

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 11/15/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff treated 2 of 2 residents (Residents 84 and 98) in a dignified and respectful manner. This failure placed the residents at risk for experiencing a high level of frustration, embarrassment, and the need to constantly advocate for their care.</p> <p>Findings included .</p> <p>The Cambridge English Dictionary, dated April 28, 1995, defines Dignity as The quality of a person that makes him/her deserving of respect, sometimes shown in behavior or appearance. According to Washington State Long-Term Care Ombudsman Program website 12/15/2023, People who live in long-term care facilities are more vulnerable than people who live independently. In 1987, the U. S. Congress recognized this fact and passed The Nursing Home Reform Act that gave nursing home residents additional legal protections, including a set of Resident Rights.</p> <p>Resident rights include the right to a dignified existence and to be treated with consideration, respect, and dignity, recognizing each resident's individuality. Quality of life is to be maintained or improved. Residents have the right to request, refuse and or discontinue treatment.</p> <p><RESIDENT 84></p> <p>Resident 84 admitted to the facility on [DATE]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], the resident had no cognitive impairment.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/05/2024 at 8:56 AM, Resident 84 stated, when they first moved into their new room, the week after September 11th they had issues with Staff F, Nursing Assistant Registered (NAR). Resident 84 stated Staff F was d*** scary. The resident said one night they had to call the aide three times because of diarrhea. The resident stated Staff F told them, You stop calling us. I cannot come in here and keep changing you. Just soil your brief and we will change you when we get to you. Resident 84 said, Do you know how much that makes your butt sore. No one should have to be in a soiled brief. The resident said Staff F told them We have other patients to take care of. Resident 84 said, (Staff F) needs to go work somewhere else. I am afraid of them. Staff F scares me. I haven't been that intimidated since high school, but I was braver then too. I now do not call anyone for help at night because I am scared, (Staff F) will come in. Staff F said they did not want them as their aide at all. Resident 84 stated they reported this to Staff K, Occupational Therapist (OT) who said they could file a complaint and ask for Staff F not to provide care to them. Resident 84 said Staff K came into their room the other night and was very intimidating.</p> <p>In an interview on 11/06/2024 at 1:52 PM, Resident 84 stated they were scared and intimidated by Staff F.</p> <p>In an interview on 11/12/2024 at 9:40 AM, Resident 84 stated staff had been nice lately. The resident stated Staff F was just dreadful.</p> <p><RESIDENT 98></p> <p>Resident 98 admitted on [DATE] and had no cognitive impairment.</p> <p>In an interview on 11/04/2024 at 11:53 AM, Resident 98 was observed in their wheelchair in their room. The walls were beige with the overbed light on. Resident 98 said their room was dark and gloomy. They said three weeks ago, there was a vacant room across the hall, so they asked Staff B, Director of Nursing to be moved to it because their room was depressing. The resident said the room light directly above their bed was fluorescent and too bright. The resident said they stared at a wall and out the window they see a brick wall. Resident 98 said Staff B, DNS told them a new resident was going into that room across the hall. Resident 98 suggested to the DNS they move to that room and the new patient come to their room. The resident said Staff B was dismissive and said Why would I move you into that room and give a new resident your room that you don't like?</p> <p>In an interview on 11/05/2024 at 10:07 AM, Resident 98 said they had a shower yesterday and they asked Staff P, LPN not to have that aide shower them again. Resident 98 said the aide later identified as Staff Q, NAC told them to just stand up, but they were unable to physically stand. The resident told Staff Q they needed to get a gait belt and assist them. The resident said the shower chair was not comfortable as they had a wound on their buttocks. Resident 98 said Staff Q was on their cell phone on 3 occasions during their shower and the NAC left them alone in the shower room three times which made them nervous. Resident 98 reported they were hurting, and the shower took so much longer since Staff Q kept going into the next stall to whisper into their phone. Resident 98 said they were cold, naked and it made them nervous that staff kept leaving them. The resident said the staff member should socialize while on breaks.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 10:17 AM, Resident 98 reported some staff do not listen to them and they find the staff to be quite rude. The resident stated they remind Staff F, NAR every time to not drag the Velcro across their skin during care. The resident stated Staff F told her that another one of her resident's had the same complaint. Resident 98 responded they told Staff F because the Velcro hurts and Staff F dismissed her concern and responded with It is Ok, it is OK. Resident 98 said Staff F gives them the side eye and will not make eye contact with them which makes them feel vulnerable as they are lying on bed with Staff F standing over them. The resident stated Staff F also makes a tskkk sound which to them is dismissive.</p> <p>In an observation on 11/06/2024 at 9:03 AM, Resident 98 was in bed eating their breakfast when Staff E, NAC came into the room and said they were there to change the resident. Resident 98 said Well I am trying to eat my breakfast. Staff E looked at their watch, tapped it and said, I will give you two minutes. The resident took a deep breath and said Wow, two minutes, you might as well do it now then pushed their overbed table with their meal away. At 9:33 AM, Resident 98 said the interaction with Staff E made them feel crappy, like chopped liver.</p> <p>In an interview on 11/07/2024 at 11:00 AM, Resident 98 said Staff E came into their room and that morning and asked if they needed something since their call light was on. Resident 98 said Yes I am wet and need to be changed. The resident said Staff E said they would be going on their break but would change them after. The resident said why would they not change them before heading to their break, knowing they were soiled. The resident said they told Staff E they should not be left wet.</p> <p>In an interview on 11/13/2024 at 1:44 PM, Resident 98 said when they were on the bus to go to their doctor appointment, an unidentified staff member got on the bus and said, Hey I need to talk to you about the shower incident. Where you naked? The resident said they told the staff yes, they were naked, they were in the shower, and they would not talk to them about it right then. The resident said they were embarrassed as the male bus driver was present for the conversation.</p> <p>In an interview on 11/14/2024 at 1:00 PM Staff A, Administrator was told about Resident 98's concerns regarding Staff E.</p> <p>In a joint interview on 11/15/2024 at 11:45 PM with Staff A, Administrator and Staff B, Director of Nursing were informed of Resident 84 and 98's concerns about treatment by staff including the resident's specific comments on how they felt by the interactions with staff.</p> <p>No additional information provided.</p> <p>This is a repeat deficiency from 12/23/2022 and 12/14/2023</p> <p>Refer to WAC 388-97-0180)(2)</p>		

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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954</p> <p>Based on interview and record review, the facility failed to honor a residents' representative's request to schedule a care meeting for 1 of 3 residents' (Resident 5) representative. The failure to honor the resident's representative's request to schedule a care meeting placed the resident at risk for unmet needs and for the resident's representative being unable to advocate for the resident.</p> <p>Findings included .</p> <p>Resident 5 admitted to the facility on [DATE].</p> <p>In an interview on 11/05/2024 at 11:27 AM, Collateral Contact 2 (CC2), family member of Resident 5, stated they set up an appointment today at 10:00 AM for a care meeting, but it still had not happened. They stated they tried to talk to Staff X, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), but when they tried to talk to them, they just stuck their arm out to them like they weren't going to talk to them. CC2 stated they could have called them and let them know the meeting wasn't going to happen and they would have rescheduled. CC2 stated they needed a meeting to discuss many issues they had with Resident 5's care. CC2 stated they had previously had a conference call with Staff B, Director of Nursing (DON), but that staff was combative, and all they offered was a suggestion that Resident 5 move to a different facility.</p> <p>In an interview on 11/05/2024 at 11:56 AM, Staff X stated they had set up a meeting, but not a time. Staff X was asked if representatives could set up appointments with the facility and the resident's doctor for a specific time, they stated they could, but that didn't happen today. Staff X stated CC2, and Resident 5 were in a meeting with the resident's physician right now.</p> <p>Review of facility notes from a Care Conference/Concern follow-up call, dated 11/14/2024, showed Concern #10 was the 10:00 AM care conference did not occur until 11:30. The notes also indicated Staff X had put their hand up to CC2 and was rude. The notes also indicated there was an issue with Staff B, DON, being rude and just offering that Resident 5 move to another facility. The facility's notes indicated they discussed that Staff A, Administrator, and they would be educating Staff B and Staff X regarding customer service, and that in the future Resident 5's representatives would work with Staff A, Administrator, on their concerns.</p> <p>Refer to WAC 388-97-0240 (7)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725</p> <p>Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences for 1 of 3 sampled residents (Resident 46) reviewed for participation in care planning. This failure placed residents at risk of not being allowed to be involved and informed about care and services and a diminished quality of life.</p> <p>Findings included .</p> <p>According to facility policy titled: Resident Participation-Assessment/Care Plans, the resident and his or her legal representative are encouraged to attend and participate in the resident's assessment and in the development of the resident's person-centered care plan. An advance notice of the care planning conference is provided to the resident and his/her representative. Such notices are made by mail, telephone, and/or electronically. The Social Services Director or designee is responsible for notifying the resident/representative and for maintaining records of such notices. Notices may include:</p> <ol style="list-style-type: none"> a. The date, time and location of the conference b. The name of each person contacted and the date he or she was contacted. c. The method of contact (e.g. mail, telephone, email, etc.) d. Input from the resident or representative if they are not able to attend. e. Refusal of participation, if applicable; and f. The date and signature of the individual making the contact. <p>Resident 46 admitted to the facility on [DATE]. According to the Minimum Data Set (MDS - an assessment tool) assessment, dated 10/17/2024 Resident 46 showed they had severe cognitive impairment. However, during my interaction with the resident they were able to make needs known and respond appropriately.</p> <p>In an interview on 11/05/2024 at 9:37 AM Resident 46 stated that they never attended a care conference (a collaborative meeting where a resident's care is discussed and coordinated by a team of health care providers, family members and residents) and would like to attend one. They also stated that they were not told about their care plan.</p> <p>In an interview on 11/06/2024 at 12:42 PM, Staff FF, Registered Nurse (RN) stated, Resident 46 was alert and oriented but forgetful, and required total assist with care.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a record review on 11/17/2024 Resident 46's Progress Note under Social Work, showed notes of interaction and updates from the Social Worker to the resident and resident's daughter but there were no notes indicating that they were care conference notes.</p> <p>In an interview on 11/12/2024 at 1:03 PM, Staff W, Social Services stated that they do quarterly or annual care conferences with residents and/or representatives and it depends on the residents' and/or representatives' preference. According to Staff W, Resident 46's family prefers annual care conferences and wants it via telephone call. Requested Staff W to show me care conference notes for Resident 46 and they stated that they don't have an actual care conference note and that they document it as a progress note when they provide updates to resident and/or representative.</p> <p>This is a repeat deficiency from 12/14/2023.</p> <p>Refer to WAC 388-97-1020 (2)(e)(f)(4)(e)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>33954</p> <p>Based on interview and record review, the facility failed to act, respond, and resolve the organized resident group's concerns for 1 of 1 Resident Council groups. The facility administration's failure to respond to the organized group's concerns resulted in an extended period where reported resident care needs went uninvestigated, unidentified and unmet due to the facility's systemic failure to investigate the concerns reported during the Resident Council meetings from May, June, July and August 2024. Additional failed practice included the facility failure to maintain complete and accurate Resident Council meeting minutes that included all concerns and grievances voiced during Resident Council meetings, and failures to log, report, investigate, and resolve concerns voiced by the Resident Council. The non-responsive facility administration's pattern of inaction placed all residents at risk for unidentified, unmet care needs and diminished quality of life.</p> <p>Findings included .</p> <p>In an interview with Resident Council representatives on 11/07/2024 at 10:00 AM:</p> <p>-Resident 50, Resident Council representative, stated overnight call light response times were slower than they should be, and there was a shortage of night shift staff.</p> <p>-Resident 19, Resident Council representative, stated residents were not getting the food they requested, and the facility was not following their menu. Resident 50 stated they thought the facility didn't have all the food on their menus and that staff were not entering their food choices accurately onto their tray cards. Resident 50 stated they thought the problem also was that staff didn't read the menus and they were so hurried with trying to get all the residents their food that they were not accurate.</p> <p>Review of the facility concern/grievance reporting log for May 2024 showed three Resident Council concerns entries, dated 05/23/2024: 1) Aides not hanging clothes in closet, 2) want someone present at nursing stations 24/7, 3) not getting what is on the menu.</p> <p>Review of a Grievance/Suggestion Communication Form, dated 05/23/2024, showed there were four Resident Council grievances: 1) Night shift wait for a long time, 1 hour, for (staff) to come, 2) Aides don't hang clothes in closet when they take them out, they threw clothes in a pile or left them in a chair, 3) nursing station 24/7 someone to be present, 4) diet slips issue, food items missing, not getting what they ordered. This form had boxes to check for who the issues were referred to, but they were all blank. The form had a box to document actions taken to address the concern/complaint/suggestion, but they were all blank. There were no resident names to identify which resident had made the allegations or to identify who could be followed up with during an investigation or to verify resolution. The form indicated it was completed by Staff HH, Director of Activities (DOA).</p> <p>Review of Resident Council meeting minutes, dated 05/23/2024, showed there was no documentation of any of the four grievances listed in the 05/23/2024 Resident Council grievance form completed by Staff HH.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of three Grievance/Suggestion Communication Forms, dated 05/23/2024, all three prepared by Staff A, Administrator, regarding:</p> <ol style="list-style-type: none"> 1) the aides not hanging up clothes in the closet, 2) residents wanting someone to be present at the nursing station 24/7. The facility response was to send a letter to residents to update concerns and for activities to follow-up with Resident Council. An attachment to the grievance indicated the facility response was if they did this, it would pull from the floor (staff) and maybe make call-light times longer, and to please ask why they would like someone at the nursing station. Did not find any documentation they had asked why residents wanted staff at the nursing station, and did not find documentation the Resident Council's concern was resolved. 3) residents not getting foods they ordered. The facility response was to send a letter to residents to update concerns and for activities to follow-up at the next Resident Council meeting. There was no documentation any residents had been interviewed to see if their food concerns had been resolved. Review of the next Resident Council meeting minutes, dated 06/27/2024, showed there was still a concern, as residents were missing items on their trays and not what they ordered. <p>Review of the May 2024 incident reporting log showed there was no Resident Council entries for the month of May.</p> <p>In an interview on 11/12/2024 at 8:47 AM, Staff HH, was interviewed regarding the Resident Council Grievance/Suggestion Communication Form, dated 05/23/2024, that did not have any specific resident names listed, they stated if there were no resident names than it was the entire resident council that had issues with that concern. Staff HH stated they had reported the resident council's concern of one hour night shift call light response times to Staff A, Administrator.</p> <p>In an interview on 11/12/2024 at 9:01 AM, Staff A was interviewed regarding the 05/23/2024 grievance regarding the night shift call lights taking an hour for staff to come, they stated the facility had not done anything to investigate those concerns, and they had not logged the concern. Staff A stated they were the facility grievance official.</p> <p>Review of the Resident Council meeting minutes, dated 06/27/2024, showed council concerns about nursing that call lights were taking too long to answer and for dietary there was a council concern about missing items on trays and foods they received were not what they ordered from their menus. There were no attached grievance/concern forms that could be related to these council concerns.</p> <p>Review of the facility concern/grievance reporting log for June 2024 showed the facility had not logged the Resident Council's concerns voiced at the 06/27/2024 Resident Council meeting.</p> <p>Review of Resident Council meeting minutes, dated 07/25/2024, showed Staff B, Director of Nursing, had attended the meeting, and there were nursing concerns of long call light waiting times and personal phones of night shift staff. There was no documentation the last months minutes of the meeting were read and approved, and there was no documentation of resolutions of concerns from the previous month meeting.</p> <p>(continued on next page)</p>

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility concern/grievance reporting log for July 2024 showed the facility had not logged the Resident Council's concerns voiced at the 07/25/2024 Resident Council meeting.</p> <p>Review of the Resident Council meeting minutes, dated 08/29/2024, showed council concerns of the night shift call lights taking too long to answer. There were no attached grievance/concern forms that could be related to this council concern.</p> <p>Review of the facility concern/grievance reporting log for August 2024 showed the facility had not logged the Resident Council's concerns voiced at the 08/29/2024 Resident Council meeting.</p> <p>In an interview on 11/12/2024 at 9:36 AM, Staff HH, was interviewed regarding the 05/23/2024 Resident Council minutes that did not have any information about the four Resident Council grievances dated 05/23/2024, they stated if there was a grievance they did not document it in the Resident Council minutes, that they did a grievance form. We discussed that the 06/27/2024 Resident Council minutes showed a concern that call lights were taking too long to answer, Staff HH stated they had not filled out a grievance form, that the minutes were all they had. Regarding the 07/25/2024 Resident Council meeting minutes, stated they didn't think they had filled out a grievance form regarding the council concerns of long call light waiting times and issues with the personal phones of night shift nursing staff. Regarding the 08/29/2024 Resident Council minutes, they stated they didn't think they had filled out a grievance regarding the council concerns of night shift call lights taking too long to answer.</p> <p>In an interview on 11/12/2024 at 10:05 AM, Staff A, stated Resident Council concerns were supposed to be documented in both the Resident Council meeting minutes and on a concern form. Staff A stated the 05/23/2024 Resident Council grievance regarding call lights taking long time/one hour to answer was an allegation that needed to be reported and investigated.</p> <p>In an interview on 11/13/2024 at 9:15 AM, Resident 50, stated staffing and call lights were issues that had never been resolved and nights were the biggest problem. Resident 50 stated they thought there were still issues with night shift and call lights, and they thought that staff maybe took their breaks at the same time as there were times when staff just was not available. Resident 50 stated they thought it was an ongoing issue with night shift and residents not getting their pullups and diapers changed and it just didn't get done for all residents. Resident 50 stated they thought the facility was running short-staffed. Resident 50 stated they had talked to administration about staffing, but not a lot as they were not sure who to go to.</p> <p>In an interview on 11/14/2024 at 8:13 AM, Staff A, stated all grievances were to be reported on the grievance log and they didn't know why the food concerns reported at the June Resident Council meeting did not get logged. Staff A was unable to provide any information why all Resident Council grievances did not get documented on the Resident Council meeting minutes and the grievance form. Staff A stated Staff HH should have reported the night shift staffing concern reported by the Resident Council in May.</p> <p>In an interview on 11/14/2024 at 10:33 AM, Staff HH, stated Staff B attended the July 2024 Resident Council meeting. Staff HH also stated every month after the Resident Council meetings they gave a copy of the meeting minutes to Staff A. Staff HH stated they knew Staff A had been aware of the call lights issues and staffing concerns from May to August as they had given Staff A the meeting minutes.</p> <p>(continued on next page)</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Refer to WAC 388-97-0920 (4)(5)</p>

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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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on interview and record review the facility failed to recognize, record and promptly resolve grievances for 5 of 5 residents (Residents 2, 37, 45, 98 and 255) reviewed for grievances. Failure to implement their grievance process placed the residents at risk for anxiety, undue stress, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the undated facility policy titled, Grievances/Complaints-Staff Responsibility showed staff members are encouraged to guide residents about where and how to file a grievance and/or complaint when the resident believes that his/her rights have been violated. The procedure showed staff members may inform the resident or the person acting on their resident behalf that he or she may file a grievance or complaint with the Administrator or other government agencies as noted on posting in the facility, without fear of threat or any form of reprisal.</p> <p><RESIDENT 98></p> <p>Resident 98 admitted to the facility on [DATE].</p> <p>In an interview on 11/04/2024 at 11:53 AM, Resident 98 stated they requested to have a half bed rail placed on her bed, but staff would not let them and said bed rails were deemed illegal by the state. Resident 98 said they asked the staff to position two-winged back chairs up to the bed so they could use them to reposition in bed. Resident 98 said they had asked Staff B, Director of Nursing Services (DNS) to be moved to the room across the hall three weeks ago and they had not been moved nor received an update on when a room change would occur.</p> <p>In an interview on 11/05/2024 at 10:27 AM, Resident 98 said their call light was not working from the first day they admitted until last week. The resident said their air mattress kept breaking at 12:00 AM to 1:00 AM in the morning a couple of times a week. They said the compressor on the bed pump did not come on and then they are lying on the metal frame and when the bed is flat their sciatica kicks in. The resident said they felt bad for the staff because they do not have time to deal with their mattress at night and the pump beeps all night long. Resident 98 said multiple aides and nurses were aware and they had also called the receptionist and asked to be transferred to the maintenance extension where they left two messages about their malfunctioning bed.</p> <p>Review of the concern log showed there were no grievances for Resident 98 regarding their mattress concerns.</p> <p>In an interview on 11/06/2024 at 2:31 PM, Staff J, Maintenance Director said they had not heard a thing about Resident 98's mattress. Staff J said they reviewed the TELS log (platform for staff to report maintenance concerns) and there were no entries about the mattress.</p> <p>Review of the TELS report showed staff had requested with medium priority for maintenance to fix Resident 98's bed air pump that kept beeping loudly on 10/21/2024.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the TELS report showed staff had requested with medium priority for maintenance to fix Resident 98's bed and call light that were not working on 10/29/2024.</p> <p>In an interview on 11/07/2024 at 11:00 AM, Resident 98 said they asked staff again about the side rail and were told they were illegal and there was a [NAME] Administrative Code (WAC) about it and the state nurse did not know what they were talking about. Resident 98 came up with the wing chair placement to be able to reposition themselves since using their overbed table was not safe as it moved. The resident said the maintenance man did come in and tell them the mattress issue had not been reported to them or logged but they had called the maintenance line twice.</p> <p>In an interview on 11/12/2024 at 9:29 AM, Resident 98 said they were still awaiting side rails and staff placed a wheelchair at bedside to use for turning. Resident 98 said they had their daughter bring in their skin medications last Thursday (11/07/2024) so they could show the nurse so they could request orders for them. Resident 98 said the nurses have lost two of their three medications including their expensive Clobetasol and Nystatin. The resident said the nurses keep telling them they are looking for them. Resident 98 said they were unaware if a grievance had been completed for their concerns.</p> <p>In an interview on 11/13/2024 at 1:44 PM, Resident 98 stated they had received their new mattress. The resident said Staff I, Social Services came in and asked if they had any grievances and she responded Yes, my missing medications.</p> <p>In an interview and observation on 11/14/2024 at 9:33 AM was sitting in their wheelchair smiling. Resident 98 said they loved their new room where they can watch the birds, courtyard activity and see the sunshine. The resident said the room move had improved her mood. Resident 98 said they did not know why they couldn't be moved over three weeks ago when they initially asked, and they remarked the initial request for the room move was a negative experience. The resident said they were still awaiting side rails, and no one had offered them reimbursement for the medications.</p> <p>In a joint interview on 11/15/2024 at 11:48 AM with Staff A, Administrator and Staff B, Director of Nursing said they were unsure why grievances were not created for Resident 98's concerns.</p> <p>37890</p> <p><RESIDENT 2></p> <p>In an interview on 11/04/24 at 1:51 PM, Resident 2 stated they had personally purchased bed pads and stated they disappeared. Resident 2 stated they tell the aids, and the nurses and staff have told them they are still looking for them. Resident 2 stated they were not aware of any formal grievance being completed related to their missing items.</p> <p>Review of the facility grievance log on 11/05/2024 showed no logged entry for Resident 2 related to missing property concern.</p> <p>47047</p> <p><Resident 37></p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 37 admitted to the facility on [DATE] with diagnoses that included bilateral below the knee amputations, type two diabetes mellitus (long term condition in which the body has trouble regulating blood sugar) and high blood pressure.</p> <p>In an interview on 11/5/2024 at 9:15 AM Resident 37 stated they were missing a tee shirt, the shirt had cost them around fifty dollars, had told several staff about it, was upset that it was missing and nothing had been done about it.</p> <p>Review of Resident 37's Minimum Data Set (MDS-an assessment tool) dated 10/22/2024 showed their cognition was intact.</p> <p><Resident 43></p> <p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), chronic kidney disease, and atrial fibrillation (an irregular heart rate).</p> <p>In an interview on 11/06/2024 at 9:00 AM Resident 43 stated their favorite pajamas were missing. Resident 43 stated they had informed a staff member, a nursing aide, and there was nothing to do about it. When asked if the aide had provided information about the grievance process to find their missing pajamas, Resident 43 stated they were not aware of the facility grievance process.</p> <p><RESIDENT 255></p> <p>Resident 255 admitted to the facility on [DATE] with diagnoses that included high blood pressure and fracture of the left leg.</p> <p>In an interview on 11/04/2024 at 3:19 PM Resident 255 stated they were missing two ice packs and covers for the ice packs that they had brought in from home. Resident 255 stated they reported it to the facility staff, and they had not been found to date.</p> <p>Review of the facility grievance log for September, October and November 2024 showed no entries related to missing belongings for Resident 37, 43 and 255.</p> <p>In an interview on 11/06/2024 at 12:59 PM Staff JJ, Nursing Assistant Certified (NAC) stated they had been working at the facility for about two weeks. Staff JJ stated they did not know of a specific process for missing items but would try to locate a missing item if they were told about it.</p> <p>In an interview on 11/06/2024 at 1:34 PM, Staff II, NAC, stated resident names are written on their clothing. When asked what the process was for when a clothing item goes missing, Staff II stated they would try to locate the missing item, take the resident who was missing the item to laundry, ask housekeeping. Staff II stated they were not aware of a form in which missing items were reported or tracked.</p> <p>In an interview on 11/06/2024 at 1:03 PM Staff N, Registered Nurse, stated they had not received any recent reports of missing items from residents. Staff N stated if a resident reported missing clothing, they would check laundry for the missing item(s).</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/06/2024 at 1:56 PM Staff A, Administrator, stated missing items are documented on a grievance form. Staff A stated staff are trained on the grievance process upon hire and at least annually. Staff A stated grievance forms located at nursing stations and in the front lobby.</p> <p>Refer to WAC 388-97-0460</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>33954</p> <p>Based on interview and record review, the facility failed to ensure residents were free from abuse and neglect due the facility failure to respond to and resolve nursing care, staffing and food services grievances voiced by 1 of 1 organized resident groups over a four-month period from May to August 2024. Facility administration chose to address only select grievances and opted not to address reported nursing staffing and food service concerns. The facility administration's systematic failure to investigate and act on residents' reported concerns deprived an unknown number of residents necessary nursing care and food service support, the extent of which could not be ascertained due to a gross lack of documentation and overt failures in the facility's Resident Council/Grievance procedures. The facility failure to ensure the necessary processes, procedures and structures were in place to prevent abuse and neglect placed all residents at risk for ongoing abuse and neglect, unmet needs, weight loss and diminished quality of life.</p> <p>Findings included .</p> <p>In an interview with Resident Council representatives on 11/07/2024 at 10:00 AM, Resident 50, Resident Council representative, stated overnight call light response times were slower than they should be, and there was a shortage of night shift staff. Both Residents 50 and 19 voiced concerns about the facility food service program as residents were not receiving the foods they had requested.</p> <p>Review of the facility concern/grievance reporting log for May 2024 showed three Resident Council concerns entries, dated 05/23/2024: 1) Aides not hanging clothes in closet, 2) want someone present at nursing stations 24/7, 3) not getting what was on the menu.</p> <p>Review of a Grievance/Suggestion Communication Form, dated 05/23/2024, showed there were four Resident Council grievances: 1) Night shift wait for a long time, 1 hour, for (staff) to come, 2) Aides don't hang clothes in closet when they take them out, they threw clothes in a pile or left them in a chair, 3) nursing station 24/7 someone to be present, 4) diet slips issue, food items missing, not getting what they ordered. This form had boxes to check for who the issues were referred to, but they were all blank. The form had a box to document actions taken to address the concern/complaint/suggestion, but they were all blank. There were no resident names to identify which resident had made the allegations or to identify who could be followed up with during an investigation or to verify resolution. The form indicated it was completed by Staff HH, Director of Activities (DOA).</p> <p>Review of Resident Council meeting minutes, dated 05/23/2024, showed there was no documentation of any of the four grievances listed in the 05/23/2024 Resident Council grievance form completed by Staff HH.</p> <p>Review of three Grievance/Suggestion Communication Forms, dated 05/23/2024, all three prepared by Staff A, Administrator, regarding:</p> <p>1) the aides not hanging up clothes in the closet,</p> <p>2) residents wanting someone to be present at the nursing station 24/7.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3) residents not getting foods they ordered. There was no documentation any residents had been interviewed to see if their food concerns had been resolved. Review of the next Resident Council meeting minutes, dated 06/27/2024, showed there was still a concern, as residents were missing items on their trays and not what they ordered.</p> <p>In an interview on 11/12/2024 at 8:47 AM, Staff HH was interviewed regarding the Resident Council Grievance/Suggestion Communication Form, dated 05/23/2024, and stated that the form did not have any specific resident names listed, they stated if there were no resident names than it was the entire resident council that had issues with that concern. Staff HH stated they had reported the resident council's concern of one hour night shift call light response times to Staff A.</p> <p>In an interview on 11/12/2024 at 9:01 AM, Staff A was interviewed regarding the 05/23/2024 grievance regarding the night shift call lights taking an hour for staff to come, and they stated the facility had not done anything to investigate those concerns, and they had not logged the concern.</p> <p>Review of the Resident Council meeting minutes, dated 06/27/2024, showed council concerns about nursing that call lights were taking too long to answer and for dietary there was a council concern about missing items on trays and foods they received were not what they ordered from their menus. There were no attached grievance/concern forms that could be related to these council concerns.</p> <p>Review of the facility concern/grievance reporting log for June 2024 showed the facility had not logged the Resident Council's concerns voiced at the 06/27/2024 Resident Council meeting.</p> <p>Review of Resident Council meeting minutes, dated 07/25/2024, showed Staff B, Director of Nursing, had attended the meeting, and there were nursing concerns of long call light waiting times and personal phones of night shift staff. There was no documentation of resolutions of concerns from the previous month meeting.</p> <p>Review of the facility concern/grievance reporting log for July 2024 showed the facility had not logged the Resident Council's concerns voiced at the 07/25/2024 Resident Council meeting.</p> <p>Review of the Resident Council meeting minutes, dated 08/29/2024, showed council concerns of the night shift call lights taking too long to answer. There were no attached grievance/concern forms that could be related to this council concern.</p> <p>Review of the facility concern/grievance reporting log for August 2024 showed the facility had not logged the Resident Council's concerns voiced at the 08/29/2024 Resident Council meeting.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/12/2024 at 9:36 AM, Staff HH was interviewed regarding the 05/23/2024 Resident Council minutes that did not have any information about the four Resident Council grievances dated 05/23/2024, they stated if there was a grievance they did not document it in the Resident Council minutes, they completed a grievance form. We discussed that the 06/27/2024 Resident Council minutes showed a concern that call lights were taking too long to answer, Staff HH stated they had not filled out a grievance form, that the minutes were all they had. Regarding the 07/25/2024 Resident Council meeting minutes, Staff HH stated they didn't think they had filled out a grievance form regarding the council concerns of long call light waiting times and issues with the personal phones of night shift nursing staff. Regarding the 08/29/2024 Resident Council minutes, Staff HH stated they didn't think they had filled out a grievance regarding the council concerns of night shift call lights taking too long to answer.</p> <p>In an interview on 11/12/2024 at 10:05 AM, Staff A stated Resident Council concerns were supposed to be documented in both the Resident Council meeting minutes and on a concern form. Staff A stated the 05/23/2024 Resident Council grievance regarding call lights taking long time/one hour to answer was an allegation that needed to be reported and investigated.</p> <p>In an interview on 11/13/2024 at 9:15 AM, Resident 50, Resident Council Representative, stated staffing and call lights were issues that have never been resolved and nights were the biggest problem. Resident 50 stated they thought there were still issues with night shift and call lights, and there were times when staff just was not available. Resident 50 stated they thought it was an ongoing issue with night shift and residents not getting their pullups and diapers changed and it just didn't get done for all residents. Resident 50 stated they thought the facility was running short-staffed. Resident 50 stated they had talked to administration about staffing, but not a lot as they were not sure who to go to.</p> <p>In an interview on 11/14/2024 at 10:33 AM, Staff HH stated Staff B came to the July Resident Council meeting. Staff HH also stated every month after the Resident Council meetings they gave a copy of the meeting minutes to Staff A. Staff HH stated they knew Staff A had been aware of the call lights issues and staffing concerns from May to August as they had given Staff A the meeting minutes.</p> <p>Refer to WAC 388-97-0640 (1)</p> <p>36787</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on observation, interview and record review the facility failed to ensure a resident's right to be free from involuntary seclusion for 1 of 1 resident (Resident 253). Failure to prevent involuntary seclusion placed the resident at risk for psychological harm.</p> <p>Findings included .</p> <p>Resident 253 was admitted to the facility on [DATE] with diagnoses that included acute cystitis (a bladder infection that begins suddenly and is usually caused by bacteria).</p> <p>In an interview on 11/04/2024 at 3:02 PM, Resident 253 stated they were not allowed to leave their room and they had to stay in their room. Resident 253 stated they get lonely because they were not able to leave their room. Resident 253 stated the nursing staff had informed them they had to stay in their room because of their infection.</p> <p>Review of Resident 253's Minimum Data Set (MDS-an assessment tool) showed resident was interviewed about their preferences for customary routine and activities and reported it was very important to them to do things with groups of people. Resident 253 was noted to be cognitively intact.</p> <p>Review of Resident 253's care plan dated 10/27/2024 showed the resident preferred to participate in self directed activities such as crafts (sewing and needle art), watching movies, and reading. The care plan showed that Resident 253 was on isolation/contact precautions related to extended spectrum beta-lactamases (ESBL-enzymes that make bacteria resistant to many common antibiotics) in their urine.</p> <p>In an interview on 11/12/2024 at 10:01 AM, Staff HH, Activities Director, stated they provided all new admissions with crossword puzzles, a daily chronicle, and magazines. Staff HH stated Resident 253 liked to do their own individual activities and did not want to do anything else but was offered other activities. When asked how an assessment was conducted with a resident on isolation/contact precautions, Staff HH stated they would contact the resident by phone to gather their information needed.</p> <p>In an interview on 11/13/2024 at 8:38 AM Staff V, Licensed Practical Nurse (LPN)-Infection Preventionist (IP) stated Resident 253 was on contact precautions and isolation for ESBL and staff were directed to have the resident in their room until the precautions could be lifted or until completion of antibiotics. Staff V stated they had not met with Resident 253. Staff V stated Resident 253 was incontinent of urine and their main concern was any potential contamination from their incontinence. Staff V stated they obtained the information about Resident 253's incontinence from the nurses and the Kardex (a tool used to provide direction on how to care for a resident).</p> <p>Review of Center for Disease Control and Prevention guidelines for nursing homes and reducing the risk of ESBL included hand washing and enhanced barrier precautions (for high contact resident care activities use of gown and gloves).</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/13/2024 at 11:54 AM Staff S, Social Services Director, stated they had only been in contact with Resident 253 at their care conference and regarding their discharge plan.</p> <p>Review of Resident 253's Nursing Assistant Documentation for October and November 2024 showed resident was documented as continent of their urine.</p> <p>Review of Resident 253's activity documentation for November 2024 showed they engaged in social activities, documented as television.</p> <p>Reference WAC 388-97-0640 (1)(3)(c)</p>

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview, and record review, the facility failed to ensure systems were in place for staff following and implementing abuse and neglect policies & procedures for reporting, investigation, and protection for 3 of 11 residents (Residents 15, 50, and 84), reviewed for abuse and neglect. The failure to identify potential abuse, timely report allegations of potential abuse, complete timely and thorough investigations of the potential abuse, assess and monitor the residents for physical and psychosocial harm, notify responsible parties and providers, and to document the allegations and revise resident care plans placed residents at risk for injury, fearfulness, frustration, humiliation, and further potential abuse.</p> <p>Findings included .</p> <p>A review of the facility's policy titled, Abuse dated 10/01/2021, showed the organization recognizes and respects that each resident has the right to be free from abuse, neglect, misappropriation of resident's property, and exploitation. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptom. The facility is committed to developing and operationalizing policies and procedures for screening and training employees, protection of resident and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property.</p> <p>The policy directed facility staff to:</p> <ol style="list-style-type: none"> 1. Screening: The organization will screen potential employees for a history of abuse, neglect or mistreating residents including background screening, employment/reference checks. 2. Training: Facility employees will be required to complete the comprehensive orientation program that includes how staff should report their knowledge of allegations without fear of reprisal and what constitutes abuse, neglect, mistreatment of and misappropriation of resident's property. 3. Prevention: The facility will not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. The facility will not employ or otherwise engage individuals who have been found guilty of abuse, neglect .or mistreatment of individuals by a court of law. The organization will maintain protocols and procedures to identify, correct and intervene in situations in which abuse, neglect, mistreatment and or misappropriation is more likely to occur. The supervision of staff to identify inappropriate behaviors, such as derogatory language, rough handling, ignoring residents while giving care, directing residents who need toileting assistance to urinate or defecate in the beds. <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Identification: Staff are encouraged to identify, correct, and intervene in situations in which abuse, neglect and/or misappropriation of resident property is more likely to occur. immediately following ensuring the resident's safety, staff are to report any allegation or observation of abuse to their supervisor, director of nursing, administrator or facility leadership member. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure that resident needs are being met in accordance with the plan of care . Administrative and facility leadership staff will supervise staff to identify inappropriate behaviors, action and response to resident needs. Resident and environmental rounds will be conducted periodically throughout the day. These rounds and frequent monitoring are to ensure that resident needs are being met in accordance with the plan of care, that residents are being supervised and that the environment is free of hazards.</p> <p>5. Investigation: Designated staff will immediately review and investigate all allegations or observations of abuse. The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>6. Protection: In the event of an allegation or observation of abuse, the facility will immediately assess the resident, notify the physician and resident representative, and protect the resident and other residents from further harm or incident. Other residents who may have potentially been affected or at risk will be identified and a plan of care will be developed or revised as appropriate to ensure their safety. When specific staff is identified as being allegedly involved in the abuse allegation, the staff may be reassigned or suspended during the investigation.</p> <p>7. Reporting: The organization will maintain systems to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services.</p> <p>< RESIDENT 15></p> <p>Resident 15 admitted on [DATE] with diagnoses to include kidney failure requiring dialysis (procedure to remove excess water and toxins from blood when kidneys are no longer functioning properly), depression, muscle weakness and right above the knee amputation.</p> <p>Review of the 08/01/2024 Fall Care Area Assessment (CAA) showed Resident 15 was a fall risk related to factors including weakness, poor trunk control and assistance was needed with all mobility and transfers.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] showed Resident 15 was cognitively intact and had lower extremity impairment on one side.</p> <p>(continued on next page)</p>		

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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	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 11/05/2024 at 1:25 PM, Resident 15 was observed sitting in their wheelchair with their right stump on the elevating leg rest. Resident 15 stated, It takes too d**n long to get your call light answered. An hour or two usually. The day before yesterday, the aide left me on the bedside commode for 45 minutes after lunch time. The aide told me to put my call light on when I was done. I did but waited and waited for 45 minutes. My butt was killing me. It hurts to be sitting on that (commode) and trying to stay up right. I was so mad. I told my nurse about it. Resident 15 stated their sitting balance was not good.</p> <p>Review of the concern and incident reporting logs on 11/05/2024 showed they did not include any concerns related to Resident 15.</p> <p>In an interview on 11/05/2024 at 1:54 PM, Staff A, Administrator and Staff C, Administrator in Training said they had not been informed about this allegation.</p> <p>In an interview on 11/05/2024 at 2:53 PM, Staff K Occupational Therapist (OT) was asked about Resident 15. Staff K said last week on Thursday (10/31/2024) or Friday (11/01/2024) essentially one of our therapists was walking by and had heard a noise from Resident 15's room, so they knocked, and Resident 15 reported they had been on the bedside commode for 40 minutes. Staff K said after that the resident was then hesitant to do toilet training during their therapy session that day which was unfortunate because that is what the resident needed to work on. Staff K commented that the commode is not the softest surface and 40 minutes is a long time sitting down. Staff K said they left a note about the resident's concern on their manager's desk. Staff K said they were not sure if their training had included neglect.</p> <p><RESIDENT 84></p> <p>Resident 84 admitted on [DATE]. According to the quarterly Minimum Data Set (MDS) assessment dated [DATE], the resident had no cognitive impairment.</p> <p>In an interview on 11/05/2024 at 8:56 AM, Resident 84 stated, when they first were moved into their new room, the week after September 11th they had issues with Staff F, Nursing Assistant Registered (NAR). Resident 84 stated Staff F was d**n scary. The resident said one night they had to call the aide three times because of diarrhea. The resident stated Staff F told them, You stop calling us. I cannot come in here and keep changing you. Just soil your brief and we will change you when we get to you. Resident 84 said, Do you know how much that makes your butt sore. No one should have to be in a soiled brief. The resident said Staff F told them We have other patients to take care of. Resident 84 said, (Staff F) needs to go work somewhere else, I am afraid of them they scare me. I haven't been that intimidated since high school, but I was braver then too. I now do not call anyone for help at night because I am scared, (Staff F) will come in. Staff F said they did not want them as their aide at all. Resident 84 said they said they reported this to Staff K, who said they could file a complaint and ask for Staff F not to care for them. Resident 84 said Staff F came into their room the other night and was very intimidating.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/05/24 at 2:50 PM, Staff K stated they needed to report allegations to their superior. Staff K said they would report concerns to Staff RR, Director of Rehab (DOR). They said if the allegation occurred over a weekend there may be a manager of the weekend, and they would report it to the Medicare team. Staff K said there were some concerns about a caregiver reported to them. They said they were told to report no matter how big or small the concern was. Staff K said two weeks ago, Resident 84 had concerns about their care, so they reported it to the unit managers. Staff K said Resident 84 reported to them that when they were in the other room, they had a concern about Staff F. The resident said they were no longer walking to the bathroom at night and Staff F told the resident to just go to the bathroom in their brief. Staff K said they wrote up a grievance and went to give it to the unit manager, but they were not at the facility, so they left it on their desk with a note. Staff K said they remembered it very vividly. Staff K said Resident 84 received improper care since during the day, the day aides or they would help the resident to the toilet. Staff K said the resident should have been supervised to the bathroom.</p> <p>In an interview on 11/06/2024 at 1:52 PM, Resident 84 stated they were scared and intimidated by Staff F.</p> <p>In an interview on 11/12/2024 at 9:40 AM, Resident 84 stated staff had been nice lately. The resident stated Staff F was just dreadful.</p> <p>In an interview on 11/14/2024 at 11:28 AM, Staff A, Administrator said Staff F would not be returning to work in the facility.</p> <p>Staff F was unable to be interviewed.</p> <p>37890</p> <p><RESIDENT 50></p> <p>Resident 50 admitted to the facility in 2022.</p> <p>Review of Resident 50's clinical record on 11/12/2024 showed an incident note dated 10/31/2024 showing the resident alleged that a nursing assistant left them in the bathroom for over an hour with their call light on 10/27/2024.</p> <p>Review of the state reporting log showed the facility failed to report Resident 50's allegation to the state agency as required until 11/07/2024.</p> <p>33954</p> <p><STAFF INTERVIEWS></p> <p>In an interview on 11/05/2024 at 2:30 PM Staff XX, LPN stated they were aware of their responsibility as a mandated reporter, but reported all allegations to their manager or the DNS only and they would then report it to the state hotline.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/05/2024 at 2:37 PM Staff VV, Nursing Assistant Registered, stated if a resident reported they waited for two hours to get their brief changed, they would help the resident and then notify the nurse. Staff VV stated they were not aware of any other reporting requirements.</p> <p>In an interview on 11/05/2024 at 2:53 PM, Staff K OT stated they filled grievance forms when there was a concern voiced by residents and left for their manager or the unit nurse managers. Staff K stated they reported all allegations to their superior, Staff RR.</p> <p>In an interview on 11/05/2024 at 2:19 PM Staff KK, OT, stated they had not called in any allegations of abuse/neglect to the state hotline, they fill out grievance forms for any resident complaints, and the management would make a report to the hotline.</p> <p>In an interview on 11/05/2024 at 2:18 PM DDD, NAC stated if a resident reported they waited for two hours to get their brief changed, they report to the department of health and the nurse.</p> <p>In an interview on 11/05/2024 at 2:30 PM Staff N, RN stated the facility's policy was to report abuse and if there was an allegation they would report it to a manager. Staff N stated if a manager was not available such as over the weekend, they would just report it to the hotline.</p> <p>In an interview on 11/08/2024 at 10:39 AM Staff RR stated they had been at the facility for [AGE] years and the long-standing culture of the facility was to report all allegations to Administration (DNS and Administrator), and they would decide when and if a report to the hotline would be done.</p> <p>In an interview on 11/08/2024 at 11:10 AM, Staff P, LPN said if a resident reported they had not been changed in an hour that would be neglect. Staff P said they would report the concern to their unit manager and report the NAC's license.</p> <p>In an interview on 11/08/2024 at 11:25 AM, Staff LL, NAC said if they could not solve the issues, they would discuss allegations with their superior, nurse or charge nurse. Staff did not verbalize the need to report to the hotline.</p> <p><RESIDENT COUNCIL></p> <p>Review of Resident Council meeting minutes and/or Resident Council Grievance/Suggestion Communication forms, dated:</p> <p>-05/23/2024: showed there was a resident care issue with night shift and waiting for a long time, 1 hour, for staff to come.</p> <p>-06/27/2024: showed a concern with nursing and call lights taking a long time to answer.</p> <p>-07/25/2024: showed a nursing concern of long call light waiting. The Resident Council minutes also indicated Staff B, DNS had attended that council meeting.</p> <p>-08/29/2024: showed a nursing concern of night shift call lights taking a long time to answer.</p> <p>Review of the incident reporting logs for May - August 2024 showed the facility had not logged any of the Resident Council's concerns about night shift, call lights taking too long to answer.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/12/2024 at 9:01 AM, Staff A, Administrator, stated the facility had not done anything to investigate or log the 05/23/2024 Resident Council allegation of night shift call lights taking an hour for staff to answer.</p> <p>In an interview on 11/12/2024 at 10:05 AM, Staff A, Administrator, stated the allegation of call lights taking long time/one hour was an allegation that needed to be reported and investigated.</p> <p>In an interview on 11/13/2024 at 9:15 AM, Resident 50, Resident Council Representative, was asked about the Resident Council's call light and staffing issues the Resident Council had reported to the facility from May - August 2024, they stated staffing and call light issues had never been resolved and they thought that nights were the biggest problem. The resident stated at night sometimes staff just were not available. Resident 50 stated they had concerns with residents' pullups and diaper changes sometimes didn't get done for all residents and it was kind of an ongoing issue that residents could not get changed and could still be wet in the morning. The resident thought the facility was running short-staffed. Resident 50 stated they had talked to administration about staffing, but not a lot of them because they didn't know who to go to, and they stated they had also talked to the director of nursing.</p> <p>In an interview on 11/14/2024 at 8:13 AM, Staff A, Administrator, stated Staff HH, Director of Activities, should have reported the night shift staffing concerns voiced by the Resident Council in May 2024, and Staff H had not reported them.</p> <p>In an interview on 11/14/2024 at 10:33 AM, Staff HH, Director of Activities, stated they knew Staff A, Administrator, was aware of the call light issues and staffing concerns from May - August, because they themselves had given them the resident council minutes. Staff HH state they had not reported the resident council's concerns to the abuse/neglect hotline, but they did know they were a mandated reporter. Staff HH stated they knew they were in a key role as residents did come to them for issues regarding their care.</p> <p>In an interview on 11/05/2024 at 2:32 PM, Staff TT, NAC, did not know they were to report allegations of abuse or neglect to the state survey agency hotline.</p> <p>Review of an incident investigation, dated 11/13/2024, showed the facility had conducted an investigation, but it was not thorough as there were no interviews or witness statements from Staff A, Administrator, Staff B, Director of Nursing, or Staff HH, Director of Activities, regarding their roles in the facility's non-response to four months of documented Resident Council staffing concerns. The investigation was also not thorough, as there were no interviews or witness statements from the Resident Council President, [NAME] President, or any other Resident Council representatives that could have provided information about the council's concerns and what their concerns had been from May to August. The investigation did not include any documentation whether the facility had substantiated abuse/neglect. The investigation really was not focused at all, as the investigation indicated it addressed the past three months of Resident Council concerns, but the council meeting minutes and related grievances showed documented council concerns from May to August. The investigation did not indicate if the council's concerns had been verified and it did not include any documentation of corrective actions taken regarding the facility's failure to respond to documented council concerns.</p> <p>This is a repeat deficiency from 12/14/2023 and 06/07/2024.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Refer to WAC 388-97-0640 (2)(a)(b)(5)(6)(a)(b)(7)(a)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to conduct a thorough investigation for 17 of 20 resident investigations (6, 15, 46, 78, 84, 454, 58, 2, 80, 31, 11, 56, 19, 66, 62, 46, 12) and 1 of 1 organized resident group (the Resident Council) reviewed for accidents and allegations of potential abuse and/or neglect . The facility failed to identify the root cause, and all contributing factors related to allegations of abuse and/or neglect placed residents at risk for injury, and additional abuse/neglect.</p> <p>Findings included .</p> <p><RESIDENT 15></p> <p>Resident 15 admitted on [DATE] with diagnoses to include cardiac disease, right above the knee amputation (AKA), muscle weakness and diabetes. The resident was alert and oriented with no cognitive impairment and required two-person extensive assistance for toileting.</p> <p>In an interview on 11/05/2024 at 1:25 PM, Resident 15 was sitting in a wheelchair with their right stump on an elevating leg rest. Resident 15 said It takes too damn long to get your call light answered. An hour or two usually. The day before yesterday, the aide left me on the bedside commode for 45 minutes after lunch time. They told me to put my call light on when I was done. I did but waited and waited for 45 minutes. My butt was killing me. It hurts to be sitting on that and trying to stay up right. I was so mad. I told my nurse about it. The resident said his sitting balance is not good. They pointed to their stump and said they couldn't get this d**n thing to cooperate.</p> <p>Review of an abuse allegation investigation for Resident 15 dated 11/05/2024 at 4:35 PM, showed the resident reported being left on the commode for 45 minutes and no one answered the call light. The summary showed multiple aides interacted with this resident that day and at no time did the resident express concerns with being on the commode too long. The summary included a statement that the resident was on the commode for no longer than 30 minutes, the time their NAC was on break. The residents statements of being left on the commode for 40-45 minutes was consistent during their investigation.</p> <p>In an interview on 11/05/2024 at 2:53 PM, Staff K, OT said Resident 15 had reported to them that last Thursday or Friday they were left on the bedside commode for 40 minutes. Staff K said another therapist heard a noise while walking by Resident 15's room and went into the room at which time Resident 15 reported they were on the commode for 40 minutes.</p> <p>Review of a statement included with the investigation from Staff K, OT on 11/05/2024, showed they did not assist Resident 15 on or off the commode on 11/03/2024.</p> <p>Review of the statement from Staff ZZ, NAC dated 11/05/2024 showed they answered the call light and where unsure what time, with their orientee and assisted Resident 15 to the commode with the sit to stand machine , made sure the resident had their call light , and left their room. Staff ZZ said they told Staff M, Agency NAC that they had put Resident 15 on the commode and Staff M told Staff ZZ and their trainee they had it from there and would take care of the resident when they were done.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a statement from Staff E, said that on Sunday before lunch they answered Resident 15's call light and the resident said they were done on the commode, so Staff M and Staff E assisted him.</p> <p>Review of a statement from Staff M, Agency NAC on 11/05/2024 at 4:21 PM showed they helped Resident 15 onto the commode and took their lunch break and informed other staff they were going on their break. Staff M said when they returned, they assumed everything was fine as Resident 15 did not say anything. Staff M said Resident 15 used the commode multiple times that day and they were not exactly sure what time the complaint was.</p> <p>Review of a second statement from Staff M, Agency NAC received on 11/06/2024 at 8:23 AM showed before their lunch break, they communicated to the other NAC's they were stepping away. Resident 15 had said he needed to use the commode and Staff ZZ, NAC said they would assist them. When Staff M returned from their break, they found Resident 15 still on the toilet visibly upset. Resident 15 yelled at them and said they had been on the toilet for a long time. Staff M told them they had been on break and someone else should have assisted them.</p> <p>The facility failed address conflicting statements from Staff M. The investigation did not include a statement from the Staff YY, NAC present for the transfer. The investigation did not include a timeline as some statements did not include times.</p> <p><RESIDENT 78></p> <p>Resident 78 admitted on [DATE] and was cognitively intact.</p> <p>Review of a grievance dated 10/29/2024 written by Staff K, OT showed CC 1, spouse of Resident 78 reported on 10/28/2024 they were upset with staff because the hospital stated Resident 78 was dehydrated and the nurses do not provide enough water. The grievance was not immediately escalated to an abuse or neglect investigation.</p> <p>Review of an investigation on 11/06/2024 at 4 PM, showed Resident 78 reported staff was not giving them enough water, they wait an hour for toileting assistance, they fell , and no one answered the call light, and the nurse did not know how to administer medications through their enteral tube (surgically implanted tube to administer nutrition).</p> <p>Review of the investigation included a note on 11/12/2024, two days after the investigation was to be completed. The notes showed the resident was to receive nothing by mouth but did not address that the resident had fluid needs through their enteral tube and orders to provide these fluids. There was an attached Medication Administration Record for October that showed wide variances in the water flushes from none to 30 ml to 1700 ml. There was no analysis of the fluid intake in correlation to the allegations. The investigation showed they were unable to rule out or substantiate a fall. Staff B, Director of Nursing documented after a review of notes from the facility and hospital , there was no mention of a fall.</p> <p>Review of the physician hospital note on 09/27/2024 showed the resident reported a fall yesterday when they felt like they were choking and lost their balance and fell and hit their right forearm.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/13/2024 at 2:53 PM, Resident 78 said Staff D, Registered Nurse(RN) had given them pills and they were in a hurry, so they told the aide (an unidentified male who had long hair in a ponytail) to watch her swallow the pills because she needed supervision. Resident 78 said when the NAC left, they choked on their baclofen pill. They said they couldn't reach the call light as it was on the other side of the bed, they fell and their tray of food went flying, it was loud and there was food all over the floor. Resident 78 said Staff D came in and said, You scared me and they helped me off the floor.</p> <p>In an interview on 11/13/2024 at 9:57 AM, Collateral Contact (CC1) , spouse of Resident 78 said the second day here, Resident 78 said they needed to go to the bathroom, and they called for an hour, and no one showed up. CC 1 said he asked the nurse why his loved one called, and no one came in when their light was on.</p> <p>Review of the progress notes did not show a choking incident or fall for Resident 78.</p> <p>Review of the incident reporting log showed no fall or choking event for Resident 78.</p> <p>The investigation did not include statements from staff about the allegations of dehydration, fall, a choking episode, or their call light not being answered while at the facility.</p> <p>In an interview on 11/13/2024 at 4:28 PM, Staff A, Administrator said they were unaware Staff D, RN did not document or report the fall or choking event both of which would need to be further investigated.</p> <p><RESIDENT 84></p> <p>Resident 84 admitted on [DATE] and was cognitively intact.</p> <p>In an interview on 11/05/2024 at 8:56 AM, Resident 84 stated, when they first were moved into their new room, the week after September 11th they had issues with Staff F, Nursing Assistant Registered (NAR). Resident 84 stated Staff F was damn scary. The resident said one night they had to call the aide three times because of diarrhea. The resident stated Staff F told them, You stop calling us. I cannot come in here and keep changing you. Just soil your brief and we will change you when we get to you. Resident 84 said, Do you know how much that makes your butt sore. No one should have to be in a soiled brief. The resident said Staff F told them We have other patients to take care of. Resident 84 said , (Staff F) needs to go work somewhere else. I am afraid of them. Staff F scares me. I haven't been that intimidated since high school, but I was braver then too. I now do not call anyone for help at night because I am scared, (Staff F) will come in. Staff F said they did not want them as their aide at all. Resident 84 said they said they reported this to Staff K, Occupational Therapist who said they could file a complaint and ask for Staff F not to care for them. Resident 84 said Staff K came into their room the other night and was very intimidating.</p> <p>Review of an incident investigation dated 11/04/2024 at 12:09 PM showed the resident reported to the state that around the time they moved to a private room (09/17/2024) they had diarrhea and Staff F, NAR told them to stop calling them as they had other patients to take care of and to soil their brief.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/05/2024 at 2:50 PM, Staff K, OT said they would report concerns to their supervisor and if it was the weekend they would report to them. Staff K said Resident 84 reported to them concerns with Staff F, NAR told Resident 84 to just go to the bathroom in their brief. Staff K said they wrote up a grievance went to give it to the nurse manager but there were not there, so they left a note on their desk.</p> <p>Review of a email from 11/05/2024 at 1:23 PM to Staff F, NAR from Staff B, Director of Nurses showed a request for a statement regarding Resident 84 who reported they told them to have a bowel movement in their brief and were unpleasant in their interactions and Resident 98 reported you scratched them with Velcro and do not clean their peri area well and they also stated that you have an unpleasant attitude when interacting with them.</p> <p>Review of an electronic statement received from Staff F on 11/05/2024 at 3:51 PM, showed they didn't tell Resident 84 to have a bowel movement in their brief.</p> <p>Review of the investigation did not include a through statement Staff F. There was no statement from Staff K or the unit managers.</p> <p>There was no additional information to clarify the other concerns in the allegation.</p> <p><RESIDENT 454></p> <p>Resident 454 admitted on [DATE].</p> <p>Review of an investigation dated 11/06/2024 at 3:13 PM, showed Resident 454 reported the nurse brought them pain medications four hours late and they were in pain.</p> <p>Review of the November Medication Administration Record (MAR) showed the resident reported a pain score of 10 on the 1 to 10 scale at 10:00 AM, and 5 at 2:00 PM on 11/05/2024.</p> <p>The investigation did not include the narcotic ledger to reveal when the medications were retrieved from the medication cards.</p> <p>On 11/15/2024 at 9:00 AM, Staff B, Director of Nursing provided the narcotic ledger that showed conflicting times between the MAR and the narcotic ledger for dates 11/04/2024, 11/05/2024, 11/06/2024 and 11/07/2024.</p> <p>Included in the investigation were staff interviews about rough handling, resident rights rather than pain management timeliness. Education provided to staff was in regards to resident rights.</p> <p>The investigation failed to identify additional concerns with narcotic documentation discrepancies.</p> <p>50725</p> <p><RESIDENT 46></p> <p>(continued on next page)</p>

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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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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 46 admitted to the facility on [DATE] with diagnosis to include Multiple Sclerosis (a disease that causes the breakdown of the protective covering of the nerves). Resident was able to verbalize needs and responded appropriately when questions were asked.</p> <p>In an interview on 11/06/2024 at 12:42 PM, Staff FF, Registered Nurse (RN) stated, Resident 46 was alert and oriented but forgetful, and requires total assist with care.</p> <p>In an interview on 11/06/2024 at 1:20 PM, Resident 46 stated that it bothered her that staff did not respond to her yelling and that they waited for an hour and a half before staff responded when they fell on [DATE].</p> <p>Record review on 11/13/2024 of an allegation of neglect investigation for Resident 46 dated 11/05/2024 at 7:25 AM, showed resident had a fall and reported that they were on the floor for 2-3 hours. According to their final review and summary, it stated that Resident 46 sustained a fall on 11/5/2024 and was heard yelling for assistance. Staff B, RN/Director of Nursing Services (DNS) was the first responder to the scene and stated that they heard resident yelling for assistance and when they entered the room, found resident on the floor and resident stated that they were on the floor for 2-3 hours and later on, resident stated 5-6 hours to the State Surveyor. A statement from Staff M, Nursing Assistant Certified (NAC), an agency staff, who was the alleged perpetrator (AP), stated that resident 46 declined staff to be in her room overnight and they did not hear any yelling when they walked by resident's room multiple times during the night. The summary ruled out that resident was on the floor for a long period of time due to resident did not sustain any deep tissue injury. Staff M will no longer be allowed to return to the facility due to concerns about customer service and rounding in resident rooms.</p> <p>Reviewed interviews made to other residents, the questions staff asked to resident were if they felt their needs were taken care of in a timely manner on day shift, and if they felt good about the care, they received that day. It did not have the date of when the interview occurred, and it did not ask about the care they received at night shift which was the shift the AP was working.</p> <p>There were no documents of interviews made to the staff that worked with the AP at the time of the incident.</p> <p>In an interview on 11/14/2024 at 12:10 PM, Staff B, RN/DNS stated that they don't remember if they got statement from the nurses and NAC's that worked with the AP at the time of the incident, but they will look into their file and will give it to me if they find them.</p> <p>Received and reviewed a witness statement from a nurse on 11/15/2024 but there was no date on when the statement was written, and the statement was not signed. There were no interviews or statements from the NAC's that worked with the AP and the day shift staff present at the time of the incident.</p> <p>The investigation made by the facility was not thorough, there were no statements from the staff that worked with AP and specific residents that were assigned to the AP when the incident happened.</p> <p><RESIDENT 6></p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 6 was admitted to the facility on [DATE] with diagnoses to include stroke with left side hemiplegia (muscle weakness or paralysis on one side of the body), left hand contracture (a permanent tightening of muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff) and right above knee amputation. According to the quarterly Minimum Data Set (MDS - an assessment tool) assessment dated [DATE] resident had mildly impaired cognition.</p> <p>In an interview on 11/12/2024 at 1:08 PM, Resident 6 stated they did not know how they got the bruise on their left arm. They added that the NAC that helped them in the shower was very short and frustrated during care. Resident also stated a police officer came and talked to them about the incident during shower and about their bruise and took pictures of their arm. Resident denied any more interaction with the staff that was rude to her.</p> <p>Review of the incident and investigation report on 11/13/2024 showed that the alleged abuse happened on 11/07/2024 at 8:42 AM. It stated that Resident 6 reported she had issues with the shower aid during their last shower and resident felt the NAC was verbally inappropriate and felt disrespected. There was a noted bruise from unknown origin after the reported shower. The report stated that they suspended the staff, but it did not name who the staff was. According to the report, resident was on 2 blood thinner medicines making them susceptible to bruising. It stated in the report that the NAC/AP was going to give shower to resident and during transport to the shower room, resident had bowel incontinence, then when shower was done, resident had another bowel incontinence and while the NAC/AP was cleaning resident that the NAC appeared irritated. It stated that the NAC/AP was educated related to dignity and respect. The note stated that resident repeatedly denied staff being rough or abusive and abuse and neglect was ruled out.</p> <p>Reviewed the printed copy of a text message from Staff UU, NAC/AP, no date, time was 7:22 PM. The text stated that Staff UU gave Resident 6 a shower and had bowel incontinence during transport to shower room and after shower before transferring resident off the shower chair. It stated that resident was very apologetic, and Staff UU told resident that there was no need to be sorry. Staff UU also stated that there was another NAC with her when they transferred resident to and from the shower chair. There was no statement seen for the other NAC that helped the AP. There were no statement from the resident's room mate. There were no other statements from any other staff that worked with the AP.</p> <p>Reviewed 2 pages of Counseling and Education form for Staff UU, NAC/AP and they were not signed. In a yellow highlighter, there was a note stating: copy, pending education. The investigation note stated they had educated staff related to dignity and respect.</p> <p>There were interviews and observations of residents and staff interviews, and they were dated 11/14/2024 which was 7 days passed the incident date. None were specific questions related to the incident.</p> <p>In a joint interview on 11/14/2024 at 12:10 PM, Staff A, Administrator and Staff B, RN/DNS, Staff A stated that they have not done their education and counseling with Staff UU, NAC/AP and they have not yet determined whether they will have Staff UU continue to work or not. Staff B was not able to give me copy of a statement from the NAC that was with Staff UU. There were no other interviews done with other staff that worked with Staff UU on the day of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility failed to provide a thorough investigation, investigation was not completed at the time frame required.</p> <p>33954</p> <p><LATE MEDICATION INCIDENT INVESTIGATIONS></p> <p><RESIDENTS 58, 2, 80, 31, 11, 56, 19, 66, 62, 46, 12></p> <p>In an interview on 11/08/2024 at 10:10 AM, Staff BB, Licensed Practical Nurse, stated they were late with administering morning medications to 16 of their residents.</p> <p>Review of 11 incident investigations for Residents 58, 2, 80, 31, 11, 56, 19, 66, 62, 46, 12, dated 11/08/2024, showed they all had late medications. The investigations were not thorough as they lacked witness statements from the licensed nurse (s) that administered late medications, there were no witness statements from any nurse managers, there was no documentation whether the licensed nurse (s) had notified their supervisor they were late passing medications, there was no documentation or analysis why the medications were administered late, there was no documentation which medications were administered late, there was no documentation which resident medication rights had been violated, there was no documentation what the facility planned to do to ensure resident medications were administered timely in the future, and there was no documentation whether the facility had substantiated abuse/neglect.</p> <p><RESIDENT COUNCIL></p> <p>Review of Resident Council meeting minutes and/or Resident Council grievances, dated 05/23/2024, 06/27/2024, 07/25/2024 and 08/29/2024 showed the Resident Council had reported concerns with staff response to call lights and residents waiting too long on night shift for staff to answer their call lights. Review of the meeting minutes and grievances showed Staff A, Administrator, Staff B, Director of Nursing, and Staff HH, Director of Activities either had knowledge of or should have had knowledge of the Resident Council's concerns voiced in council meetings for four months.</p> <p>Review of the incident reporting logs for May - August 2024 showed the facility had not logged the Resident Council's concerns.</p> <p>In an interview on 11/12/2024 at 8:47 AM, Staff HH, Director of Activities, stated they had notified the administrator of the 05/23/2024 Resident Council concerns of the one hour night shift call light wait times.</p> <p>In an interview on 11/12/2024 at 9:01 AM, Staff A, Administrator, stated the facility had not logged or investigated the Resident Council's 05/23/2024 concern with night shift call lights.</p> <p>In an interview on 11/14/2024 at 10:33 AM, Staff HH, stated they knew Staff A, Administrator, had been aware of the Resident Council's concerns with call light issues and staffing from May to August because after every council meeting they personally gave them the Resident Council meeting minutes. Staff HH stated Staff B, Director of Nursing, had attended the July Resident Council meeting.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of an incident investigation, dated 11/13/2024, showed the facility had conducted an investigation, but it was not thorough as there were no interviews or witness statements from Staff A, Administrator, Staff B, Director of Nursing, or Staff HH, Director of Activities, regarding their roles in the facility's non-response to four months of documented Resident Council concerns. The investigation was also not thorough, as there were no interviews or witness statements from the Resident Council President, [NAME] President, or any other Resident Council representatives that could have provided information about the council's concerns and what their concerns had been from May to August. The investigation did not include any documentation whether the facility had substantiated abuse/neglect. The investigation really was not focused at all, as the investigation indicated it addressed the past three months of Resident Council concerns, but the council meeting minutes and related grievances showed documented council concerns from May to August. The investigation did not indicate if the council's concerns had been verified and it did not include any documentation of corrective actions taken regarding the facility's failure to respond to documented council concerns.</p> <p>Refer to WAC 388-97-0640 (6)(a)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on interview and record review, the facility failed to ensure a system by which residents/representatives received required written notices at the time of transfer/discharge, or as soon as practicable and to provide a copy of the notice to the state Ombudsman office as required for 2 of 2 sampled residents (Resident 14 and 78) reviewed for hospitalization s. This failure placed residents at risk for inappropriate transfers and a lack of information regarding their rights and options.</p> <p>Findings included .</p> <p>Review of an undated facility policy titled, Facility Initiated Transfer and Discharge showed that before a facility transfers or discharges a resident, the facility will notify the resident and the residents representatives of the transfer or discharge and the reasons for the move in writing in a language and manner they understand. The written notice will include a statement of the resident appeal rights, including the name, address (mailing and email) , and telephone number of the entity which received such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsmen.</p> <p><RESIDENT 78></p> <p>Resident 78 admitted to the facility 09/20/2024. According to the admission Minimum Data Set (MDS) assessment dated [DATE], the resident had no cognitive impairment.</p> <p>Review of Resident 78's progress note on 09/26/2024 at 2:30 PM, showed the resident was transported to the hospital. The note showed no information regarding what information was given to the resident at the time of the discharge.</p> <p>Review of the medical records showed the nursing facility inpatient notification to Resident 78's insurance plan was submitted late on 09/30/2024. The facsimile informed the facility the insurance plan required inpatient notification within 24 business hours or the next business day. This notice did not provide resident with information on their right to appeal the discharge decision, including contact data for advocacy groups. The medical records did not contain discharge or transfer notices for 09/26/2024 or 10/28/2024.</p> <p>Review of Resident 78's progress note on 10/28/2024 at 11:33 PM, showed the resident was transported to the hospital. The note showed no information regarding what information was given to the resident at the time of the discharge.</p> <p>In an interview on 11/12/2024 at 1:10 PM, Resident 78 stated they did not receive or sign any paperwork when they were transferred to the hospital both times. They said the facility did not tell them about holding the bed or discharge rights and they did not receive any paperwork.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/13/2024 at 9:57 AM, CC 1, family member of Resident 78 said the facility did not talk to them about holding the bed or discharge rights at all. CC 1 said the facility did not give them any paperwork for transfers to the hospital on 09/26/2024 or 10/28/2024.</p> <p>In an interview on 11/14/2024 at 12:44 PM, Staff A, Administrator said the admission director obtained the bed holds and nurses were to complete the transfer discharge paperwork that was to go with the resident to the hospital. Staff A said if the admission director was not here when a resident goes to the hospital, the bed hold and transfer paperwork should be completed by the nurse and sent to the hospital with the resident.</p> <p>47047</p> <p><RESIDENT 14></p> <p>Resident 14 admitted to the the facility on 08/08/2024, discharged on [DATE] and readmitted to the facility on [DATE].</p> <p>Review of Resident 14's progress notes dated 08/12/2024 showed they had been throwing up blood, had low blood pressure and were transferred to the hospital by ambulance.</p> <p>Review of Resident 14's electronic medical record did not contain any information about a notice of discharge/transfer, if the resident or their representative had been given information contained in the notice, and if the Ombudsman had been notified of the resident's transfer to the hospital.</p> <p>In an interview on 11/13/2024 at 11:34 AM, Staff S, Social Services Director, stated they only completed the notice of transfer/discharge for planned discharges from the facility. Staff S stated they did not know who completed them for residents who were hospitalized .</p> <p>In an interview on 11/14/2024 at 11:03 AM, Staff T, Registered Nurse stated when a resident is discharged to the hospital they send the current labs, medication list, the physician order for life sustaining treatment and change in condition documentation. When asked about the notice for discharge/transfer Staff T stated they did not provide the notice and referred to the unit manager.</p> <p>In an interview on 11/14/2024 at 11:06 AM Staff U, Licensed Practical Nurse (LPN)-Unit Manager, stated they had not ever been told to complete a notice for discharge/transfer and they did not know who would be completing it.</p> <p>Refer to WAC 388-97-0120 (2)(a-d) and 388-97-0140(1)(a)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on interview and record review, the facility failed to provide a written bed-hold notice, at the time of transfer or within 24 hours of transfer to the hospital, for 1 of 2 residents (Resident 78), reviewed for hospitalization . This failure placed the resident at risk for a lack of knowledge regarding their right to hold their bed while in the hospital.</p> <p>Findings included .</p> <p>Review of the undated facility policy titled Bed Hold showed that prior to initiated transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. The policy showed residents and or representatives will be provided information on the facility's bed hold policy at the time of admission. A second written notice will be provided to the resident, and if applicable the residents representative, at the time of transfer, or in cases of emergency transfer, withing 24 hours.</p> <p><RESIDENT 78></p> <p>Resident 78 admitted to the facility 09/20/2024. According to the admission Minimum Data Set assessment dated [DATE], the resident had no cognitive impairment.</p> <p>Review of Resident 78's progress note on 09/26/2024 at 2:30 PM, showed the resident was transported to the hospital. The progress notes showed no information regarding offering a bed hold.</p> <p>Review of the clinical record showed the bed hold notice with a release of the bed was explained to Resident 78's spouse before the resident was transported to the hospital. The notice did not contain a signature from the resident or spouse. The bed hold notice did not show the written notice had been provided upon discharge.</p> <p>Review of Resident 78's progress note on 10/28/2024 at 11:33 PM, showed the resident was transported to the hospital. The note showed no information regarding offering a bed hold.</p> <p>In an interview on 11/12/2024 at 1:10 PM, Resident 78 stated they did not receive or sign any paperwork when they were transferred to the hospital both times. Resident 78 said the facility did not talk to them about holding the bed and they did not receive any paperwork.</p> <p>In an interview on 11/13/2024 at 9:57 AM, CC 1, family member of Resident 78 said the facility did not talk to them about holding the bed. CC 1 said the facility did not give them any paperwork for transfers to the hospital on 09/26/2024 or 10/28/2024.</p> <p>In an interview on 11/14/2024 at 12:44 PM, Staff A, Administrator said the admission director obtains the bed holds and if the admission director was not at the facility, the bed hold should be completed by the nurse and sent to the hospital with the resident.</p> <p>Reference WAC 388-97-0120 (4)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to ensure the Resident Assessment Instrument (RAI), an assessment of a resident's needs, strengths, goals, and preferences, included thorough summaries of the Care Area Assessments (CAA), an assessment of a specific resident care or medical issue, to holistically analyze the plan of care for 4 of 4 residents (Resident14, 43, 88 and 98) reviewed for comprehensive assessments. This failure placed the residents at risk of not having appropriate services provided based on the resident's individualized needs.</p> <p>Findings included .</p> <p>The RAI consists of three basic components: the Minimum Data Set (MDS - a resident assessment tool) assessment, the CAA process, and the RAI Utilization Guidelines (instructions for when and how to use the RAI that include instruction for completion of the RAI as well as structured frameworks for synthesizing the MDS and other clinical information).</p> <p>The CAA process was designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident.</p> <p><RESIDENT 88></p> <p>Resident 88 admitted to the facility on [DATE] with diagnoses to include surgical amputation to their right 4th and 5th toes and subsequent infection requiring a wound vacuum, urine retention requiring a catheter.</p> <p>Review of the admission MDS assessment, dated 09/13/2024, showed the CAAs did not contain input from the resident on actual or potential problems or needs. The dehydration/fluid maintenance, urinary incontinence/indwelling catheter, nutrition and functional ability CAA's did not contain a comprehensive assessment of the resident's needs, strengths, goals, life history and preferences.</p> <p><RESIDENT 98></p> <p>Resident 98 admitted to the facility on [DATE] with diagnoses to include deep tissue injury to their right heel.</p> <p>Review of the Admission MDS assessment, dated 10/21/2024, showed the CAAs did not contain input from the resident on actual or potential problems or needs. The nutritional status and pressure ulcer CAA's did not contain a comprehensive assessment of the resident's needs, strengths, goals, life history and preferences.</p> <p><RESIDENT 43></p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), chronic kidney disease, and atrial fibrillation (an irregular heart rate).</p> <p>Review of the Admission MDS assessment dated showed the CAAs did not contain input from the resident on actual or potential problems or needs. The nutritional status CAA did not contain a comprehensive assessment of the resident's needs, strengths, goals, life history or preferences.</p> <p>In a joint interview on 11/14/2024 at 12:36 PM with Staff A, Administrator and Staff B, Director of Nursing Services said the CAA's should be completed by MDS nurses.</p> <p>During the Quality Assurance Performance Improvement meeting on 11/15/2024 at 12:15 PM, Staff A, Administrator said they had not identified CAA's as an issue and there was no performance improvement plan in place for CAA's.</p> <p>Cross Reference to:</p> <p>CFR 483.21(a), (a)(1)(i)(ii), F655 - Baseline Care Plan</p> <p>CFR 483.21(b), (b)(1),(c)(3)(i - iv), F656 - Develop/implement Comprehensive Care Plan</p> <p>CFR 483.21(b),(b)(2)(i-iii), F657 - Care Plan Timing And Revision</p> <p>Refer to WAC 388-97-1000 (1)(a)(2)(q)(5)(a)</p> <p>47047</p>		

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 11/15/2024
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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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR)(a federal requirement to help ensure that individuals who had a mental disorder or intellectual disabilities were offered the most appropriate setting for their needs [in the community, a nursing facility, or acute care setting]; and received the services they need in those settings) was completed as required and that Level two comprehensive evaluations were obtained, and/or implemented, and incorporated into the Care Plan (CP) for 2 of 5 (Resident 43 and 74) residents reviewed for PASRR services. This failure placed residents at risk for not receiving necessary mental health care and services in the most integrated setting appropriate to their needs</p> <p>Findings included .</p> <p><RESIDENT 74></p> <p>Resident 74 admitted [DATE] with diagnoses which included anxiety, depression, post traumatic stress disorder and substance abuse disorder.</p> <p>Review of Resident 74's level one PASRR completed on 04/11/2024, identified the resident as having indicators of serious mental illness and substance abuse disorder and showed a referral for level two assessment was required.</p> <p>Review of Resident 74's medical record on 11/07/2024 showed no level two PASRR assessment or invalidation. The record showed only one progress note dated 08/01/2024 stating the PASRR was being reviewed for validation.</p> <p>In an interview on 11/07/2024 at 12:53 PM, Staff S, Social Services Director (SSD), stated the facility was supposed to be conducting audits of resident PASRR's at least quarterly and with significant changes. Staff S reviewed Resident 74's record and stated they could not find any documentation of a level two assessment referral on admission and only the note from 08/01/2024 stating that it was sent for review at that time but no further notes regarding follow up.</p> <p>47047</p> <p><RESIDENT 43></p> <p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), chronic kidney disease, and bipolar disorder (a mental health disorder with episodes of mood swings).</p> <p>Review of the PASRR Level I dated 09/08/2024 showed Resident 43 required a level II evaluation for serious mental health. Resident 43 was referred for a PASRR Level II evaluation on 09/08/2024 while admitted to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 43's progress notes dated 10/16/2024 through 11/04/2024 showed no documentation/notation of a PASRR level II completion.</p> <p>Review of Resident 43's electronic medical record on 11/06/2024 showed no PASRR Level II evaluation.</p> <p>In an interview on 11/07/2024 at 11:19 AM Staff S stated the facility obtained a PASRR from the hospital and reviewed a resident's medical records to gather information about their mental health or developmental disability needs. Staff S stated if a resident admitted to the facility, and they required a PASRR Level II evaluation they would coordinate/contact the evaluator. Staff S stated they had looked at Resident 43's PASRR Level I, progress notes and their email and had not received a PASRR Level II for them.</p> <p>On 11/07/2024 at 1:19 PM Staff S provided a completed PASRR Level II for Resident 43. The PASRR Level II was attached to an email with a date stamp of 11:53 AM. The PASRR had a date of completion of 10/09/2024, eight days prior to Resident 43's admission to the facility.</p> <p>Review of Resident 43's progress notes dated 11/07/2024 showed a PASRR Level II had been received and was uploaded into the electronic medical record.</p> <p>Review of Resident 43's care plan dated 10/24/2024 showed no updated focus/goal/interventions related to the PASRR Level II evaluation.</p> <p>Refer to WAC 388-97-1915 (1)(2) (a-c)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for 3 of 8 residents (Resident 24, 43, and 98) reviewed for comprehensive care planning. The failure to ensure the comprehensive care plan was person-centered to maintain or attain the residents highest practicable well-being placed the residents' at risk of not receiving services that would meet their desires or wants and a decreased quality of life.</p> <p>Findings included .</p> <p><RESIDENT 24></p> <p>Resident 24 admitted to the facility on [DATE].</p> <p>In an interview on 11/04/2024 at 10:17 AM, Resident 24 stated they had sciatica and pain in their right shoulder and the muscle was sore. The resident said they received Lidocaine patches and Gabapentin for pain.</p> <p>Review of the care plan showed Resident 24 was at risk for pain related to advanced age, recent hospitalization s and multiple cardiorespiratory conditions. The care plan did not include the resident's goals or nonpharmacological interventions for pain.</p> <p><RESIDENT 98></p> <p>Resident 98 admitted to the facility on [DATE] with diagnoses to include a right heel deep tissue injury.</p> <p>Review of Resident 98's care plan showed the resident was at risk for a pressure ulcer rather than had a pressure ulcer. The discharge care plan was canned with prompts to staff to put in the information. The care plan did not have the residents wishes or goals for the discharge present.</p> <p><RESIDENT 43></p> <p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), bipolar disorder and dementia.</p> <p>Reivew of Resident 43's care plan dated 10/24/2024 showed they were ar risk for complications due to dementia. The care plan did not contain comprehensive person centered information or measurable objectives with regard to Resident 43 and dementia care.</p> <p>In an interview on 11/14/2024 at 12:36 PM, Staff A, Administrator said care plans can be updated by the MDS nurses and unit managers.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/15/2024 at 12:30 PM, Staff A, Administrator said they were not aware of any care plan issues and there was no performance plan in place for care planning.</p> <p>This is a repeat deficiency from 12/14/2023.</p> <p>WAC Reference: 388-97-1020(1)(2)</p> <p>47047</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725</p> <p>Based on observation, interview and record review, the facility failed to implement, review and revise care plans for 1 of 14 residents (Resident 46) reviewed for care planning. These failures placed residents at risk for unmet care needs, adverse health effects and diminished quality of life.</p> <p><RESIDENT 46></p> <p>Resident 46 admitted to the facility on [DATE]. Diagnosis to include Multiple Sclerosis (a disease that causes the breakdown of the protective covering of the nerves). According to the Minimum Data Set (MDS - an assessment tool) assessment, dated 10/17/2024 Resident 46 showed severe cognitive impairment. Resident was able to verbalize needs and responded appropriately when questions were asked.</p> <p>In an interview on 11/06/2024 at 12:42 PM, Staff FF, Registered Nurse (RN) stated, Resident 46 was alert and oriented but forgetful, and requires total assist with care.</p> <p><RANGE OF MOTION (ROM -is a term used to describe how far you can move a joint or muscle in various directions) EXERCISES></p> <p>Review of Resident 46's Care Plan on 11/07/2024 showed under Focus: At risk for loss of ROM related to impaired mobility, weakness. Revised on 07/23/2023. Goal: Will exhibit no decline in ROM within confines of disease processes. Intervention: Encourage to assist resident to do active ROM (the range of movement that a person can achieve by contracting and relaxing muscles without assistance) exercises of bilateral lower extremities twice a day as resident tolerates (see exercise sheets in resident's room or in resident's chart).</p> <p>In an observation and interview on 11/07/2024 at 10:15 AM, Resident 46 was receiving peri care (washing the genitals and anal area), observed her left leg was bent, left knee was close to their chest area. Right leg slightly bent on the knee also. I requested resident to straightened both legs, resident was able to straighten the left leg but once they straightened the left leg, it went back to being bent again.</p> <p>In a joint interview on 11/07/2024 at 10:38 AM, Staff GG, NAC and Staff EE, NAC , Staff GG stated that Resident 46 was not on a restorative program. Staff GG stated that they try to do range of motion (ROM) exercises to Resident 46 but most of the time resident refuses. Staff EE stated that Resident 46 mostly refuses care and only allows specific NAC's to care for her.</p> <p>In an interview on 11/07/2024 at 10:45 AM, Staff X, Licensed Practical Nurse (LPN)/Unit Manager (UM), they stated that activity assistants who were NAC's does restorative program in the facility. Staff X stated Resident 46 is not on a restorative program. Requested Staff X to show me where staff document the ROM exercises for Resident 46 per care plan. Staff X looked in resident's electronic chart and stated they were not able to find any documentation and will work on it.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/08/2024 at 11:07 AM, Staff GG, NAC was not able to find documentation for the ROM exercises for Resident 46. Staff GG was not able to show me the exercise instructions that was either posted on resident's wall or in resident's chart according to the care plan.</p> <p>In an interview on 11/12/2024 at 12:48 PM Staff FF, RN, Resident 46's left lower extremity has some contractures and they try to put pillows under the resident's legs but resident kicks them off. Resident 46 also refuses to get out of bed when they offer. Staff FF does not think resident is on a restorative program.</p> <p>In an interview on 11/13/2024 at 9:57 AM, Resident 46 stated that they don't think they were doing exercises to their lower extremities. They stated they were interested in doing ROM exercises especially on their left leg. They were not sure when their left leg started to bend.</p> <p>In an interview on 11/13/2024 at 10:05 AM, informed Staff X, LPN/UM that the exercise instructions were not in Resident 46's wall or in resident's chart. They stated it is usually posted by the wall in resident's room. Staff X stated they were not aware that Resident 46's left lower extremity may be contracted. They stated that when a resident was at risk for developing a contracture, the NAC or the nurse notifies the Unit Manager. The Unit Manager will then get a doctor's order for Physical Therapy to evaluate resident and obtain recommendations to prevent contracture. Staff X stated that they will look at Resident 46 and follow up regarding possible contractures on their leg.</p> <p>In a joint interview on 11/14/2024 at 12:25 PM, Staff A, Administrator and Staff B, RN/Director of Nursing Services (DNS), Staff B stated that they don't have restorative program, but they have restorative tasks that the NAC does, and they come from the therapy department. Unit managers usually receive the recommendations from the therapy department, and they update the care plan, and the NAC does the exercises with the resident. Staff B was not able to provide me a copy of the NAC documentation regarding the ROM exercises for resident per their care plan.</p> <p><BED CRADLE></p> <p>In a record review on 11/7/2024, Resident 46's care plan showed: Focus: Activities of daily living self-care deficit as evidenced by increased weakness and history of multiple falls related to physical limitations-Multiple Sclerosis. Under the Interventions: it states: Resident uses bed cradle on her bed for prevention.</p> <p>In an observation on 11/07/2024 at 10:31 AM while Resident 46's was receiving care, did not see a bed cradle.</p> <p>In an interview on 11/07/2024 at 11:07 AM, Staff GG, NAC stated they did not know what a bed cradle was.</p> <p>In a record review on 11/08/2024, Resident 46's electronic chart in the provider orders section showed: Ok to use bed cradle. Order dated 11/02/2023. Reviewed consent about the bed cradle.</p> <p>In an interview on 11/12/2024 at 12:20 PM, Staff FF, RN, stated that a bed cradle was a contraption that they put at the foot of the bed, so the blanket does not touch the resident's feet. They stated that Resident 46 refused to have the bed cradle on their bed, and it was stored in resident's bathroom.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/13/2024 at 10:05 AM, Staff X, LPN/UM, stated that they were not aware that Resident 46 was not using the bed cradle per care plan and that resident refuse to use it.</p> <p>In an interview on 11/14/2024 at 12:25 PM, Staff B, RN/DNS stated that unit managers were the ones that update the care plans, and they usually do it quarterly unless there were changes. They stated that they don't allow nursing staff to update care plans, due to having many agency staff working.</p> <p>Refer to WAC 388-97-1020 (5)(b)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725</p> <p>Based on interview, observation, and record review, the facility failed to follow professional standards of practice for 4 of 29 residents (Resident 2, 5, 58, and 78) reviewed for medication administration. Failure to transcribe orders accurately upon admission and pre-signing medications in the Medication Administration Record (MAR) ahead of administration placed residents at risk for medication errors and acute medical problems.</p> <p>Findings included .</p> <p>According to the facility policy titled: Medication Administration: Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination and infection. Review Medication Administration Record (MAR) to identify medication to be administered. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time. Sign MAR after administered.</p> <p><RESIDENT 78></p> <p>Resident 78 was admitted to the facility initially on 09/20/2024 and then got re admitted to the facility on [DATE] after they were in the hospital from 09/26/2024 to 10/17/2024. Diagnoses to include oropharyngeal dysphagia (a term that describes swallowing problems occurring in the mouth and/or throat) after gastrostomy tube (G tube - a feeding tube that is inserted through the skin and the stomach wall to provide nutrition and fluids directly to the stomach) placement.</p> <p>In an observation and interview on 11/05/2024 at 1:15 PM, Staff P, Licensed Practical Nurse (LPN) administered Baclofen 15 mg tablet to Resident 78 via G tube. MAR order stated: Baclofen Oral tablet 10 mg by mouth three times a day for Stiff Person Syndrome. According to Staff P, resident was originally able to take medications by mouth but after Resident's hospitalization , they came back with a G tube and all medications were now given via G tube. Staff P stated that the nurse that did the admission should have updated the orders. They stated that the order should state via G tube and not by mouth. Staff P stated that they would update the order.</p> <p>In a record review on 11/05/2024 at 2:45 PM, Resident 78's discharge summary from the hospital dated 10/17/2024 had orders via mouth but also stated nothing by mouth (NPO).</p> <p>According to resident's electronic chart under order summary report, diet is NPO, order dated 10/17/2024. Further review of the MAR showed the following medications were all ordered to be given by mouth: Acetaminophen 325 mg tablet, Cyanocobalamin tablet 500 mcg, Diazepam 5 mg tablet, Ergocalciferol Capsule 1.25 mg, Famotidine 20 mg tablet, Gabapentin capsule 100 mg, Ibuprofen 600 mg tablet, Meclizine HCl 25 mg tablet, Ondansetron 4 mg tablet, Polyethylene glycol powder 17 grams, Senna 8.6 mg tablet, Tizanidine HCl 4 mg tablet.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/14/2024 at 12:30 PM, Staff B, Registered Nurse/Director of Nursing Services, stated that when a resident goes to the hospital and comes back all orders were considered new orders and that they will talk to the nurse that did the admission orders for Resident 78 for not clarifying the orders.</p> <p><RESIDENT 58></p> <p>Resident 58 admitted on [DATE] with diagnoses to include type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy).</p> <p>In an observation on 11/14/2024 at 5:20 PM, Staff XX, Agency LPN drew up Humalog insulin and administered the shot to Resident 58.</p> <p>In a record review and interview on 11/14/2024 at 5:25 PM Resident 58's MAR showed Humalog Insulin was administered at 4:19 PM on 11/14/2024. According to Staff XX they signed the MAR that the insulin was given at the time they checked Resident 58's blood sugar even though they have not given it at the time they signed the MAR.</p> <p><RESIDENT 2></p> <p>Resident 2 admitted to the facility on [DATE] with diagnosis to include Type 2 Diabetes Mellitus.</p> <p>In an observation record review on 11/14/2024 at 5:34 PM, Resident 2's MAR showed that Humalog insulin was signed that it was given at 4:15 PM on 11/14/2024. Observed Staff XX drew up the Humalog insulin and administered it to Resident 2 at 5:34 PM.</p> <p>In an interview on 11/14/2024 at 5:38 PM, Staff XX stated that after checking the blood sugar they signed the insulin order even though they have not given Resident 2's insulin yet. Staff XX stated that they signed that it was given so that it will not show that they were late giving the insulin in resident's electronic chart.</p> <p><RESIDENT 5></p> <p>Resident 5 admitted to the facility on [DATE] with diagnosis to include Type 2 Diabetes Mellitus.</p> <p>In a record review on 11/14/2024 at 5:39 PM, Resident 5's MAR showed that the Humalog insulin was administered at 3:56 PM on 11/14/2024.</p> <p>In an observation and interview on 11/14/2024 at 5:40 PM, Staff XX drew up Humalog insulin and administered the shot to Resident 2 at 5:40 PM. Staff XX stated that they signed that they administered the insulin ahead of time. They stated they just don't want the medications to show up late in the resident's electronic chart. They stated that this is not a safe practice. Staff XX denied that they had anymore medications that they signed ahead of time.</p> <p>Refer to WAC 388-97-1620 (2)(b)(i)(ii)</p> <p>33954</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954</p> <p>Based on interview and record review, the facility failed to provide necessary activities of daily living care and services for 2 of 4 residents (Residents 5, and 54) reviewed for bathing. The failure to bathe residents per their bathing care plans placed residents at risk for hygiene issues and for diminished quality of life.</p> <p>Findings included .</p> <p><RESIDENT 5></p> <p>Resident 5 admitted to the facility on [DATE]. According to the quarterly Minimum Data Set (MDS) assessment, dated 08/07/2024, they had no cognitive impairment, and they needed substantial/maximal assistance with bathing, and they were dependent on staff for tub/shower transfers.</p> <p>In an interview on 11/04/2024 at 10:47 AM, Resident 5 stated they had problems with bathing as the nursing assistant gave them a bed bath using the same soapy water to wash their body, then they used the same soapy water to rinse their hair and they felt itchy after. The resident stated they wanted different water to rinse.</p> <p>In an interview on 11/15/2024 at 9:42 AM, Resident 5 stated a couple of times they had refused to bathe because they were tired so they couldn't do it when asked so they had to wait a week without a bath, and evidently if you miss your bath, you are out of luck.</p> <p>Review of a care conference progress note, dated 06/14/2024, showed Resident 5 stated they were not getting their bed baths, and the social worker who wrote this note documented they showed Resident 5 and their family member their bathing schedule and it showed bed baths were being done.</p> <p>Review of a nursing progress note, dated 11/03/2024, showed Resident 5 had been placed on alert for no bath/shower for five days.</p> <p>Review of Resident 5's bathing documentation for 30 days, print date 11/13/2024, showed they wanted to bathe twice weekly. The documentation showed they had been bathed five times in the last 30 days, and they had three documented refusals.</p> <p>In an interview on 11/13/2024 at 2:18 PM, Staff X, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), stated they had not known about the resident's bathing refusals, and they thought the resident should have been re-offered to bathe the day following their refusals.</p> <p><RESIDENT 54></p> <p>Resident 54 admitted to the facility on [DATE]. According to the admission MDS assessment, dated 07/17/2024, the resident had no cognitive impairment.</p> <p>In an interview on 11/04/2024 at 2:48 PM, Resident 54 stated staff don't let them know in advance when they are going to bathe, and they always came at inconvenient times.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of 30 days of bathing documentation, print date 11/12/2024, showed Resident 54 wanted to be bathed twice a week, and they had four documented refusals.</p> <p>In an interview on 11/13/2024 at 11:18 AM, Staff X stated they were unable to provide any information about the resident's bathing refusals or their lack of documented bathing.</p> <p>Refer to WAC 388-97-1060 (1)(2)(c)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on observation, interview and record review, the facility failed to provide necessary care and services for 1 of 3 residents reviewed for non-pressure skin conditions (Resident 2), 1 of 2 residents reviewed for falls (Resident 37) and 2 of 4 residents reviewed for medication management (Residents 24 and 88) The failure to provide monitoring and assessment related to wounds, medication management, fluid restrictions and fall prevention placed residents at risk for adverse outcomes and diminished quality of life.</p> <p>Findings included .</p> <p><SKIN ASSESSMENT></p> <p><RESIDENT 2></p> <p>Resident 2 admitted [DATE] and was a long term resident with diagnoses which included diabetes and chronic ulcer of the lower leg.</p> <p>Review of Resident 2's physician's orders on 11/14/2024 9:31 AM showed the resident received dressing changes to a wound on the left posterior calf (present since admission) twice per week and an order showed wound/measurement by the licensed nurse once per week.</p> <p>Record review Resident 2's care plan on 11/07/2024 showed a care plan problem was not initiated until 11/05/2024 showing venous stasis ulcer to the left calf and instructed staff to follow treatment orders, refer to wound care as needed and conduct wound reviews.</p> <p>Review of Resident 2's clinical record on 11/07/2024 showed the most recent entry for a skin/wound assessment was on 10/22/2024 and stated only no skin concerns.</p> <p>Review of a skin/wound assessment dated [DATE] showed resident 2 had wounds on both legs with no further documentation included. Review of the scanned documents showed no wound specialty documentation in the prior year.</p> <p>In an interview on 11/14/2024 09:55 AM, Staff X, Licensed Practical Nurse, Resident Care Manager, stated Resident 2 had chronic wounds that would come and go and was seeing an outside provider. Staff X could not locate any documentation of the outside provider visit summaries or notes in the record. Staff X stated the facility should be documenting assessments of the wounds on the resident's skin check day. After review of the resident skin check notes, Staff X stated they were not there. Staff X stated the resident used to be followed by the in house wound team but was not being followed any longer and the nursing staff should be following and assessing the wounds for Resident 2. Staff X was not able to determine the current status or when the last thorough assessment of Resident 2's leg wounds had been done.</p> <p>36787</p> <p><MEDICATION PARAMETERS></p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><RESIDENT 24></p> <p>Resident 24 admitted on [DATE] with diagnoses to include high blood pressure.</p> <p>Review of Resident 24's physician orders directed staff to administer Amlodipine 10 MG once a day for hypertension and to hold the medications if the Systolic Blood Pressure (SBP) was below 110.</p> <p>Review of Resident 24's November Medication Administration Record (MAR) showed the medication was not held on 11/12/2024 for a blood pressure of 100/61.</p> <p><RESIDENT 88></p> <p>Resident 88 admitted on [DATE] with diagnoses to include multiple cardiac conditions.</p> <p>Review of Resident 88's physician orders directed nurses to administer Furosemide 40 MG daily, Spironolactone 25 MG daily, Metoprolol Succinate ER twice a day and Sacubriti-Vaslatran twice a day. Each medication directed staff to hold them medication if the SBP was less than 110.</p> <p>In an interview on 11/15/2024 at 8:28 AM, Staff B, Director of Nursing brought in copies of Resident 88's November MAR that was highlighted and said the nurses had received education on following medication order hold prompts. The November MAR showed;</p> <p>-On 11/05/2024 at 8:00 AM, the four medications were not held and administered when the BP was 97/64.</p> <p>- On 11/06/2024 at 8:00 AM, the four medications were not held and administered when the BP was 103/60. The resident received Metoprolol and Sacubitril-Valsartan was administered at 8:00 PM for a BP of 103/60.</p> <p>-On 11/10/2024 at 8:00 AM, the four medications were not held and administered when the BP was 92/57. The resident received Metoprolol and Sacubitril-Valsartan was administered at 8:00 PM for a BP of 92/57.</p> <p>In an interview on 11/08/2024 at 11:19 AM, Staff P, LPN said they take the residents vital sings and if the doctors order showed they should hold the medication for a specific systolic blood pressure, they would hold it.</p> <p>In an interview on 11/14/2024 at 4:48 PM, Staff AAA, Agency RN said they check blood pressures before administering medications that have parameters and they would hold the medication if the blood pressure was too low.</p> <p>In an interview on 11/15/2024 at 11:48 AM, Staff B, Director of Nursing (DNS) said that they talked with a few nurses who said that at the other facilities they worked at, they needed to hold medications for systolic less than a 100. Staff B said they told those staff they needed to read the entire order and hold the medications as instructed. Staff B said weights should be obtained per orders.</p> <p><WEIGHT MONITORING></p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident 88's physician orders beginning 09/09/2024 directed staff to weigh the resident daily for 3 days , them weekly for 4 weeks then monthly.</p> <p>Review of the medical record showed Resident 88 had three weights since admit (08/26/2024, 08/2024 and 11/13/2024).</p> <p>47047</p> <p><FALL></p> <p><RESIDENT 37></p> <p>Resident 37 admitted to the facility on [DATE] with diagnoses that included bilateral below the knee amputations, type two diabetes mellitus (long term condition in which the body has trouble regulating blood sugar) and high blood pressure.</p> <p>In an interview on 11/05/2024 at 11:41 AM Resident 37 stated they had a fall recently and did not why they had fallen.</p> <p>Review of Resident 37's care plan dated 10/15/024 showed they were at risk for falls related to their balance problems, weakness, obesity, and right and left below the knee amputation. The goal was for</p> <p>Resident 37 to be free from falls. Interventions included anticipating Resident 37's needs, physical therapy evaluation and treatment, and ensure their call light was within reach.</p> <p>In an interview on 11/12/2024 at 9:25 AM Staff L, Registered Nurse (RN)-Unit Manager (UM), stated they were not aware that Resident 37 had fallen.</p> <p>Review of Resident 37's electronic health record showed no documented falls.</p> <p>In a follow up interview on 11/13/2024 at 11:21 AM Resident 43 stated they had a fall during a therapy session. Resident 37 stated they had some pain but was otherwise alright and had just spoken with Staff L today about the fall.</p> <p>In a follow up interview on 11/13/2024 at 11:26 AM Staff L, RN-UM, stated they had spoken to Resident 43, and they had fallen over a weekend with therapy.</p> <p>Review of physical therapy notes dated 11/02/2024 showed Resident 43's right knee buckled while in a therapy session and was lowered to the floor with no injury.</p> <p>In a review of an incident report provided 11/13/2024 showed Resident 43 had an assisted fall while in therapy on 11/02/2024.</p> <p>In an interview on 11/13/2024 at 11:28 AM Staff B stated Resident 43 had a fall while in session with a physical therapist on 11/02/2024, an incident report was not initiated at the time of the fall, and the physical therapist had been educated that any involuntary loss of elevation was considered as a fall and needed to be reported to nursing.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This is a repeat deficiency from 12/14/2023 and 08/07/2024.</p> <p>Refer to WAC 388-97-1060(1),(2)(3)(b)(h)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to monitor and provide necessary treatment and services consistent with professional standards of practice for 3 of 4 residents (Resident 14, 43, and 98) reviewed for Pressure Ulcers. This failure placed the resident at risk for increased pressure ulcers, pain, discomfort and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility policy dated 10/01/2021, titled Pressure Injury Prevention and Management, showed that the nursing staff will develop and maintain systems and processes to ensure that the facility provides care and services consistent with professional standards of practice to promote the healing of existing pressure ulcers and prevent development of additional pressure ulcers.</p> <p><Resident 98></p> <p>Resident 98 admitted on [DATE] with diagnoses to include a right heel deep tissue injury.</p> <p>Review of Resident 98's physician's orders showed the resident had a right heel pressure ulcer and nurses were to check daily and apply skin prep and offload.</p> <p>Review of Resident 98's care plan showed the resident was at risk of skin impairment rather than the resident had actual skin impairment. An intervention was listed for nurses to monitor dressing per orders to ensure it was intact and adhering. There was no mention of an air mattress or heel protectors.</p> <p>Review of Resident 98's Kardex (a tool to inform nurses aides on how to provide care), showed the resident wore heel protectors.</p> <p>In interview on 11/05/2024 at 10:27 AM, Resident 98 said their air mattress kept breaking at 12:00 to 1:00 in the morning a couple of times a week. They said the compressor on the bed pump did not come on and then they are lying on the metal frame and when the bed is flat their sciatica kicks in. The resident said they felt bad for the staff because they do not have time to deal with her mattress at night and the pump beeps all night long. Resident 98 said multiple aides and nurses were aware and they had also called the receptionist and asked to be transferred to the maintenance extension where they left two messages about their malfunctioning bed.</p> <p>In an interview on 11/06/2024 at 2:31 PM, Staff J, Director of Maintenance said they had not heard a thing about Resident 98's mattress. Staff J said they reviewed the TELS log (platform for staff to report maintenance concerns) and there was no entry about the mattress.</p> <p>Review of the TELS report showed staff had requested with medium priority for maintenance to fix Resident 98's bed air pump that kept beeping loudly on 10/21/2024.</p> <p>Review of the TELS report showed staff had requested with medium priority for maintenance to fix Resident 98's bed and call light that were not working on 10/29/2024.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/07/2024 at 11:00 AM, Resident 98 said they developed a right heel pressure injury while at the hospital. Resident 98 said Staff P, Licensed Practical Nurse (LPN) was great at checking their heel but if another nurse was on, they had to ask them to look at their heel. Staff P said they will tell the nurse, Hey you haven't checked my heel today, please check it I do not want to lose my leg. The resident said their heels were supposed to be elevated but aren't and they cannot put the pillows under them.</p> <p>In an interview and observation on 11/12/2024 at 9:29 AM, Staff AAA, Agency Registered Nurse (RN) assessed Resident 98's right heel which showed a 4 centimeter (CM) by 4 cm resolving blood blister with traces of Betadine at the wound edges. Resident 98 said the nurse last night was supposed to put betadine, cream and a dressing over it but didn't have time. The resident said the nurse who was supposed to relieve Staff P, LPN did not show up on time.</p> <p>In an interview on 11/13/2024 at 1:44 PM, Resident 98 had a new mattress in place on the firm setting. The resident said the nurses were concerned about their right heel as they were. Resident 98 said there was no dressing on it again.</p> <p>In an interview on 11/14/2024 at 1:00 PM, Staff A, Administrator said specialty beds and their settings should be on the care plan.</p> <p>No additional information provided.</p> <p>Surveyor: Bush, Kally L.</p> <p><RESIDENT 14></p> <p>Resident 14 admitted to the the facility on 08/08/2024 with diagnoses that included dependence on renal dialysis, fracture of the patella (kneecap), and heart disease.</p> <p>In an interview and observation on 11/05/2024 at 9:17 AM Resident 14 stated they had a sore on their backside and on their heels. Resident 14 stated they developed the sores while at the facility. Resident 14 was observed upright in their wheelchair, with slippers on their feet which were on the footrests. Observed two blue heel protectors sitting on top of a chair. Resident 14 stated the staff put them on sometimes for the sores on their heels. Observed Staff T, Registered Nurse, entered Resident 14's room, removed their slippers and replaced them with the heel protectors.</p> <p>In an observation on 11/05/2024 at 10:26 AM Resident 14 was observed to have a specialized mattress on their bed.</p> <p>In an interview on 11/14/2024 at 9:26 AM Resident 14 stated the sore on their backside was causing them a lot of pain.</p> <p>Review of Resident 14's progress notes at admission, dated 09/29/2024 at 5:12 PM, showed they readmitted to the facility with no skin issues.</p> <p>Review of Resident 14's skin assessment dated [DATE] showed they had an open area to right buttock.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 14's progress notes dated 10/15/2024, showed they were initially seen by the wound specialist for sacrum and left and right heel pressure ulcers, 16 days after discovery.</p> <p>Review of Resident 14's Administration Record dated 10/16/2024 showed a physician order for them to wear foam boots to both their heels every shift.</p> <p>Review of Resident 14's Care Area Assessment (CAA-an assessment of a specific resident care or medical issue, to holistically analyze the plan of care) dated 09/11/2024 did contained a limited and canned description of their risk for developing a pressure ulcer and referred to the care plan in place.</p> <p>Review of Resident 14's care plan dated 09/05/2024 they had a potential for alteration in their skin integrity based on their declined mobility and bowel incontinence. Interventions included monitoring for nutritional status and following skin protocols. There was no information found on Resident 14's care plan about the development and treatment of their pressure ulcers, the use of foam boots, or use of a specialized mattress.</p> <p>In an interview on 11/06/2024 at 2:14 PM Staff T, RN, stated Resident 14 had pressure ulcers and required the use of foam boots and a specialized mattress.</p> <p>In an interview on 11/14/2024 at 9:41 AM Staff CCC, Regional RN stated there was not an incident report completed for Resident 14's development of pressure sores while in the facility and they would provide Staff B, Director of Nurses, with education about the process.</p> <p><RESIDENT 43></p> <p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), chronic kidney disease, and atrial fibrillation (an irregular heart rate).</p> <p>In an interview on 11/06/2024 at 8:56 AM Resident 43 stated they had a sore on their backside, not a big one, and the aides apply cream on it every time they change them.</p> <p>On 11/06/2024 at 8:50 AM observed Resident 43 laying in their bed, on their back with their head of bed elevated. Observed a specialty air mattress device attached to the foot board of the bed. The device was not making any noise, and all there were no visible lights on indicating power.</p> <p>On 11/06/2024 at 2:27 PM observed resident specialized mattress device machine attached to the foot of the bed, plugged into wall, was not firm to touch and the machine had no lights to indicate it was powered on.</p> <p>In a review of Resident 43's care plan dated 10/24/2024 showed they had an open area on admission and the interventions included a low air loss mattress with nursing to check every shift for security and function.</p> <p>In a review of Resident 43's November Medication Administration Record (MAR) 2024 showed no order or directive to nursing staff related the low air loss mattress.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/06/2024 at 2:30 PM Staff J, stated they don't really have anything to do with the functioning of the specialized mattresses other than a yearly check that is completed. Staff J stated if the mattresses don't work, they get new ones. Observed Staff J check Resident 43's specialized mattress device, there was no lights indicating the mattress was functioning, they pushed the power button and the device turned on. Staff J stated turned the specialized mattress off and stated they did not know why it was off so they would leave it off. Staff J, when asked for the user manual for the specialized mattress, deferred to the Internet, however provided a copy.</p> <p>Review of the specialized mattress, titled Joerns User-Service Manual P.O.R [NAME] Plus showed the power button was used to turn the power on and off. The manual showed there is a standby light that illuminates when the unit is initially plugged in, indicating power is available.</p> <p>Observed on 11/12/2024 at 8:21 AM Resident 43's specialized mattress device not running. Resident 43 was laying in bed, on their back, with their head of bed elevated.</p> <p>In an interview on 11/12/24 09:34 AM Staff L, RN-unit manager, stated they were not familiar with Resident 43's care and was recently assigned to them. Resident L, when asked about Resident 43's skin stated that a skin check was completed on 11/7/2024 and they were noted to have scattered bruising to abdomen and left arm. Staff L stated they did not know about Resident 43's use of a specialized mattress device and were not sure of the process for checking the function and maintenance. Staff L stated there would usually be an order for the device and the nurse would check the function of the device each shift. Staff L stated they were not aware Resident 43's specialized mattress was not turned on.</p> <p>This is a repeat deficiency from 12/14/2023.</p> <p>REFERENCE WAC 388-97-1060(3)(b)</p> <p>47047</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on observation, interview, and record review the facility failed to provide restorative/rehabilitative treatment and services for 4 of 4 residents (Residents 2, 41, 46, 88) reviewed for limited Range of Motion (ROM) and mobility to ensure the residents maintained and/or improved their level of functioning. This failure placed residents at risk of further decline in ROM, increased pain and loss of function.</p> <p>Findings included .</p> <p>Review of the undated facility policy titled: Restorative Nursing Services, showed that the residents would receive restorative nursing care as needed to help promote optimal safety and independence.</p> <p><RESIDENT 2></p> <p>Resident 2 admitted [DATE] and was a long term resident with diagnoses which included weakness and spinal stenosis.</p> <p>According to the Annual Minimum Data Set (MDS) assessment dated [DATE], the resident had impaired lower extremity range of motion on one side and required extensive or total assistance with mobility.</p> <p>Review of the care plan with revision dated 08/25/2023 showed the following restorative nursing program:</p> <p>Encourage and assist pt to do active ROM exercises of lower extremities and passive ROM exercises of bilateral upper extremities twice a day (see exercise sheets in pt room or in pt chart)</p> <p>Record review on 11/07/2024 showed no exercise instruction sheet was included in the record.</p> <p>In an interview on 11/04/2024 at 2:02 PM, Resident 2 stated they wanted more therapy or exercises and stated they wouldn't let them try to walk or sit on the side of the bed. Resident 2 stated they got no exercises at all anymore.</p> <p>In an interview and observation of the resident room on 11/07/2024 at 11:02 AM, no exercise sheet was found in the resident room, the resident stated there has never been one that they remember.</p> <p>Review of the resident record on 11/07/2024 showed no documentation that the program was being completed.</p> <p>(continued on next page)</p>		

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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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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/14/2024 at 10:04 AM, Staff X, Resident Care Manager (RCM) stated Resident 2's Restorative program should be showing up in the tasks for the NACs to chart. Staff X stated when there was an update to their system the programs disappeared so they needed to go through one by one and look at all of the care plans because they should be in the task section. Staff X stated they did not have a structured restorative program in the building and the activity department was doing some exercises but other programs were supposed to be done by the nursing assistants and Resident 2 was one of those.</p> <p>36787</p> <p><RESIDENT 88></p> <p>Resident 88 admitted on [DATE] with diagnoses to include right foot ulcer and right 4th and 5th toe amputations, weakness and limitation of activities due to disability.</p> <p>Review of the admission nursing assessment showed the resident had range of motion impairment on one side.</p> <p>Review of the admission MDS on 09/13/2024 showed the resident had no range of motion impairment.</p> <p>Review of the care plan initiated on 08/27/2024, showed Resident 88's goal was to return to their prior level of function in which they were independent with ADL's and mobility. The care plan intervention was for a PT and OT evaluation and treatment.</p> <p>In an interview on 11/14/2024 at 1:40 PM, Resident 98 said they used to get Physical Therapy (PT) and Occupational (OT) until insurance cut them off. They said no one comes in to do exercises with them. They said they need therapy because their left leg was very weak and when they tried to stand Monday, their leg did not want to work. They said they would like to get therapy but not to be in an uncomfortable wheelchair to go down to the gym. They said they would like someone to come to their room and do exercises to get their strength up.</p> <p>In an interview on 11/14/2024 at 4:48 PM, Staff A, Administrator said they did not have a budget for restorative care but do now and will be hiring for the position.</p> <p>In an interview on 11/15/2024 at 8:27 AM, Staff B, Director of Nursing provided therapy discharge communication from 10/07/2024 from PT where the Director of Rehab had recommended Active ROM of lower extremities during ADL's for 10 reps and 2 sets with rest breaks between sets. Staff B provided a new program dated 11/14/2024, 38 days after PT recommended the following Restorative Program: Range of Motion daily- Active - Lower range of motion-10 reps at 2 sets daily, Range of Motion daily- Active - Lower extremity.</p> <p>33954</p> <p><RESIDENT 41></p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 41 readmitted to the facility on [DATE] with diagnoses to include hip fracture. According to the significant change MDS, dated [DATE], the resident had no cognitive impairment, used a wheelchair, had a hip fracture, did receive occupational and physical therapy, but no restorative nursing program.</p> <p>In an interview on 11/04/2024 at 12:53 PM, Resident 41 stated the facility didn't let them walk, and nobody had asked them to walk today.</p> <p>In an interview on 11/13/2024 at 9:31 AM, Staff RR, Director of Rehab (DOR), stated the facility had not had a restorative program in years. They stated they had trained Resident 41 on a home exercise program, but they didn't have any documentation of the home exercise program.</p> <p>In an interview on 11/13/2024 at 9:58 AM, Resident 41 stated they had not been trained on a home exercise program.</p> <p>Review of Physical Therapy Evaluation and Plan of Treatment notes, start of care date: 09/18/20-24, showed the patient's goal was they wanted to be able to walk again.</p> <p>Review of Physical Therapy Discharge Summary documentation, dated 09/30/2024, showed a discharge recommendation of 24 hour care. The documentation also indicated a restorative program had been established/trained for a restorative range of motion program and the patient was educated on a home exercise program to maintain joint mobility to assist with bed mobility.</p> <p>In a joint interview on 11/13/2024 at 10:01 AM, Staff RR, DOR, stated therapy would have provided a home exercise program, and they would have provided the resident with a copy of that program. Staff RR stated the exercises would have been generic. Staff BBB, Physical Therapist, stated they had given Resident 41 a paper printout of exercises, but they couldn't recall which exercises, and they didn't have documentation of that and they could not recall what date that was. Staff BBB stated they did not coordinate with nursing.</p> <p>50725</p> <p><RESIDENT 46></p> <p>Resident 46 admitted to the facility on [DATE] with diagnoses to include multiple sclerosis (a disease that causes the breakdown of the protective covering of the nerves), severe protein-calorie malnutrition, stage 2 pressure area on right lateral foot. Resident was alert and able to make needs known.</p> <p>In an interview on 11/06/2024 at 12:42 PM, Staff FF, Registered Nurse (RN) stated, Resident 46 was alert and oriented but forgetful, and requires total assist with care.</p> <p>In an observation on 11/07/2024 at 10:15 AM Staff GG, NAC and Staff EE, NAC were providing incontinent care to Resident 46. Resident's legs were both bent in the knees, left leg more than the right leg. Requested Resident 46 to straighten their left leg. Resident was able to straighten it but cannot keep it straight and it goes back to being bent.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/07/2024 10:38, Staff GG, NAC stated that Resident 46 was not on a restorative nursing program (nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible).</p> <p>Review of Resident 46's Care Plan on 11/07/2024 showed under Focus: At risk for loss of range of motion related to impaired mobility, weakness. Revised on 07/23/2023. Goal: Will exhibit no decline in ROM within confines of disease processes. Intervention: Encourage to assist resident to do active ROM (the range of movement that a person can achieve by contracting and relaxing muscles without assistance) exercises of bilateral lower extremities twice a day as resident tolerates (see exercise sheets in resident's room or in resident's chart).</p> <p>In an interview on 11/07/2024 at 10:45 AM, Staff X, Licensed Practical Nurse (LPN)/Unit Manager (UM), they stated that activity assistants who were NAC's does restorative program in the facility. Staff X stated Resident 46 is not on a restorative program. Requested Staff X to show me where staff document the ROM exercises for Resident 46 per care plan. Staff X looked in resident's electronic chart and stated they were not able to find any documentation and will work on it.</p> <p>In a record review on 11/08/2024 Resident 46's electronic chart did not show any physical therapy notes. No physical therapy notes given when requested from the physical therapy department.</p> <p>In an interview on 11/08/2024 at 10:39 AM, Staff RR, Therapy Department Manager, stated that the facility did not have restorative nursing program and hasn't for the thirteen years they worked there. The facility does the walking and exercise program from the Activity Department. Therapy Department assist in writing the walking program. Staff RR stated that the facility has a screening process, where if a resident has a change in their functional mobility, they get notified or if the nurse that does the Minimum Data Set (MDS and assessment tool) showed that a resident had a decrease in their mobility then they assess the resident.</p> <p>In an interview on 11/08/2024 at 11:07 AM, Staff GG, NAC was not able to find documentation for the ROM exercises for Resident 46. Staff GG was not able to show me the exercise instructions that was either posted on resident's wall or in resident's chart according to the care plan.</p> <p>In an interview on 11/12/2024 at 12:48 PM Staff FF, RN stated Resident 46's left lower extremity has some contractures and they try to put pillows under the resident's legs but resident kicks them off. Resident 46 also refuses to get out of bed when they offer. Staff FF does not think resident is on a restorative program.</p> <p>In an interview on 11/13/2024 at 9:57 AM, Resident 46 stated that they don't think they were doing exercises to their lower extremities. They stated they were interested in doing ROM exercises especially on their left leg. They were not sure when their left leg started to bend.</p> <p>In an interview on 11/13/2024 at 10:05 AM, informed Staff X, LPN/UM that the exercise instructions were not in Resident 46's wall or in resident's chart. They stated it was usually posted by the wall in resident's room. Staff X stated they were not aware that Resident 46's left lower extremity may be contracted. They stated that when a resident was at risk for developing a contracture, the NAC or the nurse notifies the Unit Manager. The Unit Manager will then get a doctor's order for Physical Therapy to evaluate resident and obtain recommendations to prevent contracture. Staff X stated that they will look at Resident 46 and follow up regarding possible contractures on their leg.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a joint interview on 11/14/2024 at 12:25 PM, Staff A, Administrator and Staff B, RN/Director of Nursing Services (DNS), Staff B stated that they don't have restorative program, but they have restorative tasks that the NAC does, and they come from the therapy department. Unit managers usually receive the recommendations from the therapy department, and they update the care plan, and the NAC does the exercises with the resident. Staff B was not able to provide me a copy of the NAC documentation regarding the ROM exercises for resident per their care plan.</p> <p>This is a repeat deficiency from 12/13/2023.</p> <p>Refer to WAC 388-97-1060 (3)(d)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview, and record review, the facility failed to ensure 8 of 9 residents (25, 41, 43, 54, 78, 84, 98, and 5), reviewed for nutrition, received adequate weight monitoring, timely evaluation of weights, and implementation of effective interventions, to maintain adequate nutrition. This failure placed the residents at risk for ongoing weight loss and poor nutrition and potential harm.</p> <p>Findings included .</p> <p>Review of hte facility policy , titled, Weight Guideline created 05/2023 directed staff to weigh residents upon admission and readmission, weekly for an additional three weeks, then monthly or as indicated by the physician. The staff were to obtain an admissin weight then the following day to ensure an accurate weight. The weights and vital sign exception report will be reviewed at the morning meeting daily.</p> <p>Review of the policy reviewed 05/25/2023 titled,Weight Assessment and Intervention showed the facility will strive to prevent, monitor, and intervene for undesirable weight loss for our residents. The policy showed significant unplanned weight loss was:</p> <ul style="list-style-type: none"> * one month -5 % weight change is significant, greater than 5% is severe weight loss * three months-7.5 % weight change is significant, greater than 7.5% is severe weight loss *six months-10% weight change is significant, greater than 10% is severe weight loss <p>Any weight change of 5 % or more, nursing will immediately inform the physician and dietary team.</p> <p><RESIDENT 84></p> <p>Resident 84 admitted on [DATE] with diagnoses to include severe protein-calorie malnutrition, anemia and diarrhea.</p> <p>Review of the 5-day Minimum Data Set (MDS-an assessment tool) assessment on 08/09/2024 showed the resident had no weight loss and weighed 122 pounds.</p> <p>Review of the care plan developed on 08/07/2024 showed the resident had a nutritional problem related to severe protein calorie malnutrition and staff would minimize complications. Interventions included provide diet as ordered, monitor meal intake, Registered Dietitian (RD) to evaluate and make diet change recommendations as needed and administer medications as ordered.</p> <p>Review of the clinical record showed the resident had the following weights since admission</p> <p>08/06/2024: 121.8 pounds</p> <p>08/19/2024: 123.4 pounds</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>09/02/2024: 118.4 pounds</p> <p>11/12/2024: 102.5 pounds</p> <p>In an interview on 11/12/2024 at 9:40 AM, Resident 84 said the food was hot at lunch yesterday, but her two bowls of malt o meal cereal were cold this morning. The resident showed a laminated list of available snacks that was dropped off to them yesterday. The resident stated can you believe these were available all this time and I never knew about them. They said they never received bedtime snacks since admit. Resident 84 said they would have liked to talk to a dietician but hadn't seen one. The resident said they had a shower yesterday and their weight was down to 103 pounds. The resident said they usually weighed 130 pounds and that is what they would like to weigh. The resident said they barely weighed them here and now they are bony [NAME] The resident commented that until yesterday the staff hadn't weighed them since the beginning of September. Resident 84 said they have their son take them out for a burger and fries when they discharged later that day. The resident said they hoped they would gain weight at home where the food is hot.</p> <p>Review of a weight note on 11/12/2024 at 11:40 AM, showed the weight today showed a weight loss of 16 pounds in 60 days and resident 84 told them the weight loss was attributed to loose stools edema, and loss of appetite.</p> <p>In an interview on 11/12/2024 at 2:00 PM, Staff MM, RD said they could not speak to what has occurred before September first. Staff MM said Resident 84 did not trigger on the significant weight change report as there was not a current weight. Staff MM said they did notify the facility on 11/05/2024 and 11/11/2024, there were missing weights. Staff MM said they did not discuss Resident 84 in nutrition team as there were no weight obtained that would had shown the significant weight loss.</p> <p>In a joint interview on 11/19/2024 at 11:18 AM, Staff B, Director of Nursing acknowledged the lack of weight monitoring, and the weight loss was not identified until day of discharge.</p> <p><RESIDENT 78></p> <p>Resident 78 admitted on [DATE] with diagnoses to include adult failure to thrive, nausea with vomiting, anemia, gastro esophageal reflux disease (GERD) and hypokalemia (low potassium level) and required enteral feeding (nutrition through a tube surgically implanted).</p> <p>Review of the 5-day MDS assessment on 09/26/2024 showed the resident experienced coughing or choking during meals and when swallowing medications and complaints of pain when swallowing. The resident weighed 133 pounds and had no recent weight loss.</p> <p>Review of the admission MDS on 10/23/2024 showed the resident had no weight loss of 5 % or 10% or more in the last six months. The weight recorded was 118 pounds.</p> <p>Review of the care plan developed on 09/20/2024 showed Resident 78 was at risk for alteration in nutritional status related to adult failure to thrive, stiff man syndrome, breast cancer, nausea and vomiting, anemia, GERD, hypokalemia , anxiety and low BMI for population. The goal was for the resident to exhibit a gradual weight gain toward ideal body weight, tolerate tube feeding and show no signs of malnutrition or dehydration. Interventions included obtain and monitor labs, monitor meal intake, and medications and supplements as ordered and document consumption.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of physician documentation at the hospital on 10/10/2024 showed Resident 78 reported that for the past 2 to 3 days they had been unable to swallow anything including liquids, solids, and pills. The resident reported having to constantly spit out everything that comes into their mouth and reported that it was particularly worse with liquids. The resident denied pain with swallowing but felt unable to swallow. Resident reported while at the facility the speech therapist evaluated them and recommended, they go to the Emergency Department. The resident reported that their main concern was that they were hungry, and tired of not being able to eat and concerned that they will continue to grow weaker which would delay their upcoming planned breast surgery.</p> <p>Review of the care plan developed on 10/24/2024 showed Resident 78 was at risk for malnutrition related to their diagnoses of stiff man syndrome, dysphagia, vitamin B 12 deficiency, anemia, copper deficiency, adult failure to thrive, nausea with vomiting, GERD , hypokalemia, anxiety, history of weight loss, polypharmacy, altered labs, increased needs for healing and need for enteral nutrition. The care plan interventions showed the resident would maintain their weight status at an appropriate BMI for age without significant change and resident would maintain desirable hydration status. Nursing staff were directed to monitor and record weekly weights for four weeks then per facility protocol.</p> <p>Review of the nutrition/dietary note dated 10/31/2024 at 9:52 AM, showed Resident 78 was seen for triggering for undesirable significant weight loss of 9.6% of their body weight for one month. The RD noted that weight loss occurred outside of facility between 09/22/2024 until 10/17/2024.</p> <p>Review of the October Medication Administration Record (MAR) showed the resident did not get weighed on 10/28/2024.</p> <p>In an interview on 11/08/2024 at 11:16 AM, Staff P, Licensed Practical Nurse (LPN) said Resident 78 was on Jevity 1.2 calorie and it was changed to the 1.5 formula at 70 cubic centimeters (CC) an hour for 18 hours. Staff P said the resident reports they are thirsty. Staff P said a weight was missed. Staff P said the RD worked remotely and did not come to the facility.</p> <p>In an interview on 11/08/2024 at 1:10 PM, Resident 78 said they were losing weight and did not know why they leave them off the tube feeding so many hours. The resident said the nurse told them yesterday they would be hooked up for food at 5 PM. The resident said they told the nurse they were hungry and did not want to get sick again. Resident 78 said their tube feeding did not get started until 6 PM Resident 78 said their weigh was down to 55 kilograms and it was too low. They said they are not weighed regularly.</p> <p>In a joint interview on 11/12/2024 at 1:45 PM, Staff MM, said they do not come to the facility to talk with the residents. Staff MM said they try to call the residents. Staff MM reported their first phone conversation was yesterday with Resident 78. Staff MM said they review the medical records to obtain her information. Staff MM said the dietary manager would be unable to address Resident 78's enteral nutrition needs. Staff MM said they notified the facility of missed weights for Resident 78 on 11/05/2024 and 11/11/2024. Staff NN, Registered Dietitian Supervisor said residents were to be weighed on admission, weekly for four weeks then monthly. They said they notify the Administrator, Director of Nursing, unit managers and food services when there are missing weights.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a joint interview on 11/19/2024 at 11:18 AM, Staff B, acknowledged the lack of weight monitoring for Resident 78. Staff B said they had not been looking at missed weights. Staff A, Administrator said Staff MM and NN have not attended their Quality Assurance Performance Improvement meetings. Staff A said they will be looking for an in house RD as the current contract is not working.</p> <p>33954</p> <p><RESIDENT 54></p> <p>Resident 54 admitted to the facility on [DATE]. According to the admission MDS assessment, dated 07/17/2024, the resident had no cognitive impairment.</p> <p>Review of Resident 54's weight history showed weights to include:</p> <p>07/11/2024 no documented weight found (day of admit)</p> <p>07/14/2024 - 182.0 lbs.</p> <p>08/08/2024 - 157.2 lbs. This was significant weight loss of 13.6% in less than 30 days. There was no documented re-weight found in the electronic health record.</p> <p>08/16/2024 - 154.2 lbs.</p> <p>11/07/2024 - 150.4 lbs.</p> <p>Review of a hospital discharge summary, dated 07/11/2024, showed Resident 54's weight was 186 lbs. 11 ounces on discharge from the hospital.</p> <p>Review of a nursing progress note, dated 10/09/2024, showed staff documented the resident had no significant weight changes.</p> <p>Review of a nutrition/dietary note, dated 08/27/2024, showed the resident's weight loss was categorized as unplanned/undesired, and the 07/14/2024 weight may be an outlier. The note indicated the dietitian was unable to communicate with the resident as they were not available.</p> <p>In an interview on 11/12/2024 at 11:41 AM, Resident 54 stated they knew they had weight loss because of the way they feel and the way their clothes fit, and they thought their weight loss was due to not having as much access to food and food machines for snacks. The resident stated believe me I will eat it if you give it to me.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/12/2024 at 12:38 PM, Staff X, LPN/Resident Care Manager (RCM), stated facility weight policy was that residents were supposed to be weighed on the day of admission, then daily for three more days so they are weighed the first four days while in the facility, then weekly for four weeks, then monthly. Staff X stated for questionable weights there should be a re-weight and notification of the dietitian. Staff X stated Resident 54 should have had a re-weight on 08/08/2024, but they didn't and they didn't know why because the resident had resided on a different floor in the facility at that time. Staff X was unable to provide any information whether the resident's physician or the dietitian had been notified of the resident's significant weight loss. Staff X stated there should have been a progress note that notifications were done regarding the resident's significant weight loss. Staff X stated the resident had not been care planned for weight loss until 08/27/2024.</p> <p>In a phone interview on 11/12/2024 at 1:44 PM, Staff NN, stated they were not monitoring Resident 54's weight when it changed significantly from 182.0 lbs. to 157.2 lbs., they said to check with nursing regarding that as the dietitians were not monitoring the resident then. Staff NN stated they didn't review the resident for significant weight loss until 08/27/2024. Staff NN was unable to provide any information about missing weights for the resident.</p> <p>Review of the Facility Assessment, reviewed date 10/01/2024 by the QAPI (Quality Assessment and Performance Improvement) Committee, showed the facility had a full-time Registered Dietician who monitored weights and overall nutritional well-being of residents, and the unit managers, Director of Nursing Services, and the dietitian met weekly to discuss residents' nutritional status. The Facility Assessment also indicated the dietitian attended daily clinical meetings and QAPI meetings.</p> <p>In an interview on 11/14/2024 at 8:13 AM, Staff A, stated the facility dietitian didn't attend all daily clinical meetings, that they only came about once a week, and they had not attended at least the last two QAPI meetings they knew for sure.</p> <p><RESIDENT 41></p> <p>Resident 41 admitted to the facility on [DATE] and readmitted to the facility on [DATE]. According to a significant change MDS, dated [DATE], the resident had no cognitive impairment, they had malnutrition, and they had no weight loss of 10% or more in the last six months)</p> <p>Review of Resident 41's weight history showed weights to include:</p> <p>04/05/2024 (day of admission, no documented weight)</p> <p>04/06/2024 no weight documented (day two of admit)</p> <p>04/07/2024 no weight documented (day three of admit)</p> <p>04/08/2024 - 200.4 lbs. (this was the first weight taken this admission)</p> <p>04/12/2024 - 203.0 lbs.</p> <p>04/19/2024 - 187.8 lbs. (15.2 lbs weight loss in 5 days, significant weight loss of 6.3% in 2 weeks)</p> <p>(continued on next page)</p>		

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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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>09/18/2024 - 171.6 lbs. (day of admit)</p> <p>09/19/2024 - no weight documented (day two of admit)</p> <p>09/20/2024 - no weight documented (day three of admit)</p> <p>09/21/2024 - no weight documented (day four of admit)</p> <p>Next weight was 10/07/2024 - 182.6 lbs. (no re-weights found)</p> <p>10/14/2024 - 157.2 lbs. (Significant weight loss of 13.8% in 1 week)</p> <p>10/15/2024 - 158.6 lbs.</p> <p>10/18/2024 - 159.9 lbs. (Significant weight loss of 14.9% in 6 months (since 04/19/2024)</p> <p>In an interview on 11/04/2024 at 12:31 PM, Resident 41 stated the facility food was terrible, and it was undercooked, and they didn't get what they ordered.</p> <p>In an interview on 11/13/2024 at 10:38 AM, Staff X, LPN/RCM, was unable to provide any information about lack of weights for three days after their admission on 04/05/2024. Staff X stated there should have been a re-weight when the resident experienced a 16 lb. weight loss from 04/12/2024 to 04/19/2024. Staff X was unable to provide any information about the 25.4 lb. weight loss from 10/07/2024 - 10/14/2024 (13.9% significant weight loss in one week). Staff X stated the resident had been refusing weights, when asked for documentation of that, Staff X stated they were unable to find any documentation. Staff X stated they thought the scales on the first floor and the second floor did not weight the same.</p> <p>Review of Resident 41's September 2024 MAR showed an order dated 09/19/2024 for daily weights for three days, and a licensed nurse had signed off they had done the daily weights on 09/19/2024, 09/20/2024, and 09/21/2024. Comparison of this documentation with documented weights showed no documentation these weights had ever been done.</p> <p>In an interview on 11/13/2024 at 2:28 PM, Staff X, was unable to provide any information regarding the licensed nurse signing off they did daily weights on 09/19/2024, 09/20/2024 and 09/21/2024.</p> <p>47047</p> <p><RESIDENT 43></p> <p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), chronic kidney disease, and atrial fibrillation (an irregular heart rate).</p> <p>Review of Resident 43's MDS dated [DATE] showed they were at risk for malnutrition and was on a therapeutic diet.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 43's care plan dated 10/24/2024 showed they had dialysis on Mondays, Wednesdays and Fridays from 3:40 PM until 7:40 PM and was to take a packed lunch and/or snacks with them to dialysis and offered snacks upon their return. Resident 43's care plan also showed they were at risk for malnutrition related to their chronic diseases and were on a therapeutic diet of consistent carbohydrate (CCHO), renal and chopped meats and provide oral supplement per physician order, Prosource 30 milliliters (ml).</p> <p>Review of Resident 43's October and November 2024 MAR showed an order for daily weights for three days, then weekly for four weeks and then monthly every day shift on Mondays. Resident 43 was weighed on 10/18/2024, 10/19/2024 and 11/04/2024.</p> <p>Review of Resident 43's October 2024 MAR showed an order for Prosource No Carb Oral Liquid protein (supplement) 30 ml. The order reads mixed into beverage of choice for wound healing. **Do not allow rt [resident] to see product being added into beverages** started 10/18/2024 to be administered at 5:00PM daily. Resident 43 received Prosource at 5:00 PM daily per MAR documentation.</p> <p>In an interview on 11/12/2024 at 9:42 AM Staff L, Registered Nurse (RN)- Unit Manager, stated they did not know the process for meals for residents who received dialysis and residents should be get a sack lunch. Staff L stated residents can always get a snack when they return from dialysis.</p> <p>In an interview on 11/13/2024 at 2:24 PM Resident 43 stated they had not received a sack lunch since admission when they go to dialysis. Resident 43 stated returned from dialysis and ate their dinner left on their overbed table after it had been out for several hours and was cold.</p> <p>51312</p> <p><Resident 25></p> <p>Resident 25 was admitted to the facility on [DATE] with a diagnosis of renal failure (One or both of your kidneys no longer function well on their own) and has dialysis (Treatment for people whose kidneys are failing) three times a week. The resident is post below-knee amputation (BKA) of the right leg (right lower leg amputation).</p> <p>A record review of the Care Plan initiated on 10/02/2024 stated that the resident was to have Nepro (specialized protein drink for persons with kidney disease) three times a day with meals.</p> <p>A review of the Nutrition assessment, dated 10/02/2024, stated that Nepro 120 ml were to be given with meals three times a day to promote wound healing.</p> <p>In a review of Resident 25's November 2024 MAR, showed they received dialysis on Tuesdays, Thursdays and Sundays and were prescribed Nepro with their meals 120 ml three times a day with their meals starting 10/03/2024. From 11/01/2024 through 11/12/2024 the November MAR showed Nepro was not given to Resident 25 at lunch, documented to be out of the facility (hospitalized), for the following dates:</p> <p>Sunday 11/03/2024</p> <p>Tuesday 11/05/2024</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Thursday 11/07/2024</p> <p>Sunday 11/10/2024</p> <p>Tuesday 11/12/2024</p> <p>The record review of October's 2024 MAR showed that the 12:00 PM Nepro was not given 12 of 29 days, which were days Resident 25 was at Dialysis.</p> <p>Review of the at-risk meeting for nutrition note, dated 10/31/2024, Resident 25 was reviewed and documented they had not been getting their sack lunch on dialysis days.</p> <p>In an interview on 11/12/2024 at 11:45 AM, Staff OO, Dietary Aide, stated they made Resident 25's lunch for dialysis. Staff AAA stated Resident 25 received a sack lunch which included a peanut butter and jelly sandwich on white bread, cranberry juice, graham crackers and applesauce. Staff AAA stated they pack the same food items for residents that go to dialysis with the exception of at times a string cheese is provided at times.</p> <p>In an interview on 11/12/2024 at 1:45 PM, Staff MM, stated they were aware of Resident 25's weight loss, had addressed their weight loss with the dialysis dietician, and reviewed/evaluated their weight at their at-risk meetings. Staff MM stated they were unaware of Resident 25 had not been receiving their Nepro at lunch on their dialysis days.</p> <p>In a joint interview on 11/14/2024 at 12:30 Staff L, RCM, and Staff U, RCM, revealed that an X on the MAR represents days that Resident 25 was not receiving Nepro and that those were all days that Resident 25 was at dialysis. Staff L and Staff U stated the facility was to provide a sack lunch on dialysis days and they were unsure why Resident 25 was not receiving the ordered Nepro.</p> <p>51551</p> <p><RESIDENT 5></p> <p>Resident 5 was admitted to the facility on [DATE]. According to the quarterly MDS assessment, dated 08/07/2024, Resident 5 had no cognitive impairment.</p> <p>In an interview on 11/04/2024 at 10:41 AM, Resident 5 stated last week their daughter asked for protein drinks, and they had not got them yet.</p> <p>Review of physician order, dated 10/01/2024, directed nurses to administer nutritional shake: no sugar added with meals at 08:00 AM, 12:00 PM and 05:00 PM and at bedtime for supplement.</p> <p>Review of a wound note, dated 09/12/2024, showed non sugar added nutritional shake on order for additional protein to aid weight and wound healing.</p> <p>Review of Resident 5's breakfast tray card at 11/07/2024 at 8:23 AM and 11/08/2024 at 8:31 AM, showed they were supposed to receive Glucerna (a brand of nutritional shake) with breakfast.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 11/07/2024 at 8:23 AM and 11/08/2024 at 8:31 AM, there was no Glucerna/nutritional shake on Resident 5's breakfast tray, Resident 5 stated they did not receive it.</p> <p>Review of Resident 5's lunch tray card at 11/07/2024 at 12:14 PM, showed no documentation they were supposed to receive a nutritional shake.</p> <p>In an observation on 11/07/2024 at 12:14 PM, there was no nutritional shake on the tray.</p> <p>In an interview on 11/07/2024 at 12:20 PM, Resident 5 stated they did not get any nutritional shake today.</p> <p>Review of MAR, copy date 11/07/2024 at 14:39 PM, showed nurses had signed and documented Resident 5 had taken the nutritional shakes at 8:00 AM and 12:00 PM on 11/07/2024, and they documented with an X the percentage of shakes consumed.</p> <p>In an interview on 11/07/24 at 2:41 PM, Staff AA, RN, stated the kitchen supplied the nutritional shakes with the breakfast and lunch, so they just signed on the MAR as given. Staff AA stated they thought they saw the resident was drinking it but they were not sure.</p> <p>In an interview on 11/07/2024 at 3:00 PM, Staff G, Dietary Manager, stated the kitchen supplied nutritional shakes with meals if the kitchen received the order and the order said to go with meals. Asked why Resident 5 did not receive nutritional shake since the order said with meals. Staff G said they did not know this resident had this order. Staff G said the nurse was supposed to write a communication sheet and give it to the kitchen, but they did not receive this communication sheet and the order did not show in their system either.</p> <p>In an interview on 11/07/24 at 3:02 PM, Staff AA, stated nurses were supposed to document in the MAR how much percentage of the nutritional shake the resident took. Asked what the meaning of X meant on the MAR. They said it should not be a X, should be able to put numbers of percentage. They said they did not know the kitchen did not supply the nutritional shakes today.</p> <p>In an interview on 11/07/2024 at 3:34 PM, Staff G, stated they receive an order of providing Glucerna to Resident 5 with meals at breakfast and dinner.</p> <p>Review a dietary communication form, dated 11/05/2024, showed diet change Glucerna with breakfast and dinner.</p> <p>Review of MAR, cope date 11/07/2024 at 7:49 AM, showed Glucerna with breakfast and dinner two times a day with start date on 11/07/2024. There was no documentation of the order in the MAR from 11/05/2024 to 11/06/2024.</p> <p>In an interview on 11/08/2024 at 9:41 AM, Staff X, Licensed Practical Nurse (LPN)/Unit manager, stated they did not know if Resident 5 received Glucerna or not this morning and they stated the kitchen was supposed to provide it.</p> <p>In an observation and interview on 11/08/2024 at 10:10 AM, Staff BB, LPN, prepared and administered Resident 5's morning medications. There was no Glucerna prepared or administered. Staff BB said they just came at 10am and received report and just started medication pass.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Resident 5's MAR, dated 11/08/2024, showed Staff BB had signed and documented Resident 5 consumed 240 cc (cubic centimeters) Glucerna at 08:00AM.</p> <p>Refer to WAC 388-97-1060 (3)(h)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on observation, interview, and record review the facility failed to ensure oxygen (O2) tubing was appropriately maintained, changed regularly, and dated consistently according to with professional standards of practice for 1 of 1 sampled resident (Resident 43) reviewed for O2 tubing. Additionally, the facility failed to ensure 1 of 1 sample resident (Resident 43) physician's orders were followed related to O2. These failures placed the residents at risk for contact with contaminated care equipment, potential respiratory infections, and respiratory distress.</p> <p>Findings included .</p> <p>Review of the facility policy titled, Oxygen Administration, undated, showed the procedure for O2 administration included verification of physician orders and review of the resident's care plan.</p> <p><RESIDENT 43></p> <p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), chronic kidney disease, and atrial fibrillation (an irregular heart rate), and obstructive sleep apnea.</p> <p>On 11/06/2024 at 8:41 AM observed Resident 43 wearing a nasal cannula (device used to deliver supplemental oxygen through the nose), the tubing was not dated, and the concentrator was set to 3 1/2 liters per minute (LPM).</p> <p>In an interview on 11/06/2024 at 8:41 AM Resident 43 stated they had a feeling their oxygen would be taken away during and changed to just at night because their oxygen levels go down at night and have low blood pressure. Resident 43 stated they thought their O2 was set at 2 LPM.</p> <p>On 11/07/2024 at 11:07 AM observed Resident 43's O2 tubing not dated.</p> <p>Review of Resident 43's order summary dated 10/22/2024 showed a physician order for O2 at two LPM every night at bedtime.</p> <p>Review of Resident 43's care plan dated 10/24/2024 showed they used O2 at two liters per minute (LPM) by nasal cannula, every night at bedtime.</p> <p>In an interview on 11/12/2024 at 9:29 AM Staff L, Registered Nurse-Unit Manager stated when a resident was ordered O2 they go over all the orders, get orders put in place, put a concentrator in place and the route, how many liters they are on and why they were on it. Staff L stated they make sure there was everything available for the resident and the orders were clear. Staff L stated O2 tubing should be changed weekly but did not know the current process or how it is monitored. Staff L stated they checked Resident 43's record and they were to have O2 at night at bedtime.</p> <p>Reference WAC 388-97-1060 (3)(j)(vi)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on interview and record review, the facility failed to ensure ongoing communication and collaboration with the hemodialysis (was one way to treat advanced kidney failure) center for 1 of 1 resident (Resident 43) reviewed for hemodialysis (HD) services. The failure to consistently and accurately complete resident's pre and post dialysis assessments and lack of consistent communication between the facility and the dialysis center about what occurred during HD, placed the resident at risk for unidentified medical complications and other potential/negative health outcomes.</p> <p>Findings included .</p> <p>In a review of the facility's policy titled, End Stage Renal Disease-Care of Resident undated, showed the facility would care residents with end stage renal disease (ESRD) according to recognized standards of care including the immediate monitoring and documentation of the residents condition and access site upon return from the dialysis treatment center. Additionally, the policy outlined agreements between the facility and contracted ESRD facility would include all aspects of how the resident's care would be managed to include:</p> <ul style="list-style-type: none"> -development of a comprehensive integrated care plan -the communication process between the nursing facility and the dialysis center would reflect ongoing communication, coordination and collaboration <p><RESIDENT 43></p> <p>Resident 43 admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (long term condition in which the body has trouble regulating blood sugar), chronic kidney disease, and atrial fibrillation (an irregular heart rate), and end stage renal disease (when the kidneys permanently fail to work).</p> <p>In a review of Resident 43's dialysis care plan, dated 10/24/2024, showed they were at increased risk for complications due to requiring hemodialysis. Interventions included, weights and vitals before and after dialysis and observation for signs and symptoms of complications related to dialysis.</p> <p>In review of Resident 43's order summary dated 10/18/2024 showed and physician order for nursing to complete a post dialysis assessment to include vital signs and to review the dialysis communication form for any recommendations or new orders at bedtime every Monday, Wednesday, and Friday.</p> <p>Review of the post dialysis assessments in the User-Defined Assessments (UDA) in Resident 43's medical record showed no entries for the following dialysis days: 10/18/2024, 10/23/2024, 10/28/2024, 10/30/2024, 11/01/2024, and 11/06/2024.</p> <p>Only one dialysis communication form was in Resident 43's electronic medical record dated 10/21/2024.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/12/2024 at 9:42 AM Staff L Registered Nurse-Unit Manager stated nurses should be completing the UDA in the resident's medical record when they return from dialysis. Staff L stated there used to be a communication form that was sent to the dialysis center and returned with them, but that is not the process any longer. Staff L stated they did not know who monitored the completion of the UDA's.</p> <p>In an interview on 11/15/2024 at 11:07 AM Staff A, Administrator stated they do not have a contract with the dialysis center in which Resident 43 attended.</p> <p>Reference WAC 388-97-1900(1)(6)(a-c)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954</p> <p>Based on observation, interview and record review, the facility failed to provide sufficient numbers of adequately supervised nursing staff to provide care and services for 5 of 9 residents (Residents 5, 2, 43, 36, 15) and 1 of 1 organized resident groups (Resident Council) reviewed for nursing staffing and nursing care and services. Failures to ensure sufficient nursing staff and nursing staff supervision resulted in delays in nursing staff response to resident call lights, failures in administering nutritional supplements as ordered by physicians, missed bathing, cold food and not-accurate medical records.</p> <p>Findings included .</p> <p><RESIDENT COUNCIL></p> <p>In a group interview with Resident Council representatives on 11/07/2024 at 10:00 AM, Resident 50 stated overnight call light response times were sometimes slower than they should be, and they thought it was due to a shortage of staff. Resident 50 stated the facility was short of staff when it came time to pass out meal trays. Resident 50 stated it took staff only five minutes to bring their meal tray carts to the unit, then the cart sits in the halls and they wait for staff to bring them their food and it can get cold. Resident 50 said they have to grin and bear it when they get cold foods and staff don't have an answer to get it warm, they stated you could request alternate foods but to find staff to get it is limited. Resident 19 stated they had missed a lot of showers because staff don't come and get them and tell them it was shower days, Resident 50 said it was because they were short of staff, Resident 55 stated they too had missed showers because staff don't come and tell them, and that sometimes residents need to be transferred to a shower chair and they don't have two staff to do that. Resident 50 stated they can have late medications when agency staff was working and every now and then they were really late. Resident 55 stated they had a lot of agency staff.</p> <p>Review of Resident Council meeting minutes and related Resident Council grievances, dated 05/23/2024, 06/27/2024, 07/25/2024 and 08/29/2024 showed the Resident Council had reported concerns with long call light staff response times of up to an hour.</p> <p>In an interview on 11/13/2024 at 9:15 AM, Resident 50, Resident Council representative, stated staffing and call light issues were their biggest problem and they had never been resolved. Resident 50 verbalized specific concerns about night shift and on weekends when there were more agency (temporary) staff. Resident 50 stated they had a concern about residents not receiving necessary toileting care and services. Resident 50 stated they had reported their concerns to administration, but their concerns had never been resolved.</p> <p>In an interview on 11/12/2024 at 9:01 AM, Staff A, Administrator, stated they didn't do anything to investigate the resident council's staffing concerns.</p> <p><RESIDENT 5></p> <p>(continued on next page)</p>		

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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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 5 admitted to the facility on [DATE] with diagnoses to include hemiplegia/hemiparesis (weakness/paralysis on one side of the body, and a need for assistance with personal cares. According to the quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 08/07/2024, the resident had no cognitive impairment. The MDS indicated they required substantial/maximal assistance with toileting, bathing and lower body dressing, and they were frequently incontinent of bowel and bladder.</p> <p>In an interview on 11/04/2024 at 10:51 AM, Resident 5 stated if they said anything to the nursing assistants, they just argued with them. The resident stated many times they had to wait an hour for their call light to be answered and they've had to wait 45 minutes to be cleaned up after a bowel movement. Resident 5 stated their bed baths were inadequate because the staff used the same water with soap to wash and rinse them and wash their hair which caused them to feel itchy. The resident stated they wanted to bathe three times a week, but they only got bed baths twice a week.</p> <p>In an interview on 11/05/2024 at 11:27 AM, Collateral Contact 4 (CC4), Resident 5's family member, stated they just wanted Resident 5 to have care, but staff don't come when they were supposed to and one night Resident 5 had to call 911 because they weren't getting care. CC4 stated one night a gentleman came into the resident's room and removed their briefs and didn't come back, and the resident was left with no briefs, and they just wanted Resident 5 to be treated with dignity. CC4 stated the resident was missing 20 shirts.</p> <p>In an interview on 11/15/2024 at 9:42 AM, Resident 5 stated one night staffing was so bad they had to wait six hours, they needed a nursing assistant as they were wet and needed to be changed and they waited from midnite to 6:00 AM, so they called 911. They stated weekend staffing they have a lot of agency staff and call light staff response times can range from 1/2 hour to one hour. Resident 5 stated yesterday they got the wrong food at noon, they stated they looked on the tray card and staff had delivered them a tray for a resident from across the hall. The resident stated they had a lot of stress over bathing, that staff would wash them and rinse them with the same water. The resident stated they had missed bathing a couple times because they refused because they were so tired, but that since they had refused they had to wait a week without a bath, and evidently if you miss your bath you are out of luck as they did not come back and offer again. The resident stated you miss your bath if you can't do it on their schedule. The resident also stated they had issues with getting their Glucerna (nutritional shakes) and their daughter had to bring in some protein drinks because they couldn't get them here. The resident stated the staffing is better now, but it has been real bad, and the care changed once you (survey team) came out here, it changed because we didn't have to wait so long once you came, the wait changed. Resident 5 stated sometimes they would use their napkin box to bang it on the table because they would not answer my call light.</p> <p>Review of a physician assistant progress note, dated 05/14/2024, showed the patient reported their clothes were missing, they were informed that there was a shortage of staff which likely caused a delay in receiving their clothes from laundry. Patient thinks that staffing in the facility should be addressed because they were not happy with some of the staff or agency staff that come and works with them. Facility administration is aware of patient's concerns and working to improve staffing and patient's satisfaction.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a social services progress note, dated 09/20/2024, showed the resident had notified them that care staff did not bring supplies with them when they gave them care, and they said the care staff come in and change them, and realize they don't have the supplies and leave them there naked and don't return for a long time.</p> <p>Review of a care conference note, dated 06/14/2024, showed the resident had issues with not receiving their bed baths, and staff documented they showed them their bathing schedule and it showed their bed baths were being done.</p> <p>Review of an alert note, dated 11/03/2024, showed no bath/shower for five days.</p> <p>Review of Resident 5's bathing documentation for 30 days, print date 11/13/2024, showed they were care planned to bathe twice weekly, on Wednesday and Saturday evening shifts, and they preferred bed baths. The documentation showed they had been bathed five times in 30 days, and they had three documented refusals. Review of the progress notes on the dates of the three refusals showed no documentation staff had documented why the resident refused to bathe, and there was no documentation the resident had been offered to bathe at another time.</p> <p>In an interview on 11/13/2024 at 2:18 PM, Staff X, Licensed Practical Nurse/Resident Care Manager, stated they didn't know about the resident's bathing refusals, and they thought the resident should have been re-offered to bathe the next day, they looked in the electronic health record and stated they could find no documentation they were re-offered to bathe after refusals.</p> <p>Review of Resident 5's breakfast tray card on 11/07/2024 showed the resident was to have Glucerna on their tray. In an observation on 11/07/2024 at 8:23 AM, there was no Glucerna on the resident's breakfast tray.</p> <p>In an interview on 11/07/2024 at 12:30 PM, Resident 5 stated last night was the first time they ever got their nutritional shake.</p> <p>Review of Resident 5's Medication Administration Records (MARS), from 11/01/2024 - 11/07/2024 showed an order dated 10/01/2024 for a Nutritional Shake: no sugar added with meals for supplement and it had a box for the nurse to document the percentage of the shake consumed, but that box always had an x instead of a percentage actually consumed.</p> <p>In an interview on 11/07/2024 at 2:41 PM, Staff AA, Registered Nurse (RN), stated the kitchen usually supplied the nutritional shakes with breakfast and lunch, so they just signed off on the MARS. Staff AA stated they thought they saw the resident drinking a nutritional shake, but now they were not sure.</p> <p>In an interview on 11/07/2024 at 3:00 PM, Staff G, Dietary Manager, stated the kitchen supplied nutritional shakes with meals if they received the order and it said to go with meals. Staff G stated they did not know the resident had an order for a nutritional shake with meals because they never received a communication sheet from nursing staff. Staff G stated their system never showed an order for the nutritional shake.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/07/2024 at 3:02 PM, Staff AA, RN, was asked about their documentation of an x on the MARS for amount of nutritional shake consumed, they stated it shouldn't be an x, that it should have been a number percentage.</p> <p>50725</p> <p>In an interview on 11/15/2024 at 10:15 AM, Resident 43 stated that the time the staff answers their call light depends on how many people were working. When there's enough staff, wait time was usually 10-20 minutes and when they don't have enough staff, wait time will take half an hour or longer. Resident 43 stated that there was a time when 1 nursing assistant had to do 11 showers in a day.</p> <p>In an interview on 11/15/2024 at 10:20 AM, Resident 2 stated that nighttime is the worse time for staff to answer their call light, it takes 2 hours. Resident stated after 9 pm was when it was hard to find someone to help them.</p> <p>In an interview on 11/15/2024 at 10:25 AM, Resident 5 stated that it takes half an hour to an hour wait for someone to answer their call light. Resident stated that it also depends on who were the staff that were working. Resident thinks the norm for staff to answer call lights should be within 15-20 minutes.</p> <p>In an interview on 11/15/2024 at 10:30 AM, Resident 46 stated that they wait between 20-25 minutes for a staff to answer their call light and it was longer wait in the late afternoon. Resident stated the facility does not have enough staff to help the residents.</p> <p><RESIDENT 15></p> <p>In an observation and interview on 11/05/2024 at 1:25 PM, Resident 15 was observed sitting in their wheelchair with their right stump on the elevating leg rest. Resident 15 stated, It takes too d**n long to get your call light answered. An hour or two usually. The day before yesterday, the aide left me on the bedside commode for 45 minutes after lunch time. The aide told me to put my call light on when I was done. I did but waited and waited for 45 minutes. My butt was killing me. It hurts to be sitting on that (commode) and trying to stay up right. I was so mad. I told my nurse about it. Resident 15 stated their sitting balance was not good.</p> <p>Review of a 30-day Staffing Pattern worksheet, dated 11/05/2024, showed the facility did not have registered nursing staff on duty on night shift on 11 of 30 days reviewed.</p> <p>In an interview on 11/14/2024 at 8:13 AM, Staff A, Administrator, stated they were actively recruiting nursing staff. And Staff A stated the facility had not assessed the impact the lack of night shift registered nursing staff had on resident care and resident needs.</p> <p>Refer to WAC 388-97-1080 (1)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on interview and record review, the facility failed to ensure 1 of 5 Residents (Resident 74) reviewed for unnecessary medications were free from unnecessary psychotropic medications. Failure to provide complete and accurate informed consent for medications and identify/monitor target behaviors for as needed antipsychotic medication placed residents at risk to receive unnecessary psychotropic medications and experience adverse side effects.</p> <p>Findings included .</p> <p>Resident 74 admitted [DATE] with diagnoses to include anxiety and depression.</p> <p>Review of the Admission Minimum Data Set, dated dated dated [DATE] showed Resident 74 was their own decision maker.</p> <p>Review of Resident 74's physician's on 11/12/2024 orders showed:</p> <p>An order for Trazodone (an antidepressant medication) dated 04/12/2024. The informed consent provided and signed by the resident on 04/12/2024 failed to include the category of medication or potential side effects.</p> <p>An order for Duloxetine (an antidepressant) dated 08/10/2024. No informed consent was found for this medication.</p> <p>An order for Vistaril (an antianxiety medication) dated 04/12/2024. The informed consent provided and signed by the resident on 04/12/2024 failed to include the category of medication or potential side effects.</p> <p>An order for Ativan (an antianxiety medication) dated 10/24/2024. The informed consent incorrectly checked the category of medication as an antidepressant; therefore, the resident's informed consent did not include the correct potential side effects for antianxiety medications. This medication was ordered every 12 hours as needed for anxiety for 14 Days. Review of the November Medication Administration record on 11/07/2024 showed there was no documentation of target behaviors or non-pharmacological interventions attempted with each administration of the as needed antianxiety medication.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/13/2024 at 12:02 PM, Staff Z, Registered Nurse (RN) stated the facility had an admission nurse and that person or the Resident Care Manager (RCM) would do the admission medication orders and medication consents when a resident admitted . The nurse on the cart should verify that the consent had been done before they administer a medication. Staff Z stated if a new order was received after the resident admitted the cart nurse or the RCM would complete the consents with the residents or the representative. Staff Z stated for psychotropic medications there should be a symptom monitor in the medication administration record. Staff Z stated Resident 74 had symptoms of anxiety every day and took their as needed anxiety medication close to every 12 hours every day. Staff Z reviewed the documentation for Resident 74 and stated there was a symptom monitor for anxiety which was shown to be completed once per shift. Review of that symptom monitor with Staff Z showed most shifts were documented with zero symptoms of anxiety. Staff Z stated if the staff completed the monitor there was no way to go back and add to it, they would have to delete the entry and start over. Staff Z stated there was an auto generated note in the progress notes when the medication was administered and whether it was effective or not, but those notes showed no resident specific symptoms, triggers or non- pharmacological interventions attempted prior to the administrations of the antianxiety medication for Resident 74.</p> <p>In an interview on 11/14/2024 at 10:10 AM, Staff X, Licensed Practical Nurse, RCM, stated medication orders should be reviewed at the time they are entered to ensure there are consents completed and monitors in place.</p> <p>Refer to WAC 388-97-1060(3)(k)(i)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50725</p> <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than five percent (%), there were 29 opportunities for error observed and resulted in 68.97% medication error rate. Failure to administer the right dose of medication for 1 of 8 residents (Resident 43), failure to administer medication by the correct route for 1 of 8 residents (Resident 78), and failure to administer medications at the right time for 7 of 8 residents (Resident 2, 5, 34, 43, 58, 75, 78) placed residents at risk for adverse side effects, medical complications and diminished quality of life.</p> <p>Findings included .</p> <p>According to the facility policy titled Medication Administration: Medications administered by licensed nurses, or other staff who are legally authorized to do so in this state as ordered by the physician in accordance with professional standards of practice. Review Medication Administration Record (MAR) to identify medication to be administered. Compare medication source with MAR to verify resident name, medication name, form, dose, route, and time. Administer within 60 minutes prior or after scheduled time unless otherwise ordered by physician. Sign MAR after administered.</p> <p>In an observation and record review, on 11/05/2024 at 9:00AM, Staff P, Licensed Practical Nurse (LPN) administered medications: Tylenol 1000 milligram (mg), Gabapentin 800 mg (nerve pain medicine), and 1 unit of Humalog insulin to Resident 75. Review of the MAR for Resident 75 showed those medications were supposed to be given at 7:00 AM. The time medications were given were outside the time parameter per facility policy.</p> <p>In a record review on 11/05/2024 at 9:07 AM, Resident 43's MAR showed 8:00 AM medications were not given. These medications were: Multivitamin with minerals 1 tablet, Eliquis 2.5 mg (blood thinner medicine), Vitamin C 500 mg, Calcium Carbonate Antacid (Tums) 1177 mg chewable tablet and Arnuity Ellipta Inhalation Aerosol powder (inhaler for asthma), one puff.</p> <p>In an observation and interview on 11/05/2024 at 9:20 AM, Staff N, Agency Registered Nurse (RN) prepared the 8:00 AM medications and administered it to Resident 43. When asked about the Calcium Carbonate Antacid dose, Staff N stated that they gave resident the 750 mg chewable tablet. Staff N will contact the provider to clarify the order.</p> <p>In an interview on 11/05/2024 at 1:50 PM, Staff N stated that they were expected to pass medications within one hour before or one hour after the time that's in the MAR. They stated that when they think they will be late on passing medications, they prioritize the medications that were important such as blood pressure medications and insulin. Staff N stated that they can ask the unit manager for assistance as well.</p> <p>In an observation and record review on 11/05/2024 at 9:45 AM, Resident 4 received their medications, given by Staff XX, Agency LPN. According to the MAR, Pro Source (supplement) 30 milli liter, Lidocaine patch and Tylenol extra strength 1000 mg were all due at 7:30 AM.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and record review on 11/05/2024 at 10:00 AM, Resident 34 received her medications, given by Staff XX. According to the MAR, Artificial Tears, one drop to both eye, Aspirin Enteric Coated 81 mg, Metoprolol Extended Release 25 mg (blood pressure medicine), Senna 8.6 mg (stool softener), Multivitamin 1 tab were all due at 8:00 AM.</p> <p>In an interview on 11/05/2024 at 10:05, Staff XX, stated that they were expected to give medications within one hour prior or one hour after the time in the MAR. They stated that even if the medications were late that they'd rather give it then not give the medications at all. They stated that the unit manager may probably be able to help with giving medications when they were running late but did not ask for assistance.</p> <p>In an observation on 11/05/2024 at 1:15 PM, Staff P, LPN, administered Baclofen (muscle relaxant medicine) 15 mg tablet to Resident 78 via gastrostomy tube (G tube - a feeding tube that is inserted through the skin and the stomach wall to provide nutrition and fluids directly to the stomach). Review of MAR and doctors order showed Baclofen 15 mg, give 1 and a half tablet (10 mg tablets) by mouth at the same time another doctor's order stated nothing by mouth. Staff P stated that whoever was the staff that admitted the resident should have updated the orders and should be per G tube and not by mouth. Staff P stated that they will clarify and update the order.</p> <p>In an interview on 11/07/2024 at 10:48 AM, Staff X, LPN/Unit Manager (UM) stated that per facility policy, the timing of Medication Administration is one hour before or one hour after the time in the MAR if the medication was administered past the time that was considered as medication error. They stated that it was an expectation that the staff notifies the UM if they were running late on their Medication Administration so they can assist.</p> <p>In an interview on 11/07/2024 at 2:05 PM, Staff L, RN/UM stated that medications should be passed one hour before and one hour after the time in the MAR. They stated that if the medications were over an hour late, the Director of Nursing Services (DNS), monitors them and the DNS was the one that follows up.</p> <p>In a joint interview on 11/08/2024 at 12:34 PM with Staff A, Administrator and Staff B, RN/DNS, Staff B stated that medications should be given one hour before or one hour after the time in the MAR unless there was an unforeseen event, then they notify the provider and the nurse will prioritize on what medications to give first such as blood pressure medications and insulin. Staff B stated that they print out the medication error report in the morning and discuss it in the morning meetings and then they give it to the Staff Development Manager and the Staff Development Manager will talk to the nurse. If the nurse was a multiple offender, then they discipline them. When asked about supervision for the nurses, Staff B stated that the Unit Managers should be doing their rounds and assisting the nurses. Staff B stated that they did not count late medications as medication errors. Late medication administration was not in their QAPI. When asked what the plan of correction was when they were cited with medication error on their last survey, Staff A stated that they did audits and follow up. Staff B stated that the late medications that were given today will be logged as medication errors.</p> <p>In an observation on 11/14/2024 at 5:20 PM, Staff XX drew up Humalog insulin and administered the shot to Resident 58.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a record review and interview on 11/14/2024 at 5:25 PM Resident 58's MAR showed Humalog Insulin was administered at 4:19 PM on 11/14/2024. According to Staff XX, they signed the MAR that the insulin was given at the time they checked Resident 58's blood sugar even though they have not given it at the time they signed the MAR.</p> <p>In an observation and record review on 11/14/2024 at 5:34 PM, Resident 2's MAR showed that Humalog insulin was signed that it was given at 4:15 PM on 11/14/2024. Observed Staff XX drew up the Humalog insulin and administered it to Resident 2 at 5:34 PM.</p> <p>In an interview on 11/14/2024 at 5:38 PM, Staff XX stated that after checking the blood sugar they signed the insulin order even though they have not given Resident 2's insulin yet. Staff XX stated that they signed that it was given so that it will not show that they were late giving the insulin in resident's electronic chart.</p> <p>In a record review on 11/14/2024 at 5:39 PM, Resident 5's MAR showed that the Humalog insulin was administered at 3:56 PM on 11/14/2024.</p> <p>In an observation and interview on 11/14/2024 at 5:40 PM, Staff XX drew up Humalog insulin and administered the shot to Resident 2 at 5:40 PM. Staff XX, stated that they signed that they administered the insulin ahead of time. They stated they just don't want the medications to show up late in the resident's electronic chart. They stated that this is not a safe practice. Staff XX denied that they had anymore medications that they signed ahead of time.</p> <p>This is a repeat citation from SOD 12/14/2023</p> <p>Refer to WAC 388-97-1060 (3)(k)(ii)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954</p> <p>Based on observation, interview and record review, the facility failed to ensure 7 of 10 residents (Residents 5, 2, 58, 78, 24, 98, 453) remained free of significant medication errors when administering and documenting medication administration. The failure to administer medications within the required time frame of one hour before/after the scheduled time resulted in countless timing and/or documentation errors including breakfast and lunch insulin administrations given within minutes of each other. The facility's failed medication management practices placed residents at risk for adverse medication-related complications, diminished quality of life, and for having inadequate medical records being used to make medical decisions. Additional failed practice included lack of sorely needed nursing supervision and administrative oversight of medication management practices and systemic failures in reporting, documenting and investigating medication errors.</p> <p>Findings included .</p> <p>Review of the facility policy titled Medication Administration, undated, showed the medications were administered by licensed nurses or other legally authorized staff as ordered by the physician and in accordance with professional standards of practice. The policy indicated staff were to administer medications within 60 minutes prior to or after the scheduled time unless otherwise ordered by the physician. The policy also indicated staff were to sign the medication administration record after medications were administered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled Adverse Consequences and Medication Errors, undated, showed It was the policy of the interdisciplinary team to evaluate medication usage in order to prevent and detect adverse consequences and medication-related problems. Medication error was defined as the preparation or administration of drugs and biologicals which was not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing the service. Examples of medication errors included wrong time: and/or failure to follow manufacturer instructions and/or accepted professional standards. The policy indicated the interdisciplinary team reviewed residents' medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis. The policy indicated facility staff monitored residents for possible medication-related adverse consequences, including mental status and level of consciousness, to include when residents had a clinically significant change in condition/status, and when medication errors occurred, and when they occurred the prescriber and staff rule out medications as a cause and document it in the resident's clinical record. The policy indicated the attending physician was notified promptly of any significant error or adverse consequence, and the resident/resident representative would be notified of any significant medication error or adverse consequence and actions taken to monitor and/or treat the resident's response to the error. The policy indicated the incident would be described in the resident's medical record and would be reported to the prescribing practitioner, director of nursing/designee, and the facility administrator, and the facility would alert staff of the need to monitor the resident. The policy indicated documentation would be done in the resident's clinical record to include a factual description of the error or adverse consequence, name of physician and time notified, physician's subsequent orders, and resident's condition for 24 to 72 hours or as directed. The policy indicated data regarding medication adverse consequences and errors (e.g. total number of incidents, number of incidents by category/type, trends) would be compiled and presented to the quality assurance and performance improvement committee on at least a quarterly basis. The policy indicated the director of nursing or designee would conduct a root cause analysis of medication administration errors to determine the source of errors, implement process improvement steps, and compare results over time to determine that system improvements were effective in reducing errors.</p> <p><RESIDENT 5></p> <p>Resident 5 admitted to the facility on [DATE] and had diagnoses to include diabetes, depression, anxiety, and a communication deficit. According to the quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 08/07/2024, the resident had no cognitive impairment.</p> <p>In an interview on 11/05/2024 at 11:27 AM, Collateral Contact 2 (CC2), family member of Resident 5, stated twice when they visited, Resident 5 had low blood sugar levels where their blood sugar dipped down to 60 (low blood sugar level) and they had to yell for nursing to come and staff told CC2 to give them yogurt while they went to get juice, and that staff told CC2 the resident needed to go to a different doctor than the facility doctor because they could not manage the resident's diabetes. CC2 also stated that facility staff had double-dosed Resident 5 on medications, and they gave the resident Xanax (Alprazolam) and Triazolam (sedative medications) at the same time and when they called the facility to speak to the resident they could not speak and they thought the resident was having a stroke.</p> <p>Review of Resident 5's Medication Administration Records showed:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>November 1 - 10, 2024: there were 32 insulin doses in 10 days where the resident did not receive their insulin doses within one hour of the scheduled time, resulting in 32 medication errors. On 11/07/2024, the resident was scheduled to receive Humalog insulin at 7:00 AM, the medication records indicated the resident did not receive that insulin until 10:25 AM, then they received their scheduled 11:00 AM dose at 12:07 PM. Review of the resident's progress notes showed no documentation the facility had contacted the resident's physician regarding their late insulin medication administration.</p> <p>October 2024: there were 62 insulin doses where the resident did not receive their insulin within one hour of the scheduled time, resulting in 62 medication errors. A few examples of late Humalog insulin administration included:</p> <ul style="list-style-type: none"> -10/12/2024 7:00 AM dose, given at 10:03 AM (No physician notification found in the progress notes) -10/11/2024 7:00 AM dose, given at 10:52 AM (No physician notification found in the progress notes) -10/06/2024 11:00 AM dose, given at 1:30 PM (No physician notification found in the progress notes) <p>September 2024: there were 84 insulin doses where the resident did not receive their insulin within one hour of the scheduled time, resulting in 84 medication errors.</p> <ul style="list-style-type: none"> -09/27/2024 4:00 PM dose, given at 2:11 PM (progress note review showed no documentation why the dose was given almost two hours early, and there was no documentation a physician was notified) -09/17/2024 7:00 AM dose, given at 10:05 AM, then the 11:00 AM dose was given at 10:59 AM, only 54 minutes later (progress note review showed no documentation a physician had been notified) <p>August 2024: there were 68 insulin doses where the resident did not receive their insulin with one hour of the scheduled time, resulting in 68 medication errors.</p> <p>July 2024: there were 53 insulin doses where the resident did not receive their insulin with one hour of the scheduled time, resulting in 53 medication errors.</p> <ul style="list-style-type: none"> -07/20/2024 0700 dose, given at 11:33 AM, then two minutes later the 11:00 AM dose was given at 11:35 AM (progress notes review showed no documentation explaining this irregularity, and there was no documentation a physician was notified). <p>June 2024: there were 79 insulin doses where the resident did not receive their insulin with one hour of the scheduled time, resulting in 79 medication errors.</p> <ul style="list-style-type: none"> -06/16/2024 7:00 AM dose was given at 11:41 AM (almost 5 hours late), the 11:00 AM dose was given at 11:16 AM which was actually given before the 7:00 AM dose (progress note review showed there was no documentation explaining this irregularity). Both of these doses included scheduled prescribed dose of Humalog insulin and scheduled sliding scale Humalog insulin. -06/20/2024 7:00 AM dose was given at 11:33 AM (4 1/2 hours late), then the 11:00 AM dose was given at 12:14 PM (progress note review showed no documentation explaining this irregularity). <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a physician assistant progress note, dated 06/20/2024 at 00:00, showed the patient was seen today regarding report of taking additional doses of medication. Nursing and patient report they were given Triazolam (sedative medication) at bedtime twice on 06/16/24. Nursing reports patient was more sleepy than usual on that day, but patient was arousable. Nursing was instructed to continue monitoring patient. Patient was seen today to check on how they were feeling. They reported talking to their daughter on the phone that day and daughter told the patient they didn't seem like themselves. Patient takes Triazolam for sleep nightly. Patient recalls sleeping for more than they usually slept. Patient reports feeling fine today and back to their normal self. Review of the nursing progress notes for 06/16/2024 and 06/17/2024 showed there were no nursing progress notes explaining this situation or which nurse had reported this to the physician assistant.</p> <p>May 2024: there were 50 insulin doses where the resident did not receive their insulin with one hour of the scheduled time, resulting in 50 medication errors.</p> <p>April 2024 - December 2023 Review of medication administration records for those months showed there were over 200 medication errors found that were like the medication errors described for the months of May - November 2024.</p> <p>Review of Care Conference/Concern Follow up Call notes, dated 11/14/2024, showed there was a discussion regarding the resident's daughter's concerns about the resident's diabetes and what was causing the extreme fluctuations in blood sugar readings. The note indicated the physician and nurse manager (Staff X, LPN/RCM) agreed the cause was the resident's diet. The notes also indicated the resident's daughter's concern was the resident was not receiving the foods per their tray cards. The notes indicated the facility had discovered that tray cards were not matching what was being served on the tray.</p> <p>Review of an email interview, dated 11/18/2024, showed Staff B, Director of Nursing, reported finding discrepancies regarding Triazolam and Alprazolam (both sedative medications) being administered together on 07/15/2024, 07/31/2024, 08/23/2024, 09/06/2024 and 09/24/2024. The email indicated Staff B had opened an internal incident report and would be investigating as a medication error.</p> <p>Medication Administration observation: In an observation on 11/14/2024 at 5:40 PM, Staff XX, Agency LPN, was observed to administer the resident their insulin. Review of the insulin administration documentation on the November 2024 medication administration records showed Staff XX documented they administered the resident their insulin at 3:36 PM, which was over 2 hours earlier than they actually administered the insulin.</p> <p>In an interview on 11/14/2024 at 5:40 PM, Staff XX, Agency LPN stated that they signed that they administered the insulin ahead of time. They stated they just don't want the medications to show up late in the resident's electronic chart. They stated that this was not a safe practice.</p> <p><RESIDENT 2></p> <p>Medication Administration observation: In an observation on 11/14/2024 at 5:36 PM, Staff XX, Agency LPN, was observed to administer Resident 2 their insulin. Review of the insulin administration documentation on the November 2024 medication administration records showed Staff XX documented they administered the resident their insulin at 4:15 PM.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/14/2024 at 5:38 PM, Staff XX, Agency LPN stated that after checking the blood sugar they signed the insulin order even though they have not given Resident 2's insulin yet. Staff XX stated that they signed that it was given so that it will not show that they were late giving the insulin in resident's electronic chart.</p> <p><RESIDENT 58></p> <p>Medication Administration observation: In an observation on 11/14/2024 at 5:19 PM, Staff XX, Agency LPN, was observed to administer Resident 58 their insulin. Review of the insulin administration documentation on the November 2024 medication administration records showed Staff XX documented they administered the resident their insulin at 4:19 PM.</p> <p>In an interview on 11/14/2024 at 5:285 PM, Staff XX, Agency LPN stated they signed the MAR that the insulin was given at the time they checked Resident 58's blood sugar even though they have not given it at the time they signed the MAR.</p> <p>36787</p> <p><RESIDENT 78></p> <p>Resident 78 admitted on [DATE] with diagnoses to include stiff person syndrome.</p> <p>In an observation and interview on 11/05/2024 at 12:28 PM, Resident 78 said their nurse (Staff N, Agency RN) this morning did not know how to give their medications through their feeding tube. Resident 78 said they had to walk them through the steps to do it. The resident said they told them to crush the meds, and how to use the syringe. Resident 78 commented maybe they did not learn that at their school.</p> <p>Review of the enteral feeding competency demonstrated by Staff N, Agency RN on 11/13/2024, showed that Staff N failed to follow enhanced precautions protocol, tap water was used instead of sterile or purified water, and date and label the formula. There was no competency of medication administration via tube.</p> <p>In an interview on 11/06/2024 at 8:43 AM, Resident 78 was resting in bed and said they had missed medications on three different days, including the day before yesterday. Resident 78 said they talked to Staff O, Licensed Practical Nurse (LPN) about it and they said they passed it onto day shift to give those medications. Resident 78 said they then asked the day shift nurse that followed Staff O, and they said that was not true, Staff O was supposed to administer them.</p> <p>Review of the September, October and November MARS showed the resident was to receive Gabapentin 100 MG at bedtime. Baclofen 10 MG three times a day and Diazepam 5 MG before breakfast and at bedtime.</p> <p>Review of the MARS showed the following for Gabapentin:</p> <ul style="list-style-type: none"> - 09/24/2024 scheduled 8:00 AM, administered 9:30 AM -09/25/2024 scheduled 8:00 AM, administered 9:43 AM <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-09/27/2024 scheduled 8:00 AM, administered 10:23 AM</p> <p>-10/18/2024 scheduled 8:00 AM, administered 12:02 PM</p> <p>-11/05/2024: Scheduled 8:00 PM, administered 10:35 PM</p> <p>Review of the MARS showed the following for Diazepam:</p> <p>-09/24/2024 scheduled 7:00 AM, administered 9:32 AM</p> <p>-10/18/2024 scheduled 7:00 AM, administered 12:02 PM</p> <p>-10/29/2024 scheduled 1:00 PM, administered 2:51 PM</p> <p>-11/05/2024: Scheduled 9:00 PM, administered 10:35 PM</p> <p>-09/24/2024 scheduled 7:00 AM, administered 9:36 AM</p> <p>-09/27/2024 scheduled 7:00 AM, administered 10:23 AM</p> <p>-10/18/2024 scheduled 7:00 AM, administered 12:02 PM</p> <p>-10/19/2024 scheduled 7:00 AM, administered 9:25 AM</p> <p>-10/20/2024 scheduled 7:00 AM, administered 10:13 AM</p> <p>-10/23/2024 scheduled 7:00 AM, administered 10:20 AM</p> <p>-10/30/2024 scheduled 7:00 AM, administered 09:03 AM</p> <p>-10/31/2024 scheduled 7:00 AM, administered 8:53 AM</p> <p>-11/01/2024 scheduled 7:00 AM, administered 9:48 AM</p> <p>-11/02/2024 scheduled 7:00 AM, administered 9:11 AM</p> <p>-11/03/2024 scheduled 7:00 AM, administered 9:42 AM</p> <p>-11/04/2024 scheduled 7:00 AM, administered 8:52 AM</p> <p>-11/05/2024 scheduled 7:00 AM, administered 10:14 AM</p> <p>-11/06/2024 scheduled 7:00 AM, administered 8:28 AM</p> <p>Review of the MARS showed the following for Lidocaine patches:</p> <p>-10/18/2024 scheduled 8:00 AM, administered 12:02 PM</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10/19/2024 scheduled 8:00 AM, administered 10:27 AM</p> <p>-10/20/2024 scheduled 8:00 AM, administered 10:14 AM</p> <p><RESIDENT 98></p> <p>Resident 98 admitted on [DATE] with diagnoses to include diabetes requiring insulin.</p> <p>In an interview on 11/06/24 at 9:03 AM, Resident 98 said they get their medications helter skelter and there is no normal time. The resident said they still hasn't gotten their nasal spray today. The resident said last night the nurse refused to mix Triamcinolone with the powder for her bottom although two different nurses have used it on them. The resident said this one refused and said there was no order for it.</p> <p>Review of the MARS showed the following for insulin Lispro three times a day:</p> <p>-10/16/2024 scheduled 7:00 AM, administered 8:44 AM, Blood Glucose (BG) check was 8:40 AM</p> <p>-11/01/2024 scheduled 7:00 AM, administered 8:40 AM, BG check was 7:13 AM</p> <p>-11/02/2024 scheduled 7:00 AM, administered 8:30 AM, BG check was 8:30 AM</p> <p>-11/02/2024 scheduled 11:00 AM, administered 12:45 PM BG check was 12:45 PM</p> <p>-11/02/2024 scheduled 4:00 PM, administered 5:10 PM</p> <p>-11/03/2024 scheduled 7:00 AM, administered 8:45 AM, BG check was 8:44 AM</p> <p>-11/03/2024 scheduled 11:00 AM, administered 12:41 PM BG check was 12:42 PM</p> <p>-11/03/2024 scheduled 4 PM, administered 5:59 PM, BG check same time</p> <p>-11/04/2024 scheduled 11:00 AM, administered 12:20 PM BG check was 12:20 PM</p> <p>-11/04/2024 scheduled 4 PM, administered 5:41 PM, BG check same time</p> <p>-11/05/2024 scheduled 7:00 AM, administered 8:39 AM BG check was 8:46 AM</p> <p>-11/05/2024 scheduled 11:00 AM, administered 12:50 PM BG check was 12:50 PM</p> <p>-11/05/2024 scheduled 4:00 PM, administered 6:36 PM, BG check same time</p> <p>-11/08/2024 scheduled 7:00 AM, administered 8:23 AM, BG same time</p> <p>-11/12/2024 scheduled 8:00 PM, administered 9:41 PM</p> <p>Review of the MARS showed the following for insulin Lispro sliding scale:</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-10/16/2024 scheduled 7:00 AM, administered 8:43 AM, BG check was 7:13 AM</p> <p>-11/01/2024 scheduled 7:00 AM, administered 8:40 AM, BG check was 8:40 AM</p> <p>-11/02/2024 scheduled 7:00 AM, administered 8:30 AM, BG check was 8:29 AM</p> <p>-11/02/2024 scheduled 11:00 AM, administered 12:45 PM BG check was 12:45 PM</p> <p>-11/03/2024 scheduled 7:00 AM, administered 8:44 AM, BG check was 8:44 AM</p> <p>-11/03/2024 scheduled 11:00 AM, administered 12:41 PM BG check was 12:42 PM</p> <p>-11/03/2024 scheduled 4:00 PM, administered 5:59 PM, BG check same time</p> <p>-11/04/2024 scheduled 7:00 AM, administered 9:51 AM BG check was 9:53 AM</p> <p>-11/04/2024 scheduled 11:00 AM, administered 12:20 PM BG check was 12:20 PM</p> <p>-11/04/2024 scheduled 4 PM, administered 5:41 PM, BG check same time</p> <p>-11/04/2024 scheduled 4 PM, administered 5:35 PM, BG check same time</p> <p>-11/05/2024 scheduled 7:00 AM, administered 8:39 AM BG check was 8:46 AM</p> <p>-11/05/2024 scheduled 11:00 AM, administered 12:50 PM BG check was 12:50 PM</p> <p>-11/05/2024 scheduled 8:00 PM, administered 9:22 PM, BG check same time</p> <p>-11/08/2024 scheduled 7:00 AM, administered 8:22 AM, BG same time</p> <p><RESIDENT 453></p> <p>Resident 453 admitted on [DATE] with diagnoses to include multiple cardiac conditions, requiring medication management.</p> <p>In an interview on 11/04/2024 at 10:02 AM, Resident 453 said they were waiting on their morning meds. The resident stated their med delivery was spotty, they are late a lot. I usually get them right after breakfast with their food.</p> <p>In an interview on 11/06/2024 at 8:53 AM, Resident 453 said Staff D, RN is the only nurse who gives them their medications on time.</p> <p>Review of the MARS showed the following for Spironolactone:</p> <p>-11/02/2024 scheduled 8:00 AM, Administered 9:34 AM</p> <p>-11/04/2024 scheduled 8:00 AM, Administered 10:58 AM</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><RESIDENT 75></p> <p>In a review of the Medication Administration Audit Report dated 11/08/2024 showed Resident 75 had a physician order for Humalog Solution 100 UNIT/ml (Insulin Lispro Human) to inject as per sliding scale subcutaneously before meals for diabetes and for BS 70 follow hypoglycemic protocol. The medication was ordered to be administered before meals at 7:00 AM, Resident 75 received their medication at 8:41 AM.</p> <p><RESIDENT 77></p> <p>In a review of the Medication Administration Audit Report dated 11/08/2024 showed Resident 77 had a physician order for insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) to inject as per sliding scale and 6 units subcutaneously before meals related to DM and to follow hypoglycemic protocol for BG under 70. The medication was ordered to be administered before meals at 7:00 AM, Resident 77 received their both medications 8:42 AM and 8:43 AM.</p> <p>In a joint interview on 11/08/2024 at 12:34 AM with Staff B, Director of Nursing Services, and Staff A, Administrator, stated they had two call outs this morning and were aware of the late insulin being provided to the residents. Staff B stated the provider was notified. Staff B stated their policy allows for medication administration an hour before or after the scheduled time. Staff B stated medication administration and late medications are being monitored daily in their clinical meeting. Staff B stated they are not completing medication error reports or incident reports on late medications.</p> <p><MEDICATION ERROR MANAGEMENT></p> <p>Review of the facility incident reporting logs from May - October 2024 showed:</p> <p>May 2024: no logged medication errors</p> <p>June 2024: one logged medication error</p> <p>July 2024: three logged medication errors</p> <p>August 2024: no logged medication errors</p> <p>September 2024: one logged medication error</p> <p>October 2024: one logged medication error</p> <p>In an interview on 11/08/2024 at 12:33 PM, Staff B, Director of Nursing, was asked how many medication error reports they did a week, Staff B stated not many, what it comes down to I haven't been doing it, I need to try to make it more functional than we have been doing.</p> <p>(continued on next page)</p>		

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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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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/14/2024 at 8:13 AM, Staff A, Administrator, stated they were not aware of any medication error trends. Staff A stated they were not aware that medication errors were not being reported and investigated as Staff B had not been reporting them. Staff A stated they didn't know if Staff B had been trained on facility medication management policy. Staff A stated they didn't know about any root cause analysis being done regarding the many medication errors that had occurred, they stated they hadn't known about all of the medication errors because the director of nursing had not been reporting them.</p> <p>In an joint interview on 11/15/2024 at 11:48 AM, Staff B, Director of Nursing stated they reviewed the late medication report at stand up meeting. Staff B said they talked with some nurses who reported they are documenting their medication administration at at end of shift. Staff B said that they pulled the late medication report this morning and were pleased the report went from 77 pages down to 13 pages. Staff B said they had been more focused on missed meds than the late meds.</p> <p>This is a repeat deficiency from 12/14/2023.</p> <p>Refer to WAC 388-97-1060 (3)(k)(iii)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were secured for 4 of 4 residents (Resident 47, 78, 453 and 454) observed with medications at bedside. Further, the facility failed to discard expired in three of four medication carts reviewed. This failure placed the residents at risk for receiving compromised or ineffective medications This failure placed the residents at risk for consuming medication in excessive dosage, medical complications, and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the undated facility policy titled, Medication Storage showed the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdate, or deteriorated drugs or biologicals. All drugs shall be returned to the dispensing pharmacy or destroyed.</p> <p><RESIDENT 453></p> <p>In an observation and interview on 11/04/2024 at 10:30 AM, Resident 453 was resting in bed with Normal Saline Spray in a clear cup, Artificial tears in a medication cup and Proair inhaler on their overbed table. Resident 453 said the medications were theirs and the staff know all about it</p> <p>In an observation on 11/05/2024 at 2:20 PM, the Normal Saline Spray in a clear cup at bedside, Artificial tears, Proair inhaler.</p> <p>In an interview and observation on 11/06/2024 at 8:53 AM, Resident 453 reported a couple days ago a nurse gave me two pills that were not my Xarelto. Resident 453 said they told the nurse These are not my Xarelto, I need my blood thinner. The nurse told me oh, we don't have yours, but these two are Xarelto and just a little over your dose. The Artificial tears, nasal spray and Proair remained on their overbed table. At 4:00 PM, Resident 453 was out of their room and the artificial tears, nasal spray and Proair inhaler were on their overbed table.</p> <p>In an observation on 11/07/2024 at 11:00 AM, the artificial tears, nasal spray and Proair inhaler were on their overbed table.</p> <p><RESIDENT 47></p> <p>In an observation and interview on 11/04/2024 at 2:21 PM, Resident 47 was up in their wheelchair with Timolol eye drops on their overbed table. The resident stated they were their eye drops.</p> <p><RESIDENT 454></p> <p>In an observation and interview on 11/04/2024 at 3:09 PM, A bottle of medicated Metholatum Gold Bond Powder were at bedside on their nightstand.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><RESIDENT 78></p> <p>In an observation and interview on 11/06/2024 at 8:43 AM, Resident 78 was resting in bed. There was an orange-colored bottle filled 1/4 full with a child safety cap on it to the right of their nightstand. There was no label on it. Resident 78 said it was their Lidocaine and they used it for the pain caused from their cancer treatment. Resident 78 said their son had brought the bottle to them from home.</p> <p>In an interview on 11/14/2024 at 12:43 PM, Staff B, Director of Nursing Services (DNS) said there was only one resident in the facility on self-medication program and it was not Resident 47, 78, 453 or 454. Staff B [NAME] the expectation was meds should be secured and not be left at bedside.</p> <p>50725</p> <p><MEDICATION CARTS></p> <p>In an observation on 11/05/2024 at 1:35 PM, the Yellow Medication Cart on the first floor had 4 expired bottles of medications. They were, Calcium 600 milligram (mg), Guaifenesin 400 mg, Cetirizine HCl 10 mg, the expiration date on the bottles were 09/2024, Acetaminophen with Aspirin and Caffeine, expiration date was 03/2024. The nurse stated they will dispose the expired medications.</p> <p>In an observation on 11/05/2024 at 1:50 PM, the [NAME] Medication Cart on the first floor had 1 expired medication - Calcium 600 mg with expiration date of 09/2024. Nurse stated they will dispose of the expired medication.</p> <p>In an observation on 11/05/2024 at 2:20 PM, the Pink Medication Cart on the second floor had 2 expired medications. They were, Cetirizine HCl 10 mg with expiration date of 09/2024 and Zinc 50 mg with expiration date of 10/2024. The nurse stated they will dispose the expired medications.</p> <p>In a joint interview on 11/14/2024 at 12:20 PM with Staff A, Administrator and Staff B, DNS, Staff B stated that the nurses working the medication carts were supposed to look at the dates prior to opening containers and dispose expired medications. Staff A stated that they went through all the medication carts and checked to make sure there were no more expired medications.</p> <p>This is a repeat deficiency from 12/14/2023.</p> <p>Refer to WAC 388-97-1300 (2)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to ensure foods were served in a timely manner and were palatable for 6 of 7 residents (Resident 75, 81, 84, 95, 98 and 454) and 1 of 1 organized resident groups (Resident Council) who were interviewed about the food palatability and temperatures. Failure to meet these requirements could negatively impact the residents' nutritional status, appetite, and meal acceptance.</p> <p>Findings included .</p> <p><RESIDENT INTERVIEWS></p> <p><RESIDENT 84></p> <p>In an interview on 11/04/2024 at 11:27 AM, Resident 84 said they hate cooked spinach and they serve it to them. Resident 84 said the food could be served hotter.</p> <p>In an interview on 11/05/2024 at 8:41 AM, Resident 84 said they forgot my coffee. The resident said they just don't like spinach and they write in a lot of stuff on their tray card. Resident 84 said they must hate me in the kitchen. They do a lot of canned fruit. Lots of fruit cocktail, mostly canned. I would like fresh berries. Food is lukewarm at best. Maybe those carts are not insulated well. Food needs to be hotter.</p> <p>In an interview on 11/08/2024 at 10:14 AM , Resident 84 said their peas and carrots were not warm last night. Resident 84 showed a picture on their phone with their order for this morning which was 2 bowls of oatmeal and they had crossed off eggs and toast. The resident said they received the eggs, toast and only one bowl of cereal, Resident 84 said why did they not even look at these preferences or maybe they cannot read.</p> <p><RESIDENT 98></p> <p>In an interview on 11/04/2024 at 11:53 AM, Resident 98 stated the food services there were questionable. They said they worked in the food services for [AGE] years. The resident said they serve us cold pork chops. They said they have learned to go get their meals in the dining room so the food was palatable. The resident said they do not use spices here and they cook with a lot of salt, Resident 98 said their breakfast this morning was a piece of toast and a hash brown square and canned orange juice which was all carbs and they are diabetic. They said last week they had rice and pasta alfredo in the same meal. The resident said some of the aides will go get them a hot meal because they know they do not like cold food.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/07/2024 at 11:00 AM, Resident 98 said today they got a sausage that was cold and pork should be hot and safe. They said this morning they got a heavily iced cinnamon roll, cereal and a piece of toast. The resident said they needed to talk to the dietician but had not seen one since they admitted . Resident 98 said the heavy carb diet was not good for their diabetes. They said their fiend who is a Registered Dietician came to visit them there, looked at their food and said what are they trying to kill you? Resident 98 said they has been asking to talk with the dietician but since admit.</p> <p><RESIDENT 95></p> <p>In an interview on 11/04/2024 at 1:33 PM, Resident 95 said they had concerns about the food. Resident 95 said the food was served cold. They said the menu today said frosted cake but there was no frosting. The resident said the food is nothing to write home about.</p> <p><RESIDENT 75></p> <p>In an interview on 11/04/2024 at 1:59 PM, Resident 75 said the food needs to be hotter. They said yesterday their breakfast was served cold. Resident 75 stated they absolutely hate mushy vegetables, and all the vegetables were way overcooked.</p> <p>In a follow up interview on 11/12/2024 at 3:17 PM, Resident 75 said the food had been better since we talked and their breakfast was hot today.</p> <p><RESIDENT 454></p> <p>In an interview on 11/04/2024 Resident 454 was frowning and said the food is terrible, there is no flavor. Resident 454 said the food is not good so their family brings them food.</p> <p>33954</p> <p><RESIDENT COUNCIL></p> <p>In a group interview with resident council representatives on 11/07/2024 at 10:00 AM, Resident 50 stated staff do not warm their food when they eat in their rooms, and the food frequently came cold to their rooms and they had no way to get it warmed up, and the french fries were served ice cold. Resident 50 stated cold food was an ongoing issue and if you want to eat food and it's cold, you just have to eat it. Resident 50 stated they had talked to the kitchen staff every month and tell them they get cold food, but nothing happens. Resident 55 stated it took five minutes to bring the cart up from the kitchen, then the cart sits in the halls and they wait for staff to bring their their food and it got cold. Resident 50 stated when they came back from dialysis their food was sitting in their room cold, and what were they to do, they tell staff they have cold food and they don't do anything about it, and they just have to grin and bear it with their cold food because they don't have an answer to get it warm.</p> <p>In an interview on 11/07/2024 at 11:14 AM, Staff HH, Director of Activities/Staff that facilitates Resident Council Meetings, was asked about the resident council concerns of cold food, they stated the company don't let them have a microwave.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/08/2024 at 12:33 PM, Staff B, Director of Nursing, stated if residents had cold food they should tell staff.</p> <p>47047</p> <p><TEST TRAY></p> <p>On 11/13/2024 at 12:44 PM was provided a test tray by the aide working on the first floor. The following meal was provided: mashed potatoes and gravy, thin chicken cutlet, boiled zucchini and an uncovered fruit cocktail cup from a can. Each component of the meal had the temperature taken and was within standards.</p> <p>The mashed potatoes and gravy consisted of good flavor and texture. The chicken cutlet was thin, dry, and tough to chew with minimal flavor. The zucchini were mushy and disintegrated into mush when picked up by a fork. The fruit cocktail was not consumed as it was delivered after being walked down a hall uncovered. The meal was not palatable.</p> <p>This is a repeat deficiency from 12/14/2023.</p> <p>Reference: WAC 388-97-1100(1)(2)</p>

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>33954</p> <p>Based on observation, interview and record review, the facility failed to ensure residents' menus and individual food plans met the nutritional needs and preferences of 5 of 9 residents (Residents 2, 19, 50, 5, 81) and 1 of 1 organized resident groups (Resident Council) reviewed for food services. The failure to ensure residents received foods that met their nutritional needs, and their individual preferences placed residents at risk for weight loss, dissatisfaction with their food and diminished quality of life.</p> <p>Findings included .</p> <p><RESIDENT COUNCIL></p> <p>In a group interview with Resident Council representatives on 11/07/2024 at 10:00 AM, Resident 50 stated they can't always get alternative foods if they don't like the food they get, they stated they know there were alternatives, but to find staff to get them was limited. Resident 19 stated there was a lot of not getting foods they had requested as they were not following their menu. Resident 50 stated the tray cards (documentation for each meal what the resident had requested and what they were to receive for each meal) didn't usually match what foods they got, and they thought staff didn't enter their foods right from the menus onto their tray cards.</p> <p>Review of a Resident Council Grievance, dated 05/23/2024, showed there was a slips issue (tray cards), and residents not getting what they ordered, and an issue with missing foods. Review of documentation included with the grievance, undated, showed the facility had changed their menu system where activities was now assisting with the menus, and they hoped that solved the timeliness of the kitchen getting back the completed menus. The documentation stated to ask residents for an update at the June Resident Council meeting.</p> <p>Review of Resident Council meeting minutes, dated 06/27/2024, showed a dietary concern there were missing items on trays and the foods they received were not what they ordered from the menus.</p> <p>In an interview on 11/14/2024 at 8:13 AM, Staff A, Administrator, was asked how the facility had resolved the resident council's food concerns from the 06/27/2024 resident council meeting, they were unable to provide any information.</p> <p><RESIDENT 5></p> <p>In an interview on 11/04/2024 at 10:41 AM, Resident 5 stated the food was terrible and they didn't bring the right food to match the menu.</p> <p>Review of a physician assistant progress note, dated 05/14/2024, showed the resident complained of not receiving foods they chose from the menu.</p> <p>Review of a social services progress note, dated 09/20/2024, showed the resident stated they had not been receiving the correct food on their trays.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of physician order, dated 10/01/2024, directed nurses to administer nutritional shake: no sugar added with meals at 08:00 AM, 12:00 PM and 05:00 PM and at bedtime for supplement.</p> <p>Review of Resident 5's breakfast tray card at 11/07/2024 at 8:23 AM and 11/08/2024 at 8:31 AM, showed they were supposed to receive Glucerna (a brand of nutritional shake) with breakfast.</p> <p>In an observation and interview on 11/07/2024 at 8:23 AM, there was no Glucerna/nutritional shake on Resident 5's breakfast tray, Resident 5 stated they did not receive it.</p> <p>In an interview on 11/07/2024 at 3:00 PM, Staff G, Dietary Manager, stated the kitchen supplied nutritional shakes with meals if the kitchen received the order and the order said to go with meals. Asked why Resident 5 did not receive nutritional shake since the order said with meals, Staff G said they did not know this resident had this order. Staff G said the nurse was supposed to write a communication sheet and give it to the kitchen, but they did not receive this communication sheet, and the order did not show in their system either.</p> <p>Review of care conference/concern follow-up call notes, dated 11/14/2024, reviewed there were concerns the daily food the nursing home had provided the resident was not the food requested on the tray cards. An example discussed was on 10/31/2024 when family visited during lunch, their tray card showed they were to receive mashed potatoes with gravy, cottage cheese, diet ice cream and peanut butter and jelly and whole wheat bread, but what they received was a slice of cheese pizza, a cup of chocolate ice cream, apple sauce and a glass of cranberry juice. The facility documented in the care conference notes they had discovered that tray cards were not matching what was being served on the tray and they were going to implement an audit to compare the menu and tray card.</p> <p>In an interview on 11/15/2024 at 9:42 AM, Resident 5 stated last week they started receiving Glucerna (nutritional drink), and they weren't getting any before that, and their daughter had to bring some in because they couldn't get them here. They stated when they started receiving their Glucerna, it wasn't open and they couldn't open it, so they would have to call staff and there wouldn't be anyone, they thought staff should come and check on them during meals to see if everything was ok. Resident 5 stated there was a lot of food issues because there was food on the menu, but it was not on their trays so they would have to call someone to go get the food.</p> <p><RESIDENT 81></p> <p>In an interview on 11/06/2024 at 1:17 PM, Resident 81 stated they had a salad for lunch, but they needed another dressing, and the nursing assistant said they would get another one, but they never came back, so they just sent their lunch tray back.</p> <p>In an interview/observation on 11/07/2024 at 8:13 AM, Resident 81 stated their French fries/steak fries from last night were cold, and their macaroni salad was warm so they didn't eat it as they didn't want to take a chance getting sick. Resident 81 stated their banana with breakfast was quite brown and it's kind of rotten, and they didn't eat their yogurt, the yogurt was observe sitting by the sink with the lid to their plate warmer. Review of their breakfast tray card showed they were supposed to get sausage links, the resident said they did not receive them. The tray card said they disliked bacon, the resident stated that was not true because they did like bacon, but it was rare that they got it.</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation/interview on 11/07/2024 at 12:37 PM, observed Resident 81's lunch tray, it had a cheeseburger, onion, and tomato, soup, something that looked like cornbread, and yogurt, the resident stated they were not going to eat the cheeseburger, onion and they didn't order them. They stated the bowl of soup was not very warm and they thought it had chicken in it, so they were not going to eat it, and they stated they were not going to eat the corn bread because they were not sure what it was, and they were not going to eat the yogurt, that they always got yogurt and they always sent it back.</p> <p>Review of Resident 81's Medication Administration Records, from 11/01/2024 - 11/14/2024, showed an order for probiotic yogurt with meals for supplement, dated 07/23/2024, staff had been documenting a y for yes that the resident ate it.</p> <p>In an interview on 11/13/2024 at 3:23 PM, Staff G, Dietary Manager, stated Resident 81 like their bananas green. Regarding the yogurt, Staff G stated the resident said they wanted yogurt when they assessed them. Regarding the cheeseburger, the resident got a cheeseburger because they didn't like chicken. Staff G stated all of this tells me I need to go talk to the resident.</p> <p>In an interview on 11/15/2024 at 10:50 AM, Resident 81 was interviewed about the yogurt, they stated I don't eat yogurt, I've never eaten yogurt, I always send it back and I think they give it to someone else, I already showed you I sent it back, I don't know why they would document I ate yogurt, that's a lie, I just don't eat it and they know that.</p> <p><RESIDENT 2></p> <p>In an interview and observation on 11/04/2024 at 1:55 PM, Resident 2 stated they get the same foods days in a row and not what the menu says. Resident 2 stated the menu today stated it was supposed to be stir fry and they got chicken thighs (observation of the tray still in the resident room on the overbed table showed the remnants of the meal with small chicken fragments.) Resident 2 stated there was supposed to be alternates but you don't get the alternate that you choose, they don't follow the requests or the cards. New people bought the place and ever since the food is lousy. We used to get snacks but now it is like pulling teeth or they will say there is nothing. I get low blood sugar and they don't get me the right snacks. They will bring potato chips and say that is all there is.</p> <p>Record Review of the posted menu for 11/04/2024 lunch showed pork stir fry.</p> <p><TRAY LINE OBSERVATION></p> <p>On 11/12/2024 at from 11:20 AM until 12:00 PM observed the lunch meal tray line. During this time Staff HH, cook plated food after reviewing a diet slip passed to them on a shelf above the steam table above eye level. Observed Staff HH stand on their tips of their shoes to read the diet slip. During the tray line, observed Staff HH, make five errors in plating the food from preferences to diet texture which were identified by the dietary aide. The errors were identified by the dietary aide and the meal replated with the correct preferences and diet.</p> <p>Refer to WAC 388-97-1120 (3)(a), -1140 (6), -1180 (1)</p>		

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 11/15/2024
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)		
<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on observation, interview and record review, the facility failed to consistently offer and/or provide a nutritional snack when ordered or requested for 4 of 6 (Resident 2, 24, 84, and 50) residents reviewed for dining preferences. This failure to provide nutritional snacks at non-traditional times and meet resident choices placed residents at risk for inadequate nutrition.</p> <p>Findings included .</p> <p><BEDTIME SNACKS></p> <p><RESIDENT 2></p> <p>In an interview and observation on 11/04/2024 at 1:55 PM, Resident 2 stated. We used to get snacks but now it is like pulling teeth or they will say there is nothing. I get low blood sugar and they don't get me the right snacks, I need protein. They will bring potato chips and say that is all there is.</p> <p><RESIDENT COUNCIL></p> <p>In an interview with resident council representatives on 11/07/2024 at 10:00 AM, Resident 50, Resident Council Representative, stated they used to get snacks at bedtime, but not anymore. Resident 50 stated when they returned from dialysis every Monday, Wednesday and Friday evening, their dinner meal would be sitting in their room cold and staff tell them there is no way to heat it up for them or get them an alternate meal because the kitchen is closed.</p> <p><RESIDENT 24></p> <p>Resident 24 admitted on [DATE].</p> <p>In an interview on 11/14/2024 at 9:44 AM, Resident 24 said they were so happy with the new snack offering card and they ordered a yogurt and two puddings last night. Resident 24 said they like to have something sweet around 10 at night and they were happy they can now get bedtime snacks.</p> <p><RESIDENT 84></p> <p>Resident 84 admitted on [DATE] with diagnoses to include severe protein calorie malnutrition.</p> <p>In an interview on 11/12/2024 at 9:40 AM, Resident 84 showed a laminated list of available snacks that was dropped off to them yesterday. The resident stated can you believe these were available all this time and I never knew about them.</p> <p>(continued on next page)</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In a joint interview on 11/15/2024 at 11:32 AM with Staff A, Administrator and Staff B, Director of Nursing they were informed of the resident council concerns with lack of snacks at bedtime. Resident 24 and 84 stated they had not received any bedtime snacks since admit until this week. Staff A and B were informed of the dialysis sack lunches that contained inadequate nutrition.</p> <p>No additional information was provided.</p> <p>33954</p> <p>37890</p> <p>Reference: (WAC) 388-97-1120 (1)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47047</p> <p>Based on observation and interviews, the facility failed to ensure resident meals were prepared and stored in accordance with professional standards of food safety for 1 of 1 facility kitchens, and 1 of 1-unit refrigerators. The failure to ensure the kitchen and nourishment refrigerators were free from potential contaminants, the maintenance to ensure the kitchen refrigerator and freezer were properly maintained left residents at risk for food contamination, food borne illnesses, and spoiled food.</p> <p>Findings Included .</p> <p><WALK IN REFRIGERATOR></p> <p>During an observation [DATE] at 9:48 AM the main refrigerator located in the kitchen had a temperature log on the front door showed no logged temperatures for the PM for [DATE], [DATE], [DATE] and AM and PM for [DATE].</p> <p>During a walk through of walk-in refrigerator on [DATE] at 9:48 AM showed several undated and expired food items:</p> <ul style="list-style-type: none"> - balsamic vinegar with a use by date [DATE] -bag of everything bagels opened not dated -pickle chips opened with a month and day, but no year documented -a container labeled applesauce with a green lid with a preparation date [DATE] -shredded cheese mozzarella in an open bag with no date <p><WALK IN FREEZER></p> <p>During an observation [DATE] at 9:48 AM the main freezer located in the kitchen had a temperature log on the front door showed no logged temperatures for [DATE], [DATE], [DATE] and [DATE].</p> <p>During a walk through of walk-in refrigerator on [DATE] at 9:48 AM showed several undated and expired food items:</p> <ul style="list-style-type: none"> -a bag of frozen unidentified items not dated, located on the second shelf from the top -2 bags of yams not labeled or dated <p><KITCHEN FOOD PREPARATION AREA></p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on [DATE] at 9:48 AM the cooking and meal preparation area there was a handwashing station with a trash can next to it, the flooring soiled with debris. In a follow up visit to the kitchen on [DATE] at 11:08 AM the same debris was observed on the flooring next to the trash.</p> <p><TRAY LINE></p> <p>In observation on [DATE] at 11:24 AM observed Staff HHH, Cook, during tray line, took tongs and pushed their glasses up with them, they explained aloud they were doing that in an effort to avoid changing gloves, then plated food on a plate, dropped a piece of cooked cauliflower into the chicken and used the same tongs and took the cauliflower out of the chicken and placed it back into the cauliflower.</p> <p>In an observation on [DATE] at 11:20 AM Staff III, Dietary Aide, placed the desserts on each tray, uncovered, then place the tray into the cart to be delivered.</p> <p>In an interview on [DATE] at 11:35 AM Staff G, Dietary Manager stated they didn't cover the dessert (fruit cup) because they are placed in the cart and the cart was designed to go from room to room when meals were delivered. Staff G stated they used to cover everything and then were told to stop.</p> <p>In an observation on [DATE] at 12:44 PM a test meal tray was received and the dessert (fruit cup) was delivered uncovered, the cart not in sight,</p> <p>In an interview on [DATE] at 9:00 AM Staff G stated all opened items in the refrigerator and freezer are required to be tabled with the date opened and the use by date. Staff G stated the temperature logs were to be filled out daily in the AM and PM and the end of [DATE] was missing the temperatures at which time they provided their staff with education.</p> <p>37890</p> <p><NOURISHMENT REFRIGERATOR></p> <p>In an observation on [DATE] at 2:00 PM, the nourishment refrigerator on the second floor had spilled sticky orange matter down the inside of the door. There was gooey brown melted matter on the bottom of the fridge.</p> <p>In an interview on [DATE] at 2:-05 PM, Staff EE, Nursing Assistant, stated they did not know who was responsible to clean the refrigerators.</p> <p>Refer to WAC [DATE](3)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>42927</p> <p>Based on interview and record review, the facility failed to administer services effectively and efficiently to attain, and/or maintain, each resident's optimal physical, mental and psychosocial well-being. The facility failed to ensure all allegations had a complete and thorough investigation and failed to maintain systems to prevent repeat citations throughout the last year. In addition, the facility failed to recognize and/or correct repeated concerns that had been documented on the Resident Council meeting minutes for long call light wait times. The administrator should have been aware of these issues and did not put corrective action into place to sustain these systems. These failures placed residents at risk for the potential for continued abuse, unmet care needs and decreased quality of life.</p> <p>Findings included .</p> <p>Review of a facility policy, titled, Administrator, dated 10/01/2021, showed the administrator was responsible for the day-to-day functions of the facility and they were responsible for implementing operational policies to remain in compliance with current laws and regulations.</p> <p>Review of the facility's last annual recertification Statement of Deficiencies (SOD), dated 12/14/2023, showed the facility had repeat deficiencies cited regarding Resident rights (F550), grievances (F585), investigate/prevent/correct alleged violations (610), activities of daily living (ADL) provision for dependent residents (F677), Quality of care (F684), treatment/services to heal and/or prevent pressure ulcers (686), increase/prevent decrease in range of motion/mobility (F688), respiratory care (F695), dialysis (F698), sufficient nursing staff (F725), pharmacy services, procedures, records (F755), free of medication error rate of 5% or more (F759), free of significant medication errors (F760), and infection control procedures (F880).</p> <p>The administration failed to implement an Abuse Prohibition policy which included prevention, identification, and resident protection. Reporting of abuse violations was noted on a SOD dated 06/07/2024. These failures placed residents at risk for continued abuse, caused a delay in investigation and failed to ensure residents were protected. Refer to F607- Develop/Implement Abuse/Neglect, etc. Policies</p> <p>The Administration failed to ensure that allegations of abuse had a thorough investigation, and corrective actions put into place. Failure to conduct a thorough investigation to identify root cause and all contributing factors placed residents at risk for unidentified abuse or neglect. Refer to 610-Investigate/Prevent/Correct Alleged Violations</p> <p>During an interview on 11/15/2024 at 8:31 AM, Staff A, Administrator, reported the Director of Nursing Services completed the investigations for abuse allegations, but they were responsible to review them after completion.</p> <p><Resident Council Minutes></p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the resident council meeting minutes, dated 05/23/2024, showed it took a long time (an hour), for call lights to be answered on the night shift. Review of a grievance form dated 05/23/2024, showed the resident council had reported a concern with long call light wait times but the Action taken to Address Concern section was blank.</p> <p>Review of the resident council meeting minutes, dated 06/27/2024, showed call lights were taking too long to be answered.</p> <p>Review of the resident council meeting minutes, dated 07/25/2024, showed long call light waiting times.</p> <p>Review of the resident council meeting minutes, dated 08/29/2024, showed long call light waiting times on the night shift.</p> <p>Review of the resident council meeting minutes, dated 09/26/2024, showed that Staff X, Licensed Practical Nurse/Resident Care Manager talked to the resident council about waiting for call lights.</p> <p>During an interview on 11/14/2024 at 1:08 PM, Staff A stated they received the Resident Council Minutes monthly to review.</p> <p>Refer to WAC 388-97-1620 (1)</p> <p>33954</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36787</p> <p>Based on interview and record review, the governing body failed to provide adequate active and engaged oversight and monitoring of the facility's appointed Administrator. The governing body failed to ensure the Administrator had clinical systems in place and that were followed related to Abuse/Neglect, Resident Rights, Grievances, Pressure Ulcers, Infection Control and Prevention, Social Services, Nutrition, Care Planning, Accidents and Supervision, Transfer and Discharge, Staffing, Medication Safety, Range of Motion program, and Infection Control Practices, failed to identify and correct their own identified deficiencies to ensure sustainability with compliance for state/federal regulations and previous deficiencies. The governing body also failed to ensure the Administrator had sufficient staff to meet the needs of the residents, i.e., personal care/grooming, restorative care, and an effective call light system. These failures placed residents at risk for less-than-optimal care and services for residents. The governing body's failure to provide oversight and support to ensure all policies and procedures were being followed and ensure the facility had an effectively functioning QA&A program that consistently self-identified deficient practices, placed residents at risk for injury and abuse and unmet needs that could negatively impact their physical function, psychosocial wellbeing, quality of life and quality of care.</p> <p>Findings included .</p> <p>Review of the facility's last annual recertification Statement of Deficiencies (SOD), dated 12/14/2023, showed the facility had repeat deficiencies cited regarding Resident rights (F550), grievances (F585), investigate/prevent/correct alleged violations (610), activities of daily living (ADL) provision for dependent residents (F677), Quality of care (F684) also cited 06/07/2024, treatment/services to heal and/or prevent pressure ulcers (686), increase/prevent decrease in range of motion/mobility (F688), respiratory care (F695), dialysis (F698), sufficient nursing staff (F725), pharmacy services, procedures, records (F755), free of medication error rate of 5% or more (F759), free of significant medication errors (F760), and infection control procedures (F880).</p> <p>The governing body failed to implement an Abuse Prohibition policy which included screening, prevention, identification, and resident protection. Reporting of abuse violations was noted on a SOD dated 06/07/2024. These failures placed residents at risk for continued abuse, caused a delay in investigation and failed to ensure residents were protected. Refer to F607- Develop/Implement Abuse/Neglect, etc. Policies</p> <p>In an interview on 11/14/2024 at 10:50 AM, Staff CCC, Regional Director of Clinical Services (RDCO) said they had been with the company for a month and a half and had visited the facility twice before survey started. Staff CCC said the company was down another RDCO position so they had more facilities than the four they were assigned to. Staff CCC, said Staff EEE was hired about a month ago.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility document dated 01/03/2024 titled, Governing Body-[NAME], showed the governing body was responsible for establishing and implementing policies regarding management and operation of the facility, appointing the Administrator who is licensed by the state, responsible for management of the facility, and reports to and is accountable to the Governing Body and the QAPI program. The Governing Body will have a process in place by which the administrator reports to the Governing Body, the method of communication between the Administrator and Governing Body and how the Governing Body responds back to the Administrator.</p> <p>Review of the facility assessment last reviewed on 07/01/2024, showed Staff A, Administrator had signed off on the review. There were no signatures or review from the Governing Body.</p> <p>Review of the past six months of QAPI minutes showed the Governing Body was not in attendance.</p> <p>In an interview on 11/15/2024 at 11:06 AM, Staff A, Administrator said the facility assessment was developed primarily by them. Staff A said the Governing Body consisted of Staff FFF, Chief Nursing Operator (CNO) and Staff GGG, Chief Operating Officer (COO), Staff EEE, Regional Director of Operations (RDO) and Staff CCC, RDCO. Staff A said Staff EEE and Staff CCC did not participate in QAPI. Staff A said Staff FFF and GGG had not attended any QAPI meetings. Staff A said they had seen Staff FFF once at the facility in the last 15 months and they had never met Staff GGG. Staff A said the Governing Body did not communicate with them and they did not send any direct reports to them. Staff A said they had no documentation of any Governing Body meetings.</p> <p>In an interview on 11/15/2024 at 11:07 AM, Staff B, Director of Nursing said they send abuse allegations and weekly skin reports to Staff CCC.</p> <p>In an interview on 11/15/2024 at 11:07 AM, Staff A, Administrator stated they conducted the Quality Assurance Performance Improvement (QAPI) meetings monthly. The Administrator stated they do not any current Performance Improvement Projects (PIP) other than the dining room. The Administrator acknowledged past deficiencies had been reviewed during QAPI and the facility failed to document their review. Staff A said they follow their own past written plans of corrections to ensure on-going compliance until compliance is met. Staff A acknowledged there were 11 repeated citations from the prior re-certification survey eleven months ago.</p> <p>The Governing body failed to ensure repeat citations were corrected and sustained.</p> <p>Refer to F 835, Administration</p> <p>Reference: WAC 388-97-1620 (2)(c)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33954</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate clinical records for 4 of 4 residents (Residents 41,5,14 and 253) reviewed for care and services. The failure to ensure thorough and consistent documentation of care and services placed residents at risk for unmet needs and diminished quality of life.</p> <p>Findings included .</p> <p><RESIDENT 41></p> <p>Resident 41 readmitted to the facility on [DATE].</p> <p>Review of Resident 41's September 2024 Medication Administration Records showed an order dated 09/19/2024 for daily weights for three days, and a licensed nurse had signed off they had done the daily weights on 09/19/2024, 09/20/2024, and 09/21/2024. Comparison of this documentation with documented weights showed no documentation these weights had ever been done.</p> <p>In an interview on 11/13/2024 at 2:28 PM, Staff X, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), was unable to provide any information regarding the licensed nurse signing off they did daily weights on 09/19/2024, 09/20/2024 and 09/21/2024.</p> <p><RESIDENT 5></p> <p>Resident 5 admitted to the facility on [DATE]</p> <p>In an interview on 11/15/2024 at 9:42 AM, Resident 5 stated they had issues with getting their Glucerna (nutritional shakes) and their daughter had to bring in some protein drinks because they couldn't get them here.</p> <p>Review of Resident 5's breakfast tray card on 11/07/2024 showed the resident was to have Glucerna on their tray. In an observation on 11/07/2024 at 8:23 AM, there was no Glucerna on the resident's breakfast tray.</p> <p>In an interview on 11/07/2024 at 12:30 PM, Resident 5 stated last night was the first time they ever got their nutritional shake.</p> <p>Review of Resident 5's Medication Administration Records (MARS), from 11/01/2024 - 11/07/2024 showed an order dated 10/01/2024 for a Nutritional Shake: no sugar added with meals for supplement and it had a box for the nurse to document the percentage of the shake consumed, but that box always had an X instead of a percentage actually consumed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 11/07/2024 at 2:41 PM, Staff AA, Registered Nurse (RN), stated the kitchen usually supplied the nutritional shakes with breakfast and lunch, so they just signed off on the MARs. Staff AA stated they thought they saw the resident drinking a nutritional shake, but now they were not sure.</p> <p>In an interview on 11/07/2024 at 3:00 PM, Staff G, Dietary Manager, stated the kitchen supplied nutritional shakes with meals if they received the order and it said to go with meals. Staff G stated they did not know the resident had an order for a nutritional shake with meals because they never received a communication sheet from nursing staff. Staff G stated their system never showed an order for the nutritional shake.</p> <p>In an interview on 11/07/2024 at 3:02 PM, Staff AA was asked about their documentation of an X on the MARS for amount of nutritional shake consumed, they stated it shouldn't be an X, that it should have been a number percentage.</p> <p>47047</p> <p><RESIDENT 14></p> <p>Resident 14 admitted to the the facility on 08/08/2024 with diagnoses that included dependence on renal dialysis, fracture of the patella (kneecap), and heart disease.</p> <p>Review of Resident 14's progress notes at admission, dated 09/29/2024 at 5:12 PM, showed they readmitted to the facility with no skin issues.</p> <p>Review of Resident 14's skin assessment dated [DATE] showed they had an open area to right buttock.</p> <p>Review of Resident 14's progress notes showed multiple instances of inconsistent information with regard to their skin to include:</p> <ul style="list-style-type: none"> -A progress note dated 11/13/2024 at 3:19 PM showed the resident had a pressure ulcer. -A progress note dated 11/13/2024 at 3:17 PM showed the resident's skin check yielded no skin issues. -A progress note dated 11/12/2024 at 2:16 PM showed the resident had no skin issues. -A progress note dated 11/12/2024 by the wound care nurse showed the resident had pressure ulcers. <p>In an interview on 11/13/24 11:28 AM Staff B, Director of Nursing (DNS) stated they were not aware of the inconsistencies in Resident 14's electronic medical record. Staff B stated there are electronic form that are built into the medical record and nursing staff might be entering data too quickly without thinking.</p> <p><RESIDENT 253></p> <p>(continued on next page)</p>		

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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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 253 admitted to the facility on [DATE] with diagnoses that included acute cystitis (a bladder infection that begins suddenly and usually caused by bacteria).</p> <p>Review of Resident 253's care plan dated 10/31/2024 showed they were on contact precautions related to colonization of extended spectrum beta-lactamases (ESBL-enzymes that make bacteria resistant to many common antibiotics) in their urine and to strictly follow these precautions posted at their door entrance.</p> <p>Review of Resident 253's progress notes showed multiple instances of inconsistent information with regard to the precautions they were on to include:</p> <p>-A progress note dated 11/07/2024 at 7:35 PM showed Infection/Isolation: No active infections noted. Please use standard precautions.</p> <p>-A progress note dated 11/06/2024 at 3:51 PM showed Infection/Isolation: noted to have an active infection: Please use contact precautions</p> <p>-A progress note dated 11/05/2024 at 6:41 PM showed Infection/Isolation: No active infections noted. Please use standard precautions.</p> <p>-A progress note dated 11/04/2024 at 7:10 PM showed Infection/Isolation: No active infections noted. Please use standard precautions.</p> <p>In an interview on 11/15/2024 at 9:42 AM Staff JJJ, Medical Records, stated they had not been completing any audits for nursing records and their access to residents' Electronic Medical Record did not include some of the nursing components.</p> <p>Refer to WAC 388-97-1720(1)(a)(i)(ii)(iv)(4)(a)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725</p> <p>Based on observation, interview and record review, the facility failed to ensure staff were compliant with Infection Prevention and Control Guidelines and standards of practice for 5 of 5 residents (Resident 6, 14, 46, 54, and 81) observed during cares. Failure to wear personal protective equipment (PPE) prior to entering a precaution room(first floor) and failure to do hand hygiene between glove changes during wound care and peri care placed residents and staff at risk for potential infections.</p> <p>Findings included .</p> <p>Review of an undated facility policy titled Hand Hygiene, all staff are responsible for following hand hygiene procedures: when hands move from a contaminated-body site to clean body site during resident care and before and after wearing gloves.</p> <p>Review of facility policy titled, Infection Control Program, stated the facility has an infection control program and committee that addresses the surveillance, prevention and control of disease and infection that was consistent with the guidelines from the Center for Disease and Control (CDC) .the facility will develop and implement isolation precaution protocols for control of infectious or communicable disease in accordance with current CDC guidelines and recommendations.</p> <p><RESIDENT 46></p> <p>Resident 46 admitted to the facility on [DATE]. Diagnoses included a pressure ulcer (bed sore) on the right Lateral foot.</p> <p>In an observation on 11/07/2024 at 11:01 AM, Staff AA, Registered Nurse (RN), applied gloves prior to performing wound care. Staff AA removed the old dressing and cleansed the right lateral foot wound of Resident 46. With the same gloves, applied Medi honey (ointment used to treat wounds) using a cotton applicator and then covered the wound with a bandage. Staff AA did not change gloves or do hand hygiene after removal of the old dressing, prior to applying ointment and a new dressing to the wound.</p> <p><RESIDENT 6></p> <p>Resident 6 admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>In an observation on 11/13/2024 at 9:25 AM, Staff Y, Certified Nursing Assistant (CNA) and Staff GG, CNA both were wearing gloves. Staff Y provided peri care (washing the genitals and anal area) to Resident 6 while Staff GG was assisting in turning the resident. Once peri care was done, Staff Y removed their gloves and put on new gloves. Staff GG did not perform hand hygiene prior to putting on new gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation on 11/13/2024 at 9:36 AM, Staff Z, RN, applied gloves prior to wound care. Staff Z removed the dressing and packing strip from Resident 6's wound on their left leg. Staff Z cleansed the wound and then took their gloves off and put on new gloves. Staff Z did not perform hand hygiene prior to putting on new gloves.</p> <p>In an interview on 11/13/2024 at 9:47 AM, Staff Z stated the steps in doing a dressing change and as they recited the steps, they then realized that they forgot to wash hands prior to putting on clean gloves. They stated they missed that step when they were doing the wound care for Resident 6.</p> <p>In an interview on 11/13/2024 at 9:55 AM, Staff Y stated the steps on how to change resident's brief and while explaining the steps they realized that they forgot to clean their hands after they took their gloves off and prior to putting on clean gloves during care of Resident 6. They stated that they will not forget that step again the next time they provide peri care/brief change to residents.</p> <p>In an interview on 11/13/2024 at 10:11 AM, Staff X, Licensed Practical Nurse (LPN)/Unit Manager, stated that the infection prevention (IP) nurse does random audits and teaching to staff regarding hand hygiene.</p> <p>In an interview on 11/13/2024 at 2:15 PM, Staff V, LPN/IP nurse, stated that staff received infection prevention training upon hire and during all-staff meetings which were held every month. They stated that they do random audits and spot checks to staff while walking in the hallways. Staff V reported if they see incorrect practice, they educate the staff on the spot. Staff V reported agency staff received education on infection prevention from their company but if they happen to be working during staff meetings then they also attend the meeting and receive education from the facility.</p> <p>42927</p> <p><RESIDENT 14></p> <p>During an observation of wound care on 11/14/2024 at 3:31 PM, Staff T, RN, provided care to a wound on Resident 14's sacrum (lower part of spine, just above the buttocks). Staff T applied a gown and gloves before entering resident's room.</p> <p>Resident 14 was laying on their back in bed and had heel protector boots on and feet were on top of a pillow. Staff T removed the pillow from underneath Resident 14's feet and then removed the heel protectors and socks. Staff T applied skin prep (substance that leaves protective covering over skin) over both of residents feet and toes and then applied a vitamin enriched ointment. Staff T removed thier gloves but had another pair on underneath. Staff T reached into the box of gloves and pulled out more gloves and applied them over the top of the gloves they were wearing. Staff T did not do hand hygiene.</p> <p>Staff T assisted resident to roll onto their side in bed. Staff T pulled down on Resident 14's incontinent brief, exposing the buttocks. After touching the incontinent brief, Staff T used their contaminated gloved hands to open the bathroom door, went into the bathroom, and also opened the nightstand at the bedside and removed a container of disposable washcloths, placing them on the bed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Staff T removed the old dressing to Resident 14's sacrum. Staff T used disposable washcloths to clean the resident's buttocks. Staff T then picked up the garbage can with their gloved hands and placed it at the bedside and disposed of the disposable washcloths. Staff T then touched the package of disposable washcloths, removed more, and continued to clean the resident's buttocks. Staff T did not remove gloves or do hand hygiene.</p> <p>After cleansing Resident 14's buttocks, Staff T applied a protective ointment over the buttocks. Staff T then used his contaminated gloved finger to apply an ointment onto the resident's sacral wound. Staff T removed a pair of gloves, but still had a pair of gloves on underneath. Staff T did not do hand hygiene. Staff T applied a new dressing to Resident 14's wound, reapplied the incontinent brief and assisted resident with repositioning.</p> <p>Staff T removed all gloves but did not do hand hygiene. Staff T reached his contaminated hands into the box of gloves and applied new gloves. Staff T provided Resident 14 with their overbed table and call light, removed their gloves and washed their hands.</p> <p>During an interview on 11/14/2024 at 4:07 PM, Staff T stated that hand hygiene was to be performed before and after going into a resident room. When asked if there were any other times hand hygiene should be done, Staff T replied they do hand hygiene per common sense.</p> <p>Staff T was questioned about when hand hygiene should be done during wound care and they stated after cleansing the wound, after wound care, and at the end. When Staff T was questioned about double gloving and how was hand hygiene done if already wearing gloves, they stated they used two pairs of gloves for their protection because they were concerned about the integrity of the gloves, but they understood what surveyor was asking and that they were always learning.</p> <p>During an interview on 11/14/2024 at 5:36 PM, Staff V stated gloves and hand hygiene should be done when going in or out of a room, when handling garbage, prior to starting wound care, after removing the old dressing and when done with wound care. Staff V stated if staff touched the garbage can with their gloved hand, they should remove gloves and perform hand hygiene.</p> <p><TRANSMISSION BASED PRECAUTIONS></p> <p>During an observation on 11/14/2024 at 4:45 PM, Staff VV and Staff WW, CNAs, were observed pushing the hoier lift (machine that lifts resident from one surface to another) into a room with an Enhanced Barrier Precaution (EBP) Sign at the doorway. The staff were wearing gloves but were not wearing gowns. Resident 25 could be seen sitting in their wheelchair from the doorway.</p> <p>Review of the EBP sign at the doorway showed that staff should wear gown and gloves when doing high contact resident care activities such as transfers.</p> <p>After a few minutes, Staff WW exited the room with the hoier lift. Resident 25 was lying in bed and Staff VV was seen assisting them to reposition in bed and provided them them with the overbed table. Staff VV was observed wearing gloves but did not have a gown on.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/14/2024 at 4:54 PM, Staff VV was asked about the EBP sign at the doorway to Resident 25's room. Staff VV stated the sign was for Resident 25. Staff VV reported they had just transferred Resident 25 from the wheelchair to bed and they did not use gowns as they had not touched any wounds. Reviewed the EBP sign with Staff VV and they reported that the sign showed staff were to wear gowns with resident transfers.</p> <p>During an interview on 11/14/2024 at 5:36 PM, Staff stated staff were to use gown and gloves when providing resident transfers if resident required EBP.</p> <p>44110</p> <p>In an observation and interview on 11/06/2024 at 12:53 PM, Staff E, CNA was observed passing lunch trays in the hallway. room [ROOM NUMBER] had a contact isolation sign outside the door that advised all that enter to wear PPE including a gown and gloves prior to entering the room. Staff E was observed to approach the door to room [ROOM NUMBER] with a lunch tray, knocked on the door and entered the room. Staff E was not wearing any PPE when they entered the room. Staff E exited the room a couple minutes later. Staff E stated that the sign on the door stated that they only had to wear a gown and glove if they were helping the resident with their wound care.</p> <p>In an observation and interview on 11/06/2024 at 12:57, Staff QQ, Maintenance assistant, was observed to enter room [ROOM NUMBER]. Staff QQ did not wear any PPE when they entered the room. Staff QQ exited the room after a couple minutes. Staff QQ stated that the sign on the door stated they only had to wear PPE if they were going to have contact with the resident, and that they did not so they did not have to wear PPE.</p> <p>In an interview on 11/07/2024 at 1:28 PM, Staff V stated the expectation for residents on contact precautions was that staff were educated that before they enter the room their must be a barrier between them and the resident prior to entering the room. Staff V was informed of observations that were made during the survey process, Staff V stated that was not how they had educated the staff and was not what they expected.</p> <p><RESIDENT 253></p> <p>Resident 253 was admitted to the facility on [DATE] with admitting diagnosis to include Acute Cystitis (infection of the bladder) and on contact precaution due to Extended-spectrum beta-lactamase (ESBL- is an enzyme produced by some bacteria that makes them resistant to many antibiotics) in urine.</p> <p>In an observation and interview on 11/06/2024 at 9:35 AM, observed Staff D, RN, going into Resident 253's room with no PPE. Observed a sign on the outside of resident's room showing contact precaution. On the sign it stated to wash hands, don gown and gloves prior to entering room. After Staff D came out of the room, this writer asked why they did not wear PPE prior to entering the room, and what was the reason why resident was on contact precaution. They stated that the contact precaution sign was not there before, and that the infection was from a small scab in Resident 253's arm.</p> <p>In a record review on 11/06/2024 at 2:19 PM Resident 253's electronic chart showed that resident was on contact precaution due to ESBL in their urine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 11/07/2024 at 2:08 PM, with Staff L, RN/UM and Staff U, LPN/UM, Staff L stated that during morning meetings they were notified if new admits were on precautions, then they relayed it to the staff. The Infection Preventionist nurse also updates the staff on which residents were on precaution. Per Staff L, staff should follow what is posted on resident's door prior to entering residents' rooms and if they need clarifications to ask the managers prior to entering the room.</p> <p>In an interview on 11/13/2024 at 2:15 PM with Staff V stated that any precautions for residents were shown on resident's profile and Kardex (lists care needs for residents) in their electronic chart. They stated that it was an expectation for all staff to check resident's profile and/or Kardex prior to providing care to residents. I asked about what was observed by Staff D did and Staff V stated that Staff D talked to them about it and that they made a mistake of going in the room without PPE. Staff V stated they re- educated Staff D.</p> <p>Refer to WAC 388-97-1320 (1)(a)(c)</p> <p>33954</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37890</p> <p>Based on observation and interview, the facility failed to ensure call lights were consistently operational and functioning appropriately on 2 of 2 floors, including 6 residents (Residents 24, 50, 53, 78, 98, and 454) and potentially any of the residents who used a call light throughout the facility. The failed practice placed residents at risk of not having their needs met and psychosocial harm.</p> <p>Findings included .</p> <p><RESIDENT 50></p> <p>Review of the resident record showed the resident made an allegation on 10/27/2024 that a nursing assistant had not responded to their call light for over an hour. The nursing assistant denied that the call light was on and was alleged by the resident to be rude. Review of the facility incident investigation showed that the resident was not interviewed regarding the incident until 10/31/2024 and it was determined that the resident's call light was, in fact, not functioning. Review of the facility audit documentation following the incident showed that the facility was conducting audits of call light response, but there were no audits related to call light function.</p> <p>36787</p> <p><RESIDENT 98></p> <p>In an interview on 11/05/2024 at 10:27 AM, Resident 98 said their call light was not working and the Director of Nursing said that is why there was a delay in my care. The resident said their call light was broken from day of admit until last week. Resident 98 asked the maintenance man to check their call light and it wouldn't come on the first two times.</p> <p><RESIDENT 24></p> <p>In an interview on 11/04/2024 at 10:10 AM, Resident 24 reported their call light was not working and staff seemed unaware.</p> <p><RESIDENT 454></p> <p>In an interview on 11/04/2024 at 3:00 PM, Resident 454 said they had a few issues here when they first admitted . The resident sated they put their call light on and no one came, so they called their wife who drove down to the facility. They said staff were unaware the call light was not working and they did not know how the system worked but they kept pressing the button and no one came.</p> <p><RESIDENT 53></p> <p>In an observation on 11/05/2024 at 12:10 PM, Resident 53 was observed calling out they needed help. The resident's call light was activated, but the light did not come on outside their room door.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><RESIDENT 78></p> <p>In an interview on 11/05/2024 at 12:21 PM, Resident 78 said their call light works but sometimes it is not in reach. One night there was only one nurse and two aides and it was too hard for them to answer their light. Resident 78 said, last week, they heard their neighbor yelling out Help, Help all night. No one came to help them. They resident said they wanted to get out of bed and go help them. They timed the yelling and there was a straight hour and 20 minutes of someone yelling help, help.</p> <p><MAINTENANCE LOG (TELS) 09/01/2024 to 11/06/2024></p> <p>Review of the TELS log showed 18 call light issues logged work orders for maintenance;</p> <ul style="list-style-type: none"> * call light critical priority Resident Room-218 09/19/2024 * call light not working all the time medium priority 218 A 09/13/2024 * call light on and will not turn off medium priority 215 A 10/18/2024 * call light button missing from cord medium priority 226 A 10/15/2024 * call light not working medium priority 235 10/18/2024 * call light not working medium priority 230 10/19/2024 * call light not working medium priority 230-A 10/21/2024 * call light needs to be fixed medium priority 230-A 10/21/2024 * call light not working medium priority 128-A 10/23/2024 * call light not signaling and turning off automatically medium 128-A 10/23/2024 * bathroom light out medium priority 205 10/25/2024 * call light not working medium priority 131-A 10/29/2024 * call light not working medium priority 215-B 10/30/2024 * call light not working medium priority 134 10/30/2024 * Bathroom call light needs bulb. medium priority 203-B 10/31/2024 <p>BR call light hard to hear from</p> <ul style="list-style-type: none"> * light is not working medium priority 133 11/01/2024 * call light not working medium priority 102-B 11/05/2024 <p>(continued on next page)</p>

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>* call light outside room [ROOM NUMBER] needs replacement ASAP medium priority 232 11/05/2024</p> <p>In an interview on 11/14/2024 at 10:16 AM, Staff J, Director of Maintenance said they fix call lights whenever there is a problem. They said they just did an audit the other day and the call lights were all working 100%. Staff J said there were not new call lights available to staff because the issues were electrical maintenance needed to fix them. At 11/14/2024 at 10:28 AM, Staff J showed the call light was audit completed on 11/12/2024 and the audit was done monthly.</p> <p>33954</p> <p>Refer to WAC 388-97-2280</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>42927</p> <p>Based on interview and record review, the facility failed to ensure that facility staff were educated on all required topics that were identified on the facility assessment for 5 of 5 sampled staff (Staff DD, CC, EE, K, X) reviewed for education and training. Failure to ensure staff received required trainings placed residents at risk of not receiving competent care, unmet care needs, and a diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility assessment, review date 07/29/2024, showed the identified trainings to be provided to staff on hire and annually included:</p> <p>Culture change/person-centered care.</p> <p>Special needs of residents.</p> <p>Identification of resident changes in condition.</p> <p>QAPI (Quality Assurance Process Improvement)</p> <p>Emergency Preparedness.</p> <p>Dementia</p> <p><STAFF DD></p> <p>Review of Staff DD, Nursing Assistant Certified's (NAC) education log for the past year showed they had not received education on Culture change/person-centered care, Special needs of residents, Identification of resident changes in condition, QAPI, or Emergency preparedness.</p> <p><Staff CC></p> <p>Review of Staff CC, NAC's education log for the past year showed they had not received education on Culture change/person-centered care, Special needs of residents, Identification of resident changes in condition, or Emergency preparedness</p> <p><Staff EE></p> <p>Review of Staff EE NAC's orientation and education log since they were hired on 05/28/2024, showed they had not received education on Culture change/person-centered care, Special needs of residents, or Identification of resident changes in condition.</p> <p><Staff K></p> <p>(continued on next page)</p>		

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 11/15/2024
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)		
<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Staff K, Occupational Therapist's (OT) orientation and education log since they were hired on 06/11/2024, showed they had not received education on Culture change/person-centered care, Special needs of residents, Identification of resident changes in condition, or Dementia.</p> <p><Staff X></p> <p>Review of Staff X, Licensed Practical Nurse's education log for the past year showed they had not received education on Culture change/person-centered care, Special needs of residents, or Identification of resident changes in condition.</p> <p>During an interview on 11/14/2024 at 4:17 PM, Staff V, Registered Nurse/ Staff Development Coordinator, reported that they did not have records to show the sampled staff had received the missing education.</p> <p>During an interview on 11/14/2024 at 5:42 PM, Staff V stated they were not aware of what education was required per the facility assessment and they used the list of required educations that had been provided by the corporate office.</p> <p>During an interview on 11/15/2024 at 8:31 AM, Staff A, administrator, reported that they had just found out that the list of education per the facility assessment did not match the list of education on the in-service training policy. Staff A stated they would have to review both documents and make changes.</p> <p>Refer to WAC 388-97-1680 (2)(b)(ii)</p>		