STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505319	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alderwood Post Acute & Rehabilitation	3701 188th Street Southwest Lynnwood, WA 98037

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a patient-centered discharge planning by the interdisciplinary team, involved resident and/or representative in the discharge planning, direct communication with the resident and/or representative about discharge process, and document required discharge information for 2 of 4 sample residents (Resident 5 and 6) reviewed for discharge planning. This failure placed residents at risk for unmet care needs, psychological distress and decreased quality of life. Findings included . Review of the facility policy titled, Transfer or Discharge, preparing a Resident for, dated 10/01/2021, documented a post-discharge plan was developed for each resident prior to transfer or discharge and the plan would be reviewed with the resident, and/or family at least twenty-four hours before resident's discharge or transfer from the facility. <RESIDENT 5> Resident 5 admitted to the facility on [DATE] and discharged home on [DATE]. According to the discharge Minimum Data Set (MDS-an assessment tool) assessment, dated 06/07/2025, Resident 5 was cognitively intact. In an interview on 06/17/2025 at 1:55 PM, a Collateral Contact (CC) 1, family of Resident 5, stated both the resident and family did not receive any information about the discharge planning since the admission. CC1 stated they were not sure what the plan was or the timeline of discharge, and Resident 5 kept asking social services, multiple nurses every day for discharge plan update but nobody told them anything. CC1 stated the staff told them Resident 5 could go home abruptly on the discharge day. In an interview on 06/24/2025 at 9:44 AM, Resident 5 stated they did not know about their discharge planning process; was not notified of any update and were not informed about the timeline of discharge during the stay in the facility. Resident 5 stated they kept asking what the discharge plan was, but nobody explained to them. Resident 5 stated the facility told them they could go home on the same day, but they did not even have time to prepare. Resident 5 had to ask to be discharged the next day in order to have time to arrange someone to pick them up. (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a follow up interview on 06/26/2024 at 11:01 AM, Resident 5 stated they were frustrated and stressed because they had trouble getting assist for transportation for their medical appointments. Resident 5 stated they were not qualified for home health service which was referred by the facility upon discharge and they had no other resources at this moment. Review of a social services progress note dated 05/09/2025, documented Resident 5 would like to remain in the facility for a short time but wanted to go home and the social service documented to check in with Resident 5 next week. Review of a social services progress note dated 06/06/2025, documented Resident 5 would discharge home with family tomorrow. Review of the electronic health record (EHR) from 05/09/2025 to 06/06/2025, there was no documentation that social services checked in with Resident 5 after 05/09/2025; there was no documentation that a discharge plan was developed from the multidisciplinary team addressed the resident's discharge goals, identified needs, and referrals to local contact agencies; there was no documentation that Resident 5 and the family were involved in discussions regarding their person-centered discharge planning; there was no documentation that Resident 5 and the family were directly communicated about the discharge planning, process and preparation; there was no documentation about how discharge timeline was decided. In an interview on 06/24/2025 at 2:36 PM, Staff F, Social Services, stated they set up the discharge date for Resident 5 because the resident told them they were ready to go home, and the resident was independent. Staff F stated they talked with the nurse manager and rehab therapists if Resident 5 was ready to be discharged but they did not document that and could not provide any information when they talked with the team. Staff F stated they informed the resident and the family that the resident could go home on [DATE], the day before discharge day. Staff F stated they communicated with Resident 5 and the family about the discharge planning and preparation before 06/06/2025 but they did not document it and could not provide any information of when that was. Staff F stated they would get back to the surveyor. No further information provided. <RESIDENT 6> Resident 6 admitted to the facility on [DATE] and discharged home on [DATE]. According to the discharge MDS assessment, dated 06/06/2025, Resident 5 was cognitive moderately impaired. Review of Resident 6's care plan, copy date 06/24/2025 at 3:27 PM, one intervention under discharge focus initiated on 01/19/2025, documented to review and update discharge plans with the resident when needed. Review of the social service initial evaluation dated 12/14/2024, documented Resident 6 would need 24/7 cares to return home under the physician's input regarding discharge. Review of a social services quarterly assessment dated [DATE], documented Resident 6 had declined in cognitive status and mental status. Under the quarterly discharge plan review area, it was blank. Review of the Discharge summary dated [DATE], documented Resident 6 discharged home with the daughter and Resident 6 was very forgetful, using brief, and required assistance with bathing. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 6's EHR, after 12/24/2024 till 06/06/2025, showed there was no documentation that directly communication about discharge planning with the resident and/or family; there was no documentation that a discharge planning and the timeline were discussed from the multidisciplinary team and addressed the resident's discharge goals, needs, and referrals to local contact agencies; there was no documentation that Resident 6 and the family were involved in discussions regarding their person-centered discharge planning; there was no documentation if the discharge planning was reevaluated, modified or updated to reflect Resident 6's cognitive status declines; there was no documentation if the family was prepared or received any care giver training before discharge or if there was 24/7 cares available. In an interview and record review on 06/24/2025 at 3:03 PM, Staff G, Social Services, stated Resident 6's family came to the facility on [DATE] and asked to bring the resident home. Staff G stated they did not communicate with Resident 6 and the family about the discharge planning and there was no documentation about the discharge planning since 12/24/2024. Staff G stated they tried to contact the daughter but failed. Staff G could not provide any information when they tried to contact the daughter and stated they should document it but they did not. Staff G stated they asked the rehab therapist about any equipment needed but they did not document it. Staff G stated they could not find any documentation about discharge planning was developed and discussed with the team. In an interview on 06/24/2025 at 5:40 PM, Staff A, Administrator, stated residents required patient-centered specific discharge planning and they expect the social services documented about the discharge planning and process. Reference WAC 388-97-0080 (1)(b)(2)(a)(d)(6)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review, the facility failed to ensure sufficient nursing staff were available to provide timely medication administration, provide care without residents having to wait a long time and licensed nursing staff were able to adequately monitor resident's conditions and supervise nursing assistants to ensure care was provided timely for 2 of 2 units (first floor, second floor) reviewed for sufficient staffing. Failures to ensure sufficient nursing staff resulted in delays in nursing staff response to residents' call lights, delays in administering medications, and placed residents at risk for unmet care needs, complications of medical condition and a diminished quality of life. Findings included . Review of an anonymous report to the state agency on 06/10/2025 at 2:01 PM documented a concern of sufficient nursing staff at facility. The report documented that residents were getting their medications late and call lights were not being answered timely. During an observation and interview on 06/24/2025 at 8:51 AM, Staff B, Registered Nurse (RN), was standing at the pink medication cart and had the electronic Medication Administration Record (emar) screen open. Staff B explained that the three residents' profiles showing in red were because those residents' medications were late. Staff B reported they had not had a chance to get to those residents yet because they were short today. Staff B stated they had notified the director of nursing and the staffing coordinator but had not received any assistance to help with resident care or medication pass. During an observation and interview on 06/24/2025 at 8:58 AM, Staff B prepared medications for Resident 1. Staff B stated that Resident 1 had scheduled medications for 7:00 AM, but they were covering two medication carts and had not had a chance to give Resident 1 medications until this time. During an observation on 06/24/2025 at 9:14 AM, Staff B was observed to administer three medications scheduled for 8:00 AM and one medication scheduled for 7:00 AM. During an interview on 06/24/2025 at 9:28 AM, Staff C, Licensed Practical Nurse (LPN), reported that they had completed the morning medication pass for [NAME] medication cart but had not started any of the medications on the blue medication cart that they were sharing with Staff B. Staff C reported that they had too many residents assigned to them today, and they had just as many residents yesterday, 06/23/2025. During an observation on 06/24/2025 at 9:49 AM, Staff D, MDS (minimum data set assessment) coordinator, reported they were covering the medication cart. Staff D administered a medication to Resident 3 that had been scheduled for 7AM. During an observation on 06/24/2025 at 10:01 AM- surveyor observed the emar screen on the blue medication cart. The screen had six resident profiles showing in red. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/24/2025 at 10:12 AM, Staff E, Resident Care Manager, was at the blue medication cart with the facility provider. Staff E reported that they were discussing with the provider, the residents, that had late medications to see if they needed to make any adjustments to the orders for the day. Resident 4 was sitting in their wheelchair next to the medication cart and reported that they wanted their medications for the morning and would like them earlier in the day. Staff E provided Resident 4 with their medications at 10:16 AM. Staff E reported that the medications were scheduled between 6:00 AM- 10:00 AM, so the medications were only 16 minutes late. During a follow-up interview on 06/24/2025 at 11:17 AM, Staff E reported that the emar is color coded: green means residents have all medications provided, Yellow means residents have something scheduled in the window of one hour before or after the scheduled time, and red means the medications are already outside of the administration time and they are late. Staff E reported that they also covered a medication cart on 06/23/2025 and almost all of the residents' medications were late and they had to be placed on alert. During an interview on 06/24/2025 at 11:20 AM, Staff H, Licensed Practical Nurse, stated there were only two cart nurses covering the whole floor with a census of 39 and it had been this way every day for about two weeks. Staff H stated it was too much work and they could not finish the morning medication pass until lunchtime. During an interview on 06/24/2025 at 3:25 PM, Resident 4 reported that they almost always get their medications late. Resident 4 stated that they don't get their medication until 9:45 PM, and she would like to have them earlier so they could go to sleep. Resident 4 stated they tried to stay awake until they had received their medications, so they didn't get missed. <ANONYMOUS STAFF> During an interview on 06/24/2025 at 3:02 PM, Anonymous Staff 1 (A1), stated they have been working short staffed (only two nurses on unit) a few days a week. Staff A1 reported that if there were only two nurses on shift, there was not enough time to get the care done timely. Staff A1 reported that they would stay over to get medications and treatments done, but they were not completed on time. Staff A1 reported when there are three nurses scheduled, they can get their work done in a timely manner, but if only two nurses were working, the nurse was not able to supervise the aides and make sure residents are getting the care they require, not able to give medications timely and not enough time to follow up on resident issues. Staff A1 had reported their concerns to management and the staffing coordinator but stated they hadn't received any assistance. During an interview on 06/24/2025 at 3:12 PM, Anonymous staff 2 (A2), reported they work with one less nurse a third of the time. When they have less nurses on duty, Staff A2 reported they start work on their usual assigned cart and were not able to monitor the other residents for the first 3-4 hours of their shift, which they felt was unsafe. Staff 2 reported they did not have time to spend adequate time with their residents. <STAFFING COORDINATOR> (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/24/2025 at 11:00 AM, Staff I, staffing coordinator, explained when there is a full resident census, they have 3 nurses for first floor and second floor on both day and evening shifts. Staff I stated the census was down at this time, so they have to cut a nurse shift each day. Staff I reported that they were instructed to cut an entire nurse each day and not to cut each unit for a few hours. Staff I reported that they had been rotating the shift and the unit that was working with one less nurse. Staff I reported the current resident census on Second floor was 57 residents and the first floor was 39, but they were rehab residents that required more assistance. Review of the facility assignment sheets from 05/24/2025- 06/24/2025 showed: Second floor day shift: 13.5 out of 32 shifts had only two nurses on unit. Second floor evening shift: 8 out 32 shifts had only two nurses on unit. First floor day shift: 12 of 32 shifts had only two nurses. First floor evening shift: 13 of 32 shifts had only two nurses. On 05/29/2025 and 06/09/2025 through 06/24/2025, showed two or more shifts each day where nurses were sharing a medication cart. In an interview on 06/17/2025 at 1:55 PM, Collateral Contact (CC1), family of Resident 5, stated the resident had to wait for one hour or longer to get the call light answered, and it happened on a daily basis. CC1 stated one nurse told them the facility was very short of nursing staff. In an interview on 06/24/2025 at 9:44 AM, Resident 5 stated every time they pressed the call light, nobody answered it, and they had to walk to the nurses' station to ask for help. Resident 5 stated the facility did not have enough nurses. In an interview on 06/24/2025 at 11:05 AM, Resident 8 stated they had to wait for one hour for the nurse to answer the call light and it happened every day on all shifts. Resident 8 stated the facility did not have enough nurses. <GRIEVANCES> Review of a grievance form dated 06/04/2025, Resident 9 reported they had to yell to get help. Resident 9 reported they waited for 45 minutes to one hour to get the call light answered and the staff came in and said they would come back but never return. The facility investigation documented that the licensed nurse staffing was an issue, and the scheduler made some staffing changes. Review of a grievance form dated 06/04/2025, Resident 11 reported they pressed call light at 6:55PM and nobody show up until 7:45 PM. Resident 11 also reported long call light times all evenings. The facility investigation documented scheduling issues noted and the facility assigned more stable staffing. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a grievance form dated 06/05/2025, Resident 10 reported they pushed the call button at 3:45 AM for bad spasms and pain and aide did not come until 4:30 AM and they did not get the pain medication until 5:00 AM. The facility investigation documented there was a staffing issue and made some staffing changes. Reference WAC 388-97-1080(1)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than five percent. 8 medication errors were identified out of 29 opportunities due to the failure of 2 of 2 nurses (Staff B and D) provided medications outside of the scheduled administration time. This resulted in a medication error rate of 27 percent. This failure placed residents at risk of reduced medication effectiveness, worsening of symptoms, and/or complications of medical condition. Findings included . <RESIDENT 1> In an observation on 06/24/2025 at 8:58 AM, Staff B, Registered Nurse, prepared medications to be administered to Resident 1. Staff B administered the medications below to the resident at 9:04 AM. Staff B reported that the medications scheduled for 7:00 AM were administered late. Review of the June 2025 Medication Administration Records (MAR) for Resident 1 showed the following orders: - Levothyroxine (thyroid medication) once a day. Dose scheduled at 7:00 AM. - Acetaminophen (pain reliever) three times a day. Doses scheduled at 7:00AM, 3:00PM and 9:00PM. - Diclofenac gel (pain medication) three times a day. Doses scheduled at 7:00AM, 3:00PM and 9:00PM. <RESIDENT 2> In an observation on 06/24/2025 at 9:14 AM, Staff B prepared medications to be administered to Resident 2. Staff B administered the medications below to Resident 2 at 9:24 AM. Review of the June 2025 MAR for Resident 2 showed the following orders: - Acetaminophen three times a day. Doses scheduled at 7:00AM, 3:00PM and 9:00PM. - Diamox Extended release 12-hour capsule (fluid retention medication) twice a day. Doses scheduled at 8:00 AM and 8:00 PM. - Dorzolamide-timolol (eye pressure medication) twice a day. Doses scheduled for 8:00 AM and 8:00 PM. - Protonix (acid reflux medication) once a day. Dose scheduled for 8:00 AM. <RESIDENT 3> In an observation on 06/24/2025 at 9:38 AM, Staff D, MDS (assessment of resident care needs) coordinator, prepared medications to be administered to Resident 3. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the June 2025 MAR for Resident 3 showed an order for Hydrocortisone cream (anti-inflammatory medication) three times a day. Doses were scheduled for 7:00AM, 3:00PM and 9:00PM. Staff D administered the medication to Resident 3 at 9:58 AM. During an interview on 06/24/2025 at 11:17 AM, Staff E, Resident Care Manager, stated medications that are timed for a specific time need to be administered an hour before or an hour after the scheduled time. During an interview on 06/24/2025 at 4:16 PM, Staff A, Administrator, stated the facility did not have a policy for window of time medication was to be administered if medication was ordered at a specific time. Staff A reported the timeframe should be one hour before or after the scheduled time to remain in compliance. Reference WAC 388-97-1060 (3)(k)(ii)