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	03/30/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise care plans accurately to reflect the resident's needs for 3 of 4 residents (Residents 1, 2 and 3), reviewed for care planning revision. This failure placed the residents at risk for unidentified and unmet care needs, and a diminished quality of life. Findings included . Review of the facility's undated policy titled, Care Planning - Interdisciplinary Team, documented that the care planning/interdisciplinary team was responsible for the development of an individualized comprehensive care plan for each resident. <RESIDENT 1>Resident 1 admitted to the facility on [DATE] with diagnoses to include hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebrovascular disease (conditions affecting blood flow to the brain, including stroke or bleeding) and mononeuropathy (the damage of a single peripheral never which leads to localized numbness, tingling and pain) of upper limb. According to the admission Minimum Data Set (MDS-an assessment tool) assessment, dated 01/27/2026, the resident had intact short and long memory and had impairment to one-sided upper extremity. In an interview on 03/24/2026 at 11:23 AM, Resident 1 stated they had bilateral shoulders surgery and could not tolerate blood pressure (BP) taking on the upper arms due to pain. Resident 1 stated they preferred the BP cuff to be placed on the forearm and had informed multiple nursing staff of this preference, yet staff continued to apply the cuff to the upper arms. In an interview on 03/30/2026 at 11:01 AM, Resident 1 expressed frustration, stated they were tired of repeating the request to nursing staff and asked, why cannot they document it? Review of Resident 1's care plan, initiated 01/21/2026, showed no intervention or instruction regarding taking BP on the forearms. Review of Resident 1's Kardex (a tool used to provide directions on how to care for a resident), as of 03/25/2026, there was no care instruction regarding forearm BP cuff placement. In an interview on 03/30/2026 at 11:30 AM, Staff F, Nursing Assistant Certified (NAC), stated they were not aware of the resident's preference for forearm BP readings until the resident told them directly. Staff F confirmed this care instruction was not documented in the residents' Kardex. In an interview on 03/30/2026 at 11:38 AM, Staff G, Registered Nurse/Unit Manager (UM), stated they were responsible for revising and reviewing the comprehensive care plan whenever there were changes to residents. Staff G stated the nursing staff obtains care instructions from the care plan and Kardex. Staff G confirmed they were not aware Resident 1 wanted BP taken on the forearms and stated this information should have been updated in the care plan. <RESIDENT 2>Resident 2 readmitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage (sudden bleeding into the space surrounding the brain), contracture of left hand, and weakness. According to the quarterly MDS assessment, dated 01/29/2026, the resident was cognitive intact and required maximum assistance for bed mobility. <GET OUT OF BED>In an interview on 03/24/2026 at 10:22 AM, Resident 2 stated they were supposed to get out of bed for two hours every day, but some NACs were not aware of this care.Review of Resident 2's March 2026 Medication Administration Record/Treatment Administration Record (MAR/TAR), showed an order to document the time the resident got up and the time resident returned to bed daily, initiated on (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/08/2026. Review of Resident 2's care plan, initiated 06/09/2025, showed no intervention regarding getting the resident up or out of bed. Review of Resident 2's Kardex, as of 03/25/2026, showed no care instruction for getting the resident up or out of bed. In an interview and record review on 03/30/2026 at 11:48 AM, Staff H, NAC, stated the NACs obtained care instruction from Kardex, but confirmed there was no instruction for getting the resident out of bed. in their Kardex. In an interview and record review on 03/30/2026 at 11:54 AM, Staff I, Licensed Practical Nurse (LPN)/UM stated the NAC obtained care instruction from Kardex before their work. Staff I confirmed that the care instruction for getting the resident up/out of bed was not in their care plan and Kardex and could be updated in the care plan. <PRECAUTION>In observations on 03/24/2026 at 10:22 AM and 03/30/2026 at 10:02 AM, observed a contact precaution signage posted outside of Resident 2's door. Review of a progress note dated 03/10/2026 at 9:01 AM, documented Resident 2 was placed on contact precaution. Review of Resident 2's care plan, initiated 01/05/2025, documented Resident 2 required Enhanced Barrier precautions for isolation. Review of Resident 2's Kardex, as of 03/25/2026, there was no care instruction of contact precaution. In an interview and record review on 03/30/2026 at 11:54 AM, Staff I confirmed that Resident 2 was on contact precautions and the care plan was not updated. In an interview and record review on 03/30/2026 at 1:08 PM, Staff J, LPN/Infection Preventionist, stated Resident 2 was placed on contact precautions and the care plan and Kardex should be updated. <RESIDENT 3>Resident 3 was admitted to the facility on [DATE] and discharged on 03/02/2026. Review of a progress note dated 02/23/2026 at 4:53 PM, documented Resident 3 had a pressure ulcer and repositioning the resident as tolerated. Review of Resident 3' s March MAR/TAR, documented an order for reposition every two hours to maintain skin integrity and relieve pressure off at coccyx area, initiated on 02/19/2026. Review of Resident 3's care plan, initiated on 02/23/2026, the focus under skin impairment documented the resident had moisture associated skin damage at coccyx. However, there was no intervention of repositioning the resident every two hours. In an interview and record review on 03/30/2026 at 1:08 PM, Staff J, stated there was an order of repositioning the resident every two hours which was not updated in the care plan and Kardex. In a joint interview on 03/30/2026 at 4:10 PM, Staff A, Interim Administrator, and Staff B, Director of Nursing, stated the expectation was for the interdisciplinary team to update care plans timely to ensure all residents' needs and physician orders were accurately reflected. Reference WAC 388-97-1020 (2)(a)(5)(b)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received restorative services (movement of joints to maintain range of motion and/or splint brace assistance) to maintain and/or prevent declines in mobility and contracture for 2 of 2 sampled resident (Residents 1 and 2) reviewed for range of motion (ROM)/mobility. This failure placed residents at risk for development of contractures (joints become fixed in place), further decline in ROM, decreased mobility and a diminished quality of life. Findings included . Review of the facility undated policy titled, Restorative Nursing Services, documented residents would receive restorative nursing care as needed to achieve and maintain optimal physical, mental and psychosocial functioning. The policy specified that residents may initiate a restorative nursing program upon discharge from rehabilitative care. <RESIDENT 1>Resident 1 admitted to the facility on [DATE] with diagnoses to include hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following cerebrovascular disease (conditions affecting blood flow to the brain, including stroke or bleeding), left lower leg fracture, and weakness. According to the admission Minimum Data Set (MDS-an assessment tool) assessment, dated 01/27/2026, the resident had intact short and long memory, required moderate assistance for bed mobility and transfers, and had impairment to one-sided upper and lower extremities.In an observation and interview on 03/24/2026 at 11:23 AM, observed resident 1 was lying in bed with a bent inward left forearm and hand. Resident 1 stated they were no longer receiving services from therapists, and no nursing staff was assisting with exercise either. In an interview on 03/25/2026 at 10:27 AM, Collateral Contact 1 (CC1), family member of Resident 1, stated the resident had not received any therapy exercises or restorative service since February. Review of Resident 1's care plan, initiated 01/21/2026, showed Resident 1 was not receiving restorative services.Review of the care plan history showed Resident 1 had never received any restorative services. Review of Resident 1's electronic health record (EHR), there was no documentation that the resident received any restorative nursing interventions. Review of Physical Therapy PT Discharge Summary, dated and signed on 02/21/2026 at 7:01 PM, documented Restorative Programs Established/Trained=Restorative Range of Motion Programs, Restorative Transfer Program, Range of Motion Program Established/Trained: PROM (Passive Range of Motion) to L UE (Upper Extremities) and L LE (Left Extremities), Transfer Program Established/Trained and Restorative Nursing interventions: providing stand-by assist with transfer.Review of Occupational Therapy OT Discharge Summary, dated and signed on 02/12/2026 at 4:38 PM, documented recommendations for a splint/brace.In a joint interview and record review on 03/25/2026 at 11:44 AM, Staff D, Occupation Therapist (OT), stated that the OT discharge summary recommended splint and brace for Resident 1 to prevent contracture because the resident's left upper extremity had impaired range of motion and strength. Staff D stated, however, they did not have the time or opportunity to try the splint or brace on the resident before the insurance was discontinued. Staff C, Director of Rehab, stated they were not aware the resident still required therapy service for splint measurement and fit testing and they should continue the therapy under Medicaid Part B. Staff C stated that the expectation was for therapists to fill out referral forms in the EHR to initiate restorative programs for the MDS Coordinator to implement. In a follow-up interview on 03/25/2026 at 12:13 PM, Staff D stated they could not find any initial referral documentation in EHR.In an interview and record review on 03/25/2026 at 12:32 PM, Staff E, Licensed Practical Nurse/MDS coordinator, stated Resident 1 had not received restorative services and they were unaware of the recommendations because no referral was ever placed in the EHR by the therapy department. <RESIDENT 2>Resident 2 readmitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis following nontraumatic subarachnoid hemorrhage (sudden bleeding into the space surrounding the brain), contracture of left hand, and (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weakness. According to the quarterly MDS assessment, dated 01/29/2026, the resident was cognitive intact, required maximum assistance for bed mobility, and total assistance for transfers. The assessment showed the residents had bilateral upper and lower extremities impairment and no therapy or restorative nursing programs.In an interview on 03/24/2026 at 10:22 AM, Resident 2 stated their therapy service was discontinued since last October and there was no restorative nursing staff who were assisting with exercise. Review of Resident 2's care plan, initiated 06/09/2025, showed Resident 1 was not receiving restorative services.Review of Resident 2's EHR, there was no documentation of the resident receiving any restorative services. Review of Occupational Therapy OT Evaluation and Plan of Treatment, dated and signed on 10/27/2025 at 5:22 PM, documented Resident 1 had left upper extremity range of motion impairment and a left-hand contracture, and the resident was wearing left orthotic to manage flexion tone prior to admission.Review of Occupational Therapy OT Discharge Summary, dated and signed on 11/26/2025 at 9:29 AM, documented a discharge recommendation for Restorative care and assistance with donning/doffing orthotic wear.Review of Physical Therapy PT Discharge Summary, dated and cosigned on 11/25/2025 at 4:37 PM, documented showed a recommendation for restorative programs if the resident did not continue with Medicaid Part B services.In an interview on 03/25/2026 at 11:01 AM, Staff C confirmed Resident 2 discontinued therapy services on 11/26/2025 and did not continue with Medicaid Part B services. Staff C stated they recommended the resident be on restorative nursing programs after their therapy services were discontinued. In an interview and record review on 03/25/2026 at 12:02 PM, Staff E stated that Resident 2 had no restorative nursing programs since readmission in October. Staff E stated the therapists needed to re-evaluate the resident after hospitalization and initiate new restorative programs recommendations into EHR. Staff E confirmed that they were not aware of the recommendations and there was no referral documentation in the system.In an interview on 03/25/2026 at 12:13 PM, Staff C stated they could not find any restorative program referrals from the therapists in the EHR after readmission in October.In a joint interview 03/30/2026 at 4:10 PM, Staff A, Interim Administrator and Staff B, Director of Nursing, stated they the expectation was for all residents to receive recommended restorative nursing programs. Staff B stated that once therapists discharged a resident, they should initiate the recommended restorative programs in the EHR for MDS Coordinator to follow up and implement. Reference WAC 388-97-1060(3)(d)(j)(ix) .