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	09/03/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were free from abuse for 1 of 1 sampled resident (Resident 1) reviewed for allegation of abuse and neglect. The facility failed to ensure resident protection by allowing alleged staff to continue to work with vulnerable residents, failed to report and investigate an injury of unknown source in a vulnerable area and implement interventions to prevent mental and physical abuse. This failure placed residents at risk for psychosocial harm and a diminished quality of life. Findings included.Review of facility policy titled Abuse, dated 10/20/2022, documented under protection- in the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and representative, and protect the resident and other residents from further harm or incident. Reporting: the organization will immediately report the alleged violations involving neglect, abuse, including injuries of unknown sources. Resident 1 was admitted to the facility on [DATE] with diagnoses to include sepsis (infection in the blood), anxiety disorder, depression, hemiplegia (paralysis to one side of the body) and hemiparesis (a condition that causes weakness or partial paralysis on one side of the body) affecting their left side. According to the admission Minimum Data Set (MDS-an assessment tool) assessment, dated 06/05/2025, indicated the resident had moderate cognitive impairment and required substantial to maximum assistance from staff with toileting.Review of the facilities state reporting log for August 2025, documented on 08/18/2025 Resident 1 had an allegation of abuse, with no injury and the actions taken by the facility included staff training/counseling and care plan revisions.Review of the unsigned facility investigation summary conclusion dated 08/22/2025, documented that Resident 1 reported an allegation of sexual assault on 08/18/2025. The investigation documented that abuse and neglect were ruled out through investigation, and staff and resident interviews, resident skin check resulted no new skin issues and staff member suspended will be educated to follow the care plan and ensure they are properly communicating with the residents while performing care. The conclusion also documented interventions implemented after the allegation that included skin check performed, family and provider notified, care plan updated to reflect female care only and cares in pairs. Review of Resident 1's clinical record showed no documentation that the resident received any thorough assessment to include a skin assessment following the report of an allegation of sexual assault. There was no documented skin check to show the resident was assessed for injuries. There was no documentation that Resident 1 was offered to go to the emergency room for evaluation following an allegation of sexual assault. Further review of the facilities investigation showed a form titled Suspension Pending Investigation, dated 08/18/2025, Staff A documented that Staff E, Nursing Assistant Certified (NAC), was suspended pending investigation on 08/18/2025. Staff A documented Over phone on the line of the form intended for the employee's signature. On 09/03/2025 at 2:00 PM, Staff A reviewed the form and stated that he did not review this form with Staff E until 08/22/2025 but had completed the form himself on 08/18/2025 so that the employee could get paid for their time off while suspended. Staff E's statement was included in the investigation and dated 08/22/2025, four days after the report of the allegation. Review of Staff E's timecard dated 08/18/2025 documented that they worked a full shift from 10:10 PM to 6:20 AM on 08/19/2025, when they should have been suspended. Staff A stated that the prior DNS should have suspended the staff member but did not.Review of a nursing progress note dated 08/23/2025 at 10:35 PM, documented patient having a new skin tear around her left labia. Further review of progress notes showed no further documentation regarding this injury of unknown origin. There was no documentation that a thorough skin check had been completed at the time of this discovery. Review of Resident 1's Treatment Administration Record (TAR) showed that treatment was initiated for the skin tear to the resident's labia on 08/23/2025. Further review showed that male staff documented this treatment as being completed by them on 08/23/2025, 08/25/2025, 08/26/2025 and 08/27/2025, when the Resident was care planned for female care only. In an interview on 09/03/2025 at 12:30 PM, Staff D, Licensed Practical Nurse (LPN)/Nurse Manager stated that they were notified on 08/23/2025 that Resident 1 was found to have a skin tear on their labia, I haven't actually seen this skin tear myself. Staff D stated that this resident has a lot of skin issues in other places, so they felt it was because they have really fragile skin. Staff D stated that due to the fact this skin issue was in a concerning place and the resident's recent allegation of sexual assault this concern should have been reported and investigated but they had not reported or investigated this. Staff D stated that the interventions placed following the initial allegation of sexual assault include female care only and care in

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report to the state survey agency allegations of injury of unknown origin in a vulnerable area for 1 of 1 sampled resident (Resident 1) reviewed for abuse. This failure placed residents at risk of undiscovered and potential, continued abuse.Findings include .Resident 1 was admitted to the facility on [DATE] with diagnoses to include sepsis (infection in the blood), anxiety disorder, depression, hemiplegia (paralysis to one side of the body) and hemiparesis (a condition that causes weakness or partial paralysis on one side of the body) affecting their left side. According to the admission Minimum Data Set (MDS-an assessment tool) assessment, dated 06/05/2025, indicated the resident had moderate cognitive impairment and required substantial to maximum assistance from staff with toileting. Review of a nursing progress note dated 08/23/2025 at 10:35 PM, documented patient having a new skin tear around her left labia. Further review of progress notes showed no further documentation regarding this injury of unknown origin. In a phone interview on 08/26/2025 at 1:35 PM Staff B, Former Director of Nursing (DNS) stated that there last day working at the facility was 08/21/2025, they were unaware staff had documented that Resident 1 had a skin tear to their labia and stated this absolutely should have been reported and investigated, especially considering the residents recent allegation of sexual assault made on 08/18/2025. In a interview on 09/03/2025 at 12:30 PM, Staff D, Licensed Practical Nurse (LPN)/Nurse Manager stated that they were notified on 08/23/2025 that Resident 1 was found to have a skin tear on their labia, I haven't actually seen this skin tear myself. Staff D stated that due to the fact that this skin issue was in a concerning place and the resident's recent allegation of sexual assault, this should have been reported and investigated but they had not reported or investigated this. On 09/03/2025 at 2:00 PM, Staff A, Administrator, stated this was the first they were reading this progress note and stated that it should have been reported and investigated. No further information was provided. Staff A was unable to provide an investigation for this allegation, and the allegation was not reported to the state survey agency. Refer to F-600 and F610Reference WAC 388-97-0180-0640 (6)(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate allegations of sexual assault to rule out abuse/neglect, protect residents, and prevent further incidents of abuse for 1 of 1 sampled resident (Resident 1) reviewed for abuse. These failures placed residents at risk for continued abuse, increased risk of harm, having allegations of abuse not being responded to and thoroughly investigated, and a diminished quality of life. Findings included. According to the Washington State Reporting Guidelines for Nursing Homes (Purple Book), dated October 2015, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It includes guidelines for prevention and protection, incident identification, investigation and reporting for nursing homes, the facility investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened including the probable or reasonable cause.Resident 1 was admitted to the facility on [DATE] with diagnoses to include sepsis (infection in the blood), anxiety disorder, depression, hemiplegia (paralysis to one side of the body) and hemiparesis (a condition that causes weakness or partial paralysis on one side of the body) affecting their left side. According to the admission Minimum Data Set (MDS-an assessment tool) assessment, dated 06/05/2025, indicated the resident had moderate cognitive impairment and required extensive assistance with activities of daily living including bed mobility, transfers, dressing, toilet use and personal hygiene.Review of the facilities state reporting log for August 2025, documented on 08/18/2025, Resident 1 had an allegation of abuse, with no injury and the actions taken by the facility included staff training/counseling and care plan revisions. Review of the unsigned facility investigation summary conclusion dated 08/22/2025, documented that Resident 1 reported an allegation to a therapist on 08/18/2025. The resident reported that on 08/16/2025 a male Certified Nursing Assistant (CNA) straddled them and reached into their pants with an ungloved hand, like a man does to a woman. The investigation documented that abuse and neglect were ruled out through investigation, and staff and resident interviews. Resident skin check resulted with no new skin issues. Staff member suspended will be educated to follow the care plan and ensure they are properly communicating with the residents while performing care. The conclusion also documented interventions implemented included skin check performed, family and provider notified.Further review of the investigation showed no interview/witness statement from Resident 1, or the staff that worked directly with the resident on the date/time (08/16/2025) of the reported allegation. Further review of the facilities investigation showed a form titled Suspension Pending Investigation, dated 08/18/2025, Staff A, Administrator documented that Staff E, Nursing Assistant Certified (NAC), was suspended pending investigation on 08/18/2025. Staff A documented Over phone on the line of the form intended for the employee's signature. On 09/03/2025 at 2:00 PM, Staff A reviewed the form and stated that they did not review this form with Staff E until 08/22/2025 but had completed the form themselves on 08/18/2025, so that the employee could get paid for their time off while suspended. Staff E's statement was included in the investigation and dated 08/22/2025, four days after the report of the allegation. Review of Staff E's timecard dated 08/18/2025, documented that they worked a full shift from 10:10 PM to 6:20 AM on 08/19/2025, when they should have been suspended. Staff A stated that the prior DNS should have suspended the staff member but did not. Review of Staff E's statement dated 08/22/2025, documented that two other staff members always helped them change Resident 1, they only helped with turning the resident. There was no information included related to the specific day/time of the allegation or the care provided to the resident during the time of the allegation. Review of Resident 1's progress notes for 08/18/2025 through 09/03/2025, showed no documentation that the resident was placed on alert monitoring to assess for psychosocial harm, and that the resident's power of attorney or physician had been notified of the allegation reported on 08/18/2025.Review of Resident 1's skin assessment documentation for 08/18/2025 showed no thorough skin check had been completed following the resident's reported allegation of sexual assault. Review of a nursing progress note dated 08/23/2025 at 10:35 PM, documented patient having a new skin tear around her left labia. Further review of progress notes showed no further documentation regarding this injury of unknown origin. There was no documentation that a thorough skin check had been completed. In an interview on 08/26/2025 at 4:08 PM, Staff E stated that they were unaware of the allegation made by Resident 1 on 08/18/2025. Staff E stated that they worked the night shift on 08/18/2025 and were told by Staff A to just not work with Resident 1, so they didn't. Staff E stated no one told them that they were

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to designate and ensure a full-time Registered Nurse (RN) to serve as the Director of Nursing (DON) on a full-time basis. This failure could negatively impact the care and services to the residents that could result in potential harm and unmet care needs. Findings included .On 08/25/2025 at 11:35 AM, upon entry into the facility, approached the front desk. Staff C, Receptionist greeted this investigator. Staff C stated that the Administrator had just stepped out of the facility, so they were asked to get the DON. Staff C stated that there was not a current DON as of last week. A review of the facility's list of Key personnel on 08/27/2025 documented that the facility currently did not have a full time DON.On 08/25/2025 at 1:20 PM, Staff A, Administrator stated the facility currently did not have a designated full-time RN to serve as the DON. Staff A stated that the previous DON, Staff B, was termed last week. Staff A stated that there was a corporate nurse covering the DON position as needed until the position is filled. In a follow-up interview on 09/03/2025 at 2:00 PM, Staff A confirmed again that there was not currently a full-time DON at the facility. Staff A stated that they had just interviewed and made an offer to a potential new DON, but the corporate nurse was still covering, however they are not full-time. Reference WAC 388- 97-1080(2)(a)