STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505338	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snohomish of Cascadia, LLC	800 10th Street Snohomish, WA 98290

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to thoroughly investigate incidents for one of one resident (Resident 1) reviewed for medication errors. This failure prevented the facility from identifying the potential causes of the occurrence, placed residents at risk for repeated errors, substantial injury, left unanswered questions whether the incident was potentially related to neglect, and unmet care needs. Findings included . According to the Washington State Reporting Guidelines for Nursing Homes (Purple Book), dated October 2015, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It includes guidelines for prevention and protection, incident identification, investigation and reporting for nursing homes, the facility investigation should end with the identification of who was involved in the incident, and what, when, where, why, and how the incident happened including the probable or reasonable cause. <RESIDENT 1>Resident 1 admitted to the facility on [DATE] with diagnoses to include fistula (an abnormal tube-like passage that connects two parts of the body that are not normally connected) of the vagina to small intestine, and ileostomy (an opening on your abdomen that diverts stool to from the small intestine directly to the outside of the body). Review of the facilities State Incident Reporting log, dated August 2025 did not show a medication error for Resident 1. Review of the facilities Med Error Reporting Log Form did not show a medication error for Resident 1. Review of a physician progress note dated 08/21/2025 showed Resident 1 was having diarrhea and creatinine (shows kidney function) was elevated. Assessment/Plan: Will give 1 liter (L) normal saline (NS). Review of Resident 1's physician orders showed a prescriber entered order dated 08/21/2025 for Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) Use 1 liter intravenously one time only for diarrhea for 3 days give 1L NS. Review of Resident 1's Medication Administration Record (MAR) dated August 2025 showed an entry dated 08/21/2025 at 8:15 PM PENDING CONFIRMATION Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) Use 1 liter intravenously one time only for diarrhea for 3 days give 1L NS. There was no documentation on the MAR that IV NS was administered. In an interview on 09/15/2025 at 11:00 AM, Staff D, Licensed Practical Nurse (LPN) stated if a medication error was identified an incident report would be initiated.In an interview on 09/15/2025 at 1PM, Staff E, LPN, Nurse Manager, stated if a medication error was identified, an investigation would be completed by the Director of Nursing (DNS) or Assistant Director of Nursing. In an interview on 09/15/2025 at 1:26 PM, Staff B, DNS stated if a medication error was identified the medication error would be investigated to determine if it is a true medication error and then guidelines would be followed. Staff B acknowledged that a medication error investigation was not completed for Resident 1. Reference WAC 388-97-0640 (6)(a)

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
	505338	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snohomish of Cascadia, LLC	800 10th Street Snohomish, WA 98290

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505338	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snohomish of Cascadia, LLC	800 10th Street Snohomish, WA 98290

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 1) reviewed for intravenous (IV) hydration use was free from medication errors. Failure to follow physician orders to administer IV hydration placed the resident at risk for complications from dehydration, a decline in their condition, and decreased quality of life. Findings included .Review of a facility policy titled Medication Error revised 08/01/2023 showed;Medications are managed and safely administered to residents with a minimum of medication errors (not 5% or greater) and residents are free of any significant medication errors. Definitions:Medication ErrorMeans the observed or identified preparation or administration of medications or biologicals which is not in accordance with: The observed preparation or administration of drugs or biologicals that are not in accordance with:a. Prescriber's Ordersb. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological; orc. Accepted professional standards and principles that apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils. <RESIDENT 1>Resident 1 admitted to the facility on [DATE] with diagnoses to include fistula (an abnormal tube-like passage that connects two parts of the body that are not normally connected) of the vagina to small intestine, and ileostomy (an opening on your abdomen that diverts stool to from the small intestine directly to the outside of the body). Review of the facilities State Incident Reporting log, dated August 2025 did not show a medication error for Resident 1. Review of the facilities Med Error Reporting Log Form did not show a medication error for Resident 1. Review of a physician visit progress note dated 08/21/2025 showed Resident 1 was having diarrhea and creatinine (a blood test that measures how well the kidneys are filtering waste from blood) was elevated. Assessment/Plan: Will give 1 liter (L) normal saline (NS).Review of Resident 1's physician orders showed a prescriber entered order dated 08/21/2025 for Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) Use 1 liter intravenously one time only for diarrhea for 3 days give 1L NS.Review of Resident 1's MAR dated August 2025 showed an entry dated 08/21/2025 at 8:15 PM PENDING CONFIRMATION for Normal Saline Flush Intravenous Solution 0.9% (Sodium Chloride Flush) Use 1 liter intravenously one time only for diarrhea for 3 days give 1L NS. There was no documentation that the NS was administered. In an interview on 09/11/2025 at 3:05 PM, Staff C, Licensed Practical Nurse (LPN), stated the nurses are responsible for checking for orders that need to be confirmed. Staff C there is an alert under the resident profile that would be red indicating that an order needed to be confirmed. Staff C stated the nurse assigned to the resident would be responsible for checking and confirming pending orders. In an interview and record review on 09/15/2025 at 1PM, Staff E, LPN, Nurse Manager, stated there is a clinical tab for pending orders in the electronic medical record system and all nurses on duty should be checking for new orders. Staff E stated they were notified on 08/24/2025 that pending orders for IV NS dated 08/21/2025 had not been processed for Resident 1. Staff E stated they advised the nurse to contact the provider and notified Staff B, Director of Nursing (DNS). Staff E reviewed Resident 1's MAR dated August 2025 and confirmed an order for IV NS dated 08/21/2025 was not confirmed, was not administered and was discontinued on 08/24/2025.In an interview and record review on 09/15/2025 at 1:26 PM, Staff B, DNS, stated they were aware that Resident 1 had not received IV NS as ordered on 08/21/2025 and stated the IV NS had not been administered because nursing staff were unable to start an IV line. Staff B reviewed Resident 1's MAR dated August 2025 and confirmed that Resident 1 had orders for IV NS dated 08/21/2025 and acknowledged that the physician order had not been confirmed. Staff B stated the expectation was for the nurse to notify the provider and document if they were unable to start an IV and if unable to place an IV after 24 hours, they should notify the provider. Staff B stated unconfirmed orders will stay in the computer as pending until discontinued or confirmed. Staff B stated they would attempt to find documentation that the provider was notified of attempts to place an IV for Resident 1 and provide if found. In an interview on 09/15/2025 at 2:43 PM, Staff B stated they were unable to find documentation of provider notification. No further information was provided. Refer to WAC 388-97-1060 (3)(k)(iii)