STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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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** Based on observation, interview, and record review, the facility failed to ensure resident environment were maintained for 3 of 6 rooms (Rooms 111, 314 & 317), for 2 of 3 floors (Third Floor & First Floor Hallway Ceiling), for 1 of 1 resident bed linen (Resident 30), for 3 of 3 elevator jambs (First Floor, Second Floor & Third Floor), and for 1 of 1 bed (Resident 1), reviewed for environment. The failure to ensure resident rooms were maintained, wall fans were properly mounted, condensation from ceiling pipes were prevented, elevator jambs were repaired, bed linens were changed, and/or bed were in good repair placed the residents at risk for a less than homelike environment and a diminished quality of life.Findings included. Review of the facility's policy titled, Preventative Maintenance, dated July 2008, showed that the intention of the policy is to establish a building where the environment is safe and comfortable, essential utilities were delivered without interruption and mechanical systems and equipment operate safely, accurately, and reliably. The policy further showed that all areas of the Center and equipment therein, are inspected and maintained in accordance with the scheduled maintenance system. The maintenance department is responsible for the condition and function of the Center's physical plant including utilities, grounds, and equipment. Review of the facility's job description for Certified Nursing Assistant (CNA), updated in March 2025, showed changing bed linens were included in their job duties. room [ROOM NUMBER]Review of a face sheet printed on 09/08/2025, showed Resident 66 was readmitted to the facility on [DATE] to room [ROOM NUMBER]. In an interview and observation on 09/03/2025 at 12:41 PM, Resident 66 stated they had a concern and asked to have their bathroom assessed. Resident 66's bathroom had a hole in the wall that was between the faucet and the toilet, a hole on the floor and a round raised metal piece attached to the floor. Resident 66 stated that they used the bathroom and that they had tripped on the round raised metal piece that was on the floor. Observations on 09/04/2025 at 2:46 PM, on 09/05/2025 at 2:16 PM and on 09/08/2025 at 4:25 PM, showed Resident 66's bathroom had a hole in the wall that was between the faucet and the toilet, a hole on the floor and a round raised metal piece attached to the floor. Review of the maintenance logbook on 09/10/2025 at 10:30 AM, showed no log for room [ROOM NUMBER]. In an interview and joint observation on 09/10/2025 at 10:49 AM, Staff S, CNA, stated that if (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	something in the facility needed to be fixed, they would put in a request in the maintenance logbook. Staff S stated that if there was no action taken, they would talk to the maintenance department. Staff S stated that Resident 66 used the bathroom and if they were strong, they were able to walk independently to the bathroom. A joint observation of Resident 66's bathroom showed a hole in the wall that was between the faucet and the toilet, a hole on the floor and a round raised metal piece attached to the floor. Staff S stated, I've always seen it and that they were not sure if they had put in a request in the maintenance log and that they thought that someone had already put one in. A joint observation and interview on 09/10/2025 at 10:58 AM with Staff H, Maintenance Director, showed the bathroom in room [ROOM NUMBER] had a hole in the wall that was between the faucet and the toilet, a hole on the floor and a round raised metal piece attached to the floor. Staff H stated that they were notified of it. When asked if they were aware of it before today, Staff H stated that they were not aware and that they expected staff to put in a repair request in the maintenance log. In an interview on 09/10/2025 at 11:21 AM, Staff A, Executive Director, stated that they expected the facility environment to have ongoing maintenance and any issues to be communicated to the maintenance department. Staff A further stated that they expected the holes on the bathroom wall/floor and the round raised metal piece on the bathroom floor to have been communicated in the maintenance log or to the maintenance department. room [ROOM NUMBER]Observation on 09/03/2025 at 8:50 AM, showed a light fixture over the bathroom sink. Two out of the three bulbs in this fixture did not light up when the bathroom lights were turned on. A joint observation and interview on 09/10/2025 at 2:02 PM with Staff H showed the light fixture over the bathroom sink had two of the three bulbs out. Staff H stated that they should have replaced the bulbs if they had been made aware. The bathroom wall facing the toilet showed a deep gauge in the wall, measuring about a one-foot gap between the wall and the bathroom base cover. Staff H stated that this wall damage was probably created by a wheelchair and would be an easy fix. A joint observation showed the bathroom ceiling; dry wall tape was visible around where sheet rock may have been cut out. Staff H stated that this looked like an unfinished roof related fix and that it measured around two by three feet. In another joint observation of the wall in room [ROOM NUMBER] showed dry wall damage in multiple areas that stripped the top layer, measuring from two inches to six inches in length and up to two inches wide. Staff H stated that the damage looked like it was caused by the cord covers that were applied to the wall with adhesive strips. A joint observation showed the window screen in room [ROOM NUMBER] had a tear in the lower right corner. Staff H stated the tear on the screen looked like it was about two feet long. room [ROOM NUMBER]Observation on 09/03/2025 at 9:44 AM, showed room [ROOM NUMBER] had an electric wall fan partially mounted on the wall and was turned on. The top screw on the wall mount was an inch out of the wall causing the fan to tilt downward. A joint observation and interview on 09/10/2025 at 2:02 PM with Staff H, showed an electric wall fan running. The fan was around 16-24 inches in diameter and was anchored on the wall by three screws. The single screw on the top was hanging one inch off the wall, leaning downward. Staff H stated that the fan was not safe and would take care of it first. Staff H stated that no one had alerted them that the fan needed to be fixed. HALLWAY CEILING-THIRD FLOOR AND FIRST FLOORObservation on 09/05/2025 at 8:21 AM, showed (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was condensation dripping onto the hand sanitizer dispenser that was mounted outside of room [ROOM NUMBER]. There was a gap at the edge of the ceiling where piping was exposed, and each side of this gap had two-inch black spots that looked like organic matter. Observation on 09/08/2025 at 11:19 AM, showed condensation under the air conditioning unit installed on the upper part of the wall, outside of room [ROOM NUMBER]. A joint observation and interview on 09/10/2025 at 2:15 PM with Staff H, showed there were condensation drops on the hand sanitizer dispenser on the wall outside of room [ROOM NUMBER]. Staff H stated that it was an easy fix and looked like the refrigeration lining (foam insulation with high resistance to water vapor to prevent condensation formation) needed to be replaced. A joint observation and interview on 09/10/2025 at 9:33 AM with Staff H, showed there was condensation under the first-floor air conditioner. Staff H stated that this was manageable and would replace the refrigeration lining. In an interview on 09/11/2025 at 10:00 AM, Staff A stated that they expected the conditions of the general environment to be maintained and cleaned. BED LINENObservation on 09/03/2025 at 9:16 AM, showed the fitted sheet on Resident 30's bed had orange, brown stains on the left side. Just below the stains, was an empty can of Chef Boyardee [brand name for canned pasta] on the floor. Additional observations on 09/09/2025 at 9:34 AM and 09/10/2025 at 9:14 AM showed the fitted sheet on Resident 30's bed had the same orange, brown stains that was observed on 09/03/2025. In an interview on 09/10/2025 at 9:14 AM, Resident 30 stated that the staff had not offered to change their sheets in a while. In an interview on 09/10/2025 at 9:31 AM, Staff GG, CNA, stated that their duties included changing bed linen. In an interview on 09/05/2025 at 2:08 PM, Staff G, Resident Care Manager, stated that care staff duties included changing bed linen. Staff G stated that staff would change the bed linen routinely and when it was soiled. Staff G further stated that they would change their bed linen as preferred and requested by residents. In an interview on 09/10/2025 at 2:49 PM, Resident 30 stated that if they were not in bed, they would not mind if staff came in and changed their bed sheets when they were not in their room. In an interview on 09/11/2025 at 10:00 AM, Staff B, Director of Nursing, stated that they expected that when linen was soiled, it should be changed. ELEVATOR JAMBSObservation on 09/04/2025 at 10:08 AM showed the facility's First Floor and Second Floor elevator jambs paints were scraped, damaged and had multiple scratch marks. In an interview and joint observation on 09/10/2025 at 9:25 AM, Staff H stated that the building's scrapes and scratched paints would be patched and repainted including the elevator jambs. A joint observation of the First, Second, and Third Floor elevator jambs had multiple scrapes and scratched (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	marks. Staff H stated that they had a plan to patch and repaint the elevator jambs. In an interview on 09/11/2025 at 8:40 AM, Staff A stated that they expected the building to be regularly maintained, including repatching and repainting of elevator jambs. RESIDENT 1Observations on 09/04/2025 at 8:05 AM and on 09/05/2025 at 10:40 AM, showed Resident 1's bed with the veneer (thin slice of natural wood) peeling off in multiple areas on the footboard. A joint observation and interview on 09/10/2025 at 10:55 AM with Staff X, CNA, showed Resident 1's bed with the veneer peeling off in multiple areas on the footboard. Staff X stated, it's [it is] coming off, I will tell the nurse. In an interview and joint observation on 09/10/2025 at 11:15 AM, Staff H stated that they keep an eye on them [footboards] and if the veneer was coming off a resident can cut a finger. A joint observation of Resident 1's bed showed the veneer was peeling off in multiple areas on the footboard. Staff H stated that the peeling veneer should come off. Staff H further stated that it [footboard] will be replaced. In an interview on 09/11/2025 at 8:03 AM, Staff A stated, I would not expect the [veneer] to be peeling off. I would expect it to be fixed or replaced. 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 - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accurately assess 4 of 24 residents (Residents 8, 86, 32 & 45), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments regarding prognosis, Pressure Ulcer (PU)/Pressure Injury (PI-bed sore), and mechanical ventilation (a medical procedure that uses a machine to assist or replace spontaneous breathing) 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. It further showed to code yes for J1400 (Prognosis [a prediction of the likely outcome or future course of a medication condition or disease]), if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services. 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). Review of the facility's policy titled, Resident Assessment Instrument Policy, updated in March 2019, showed that the facility would complete MDS in accordance with state and federal regulations per the RAI manual. RESIDENT 8Review of the hospice certification of illness note dated 07/12/2025, showed that Resident 8's prognosis was six months or less if the disease ran its normal course. Review of Resident 8's Significant Change in Status Assessment (SCSA) MDS dated [DATE], showed that Section J1400, Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 [six] months? was marked no. RESIDENT 86Review of the hospice certification of illness note dated 08/05/2025, showed that Resident 86 had a terminal diagnosis and a prognosis of six months or less if the disease ran its normal course. Review of Resident 86's SCSA MDS dated [DATE], showed that Section J1400 was marked no. In an interview and joint record review on 09/08/2025 at 11:18 AM, Staff D, MDS Coordinator, stated that they followed the RAI manual and that when completing Section J1400 they looked for the physician determination documentation and would mark the MDS based on that document. A joint (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review of Resident 8's SCSA MDS dated [DATE], showed that it was marked no for Section J1400. A joint record review of the hospice certification of illness note dated 07/12/2025, showed that Resident 8's prognosis was six months or less if the disease ran its normal course. Staff D stated that the SCSA MDS was not accurate and that they would modify it. A joint record review of Resident 86's SCSA MDS dated [DATE], showed it was marked no for Section J1400. A joint record review of the certification of illness note dated 08/05/2025, showed that Resident 86 had a terminal diagnosis and a prognosis of six months or less if the disease ran its normal course. Staff D stated that Resident 86's SCSA MDS was not accurate. In an interview on 09/09/2025 at 2:22 PM, Staff B, Director of Nursing, stated that they expected the MDS to be completed timely and accurately including the SCSA MDS. RESIDENT 32The RAI manual defines PU/PI as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. For each PU/PI coded on MDS, the RAI manual directed staff to determine if the PU/PI was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. The RAI manual defines PU/PI stages: -Unstageable PU/PI is when the wound's anatomical (body structure) tissues are obscured such that the extent of soft tissue damage cannot be observed or palpated. -Stage 4 PU/PI is a full thickness tissue loss with exposed bone, tendon or muscle. Resident 32 was readmitted to the facility on [DATE]. Review of the admission-readmission nursing evaluation dated 02/19/2024 showed that Resident 32 was readmitted with three stage 4 PU/PI. Review of the SCSA MDS dated [DATE], showed Resident 32 had five unstageable PU/PI coded as acquired at the facility. Review of the quarterly MDS dated [DATE], showed Resident 32 had one stage 4 and six unstageable PU/PI. Further review of the MDS showed the stage 4, and the five unstageable PU/PI were coded as present upon reentry. In an interview and joint record review on 09/10/2025 at 11:02 AM, Staff D stated that they would follow the RAI Manual for MDS accuracy, and they would review skin evaluation, progress notes and wound consultant notes to complete Section M (Skin Conditions) of the MDS. A joint record review of Resident 32's SCSA MDS dated [DATE], showed that Resident 32 had five unstageable PU/PI acquired at the facility. A joint record review of Resident 32's quarterly MDS dated [DATE], showed Resident 32 had seven PU/PI and six out of the seven PU/PI were present on admission. Staff D stated that Resident 32 was refusing wound assessment, and they coded the MDS based on the physician diagnosis list dated 06/10/2025. Staff D further stated that the quarterly MDS dated [DATE] may not be accurate. In an interview on 09/10/2025 at 3:00 PM, Staff B stated that they expected the MDS to be accurate. RESIDENT 45Resident 45 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypercapnia (a medical emergency where the body fails to adequately remove carbon dioxide [gas] from the bloodstream). (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 admission physician progress notes dated 05/08/2025 showed Resident 45's was admitted with a tracheostomy (an incision on the front of the neck to open a direct airway to windpipe to relieve an obstruction to breathing) requiring ongoing care and cool humidified air. Further review of the note showed Resident 45 was not on a mechanical ventilator. Review of the quarterly MDS dated [DATE] showed Resident 45 was coded to be on a mechanical ventilator. In an interview and joint record review on 09/10/2025 at 9:31 AM, Staff AA, Respiratory Therapist, stated that Resident 45 had a tracheostomy and have never been on a ventilator machine. A joint record review of Resident 45 physician's orders showed no mechanical ventilator order. In an interview on 09/10/2025 at 9:42 AM, Staff D, stated that the resident had a tracheostomy and was never on a mechanical ventilator. Staff D further stated Resident 45 quarterly MDS was inaccurate. In an interview on 09/10/2025 at 10:50 AM, Staff B stated that they expected the MDS to be completed accurately. Reference: (WAC) 388-97-1000(1)(b) .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary assistance with Activities of Daily Living (ADL) for 4 of 10 residents (Residents 4, 33, 7 & 23) reviewed for ADLs. The failure to provide residents who were dependent on staff for assistance with personal hygiene placed the residents at risk for unmet needs and a diminished quality of life.Findings included. NAIL CARERESIDENT 4Review of Resident 4's comprehensive care plan, revised on 08/05/2025, showed that Resident [Resident 4] will have ADL needs met. It further showed that Resident 4 needed extensive assistance with grooming. Observations on 09/04/2025 at 8:10 AM and on 09/08/2025 at 9:00 AM, showed Resident 4 had brown matter under their nails on their right hand. Observation on 09/09/2025 at 10:30 AM, showed Resident 4 coming back from the shower room. It further showed that Resident 4 had brown matter under their nails on their right hand. In an interview and joint observation on 09/10/2025 at 10:55 AM, Staff X, Certified Nursing Assistant (CNA), stated that CNAs were responsible for cleaning hands, including under nails for dependent residents. Joint observation of Resident 4's hands showed that Resident 4 had brown matter under their nails on their right hand. Staff X stated that the nails on Resident 4's right hand looked dirty. In an interview on 09/10/2025 at 1:34 PM, Staff Y, Registered Nurse (RN), stated that they did not expect there to be brown matter under Resident 4's nails and they should be clean. In an interview on 09/10/2025 at 1:50 PM, Staff F, Resident Care Manager (RCM), stated that they expected staff to help dependent residents with ADLs, including nail care and washing hands. Staff F further stated that they would not expect there to be brown matter under Resident 4's nails after they had a shower. In an interview on 09/11/2025 at 11:30 AM, Staff B, Director of Nursing, stated that they expected staff to provide ADLs for dependent residents, including cleaning their hands/nails. Staff B further stated that they expected them [staff] to provide the needs for the residents if they can't [cannot] do it themselves. RESIDENT 33Review of the significant change in status Minimum Data Set (MDS – an assessment tool) dated 08/20/2025 showed that Resident 33 readmitted to the facility on [DATE] with diagnoses that included persistent vegetative state (a condition where a person is awake but shows no signs of awareness or cognitive function), type 2 diabetes, and contracture (a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff) of the muscle. It further showed that Resident 33 had functional limitation in range of motion to both sides of their upper extremities and was dependent on staff for personal hygiene. Review of Resident 33's baseline care plan intervention dated 11/09/2022, showed to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. In an interview on 09/04/2025 at 9:52 AM, Resident 33's representative stated that Resident 33 liked their nails short. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 09/04/2025 at 9:26 AM, on 09/05/2025 at 2:38 PM, on 09/08/2025 at 8:59 AM, on 09/09/2025 at 9:34 AM and on 09/10/2025 at 10:35 AM, showed Resident 33's fingernails on both hands were long. In an interview and joint observation on 09/10/2025 at 10:43 AM, Staff S, CNA, stated that they followed the resident's care plan. Staff S stated that they provided nail care as needed and that if a resident had diabetes, the nurses would do it. Joint observation of Resident 33's fingernails showed that they were long on both hands. Staff S stated, They're [they are] really long and that they would notify the nurse. In an interview on 09/10/2025 at 2:24 PM, Staff N, LPN, stated that they provided nail care to residents who had diabetes and that the CNA provided nail care to residents who did not have diabetes. Staff N stated that they provided nail care during skin checks and as needed if they were too long. Staff N stated that they trimmed Resident 33's fingernails and when asked if Resident 33's fingernails were long, Staff N stated, Yes, that's [that is] why I trimmed them. In an interview and joint record review on 09/11/2025 at 8:57 AM, Staff E, RCM, stated that their process for nail care was that they would follow the physician orders and as needed. If a resident did not have an order, they would follow general practice. Staff E stated that the nurses would provide nail care for residents with diabetes and those who did not have diabetes, the CNA would provide them. Staff E stated that staff would assess during care/showers and that if their fingernails were too long, they would ask the residents if they would like nail care to be provided. Staff E stated that nail care would be included in their care plan. Joint record review of Resident 33's care plan showed to check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Staff E further stated that they would have expected nursing to have provided nail care if Resident 33's fingernails were long. In an interview on 09/11/2025 at 9:44 AM, Staff B stated that they expected nail care to be provided weekly and as needed during bath days. RESIDENT 7 Resident 7 was admitted to the facility on [DATE] with diagnoses to include anoxic brain injury (a severe condition that occurs when the brain is deprived of oxygen for a prolonged period and can lead to cognitive impairment and/or paralysis [medical condition characterized by the loss or impairment of voluntary movement and sensation in one or more parts of the body]) and Type II Diabetes (a condition characterized by persistently high blood sugar). Review of the quarterly MDS dated [DATE] showed Resident 7 had severely impaired cognition and was dependent on staff for ADLs. Review of Resident 7's care plan for ADLs, revised on 09/03/2025, showed interventions for diabetic nail care weekly and as needed, with referral to a podiatrist (foot doctor) if staff were unable to provide the care.Observation on 09/02/2025 at 2:00 PM showed Resident 7's right and left-hand fingernails were long and untrimmed. In an interview and joint observation on 09/09/2025 at 11:10 AM, Staff Z, Licensed Practical Nurse (LPN), stated they followed the resident's care plan and that nurses were responsible for providing weekly diabetic nail care. Staff Z further stated that if they could not trim or file down the nails, they would refer the resident to a podiatrist. A joint observation showed Resident 7's right and left-hand fingernails were long. Staff Z stated Resident 7's fingernails needed to be trimmed or filed down. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ORAL CARERESIDENT 23 Resident 23 was admitted to the facility on [DATE] with diagnosis that included diffuse traumatic brain injury (a brain injury that can lead to disability and cognitive issues). Review of the quarterly MDS dated [DATE] showed Resident 23 had severely impaired cognition and was dependent on staff for ADLs.Observations on 09/05/2025 at 8:09 AM and 2:23 PM, and on 09/08/2025 at 9:49 AM, showed Resident 23's mouth was wide open with dry brown crust on their tongue.In an interview and joint observation on 09/08/2025 at 10:32 AM, Staff BB, Respiratory Therapist, stated they were responsible for oral care on all residents on ventilator machines (a medical procedure that uses a machine to assist or replace spontaneous breathing). Staff BB further stated that oral care was provided once a shift and as needed. A joint observation showed Resident 23's tongue had brown crust and dry yellow mucus hanging on the roof of the mouth. When asked if Resident 23's mouth looked clean, Staff BB stated, no.In an interview on 09/10/2025 at 10:05 AM, Staff B, stated staff were expected to follow the care plan and check nails weekly to ensure they were not long and to trim or file them down. Staff B further stated that oral care should have been completed for Resident 23. Reference: (WAC) 388-97-1060 (2)(c) .

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	505311	A. Building B. Wing	09/11/2025

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Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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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. Based on observation, interview, and record review, the facility failed to ensure medical supplies were dated and discarded when expired and/or failed to maintain the required temperatures range for 2 of 2 medication refrigerators (First Floor Medication Refrigerator & Third Floor Refrigerator) and failed to ensure medications were properly stored and secured for 3 of 4 residents (Residents 37, 3 &11), reviewed for medication storage. These failures placed the residents at risk of receiving compromised medications/supplies and related complications. Finding included. Review of the facility's policy titled, Storage of medication, dated 01/23 [January 2023], showed, Outdated ., deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal. Medications requiring refrigeration or temperatures between 2°C ([Celsius- unit of measurement]), 36°F [Fahrenheit- unit of measurement] and 8°C (46°F) are kept in a refrigerator with a thermometer to allow temperature monitoring. A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. The temperature of any refrigerator that stores vaccines should be monitored and recorded twice daily. FIRST FLOOR MEDICATION REFRIGERATORA joint observation and interview on 09/08/2025 at 1:35 PM with Staff E, Resident Care Manager (RCM), showed expired and undated medical supplies, including ultrasound (medical imaging that used sound wave) gel with an expiration date of 03/25/2025 and cornstarch powder (to prevent skin moisture) with no manufacturer/expiration date. Staff E stated they were expired and should have been discarded. THIRD FLOOR MEDICATION REFRIGERATORA joint observation on 09/08/2025 at 2:10 PM with Staff G, RCM, showed the third-floor refrigerator temperatures were out of range, the freezer read 49°F and refrigerator read 48°F. Further observation showed the ice was melting and water draining into the refrigerator compartment. In an interview and joint record review on 09/08/2025 at 3:07 PM, Staff G stated that they expected the refrigerator temperatures to be within normal range of 34 to 40°F for the refrigerator and 0 to negative 2°F for the freezer. Staff G stated that temperatures in the refrigerator were out of range. A joint record review of the refrigerator temperature logs showed missing temperature logs for 08/09/2025, 08/10/2025, and 08/26/2025. Staff G stated that if the fridge temperature was not logged, it was not completed. Staff G further stated it was their expectation that refrigerator temperatures were checked and documented daily. In an interview on 09/10/2025 at 3:07 PM, Staff B, Director of Nursing, stated it was their expectation that staff would check and record refrigerator temperatures daily and that all expired medications be discarded according to facility policy. MEDICATIONS AT BEDSIDERESIDENT 37Observations on 09/03/2025 at 2:50 PM and on 09/05/2025 at 2:53 PM, showed Resident 37 had one opened bottle of Flonase (medication that reduces swelling in the nose due to allergies), one opened bottle of Mucinex (medication that makes mucus thin and loose making it easier to cough it up), one opened bottle of normal saline nasal spray (saltwater (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	solution that adds moisture to nasal passages to help clear congestion, relieve dryness, and flush out irritants like dust and pollen), and one opened bottle of Derma Daily medications (powder to apply in moist skin) on their bedside table. A joint observation and interview on 09/09/2025 at 1:37 PM with Staff HH, Licensed Practical Nurse (LPN), showed Resident 37 had Flonase, Mucinex, nasal saline spray, and derma daily medication on their bedside table. Resident 37 stated they had possessed the medications for a while and had been using them. Staff HH stated that resident's medication should not be stored at their bedside. In an interview on 09/10/2025 at 2:16 PM, Staff F, RCM, stated that Resident 37 was preparing for discharge to home and had been trained to self-administer medications. When asked if medications were allowed to remain on the bedside table, Staff F stated medications were required to be locked in a safe place, either in the medication cart or in a locked drawer in the resident's room. In an interview on 09/10/2025 at 2:56 PM, Staff B stated it was their expectation that staff would not leave medications at the bedside, would observe the resident take all medications and store medications in the medication cart or locked in the medication drawer. RESIDENT 3Observation on 09/03/2025 at 11:50 AM, showed one opened bottle of Turmeric and Ginger supplement (dietary supplement) on top of Resident 3's nightstand. Resident 3's representative stated that Resident 3 takes them [Turmeric and Ginger supplement] once a day. Additional observations on 09/08/2025 at 10:28 AM and on 09/09/2025 at 8:50 AM, showed one opened bottle of Turmeric and Ginger supplement on top of Resident 3's nightstand. In an interview and joint observation on 09/09/2025 at 10:46 AM, Staff Y, Registered Nurse, stated that medications, including supplements, should be stored in medication carts and locked containers. Staff Y stated that medications should not be at the bedside. Joint observation showed one opened bottle of Turmeric and Ginger supplement bottle on top of Resident 3's nightstand. Staff Y stated that they had seen Resident 3's Turmeric and Ginger supplement bottle before and did not know if Resident 3 was taking them. Staff Y stated that there was no order for the supplement, and it should not be on the nightstand. In an interview on 09/09/2025 at 10:58 AM, Staff F stated that residents could have medications at the beside if they were assessed on properly storing [medications], properly administering [medications], had a [physician's] order, and care plan. Staff F stated that medications at the bedside should be stored in a lock box. Staff F further stated that they would not expect Resident 3 to have a supplement at the bedside. In an interview on 09/09/2025 at 1:35 PM, Staff B stated that they expected medications to be secured and locked. RESIDENT 11Observation on 09/05/2025 at 1:20 PM showed there was an unopened box of lidocaine pain-relief gel patches sitting on Resident 11's dresser and there were clear plastic drawers where other medications were visible which contained the following medications:-one open bottle of cyclopentolate hydrochloride ophthalmic eye drops (treats dry eyes)-one bottle of brimonidine eye drops (treats dry eyes)-one bottle of prednisolone acetate eye drops (treats inflammation of the eyes)-eight Bisacodyl suppositories (for bowel management)-one mini enema kit (for bowel management)-a tube of an over-the-counter muscle rub, greaseless pain-relieving cream (treats (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muscle pain) In an interview on 09/05/2025 at 1:20 PM, Resident 11 stated that they kept the lidocaine and the pain-relieving creams in their room so that they could instruct staff where to apply them. In an interview on 09/05/2025 at 2:37 PM, Staff U, LPN, stated that there were no residents on the third floor that was on a self-medication administration program and that residents were not to store medications in their rooms. Staff U further stated that Resident 11 had refused to take their prescription eye drops and was not supposed to have them in their room. In an interview on 09/05/2025 at 2:41 PM, Staff G stated that they did not have any residents on self-medication administration program. Staff G stated that Resident 11 would go out and buy their own over the counter medications and eye drops. Staff G further stated that medications stored in resident rooms should be stored in a lockable storage. In an interview on 09/11/2025 at 10:30 AM, Staff B stated that they expected medications to be secured and a self-medication administration assessment to have been completed. 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. Based on observation, interview, and record review, the facility failed to ensure expired food items were discarded for 2 of 4 refrigerators (Kitchen Walk-In Refrigerator & Second Floor Refrigerator) and 1 of 1 dry storage (Kitchen Dry Storage Room), reviewed for food service safety. These failures placed the residents at risk of food-borne illness (caused by the ingestion of contaminated food or beverages).Findings included .Review of the facility's policy titled, Food Storage, updated October 2017, showed, Food products are used within one year unless the manufacturer's expiration date is different.The manufacturer's expiration date, when available, is the use by date for unopened items.KITCHEN WALK-IN REFRIGERATORA joint observation and interview on 09/03/2025 at 9:13 AM with Staff J, Dietary Manager, showed one unopened Darigold (brand name) heavy whipping cream with a best buy date of 08/29/2025. Staff J stated that the heavy whipping cream best buy date was 08/29/2025 and that it should have been discarded.SECOND FLOOR REFRIGERATORA joint observation and interview on 09/03/2025 at 2:43 PM with Staff L, Certified Nursing Assistant, showed an opened thicken apple juice with a used by once open date of 08/29/2025. Staff L stated that the thicken apple juice was to be used by 08/29/2025 and that it should have been discarded.KITCHEN DRY STORAGEA joint observation and interview on 09/05/2025 at 9:21 AM with Staff J, showed two unopened Medplus 2.0 (type of fortified nutritional shake) vanilla flavored supplement with a used by date of 12/28/2024 and 08/24/2025. Staff J stated the two supplements should have been discarded.In an interview on 09/09/2025 at 11:16 AM, Staff A, Executive Director, stated they expected expired or passed the used by date food items in the refrigerators and/or dry storage should have been discarded.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 Enhanced Barrier Precautions (EBP-precaution to protect residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections]) practices were followed for 1 of 1 resident (Resident 77), failed to ensure sharps were disposed of properly for 1 of 3 shower rooms (Second Floor Shower Room) and for 1 of 2 clean utility rooms (First Floor Clean Utility Room), reviewed for infection control. In addition, the facility failed to ensure proper hand hygiene/glove use practices were followed for 1 of 3 residents (Resident 2) and for 1 of 3 staff (Staff Q). These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included. EBPReview of the facility's policy titled, Enhanced Barrier Precautions, revised on 03/26/2024, showed that Enhanced Barrier Precautions (EBP) are used in conjunction with standard precautions and expand the use of PPE [Personal Protective Equipment-gown, gloves, masks] to donning [putting on] of gown and gloves during high-contact resident care activities. It showed that EBP are indicated for residents with indwelling medical devices including tracheostomies (a surgical procedure that creates an airway through the neck). It showed that EBP requires use of gown and gloves during high-contact resident care activities including transferring residents. It further showed that when EBP are implemented, the appropriate notice [is posted] on the room entrance door.so that all personnel will be aware of precautions. Review of Resident 77's comprehensive care plan, revised on 06/05/2025, showed that the resident has a tracheostomy. Observation on 09/03/2025 at 9:28 AM, showed no EBP signage outside Resident 77's room. Observation and interview on 09/05/2025 at 8:27 AM, showed no EBP signage outside Resident 77's room. Staff V, Certified Nursing Assistant (CNA), entered Resident 77's room, without wearing a gown or gloves, while they delivered Resident 77's meal tray. Staff V then assisted Resident 77 to sit up in bed and had contact with the resident's body and clothes. When asked if Resident 77 was on EBP, Staff V stated, there's [there is] no sign. I don't [do not] work over here, so I don't know. Staff V further stated that Resident 77 had a tracheostomy and when asked if they wore PPE when moving Resident 77 from laying to sitting up in bed, Staff V stated, no. In an interview on 09/11/2025 at 8:08 AM, Staff B, Director of Nursing, stated that they expected staff to use gowns and gloves if they were going to have high contact with a resident on EBP, which included repositioning them in bed. Staff B stated that if staff did not see EBP signage and a resident had a tracheostomy, staff should clarify with a nurse. SHARPS DISPOSALReview of the facility's policy titled, Regulated Waste Labeling and Disposal, last revised on 03/24/2025, showed, Regulated waste is labeled and disposed of in accordance with applicable Occupational Safety and Health Administration (OSHA) regulations. Regulated waste is contained, stored and transported in a manner that protects personnel from exposure to blood or other potentially infectious material (OPIM). The policy showed semi-liquid blood or other OPIM contaminated items and contaminated sharps are considered as regulated waste. The policy further showed regulated waste must be placed in containers which are closable and labeled or color coded in accordance with OSHA regulation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SHARPS DISPOSAL-SECOND FLOOR SHOWER ROOMObservation on 09/03/2025 at 11:18 AM, showed the Second Floor Shower Room, had a red sharps container that was not secured and was on the ground. It further showed that the sharps container had an opening on the lid and was filled with used razors; the used razors were accessible through the opening. Joint observation and interview on 09/04/2025 at 2:08 PM with Staff W, CNA, showed the Second Floor Shower Room, had red sharps container that was not secured and was on the ground. It further showed that the sharps container had an opening on the lid and was filled with used razors; the used razors were accessible through the opening. Staff W stated that they disposed of used razors in the red sharps container and described it as open and that the container should be covered. Joint observation and interview on 09/05/2025 at 1:25 PM with Staff C, Infection Preventionist, showed the Second Floor Shower Room, had a red sharps container that was not secured and was on the ground. It further showed that the sharps container had an opening on the lid and was filled with used razors; the used razors were accessible through the opening. Staff C stated that the sharps container should be secured, and it should not be on the floor. Staff C stated it can be an infection risk. In an interview on 09/09/2025 at 1:45 PM, Staff B stated that they expected the sharps container to be secured and has to meet standards, where you can put [sharps] in and can't [cannot] get them back out. SHARPS DISPOSAL-FIRST FLOOR CLEAN UTILITY ROOMObservations on 09/04/2025 at 10:18 AM and on 09/05/2025 at 11:12 AM, showed a full sharp container containing contaminated sharps and used blood draw items stored in the bottom cabinet of the First Floor Clean Utility Room. In an interview on 09/05/2025 at 1:15 PM, Staff T, Licensed Practical Nurse, stated that full sharp containers would be stored in biohazard bin located in the dirty utility room. In an interview and joint observation on 09/05/2025 at 1:28 PM, Staff C stated that a full sharp container would be stored in the biohazard bin located in the dirty utility room and should not be stored in the clean utility room. Joint observation at 1:38 PM showed there was a full sharp container containing contaminated sharps and used blood draw items that was stored in the bottom cabinet of the First Floor Clean Utility Room. Staff C stated that the sharp container should not have been stored in the clean utility room. In an interview on 09/10/2025 at 2:38 PM, Staff B stated that that they expected full sharp containers to be disposed in the biohazard bin located in the dirty utility room and should not have been stored in the clean utility room. HAND HYGIENE/GLOVE USEReview of the facility's policy titled, Handwashing/Hand Hygiene, updated in August 2025, showed, Hand hygiene is performed as soon as feasible, after hands become contaminated and frequently during the working day. Examples of situations when hand hygiene is performed, includes but is not limited to.Before and after handling invasive devices.Before and after dressing change/wound care.After contact with potentially contaminated surfaces or items in the resident's environment.After removing gloves. It further showed, The use of gloves does not replace hand washing/hand hygiene. RESIDENT 2Observation on 09/08/2025 at 2:37 PM, showed Staff R, Respiratory Therapist, applied (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	new gloves and assessed Resident 2's inner cannula (a removable thin tube inside their tracheostomy). Staff R then removed the dressing that was on each side of Resident 2's tracheostomy, took a gauze (a woven cloth used for wound care) and wiped off the secretions that were on Resident 2's neck and tracheostomy. When Staff R was done, they removed their gloves and applied new gloves without performing hand hygiene. Staff R then applied a new dressing on each side of Resident 2's tracheostomy. In an interview on 09/08/2025 at 4:27 PM, Staff R stated that their process was to perform hand hygiene between glove use and that they should have performed hand hygiene between glove use when they provided tracheostomy care. STAFF QObservation on 09/05/2025 at 11:29 AM, showed Staff Q, Housekeeping Aide, cleaning room [ROOM NUMBER] that had an EBP signage by the door. Staff Q had gloves on and emptied the trash cans that were in the room and placed them in a trash can that was outside the room. Staff Q then mopped and swept room [ROOM NUMBER]. Staff Q then removed their gloves and threw them in a trash can outside the room. Staff Q took new trash bags that were tied to the trash can that was outside the room, took new gloves and a broom and brought them to room [ROOM NUMBER]. Staff Q then applied the new gloves and emptied out the trash cans in room [ROOM NUMBER]. Staff Q did not perform hand hygiene between glove use, and between cleaning room [ROOM NUMBER] and room [ROOM NUMBER]. In an interview on 09/05/2025 at 11:46 AM, Staff Q stated that they would perform hand hygiene after cleaning and when they would remove their gloves. When asked why it was important to perform hand hygiene, Staff Q stated, because there's [there is] bacteria [germs]. Staff Q stated that they should have performed hand hygiene after removing their gloves. In an interview on 09/10/2025 at 8:57 AM, Staff P, Housekeeping Supervisor, stated that staff were to perform hand hygiene before entering/exiting resident rooms and between glove use. Staff P further stated that Staff Q should have performed hand hygiene after removing their gloves. In an interview on 09/10/2025 at 9:15 AM, Staff B stated that their process for glove use was for staff to perform hand hygiene before glove use, between dirty to clean tasks and between glove use. Staff B further stated that Staff R and Staff Q should have performed hand hygiene after they removed their gloves. Reference: (WAC) 388-97-1320(1)(a)(c)(4) .

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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** Based on observation, interview, and record review, the facility failed to provide care and services in a manner that maintains and promotes dignity and respect for 2 of 4 residents (Residents 23 & 55), reviewed for dignity. The failure to knock on the door and introduce themselves before entering, ensure oxygen concentrator (a machine that generates oxygen) was correctly labeled, and provide adequate covering was provided to maintain privacy during transfer placed the residents at risk for lack of privacy, decreased self-worth, potential embarrassment, and diminished quality of life.Findings included.Review of the facility-provided document titled, Notice of Resident Rights under Federal Law, updated in July 2015, showed the center will protect and promote these rights to the best of their ability. The document further showed, The resident has the right to personal privacy. the resident has the right to a dignified existence and self-determination.RESIDENT 23Resident 23 was admitted to the facility on [DATE] with diagnoses that included diffuse traumatic brain injury (a brain injury that can lead to prolonged coma [a state of prolonged unresponsiveness and unconsciousness], disability, and cognitive issues).Observation on 09/04/2025 at 10:49 AM, showed Resident 23's door was closed. Staff K, Certified Nursing Assistant (CNA), opened the door and, together with Staff V, CNA, entered Resident 23's room without knocking on or introducing themselves.Observation on 09/04/2025 at 2:39 PM, showed Staff Z, Licensed Practical Nurse, opened Resident 23's door and entered the room without knocking or requesting permission to enter, and did not introduce themselves.Observation on 09/05/2025 at 8:19 AM, showed Resident 23's oxygen concentrator had another resident's name sticker on it.During a joint observation and interview on 09/05/2025 at 10:31 AM with Staff AA, Respiratory Therapist, showed Resident 23's oxygen concentrator had another resident's name sticker on it. Staff AA stated the name on the concentrator was wrong and should have been labeled with Resident 23's name.Observation on 09/08/2025 at 10:38 AM, showed Staff BB, Respiratory Therapist, opened Resident 23's door and entered without knocking or introducing herself.During an interview on 09/08/2025 at 10:48 AM, Staff BB stated that it was expected for the staff to knock and introduce themselves before entering a resident's room. When asked if they knocked before entering, Staff BB stated, no, but I should have.RESIDENT 55Review of a face sheet printed on 09/11/2025 showed Resident 55 was admitted to the facility on [DATE].Review of the annual Minimum Data Set (an assessment tool) dated 07/09/2025 showed Resident 55 had severe cognitive impairment and was totally dependent on staff for activities of daily living.Observation on 09/05/2025 at 9:24 AM, showed Staff W, CNA, transferred Resident 55 in the hallway using a mechanical lift (a medical device used to safely and efficiently move residents with limited mobility). Staff W covered Resident 55's upper body with a white sheet. When Resident 55 was lifted up using the mechanical lift, the bottom back side of the resident was completely exposed and people in the hallway could see Resident 55's bottom.In an interview on 09/05/2025 at 9:37 AM, Staff W stated they covered Resident 55 with a white sheet and was not aware that their bottom was exposed. When asked if they would normally check to ensure residents were covered before transfer, Staff W stated they normally would, and they did not check at that time.In an interview on 09/09/2025 at 2:00 PM, Staff F, Resident Care Manager, stated staff were expected to knock on the door, introduce themselves, and request permission to enter a resident's room. Staff F further stated that staff were expected to ensure residents were properly covered to provide privacy, and ensure equipment was labeled with the correct resident's name.In an interview on 09/10/2025 at 10:42 AM, Staff B, Director of Nursing, stated it was their expectation that staff knock on the resident s door, introduce themselves, request permission to enter, and inform the residents of what they were going to do. Staff B further stated that respiratory equipment should be labeled with the correct resident's name and that residents should be properly covered to ensure privacy during transfer.Reference: (WAC) 388-97-0880 (1)(a)(b).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written notices of transfer/discharge to the resident and/or their representative and failed to notify the Office of the State Long Term Care Ombudsman (an advocacy group for residents), describing the reason for transfers/discharge for 2 or 3 residents (Residents 101 & 8), reviewed for hospitalization and discharge. These failures placed the residents at risk for not having the opportunities to make informed decisions about transfers/discharges. Findings included . Review of the facility's policy titled, Transfer and Discharge, updated in May 2025, showed, When the transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge which includes the following items: date of notice is given, effective date of the transfer/discharge, reason for the transfer/discharge, where the resident is to be moved, contact information for the state Long-Term Care Ombudsman . It further stated, The facility sends a copy of the notice to the State Long-term Care Ombudsman. The notice is provided at least 30 days before the transfer or discharge; the following are exceptions: when a resident's urgent medical needs require more immediate transfer. In these cases, notice must be given as soon as practical before or at the time of transfer or discharge. RESIDENT 101Review of Resident 101's admission record printed on 09/04/2025, showed Resident 101 admitted to the facility on [DATE] and discharged to acute care hospital on [DATE]. Review of the nursing progress notes dated 07/17/2025 showed Resident 101 had a change in condition and was transferred to the hospital for further evaluation. Review of Resident 101's electronic health record (EHR) in the progress notes and documents tabs did not show documentation that a written notice of transfer/discharge was provided to Resident 101 and/or their representative. Further review of the EHR did not show documentation that the Ombudsman was notified of Resident 101's transfer/discharge to the hospital. In an interview on 09/08/2025 at 2:04 PM with Staff F, Resident Care Manager (RCM), stated that when residents were transferred/discharged to the hospital, the nurses would do a change of condition (CIC), call report to the hospital, and send a packet with the resident to the hospital. Staff F further stated a paper form of the written notice of transfer/discharge was also completed. A joint record review of Resident 101's EHR in the documents tab did not show documentation that a written notice of transfer/discharge was provided. In an interview on 09/08/2025 at 2:21 PM, Staff I, Social Services Director, stated they would do the written notice of transfer/discharge form and that they would fax the form to the Ombudsman. Staff I further stated they would scan the notice of transfer/discharge form and fax confirmation into the EHR documents tab. Staff I stated there was no nursing home transfer/discharge notice given to Resident 101 and/or their representative when they transferred/discharged to the hospital on [DATE]. In an interview on 09/09/2025 at 11:10 AM, Staff A, Executive Director, stated, they expected staff to provide a written notice of transfer/discharge to the resident and/or their representative when they transferred/discharged to the hospital on [DATE] and to notify the Ombudsman of the transfer (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or discharge. RESIDENT 8Review of the nursing progress note dated 07/03/2025 showed Resident 8 was transferred to the emergency room for further evaluation. Review of Resident 8's EHR did not show documentation that a written notice of transfer/discharge was provided to Resident 8 and/or their representative. Further review of the EHR did not show documentation that the Ombudsman was notified of Resident 8's transfer/discharge. In an interview on 09/09/2025 at 1:27 PM, Staff E, RCM, stated that when residents were transferred to the hospital, they would be given written notice of transfer/discharge along with their discharge packet and that they would send a copy to the resident's representative. Staff E stated that it would be documented in the progress notes that the written notice of transfer/discharge was given and that a copy would be saved under documents in their EHR. Staff E further stated that they did not see any documentation that a written notice of transfer/discharge was provided to Resident 8 and/or their representative and that they were still looking. In a joint record review and interview on 09/09/2025 at 2:00 PM with Staff I, showed the Nursing Home Transfer or Discharge Notice, dated 09/04/2025, revealed that Resident 8 transferred to the hospital on [DATE] and that the notice was provided to Resident 8's representative on 09/04/2025, (63 days after transfer to hospital). A joint record review of the document titled facsimile transmission to the Ombudsman was dated 09/05/2025. Staff I stated that they would have expected a written notice of transfer/discharge to be provided to Resident 8 and/or their representative, and a copy sent to the Ombudsman. In an interview on 09/10/2025 at 10:15 AM, Staff A stated that they expected residents to receive a written notice of transfer/discharge when they were transferred/discharged to the hospital and a copy of the notice to be sent to the Ombudsman. Reference: (WAC) 388-97-0120 (2)(a)(b)(c)(d) .

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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 (PASARR-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 77), reviewed for PASARR 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 Process Policy and Procedure, revised on 01/01/2025, showed upon admission the admissions coordinator or designee validates the Level I PASRR and, if Level II was indicated, the Social Worker ensures timely referral to a Licensed Mental Health Professional.Resident 77 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behavior), bipolar disorder (a chronic mental health condition characterized by extreme mood swings between periods of mania [elevated mood] and depression), and major depressive disorder (mental health characterized by persistent low mood and loss of interest or pleasure in thinks once enjoyed doing).Review of Resident 77's Level I PASARR dated 03/14/2025 showed Section 1A (SMI indicator) was marked yes for schizophrenia and mood disorders. Further review showed, No Level II evaluation indicated.In a joint record review and interview on 09/09/2025 at 11:01 AM with Staff I, Social Service Director, showed Resident 77's Level I PASARR from the hospital indicated no Level II was required. Further review showed schizophrenia and mood disorders were marked yes. Staff I stated Resident 77 should have been referred for Level II PASARR evaluation and was not.In an interview on 09/10/2025 at 8:37 AM, Staff B, Director of Nursing, stated they expected PASARR screenings to be completed accurately and a Level II PASARR referral completed. residents further stated that if SMI indicators were marked yes, then the resident should have been referred for Level II evaluation.In an interview on 09/11/2025 at 9:17 AM, Staff A, Executive Director, stated that if Level I PASARR indicated SMI, then the resident should have been referred for a Level II PASARR evaluation.Reference: (WAC) 388-97-1975(1)(2).

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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. Based on observation, interview, and record review, the facility failed to follow hospice (specialized care for people who are nearing the end of their life) physician orders and effectively communicate/coordinate hospice plan of care for 1 of 1 resident (Resident 8), reviewed for hospice services. This failure placed the resident at risk for delayed treatment, unidentified decline, and unmet care needs.Findings included . Review of the facility's policy titled, Hospice - Provision of Care by Outside Providers, updated September 2017, showed, The hospice and center communicate, establish, and agree upon a coordinated Plan of Care (POC) reflecting the hospice philosophy and based on an evaluation of the individual needs of the resident. The POC includes: directive for managing pain and other uncomfortable symptoms, and the care and services the Center and hospice provide in order to be responsive to the unique needs of the resident and his/her expressed desire for hospice care. It further showed, Medications, medical supplies and services are provided as indicated by the agreement for coordination of services. Review of the Significant Change in Status Minimum Data Set (an assessment tool) dated 07/17/2025, showed that Resident 8 received hospice services. Review of Resident 8's terminal dx [diagnosis] care plan initiated on 07/13/2025, showed that Resident 8 was admitted to hospice on 07/12/2025. The care plan further showed the following interventions:- Facility to provide daily care and management, Hospice to provide DME [Durable Medical Equipment], assist with pain management for further delineation of duties refer to Hospice/center care coordination form.- Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. Review of the hospice nurse visit note dated 08/26/2025, showed [Staff N, License Practical Nurse] noted pt [patient] has erythema (redness of the skin) and moistened skin under folds of neck. [physician] ordering Nystatin [antifungal medication] powder. Review of the document titled, Hospice Physician Order, with an order date of 08/26/2025, showed, Nystatin powder topical [surface of skin], apply to affected area twice daily for seven days for rash. It further showed, Instructions: Apply to affected area (under folds of neck) twice daily for 7 [seven] days. Review of Resident 8's August 2025 and September 2025 medication administration record did not show an order for Nystatin powder. Observations on 09/03/2025 at 2:02 PM, on 09/04/2025 at 2:43 PM, on 09/05/2025 at 11:10 AM and 09/08/2025 at 2:38 PM, showed Resident 8 had redness on their neck. A joint observation and interview on 09/09/2025 at 10:00 AM, Collateral Contact 1 (CC1), showed Resident 8 was pointing to redness on their neck. CC1 stated that they had informed Staff N about it and that they thought they observed the redness two weeks ago. In a joint observation on 09/09/2025 at 10:34 AM with Staff N showed Resident 8 had redness under their neck folds. When Staff N attempted to lift Resident 8's neck fold to take a closer look, Resident 8 winced and pushed Staff N's hand away. In an interview and joint record review on 09/09/2025 at 11:42 AM, Staff N stated that they communicated with the hospice team and notified them of any changes to the residents and any supplies that the residents needed. Staff N stated that they received hospice physician orders through fax. Staff N stated that they were aware of the redness on Resident 8's neck folds, that they verbally notified the hospice nurse and that they did not receive an order for it. Staff N stated that they did not write a progress note about the communication they had with the hospice nurse. When asked if they followed up with the hospice team, Staff N stated that they did not. Staff N stated that they did not work on the weekends and that they guess no one followed up. A joint record review of the hospice physician note dated 08/26/2025, showed an order for Nystatin powder. Staff N stated, I didn't [did not] know about this until you showed me and that they had never seen it. Staff N further stated that they should have followed up with the hospice team and checked in with Staff E, Resident Care Manager (RCM), but that they did not. In an interview on 09/09/2025 at 1:38 PM, Staff E stated that they would communicate and coordinate with the hospice team with any change in condition of the residents. Staff E stated that the hospice team would fax physician orders to the nurse's station or would get them through medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	records. If the fax was not working, they would call the hospice team. Staff E stated that when they received the order, their in-house provider would be notified and then the order would get carried out. Staff E stated that they could either get verbal or faxed orders. Staff E stated that they were not aware of the redness on Resident 8's neck or the Nystatin order dated 08/26/2025. Staff E further stated they would have expected Staff N to have followed up with the hospice team when they did not receive a treatment order. In a phone interview on 09/10/2025 at 2:12 PM, CC2, stated they had verbalized to the facility nurse that the physician was possibly going to write an order for Nystatin for Resident 8 and that it would come, that it would get there. In an interview on 09/11/2025 at 9:45 AM, Staff B, Director of Nursing (DON), was asked how the facility ensured ongoing communication with the hospice team, Staff B stated that what they would like to see was timely and ongoing communication between the facility and the hospice team during in-person visits and through written documentation at a reasonable time frame so that facility representatives (nurse, RCM, DON) could read and review them. Staff B stated that the hospice team checks in with them every time they were in the facility and that the nurse checks in with them as well. Staff B stated that when hospice visits the resident, they expect their visit notes to be sent to medical records through fax or electronic-fax (e-fax) within 24 to 48 hours and that they expected that they should have been communicated in person and writing would just be verification. When asked how they ensured hospice physician orders were carried out, Staff B stated through communication. Staff B stated that their nurses could take verbal orders from their physician or written orders via fax or e-fax and then they would put it in their electronic health record. Staff B stated that if a resident was found or reported to have redness on their neck, they would have expected the nurse to have followed their process which was to assess the resident, communicate their findings to their physician/hospice team and from there, initiate POC if necessary. Staff B stated that Resident 8 needed treatment for their rash and that they expected timely communication, timely treatment and their skin to be evaluated. Reference: (WAC) 388-97-1060 (3)(b).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff followed safe transfer practices when using a mechanical lift (a medical device used to safely and efficiently move residents with limited mobility) for 1 of 4 residents (Resident 55), reviewed for accident prevention. This failure placed the resident at risk of falls, injury, and compromised safety.Findings included.Review of a face sheet printed on 09/11/2025 showed Resident 55 was admitted to the facility on [DATE]. Review of the annual Minimum Data Set (MDS - an assessment tool) dated 07/09/2025 showed Resident 55 had severe cognitive impairment and was totally dependent on staff for activity of daily living.Observation on 09/05/2025 at 9:24 AM showed Staff W, Certified Nursing Assistant (CNA), transferred Resident 55 from a shower bed using a mechanical lift without a second person present. Staff DD, Respiratory Therapist Supervisor, was present holding the ventilator (a medical device that assists or takes over breathing for individuals who are unable to breathe adequately on their own) tubing but was not assisting with the transfer.In an interview on 09/05/2025 at 9:33 AM, Staff DD stated they were not trained to use the mechanical lift, and their role was only to manage the ventilator machine tubing.In an interview on 09/05/2025 at 9:37 AM, Staff W stated that normally two staff would assist with a mechanical lift transfer and stated that enough staff were present on the floor but were not utilized.In an interview on 09/09/2025 at 2:00 PM, Staff F, Resident Care Manager, stated that mechanical lift transfers required two trained staff.In an interview on 09/10/2025 at 11:15 AM, Staff B, Director of Nursing, stated that it was their expectation that two staff assisted with mechanical lift transfer and that respiratory therapists were not considered as the second staff.Reference: (WAC) 388-97-1060(3)(g).

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on interview and record review, the facility failed to obtain registry verification to ensure staff met competency evaluation requirements before allowing to serve as a nurse aide for 1 of 5 nurse aides (Staff M), reviewed for nursing aide registry. This failure placed the residents at risk for potential abuse, neglect, and unmet care needs.Findings included .Review of the facility's policy titled, Screening, updated October 2022, showed, The Center conducts registry checks for all employees before hire, annually, and more frequent as required by state law and regulation.Review of Staff M's personnel records showed they were hired by the facility on 08/01/2025 as a Certified Nursing Assistant. Further review showed Staff M's records did not include documentation from the nurse aide registry.In an interview on 09/10/2025 at 3:38 PM, Staff B, Director of Nursing, stated that Staff M's registry verification was not completed before the employee's start date. Staff B further stated that the facility should have had registry verification before Staff M started working at the facility.In an interview on 09/11/2025 at 8:39 AM, Staff A, Executive Director, stated that their expectation was the facility to obtain staff registry verification prior to hire date.Reference: (WAC) 388-97- 1660 (3)(c).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure pharmacy services were provided to meet the needs of 1 of 5 residents (Residents 9), reviewed for unnecessary medications. The failure to administer and/or document medication administration in accordance with professional standards of practice placed the residents at risk for negative outcomes and a diminished quality of life.Findings included .Review of the facility's policy titled, Medication Administration General Guidelines, dated 01/24 [January 2024] showed, Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. The individual who administers the medication dose, records the administration on the resident's MAR [Medication Administration Record] immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. The resident's MAR/TAR [Treatment Administration Record] is initialized by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration and time.Resident 9 admitted to the facility on [DATE] with diagnoses that included high blood pressure, diabetes (a condition that affects the level of sugar in the blood), chronic arterial fibrillation (a condition where the upper chambers of the heartbeat irregularly and rapidly), and Gastroesophageal Reflux Disease (GERD - condition where stomach acid flows back up into the esophagus [tube that carries food from the throat down to the stomach], causing irritation and discomfort). Review of the quarterly Minimum Data Set (an assessment tool) dated 08/04/2025, showed Resident 9 had impairment in cognition and dependent on staff with all aspects of care.Review of Resident 9's July 2025 MAR showed that the following medications were not administered to Resident 9 on 07/26/2025 and 07/27/2025 and were documented on the MAR as 9 [Other/See Progress Notes]:Lansoprazole (medication for GERD) at 8:00 AMLiquid protein supplement at 12:00 PMLisinopril (blood pressure medication) at 8:00 AMMultiple Vitamins-Minerals (supplement) at 8:00 AMRosuvastatin Calcium (medication that lowers cholesterol [a waxy substance found in the blood]) at 8:00 AMApixaban (blood thinner) at 9:00 AMCarvedilol (blood pressure medication) at 9:00 AMInsulin Glargine (medication that regulates blood sugar) at 8:00 AMMetformin (medication that helps manage blood sugar levels) at 8:00 AMMiraLax (stool softener) at 8:00 AMSenna (stool softener) at 8:00 AMBaclofen (muscle relaxant) at 9 AM and 3:00 PMInsulin Lispro (medication that regulates blood sugar) at 8:00 AM, 12:00 PM and 6:00 PMTylenol (pain medication) at 8:00 AM and 12:00 PMReview of the nursing progress note dated 07/26/2025 and 07/27/2025 did not show why the medications listed above were not administered to Resident 9.In an interview and joint record review on 09/11/2025 at 9:18 AM, Staff B, Director of Nursing, stated that their expectation was for the staff to follow the physician order in medication administration. A joint record review of the July 2025 MAR showed that the above listed medications were not administered to Resident 9 on 07/26/2025 and 07/27/2025 and were documented on the MAR as 9. Staff B stated that their expectation was when a medication was not administered and documented as 9, there should be a nursing note why the medications were not administered. Staff B further stated they would start an investigation into it.Reference: (WAC) 388-97-1300 (1)(b)(ii)(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate monitoring was conducted before administering Blood Pressure (BP- the force of blood flowing through blood vessels) medication with parameters for 1 of 5 residents (Resident 77), reviewed for unnecessary medications. This failure placed the resident at risk for complications related to untreated or uncontrolled BP and a diminished quality of life.Findings included .Review of the facility's policy titled, Medication Administration General Guidelines, dated January 2024, showed medications were to be administered in accordance with the prescriber's written order. The policy further directed staff to review and confirm each medication order on the Medication Administration Record (MAR) prior to administration, and to obtain and record any required vital signs before giving medications.Resident 77 was admitted to the facility on [DATE] with diagnoses that included hypotension (low BP). Review of the physician's orders printed on 09/11/2025, showed Resident 77 was prescribed midodrine (a medication to treat low BP) three times daily, at three to four hours intervals, with the last dose before 6:00 PM. Further review of the physician order showed to hold medication if systolic pressure (pressure produced when the heart contracts and pushes out blood) greater than 150 or diastolic pressure (pressure produced when the heart relaxes and fills with blood between heartbeats) greater than 90.Review of the September 2025 MAR showed Resident 77 received midodrine as ordered. Further review of Resident 77's BP log prior to the 6:00 PM dose showed BPs were not taken three times daily. Documentation showed BP was taken: - One time per day on 09/02/2025, 09/03/2025, 09/04/2025, 09/05/2025, 09/06/2025, and 09/07/2025.- Two times per day on 09/01/2025.In an interview and joint record review on 09/09/2025 at 9:04 AM, Staff CC, Licensed Practical Nurse, stated that BP should always be checked prior to giving midodrine and that monitoring was documented in the resident Electronic Health Record (EHR). Staff CC confirmed that BP readings were not consistently obtained and documented in accordance with the physician's order.In an interview on 09/09/2025 at 9:27 AM, Staff F, Resident Care Manager , stated that staff were expected to follow physician orders and obtain BP prior to administering midodrine, with documentation entered into the resident's EHR.In an interview on 09/11/2025 at 9:17 AM, Staff B, Director of Nursing, stated it was their expectation that BP be obtained and documented prior to administering BP medication.Reference: (WAC) 388-97-1300 (4)(ii).

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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** Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (used to prevent pneumonia [a lung infection]) was provided for 2 of 5 residents (Residents 9 & 77), reviewed for immunizations and infection control. This failure placed residents at risk of acquiring, transmitting, and/or experiencing potentially avoidable complications from pneumococcal disease.Findings included.Review of the facility's policy titled, Pneumococcal Vaccination of Residents, dated March 2022, showed, PCV-20 [Pneumococcal Conjugate Vaccine-vaccine that protects against 20 types of bacteria that cause pneumonia] is recommended for all adults 65 or older. Adults 19 through [AGE] years old with certain underlying medical conditions or other risk factors the Center follows the CDC [Centers for Disease Control and Prevention]. It further showed, Residents may refuse vaccination. Vaccination refusal and reasons why (e.g., [example] contraindicated, did not want vaccine, etc.) are documented.RESIDENT 9Review of facility's form titled, Pneumococcal Vaccine Informed Consent, updated October 2024, showed that it was signed on 05/20/2025 and that Resident 9's representative consented for Resident 9 to receive the pneumococcal vaccine.Review of Resident 9's Electronic Health Record (EHR-medication administration record, progress notes, and attachments) from May 2025 to September 2025, showed no documentation that the pneumococcal vaccine was provided to Resident 9.RESIDENT 77Review of facility's form titled, Pneumococcal Vaccine Informed Consent, updated October 2024, showed that it was signed on 03/14/2025 and that Resident 77's representative consented for Resident 77 to receive the pneumococcal vaccine.Review of Resident 77's EHR from March 2025 to September 2025, showed no documentation that the pneumococcal vaccine was provided to Resident 77.In an interview on 09/10/2025 at 10:22 AM, Staff B, Director of Nursing, stated they offered vaccines to residents on admission and whenever recommended.A joint record review and interview on 09/11/2025 at 8:08 AM with Staff B, showed the facility's form titled, Pneumococcal Vaccine Informed Consent, updated October 2024, showed it was signed on 05/20/2025 and that Resident 9's representative consented for Resident 9 to receive the pneumococcal vaccine. A joint record review of Resident 9's EHR showed no documentation that the pneumococcal vaccine was given to Resident 9. Staff B stated, I don't [do not] see anything that it was given or that the patient was not eligible and I would expect them [staff] to document any follow up. In another joint record review of the facility's form titled, Pneumococcal Vaccine Informed Consent, updated October 2024, showed it was signed on 03/14/2025 and that Resident 77's representative consented for Resident 77 to receive the pneumococcal vaccine. A joint record review of Resident 77's EHR showed no documentation that the pneumococcal vaccine was given to Resident 77. Staff B stated, I would expect it to be given if she's [Resident 77] eligible or documentation if not eligible and I have no evidence that it [pneumococcal vaccine] was given.Reference: (WAC) 388-97-1340 (2).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505311	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seattle Medical Post Acute Care	555 16th Avenue Seattle, WA 98122

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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. Based on interview and record review, the facility failed to ensure the COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases can cause difficulty breathing and could result in impairment or death) vaccine was offered to 1 of 5 residents (Resident 3), reviewed for immunizations. The failure to educate and offer the COVID-19 vaccination placed the resident at risk for contracting the COVID-19 virus and related complications. Findings included.Review of the facility's policy titled, SARS-CoV-2 [strain of the virus that causes COVID-19] (COVID-19) SNF [Skilled Nursing Facility], dated January 2025, showed that, residents are offered recommended COVID-19 vaccinations upon admission and as eligible per CDC [Centers for Disease Control and Prevention] recommendations.Review of the CDC online document titled, Staying Up to Date with COVID-19 Vaccines, dated 06/06/2025, recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 and older. It further showed that getting the 2024-2025 COVID-19 vaccine is especially important if you.are living in a long-term care facility.Review of the Immunizations tab in Resident 3's Electronic Health Record (EHR- medication administration record, progress notes, attachments, and immunizations tab), showed the last documented COVID-19 vaccine was administered on 12/06/2023.Review of Resident 3's EHR, from September 2024 through September 2025, showed no documentation that Resident 3 was offered the most recent COVID-19 vaccine.In an interview on 09/10/2025 at 1:29 PM, Staff B, Director of Nursing, stated that they offered covid vaccinations to residents per recommendation by the CDC. Staff B further stated, I can't [cannot] find documentation that it was offered [to Resident 3].No associated WAC.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, homelike, and safe environment for 1 of 2 rooms (room [ROOM NUMBER]), reviewed for safe and sanitary environment. The failure to ensure rooms were free from odors and maintained in safe and sanitary conditions placed the residents at risk of infection, poor living conditions, and a diminished quality of life.Findings included.Review of the facility's policy titled, Guidelines for Cleaning and Disinfecting Resident Rooms, dated May 2015, showed housekeeping surfaces were cleaned on a regular basis, when spills occur, and when these surfaces were visibly soiled. The policy showed resident room cleaning would include cleaning horizontal surfaces (such as bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution, and walls when they were visibly soiled.Observation on 09/03/2025 at 9:16 AM showed Resident 29 and Resident 30 shared room [ROOM NUMBER]. The room had a strong unpleasant odor. On Resident 29's side of the room, next to the door, showed a nightstand full of drink bottles, some were empty or half full. On Resident 30's side of the room, next to the window, showed the bed and floor had piles of clothing and shoes. Resident 30's nightstand was full of empty drink bottles and two bedside tables against the wall full of various food items. Observation showed an empty Chef Boyardee [brand name of canned pasta] can on the floor next to the bed and other parts of the floor on Resident 29's side had dried up drink stains. On the bottom half the bathroom door showed dried brown splatter marks. Observation of the bathroom showed the bathroom sink had brown stains in the basin and debris around the facet handles.In an interview on 09/03/2025 at 9:16 AM, Resident 30 stated that staff would come in and mop the floors but did not clean their room.In an interview on 09/05/2025 at 1:18 PM, Staff EE, Housekeeping Aide, stated that they would be cleaning room [ROOM NUMBER] next.Another interview on 09/05/2025 at 1:54 PM, Staff EE stated that they had finished cleaning room [ROOM NUMBER]. Staff EE stated that their daily room cleaning included mopping, dusting, and cleaning the bathroom sink and toilets. Staff EE further stated that they only mopped the floor in room [ROOM NUMBER]. Staff EE declined to answer if they were going to circle back and do any more cleaning in room [ROOM NUMBER], then stated that the housekeeping supervisor would answer these questions.In an interview and joint observation on 09/05/2025 at 1:57 PM, Resident 29 stated that Staff EE did not clean anything in the room but the floor. Resident 29 pointed out the old brown splatter marks on the bottom half of the bathroom door and stated that these stains were from the coffee that Resident 30 had spilled and tried to clean it up themselves. Resident 29 then lifted the toilet seat to show there were brown organic matter on the underside of the seat that had not been cleaned, and the sink had debris around the faucet handles and the basin.In an interview on 09/09/2025 at 9:36 AM, Staff FF, Housekeeping Aide, stated that when they cleaned rooms, they would take out the garbage, pick up the floor, clean the little table, dust and mop. Staff FF further stated that cleaning the bathroom in the resident's room was included and that they cleaned the sinks, the toilets, removed the stains, and restock with toilet paper.In an interview on 09/10/2025 at 10:27 AM, Staff P, Housekeeping Supervisor, stated that they expected housekeepers to clean resident bathrooms everyday which included the sink and the toilet. Staff P stated that if residents refused to have their room cleaned, they would move on to the next room but come back and try again later that same day. A joint observation and interview on 09/10/2025 at 2:58 PM with Staff P showed the garbage can in room [ROOM NUMBER] was still full, the coffee marks on the bathroom door were still there. Observation of the toilet seat showed there were dark brown stains under the toilet seat. Staff P stated that Staff EE had left for the day without coming back to clean room [ROOM NUMBER]. Staff P stated that they would clean the bathroom themselves since Staff EE had already left. Staff P further stated that they expected staff to inform the nurse when residents refused to (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have their rooms cleaned.On 09/10/2025 at 10:00 AM, Staff A, Executive Director, stated that their expectations for daily room cleaning included cleaning spills, wall stains, bathroom sinks and toilet.Reference: WAC 388-97-3220(1).