urinary system) without an indwelling catheter (tube left in the bladder that drains urine into a drainage bag) must meet criteria 1 and criteria 2 for symptomatic UTI infection. Criteria 1- At least one symptom - acute dysuria (burning sensation during urination); or acute pain, swelling, or testicular (testicles - organ that produce sperm in men) tenderness; or fever or leukocytosis (high white blood cell count) and at least one of the following localized urinary tract sub-criteria: acute back pain or tenderness, suprapubic (lower abdominal area) pain, gross hematuria (blood in urine), new or marked increased incontinence, urinary urgency or frequency; In the absence of fever or leukocytosis, then at least 2 or more localizing urinary symptoms need to be met. Criteria 2- culture identified no more than 2 species of microorganisms of more than 100,000 colony count (number of microorganisms grown) in a voided urine; or more than 100 colony count of any number of organisms in a specimen collected by in-and-out catheter.RESIDENT 63Review of the November 2025 Medication Administration Record (MAR) showed Resident 63 was administered Macrobid (an antibiotic) two times a day for five days from 11/06/2025 to 11/11/2025 for UTI. Review of an Infection Surveillance document for UTI dated 11/06/2025 showed Resident 63 had no indwelling catheter and started to have UTI symptoms on 11/05/2025. Further review of the document showed, Urinary Tract Infection for residents without an indwelling catheter-Both criteria 1 and 2 must be present. Additionally, the document showed Resident 63 had two symptoms (dysuria and increased urinary urgency) marked under criteria 1 and no qualified items were marked under criteria 2. Furthermore, the document showed, Surveillance criteria adopted from the Updated McGeer Criteria for Long Term Care Surveillance Definitions of Infections, 2012.Review of Resident 63's urine culture results collected on 11/04/2025 showed that the urine culture did not meet McGeer's criteria 2.A joint record review and interview on 03/23/2026 at 3:21 PM with Staff B, Director of Nursing, showed Resident 63's infection surveillance document (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505262	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shoreline Health and Rehabilitation	2818 Northeast 145th Street Seattle, WA 98155

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that criteria 1 had symptoms marked, and criteria 2 was blank. Staff B stated that McGeer's criteria were used for the initiation of antibiotics. A joint record review of the document showed Urinary Tract Infection for residents without an indwelling catheter-Both criteria 1 and 2 must be present. Staff B stated that for residents without an indwelling catheter, criteria 2 did not have to be met. Staff B stated that Resident 63 completed their antibiotic as ordered.RESIDENT 95Review of the February 2026 MAR showed Resident 95 was administered nitrofurantoin (an antibiotic) twice a day for five days from 02/17/2026 to 02/22/2026 for UTI.Review of an Infection Surveillance document for UTI dated 02/17/2026 showed Resident 95 had no indwelling catheter and started to have UTI symptoms on 02/13/2026. Further review of the document showed, Urinary Tract Infection (UTI) for residents without an Indwelling Catheter - Both criteria 1 and 2 must be present. Additionally, the document showed that Resident 95 had four symptoms (dysuria, suprapubic pain, increased urinary urgency, and increased urinary frequency) marked under criteria 1 and there were no qualified items marked under criteria 2. Furthermore, the document showed, Surveillance criteria adopted from the Updated McGeer Criteria for Long Term Care Surveillance Definitions of Infections, 2012.Review of Resident 95's urine culture and sensitivity (identifies bacteria in urine sample and determines which antibiotic medications are effective) laboratory results dated [DATE] showed the urine sample was collected via clean catch (voided urine sample) on 02/17/2026 and it grew Enterobacter cloacae complex [a type bacteria that causes infection] of 50,000 to 99,000 colony count. Further review of the laboratory results did not show that the McGeer's microbiologic (bacteria and their colony count indicating a true infection) criteria (of more than 100,000 colony count) was met.A joint record review and interview on 03/24/2026 at 12:26 PM with Staff B showed Resident 95's infection surveillance form dated 02/17/2026 was completed for UTI for a resident without an indwelling catheter. Staff B stated that Resident 95 had at least two symptoms of criteria 1 and that their urinalysis results showed a colony count of 50,000 to 99,000 for Enterobacter cloacae complex. Staff B s further stated that they did not use Situation Background Assessment Recommendation (SBAR, a structured communication tool for change of condition) or Loeb's criteria because McGeer's criteria has the same symptoms check. When asked what minimum criteria the facility used for starting antibiotics, Staff B stated, McGeer's criteria. When asked what criteria the facility used for infection surveillance, Staff B stated, McGeer's criteria.No Associated WAC.