STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505319	A. Building B. Wing	08/20/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate treatment, services and interventions to prevent an avoidable reduction of range of motion (ROM) for 1 of 4 sampled residents (Resident 4) reviewed for ROM. Resident 4 experienced harm as evidenced by moderate pain and decreased functional ability due to the formation of a hand contracture (joint becomes fixed in place) which was not present on admit. The failure to not provide appropriate services/interventions for ROM placed other residents at risk of developing new contractures and/or worsening of existing contractures. Findings included.Review of the undated facility policy titled, Resident Mobility and Range of Motion, documented: During resident's comprehensive assessment, the licensed nurse identifies the resident's current joints ROM, limitation of movement, contractures, pain or other complications could cause or contribute to impaired ROM, underlying contributing factors to ROM such as neurological conditions, e.g. cerebral-vascular accident. The care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline and/or improve ROM. Interventions include therapies, the provision of necessary equipment, and/or exercises. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. Resident 4 readmitted to the facility on [DATE] with diagnoses to include right hemiplegia and hemiparesis (one side weakness or inability to move) following stroke (damage to brain tissue). According to the quarterly Minimum Data Set (MDS-an assessment tool) assessment, dated 06/06/2025, the resident was cognitively intact, had no diagnosis of contracture or impaired joints, and received no restorative programs or therapies services. In an observation and interview on 08/13/2025 at 11:15 AM, Resident 4 stated they could not straighten out their fingers on their right hand. Resident 4 stated the facility had not provided any exercise or service for their hand and arm. Resident 4 attempted to open their right hand with their left but could not get the hand flat. The second, third and fourth fingers were bent in a fixed position. Resident 4 was observed to have their right elbow bent in a rigid position and held closely to their body and their right hand closed tightly in a fist. Resident 4 stated they could not use their right hand to press the buttons on the TV remote and the call light in the past but no longer was able to. Resident 4 stated it hurt when they tried to open their right hand or move their right elbow and shoulder. In an interview on 08/18/2025 at 9:25 AM, Resident 4 stated they had never had any restorative program or services on their right upper extremity (hand, wrist, elbow and shoulder). In an interview on 08/19/2025 at 9:17 AM, Resident 4 stated they asked to see therapist because they felt their “right hand and arm had more pain and was getting worse than half a year ago.” Resident 4 rated their right upper extremity pain was five on the scale of zero to ten. Review of Resident 4's physician note, dated 08/10/2025 at 1:49 PM, documented the resident had moderate risk for developing contractures if not receiving adequate therapy. Review of Resident 4's physician note, dated 08/13/2025 at 8:39 PM, documented the resident had moderate risk for developing contractures if not receiving adequate therapy. Review of Resident 4's care task list, print date (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0688 Level of Harm - Actual harm Residents Affected - Few	08/14/2025, showed Resident 4 had no restorative programs for upper body ROM or contracture. Review of Resident 4's care plan, print date 08/14/2025, showed no focus care area about limitation ROM or contracture management. Review of Resident 4's functional abilities and mobility care area assessment, dated 03/11/2025, showed no documentation about Resident 4's limitation of movement, pain or any other risks for complications and/or contributing factors to maintain or prevent a decrease in ROM and mobility. Review of Resident 4's Occupational Therapy (OT) evaluation, dated 03/02/2025, documented Resident 4 had no functional limitations present, no contracture and right upper extremity ROM and strength were WFL (within functional limits-indicate that range of motion is sufficient to perform the daily activities). Review of Resident 4's OT evaluation, dated 08/15/2025, documented Resident 4 was seen due to exacerbation of limited and painful movement and decrease in range of motion. The evaluation documented that the resident had right hand and elbow contractures, and right upper extremity ROM and strength were impaired. In an interview on 08/15/2025 at 12:51 PM, Staff GG, Nursing Assistant Certified (NAC), stated Resident 4 had contracture at right upper arm and could not open their right hand. Staff GG stated Resident 4 complained about pain in their right hand and arm during upper body dressing and repositioning. Staff GG stated the resident had no restorative programs for the contracture and ROM. In an interview on 08/18/2025 at 9:22 AM, Staff N, Licensed Practical Nurse (LPN), stated Resident 4 had a right upper extremity contracture but no restorative program for the right upper extremity. In an interview on 08/18/2025 at 9:30 AM. Staff II, Restorative aide/NAC, stated they did not have a restorative program for right upper arm for Resident 4, and they were not sure if the resident had contractures. In an interview on 08/18/2025 at 9:50 AM, Staff NN, Rehab Director, stated Resident 4 was never seen by therapy for their right upper extremity ROM or contracture prior to 08/15/2025. In an interview on 08/18/2025 at 9:55 AM, Staff RR, OT, stated they just started to see Resident 4 on 08/15/2025 for right hand pain, contracture, and decrease in ROM. Staff RR reviewed all the past therapy records and stated Resident 4 did not have documentation of having a right upper extremity contracture. In an interview on 08/18/2025 at 10:30 AM, Staff L, LPN/second floor Unit Manager, stated Resident 4 had the right upper extremity contracture. Staff L stated Resident 4 had no restorative program for the contracture. Staff L stated there was no care plan about the contracture and ROM. In an interview on 08/19/2025 at 2:53 PM, Staff B, Director of Nursing Services, stated they expected a resident with ROM limitation or contracture to be identified early, evaluated, treated and followed with restorative programs to maintain, improve or prevent further functional decline. Reference WAC 388-97-1060 (3) (d)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to designate a person to serve as the director of food and nutrition services with the proper qualifications. This failure placed all residents at risk of receiving dietary services from staff without the required competencies and skills to carry out food and nutrition services. Findings included .Review of the key personnel list, provided by the facility during the entrance conference meeting on 08/13/2025, showed Staff C was listed as the Dietary Services Manager. Staff C was stated to be on leave of absence. During an interview on 08/20/2025 at 09:15 AM, Staff A, Administrator, confirmed that the facility did not have a full-time registered dietician and that Staff C was designated as the facility Dietary Services Manager. Staff A acknowledged that Staff C had not yet completed the required certification for Dietary Services Manager. Reference WAC 388-97-1160 (3)(b)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure the designated Infection Preventionist (IP) met the qualifications for experience, education, and training or certification for the role to assume responsibility for the facility's Infection Prevention Control Program (IPCP). This failure placed residents, family members, and staff at risk for unmet infection control issues and lack of oversite of the facility staff's infection control practices. Findings included . Review of the facility policy titled, Infection Prevention and Control Committee, undated the Infection Preventionist will oversee the Infection Prevention and Control Program and report to the Infection Prevention and Control Committee and/or Quality Assurance and Performance Improvement (QAPI) committee. The Administrator will be responsible for oversight of the Infection Prevention and Control Program. In an interview on 08/13/2025 at 9:30 AM, during entrance conference with Staff A, Administrator, they stated the facilities designated IP was Staff D, Licensed Practical Nurse (LPN)/IP. Staff A stated they would provide Staff D's IP credentials. On 08/14/2025 at 11:06 AM, Staff A provided a certificate for Staff D, that showed they had completed Module 1 of the Center for Disease and Control (CDC) Train Infection Preventionist Program. In a review of CDC Train IP program, the qualifications for completion of their program consisted of the completion of 23 individual modules, a test and certification letter. In an interview on 08/19/2025 at 12:04 PM, with Staff B, Director of Nursing Services (DNS) and with Staff D on the phone, Staff D was asked to provide the remainder of the other 22 modules, and certificate to show they had completed the class. Staff D stated they had already completed them and would provide. Staff B stated they were sure they had completed the course and would get that information to us quickly. In an interview on 08/19/2025 at 1:29 PM, Staff A stated they were under the impression Staff D had completed their training as they had been cited for the same deficiency in March of 2025 and assumed they were done with the course. On 08/19/2025 at 2:11 PM, Staff B, emailed completed Modules for the CDC Train IP program that Staff D had completed. The last Module was dated with a completion date of 08/19/2025. There was no certificate of completion of the course provided. Refer to WAC 388-97-1320(1)(a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure the facility environment was maintained in a clean, comfortable, homelike and safe environment, for one of two floors (2nd floor), 1 of 1 resident reviewed for missing property (Resident 26), and 2 of 2 residents reviewed for noise complaints (Residents 4 and 102). Failure to ensure the facility maintained comfortable noise levels, ensured security of resident property, maintained flooring and controlled odors placed residents at risk for a decreased quality of life.Findings included .<ODOR> In an observation on 08/12/2025 at 9:23 AM, there was a strong unpleasant odor in the hall for room's 228 to 239. Observation of an area of one-foot by one foot round dark color-stained spot on the carpet in the middle of the hallway. In an observation on 08/13/2025 at 11:36 AM, smelled odor which resembled the odor of mildewed clothes after being left in the washer in the hall for room 's 228 to 239. In an observation on 08/14/2025 at 11:39 AM, smelled urine odor outside of room [ROOM NUMBER]. In an observation on 08/15/2025 at 8:57 AM, The second floor TV lounge room was observed to be missing a flooring transition piece in the doorway where the laminate flooring in the hall transitioned to the carpet in the lounge room. There were also missing flooring transition pieces at resident rooms [ROOM NUMBERS]. A flooring transition piece was present at room [ROOM NUMBER], however it was separated and lifting at the door hinge side. In observations of carpet on 08/15/2025 at 9:04 AM, the second-floor carpeted hallways had a strong musty, mildewy odor throughout. There was a large dark spill stain in the center of the lounge room carpet. There were large dark areas of staining outside resident rooms [ROOM NUMBERS]. Resident room [ROOM NUMBER] showed dark staining from the hallway into the room at and near the resident sink area. In an interview on 08/15/2025 at 9:07 AM and 08/18/2025 at 11:55 AM, Resident 102 stated there always a bad odor in the hall and at the nurses' station. In an interview on 08/19/2025 at 10:05AM, Resident 102 stated the smell from the hall made them nauseous. In an interview on 08/20/2025 at 9:42 AM, Staff MM, Maintenance Assistant, stated they were aware of the odor in the hall. Staff MM stated the odor from the carpet was from when the carpet was cleaned and did not dry fast enough. Staff MM stated the stained spots on the carpet were from the spilled coffee and food. In an interview on 08/20/2025 at 9:26 AM, Staff A, Administrator, stated they were aware of the odor from the carpet. Staff A stated they did not have access to carpet cleaning machine. Staff A stated there should not be any unpleasant odors coming from the carpet. <RESIDENT 26>Resident 26 was admitted to the facility on [DATE]. In an interview on 08/14/2025 at 9:33 AM, Resident 26 stated that they had some missing clothing and blankets, and the staff were aware of the missing items. Resident 26 stated they were unsure if there was a grievance for the missing items and planned to go to the laundry to look for the items. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the grievance log date August 2025 did not show a grievance for Resident 26's missing items. In an interview on 08/18/2025 at 1:24 PM, Resident 26 stated they had not received the missing items and Staff U, Environmental Service Manager, was aware and looking for them. In an interview on 08/19/2025 at 9:38 AM, Staff U stated if laundry was reported missing, they would be notified verbally and would keep an eye out for the missing items for about a week. If the missing items were not located, they would notify Staff A who would replace or re-imburse the resident for the missing items. Staff U stated they were aware of Resident 26's missing items and had not been able to find them. In an interview on 08/19/2025 at 2:20 PM, Staff A stated a grievance form would be filled out for reported missing items. A staff member would assist the resident to find the missing items and if the items were not found they would be replaced or re-imbursed. Staff A stated they were made aware of Resident 26's missing items on 08/19/2025 and it will be escalated for replacement or re-imbursement related to the length of time the items had been missing. Staff A acknowledged that there was not a grievance form completed for Resident 26's missing items. <NOISE>In an interview and observation on 08/12/2025 at 9:21 AM, Resident 102 (in room [ROOM NUMBER]) stated the television (TV) was too loud from the room across the hall (room [ROOM NUMBER]) and next door (room [ROOM NUMBER]). Resident 102 stated the facility needed to reinforce the quiet hour time. Resident 102 stated they heard the loud TV almost all the time, day and night, every day. Resident 102 stated they reported to the staff and administrator but there was no change. While speaking with Resident 102, observed the door of room [ROOM NUMBER] was open and TV could be heard clearly in Resident 102's room. In an interview on 08/15/2025 at 9:07 AM, Resident 102 stated the TV was really loud at 4:30 AM. Resident 102 stated the resident in room [ROOM NUMBER] was very mean and nurses did not want to ask them to turn down their TV or close their door because that resident could yell at the nurse. In an observation on 08/18/2025 at 9:17 AM, the TVs were heard from room [ROOM NUMBER] and room [ROOM NUMBER], they could be heard clearly when standing at the nurses' station, which was about 15 feet away from room [ROOM NUMBER]. In an interview on 08/15/2025 at 9:34 AM, Resident 4 (in room [ROOM NUMBER]) stated they could hear the TV from the next-door room [ROOM NUMBER]. In an interview on 08/15/2025 at 9:51 AM, Staff K, Nursing Assistant Certified (NAC), stated Resident 102 reported concerns of loud TVs. Staff K stated the resident in room [ROOM NUMBER] was hard of hearing and did not want to close their door. Staff K stated the resident would get mad and yell at the nurse who tried to close their door. Staff K stated the resident in room [ROOM NUMBER] was also hard of hearing. In an observation and interview on 08/19/2025 at 9:11 AM, Staff K stated the TV was heard pretty loud in the hallway and no wonder Resident 102 complained about it. In an interview on 08/20/2025 at 12:05 PM, Staff A, Administrator, stated they were aware of the grievance of loud TVs. Staff A stated they educated residents about quiet hours and would provide headphones for residents. Reference WAC 388-97-0880 (1)(2)(4)(b)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer bed holds and provide a written transfer notice upon transfer to the hospital and notify the Office of the State Long Term Care Ombudsman (LTCO) for 5 of 5 residents (10, 12, 82, 108 & 109) who were reviewed for hospitalization. Failure to offer bed holds placed residents and their representatives at risk of not being informed of their right to, and the cost of, holding the resident's bed while hospitalized . Failure to notify the LTCO and ensure written notification was provided to the resident/resident representative, in a language and manner they understood, placed residents at risk for lack of advocacy, not having an opportunity to make informed decisions about their transfer/discharge rights and possible unidentified or unmet care needs.Findings included .According to the facility's Bed Hold policy, undated, prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. 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, within 24 hours. The facility will document multiple attempts to reach the residents representative in cases where the facility was unable to notify the representative.According to the facility's Transfer and Discharge policy, dated 10/01/2021, the business office and or social services was responsible for informing the resident, or their representative of the facility readmission appeal rights, bed holding policies, etc.<RESIDENT 82> Review of Resident 82's progress note dated 08/14/2025 at 11:14 AM, documented they returned from the hospital at approximately 11:00 AM after being sent to the hospital the previous night due to coffee ground emesis (a serious symptom of blood in emesis). Review of the progress notes on 08/13/2025 showed there was no documentation the resident had been transferred to the hospital, there was no documentation about bed holds, transfer notice, physician and family notification nor report to the receiving hospital for continuity of care. In an interview on 08/19/2025 at 11:27 AM, Staff P, Licensed Practical Nurse/weekend manager confirmed Resident 82's medical record did not include that they were sent to the hospital on [DATE] nor the bed hold or transfer notice was provided to the resident. Staff P stated social services should document to the discharge. Staff P stated their expectation was that the nurse who sends the resident out to the hospital needed to document why they were sent out, family and physician notification in the progress notes and obtain the bed hold and provide the notice of discharge paperwork to the resident or their responsible party. Staff P stated the nurse should also call the emergency department with a report on the residents' condition. In an interview on 08/20/2025 at Staff A, Administrator stated they were aware there were transfer and bed hold issues. Staff A stated the policy of the bed holds were to be discussed with the residents on admit. If the resident went out to the hospital after hours, the bed hold and discharge paperwork should be sent with them. The nurses needed to make a progress note about why the resident was sent out, and also about the physician and family notification. Staff A stated the day after hospital admission, the business office should reach out to offer the bed hold if it had not been done yet. <RESIDENT 12> Resident 12 was discharged to the hospital on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a review of Resident 12's progress note, on 04/24/2024 at 3:34 PM, Staff BB, Registered Nurse (RN), documented that family member was made aware of the situation and agreed to send Resident 12 to the hospital. There was no documentation provided of the bed hold policy or notice of transfer and discharge to responsible party. <RESIDENT 10> Resident 10 was admitted on [DATE] and was transferred to the hospital on [DATE], and 04/28/2025. Record review of Resident 10's electronic chart did not show any documentation that the facility had notified the state ombudsman of resident's transfers to the hospital. <RESIDENT 108> Resident 108 was admitted to the facility on [DATE] and discharged home on [DATE]. Record review of Resident 108's electronic chart did not show any documentation that they have notified the state ombudsman of resident's discharge. In an interview on 08/18/2025 at 2:16 PM, Staff F, Medical Records, stated that they received copies of discharge packets from the Resident Care Manager (RCM), then they scanned and loaded it in resident's electronic chart. Staff F stated they don't have discharge packets for the residents that got transferred to the hospital. If there were missing documents, they email the RCM requesting them to provide copies of the missing documents. Staff F was not able to provide a copy of the discharge packet for Resident 108 and evidence that they notified the state ombudsman of the resident's discharge. In an interview on 08/18/2025 at 2:29 PM, Staff G, Social Service Department, stated that for residents that discharge from the facility, they would complete the Nursing Home Transfer and Discharge Notice form and fax it to the state ombudsman and then give a copy to Medical Records to be scanned into the resident's electronic chart. A request to Staff G was made to provide a copy of the evidence that the state ombudsman was notified of Resident 108's discharge and a copy of the notification to the state ombudsman of the discharges in the facility. Staff G could not provide any documentation. <RESIDENT 109> Resident 109 was admitted to the facility on [DATE] and left against medical advice on 07/26/2025. Record review of Resident 109's electronic chart did not show any documentation that they have notified the state ombudsman of resident's discharge. In an interview on 08/18/2025 at 2:03 PM, Staff H, Social Services Department, stated that if it's a facility-initiated discharge, they complete the Nursing Home Transfer and Discharge Notice form and fax it to the state's ombudsman and give a copy to Medical Records to be scanned into resident's electronic chart. Staff H stated they also notify the state ombudsman of any unplanned discharges such as hospitalization, leave against medical advice and resident-initiated discharges. A request to Staff G was made to provide a copy of the evidence that the state ombudsman notification on (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharges. No documentation provided. In an interview on 08/19/2025 at 11:49 PM, Staff A, Administrator stated that they found out that the facility was not regularly notifying the state ombudsman of the discharges monthly. Reference WAC 388-97-0120

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on 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, and included thorough summaries of the Care Area Assessments (CAA's), an assessment of a specific resident care or medical issue, to holistically analyze the plan of care for 4 of 6 residents (Residents 3, 4, 33 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 and placed all other residents at risk of their needs and preferences not met. Findings included .Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.19.1, dated October 2024, showed the RAI consisted of three basic components: the Minimum Data Set (MDS - and 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). The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified is the basis of the CAA process and can help provide additional information for the development of an individualized care plan. Review of the undated facility policy titled, Care Area Assessments, documented the CAA documentation should include causes and contributing factors for the triggered care areas, the nature of the condition, complications contributing to the are area, risk factors related to the condition, factors considered in developing the care plan, any need for further evaluation by other healthcare provider.<RESIDENT 33> Resident 33 admitted on [DATE] with diagnoses to include chronic pain syndrome. Review of the admission MDS dated [DATE] included a triggered CAA for pain. Review of the MDS assessment, dated 06/06/2025 showed the CAAs did not contain comprehensive summaries or analysis that included the current goals, preferences, strengths or needs for the specific care areas, which were necessary to determine if updates to the resident's care plan (CP) was needed. <RESIDENT 98> Resident 98 admitted on [DATE] with diagnoses to include spinal stenosis (narrowing of bones in spine), left and right foot drop (inability to lift the foot) and lymphedema (swelling due to excess fluid in body tissue). Review of the admission MDS assessment, dated 08/01/2025, included triggered CAA for pain. Review of the MDS assessment, dated 08/01/2025, showed the pain CAA was blank with the exception of one line that showed Resident 98 complained of pain during interview. In an interview on 08/20/2025 at 9:38 AM, Staff R, Registered Nurse (RN) MDS Nurse stated the CAA's should address anything that is triggered. Staff R stated they did not complete the MDS assessments for Resident 33 and 98. Staff R confirmed the pain CAA's did not address all issues (continued on next page)

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	505319	A. Building B. Wing	08/20/2025

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

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	which should include what pain medications they are on, if the resident was experiencing any adverse side effects. <RESIDENT 4> Resident 4 readmitted to the facility on [DATE] with diagnoses to include right hemiplegia and hemiparesis (one side weakness or inability to move) following cerebrovascular disease (stroke-serious condition where blood flow to the brain is interrupted causing brain cell to die). Review of Resident 4's Annual MDS, dated [DATE], showed the Functional Abilities (Self-care and Mobility) CAA was blank. Further reviews of all other triggered CAAs including communication, urinary incontinence and indwelling catheter, nutritional status, dehydration and fluid maintenance, dental care, pressure ulcer/injury did not contain any comprehensive assessments. In an interview and record review on 08/18/2025 at 1:58 PM, Staff R, RN/MDS Nurse, stated they were supposed to summarize actual or potential problems and analyze the findings of Resident 4's functional ability and ROM, triggered contributing and risk factors and referred to therapies if needed. Staff R stated they were not sure why there was no assessment at all for CAAs. <RESIDENT 3> Resident 3 admitted to the facility on [DATE]. Review of Resident 3's admission nursing collection tool on 03/17/2025 at 5:29 PM, documented the resident had broken or loose teeth. Review of Resident 3's MDS summary assessment on 03/18/2025, documented Resident 3 had obvious or like cavity or broken natural teeth, inflamed or bleeding gums or loose natural teeth, and mouth or facial pain. Review of Resident 3's admission MDS, dated [DATE], showed Dental Care CAA was blank. Further reviews of all other triggered CAAs including cognitive loss/dementia, visual function, functional ability, urinary incontinence, psychosocial well-being, activities, falls, nutritional status, pressure ulcer, psychotropic drug use and pain did not contain any comprehensive assessments. In an interview and observation on 08/18/2025 at 11:43 AM, Resident 3 stated they had broken, missing and loose teeth since admission and they had not seen a dentist. Resident 3 stated they had discomfort to their front teeth. Resident 3 was observed to have broken upper front teeth, missing upper and lower back teeth, and loose lower front teeth. In an interview and record review on 08/19/2025 at 1:25 PM, Staff R stated the MDS assessment coded Resident 3 had broken teeth, gum inflammation and pain which triggered dental care CAA. Staff R stated the CAAs were supposed to include analysis of findings, the resident's dental assessment, dental and oral care and assistant level and necessary referral if needed. Staff R stated there was nothing documented under dental CAA which was not supposed to and was not sure why all CAAs had no assessments. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/19/2025 at 2:53 PM, Staff B, Director of Nursing Services, stated they expected the MDS assessment and CAA was complete and accurate. This was a repeat deficiency from SOD dated 11/15/2024. WAC reference: 388-97-1000(1)(b)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR - a federally required screening of all individuals who has both an Intellectual Disability (ID) or Related Condition (RC) and a serious mental illness (SMI) prior to admission to a Medicaid-certified nursing facility or a significant change of condition) form was completed prior to admission and according to the guidelines specified for 5 of 5 sampled residents (1,11, 22, 81, and 98) reviewed for PASRR. Incomplete or inaccurate PASRR's placed residents at risk for inappropriate placement and/or lack of access to specialized services for residents with identified mental health diagnoses or disability. Findings included . Review of a facility policy titled Long-Term Services and Supports (LTSS), Preadmission Screening and Resident Review (PASRR) Policy, undated, showed the organization observed preadmission screening requirements to ensure that :Medicaid-eligible individuals meet required level of care criteria for Long-Term Services and SupportsPeople with known or suspected mental illness, intellectual disabilities, and/or related conditions are not inappropriately institutionalized or marginalized; to make sure that every individual receives the services and supports that will optimize their success in the least restrictive setting. Resident with these specific types of disabilities are admitted or allowed to remain in the facility, only if the facility can provide them with the services they need. <RESIDENT 22>Resident 22 admitted to the facility on [DATE] with diagnoses to include generalized anxiety disorder and post-traumatic stress disorder (PTSD) and readmitted to the facility on [DATE] with additional diagnosis of major depressive disorder. A Level 1 PASRR dated 06/20/2025 was completed prior to admission and did not show SMI. Review of the hospital Discharge summary dated [DATE] showed chronic medical problems of depression, anxiety, and PTSD. Review of Resident 22's medical record showed a progress note dated 07/07/2025, at 1:49 PM, titled “Social Services”, Note Text “PASRR is being sent for invalidation 7/7/25.” There was no other documentation for PASRR in the progress notes. In an interview on 08/19/2025 at 2:20 PM Staff A, Administrator, stated Staff H, Social Services, was responsible for the resident PASRRs. Staff A stated the facility identified that the PASRR coordinator had been emailing the wrong person at the facility and has been corrected. Staff A stated PASRRs are reviewed by admissions prior to resident admission to the facility. If a PASRR is identified as incorrect after a resident had admitted to the facility Staff H would communicate with the PASRR coordinator which takes a long time. In an interview and record review on 08/19/2025 at 2:40 PM, Staff H stated they were responsible for reviewing and following up with resident PASRR's when a resident admits to the facility. Staff H stated if the PASRR received at the time of admission was incorrect they would complete a new PASRR and send it to the PASRR coordinator who would either validate it as a Level I or invalidate it. If the PASRR was invalidated, the PASRR coordinator would interview the resident and make recommendations that would be provided to the facility. Staff H reviewed the resident's medical record and acknowledged Resident 22's diagnoses of depression, anxiety and PTSD and stated Resident 22's PASRR was incorrect. Staff H stated Resident 22's admission PASRR was not corrected but was sent to the PASRR coordinator via email to validate or invalidate the PASSR the first of August 2025. Staff H stated they had not received any further information and was unable to provide any documentation of communication with the PASRR (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coordinator. Staff H acknowledged a progress note written on 07/07/2025 that Resident 22's PASRR was sent for invalidation and stated they had received nothing further. No further information was provided. <RESIDENT 1>Resident 1 was admitted to the facility on [DATE], with diagnoses that included depression. The admission MDS dated [DATE] showed the resident had moderate depression. Review of Resident 1's physician orders showed the resident was prescribed duloxetine (antidepressant) which started on 07/29/2025. Review of Resident 1's admission PASRR Level 1 dated 07/02/2025 stated the resident had no mental health concerns and no Level 2 evaluation was completed. <RESIDENT 11>Resident 11 was admitted to the facility on [DATE] with no diagnosis of mental health. Review of Resident 11's medical records showed on 08/11/2024 the resident was given a new diagnosis that included anxiety. Resident 11 was then started on an anti-anxiety medication at that time. Review of Resident 11's medical record on 08/15/2025 showed no updates to the Level 1 PASRR were completed after the resident had a new mental health diagnosis and treatment ordered in August of 2024. Review of Resident 11's medical record on 08/16/2025 showed that the resident had a significant change in April of 2025 and was placed on Hospice services and was prescribed two antipsychotic medications. No updates were made to the Level 1 PASRR. In an interview on 08/18/2025 at 2:24 PM, Staff H, Social Services stated they review the PASRRs after the admission to ensure they are accurate. Staff H stated if they are not, they will complete a new one and send them to the PASRR coordinator for validation or invalidation. Staff H stated the expectation was if a resident had a change in condition or a new mental health diagnosis, they are to resubmit a new updated PASRR. Staff H was asked if they reviewed Resident 1's PASRR after their admission for accuracy, Staff H stated they had reviewed it and found it to be inaccurate. Staff H stated they thought they had resubmitted a new PASRR for Resident 1. Staff H was asked where that would be documented, and Staff H was unable to provide any documentation that had been completed. Staff H was asked if Resident 11 was reviewed after their change in mental health in August of 2024 or with the significant change in April of 2025. Staff H stated they were not aware of any updates made to Resident 11's PASRR. <RESIDENT 81>Resident 81 admitted to the facility on [DATE] with diagnoses to include generalized anxiety disorder and PTSD. A Level 1 PASRR dated 07/23/2025 was completed prior to admission showed PTSD was marked and anxiety had not been selected. Review of the skilled nursing facility transfer orders from the hospital on [DATE] showed Resident 81's discharge diagnoses included anxiety and PTSD. Review of the physician orders showed Resident 81 was taking Seroquel, an anti-psychotic medication twice a day for behaviors and insomnia. Review of the comprehensive Minimum Data Set (MDS, an assessment tool) accepted on 08/03/2025, showed the resident had a diagnosis of anxiety and PTSD. Review of the clinical record on 08/15/2025 documentation showed that a new PASRR referral had not been submitted to the PASRR evaluator so they could appropriately assess the resident who was taking Seroquel and also had a current diagnosis of anxiety. <RESIDENT 98>Resident 98 admitted to the facility on [DATE] with diagnoses to include depression and sleep disorder. The resident was ordered to take a medication for the diagnosis of anxiety. A Level 1 PASRR was completed prior to admission showed mood disorder and anxiety had not been selected. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the psychotropic informed consent on 07/25/2025, Resident 98 consented to taking Hydroxyzine, medication with sedative effects for anxiety and Trazadone, an anti-depressant for sleep/wake disorder and mental, behavioral or psychosocial symptoms that were persistent and clinically significant. Review of the comprehensive MDS accepted on 08/05/2025, showed the resident had a diagnosis of depression. Review of the clinical record showed that a new PASRR referral had not been submitted so the PASRR evaluator could appropriately assess the resident who was taking medications for anxiety and depression. In an interview on 08/20/2025 at 9:52 AM, Staff A, Administrator, stated they were aware of PASRR issues, and they had been addressing them by reviewing new admission PASRR's for accuracy. This is a repeat deficiency from SOD dated 11/15/2024. Reference WAC 388-97-1915 (1)(2)(a-c)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop comprehensive care plans to reflect the resident's current medical status and/or to include all provided nursing services for 1 of 1 resident (Resident 101) for dialysis management, 1 of 4 resident (Resident 26) for pain management, 1 of 3 resident (Resident 4) for mobility, 2 of 6 resident (Residents 1 and 22) for mood and behaviors, and 3 of 6 residents (Residents 3, 22, and 81) for nutrition. This failure placed residents at risk of not receiving needed care, a decline in their condition, and diminished quality of life. Findings included . Review of the facility policy titled, Care Planning - Interdisciplinary Team, undated, facility was responsible for the development of an individualized comprehensive care plan for each resident. The comprehensive care plan within seven days of completion of the resident assessment. Review of the undated facility policy titled, Resident Mobility and Range of Motion, documented the care plan will include specific interventions, exercises, and therapies to maintain, prevent avoidable decline and/or improve ROM. Interventions include therapies, the provision of necessary equipment, and/or exercises. The care plan will include the type, frequency, and duration of interventions, as well as measurable goals and objectives. Review of the undated facility policy titled, Nutrition Assessment, documented individualized care plans will address the identified causes or risks of impaired nutrition, residents' personal preferences, goals and benchmarks for improvement and time frames and parameters for monitoring and reassessment. <RESIDENT 22> Resident 22 admitted to the facility on [DATE] with diagnoses of generalized anxiety disorder and post-traumatic stress disorder (PTSD) and readmitted to the facility on [DATE] with additional diagnosis of major depressive disorder. Review of Resident 22's care plan showed a focus dated 07/07/2025 for PASRR. The care plan did not include person centered goals or interventions for their diagnoses of major depressive disorder, anxiety, or PTSD. Review of Resident 22's nutritional/hydrational status care plan dated 06/25/2025 did not show person centered goals or interventions to monitor or prevent weight loss. The care plan showed two interventions that encouraged the resident to eat and for a RD (registered dietician) consult as needed. In an interview and record review on 08/19/2025 at 2:40 PM Staff H, Social Services stated that the care plan was an interdisciplinary effort, and PASRR Level II evaluation recommendations should be care planned. Staff H acknowledged the PASRR care plan was incomplete and not person centered for Resident 22. In an interview and record review on 08/19/2025 at 10:24 AM, Staff Q, Licensed Practical Nurse (LPN)/Nurse Manager, stated care planning was an interdisciplinary process, and they were responsible for evaluating and updating the care plan. Staff Q stated Resident 22's nutrition care plan was not resident centered. <RESIDENT 26> (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 26 admitted to the facility on [DATE] with diagnoses to include arthritis and pain in right hip. Review of the Resident 26's opioids care plan was not personalized, had generic interventions and did not show non-pharmacological interventions. In an interview on 08/19/2025 at 3:50 PM, Staff B, Director of Nursing Services (DNS) stated non-pharmacological interventions should be on the care plan. <RESIDENT 101> Resident 101 was admitted in February of 2023 with a diagnosis of End Stage Renal Disease requiring hemodialysis (process of removing toxins from the blood). Review of Resident 101's medical record documented that the resident had an indwelling tunneled jugular (IJ) catheter (directly inserted into large vein creating a permanent access for dialysis) in the right upper chest as their dialysis access. The IJ catheter was utilized and accessed only by the kidney center. The facility was to monitor only. In an interview and observation on 08/14/2025 at 09:00 AM, Resident 101 stated they go to dialysis three days a week. Resident 101 pulled down the top right corner of their shirt to show their tunneled dialysis catheter with a clear dressing over the top. Resident 101 stated the staff here aren't doing anything with it, they take care of it at the kidney center. Review of Resident 101's care plan dated 02/03/2025 showed generic interventions in place for dialysis which had not been personalized to state the resident's dialysis access that was an IJ catheter. The care plan included interventions and monitoring for an AV fistula (a different type of dialysis access; a surgically created connection between an artery and a vein) which included interventions to monitor for bruit and thrill (turbulent sounds and palpable vibrations specific to AV fistulas which indicate they are functioning properly). In an interview on 08/19/2025 at 1:49 PM, Staff L, LPN/Unit Manager, stated they had not noted that the care plan for Resident 101 had not been completed accurately with respect to their dialysis access and monitoring. The care plans were reviewed quarterly and with changes. <RESIDENT 4> Resident 4 readmitted to the facility on [DATE] with diagnoses to include right hemiplegia and hemiparesis (one side weakness or inability to move) following cerebrovascular disease (stroke-serious medication condition where blood flow to the brain is interrupted causing brain cell to die). In an observation and interview on 08/13/2025 at 11:15 AM, Resident 4 stated they could not straighten out their fingers on their right hand. Resident 4 stated the facility had not provided any exercise or service for their hand and arm. Resident 4 attempted to open their right hand with their left but could not get the hand flat. The second, third and fourth fingers were bent in a fixed position. Resident 4 was observed to have their right elbow bent in a rigid position and held closely to their body and their right hand was closed tightly in a fist. Resident 4 stated they could not use their right hand to press the buttons on the TV remote and the call light. Resident 4 stated it hurt when they tried to open their right hand or move their right elbow and shoulder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 4's comprehensive care plan, print date 08/14/2025, showed there was no focus care area about limitation Range of Motion (ROM) or contracture (permanent shortening of the muscles and tendons) management. There were no interventions to maintain or prevent avoidable ROM decline. In an interview on 08/18/2025 at 10:30 AM, Staff L, LPN/Second Floor Unit Manager, stated Resident 4 had contractures and the comprehensive care plan was supposed to address the ROM and contracture management including specific goals and interventions. Staff L was not sure why the care plan was not there. <RESIDENT 3> Resident 3 admitted to the facility on [DATE]. Review of Resident 3's weight record since admission, showed they had 16.77% weight loss from 03/25/2025 to 08/01/2025. There was no weight record in between. Review of Resident 3's comprehensive care plan, print date 08/15/2025 at 1:39 PM, showed there was no care area that addressed the nutritional status. There were no interventions regarding weight monitoring, oral intake monitoring, food preferences, maintaining nutrition and hydration or to prevent malnutrition. In an interview on 08/18/2025 at 2:21 PM, Staff L stated the comprehensive care plan was supposed to include the focus care area of nutritional and hydrational status and they did not know why the care plan did not have it. In an interview on 08/19/2025 at 2:53 PM, Staff B, DNS, stated they expected the care plan to be comprehensive, with ROM, contracture management, and nutritional status be included. <RESIDENT 1> Resident 1 was admitted to the facility on [DATE], with diagnoses that included depression. The admission MDS dated [DATE] showed the resident had moderate depression. Review of Resident 1's physician orders showed an order for duloxetine (anti-depressant medication) for depression. Review of Resident 1's comprehensive care plan, print date 08/13/2025, did not include any person-centered goals, or interventions for the diagnosis and treatment of their depression. In an interview on 08/18/2025 at 12:51 PM, Staff K, Nursing Assistant Certified (NAC) stated they rely on the Kardex (short, condensed version of the care plan) for up-to-date information on what care and services each resident requires. In an interview on 08/18/2025 at 1:38 PM, Staff N, LPN stated the unit nurse managers are responsible for creating and updating the care plans. In an interview on 08/19/2025 at 8:26 AM, Staff L, LPN/Unit Manager stated the comprehensive care plan was an interdisciplinary team effort and stated the specific behaviors and interventions for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	behavior monitoring should be on the physician orders as well as the care plan. Staff L confirmed the care plan for Resident 1 did not have any person-centered area, goals or interventions for their depression. In an interview on 08/19/2025 at 1:56 PM, Staff B, DNS stated their expectation was that the care plan was comprehensive and completed in the appropriate time frame. Staff B confirmed that each comprehensive care plan should be personalized to each resident. Staff B confirmed Resident 1 did not have person centered goals and interventions for their depression. <RESIDENT 81> Resident 81 admitted on [DATE] with diagnoses to include severe protein-calorie malnutrition, gastrointestinal reflux syndrome (acid reflux), electrolyte disturbances and chronic lung disease. Review of the admission MDS dated [DATE] showed the resident was 64 inches tall and weighed 62 pounds and had no teeth. Review of the nutrition Care Area assessment dated [DATE] showed the resident had a body mass index (BMI) of 10.6 which indicated significantly underweight status, a serious health issues with compromised immune system and increased risk of disease and fatigue. Review of the nutritional care plan 08/14/2025 showed the resident was at nutritional risk due to advanced age, goals of care, underweight BMI and past medical history. The care plan included only one intervention for RD consult. The care plan did not include the residents' goals, food preferences, or other interventions. In a joint interview on 08/20/2025 at 9:52 AM, Staff A, Administrator, said they were not aware of any care plan issues and there was no performance plan in place for care planning. Staff B, DNS stated they are going through new admission and quarterly care plans. Staff B stated they were aware the MDS nurses were using pre-populated interventions, and their expectation was for care plans to be individualized to the residents. This is a repeat deficiency from 11/15/2024 Reference 388-97-1020 (1)(2)(a)(b)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise quarterly care plans accurately to reflect the resident's needs for 2 of 7 residents (Residents 12 and 72), reviewed for care planning. This failure placed the residents at risk for unidentified and unmet care needs, and a diminished quality of life. Findings included .Review of the facility's undated policy titled, Care Planning - Comprehensive Person-Centered, documents that the care planning/interdisciplinary team is responsible for the review and updating of care plans when goals, needs, and preferences change, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly and after each MDS assessment.<RESIDENT 12> Resident 12 was readmitted from the hospital on [DATE] with diagnoses to include right leg pain. In an observation on 08/13/2025, at 1:11 PM, a green boot for relieving pressure was observed on a chair in Resident 12's room. In an observation on 08/15/2025, at 10:21 AM, and 2:23 PM the green pressure relieving boot was observed in their room on their chair. Review of the Resident 12's Minimum Data Set (MDS, an assessment tool), dated 07/01/2025, documented an unstageable pressure ulcer (wound with necrotic/dead tissue) to right heel. Review of Resident 12's care plan dated 06/12/2025 showed documentation of right heel pressure ulcer did not include pressure relieving devices ordered for resident. Review of Resident 12's physician orders, beginning 06/26/2025 directed staff to apply a right heel floater. In an interview on 08/19/2025, at 10:12 AM, Staff X, Licensed Practical Nurse (LPN)/Admissions Nurse and Collateral Contact (CC) 3, Physician's Assistant (PAC), with contracted wound provider stated that Resident 12 should have had the pressure relieving green boot on their right foot for pressure ulcer healing. In an interview on 08/19/2025, at 10:58 AM, Staff AA, Nursing Assistant Certified (NAC), stated Resident 12 was to wear their boot on the right foot when in bed. Staff AA stated it was not documented in the Kardex. In a joint interview on 08/19/2025, at 1:08 PM, Staff L, LPN/Unit Manager, and Staff H, Social Services (SS), confirmed that Resident 12's pressure relieving boot was not in the care plan or Kardex but should have been. <RESIDENT 72> In an interview and observation on 08/13/2025, at 10:54 AM, Resident 72 stated that both feet have redness. The resident was observed to be wearing non-skid socks and a heel protector boot on their left foot. (continued on next page)

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	505319	A. Building B. Wing	08/20/2025

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 08/19/2025, at 9:58 AM, Resident 72 was observed in bed with a heel protector boot on their right foot. In a review of Resident 72's care plan on 08/15/2025, it was documented that there was skin impairment to both left and right foot. The heel protector boot was not documented on the care plan. In a review of Resident 72's physician orders on 08/15/2025, directed staff to apply skin prep to both heels and toes every day and evening shift for redness beginning 08/11/2025. In an interview on 08/19/2025 at 11:19 AM, Staff CC, NAC, stated that Resident 72 wore the protective boot for comfort and that sometimes they switched which foot they would like it on. In an interview and observation on 08/19/2025 at 1:08 PM, Staff L, LPN/Unit Manager (UM) confirmed that Resident 72's heel protector boot was not documented in the care plan or Kardex. Observation of Resident 72's right foot with Staff L confirmed there was a scab on their right heel and Staff L stated that was why they did the skin prep order. This is a repeat deficiency from SOD dated 11/15/2025 Reference: (WAC) 388-97-1020 (2)(a)(5)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide the assistance with activities of daily living (ADL's) for 5 of 5 sampled dependent residents (Residents 1, 33, 81, 98, and 99) reviewed for ADLs. The facility failed to provide showers/bathing assistance to residents (Residents 1, 33, 81, and 98), who were dependent on staff for bathing, and failed to ensure Resident 99, who was dependent for splint placement was provided the necessary assistance. These failures placed the residents at risk for embarrassment, poor hygiene, unmet care needs and a diminished quality of life. Findings included . Review of the facility policy titled, Shower/Tub Bath, undated, documented general guidelines that qualified nursing staff would provide two full baths or showers per week, and at a minimum offer a bed bath as needed. Resident preferences would be considered and honored. Review of the facility policy titled, Resident Mobility and Range of Motion, undated, documented all residents will receive the necessary treatment and services to increase and/or prevent a decline in their range of motion. <RESIDENT 81> Resident 81 admitted on [DATE] with diagnoses to include chronic lung disease, severe protein calorie malnutrition, anxiety and pain Review of the admission Minimum Data Set (MDS, an assessment tool) dated 07/29/2025, showed Resident 81 did not reject care. In an observation on 8/13/2025 at 1:57 PM, Resident 81 was in bed with long messy hair. In an observation on 08/14/2025 at 2:25 PM Resident 81 was in bed. Their hair was messy and greasy. In an interview and observation on 08/18/2025 at 9:21 AM, Resident 81 was sitting up in bed. Their hair remained greasy. The resident stated they wondered if the facility had a bathtub, as they had only had “spit baths” here and they would really like a bath as they were not a “shower person.” In an interview and observation on 08/19/2025 at 12:48 PM, Resident 81 was in bed eating lunch. Their long, greasy hair was uncombed with a ball of tangles below their ponytail. The resident stated they thought the facility was ordering aloe vera wipes for them for bed baths. The residents stated they wanted their hair washed and they did not know how or when staff would do that. Resident 81 asked if someone had complained about their lack of bathing. In an interview on 08/19/2025 at 2:37 PM, Staff Q, Licensed Practical Nurse (LPN)/ Unit Manager was informed that Resident 81 stated they had not had their hair shampooed since they admitted last month and their hair was tangled. Staff Q stated that staff could wash the resident hair while they were in bed and there was no excuse not to. In an interview and observation on 08/20/2025 at 9:00 AM, Resident 81 was sitting up in bed eating breakfast. Their hair was down and there was two 5 inch by 5-inch tangled balls of matted hair. The resident stated they finally had a shower last night and two aides tried to use detangler and get the balls out but they couldn't. There was a bottle of hair detangler at the bedside. Review of the first-floor shower schedule showed Resident 81 was assigned to receive showers on (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tuesday and Friday evenings. Review of the 30-day shower documentation showed Resident 81 had no showers in July and one bed bath on 08/01/2025 as of 08/19/2025 at 1:21 PM. <RESIDENT 33> Resident 33 admitted [DATE] with open wounds to both legs. Review of the admission MDS dated [DATE], showed the resident did not reject care. Review of the first-floor shower schedule document showed the resident's room was not assigned to a bathing schedule. In an interview and observation on 08/14/2025 at 8:54 AM, Resident 33 was in bed. The room had a foul odor. Review of the plan of care showed Resident 33 was scheduled to have a shower every Monday and Thursday on day shift. Review of Resident 33's documentation report for July 3rd (Thursday) – August 20th (Wednesday) had no showers documented on 07/03/2025, 08/11/2025 and 08/18/2025. In an interview on 08/19/2025 at 10:47 AM, Staff P LPN/Weekend Manager stated they audited shower documentation in the electronic medical record (EMR). Staff P stated there was a report that showed up on the computer when there has been no shower for 3 or 5 days. Staff P stated something must be wrong with the charting. Staff P stated when they see missed showers, then they update the documentation after interviewing the residents. Staff P stated Resident 33 gets at least one shower every week or twice a week, and there was a discrepancy in the documentation. Staff P could provide no further documentation. In an interview on 08/19/2025 at 2:23 PM, Staff S, Nurse's Aide Certified (NAC) stated they were directed to follow the shower schedule for that day. Staff S stated Resident 33 did not refuse care and they had not given them a bath before. Staff S stated there was no designated shower aide and so they had to give two to three showers a shift in addition to their work, and they sometimes could not get three done. <RESIDENT 98> Resident 98 admitted on [DATE] with diagnoses to include spinal stenosis (narrowing of bones in spine), left and right foot drop (inability to lift the foot) and lymphedema (swelling due to excess fluid in body tissue). Review of the admission MDS assessment, dated 08/01/2025, showed Resident 98 did not reject care. Review of the plan of care on 08/15/2025 showed Resident 98 was scheduled to have a shower every Monday and Thursday on evening shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 98's documentation report for July 24th (Thursday) – August 20th (Wednesday) showed the resident received bathing on 07/31/2025 and 08/07/2025. In an observation on 08/13/2025 at 12:15 PM, Resident 98 was in bed and their hair was greasy. In an observation on 08/14/2025 at 1:15 PM Resident 98 was asleep in bed, their hair remained greasy. In an observation and interview on 08/20/2025 at 9:01 AM, Resident 98 was sitting on the side of their bed. The resident looked at their calendar and stated they were supposed to get baths on Mondays and Thursdays but did not get one on August 4th, 7th, 11th or 14th. They stated their last bath was 08/18/2025. They stated they asked every day for showers and had reported their missed bathing concern to Staff B, Director of Nursing Services (DNS). Resident 98 stated Staff B told them that it was not OK, and they would have their best staff give them a bath. The resident stated they just get baths because the aides told them they were too big to go into the shower room. The resident wiped a tear away and stated they had only had her their hair shampooed once since admit and that was not enough. <RESIDENT 82> Resident 82 admitted on [DATE] with diagnoses to include cancer. Review of the admission MDS dated [DATE], showed Resident 82 did not reject care. Review of the shower documentation report for July and August 2025 showed no showers or bathing occurred. In an interview on 08/19/2025 at 2:37 PM, Staff Q LPN/ Unit Manager stated showers were to be completed by the NACs on the floor. Staff Q stated they looked for alerts on the EMR dashboard if the showers were missed then they would follow up. Staff Q said they were aware of some concerns with showers. Staff Q stated the expectation was that showers were to be given twice a week. Staff Q stated if showers popped up on their alert, the resident had missed a week of showers and sometimes they were not documented. <RESIDENT 1> Resident 1 was admitted to room [ROOM NUMBER] bed A, in the facility on 07/29/2025, with diagnoses that included a history of stroke that affected the left upper side of body. In an interview and observation on 08/13/2025 at 10:28 AM, Resident 1 stated they had been admitted to the facility a couple of weeks ago and had not been given a shower since admission. Resident 1's hair was observed to be disheveled, and greasy. Review of the second-floor shower schedule document on 08/14/2025, showed room [ROOM NUMBER] bed A was scheduled to have a shower every Monday and Thursday on day shift. Review of Resident 1's documentation report for July 29th (Tuesday) – July 31st (Thursday) had no shower documented. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 1's documentation report for August 1st – August 19th had no shower documented. In an interview on 08/18/2025 at 12:51 PM, Staff K, NAC stated they followed the schedule in the shower book. Staff K stated when a resident refused a shower they would reapproach and let the nurse know. Staff K was asked where the refusals were documented, and they stated they sometimes documented in the electronic medical record (EMR), but at times they would just let the nurse know. In an interview on 08/18/2025 at 1:45 PM, Staff M, NAC stated Resident 1 did not have a history of refusing care, and if they did, they would document that in the EMR. In an interview on 08/18/2025 at 1:38 PM, Staff N, LPN stated the facility did not have shower aids specifically for showers, the floor NACs were responsible for providing the showers. Staff N stated all showers and refusals should be in the EMR. In an interview on 08/19/2025 at 8:26 AM, Staff L, LPN/ Unit Manager stated the floor NACs were responsible for providing showers to the resident according to the shower schedule. In an interview on 08/19/2025 at 1:56 PM, Staff B, DNS stated it was their expectation that the staff were following and providing the showers as scheduled. Staff B stated if a resident had refused, they would expect the staff to communicate that so they would be able to resolve the issue. Staff B stated they were not aware that Resident 1 had received no showers since their admission. <RESIDENT 99> Resident 99 was admitted on [DATE] with diagnoses to include stroke, hemiplegia (paralysis to one side of the body), and contracture (permanent tightening of muscles which limits the normal movement of a body part) to left hand. During an observation and interview on 08/15/2025, at 8:55 AM, Resident 99 stated that they had a contracture on their left hand from their stroke. Resident 99 said they used to have a splint previously but had not had it in a while. The resident's left hand was observed with a contracture and without a splint applied. In an observation on 08/15/2025, at 9:45 AM and 1:03 PM, Resident 99 was observed with no splint to the left hand. In an observation and interview on 08/18/2025 at 08:57 AM, Resident 99 had a splint to their left hand. Resident stated that the splint was new today. In a record review of Resident 99's MDS dated [DATE], it was documented that they have impairment to one side and required substantial or were dependent for ADLs. In a record review of Resident 99's care plan dated 05/16/2025, it was documented that Resident 99 had a contracture to their left hand and was at risk of worsening contracture, pain and skin breakdown. The care plan directed the staff to apply a palm guard splint to left hand beginning 12/05/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/19/2025 at 11:02 AM, Staff II, Restorative Aide/NAC, stated that resident 99 had a contracture to their left hand and should have had a splint on. They stated the resident used to have a splint. Staff II stated that the aides on the floor would be the ones to assist Resident 99 with splint application. Staff II stated that the splint they have on now was new. This is a repeat deficiency from 11/15/2025. Reference WAC: 388-97-1060(2) (a)(i) (c) (3) (d)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the failed to ensure that 3 of 3 residents (Residents 12, 40 and 81) reviewed for pressure ulcers (PU), were provided interventions that were required for the prevention of a PU. This failure to implement pressure reducing interventions in accordance with physician's orders placed residents at risk for PU development, prolonged wound healing, and a diminished quality of life.Findings included .Review of the undated facility policy titled, Pressure Injury Prevention and Management, documented that the facility would promote the prevention of PU development, promote healing of exiting PU, and prevent development of additional PU. Preventative interventions included frequent assistance with repositioning, use of pressure reducing devices, and encouragement for adequate nutrition. Treatment protocols outlined in the policy documented that treatments would be ordered by the physician and may include medications to promote healing, special wound dressings, use of supportive devices, referrals to therapy and dietary. The care plan section of the policy documented that a resident centered care plan would be developed and implemented to address the resident's risk for development of a PU and to promote healing if the resident had an existing PU. The NPUAP (2017), Educational and Clinical Resources and PI Prevention Points, advises to inspect the skin at least daily for signs of pressure injury, assess pressure points, reposition all individuals at risk for pressure injury based on support surfaces and individual preference.The Resident Assessment Instrument (RAI) Manual defined the stage of a pressure ulcer (PU) as followed:- A stage II PI (ulcer) was described a partial thickness loss of the skin;- A stage III PI (ulcer) was described a full thickness loss of the skin;- An unstageable PI (ulcer) was a full thickness skin and tissue loss was obscured by slough (non-viable tissue) or eschar (dead or devitalized tissue); and- A Deep Tissue Injury (DTI) was described as intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, or purple discoloration. <RESIDENT 12> Resident 12 readmitted to the facility on [DATE] with diagnoses to include heart failure, right leg pain, diabetes, and peripheral vascular disease (blood circulation disorder). In an observation on 08/13/2025 at 1:11 PM, Resident 12 was observed sitting in their wheelchair and a heel protector boot was placed on a chair in the room. In an observation on 08/14/2025 at 2:44 PM, Resident 12 was observed lying flat in bed with both heels directly on the bed with no heel protector on. A wound was observed to their right heel that appeared to be black and dry, without drainage, and no dressing on. In an observation 08/15/2025 at 11:08 AM, Resident 12 was observed lying on their back in bed with both heels directly on the bed. At 2:23 PM, Resident 12 was on their back in bed, both heels were on the bed without a heel protector boot on. In an observation on 08/18/2025 at 9:03 AM, Resident 12 was observed to be in bed with both heels directly on the bed and their heel protector boot was not on. At 1:35 PM, Resident 12 was in their wheelchair with non-skid socks on without footrests attached and no heel protector on. In an observation and interview on 08/19/2025 at 10:12 AM, the contracted wound provider came to assess and change Resident's 12 right heel wound dressing. Collateral Contact (CC) 3, Physician Assistant Certified (PA-C) and Staff X, Licensed Practical Nurse (LPN) performed wound care. The right heel wound was observed to be black with a new open area. CC3 stated the heel protector boot (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have been on while Resident 12 was in bed. Review of Resident 12's progress note dated 05/02/2025 at 12:59 PM, documented a blood blister was present on the right heel. Review of Resident 12's order dated 05/02/2025, directed staff to apply skin prep (a medication wipe that helps protect the skin barrier) to right inner heel blister two times a day and to ensure both legs were separated and floated to reduce pressure. Review of a skin observation assessment dated [DATE], by Staff Y, LPN showed no documentation of any skin conditions. The first skin observation assessment to document a ‘wound' to the right heel was dated 06/24/2025. Review of records for Resident 12's care plan dated 06/12/2025 documented a right medial heel/right distal foot deep tissue pressure injury (DTPI). The care plan also documented that the resident's skin impairment would heal and resolve within the review period. There was no documentation related to the heel protector boot. Review of Resident 12's progress notes on 05/28/2025, at 5:20 PM, CC 3, PA-C from the wound care provider, documented their first evaluation of the right heel wound. CC 3 documented they were asked to evaluate R (right) heel wound. CC 3 documented the wound was discovered over the last week. CC3 documented the current interventions included offloading and repositioning, and tolerance of treatment was reported to be good. CC3 documented the wound classification was a DTPI. On 08/05/2025, at 7:31 PM, CC3 documented that the wound severity was now unstageable. In an interview on 08/19/2025, at 10:58 AM, with Staff AA, Nursing Assistant Certified (NAC), stated that Resident 12 was to wear their boot while in bed. When asked how do they know when the boot was to be on, Staff AA stated the nurse told them and confirmed it was not in the care plan or Kardex (a nursing worksheet that includes daily care schedules/patient specific care needs). In an interview on 08/19/2025, at 1:08 PM, with Staff L, LPN/Unit Manager (UM) was asked who was responsible for the resident's care planning and both stated it was an interdisciplinary team process. When questioned about Resident 12's heel protector boot, Staff L confirmed that it was not in the care plan or Kardex. <RESIDENT 40> Resident 40 was admitted to the facility on [DATE] with diagnoses that included diabetes and schwannomatosis (rare genetic disorder where non-cancerous tumors form along the spinal cord causing pain, numbness and weakness of the entire body). Review of Quarterly MDS dated [DATE] documented the resident was dependent on staff for all activities of daily living, had no active pressure ulcers at the time of the assessment. Review of Resident 40's assessment titled, “Wound Evaluation Weekly,” dated 07/30/2025 documented the resident had a new pressure ulcer injury to their sacrum area that measured 1 centimeter (cm) x 0.5 cm x 0.1 cm. Review of Resident 40's physician orders on 08/15/2025 showed documentation of a preventive (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment of topical ointment to be applied to the resident's coccyx area three times a day to prevent breakdown to that area beginning 05/05/2025, there were no new orders put in place related to the new sacrum wound. Review of Resident 40's care plan on 08/15/2025, that documented revised focus area for skin impairments on 08/07/2025 that documented the resident had a new pressure ulcer to their sacrum area. No new goals of care or interventions were put in place related to the new sacrum wound. Review of Resident 40's progress notes from 07/30/2025 through 08/15/2025 showed there was no documentation that the resident had a new sacrum wound, that the physician had been notified, no new orders implemented and no monitoring of the wound. In an observation and interview on 08/15/2025 at 9:41 AM, Staff T, Registered Nurse (RN) stated they were going to assess the resident's sacrum area. Staff T stated they were not aware the resident had a potential pressure ulcer to their sacrum. Resident 40's sacrum was observed to be non-blanchable, and slightly pink, there was no open area during the observation. In an interview on 08/18/2025 at 12:51 PM, Staff GG, NAC stated that they are educated to notify the nurse if they find an open area on any resident. Staff GG stated the wound nurse was in the facility every Tuesday to round on residents. In an interview on 08/18/2025 at 1:38 PM, Staff N, LPN stated the expectation for new skin concerns were the floor nurse would start an incident report, and inform the nurse manager or DNS. Staff N stated they would usually notify the wound nurse and let the provider know. Staff N stated they would usually implement a treatment plan to start with then place the resident on alert monitoring for three days. Staff N stated Resident 40 had an open area to their sacrum, but stated they thought the wound had closed. In an interview on 08/18/2025 at 1:45 PM, Staff M, NAC stated Resident 40 was fully dependent on staff for all cares. Staff M was not aware of any open area to Resident 40's sacrum. In an interview on 08/19/2025 at 8:26 AM, Staff L stated when a resident had a new skin concern that required wound care, they would be the one to notify the wound nurse. Staff L stated the licensed staff would usually start a treatment for the area, notify the provider, and the wound should be monitored for at least three days. Staff L was asked if the skin/wound process was completed for Resident 40's wound documented on 07/30/2025. Staff L stated the resident had continuous wounds that open and close all the time. Staff L was unable to provide any documentation that the resident was placed on alert, a treatment was set in place, that the wound nurse was notified, or that the plan of care was revised. In an interview on 08/19/2025 at 1:56 PM, Staff B, DNS stated that their expectation at the facility for all skin concerns was the licensed staff were to notify the Unit Manager, and then, start a treatment of the wound, document in the medical record, and report to the provider. Staff B was not aware that Resident 40 had a reported open area to their sacrum on 07/30/2025. Staff B could not provide any further information for the wound management of Resident 40. <RESIDENT 81> Resident 81 admitted on [DATE] with diagnoses to include severe protein-calorie malnutrition and (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic lung disease. Review of the admission orders on 08/14/2025 showed that Resident 81 received oxygen 2 to 4 liters via nasal cannula (flexible tubing that goes around your head into your nose to deliver supplemental oxygen) every shift related to chronic respiratory failure. Review of the admission MDS submitted 08/03/2025, showed Resident 81 weight 62 pounds and had an unhealed pressure ulcer/injury. Review of Resident 81's admission nursing evaluation on 07/23/2025, showed Resident 81 had a stage I sacral pressure ulcer (PU) measuring 9 cm by 7 cm. Review of the admission Braden scale (assessment to determine risk for pressure ulcer development) dated 07/23/2025, showed the resident was a high risk for pressure ulcer development. Review of the nutrition Care Area assessment dated [DATE], showed the resident had a body mass index (BMI) of 10.6 which indicated significantly underweight status, a serious health issue that compromised immune system, and increased risk of disease and fatigue. Review of a weekly skin observation progress note on 08/03/2025 at 11:28 PM, documented a pressure ulcer to coccyx (tailbone) measured 1.1 cm in length and 0.5 cm in width with reddened skin around the pressure ulcer. Review of the skin care plan developed on 07/24/2025, showed the resident had a skin impairment of an unstageable pressure injury to their coccyx. The goal was for the resident not to have any further skin impairment and for the skin impairment to heal. The interventions directed staff to observe for signs and symptoms of infection, wound reviews as indicated, treatment per Treatment Administration Record, weekly skin observation and to keep the skin clean and dry as possible. Review of the respiratory care plan dated 07/23/2025, directed staff to provide oxygen 2 to 4 liters per minute. The care plan did not include an intervention for padding the nasal canula to prevent pressure ulcers. Review of the care plan titled at risk for pressure ulcer dated 07/24/2025, included Resident 81 was at risk for pressure ulcers and skin impairment related to chronic health conditions, end of life stage, immobility, incontinence, protein calorie or vitamin malnutrition. The care plan did not include the pressure ulcer to the sacrum or an intervention for padding the nasal canula to prevent pressure ulcers. Review of the weekly skin assessments showed Resident 81 had the following weekly skin integrity data collection assessments: -07/25/2025 no skin issues noted, -08/01/2025 no skin check was documented in the progress notes, -08/08/2025 no skin check was documented in the progress notes, -08/15/2025 no skin check was documented in the progress notes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a progress note dated 08/19/2025 at 11:49 AM, showed Resident 81's skin was observed, and no skin conditions were noted. In an interview and observation on 08/19/2025 at 12:48 PM, Resident 81 was in bed, they winced and readjusted off their bottom and said the sore on their bottom hurt and they needed a pain pill. Below their oxygen tubing on the left side of their cheek was an indented red line approximately 2 cm in length. The residents touched their left cheek under the tubing and stated they wanted a mirror to see the area because they could feel something there. They stated they were unable to get up to the sink to look in the mirror because they could not walk. In an interview on 08/19/2025 at 1:38 PM, Staff PP, LPN was asked about their documentation that showed no skin issues for Resident 81 at 11:49 AM that day despite the resident was observed to have a red area linear mark/indentation consistent with pressure under their 02 tubing. Staff PP was notified that the resident was complaining of pain to their left cheek where there was an indentation, and they would like to see a mirror. Staff PP stated they would take a look at the resident and fix their charting. At 1:45 PM, Staff PP walked by and showed a package of 02 tubing padding and stated they were going to go add this to Resident 81's 02 tubing. At 1:57 PM Staff PP stated they went and assessed Resident 81's skin and there was a wound to their left cheek that was red and not blanchable. Staff PP stated they had seen this happen before with continuous oxygen. In an interview and observation on 08/20/2025 at 9:00 AM, Resident 81 was sitting up in bed and their 02 tubing was padded to protect their skin. Resident 81 said their left cheek hurt. They pushed on the left cheek area below the oxygen tubing that measured 1 cm, and it did not blanch (skin did not lighten under pressure, signaling a pressure sore). Review of the July and August 2025 Nursing Assistant (NA) documentation showed no documentation the Resident 81 was repositioned. In an interview on 08/20/2025 at 9:52 AM Staff B, DNS stated they were aware of pressure ulcer issues. Staff B stated two weeks ago they started having weekly skin and nutrition meetings to look at high risk residents and address issues right away. Nursing documentation did not contain evidence of ongoing assessment, implementation of interventions and re-evaluation of interventions consistent with professional standards. The nursing documentation also did not reflect a proactive approach to skin management. Reference WAC 388-97-1060(3)(b)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure 3 of 6 medication carts (Yellow, Blue and Pink Carts) and 1 of 2 medication rooms (second floor medication room) had unexpired medications and/or biologicals, reviewed for medication storage. These failures placed residents at risk of receiving compromised or ineffective medications and biologicals. Findings included .Review of the undated facility policy titled, Medication Storage, showed the facility shall not use discontinued, outdate, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.Review of the undated facility policy titled, Self-Administration of Medications and Treatments, showed residents will be assessed to determine whether self-administering medications and or treatment is clinically appropriate for the resident. Self-administered medications and or treatments supplies will be stored in a safe and secure place, not accessible to other residents. <MEDICATION SECURITY> In an observation on 08/13/2025 at 11:04 AM, the yellow med cart was unlocked. Staff DD, Registered Nurse (RN) was at the nurse's station without direct visualization of the cart. Staff DD noticed after several minutes their medication cart had been unlocked, they walked over and locked it. At 11:07 AM Staff DD acknowledged they had left their cart unlocked and they stated medication carts were supposed to be locked. In an observation on 08/14/2025 at 8:54 AM, Resident 33 was in their bed. There was a prescription ointment and artificial tears eye drops on their overbed table. In an observation on 08/15/2025 at 8:36 AM, while walking down the 120 hall there was a pink round pill on the carpet in the middle of the hall next to the nurse's cart. Staff SS, RN was informed there was a pill on the carpet. Staff SS stated Oh and bent to retrieve it. In an observation on 08/15/2025 at 1:08 PM, the medication cart in the 120 hall was unlocked. There were no staff or residents present. This surveyor observed the cart, then went to the nurse's station and was told the nurse was on their break. At 1:16 PM, Staff SS, RN noticed their cart was unlocked and they locked it. Staff SS stated their medication cart should have been locked. At 1:32 PM, a vial of Tuberculin solution was left unattended and unsecured on top of the 120-hall medication cart. At 1:41 PM, Staff SS returned to their cart and acknowledged the Tuberculin solution was on top of the cart. Staff SS stated the vial should have been secured in their medication cart. In subsequent observations on 08/15/2025 at 1:21 PM, 08/18/2025 at 11:06 AM and 2:35 PM, 08/19/2025 at 1:00 PM the prescription ointment and eye drops remained at Resident 33's bedside. In an interview on 08/18/2025 at 2:41 PM Collateral Contact (CC) 1 stated they were the pharmacy consultant for the facility and were there on a quarterly audit removing all the expired medications from the carts there. CC 1 stated they had hoped to complete the audit before survey. CC 1 had a tablet with multiple expired medications written down for their report to provide to the facility. In an interview on 08/19/2025 at 11:08 AM, Staff P, LPN/Weekend Supervisor with Staff B, Director of Nursing Services (DNS) present, stated they were disappointed there were observations of unlocked medication carts with Staff DD and Staff SS. Staff P stated the expectation was that medication carts should be locked and medications secured. Staff P stated this was very serious and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	commented it was the agency nurses who failed to secure their medications. They stated that every time a new nurse started, they would show them a sign they displayed that stated PLEASE LOCK CART. Staff P was informed of Resident 33's prescription ointment and eye drop at their bedside. Staff P stated there had been no self-medication assessment (SMP) completed. Staff P stated the residents spouse snuck things in for them. Staff P stated that everyone knows they have to be assessed for SMP, an order from the doctor for the medications at the bedside and the medications needed to be secured. In an interview on 08/19/2025 at 2:37 PM, Staff Q, LPN/Unit Manager stated they were not aware of Resident 33 having medications at bedside. Staff Q stated the resident was very aware of their medications and what they take, and the spouse would sometimes bring in supplies from home. In an observation on 08/20/2025 at 8:50 AM, Resident 33 was in bed. There were eye drops on the overbed table. The nightstand to the left of their bed had two topical creams present. In an interview on 08/20/2025 at 9:52 AM, Staff B, DNS was informed of the observations of the unlocked med carts, unsecured medications on carts and continued observation since 08/14/2025 of resident 33's medications at bedside as well as expired medications. Staff B stated the residents spouse brings in items from home and they would provide education to them on not bringing medications in. Staff B stated their expectation was that the med carts would be locked and there were no expired medications in the carts or med rooms. <MEDICATION CARTS> In an observation on 08/14/2025 at 5:16 PM, reviewed the Yellow Medication Cart on the first floor with Staff LL, Registered Nurse (RN). The cart included one bottle of Narcan (medication that reverses opioid overdose) spray with expiration date 06/28/2025, one bottle of Calcium tablets and a bottle of Vitamin D with expiration date 05/2025, two bottles of Aspirin with expiration date 04/2025, one undated bottle of iron. In an interview on 08/14/2025 at 5:41 PM, Staff B, Director of Nursing Services, confirmed there was no date on the bottle of iron and confirmed other medications were expired. Staff B stated all those medications should be disposed of. In an observation and interview on 08/15/2025 at 10:03 AM, reviewed the Blue Medication Cart on the second floor with Staff O, RN. There were 16 laxative suppositories with expiration date 01/2025 found in the cart. Staff O stated the 16 suppositories were expired and would be disposed of. In an observation and interview on 08/15/2025 at 10:14 AM, reviewed the Pink Medication Cart with Staff BB, RN. One bottle of iron with no expiration date, one bottle of Dakin's solution (medication cleansing solution) with an expiration date 07/2025, one bottle of eye drop solution with opened date 07/12/2025 were found. Staff BB confirmed the bottle of iron had no expiration date and would be disposed with other expired medications. Staff BB stated the eye drops could be used for 90 days after they had been opened per the consulting pharmacy recommendations. In an interview on 08/19/2025 at 11:34 AM, a Collateral Contact (CC)1, contracted Pharmacy Consultant Nurse, stated eye drops were good for 28 days after they are opened. In a follow up email from CC1, confirmed eye drops were good for 28 to 30 days per their research. The eye drops in the medication cart opened on 07/12/2025 were expired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<MEDICATION STORAGE ROOM> In an observation and interview on 08/14/2025 at 2:54 PM, the medication storage room on the second floor with Staff L, LPN/Unit Manager found two bottles of Vitamin E with expiration date 01/2025, one bottle of Vitamin D with expiration date 05/2025, one bottle of Aspirin with expiration date 06/2025, one bottle of Prenatal vitamins with expiration date 01/2025, one bottle of liquid multi-vitamin with expiration date 06/2025 were found in the medication room. Staff L stated those expired medications were not supposed to be in the medication room and would be disposed of. In an interview on 08/19/2025 at 2:53PM, Staff B, DNS stated they expected no expired medication in the medication storage rooms and medication carts. This is a repeat deficiency from 11/15/2024. Reference WAC: 388-97-1300(2)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure dental services were provided for 6 of 6 Medicaid residents (Residents 3, 12, 79, 81, 85, and 101) reviewed for dental services. Failure to follow up on dental referrals and timely assistance with appointment scheduling extended the time residents had to wear ill-fitting dentures. These failures placed residents at risk of difficulty chewing, oral pain, decreased self-image and diminished quality of life. Findings included .<RESIDENT 81> Resident 81 admitted on [DATE] with diagnoses to include severe protein-calorie malnutrition. Review of the admission transfer orders from the hospital on [DATE] directed staff to weigh Resident 81 daily and provide a pureed diet and nutritional supplements daily. Review of the initial nutritional at risk assessment dated [DATE], showed the diet was listed as regular texture rather than the ordered pureed texture. Review of the admission Minimum Data Set (MDS, an assessment tool) dated 07/29/2025, showed the resident had no teeth. Review of the nutrition Care Area Assessment (CAA) dated 07/29/2025, showed the resident had a body mass index (BMI) of 10.6 which indicated significantly underweight status, a serious health issues that compromised immune system and increased risk of disease and fatigue. The CAA noted that the resident had poor oral intake. Per Registered Dietician notes, Resident 81 reported feeling okay with fair appetite and denied any gastrointestinal symptoms or issues with chewing/swallowing. The note stated the resident had poor dentition and preferred meats and vegetables to be cut into small pieces. They reported mild stomach discomfort. Review of the nutritional care plan dated 07/23/2025 showed the resident was at nutritional risk due to advanced age, goals of care, underweight BMI and past medical history. The care plan included only one intervention for a RD consult. The care plan did not include the residents' goals, food preferences, missing dentures, or other interventions. Review of a Hospice handwritten note dated 07/28/25, documented Resident 81 needed their teeth which they had communicated to their nurse. Review of the progress note on 08/04/2025 at 12:00 AM, from Collateral Contact (CC) 2, Physician Assistant showed the resident was underweight with severe protein/calorie malnutrition and sporadic meal intakes. CC2 documented the resident appeared to have lost their dentures and they were unable to tolerate the regular texture diet. CC 2 downgraded the diet to mechanical soft. In an interview and observation on 8/13/2025 at 1:57 PM, Resident 81 stated they ate lunch, and the food was ok, but it was harder to eat without any teeth. The resident stated they lost their dentures someplace and they need new dentures. The resident stated their other dentures were in bad shape and they needed new ones as those were cutting into their gums. The resident stated they told the nurses and also hospice. In an interview and observation on 8/20/2025 at 9:00 AM, Resident 81 was sitting up in bed, and (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated they could not eat the ham as they had no teeth. The resident said they loved ham but could not eat it. The resident stated they still did not have dentures, and they talked to the hospice nurse about it. <RESIDENT 12> Resident 12 was admitted on [DATE]. In a record review of Resident 12's admission MDS, dated [DATE], it was documented that they had obvious or likely cavity or broken natural teeth. In an observation on 08/14/2025 at 9:37 AM, Resident 12's teeth appeared to have both missing and discolored teeth. In a review of Resident 12's care plan on 08/18/2025, documentation showed Resident 12 has oral/dental health problems related to obvious or likely cavity or broken natural teeth. Care plan intervention was to refer to a dentist as indicated. In an interview on 08/19/2025, at 1:08 PM, with Staff H, Social Services stated that they offered dental services to every resident for routine services. When in facility dental services occur, the provider will document a report and the results should go into the resident's medical record. Staff H confirmed no documentation in Resident 12's clinical record showed no documentation of any dental services being offered, refused, or completed. Staff H stated the in house dental provider was on site that day and that Resident 12 should be on the list for today. Confirmed with Collateral Contact (CC 6),dental provider on 08/19/2025 at 1:33 PM, that Resident 12 was not on the dental services list for that day. <RESIDENT 85> Resident 85 admitted to the facility on [DATE]. In an interview on 08/13/2025 at 10:56 AM, Resident 85 stated they wanted dentures, they only had 3 teeth on top and would have to go to a hospital for extractions in order to get dentures. Review of a document from outside dental provider dated 02/17/2025 showed Resident 85 would like extractions. In an interview and record review on 08/15/2025 at 1:36 PM, Staff L, LPN/Unit Manager (UM) stated social services was responsible for scheduling and following up for dental appointments. Staff L reviewed the documents from the contracted dental provider dated 02/17/2025, and stated the resident was seen at the facility and they do not extract teeth at the facility. Staff L stated after evaluating the resident the dental provider would give the form to social services. In an interview and record review on 08/15/2025 at 1:42 PM, Staff H, Social Services, stated they were responsible for scheduling dental appointments for residents and reviewed the dental services visit report. Staff H reviewed the contracted dental visit form for Resident 85, dated 02/17/2025 and stated they had recommended the resident for a few extractions. Staff H stated Resident 85 would have to be sent to outside hospital for the extractions due to insurance and need for a mechanical life. Staff H stated Resident 85 was on a waiting list which could take up to six months and the hospital (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would contact them when an appointment became available. Staff H stated they would follow up with the hospital monthly until an appointment was scheduled and would document in the resident record. Staff H stated the resident was recently seen by contracted dental provider on 08/04/2025 and a referral was sent to the local hospital a couple of days later. Staff H reviewed the resident's medical record and was not able to find documentation of communication with the local hospital or dental provider. Staff H stated Resident 85 would refuse to go out of the facility for extractions but they would schedule the appointment. In an interview on 08/18/2025 at 1:12 PM, Staff H stated they were unable to find documentation of the contracted dental visit on 08/04/2025 and would check with medical records. No further information was provided. In an interview on 08/19/2025 at 3:51 PM, Resident 85 stated they had decided to get dentures and had agreed to go out of the facility for extractions. The resident stated that Staff H spoke with them that morning and stated they would try and set up an appointment for extractions and would let them know when the appointment was scheduled. In an interview on 08/19/2025 at 3:50 PM, Staff B, Director of Nursing Services (DNS) stated social services was responsible for following up on referrals and scheduling appointments for dental services. Staff B stated the facility is trying to improve the system for scheduling appointments and this was a focus. Staff B stated documents from appointments should be uploaded into the resident's medical record. <RESIDENT 79> Resident 79 admitted [DATE] with full upper and lower dentures. Review of the care plan on 08/14/2025 showed the resident had full upper and lower dentures. Review of a dental visit note dated 02/17/2025, stated the resident had been missing their lower denture for several months. The follow up recommendation was to have Resident 79's upper denture re-lined, and to have the lower denture replaced. In an interview on 08/13/2025 at 1:51 PM, Resident 79 stated they were missing their lower denture for quite a while and wanted to have it replaced. Resident 79 stated the denture clinic should still have the molds. Resident 79 stated it went missing here at the facility, but they did not know what, if anything, was being done to get it replaced. Resident 79 stated it was hard for them to eat without their lower teeth. <RESIDENT 101> Resident 101 admitted in February of 2023 and was alert and oriented. In an interview on 08/14/2025 at 9:06 AM, Resident 101 stated that after two years they finally got someone to clean their teeth. Resident 101 stated they had a molar with a crack in it and they needed to get the crack fixed. Resident 101 stated they have not heard about any follow up, they stated it was painful to chew on hard things, so they have to avoid that side. Resident 101 stated they were already missing some teeth so they don't want to lose any more. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a dental provider note dated 05/27/2025, showed Resident 101 was identified as having a broken tooth. The recommendation was highlighted stating “Refer to dentist.” Review of Resident 101's record showed a progress note dated 05/28/2025 at 10:53 AM from Staff H, Social Services which stated the resident was seen by the Dental Hygienist that day. The resident had their teeth cleaned and wanted to be referred to an outside dentist for a broken tooth, will make a follow up dental appointment. In an interview on 08/18/2025 at 1:24 PM, Staff H, Social Services, confirmed that they were responsible for making dental referrals and appointments, and Staff H stated they had not been aware of Resident 79 missing their lower denture, so no referrals had been started and no appointments had been made. Staff H stated they would make an appointment for Resident 79 with the facility denturist. Staff H stated following visits from the dental providers, the providers would leave the notes and they would make them aware of residents that needed further follow up appointments. Staff H stated that they had sent a referral out for Resident 101, and they were on a waiting list. Staff H stated it often could take 6 months to get appointments for Medicaid residents. Resident 101's dental appointment had been in February (6 months ago) and Staff H was asked about the status of that referral. Staff H did not have any documentation that a referral was sent, any follow up communication or status of the referral. <RESIDENT 3> Resident 3 admitted to the facility on [DATE]. In an interview and observation on 08/18/2025 at 11:43 AM, Resident 3 stated they had broken, missing and loose teeth since admission and they had not been seen by a dentist. Resident 3 stated they had front teeth pain. Resident 3 stated it was hard to chew food because of their teeth. Resident 3 was observed with broken upper front teeth, missing upper and lower back teeth, and loose lower front teeth. In an interview on 08/19/2025 at 9:26 AM, Resident 3 stated they did not have toothbrushes and did not brush their teeth. Review of Resident 3's admission nursing collection tool on 03/17/2025 at 5:29 PM, documented the resident had broken or loose teeth. Review of Resident 3's admission MDS on 03/23/2025, showed Resident 3 had obvious or like cavities or broken natural teeth, inflamed or bleeding gums or loose natural teeth, and mouth or facial pain. Review of Resident 3's clinical record on 08/15/2025, showed no documentation the resident was referred to a dentist, ever seen by a dentist or offered assistance in arranging dental services. In an observation, interview and record review on 08/19/2025 at 9:43 AM, Staff EE, Nursing Assistant Certified (NAC), stated Resident 3 required set up assistant on oral care. Staff EE could not locate where the resident's oral care items were. Staff EE stated they obtained the oral care instruction from the Kardex (a tool used to provide direction on how to care for a resident). Review of Resident 3's Kardex with Staff EE, verified there was no oral care instruction. Staff EE stated they felt it was difficult to take care of residents when the care instructions were not specific or missing in the (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Kardex. In an interview on 08/19/2025 at 1:55 PM, Staff Q, LPN/ UM, stated the facility in house dental hygienist visited residents quarterly and the social services department was in charge of enrolling residents and preparing the list for the dental visit. Staff Q stated the facility was supposed to address residents' dental concerns upon admission and social services were responsible for any outside dentist referral and transportation arrangement if residents had a toothache. Staff Q stated Resident 3 had dental concerns and when Resident 3 transferred to a new unit, they informed the unit social worker (Staff H) that Resident 3 required dental services. Staff Q stated they were not aware Resident 3 had a toothache when the resident stayed on their unit and why Resident 3 had not been seen by a dentist. In a joint interview on 08/18/2025 at 2:21 PM, Staff L, LPN/ UM, and Staff H, Social Services, stated they were both not aware of Resident 3's dental concerns and not sure why the resident was not seen by a dentist since admission. In an interview on 08/19/2025 at 11:14 AM, Collateral Contact (CC) 6, Dental Hygienist, stated they provided in house dental visits every three months and Resident 3 was just enrolled that day on their dental services. In a follow up interview on 08/19/2025 at 1:21 PM, CC6 stated Resident 3's had not brushed their teeth and the resident had teeth bone loss which caused pain, missing, broken and loose teeth and gum disease. In an interview on 08/19/2025 at 2:44 PM, Staff L stated the Kardex should include oral care instructions so nurse aides would follow and assist Resident 3 on oral care. Staff L stated they did not know why it was missing. In an interview on 08/19/2025 at 2:53 PM, Staff B, DNS, stated they expected staff to identify oral and dental concerns and referred to dentists as soon as possible. In an interview on 08/20/2025 at 9:52 AM, dental concerns for Resident's 3, 12, 79, 81, 85 and 101 were discussed with Staff A, Administrator and Staff B, DNS. Staff A stated they were not aware of any dental concerns except with Resident 101.Staff A stated they are working on helping those residents that want to use their own dentist and arranging transportation which was cumbersome. Staff A stated their expectation was that they would get a plan in place within the three-day window for dental emergencies. They stated they could not always get the dental appointments at that time so they would come up with an alternate plan. Staff A stated they offered dental visits every three to six months for cleaning and identification of dental issues. Reference WAC: 388-97-1060(1)(3)(j)(vii)

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	505319	A. Building B. Wing	08/20/2025

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to store food for residents in accordance with professional standards in 1 of 2 nourishment refrigerators (second floor) reviewed for food service safety. The failure to maintain safe refrigerator temperatures placed residents at risk of foodborne illness. Findings included .In an observation on 08/15/2025 at 9:39 AM, the second-floor nourishment refrigerator door was found to be ajar and the thermometer on the inside of the refrigerator door read 55 degrees. The refrigerator was observed to contain cheese, yogurts, milk, puddings, sandwiches, pitchers of fruit juices and a plastic container of sushi labeled 08/13/2025 and labeled with the name of a facility resident. The temperature log was already signed for the day (08/15/2025) with no time, and the temperature was documented as 39 degrees on the log. In a follow up observation and interview on 08/15/2025 at 10:52 AM, the second-floor nourishment refrigerator door was again found to be ajar and the temperature on the thermometer inside the door read 58 degrees. Items inside the fridge did not feel cold to touch. Staff K, Certified Nursing Assistant, was observed to enter the nourishment room. Staff K was on the way out of the nourishment room, passing the refrigerator on the way out. Staff K was asked if they had noted any issues with the nourishment refrigerator, to which Staff K stated “no.” Staff K was asked if they had noticed any issue with door not being completely closed or any issue with the refrigerator not being cold enough and Staff K stated “no, I have not noticed that.” It was observed that the refrigerator door was now closed. In a third observation on 08/15/2025 at 11:57 AM, the second-floor nourishment refrigerator door was noted to be closed, and the temperature had decreased but still read 48 degrees. In an observation and interview on 08/15/2025 at 12:02 PM, the refrigerator was noted to be slightly open, with no staff having been observed to go into the room since Staff K. Staff J, Staffing Coordinator, was standing near the door to the nourishment room and observed the refrigerator and the thermometer inside the door which was reading 50 degrees. Staff J reviewed the temperature logs and stated they would call maintenance to look at the refrigerator. In an interview on 08/19/2025 at 2:20 PM, Staff A, Administrator, stated that the seal on the refrigerator was found to be broken. The entire refrigerator was replaced and the food items had been removed. Staff A stated the expectation was that staff would report faulty equipment right away. Refer to WAC 388-97-1100 (3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a system in which residents' records were complete, accurate, and accessible for 2 of 2 residents (Residents 9 and 85) reviewed for physician visits, 1 of 5 residents (Resident 72) reviewed for unnecessary medications, and 1 of 3 residents (Resident 82) for hospitalizations. The facility failed to ensure the residents' medical records were complete and accurate which placed the residents at risk for medical complications, unmet care needs, and diminished quality of life.Findings included .According to the facility's Transfer and Discharge policy, dated 10/01/2021, nursing services and/or social services are responsible for completing the discharge note in the medical record.In a review of facility policy, dated 10/01/2021, titled, Weight Assessment and Intervention, documented that weights will be recorded in the resident's medical record. <RESIDENT 82> Review of the progress note dated 08/14/2025 at 11:14 AM, documented Resident 82 returned from the hospital at approximately 11:00 AM after being sent to the hospital last night due to coffee ground emesis (a serious symptom of blood in vomit). Review of the progress notes on 08/13/2025 showed there was no documentation the resident had been transferred to the hospital, the physician and family were notified and that a report was given to the receiving hospital for continuity of care. In an interview on 08/19/2025 at 11:27 AM, Staff P, Licensed Practical Nurse/Weekend Manager confirmed Resident 82's medical record did not include any documentation the resident was sent to the hospital on [DATE]. Staff P stated social services should document to the discharge. Staff P stated their expectation was that the nurse who sends the resident out to the hospital needed to document why they were sent out, family and physician notification in the progress notes and obtain the bed hold and provide the notice of discharge paperwork to the resident or their responsible party. Review of the clinical record on 08/20/2025 showed there were no hospital records from the hospitalization on 08/13/2025 in the clinical record. In an interview on 08/20/2025, at 9:52 AM Staff A, Administrator stated the nurses need to make a progress note about why the resident was sent out, and also about the physician and family notification. <RESIDENT 85> Resident 85 admitted to the facility on [DATE]. In an interview on 08/13/2025 at 10:56 AM, Resident 85 stated they wanted dentures, and would have to go to a hospital to get the teeth extracted in order to get dentures. Review of a document from the contracted dental clinic, dated 02/17/2025, showed Resident 85 would like extractions. In an interview and record review on 08/15/2025 at 1:42 PM, Staff H, Social Services, stated they were responsible for scheduling dental appointments for residents. Staff H stated that Resident 85 would have to be sent to the hospital for the extractions and was on a waiting list which could take up to six months. Staff H stated the hospital would contact them when an appointment became (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	available and they would follow up monthly and document in the resident record. Staff H stated the resident was recently seen by contracted dental clinic on 08/04/2025 and a referral was sent to the hospital a couple of days later. Staff H reviewed the resident's medical record and was not able to find documentation of communication with hospital or documentation of the contracted dental appointment from 08/04/2025. Staff H stated they would look for the information and provide if found. In an interview on 08/18/2025 at 1:12 PM, Staff H stated they were unable to find documentation of the contracted dental visit from 08/04/2025 or documentation of attempts to schedule an appointment for extractions for Resident. Staff H stated they would check with medical records. No further information was provided. In an interview on 08/19/2025 at 3:50 PM, Staff B, Director of Nursing Services (DNS) stated social services was responsible for following up on referrals and scheduling appointments for dental services. Staff B stated the facility is trying to improve the system for scheduling appointments and this was a focus. Staff B stated documents from appointments should be uploaded into the resident's medical record. <RESIDENT 72> Resident 72 was admitted to the facility on [DATE]. In a record review of Resident 72's orders, an physician order directed staff to “weigh on admission, weekly times 3, then monthly,” was started on 06/25/2025. In a review of the resident's weight, there was a weight documented on 06/25/2025 and 08/08/2025. In a review of Resident 72's July 2025 medication administration record (MAR), a weight was ordered for 07/03/2025 and was documented “NA.” A weight was ordered for 07/10/2025 and was blank in the MAR. In an interview on 08/20/2025, 9:15 AM, Staff BB, Registered Nurse confirmed that Resident 72 was missing documented weights and the physician's orders were not being followed. <RESIDENT 9> Resident 9 was admitted to the facility on [DATE] with diagnoses to include obstructive uropathy (blockage of the urinary tract), kidney stones, and quadriplegia (unable to move all limbs). Review of Resident 9's physician orders showed an active order for a urinary catheter (tube inserted into the body to drain fluids) with a start date of 06/14/2025. Review of Resident 9's care plan on 08/13/2025 showed a focus dated 07/16/2025 that the resident required a urinary catheter related to their obstructive uropathy. Interventions included changing the catheter per the physician orders, empty as needed, maintain catheter anchor, maintain catheter privacy bag, and enhanced barrier precautions for direct care. In an observation on 08/13/2025 at 1:35 PM, Resident 9 was observed to not have a urinary catheter in place. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/13/2025 at 1:37 PM, Staff T, RN stated that the resident previously had a catheter, but did not now and they were not aware of when or why it was removed. In a review of Resident 9's medical record on 08/14/2025, showed no record of removal or discontinuation of their urinary catheter. In an interview on 08/19/2025 at 8:26 AM, Staff L, Licensed Practical Nurse (LPN)/ Unit Manager stated that when a resident was seen by a provider outside of the facility they will return with after visit summary (AVS) for the staff to review and then medical records would upload it into the medical record. Staff L stated that if they do not receive that information, they will reach out to the provider, or the medical records staff member will obtain that information. In a follow up interview on 08/19/2025 at 9:32 AM, Staff L stated that Resident 9 had their urinary catheter removed when they went to a urology appointment. Staff L was asked where that information would be documented, and they said it would be an AVS in their scanned documents. Staff L was not aware there was no information in Resident 9's medical record related to the discontinuation of the urinary catheter and that the medical record reflected the resident still had a urinary catheter. In an interview on 08/19/2025 at 10:40 AM, Staff U, Medical Records stated they were not aware that Resident 9 had missing items from their medical record. In an interview on 08/20/2025 at 9:52 AM, Staff V, Regional Director of Clinical Services stated that the medical records position had only been a part time position. This is a repeat deficiency from SOD dated 11/15/2024. Reference WAC: 388-97-1720(1)(i-iv)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 3 of 5 residents (Resident's 2, 12 and 116) reviewed for transmission-based precautions (TBP), 2 of 2 staff (Staff AA, Nursing Assistant Certified - NAC and Staff CC, NAC) reviewed for environmental disinfection of equipment, 2 of 2 drainage bags (Resident's 82 and 96) were secured off the floor and 1 of 1 facility water management plan. The facility failed to ensure the staff were wearing appropriate personal protective equipment (PPE) in accordance with recommended national standards, failed to ensure staff were compliant with appropriately disinfecting reusable resident equipment, and failed to ensure an appropriate placement of urinary drainage tubing. The facility failed to establish a water management plan for the facility that could place the facility residents and staff at an increased risk for Legionella or other opportunistic waterborne pathogens in the facility's water system. These failures placed all residents and staff at risk of potential infection. Findings included . Review of the facility policy titled, Surveillance for Infections, undated, documented the facility would conduct ongoing surveillance of infection that have potential resident outcomes and require the use of transmission-based precautions .purpose was to identify and guide appropriate interventions and prevent further infections. Review of the facility policy titled, Infection Control Program, undated, documented the facility had an infection control program and committee that would address surveillance, prevention and control of disease and infection, and that it was consistent with guidelines from the Centers for Disease and Control (CDC) and other federal national standards and regulations. Review of the facility policy titled, Water Management Program, undated documented the facility would establish a water management plan for reducing the risk of Legionella and other opportunistic pathogens in the facility's water system .compliance guidelines were to establish a water management team, provide documentation of the facility's water system, complete a risk assessment to identify where potential pathogens could grow and spread, based on the risk assessment develop control points and control measures, testing protocols and limits, verification of process and effectiveness of the water program will be done annually. <ENHANCED BARRIER PRECAUTIONS> In an observation and interview on 08/19/2025, at 10:12 AM, Collateral Contract (CC 3) Contracted Wound Care Provider came to assess and change Resident's 12 right heel wound. CC 3, and Staff X, Licensed Practical Nurse (LPN) with the facility performed wound care. Observed the right heel wound to be open. Confirmed with CC 3 and Staff X that Resident 12 should be on Enhanced Barrier Precautions (EBP – wearing gown and gloves during high-risk activities for all staff). Resident 12 did not have signage or PPE outside of the room to alert staff of the precautions needed during high contact care. In a phone interview on, 08/19/2025, at 12:04 PM, with Staff D, LPN/Infection Preventionist/Staff Development Coordinator and Staff B, DNS confirmed that a resident with a wound would indicate use of EBP. Staff D stated that if a resident is on EBP then a sign would be posted outside of the resident's room with available PPE. Notified Staff D and B of Resident 12's and Resident 2's wound that did not have any EBP signage or PPE available. They both confirmed that they were unaware of the wounds. <RESIDENT 2> Review of Resident 2's medical record on 08/15/2025 documented a chronic wound to the resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	right leg. In an observation of wound care on 08/19/2025 at 10:55 AM, it was confirmed that the resident had a current chronic open wound to the right lower leg and did not have EBP in place to alert staff of the need for PPE during direct contact activities. <DRAINAGE BAGS> <RESIDENT 82> In an observation on 08/13/2025 at 10:58 AM, Resident 82 was in bed. The residents nephrostomy (drain placed to bypass blockage in urinary system) drainage bag was directly on the floor without a privacy cover. <RESIDENT 96> In an observation on 08/14/2025 at 8:45 AM, Resident 96 was visiting with a friend. The urinary catheter (tube placed to collect urine from the bladder) drainage bag was directly on the floor without a privacy cover <DISINFECTING> In an observation on 08/15/2025, at 9:22 AM, Staff AA, NAC was observed to take the Hoyer (mechanical equipment to assist resident transfers) into resident room [ROOM NUMBER]. At 9:32 AM, it was observed that the Hoyer came out of the room and was placed in the hallway without disinfection. In an observation on 08/19/2025, at 3:18 PM, Staff CC, NAC was observed to bring the Hoyer out of a resident's room and placed in the pink hallway without disinfection. In an interview on 08/19/2025, at 11:19 AM, Staff AA, NAC stated that the expectation for sanitizing reusable equipment was to use disinfectant wipes before and after use. Staff AA stated you only to sanitize reusable equipment if using the equipment on a resident on precautions. In a phone interview on, 08/19/2025, at 12:04 PM, with Staff D, LPN/IP/SDC and Staff B, DNS stated that the expectation for sanitizing reusable equipment would be after each resident use. <RESIDENT 116> Resident 116 admitted to the facility on [DATE] with diagnoses that included pressure ulcer of the sacrum region Stage 4 (severe wound, full thickness with exposed bone, tendon or muscle), urinary tract infection, and resistance to multiple organisms. Review of Resident 116's care plan documented a focus area dated 08/15/2025 that the resident required isolation for infection to wound in the sacral region. Interventions were to wear appropriate PPE. In an observation on 08/18/2025 at 8:42 AM, resident room [ROOM NUMBER] had a contact isolation sign and PPE bin outside of the room. The sign instructed all staff to perform hand hygiene, and to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wear a gown and gloves prior to entering the room. In an observation and interview on 08/18/2025 at 12:10 PM, Staff M, NAC was observed to enter room [ROOM NUMBER] with a lunch tray. Staff M knocked, then entered the room. Staff M was not wearing a gown or gloves. A couple minutes later, Staff M exited the room. Staff M was asked if Resident 116 was on contact isolation, Staff M replied they were not sure. Staff M then walked back to room [ROOM NUMBER] and read the isolation sign on the wall outside of the room, and replied “I did not know, I should have worn a gown and gloves before I entered the room.” In an interview on 08/19/2025 at 10:47 AM, Staff EE, NAC stated they were not aware of any process for disinfecting resident reusable equipment such as the Hoyer's, and vital carts. Staff EE stated they were not clear on when or why residents would be placed on isolation, they just know they are supposed to follow whatever sign is outside of the room. Staff EE could not explain what EBP stood for. In a phone interview on 08/19/2025 at 12:04 PM, Staff D, LPN/IP stated their expectation was staff were to disinfect all resident reusable equipment such as Hoyer's, and vitals carts after every use, between residents. Staff D stated the facility utilized EBP for residents that have catheters, wounds and other devices. Staff D stated they are to wear gown and gloves for all direct contact interactions with the resident. Staff D confirmed that the staff should wear a gown and gloves prior to entering the room for all residents that were on contact isolation precautions. Staff D was not aware that staff were not following the isolation signs outside of the room for Resident 116. Staff D was unaware that Resident 2 and Resident 12 required the use of EBP for all direct contact care and was not aware they had not been on EBP during survey observations. <WATER MANAGEMENT PLAN> On 08/18/2025 at 9:41 AM, a request to Staff A, Administrator, was made to review the facility's water management plan. On 08/18/2025 at 11:11 AM, the facility provided a policy for their water management plan, no plan was provided. On 08/18/2025 at 11:55 AM, a request to Staff FF, Maintenance Director, for the facility water management plan. Staff FF stated they did not have a formal program or any documentation, they were not tracking any systems for water management. In a phone interview on 08/19/2025 at 12:04 PM, Staff D, LPN/IP stated they were not aware of any water management plan for the facility. In an interview on 08/19/2025 at 1:29 PM, Staff A stated the facility did not really have any areas where there was standing water. Staff A was asked if they had a water management plan, and they stated they did not. This is a repeat deficiency from SOD dated 11/15/2024. Reference WAC 388-97-1320(1)(a)(2)(a-c)(5)(c)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an advance directive (AD-a written instruction, such as a living will or Durable Power of Attorney [DPOA] for health care [a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so]) was obtained and completed for 4 of 21 sampled residents (Residents 3, 4, 22 and 82), reviewed for advance directives. This failure placed the residents and/or their representatives at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice. Findings included . Review of the undated facility policy titled, Advance Directives, documented the social services director or designee will inquire of the resident or family members or legal representatives about the existence of any written advance directives. Information about whether the resident had executed an advance directive shall be displayed prominently in the medical record. The facility staff would offer assistance in establishing advance directives if the resident indicated that he or she has not established advance directives. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive. <RESIDENT 3> Resident 3 admitted to the facility on [DATE]. According to the Quarterly Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident had moderate cognitive impairment. Review of Resident 3's electronic health record (EHR) showed no AD documentation or Resident 3 had been provided with assistance to formulate an AD. Review of Resident 3's care plan, print date [DATE] at 1:39 PM, there was no focus care area addressing an AD. <RESIDENT 22> Resident 22 readmitted to the facility on [DATE]. According to the admission MDS, dated [DATE], Resident 22 had moderate cognitive impairment. Review of Resident 22's EHR showed no AD documentation or documentation that AD had been discussed. In an interview and record review on [DATE] at 2:20 PM, Staff G, Social Services, stated they would check for POA documentation and if unable to find documentation they would ask the resident who the contact person would be. Staff G acknowledged there was no AD or documentation of discussion of AD for Resident 22. <Resident 4> Resident 4 readmitted to the facility on [DATE]. According to the Quarterly MDS dated [DATE], the resident was cognitively intact. Review of Resident 4's EHR showed no AD documentation or that the resident had been provided with assistance to formulate an AD. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 4's care plan, print date [DATE] at 2:47 PM, there was no focus care area addressing an AD. In an interview on [DATE] at 8:36 AM, Staff F, Medical Records, was asked about the location of AD documentation in the medical record. Staff F stated they would look for it but no further information was provided. In an interview on [DATE] at 10:19AM, Staff H, Social Services, stated they asked residents and/or representatives to bring in the AD during admission and they would follow up in care conferences if there was no copy. Staff H stated they could arrange help if they needed assistance. Staff H stated they would look for AD documentation for Resident's 3 and 4. In an interview and record review on [DATE] at 11:25 AM, Staff H stated they found AD documentations for Resident 3 and 4. Staff H provided copies of the POSLT (Directive if would like CPR if heart stopped) but did not provide evidence of their being a POA or living will or the residents were provided resource to put into place. In an interview and record review on [DATE] at 1:16 PM, Staff H stated they documented AD information in the care conference notes. Review of Resident 3 and 4's care conferences printed by Staff H, there was no documentation whether the facility received copies of AD or provided with assistance to formulate an AD. Staff H stated the received AD would be uploaded into EHR; if not, that meant the facility did not have the copy. In an interview on [DATE] at 9:42 AM, Staff A, Administrator, stated they expected staff to request a copy of the resident's AD for the medical record on the initial care conference, and staff should provide education on how to obtain an AD if residents did not have one in place. Staff A stated they expected the AD information to be documented on the medical record. <RESIDENT 82> Resident 82 was admitted to the facility for hospice care on [DATE] with diagnoses to include cancer. Review of the resident's hospital medical record revealed the resident elected for no Cardio Pulmonary Resuscitation and that the resident had an advanced directive. Review of the facility advance directives tab showed Resident 82 had a Physician Orders for Life-Sustaining Treatment,” POLST developed on [DATE] in place but no AD. POLST as a medical order from a physician, nurse practitioner or physician's assistant to other health professional with instructions that complement an advanced directive. The residents POLST showed they did not want resuscitation attempted and chose comfort-focused treatment. The POLST does not take the place of an Advance Directive or replace the need for or the importance of a durable power of attorney for healthcare. Review of the care conference note dated [DATE] at 3:19 PM, showed no discussion of AD. In an interview on [DATE] at 3:18 PM, Staff A, Administrator, stated they had not located the list of advanced directives as requested including an AD for Resident 82. Staff A stated they were checking with the hospital to see if they had their AD. (continued on next page)

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	505319	A. Building B. Wing	08/20/2025

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an email dated [DATE] at 1:36 PM, received from Staff A showed the facility had only located the POLSTS rather than the AD for Resident's 3, 22 and 82. In an interview on [DATE] at 9:52 AM, Staff A stated they were not aware of an issue with advanced directives. Staff A stated their expectation was that at the initial care conference, staff should request a copy of the residents' AD and if they did not have one, then staff should provide education to the residents on how to obtain them. If the resident did have one, they should receive the copy for the medical record. This should be documented in the medical record. Reference WAC 388-97-0280 (1)(3)(a)(c)(ii)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 2 of 5 residents (Resident's 22 and 81) were reviewed for unnecessary medications (a drug that affects brain activities associated with mental processes and behavior). The facility failed to provide a valid diagnosis for the use of psychotropic medications, ensure a consent was obtained, attempt non-pharmacological interventions, and monitor hours of sleep which placed residents at risk for receiving unnecessary psychotropic medications, for adverse events and diminished quality of life. Findings included .Review of the policy titled, Anti-psychotic Medication Use undated stated residents will only receive anti-psychotic medications when necessary and when necessary to treat specific conditions for which they are indicated and effective. Diagnosis of a specific condition for which anti-psychotic medications are necessary to treat will be based on a comprehensive assessment. Nursing staff shall monitor for and report adverse side effects. <RESIDENT 81> Resident 81 admitted on [DATE] with diagnoses to include generalized anxiety disorder and post traumatic stress syndrome (PTSD). Review of the admission Minimum Data Set (MDS), an assessment tool dated 07/29/2025 showed the resident did not show signs of psychosis (delusions and hallucinations). The MDS showed the resident was taking anti-psychotic and anti-anxiety medications. Review of the physician orders documented Resident 81 was taking Seroquel (anti-psychotic medication) twice a day beginning 07/29/2025 for behaviors and insomnia, an inappropriate indication for the medication use. Review of the clinical record showed Resident 81 had no signs of psychosis or insomnia. There was no consent for the Seroquel located in the clinical record. Review of a progress note dated 07/24/2025 at 12:00 AM, showed the resident was assessed for depression and denied trouble sleeping, staying asleep or sleeping too much. Review of the July Medication Administration Record (MAR) directed staff to monitor for behaviors of repetitive questions, withdrawal from activities and expressions of unrealistic fears every shift beginning 07/23/2025. All shifts showed there were no signs of anxiety. There was no sleep monitor in place. Review of the August MAR anti-anxiety monitor showed the resident experienced anxiety on 4 of 55 shifts. The documentation did not reflect which of the behaviors the resident experienced nor what nonpharmacological interventions were attempted. There was no sleep monitor in place. In an interview on 08/20/2025 at 9:52 AM, Staff B, Director of Nursing Services stated they were not aware of issues with psychotropic medications. Staff B stated they audit these medications to make sure they are only giving anti-psychotics for diagnoses that are appropriate. Staff B stated Resident 81's medication without the appropriate diagnosis must have been isolated. They stated they should have consents and non-pharmacological interventions in place. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<RESIDENT 22> Resident 22 admitted to the facility on [DATE] with diagnoses to include generalized anxiety disorder and PTSD and readmitted to the facility on [DATE] with additional diagnosis of major depressive disorder. Review of physician orders showed an order dated 08/05/2025 for Hydroxyzine (medication with sedative effects) for anxiety and insomnia daily at bedtime. Review of the August MAR did not show non-pharmacological interventions or monitoring hours of sleep. In an interview on 08/19/2025 at 12:25 PM, Staff DD, Registered Nurse (RN), stated non-pharmacological interventions would be attempted prior to the administration of antianxiety medication and documented on the MAR. Hours of sleep would be monitored for sedative medications and documented on the MAR. In an interview and record review on 08/19/2025 at 12:50 PM Staff Q, Licensed Practical Nurse/Unit Manager stated non-pharmacological interventions should be attempted prior to the administration of psychotropic medication. Staff Q stated they would be included in the physician order and documented on the MAR. They stated that hours of sleep would be documented for sedative/hypnotic medication. Staff Q acknowledged that non-pharmacological interventions and monitoring of sleep hours were not on the physician orders or documented on the MAR for Resident 22. Reference WAC 388-97-0620(1)(b)(4)(a)(b)(c)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the recommendation of the Level ll Preadmission Screen 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]) evaluation was submitted after a hospital exemption was no longer valid for 1 of 5 residents (Resident 72) reviewed for PASRR. This failure placed residents at risk of behavioral health needs not being met and a diminished quality of life.Findings included.Review of the undated facility policy titled, Long-Term Services and Supports Screening, PASRR Policy, documented that when a resident has a positive Level l screening, the facility will initiate the Level ll screening.<Resident 72> Resident 72 was admitted on [DATE] with diagnoses to include Major Depressive Disorder (MDD), severe with psychotic symptoms and anxiety. In a review of Resident 72's PASRR Level l, it was documented the resident had a serious mental illness (SMI) with mood disorders and that there was evidence that the person exhibits serious function limitations during the past six months related to a SMI. The PASRR Level l indicated a Level ll must be completed if scheduled discharge did not occur. In review of Resident 72's progress notes, it was documented that the resident had a hospital exempt PASRR (if stay at facility was to exceed 30 days, must have a level II completed) by Staff H, Social Services (SS), dated 07/07/2025. On 07/09/2025, it was documented that Resident 72 will be staying at this facility as a long-term care resident by Staff G, SS. In an interview on 08/19/2025, at 2:45 PM, with Staff H, SS stated that if a PASRR comes from the hospital with an exemption but indicated for a Level ll, then the process would be to send in a Level ll for validation. Staff H confirmed no Level ll PASRR was sent in for Resident 72. This is a repeat deficiency from 11/15/2024. Refer to WAC 388-97-1975(5)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide an environment that was free from accident hazards over which the facility had control for 1 of 3 residents (Resident 5) reviewed for falls. Failure to identify hazards and implement safety interventions in the facility therapy courtyard, resulted in Resident 5 experiencing a fall and placed residents at risk for injury. Findings included.Resident 5 admitted on [DATE] following an orthopedic surgery. Resident 5 was alert and oriented, and was wheelchair bound. In an observation and interview on 08/14/2025 at 9:42 AM, Resident 5 stated they had fallen about a week prior while outside in the courtyard. Resident 5 stated they were in their wheelchair with their back facing what they believed was a paved ramp. Resident 5 stated they began to wheel themselves backwards, and then suddenly fell back off a step, landing on their back on the cement ground. Resident 5 stated they hit their head and were scratched up on their elbows. Resident 5 stated they were very lucky not to have been seriously hurt and stated the step should have been more obvious, it just blended in with the cement. Resident 5 stated after they fell, the facility tied some ribbon across the top of the step. Resident 5 was observed to have several scratched areas on their arms covered with band aids. In an observation on 08/14/2025 at 2:00 PM, the first-floor courtyard was observed to have a cement pathway which included a ramp, followed by a left turn with a straight section which led to the cement step. The cement step area had metal railings on both sides, but no gate or barrier at the top, and no identifying paint or other markings to indicate that it was a step. Orange flag tape had been tied across the hand railings at the top of the step. After stepping up, the path turned left again and returned to the main courtyard near the door. In an interview on 08/19/2025 at 2:19 PM, Staff A, Administrator, stated the configuration of the courtyard was due to it being a “therapy” courtyard, so it intentionally included changes in elevation and the step. Staff A stated the facility had previously not provided supervision when residents were in the courtyard. Staff A stated they wanted residents to be able to use it but had not previously identified the step as a potential hazard. Staff A stated there was a temporary marker in place and a removable solid barrier had been ordered. Reference WAC 388-97-1060 (3)(g)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 2 of 6 sampled resident's (Residents 3 and 81) reviewed for nutrition, received adequate weight monitoring, and implemented effective interventions to maintain adequate nutrition and hydration. This failure placed residents at risk of ongoing weight loss, poor nutrition, and potential harm. Findings included.Review of the facility policy titled, Weight Assessment and Intervention, dated 10/01/2021, documented the nursing staff will measure resident weights as ordered by the physician/practitioner and recorded in the medical record . The dietary staff will review the weight records, and the treatment team will evaluate negative trends . Unplanned significant weight change will be investigated and analyzed by the interdisciplinary team . Care planning for unplanned wright changes or impaired nutrition risks will be an interdisciplinary effort, including causes of weight loss, goals, time frames and parameters for monitoring . Interventions for significant weight loss include nutrition and hydration needs of the resident, chewing and the need for diet modifications, the use of supplementation .The interdisciplinary team will make additional evaluations including referrals to dental consult. <RESIDENT 81> Resident 81 admitted on [DATE] with diagnoses to include severe protein-calorie malnutrition, gastrointestinal reflux syndrome (acid reflux), electrolyte disturbances and chronic lung disease. Review of the admission transfer orders from the hospital on [DATE] directed staff to weigh Resident 81 daily and provide a pureed diet and nutritional supplements, berry preferred daily. Review of the July Medication Administration Record (MAR) directed staff to weigh the resident on admission on [DATE] and weekly three times, then monthly on Thursdays. Review of the initial nutritional at risk assessment dated [DATE], showed the resident was underweight at 62 pounds and their ideal body weight was 120 pounds. The diet was listed as regular texture rather than the ordered pureed texture. The assessment was incomplete and did not include nutrition education or a mini nutritional assessment that would score the residents nutritional status. Review of the August MAR showed a weight refusal on 08/07/2025 and a weight of 62 pounds on 08/14/2025. There were no further weights recorded. Review of the admission MDS dated [DATE] showed the resident was 64 inches tall, weighed 62 pounds and had no teeth. Review of the nutrition Care Area Assessment (CAA) dated 07/29/2025 showed the resident had a body mass index (BMI) of 10.6 which indicated significantly underweight status, and serious health issues like compromised immune system, increased risk of disease and fatigue. The CAA noted that the resident had poor oral intake. Resident 81's Registered Dietician (RD) notes showed the resident reported feeling okay with fair appetite, denies any gastrointestinal symptoms or issues with chewing/swallowing, though noted poor dentition and they preferred meats and vegetables to be cut into small pieces. The notes documented Resident 81 reported mild stomach discomfort, and they were aware of weight loss but unsure of the amount, and they appeared very thin with signs of possible malnutrition. Resident 81 was at risk for unavoidable weight loss and potential skin breakdown due to their care goals. Weight loss was expected given their poor appetite and inconsistent intake. The focus remained on promoting satiety and comfort, with no current complaints (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of thirst or hunger and their dietary preferences would continue to be honored. Resident 81 enjoyed cream of rice prepared with two packets of brown sugar and one packet of table sugar. The resident did not consume juice and preferred tea and water. Review of the nutritional care plan dated 07/23/2025 showed the resident was at nutritional risk due to advanced age, goals of care, underweight BMI and past medical history. The care plan included only one intervention for RD consult. The care plan did not include the residents' goals, food preferences, missing dentures, or other interventions. Review of a weight note on 07/31/2025 at 2:25 PM, showed the weight was reviewed with the RD and the RD would evaluate the resident for a weight gain supplement. Review of the progress notes showed there was no further mention or orders for nutritional supplement although ordered on admission. Review of the clinical record showed the resident had the following weights since admission: · 07/23/2025: 62.0 pounds · 07/31/2025: 62.0 pounds · 08/07/2024: 62.0 pounds Review of a progress note dated 08/04/2025 at 12:00 AM from Collateral Contact (CC) 2, Physician Assistant, showed the resident was underweight with severe protein/calorie malnutrition and noted sporadic meal intakes. CC2 documented the resident appeared to have lost their dentures and they were unable to tolerate the regular texture diet. CC 2 downgraded the diet to mechanical soft. In an interview on 08/20/2025 at 9:52 AM Staff B, Director of Nursing Services stated they were aware of nutrition issues. Staff B stated two weeks ago they started having weekly skin and nutrition meetings to look at high risk residents and address issues right away. Nursing documentation did not contain evidence of ongoing assessment, implementation of interventions and re-evaluation of interventions consistent with professional standards. The nursing documentation also did not reflect a proactive approach to weight monitoring and nutritional management. <RESIDENT 3> Resident 3 admitted to the facility on [DATE]. In an observation on 08/14/2025 at 10:17 AM, Resident 3 was observed lying in bed with their eyes closed, the overbed table had their uneaten breakfast tray was present. In an observation and interview on 08/15/2025 at 9:38 AM, Resident 3's breakfast tray was observed in front of them untouched. Resident 3 stated they would not eat because they had no appetite for three months. In an observation on 08/15/2025 at 10:39 AM, Resident 3 was sleeping in the bed, their breakfast tray (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was still on the bedside table untouched with a half cup of yellow color juice left on the table. In an observation and interview on 08/15/2025 at 12:36 PM, Resident 3's breakfast tray was on the chair at the bedside, and the lunch tray was in front of them. Resident 3 stated they did not eat breakfast and did not want to eat lunch either. Resident 3 stated the nurse did not give them any substitute in the morning and they did not want to eat anything. In an observation and interview on 08/18/2025 at 8:41 AM, Resident 3's breakfast tray was observed on the bedside table in front of them untouched. Resident 3 stated they had dental pain, and they did not want to eat. The food on the tray was observed to be regular texture. Resident 3 stated they started to lose their appetite in April. Resident 3 stated they felt they were losing weight because their clothes got very loose. Resident 3 stated they wanted to “have my appetite back.” In an observation on 08/18/2025 at 9:50 AM, 10:17 AM and 11:43 AM, Resident 3's breakfast tray remained on the bedside table untouched. In an observation and interview on 08/18/2025 at 11:43 AM, Resident 3's lunch had regular textured ham. Resident 3 stated they liked ham, but they could not chew due to their broken teeth and toothache. Resident 3 stated they had teeth problems since admission. Resident 3 stated their only intake today was half cup of orange juice. In an observation and interview on 08/19/2025 at 9:26AM, Resident 3 stated they did not eat anything yesterday and drank about 12-14 ounces liquid the whole day. Resident 3 stated they did not drink enough and wanted to drink more water. There was no water pitcher or cup in the room. Resident 3 stated they had no water to drink; someone took the water pitcher away yesterday morning and did not bring it back. In an observation and interview on 08/19/2025 at 1:15 PM, Resident 3 stated they felt “weak.” Resident 3 stated they still did not eat anything at breakfast and lunch and only drank some fluid. Review of Resident 3's diet order, ordered date 03/17/2025, indicated Resident 3's diet was regular texture. Review of Resident 3's nutritional at risk assessment on 06/14/2025, documented average oral intake was 35% per meal monitor and the goal was to keep their meal intake more than 85%. The assessment documented that a current weight was needed. Review of the physician's orders directed staff to weight the resident on admission, weekly for three weeks, and one time a day every 28 days beginning 07/09/2025. Review of Resident 3's weight record since admission, showed the resident weighed 271.5 lb on 03/17/2025, 258.8 lb on 03/25/2025 and 215.4 lb on 08/01/2025. There was no weight record other than the three weights. Resident 3 had 16.77% weight loss from 03/25/2025 to 08/01/2025. Review of Resident 3's care plan dated 08/15/2025 at 1:39 PM, showed there was no care area addressing nutrition status. Review of Resident 3's care record on 08/19/2025, showed there was no fluid intake amount (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recorded. Review of a note from Collateral Contact (CC) 2 note on 08/07/2025 at 12:00 AM, directed staff to add a nutritional shake for Resident 3. Review of Resident 3's August 2025 MAR, showed there was no documentation of how much nutritional shake Resident 3 consumed. Review of Resident 3's progress notes from 08/07/2025 to 08/18/2025, did not include documentation of how much nutritional shake Resident 3 had consumed. Review of a dietitian progress note on 08/15/2025 at 1:03 PM, documented Resident 3 had minimal appetite for the past one to two months. In an interview on 08/15/2025 at 1:41 PM, Staff HH, Nursing Assistant Certified (NAC), stated Resident 3 was not eating at all and stated they had a toothache. In an interview on 08/15/2025 at 1:52 PM, Staff O, Registered Nurse (RN), stated Resident 3 had been refusing meals. Staff O stated Resident 3 had a meal intake monitor but not a fluid intake monitor and there was no documentation of how much fluid the resident drank. In an interview on 08/18/2025 at 2:21 PM, Staff L, Licensed Practical Nurse (LPN)/Unit Manager, stated the resident weights were supposed to be monitored on admission, then weekly for three weeks, then monthly. Staff L was not sure why Resident 3 had no weight recorded from 03/25/2025 to 08/01/2025. Staff L stated Resident 3 drank water and juice and nurses were supposed to document and record how much fluid and health shake was accepted by the resident. Staff L stated they were not aware that Resident 3 had dental problems and toothache. Staff L stated the care area of nutrition was supposed to be in the comprehensive care plan. In an interview on 08/19/2025 at 8:35 AM, Staff JJ, Cook, stated they were not aware of Resident 3's dental problems and toothache until yesterday. Staff JJ stated the resident's diet could be downgraded if there was a speech therapy's order or provider's order. In a phone interview on 08/19/2025 at 11:45 AM, Collateral Contact (CC) 5, Dietitian, RD, stated there was lack of obtaining of routine weights in the facility. CC5 stated if Resident 3 had routine weight monitoring, they could do a better assessment and provide better interventions. CC5 stated Resident 3 had lost their appetite for the last two months and they had not been informed. CC5 was concerned about Resident 3's nutrition and protein adequacy. CC5 stated they reviewed Resident 3's laboratory result and they were concerned about hydration status, and the fluid intake monitor should be in place. In an interview on 08/19/2025 at 2:10 PM, CC2, Physician Assistant, stated they were concerned about Resident 3's weight and fluid intake due to the resident taking a diuretic. CC2 stated they were unable to review the weight because there were no weights recorded. CC2 stated they had requested staff to obtain the weight every time they reviewed the resident. CC2 stated they were not informed that Resident 3 had a decreased appetite in the last two months, and they would have started interventions earlier if they knew. In an interview on 08/19/2025 at 2:53 PM, Staff B, Director of Nursing Services, stated they expected (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monthly weight monitoring for long term residents and there were other ways to monitor weight even if residents refused to use weight scales. Staff B stated they expected there was fluid intake monitoring for residents taking diuretics and poor oral intake. Staff B stated the nutrition care plan was supposed to be included in the comprehensive care plan and the dental concerns were supposed to be identified early and referred to the dentist as soon as possible. In an interview on 08/20/2025 at 9:26 AM, Staff A, Administrator, stated the expectation was to monitor weight at least monthly or more frequently for some clinical situations; and monitor nutritional status, and to identify dental concerns and refer for treatment early. This is a repeat deficiency from SOD dated 11/15/2024. Reference WAC 388-97-1060 (3)(h)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure 1 of 1 resident (Resident 101) reviewed for dialysis services received accurate, specific care and monitoring and received coordinated communication and collaboration with the dialysis facility. These failures had the potential to cause unmet care needs and unrecognized medical complications. Findings included.Resident 101 was admitted in February of 2023 with a diagnosis of End Stage Renal Disease requiring hemodialysis (process to filter toxins from the blood). Review of Resident 101's medical record documented that the resident had an indwelling tunneled jugular (IJ) catheter (directly inserted into large vein creating a permanent access for dialysis) in the right upper chest as their dialysis access. The IJ catheter was utilized and accessed only by the kidney center. The facility was to monitor only. In an interview and observation on 08/14/2025 at 09:00 AM, Resident 101 stated they go to dialysis three days a week. Resident 101 pulled down the top right corner of their shirt to show their tunneled dialysis catheter with a clear dressing over the top. Resident 101 stated the staff here weren't doing anything with it, they take care of it at the kidney center. Review of Resident 101's care plan dated 02/03/2025 showed generic interventions in place for dialysis which had not been personalized to state the resident's dialysis access was an IJ catheter. The care plan included interventions and monitoring for an AV fistula (a different type of dialysis access; a surgically created connection between an artery and a vein) which included interventions to monitor for bruit and thrill (turbulent sounds and palpable vibrations specific to AV fistulas which indicate they are functioning properly). Review of the Treatment Administration Record (TAR) dated 02/03/2025 showed an entry instructing nurses that if the resident had a fistula for staff to remove the dressing four hours following return from dialysis. This was not applicable for Resident 101, as they did not have a fistula, yet nursing staff were signing it as completed. The TAR also instructed staff each shift to “check access at right upper chest for lack of bruit/thrill, signs of infection, swelling, or bleeding and report to physician.” The documentation included “y” or “n” with no clarification of what constituted “y” or “n,” and review of the documentation responses for the month of August 2025 (review date 08/18/2025) showed 36 “n” responses, 7 “y” responses, 1 “0” response, and 7 blank responses. In an interview on 08/19/2025 at 12:53 PM, Staff N, Registered Nurse, reviewed the documentation on the TAR for Resident 101. Staff N confirmed they worked full time and stated Resident 101 had an indwelling catheter on their right chest that they monitored. Staff N confirmed that the dialysis center did the dressing changes and managed the care of the catheter. Staff N confirmed their initials on the TAR for Resident 101 and was asked regarding conflicting documentation. On August 1,3,4,5,6,7,10,12,14,15, and 18, 2025, Staff N initialed and charted “n” on the TAR. On August 8 and 13, 2025, Staff N initiated and charted “y.” Staff N stated they were confused about what was meant by “n” or “y,” but stated they meant to indicate that there were no complications. Staff N stated the nurses must be making a mistake when reading it. Staff N stated they had not noticed that the TAR incorrectly directed them to assess for a bruit and thrill that did not apply to the resident. Review of the dialysis communication system on 08/19/2025 showed that the facility sent a paper with the resident's “pre” dialysis vital signs and status with the resident. The (continued on next page)

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	505319	A. Building B. Wing	08/20/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	“post” dialysis was not completed by the dialysis center, instead it was faxed over to the facility and scanned in the record. The facility also completed an electronic version of the “pre” dialysis and a separate “post” dialysis assessment. The process was inconsistent and did not show an organized system for communication and monitoring of the resident “pre” “during” and “post” treatment between the facility and the dialysis center. In an interview on 08/19/2025 at 1:49 PM, Staff L, Licensed Practical Nurse/Unit Manager, stated they had not noted that the care plan for Resident 101 had not been completed accurately with respect to their dialysis access and monitoring. The care plans were reviewed quarterly and with changes. Staff L stated the dialysis center sent the treatment sheets over separately and did not complete the paper that the facility sent. Staff L stated that Medical Records was sometimes slow to scan in the dialysis sheets and that they had not been auditing whether all of the sections of the assessments were completed in the electronic record. This is a repeat deficiency from 11/15/2024. Reference WAC 388-97-1900

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and record review, the facility failed to provide nonpharmacological interventions prior to the use of as needed pain medications for 1 of 1 sampled residents (Resident 26) reviewed for pain medication use. The facility failed to provide nonpharmacological interventions These failures placed residents at risk for receiving unneeded mediations, related side effects of medications and a diminished quality of life.Findings included .Review of a facility policy titled Pain Management, undated showed;9. Various strategies and modalities may be utilized to assist the resident in achieving optimal comfort. Such strategies and modalities may include, but are not limited to: a. Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: i. Environmental-adjusting the room temperature, smoothing he linens, providing a pressure reducing mattress, repositioning, etc; ii. Physical-ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; iii. Exercise-range of motion exercises to prevent muscle stiffness and contractures; iv. Cognitive or Behavioral-relaxation, music, diversions, activities, etc. <RESIDENT 26> Resident 26 admitted to the facility on [DATE] with diagnoses to include arthritis and pain in right hip. Review of Resident 26's physician orders showed the resident receives pain medication as needed (PRN) for pain management. Review of Resident 26's Medication Administration Record (MAR) dated 07/21/2023 through 07/31/2025 showed the resident used PRN pain medication 38 times. Review of Resident 26's MAR dated 08/01/2023 through 08/17/2025 showed the resident used PRN pain medication 43 times. In an interview on 08/19/2025 at 12:25 PM, Staff DD, Registered Nurse (RN), stated non-pharmacological interventions would be attempted prior to the administration of PRN pain medications. In an interview and record review on 08/19/2025 at 12:50 PM, Staff Q, Licensed Practical Nurse (LPN), Nurse Manager confirmed non-pharmacological interventions should be attempted prior to administration of PRN pain medication and would be documented on the MAR. Staff Q acknowledged non-pharmacological interventions were not being provided for Resident 26. In an interview on 08/19/2025 at 3:50 PM, Staff B, Director of Nursing Services acknowledged non-pharmacological interventions should be attempted prior to administering PRN pain medication but would not be documented the MAR. Reference WAC 388-97-1060(3)(k)(i)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 5 residents (Resident 44) remained free of significant medication errors during medication administration. This failure of administrating expired insulin injection placed residents at risk for unnecessary medication-related complications and diminished quality of life.Findings included. Resident 44 readmitted to the facility on [DATE] with diagnoses to include Type 2 Diabetes Mellitus (DM - a chronic metabolic disorder characterized by persistent high blood sugar). Review of Resident 44's physician orders dated 11/06/2024 documented to administer Humalog Solution (medication inserted into the body to help regulate blood sugar levels) subcutaneously three times a day for diabetes. In a medication administration observation and interview on 08/14/2025 at 4:24 PM, Staff KK, Registered Nurse (RN) withdrew the insulin vial and was about to administer to Resident 44. The insulin vial had a label with an open date of 07/10/2025. Staff KK was asked how long the facility kept the insulin vial after it had been opened. Staff KK confirmed the insulin was opened on 07/10/2025 as written on the label and they stated the after-open-use date at minimum would be 24 days and could be used until the end of August. Staff KK was stopped prior to administering the expired insulin. In a following joint interview on 08/14/2025 at 4:30 PM with Staff KK, and Staff L, Licensed Practical Nurse/Unit Manager, Staff L stated the insulin vial was good for 28 days after it was opened and this insulin was already expired. Staff KK disposed of the insulin vial and the prepared insulin injection syringe and stated they would have injected the medication to the resident if they had not intervened. In an interview on 08/14/2025 at 4:44 PM, Staff L stated it would be a medication error if the expired insulin had been administered to the resident. In an interview on 08/18/2025 at 2:41 PM Collateral Contact (CC) 1 stated they were the pharmacy consultant for the facility and were there on a quarterly audit removing all the expired medications from the carts there. CC 1 stated they had hoped to complete the audit before the survey. CC 1 had a tablet with multiple expired medications written down for their report to provide to the facility. In an interview on 08/19/2025 at 2:53PM, Staff B, Director of Nursing Services, stated they expected nurses to check the medication expiration date and not administer expired insulin to residents. This is a repeat deficiency from SOD dated 11/15/2024. Reference WAC 388-97-1060-3(k)(iii)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure laboratory (labs) tests were completed as ordered and to provide timely laboratory results to meet the needs of 1 of 3 residents (Resident 33) reviewed for laboratory services. These failed practices had the potential for negative complications related to delay of obtaining and review of lab results. This failure had potential for risk for medical complications, related to a lack of monitoring chronic medical conditions and delayed identification and treatment of underlying health conditions.Findings included.Review of facility policy titled, Lab and Diagnostic Lab Results dated 10/01/2021 documented the facility will provide notification and follow up of practitioner recommendations regarding labs. <RESIDENT 33>Resident 33 was re-admitted on [DATE] with diagnoses to include iron deficiency anemia secondary to blood loss, a left hip pressure ulcer, cellulitis (infection of the skin) of their right leg and an open wound to their left lower leg.Review of the physician's order on 06/13/2025, directed staff to obtain complete blood count (CBC) with differential and complete metabolic panel (CMP) weekly.Review of the June Medication Administration Record (MAR), showed the nurse signed the CBC and CMP lab had been obtained on 06/03/2025 and 06/20/2025.Review of the clinical record showed CBC/CMP lab results for 06/02/2025, 06/11/2025 and 06/20/2025. There was no lab result for the week of 06/27/2025.Review of the July MAR showed the nurse signed the CBC and CMP lab had been obtained on 07/04/2025 and 07/11/2025.Review of the clinical record showed CBC/CMP lab results for 07/07/2025, 07/14/2025 and 07/29/2025. There was no lab result for the week of 07/21/2025.Review of the August MAR showed the nurse signed the CBC and CMP lab had been obtained on 08/01/2025, 08/08/2025 and 08/15/2025.Review of the clinical record showed CBC/CMP lab results for 08/05/2025 only as of 08/20/2025 at 8:02 AM. There were no lab results for the week of 08/12/2025.In an interview on 08/19/2025 at 9:49 AM, Collateral Contact 2, Physician's Assistant, said they wanted Resident 33 to have their CBC and CMP drawn weekly. CC 2 stated most of the time they get the lab results as ordered. CC 2 stated that sometimes labs were drawn one day and then also the next day, so another lab was drawn which was unnecessary. CC 2 stated they were not sure why Resident 33's labs were not drawn weekly as ordered. CC 2 stated if they noticed there were no lab results that they were expected to review, then they would fill another lab slip out and make sure there was a current lab order.In an interview on 08/19/2025 at 2:37 PM, Staff Q, Licensed Practical Nurse/Unit Manager stated they had heard that Resident 33 had missed some of their weekly labs. Staff Q did not provide any additional information. In an interview on 08/20/2025 at 9:52 AM, Staff B, Director of Nursing stated they were not aware of any lab concerns and Resident 33's missed labs were an isolated event. Staff B stated they checked for lab completion every day.No additional information was provided.Reference WAC 388-97-1620(2)(b)(i)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food services met the individual food plans, nutritional needs and preferences for 1 of 2 sampled residents (Resident 102) reviewed for nutrition and preferences. The failure placed residents at risk for not having their food choices honored, dissatisfaction with meals, unmet nutritional needs, and a diminished quality of life. Findings included.Review of the facility policy titled, Food and Nutrition Services, dated 10/01/2021, documented food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident. Resident 102 was admitted to the facility on [DATE]. According to the Annual Minimum Data Set (MDS-an assessment tool), dated 07/13/2025, the resident was cognitively intact. In an interview on 08/13/2025 at 10:27 AM, Resident 102 stated the food served did not match the tray card or what they ordered from the menu. In an observation, interview and record review on 08/13/2025 at 11:59 AM, Resident 102 stated they had no meatballs on their lunch plate. Review of the tray card documented large protein serving and included meatballs/beef, mixed vegetables and oven roasted potatoes. Resident 102's lunch tray did not contain meatballs/beef, no roasted potatoes and no vegetables, but a slice of pizza. Resident 102 stated their slice of pizza was not considered a large protein serving. In an observation, interview and record review on 08/14/2025 at 12:00 PM, Resident 102's lunch tray had a fruit plate including strawberries, grapes and watermelon, 2 small packages of biscuits, one small container of cottage cheese, sherbet and cranberry juice. Review of their tray card documented the lunch should have vegetable stuffed peppers, yellow rice, and asparagus spears. Resident 102 stated the tray did not include the ordered vegetable stuffed peppers, rice or asparagus spears on their plate and they commented they disliked cottage cheese. In an observation, interview and record review on 08/15/2025 at 8:10 AM, Resident 102 stated they were supposed to have pancakes on the breakfast tray. Review of the tray card documented homestyle pancakes. The breakfast tray was observed to include two pieces of bread and no pancake. In an observation, interview and record review on 08/19/2025 at 8:25 AM, Resident 102 stated they were supposed to have four slices of bacon but there were only two on the meal tray and no sausage links. Review of tray card documented 4 slices of bacon and 2 oz sausage links. The breakfast tray only had 2 slices of bacon and no sausage links. In an interview on 08/15/2025 at 9:51AM, Staff K, Nursing Assistant Certified (NAC), stated that at times that Resident 102's meals served did not match the tray card and the resident would get upset about that. In an interview on 08/20/2025 at 9:16 AM, Staff EE, NAC, stated the food served and the tray card did not match sometimes, and they did not understand why. In an interview on 08/19/2025 at 11:45 AM, Collateral Contact (CC) 5, Registered Dietitian, stated their record indicated Resident 102 needed large portions of protein. CC 5 stated they had heard from other residents that they did not get the food served according to their tray cards. In an interview on 08/19/2025 at 3:54 PM, Staff JJ, Cook, stated they were aware that sometimes the tray card and the food served did not match but they were supposed to match. In an interview on 08/20/2025 at 9:26 AM, Staff A, Administrator, stated they expected the food served to match the tray card and match what residents chose from the menu. Reference WAC 388-97-1180(1)-1120 (3)(a)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide the required specialized rehabilitative services for 1 of 2 residents (Resident 1), reviewed for rehabilitation services. This failure placed the residents at risk for the decline in function, unmet care needs and a diminished quality of life. Findings included . Resident 1 was admitted to the facility on [DATE], with diagnoses that included a history of a stroke that affected mobility to the left side of their body, muscle weakness, limited activity due to disability, and depression. The admission Minimum Data Set (MDS - an assessment tool) dated 08/04/2025 showed the resident had no cognition impairment, and no refusal of care, and the resident was dependent for toileting care, and required substantial to maximum assistance for transfers. Review of Resident 1's hospital transfer orders dated 07/29/2025, documented orders for evaluation and management for Physical Therapy (PT), and Occupational Therapy (OT). Review of Resident 1's facility physician orders dated 07/29/2025, showed orders for evaluation and treatment as indicated for PT, OT and Speech Therapy (ST). Review of Resident 1's care plan had a focus dated 07/29/2025 that the resident had admitted to the facility for rehabilitation and required assistance with their activities of daily living (ADLs) due to history of a stroke that affected the left side of their body. Interventions included skilled physical therapy, skilled occupational therapy, and skilled speech therapy. Review of Resident 1's PT evaluation dated 07/30/2025 documented recommended treatment for PT would be five days a week. The resident stated their goal was to walk around in their home again. The evaluation documentation showed the resident demonstrated fair potential for rehabilitation with a focus of treatment to be restoration and adaptation. Review of Resident 1's OT evaluation dated 07/30/2025 documented recommended treatment for OT would be five days a week. The resident stated their goal was to increase strength to ambulate again. The evaluation documentation showed the resident had good rehabilitation potential as they were able to follow directions, make their needs known, and actively participate in the skilled treatment. The focus of treatment would be restoration, compensation and adaptation. Review of Resident 1's ST evaluation dated 08/02/2025 documented recommended treatment for three days a week. Resident demonstrated excellent rehabilitation potential. Review of Resident 1's provider note dated 08/12/2025 documented that the resident was admitted to the facility for ongoing PT and OT treatment to improve weakness, and ongoing rehabilitation. In an interview on 08/13/2025 at 10:28 AM, Resident 1 stated they came to the facility from the hospital because they needed more physical therapy so they could walk again. Resident 1 stated they were seen by therapy when they first admitted but have had no treatments since then. Resident 1 expressed concern they would lose ability to stand and not be able to return home. In an interview on 08/15/2025 at 11:25 AM, Staff NN, Director of Rehabilitation (DOR) stated that the (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility only conducted evaluations on Resident 1 when they admitted , and that therapy was not treating the resident at this time due to the resident had no insurance to cover therapy services. In a follow-up interview on 08/15/2025 at 12:08 PM, Staff NN stated when the residents admit to the facility for skilled services the facility will obtain Medicare authorization for therapy treatment services prior to admission. Staff NN stated Resident 1 did not have any Medicare days available and was admitted under their state Medicaid insurance. Staff N stated residents that admit with no Medicare funding, the facility must try and request authorization to get approved for therapy reimbursement services through the state Medicaid insurance. Staff NN stated they completed the evaluation and then forwarded that information to the business office, who then request authorization for therapy services. Staff NN stated that without that authorization, they are not allowed to treat the resident as they may not get reimbursement for the services they have provided. Staff NN stated that was why Resident 1 had not had any therapy services since their evaluations, as no authorization had been completed. In an interview on 08/15/2025 at 1:33 PM, Staff OO, Business Office Manager (BOM), stated the therapy department will make a request for state Medicaid insurance reimbursement so they can provide therapy treatment services to a resident. Staff OO stated they were not aware that Resident 1 admitted with physician orders for PT, OT and ST. In an interview on 08/19/2025 at 8:26 AM, Staff L, Licensed Practical Nurse (LPN)/Unit Manager was asked if they we were aware Resident 1 admitted on [DATE] with PT, OT, and ST orders but had not been seen due to their insurance would not cover the reimbursement. Staff L stated they were involved with therapy orders. Staff L was asked if they communicated with the provider, or any other department manager that Resident 1 had not received therapy services as ordered. Staff L stated they were not aware of any communication to get the resident the therapy services as ordered. In an interview on 08/19/2025 at 10:17 AM, Staff OO was asked where they document in the medical record when authorization request was made to the insurance company for therapy reimbursement. Staff OO stated they usually do not document that in the medical record. Staff OO was asked when they requested therapy reimbursement for Resident 1. Staff OO was unable to provide that information and stated Resident 1 was approved for a few PT and ST visits on 08/15/2025, 17 days after the resident admitted . In an interview on 08/19/2025 at 1:29 PM, Staff A, Administrator stated the facility will discuss in their morning interdisciplinary team (IDT) meetings on which residents were admitting that day. Staff A stated they thought Resident 1 was admitted to the facility as a long-term resident as they had no insurance to pay for skilled therapy services. Staff A stated they were aware that the resident had physician orders for skilled therapy, but stated they thought the orders were removed before the resident admitted . Staff A stated they would not have admitted Resident 1 if they had skilled therapy orders and no payor source. Staff A stated they had received approval from insurance to provide some limited visits to the residents for therapy services. Staff A confirmed they would not provide therapy services to the resident without a payor source. Reference WAC 388-97-1280(1)(a-b)(2)