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	12/03/2025

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 0698 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate dialysis care/services for a resident who requires such services. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received scheduled hemodialysis (HD- a form of dialysis - an artificial filtration of waste products and excess fluid of the body from the blood using a machine with a special filter) treatment as ordered for 1 of 2 residents (Resident 1) reviewed for HD. Resident 1 experienced harm when they had volume overload (a condition where the body holds too much fluid) requiring hospitalization to intensive care unit due to missed HD treatments. This failure placed other residents that required HD at risk for unmet care needs, decline in medical condition and related complications.Findings included.Resident 1 admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include end stage renal (kidney) failure and dependence on renal dialysis. In a telephone interview on 12/02/2025 and 11:30 AM, Collateral Contact 1 (CC1), stated the facility had not notified them that Resident 1 missed all scheduled HD treatment since admission. CC1 stated Resident 1 was unable to tolerate sitting in a wheelchair due to weakness and declining condition. CC1stated Resident 1 needed a closer HD center that provides a stretcher or bed during HD treatment. CC1 stated the facility did not do anything to accommodate Resident 1's needs and preferences to change transportation time or arrange a closer HD center. CC1 stated Resident 1 was admitted to intensive care unit on 11/27/2025 due to fluid retention from missed HD. In a telephone interview on 12/03/2025 at 2:36 PM, Resident 1 stated they canceled the scheduled HD while at the facility because they could not sit for five to six hours, and they needed a closer HD center that could provide a bed during HD treatment. Resident 1 stated they told [an unknown] facility nurse many times that they could not sit for more than two hours and needed to change to a closer HD center. Resident 1 stated the facility did not attempt to change the center or the transportation time. Resident 1 stated they were very upset they could not go to HD and ended up in the hospital in the intensive care unit. Resident 1 was still in the hospital at the time of this interview and stated they would not be returning to this facility. In a telephone interview on 12/02/2025 at 2:14 PM, CC2 stated Resident 1 was scheduled for HD on Tuesday, Thursday and Saturday every week had not attended the HD center since the end of October 2025. CC2 stated Resident 1 expressed they preferred a later transportation time and a closer dialysis center that could provide a bed during HD treatment. CC2 stated the facility never notified them when Resident 1 canceled or postponed their appointment and the facility never communicated with them about Resident 1's preferences or arrangement of a different time or location. CC2 stated they called the facility on 11/26/2025 and informed them that Resident 1 had not attended any HD treatment since the end of October [2025] and Resident 1 would lose their appointment spot. CC2 stated they had to reach out to the facility many times to identify where the resident was or if the resident was coming for dialysis.In an interview on 12/02/2025 at 2:29 PM, Staff E, Physician Assistant, stated they were not aware Resident 1 had not gone to any HD treatment since they readmitted to the facility until they were notified by the Social Worker [Staff B] on 11/27/2025. In an interview on 12/02/2025 at 3:09 PM, Staff B stated they were not aware that Resident 1 had missed all their HD treatment until the dialysis center called them. Staff B stated they were not aware of which staff member handled transportation arrangements or how to coordinate another HD center. Staff B further stated that they thought the HD center would find Resident 1 a closer HD center where a bed was provided. In an interview on 12/03/2025 at 1:17 PM, Staff D, Business Office Manager, stated they arranged Resident 1's HD transportation and they were not aware that Resident 1 preferred a different transportation time and center. Staff D stated they were not aware Resident 1 preferred a stretcher until the HD center notified Staff B on 11/26/2025. In an interview on 12/02/2025 at 3:31 PM, Staff C, Unit Manager, stated they were not aware that Resident 1 canceled their HD appointment. Staff C stated they were not aware Resident 1 had missed all the scheduled dialysis treatment until the HD center talked with Staff B. A joint record review with Staff C showed no documentation to show why Resident 1 had canceled their HD and no documentation of risk and benefit discussed with the resident, nor was there any notification to the provider and resident representative about missed HD treatment. Staff C stated they could not find documentation to show Resident 1's condition was monitored due to missed HD. Staff C stated they expected the nurse to document every time a resident missed their HD treatment and to notify the provider, resident representative, and facility management. Staff C further stated the nurse was to document the monitoring of edema (swelling caused by excess fluid trapped in the body's tissues), shortness of breath, change of blood pressure, and blood sugar, and discuss and document the risk and benefit with the resident