

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Alderwood Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews, the facility failed to provide sufficient qualified staff to provide care and services for 15 of 24 sampled residents (Residents 8, 16, 19, 24, 25, 28, 31, 42, 45, 46, 58, 61, 73, 94 and 99) and 1 of 3 family members that had concerns related to staffing. The facility had insufficient staff to ensure residents received prompt call light response, medications delivered timely, assistance with activities of daily livings (ADLs) including bathing/meal assistance, supervision to prevent accidents and altercations and to ensure care was completed in accordance with established clinical standards, the facility assessment, and resident's needs and preferences. These failures placed residents at risk of experiencing feelings of frustration, vulnerability, diminished quality of life, and unmet care needs Findings included. In an entrance conference interview on 07/08/2026 at 9:19 AM, Staff A, Administrator, stated the facility had no staffing issues and they were using agency only during emergencies. They stated there were no agency staff today. <FACILITY ASSESSMENT> Review of the facility assessment dated [DATE], documented staffing would be adequate to meet the needs of the residents in the facility as evidenced by staff's ability to assist residents with ADLs, medication administration, incontinence care, toileting and human needs according to the plan of care. The assessment documented staffing was adequate as evidenced by their ability to deliver food in a timely manner. The assessment documented the nurse aides to resident ratio was one to 10 on days and evenings and one to 16 on night shift. The assessment documented the nurse to resident ratio was one to 19 on days and evenings and one to 32 on night shifts. <STAFFING PATTERN> Review of the staffing pattern from 06/08/2026 to 07/08/2026 showed there was inconsistent staffing. There were five to 12 nurses on day shifts, five to six nurses on evening shifts and three nurses on night shift. There were nine to 10 aides on day shifts, eight to nine aides on evening shifts and five to six aides on night shift. (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<GRIEVANCE LOG> Review of the grievance log from 04/02/2026 through 07/04/2026 documented 11 missed care/poor hygiene or call bell concerns logged as follows: -Missed care concern/ poor hygiene 04/06/2026 -Missed care concern poor hygiene 04/23/2026 -Missed care concern 04/30/2026 -2 Missed care concern/poor hygiene 05/11/2026 -2 Missed care concern 05/21/2026 -2 Missed care concern/poor hygiene 06/25/2026 -Call bell delays -07/03/2026 -Missed care concern/poor hygiene 07/04/2026 <RESIDENT INTERVIEWS> <RESIDENT 94> In an interview on 07/08/2026 at 9:40 AM, Resident 94 stated some nurses were not the most helpful and they waited for Nursing Aide Certified (NAC)'s to help them. They stated the nurses would try to turn their call light off and they told them not to turn it off until their needs were met. They stated on their second or third night there, their call light fell to the floor and they had to yell for help. <RESIDENT 25> In an interview on 07/08/2026 at 10:06 AM, Resident 25 stated they waited two to three hours for medication. They stated night shift was the worst, day shift was better and evening shift medications were not on time. They stated two to three times a week they wait three hours and their pain had got worse. They stated there should not be any lapses for pain medication requests. <RESIDENT 45> In an interview on 07/08/2026 at 10:06 AM, Resident 45 stated staffing was a problem on the weekends. They stated their old roommate would fall and they would have to go find staff to help them. They stated one time a lady down the hall told them they were having a heart attack. They stated they went racing to the nurse's station and there was no one there and they had to go find staff for the code blue. The resident stated other residents tell them it took too long to get help. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	<RESIDENT 61> In an interview on 07/08/2026 11:21 AM, Resident 61 stated there were not enough staff and they had to call and call for pain pills. <RESIDENT 8> In an interview on 07/08/2026 at 12:00 PM, Resident 8 stated the facility was short staffed. They stated they waited fifteen to thirty minutes for help. They stated there were two instances where they waited for over two hours to get help into bed after returning from dialysis. They stated they didn't think the staff understood when they returned from dialysis, they were cold, tired and ready for bed. <RESIDENT 99> In an interview on 07/08/2026 at 12:28 PM, Resident 99 stated staff were not answering call lights timely and they could not take themselves to the bathroom, so they wet themselves. The resident stated it was humiliating to wet themselves. They stated at times they waited two hours for help. They stated it was especially bad at shift change between day and evening shift and evening to night shift and waiting was worse between 2 AM to 6 AM. <RESIDENT 31> In an interview on 07/08/2026 at 1:29 PM, Resident 31 stated the resident across the hall frequently yelled Help me, help me. They stated they thought the staff should come around every hour or so to check on them and see if they needed anything. They stated their medications were late today because the nurse arrived late. <RESIDENT 58> In an interview on 07/08/2026 at 2:13 PM, Resident 58 stated at nighttime no one answers their call light. They stated they waited for two hours for help. They stated the night shift staff need fired because they keep sleeping instead of working. <RESIDENT 16> In an interview on 7/08/2026 at 2:26 PM, Resident 16 stated staff slept during the night shift on the couch or in an empty room. They stated call lights were responded to in twenty minutes at a minimum and twenty to forty five minutes was not uncommon. They stated night nurses take their breaks together, leaving no nurse present on the floor. <RESIDENT 19> In an interview on 07/08/2026 at 3:16 PM, Resident 19 stated that staff no longer say they were not my resident after they were talked to, but they still didn't answer their call light if they were not (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 07/10/2026 at 9:24 AM, Staff E stated that there were two carts that were delivered to the first floor. The NACs were responsible for passing the meal trays out before they could assist any residents that needed assistance with meals. Staff E stated that Resident 20's tray was one of the first trays that was delivered on the floor, so they just set it on the sink or table next to their bed until they were done passing all the trays. Staff E stated Resident 20 required one-to-one assistance with meals as they had severe cognitive impairment and needed someone to help them. Staff E stated unfortunately, the food just sits there until we have the time to feed them. In a joint interview on 07/14/2026 at 10:12 AM, Staff N, LPN/UM, and Staff G LPN/UM, Staff G stated the NACs were the primary staff that passed out meal trays to the residents. Staff N was told of the observations for Resident 20 having to wait at least 45 minutes for meals due to staff not being able to assist until all the trays were passed. Staff G stated well, that's not okay. Staff N and Staff G were not aware Resident 20 did not receive adequate and timely assistance with meals. In an interview on 07/14/2026 at 10:19 AM, Staff C, Director of Nursing, was made aware of observations and interviews with staff related to Resident 20's lack of timely assistance with meals. Staff C stated that was an issue and they would need to make some changes. <RESIDENT TO RESIDENT ALTERCATION> In an observation on 7/13/2026 at 4:00 PM on the second floor across from the nurse's station Resident 46 was self-propelling in their wheelchair in front of, and right up to Resident 73's wheelchair. Both Residents 46 and 73 were angry, agitated and making hand gestures at each other. Resident 28 was in their wheelchair crying seated within 4 inches from Resident 46. Resident 73 pointed to Resident 46 and 28. Resident 28 then loudly shouted, Shut up, shut up. There were no staff present and the residents were unsupervised in close proximity to each other. An unidentified male resident witnessed the altercation and stated They are just in a spat. This is a common occurrence. In an interview on 07/14/2026 at 12:25 PM, Staff B, DNS, stated the expectation was that staff provide the care and services residents need, including oral care, toileting, showers, and all ADLs, based on their individual preferences and established plan of care. No additional information was provided. Refer to WAC 388-97-1080 (1)		

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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. Based on observation and interview, the facility failed to ensure a safe, clean, comfortable environment on 2 of 2 floors. Failure to ensure resident rooms and spaces received routine cleaning placed residents at risk for decreased quality of life. Findings included . In an observation on 07/10/2026 at 9:58 AM, the first-floor hallway had coffee spills and multiple dried soiled areas of various sizes. In an observation on 07/13/2026 at 10:02 AM, the first-floor hallway had multiple black sticky areas on the wood floors of various sizes. The elevator had numerous black marks on the floor. In an observation on 07/14/2026 at 1:53 PM, the first-floor hallway had multiple black sticky areas on the wood floors. The elevator floor continued with multiple black marks all over and no evidence of cleaning or mopping. In an interview on 07/14/2026 at 3:00 PM, Staff A, Administrator was shown the black marks present on the first floor hallway and stated the facility had a floor guy, and they needed to mop the area. In an observation of Resident 3's room on 07/08/2026 at 2:00 PM, there was plant dirt spilled on the carpet below the window. The resident's wheelchair was parked over the top of the spilled dirt pile. A potted plant was observed tipped on its side sitting on the air conditioner box below the window. Observation of the resident's bathroom found feces smeared on the inner rim of the toilet seat at 9 o'clock, the floor of the bathroom was streaked with a light brownish haze. In an observation on 07/09/2026 at 2:10 PM, Resident 3 was up in their chair in the hallway, the spilled plant dirt remained in the same place in the room and the bathroom had smeared feces on the toilet in exactly the same spot, and the same brown hazy floor. In an observation on 07/10/2026 at 8:49 AM, the same spilled plant dirt remained in the same place on the carpet and the bathroom soiled toilet seat and flooring remained unchanged. In an interview on 07/10/2026 at 10:42 AM, Staff FF, Housekeeping Aide, stated there was one housekeeper on each floor and their shift was 6am until 2pm. Staff FF stated their responsibilities included cleaning each room every day, including cleaning bathrooms and vacuuming. Staff FF stated the main hallway floors were done by someone else. Staff FF stated their section included Resident 3's room and Staff FF stated they cleaned that room. In a follow-up observation on 07/10/2026 at 2:26 PM, Resident 3's room still included the same pile of plant dirt, the same smeared feces on the toilet seat and brown hazy bathroom floor. In an observation on 07/13/2026 at 9:00 AM, the pile of plant dirt was no longer on Resident 3's carpet, but the bathroom toilet and floor had still not been cleaned. This is a repeat deficiency from SOD dated 08/20/2025. (continued on next page)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 5 medication carts was locked (Blue Medication Cart), failed to ensure proper storage and labeling of medications for 5 of 7 residents (Residents 8, 42, 61, 71 and 100), and failed to dispose and replace expired medications and equipment in 2 of 2 crash carts. These failures placed residents at risk for having access to medications not prescribed to them, missing medications, and receiving compromised or ineffective medication/equipment. Findings included. Review of the facility policy titled, Emergency Management, revised 11/2013, documented that crash cart maintenance should include checking emergency care items and equipment stored in the crash cart against the crash cart checklist once a month and whenever the cart was opened to validate contents and expiration dates. The designee was to replace expired items and sign and date the crash cart checklist. Review of the undated facility policy titled, Medication Storage, documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. Compartments (drawers, cabinets, rooms, refrigerators, carts) containing drugs and biologicals shall be locked when not in use. Items shall not be left unattended. potentially available to others. <CRASH CART> In an observation of the first-floor crash cart, on 07/10/2026 at 2:51 PM, revealed an intravenous (IV) kit with an expiration date of 05/31/2021, saline solution with an expiration date of 10/2021, oxygen tubing with an expiration date of 01/01/2024, and lubricating jelly with an expiration date of 05/2021. In an interview on 07/10/2026 at 2:51 PM, Staff S, Infection Preventionist/Staff Development Coordinator, verified the expired medications on the first-floor crash cart and stated that night shift nurses were to be checking the crash carts and completing the crash cart checklist binders. In an observation of the second-floor crash cart, on 07/10/2026 at 3:01 PM, revealed IV needles that expired 05/31/2026 and IV needles that expired 02/28/2025. In an interview on 07/10/2026 at 3:01 PM, Staff K, Licensed Practical Nurse (LPN)/Unit Manager (UM), stated that the crash cart should be checked and have expired products removed. In an interview on 07/10/2026 at 3:05 PM, Staff G, LPN/UM, stated their expectation would be no expired medications or equipment in the crash carts. Staff G stated crash cart checklist binders should be done nightly by the nurses. Staff G stated the night nurses were to go through the crash carts and replace anything needed and then document in the crash cart checklist. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<UNSECURED MEDICATIONS> <RESIDENT 71> In an observation on 07/08/2026 at 9:57 AM, Resident 71 had a clear plastic cup with one white oblong pill and one large round tablet on their overbed table. The resident stated the pills were left by the nurse before breakfast time and they were not sure what they were. They stated they liked to take their pills with food, and they were dropped off before they ate. They confirmed the medications were left for them to take when they wanted. <RESIDENT 42> In an observation on 07/08/2026 at 12:28 PM, Resident 42's Lispro insulin vial and syringe were on top of the medication cart located on a tray to the left of room [ROOM NUMBER]. There was no nurse present. At 12:31 PM, Staff F, Registered Nurse came out of a room, walked by the cart where the insulin was still present and unsecured. At 12:34 PM, Staff F removed the insulin and syringe. At 12:37 PM, Staff F stated they should have secured them, but they were called to a different room. <RESIDENT 61> In an observation on 07/08/2026 at 11:19 AM, 1:32 PM and 3:04 PM, anti-fungal powder was located on resident 61's sink. In an observation on 07/09/2026 at 10:41 AM, 11:34 AM, 1:09 PM, and 3:08 PM, anti-fungal powder was located on the resident's sink. In an observation on 07/10/2026 at 8:44 AM, 9:53 AM, 10:19 AM and 12:34 PM, anti-fungal powder was located on the resident's sink. In an observation on 07/13/2026 at 12:50 PM, anti-fungal powder was located on the resident's sink. <RESIDENT 8> In an observation on 07/08/2026 at 12:04 PM, a bottle of chewable TUMS was located in Resident 8's top nightstand drawer. In an observation on 07/09/2026 at 1:37 PM, the bottle of chewable TUMS was still present in their top nightstand drawer. In an interview on 07/14/2026 at 11:21 AM, Staff G, LPN/Unit Manager stated they had addressed staff leaving medications with Resident 71 several times with several nurses. Staff G stated the nurses knew they were not to leave medications in resident rooms. They stated the resident usually had three to four pills at bedside, and they just took a cup of medications out of their room the other day. Staff G stated they had provided education to Resident 71 about the nurses not leaving their medications and the need to observe them consuming the medications. They were not aware of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Alderwood Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3701 188th Street Southwest Lynnwood, WA 98037	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 42's unsecured insulin and syringe, Resident 61's Anti-fungal powder at the sink or Resident 8's bottle of chewable TUMS in their nightstand. They stated they would make sure they came out of their drawer. Staff G stated Staff F must have gotten pulled away. Staff N, LPN was present and stated the residents yelled at them when they passed meds and told them they were the only nurse who didn't leave them. Staff N stated they would secure the anti-fungal powder. In an interview on 07/14/2026 at 11:43 AM, the unsecured medications were discussed with Staff C, Director of Nursing. Staff C stated their expectation was for no meds left at bedside and they should be secured in the cart. <RESIDENT 100> Resident 100 was a long term care resident who left the facility three times per week for outside medical treatment. In an interview on 07/09/2026 at 2:50 PM, Resident 100 stated they took a communication binder with them to each treatment, and between treatments, the binder was either at the nursing station or in their room. In an observation of Resident 100's communication binder on 07/09/2026 at 3:00 PM, the binder was found in the resident's room. Resident 100 was not in the room. Review of the binder revealed pages with treatment notes dating back to January of 2026. A page dated 01/14/2026 was observed to have a plastic envelope stapled to the corner which contained one pink colored round pill. There was black marker writing on the outside of the envelope with the resident's name, the name of the medication, and parameters instructing when to hold it based on the resident's blood pressure reading. In an interview on 07/09/2026 at 3:44 PM, Staff R, Registered Nurse (RN), stated Resident 100 took the communication binder to each treatment and stated the provider would review the book at the appointment. Staff R stated if a resident had medication sent with them to an appointment or outing, it should be labeled and there should be follow up regarding whether or not it was given. Staff R identified the medication stapled in the binder as Resident 100's blood pressure medication. Staff R stated the binder should be kept at the nursing station and should not include unsecured medications. <MEDICATION CART> During an observation on 07/09/2026 at 5:36 AM, the blue medication cart was outside the second-floor resident TV room/ lounge. The medication cart was noted to be unlocked, and no staff were within the immediate area. During an interview on 07/09/2026 at 5:40 AM, Staff Q, RN, stated they had just unlocked the medication cart as they were passing medications. Staff Q did not respond to the medication cart being unattended while they were away from the immediate area. During an interview on 07/10/2026 at 8:14 AM, Staff C stated they expected the nurses to ensure the medication cart was locked when they were not in direct supervision of the cart. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This is a repeat deficiency from SOD dated 08/20/2025. Refer to WAC 388-97-1300 (2)		

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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 2 of 5 residents (Residents 10 and 16) reviewed for Pre-admission Screening and Resident Review (PASRR - a federal requirement which identifies individual with Serious Mental Illness (SMI) or intellectual or developmental disabilities (I/DD) to provide appropriate services), received the required screening for necessary services. This failure placed the residents at risk for unidentified mental health needs. Findings included . <RESIDENT 16> Resident 16 was admitted to the facility on [DATE] with diagnoses to include major depressive disorder, and generalized anxiety disorder. Review of Resident 16's PASRR, dated 02/10/2026, documented the PASRR Level II (an in-depth, federally mandated evaluation triggered when an initial screen suspects SMI or I/DD) was not indicated due to 30-day hospital exemption and a PASRR level II must be completed if a scheduled discharge did not occur in 30 days. Review of Resident 16's progress notes from 02/17/2026 through 07/09/2026 showed no documentation related to PASRR Level II follow-up. In an interview on 07/09/2026 at 2:15 PM, Staff M, Social Services (SS), stated for residents with 30-day hospital exemptions, they follow up with the PASRR Coordinator if they had not received Level II evaluation or invalidation 10 days prior to the expiration. Any follow-up regarding the PASRR should be documented in the resident's chart. Staff M reviewed Resident 16's chart and stated there were no Level II evaluation or invalidation for the resident and there were no documentation of any follow-up. <RESIDENT 10> Resident 10 was admitted to the facility on [DATE] with diagnoses to include depression, and generalized anxiety disorder. Review of Resident 10's PASRR, dated 05/22/2026, documented the PASRR Level II was not indicated due to 30-day hospital exemption. Review of Resident 10's progress notes with a print date of 07/09/2026 documented that on 07/01/2026 Staff L, SS, followed up with the PASRR Coordinator regarding Level II evaluation for the resident which was past the 30-day hospital exemption. In an interview on 07/09/2026 at 1:35 PM, Staff L stated residents that had PASRRs with 30-day hospital exemption were followed up with the PASRR Coordinator if they had not received an invalidation or a Level II evaluation prior to the 30 days. Staff L stated any follow-up was documented (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the resident's progress note. Staff L reviewed Resident 10's chart and stated they were late in following up with Resident 10's Level II evaluation. This is a repeat deficiency from SOD dated 08/20/2025. Reference WAC 388-97-1915 (1)(2)		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure nursing assistants received the required 12 hours of in-service education per year, and the in-service education included abuse, dementia and infection prevention related training for 3 of 5 staff reviewed (Staff E, X and Y). Failing to ensure nursing assistants received the required in-service education had the potential to result in staff failing to meet their licensing requirements and decreased staff competency to provide safe and compassionate resident care. Findings included . Review of employee records provided for Staff E, Nursing Assistant-Certified (NAC), documented Staff E was hired 08/24/2023. No evidence of completed in-service education was provided for the prior year for Staff E. Review of employee records provided for Staff X, NAC, documented Staff X was hired 01/07/2025. No evidence of completed in-service education was provided for the prior year for Staff X. Review of employee records provided for Staff Y, NAC, documented Staff Y was hired 10/11/2023. In-service education provided showed Staff Y completed less than 12 hours of in-service education for the prior year, and hours completed did not include abuse, dementia or infection prevention in-services. In an interview on 07/13/2026 at 1:44 PM, Staff S, Licensed Practical Nurse/ Staff Development Coordinator, stated the facility changed training software and no longer had access to the old system where some of the staff education may be located. Staff S stated the facility had no evidence of completion of the required trainings for the requested staff. Refer to WAC 388-97-1680 (2)(b)(c)		