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	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snohomish Health and Rehabilitation of Cascadia	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 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 interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 4 of 4 sampled residents (Residents 1, 2, 3, and 4) reviewed for care planning. The failure to ensure the comprehensive care plan was person-centered to maintain and or attain the resident's highest practicable well-being placed the residents at risk of not receiving services and monitoring that would meet their needs, adverse health effects and a decreased quality of life. Findings included .Review of a facility policy titled, Comprehensive Care Plans and Conferences, revised date 09/03/2025, documented the facility will ensure that each resident has a timely, person-centered comprehensive care plan developed and maintained in accordance with professional standards of practice. The care plan will reflect the individual conditions, risks, needs, behaviors, cultural values, and preferences, and will include measurable goals, appropriate interventions, and realistic timeframes. The plan will be created, reviewed, and revised by an interdisciplinary team familiar with the status and care needs, with active involvement from the residents and their representative, when applicable. Updates to the care plan will occur as needed based on the response to interventions or changes in condition.<RESIDENT 1>Resident 1 re-admitted to the facility on [DATE] with diagnoses including falls and left femur fracture. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 03/14/2026, showed the resident had moderate cognitive impairment. Resident 1 was independent with walking with a front wheeled walker(FWW), bed mobility, and transfers.Review of the facilities reporting log dated March 2026 showed the resident had a fall with fracture on 03/31/2026 at 5:15 PM.Review of an incident investigation, dated 03/31/2026 documented Resident 1 rolled out of bed and sustained a non-displaced humeral neck fracture (a broken upper arm bone just below the shoulder joint not requiring surgery) to their left arm.Review of a progress note titled Skilled Daily Progress Note dated 04/01/2026 at 4PM, Staff D, Licensed Practical Nurse (LPN), documented Resident 1 returned from the hospital with a sling to their left arm and instructions not to move their left arm until further notice. Review of Resident 1's electronic medical record (EMR) showed documentation from an orthopedic appointment dated 04/09/2026 that Reisdent1 was to wear a sling to their left arm, and was non-weight bearing to their left arm. Review of Resident 1's comprehensive care plan showed there was no care plan developed for the fracture to their left arm , did not show use of sling to their left arm, the increased need for assistance for activities of daily living (ADLs). The care plan did not show the resident was non weightbearing to the resident's left arm until 04/13/2026. Review of Resident 1's Kardex (a tool used to provide directions on how to care for a resident), dated 04/09/2026, showed no documentation that Resident 1 was to wear a sling and was non-weight bearing to their left arm. The Kardex showed the resident was independent with transfers, bed mobility, and ambulation with a walker.In an interview on 04/13/2026 at 3:37 PM, Staff C, Certified Nursing assistant stated information about a resident's care and preferences would be found on the Kardex.In an interview on 04/14/2026 at 11:48 AM, Staff E, LPN, stated nurse managers updated care plans and that a fracture should be care planned especially if they have restrictions. Staff F stated (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	slings, braces and skin issues should be care planned so that everyone monitoring. In an interview and record review on 04/14/2026 at 1PM, with Staff G, Registered Nurse (RN), Nurse Manager, stated the Resident 1 sustained a left arm fracture from a fall on 03/31/2026 and the care plan was not updated to show left arm fracture, use of sling to their left arm, and changes to the assistance the resident would need. Staff G stated the resident is no longer using a walker and is not getting out of bed, the care plan has not been updated.In an interview on 04/14/2026 at 2:22PM, Staff B, RN, Director of Nursing, staff B stated if there is a change to a resident's mobility the care plan should be updated. When the care plan is updated the Kardex is also updated. <RESIDENT 2>Resident 2 admitted to the facility on [DATE] with diagnoses including fall, muscle weakness, unsteadiness on feet, and need for assistance with personal care. Review of the admission MDS, dated [DATE], showed the resident had severe cognitive impairment. Resident 2 was independent with bed mobility, dressing, transfers and toileting with FWW.Review of the facilities reporting log dated March 2026 showed the resident had a fall with fracture on 03/05/2026 at 11:20 AM. Review of Resident 2's physician orders dated 03/02/2026 showed an order for an Xray to the residents left shoulder.Review of Resident 2's left shoulder Xray results dated 03/03/2026 at 5:55 PM, showed the resident had a possible non-displaced humeral neck fracture to their left arm.Review of a progress note titled Health Status Note dated 03/04/2026 at 6:11 AM, Staff H documented the provider ordered use of a sling to Resident 2's left arm.Review of the resident 2's care plan showed there was no care plan developed for the fracture to their left arm, use of sling and non-weight bearing to left arm. The care plan for a Focus titled Physical Mobility Impaired related to, dated 3/5/2026, was incomplete for bed mobility and transfers.Review of Resident 2's Kardex showed the resident was independent with bed mobility, dressing, transfers and toileting with FWW. The Kardex did not show use of sling or non-weight bearing to the resident's left arm.In an interview and record review on 04/14/2026 at 1PM, Staff F, RN, Nurse manager reviewed Resident 2's care plan and confirmed the care plan did not show the fracture to the left arm, sling to left arm, and non-weight bearing to left arm. Staff F stated they did not complete the care plan for a focus titled status/post (s/p) fall-physical mobility. <RESIDENT 3>Resident 3 admitted to the facility on [DATE], with diagnoses including dementia, need for assistance with personal care, muscle weakness, and unsteadiness on feet. Review of the Quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment. Review of the facilities reporting log dated March 2026 showed the resident had a fall with fracture on 04/2/2026 at 12:30 AM. Review of a hospital document titled After Visit Summary, dated 04/02/2026 at 3:56 AM, showed Resident 3 had a broken nose, abrasion to the face, and laceration with sutures to their forehead. Review of the resident 3's care plan showed there was no care plan developed for the fracture to their nose, laceration to forehead or abrasion and bruising to their face. In an interview and record review on 04/14/2026 at 1PM, Staff F, RN, Nurse Manager, reviewed Resident 3's care plan and confirmed that the fractured nose, laceration to forehead, abrasion and bruising to face were not on the care plan. <RESIDENT 4>Resident 4 admitted to the facility on [DATE] with diagnoses including stroke, falls, hemiplegia (paralysis) and hemiparesis (partial weakness) of right side, muscle weakness, and anxiety. Review of the Quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment.Review of the facilities reporting log dated March 2026 showed the resident had a fall with fracture on 03/07/2026 at 6:20 PM.Review of Resident 4's hospital document titled After Visit Summary dated 03/07/2026 at 11:16 PM showed a fracture to the fifth left finger and to keep the left hand in the splint and a laceration to the forehead with sutures.Review of Resident 4's Kardex, dated 04/09/2026, showed the resident was non-weight bearing to their right wrist (resident to wear ulnar brace).Review of the resident 4's comprehensive care plan showed there was no care plan developed for the fracture to their left fifth finger, laceration to left side of face, or bruising to the face. The care plan entry dated 03/18/2026,showed the resident was non-weight bearing and had a brace to their right wrist.In an interview and record review on 04/14/2026 at 1PM, Staff G, reviewed Resident 4's care plan and confirmed the fracture the left fifth finger, brace to the left wrist, laceration to left side (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of face, and bruising to face were not on the care plan. Staff G acknowledged the care plan showing non-weight bearing and brace to right wrist was documented as the wrong hand and was not initiated until 03/18/2026.In an interview and record review on 04/14/2026 at 3:19 PM Staff B stated resident care plans should be updated to show fractures, braces, slings, and weight bearing status. Staff B stated resident care plans should be updated if there is a change in the ability to mobilize or complete ADLs and injuries would be included in the care plan.Reference WAC 388-97-1020 (1)(2)(a)(3)

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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 obtain physician orders and provide monitoring of fall related injuries and interventions for 3 of 4 sampled residents (Residents 1, 2, 3 and 4), document fall related injuries on the reporting log for 2 of 4 sampled residents (Residents 3 and 4), and documentation of fracture in the investigation summary for 1 of 4 sampled residents (Resident 2) reviewed for accidents. The facility failure to provide documentation and monitoring of injuries, non-weight bearing status, braces and slings placed residents at risk for further injury, unmet care needs, and a diminished quality of life. Findings included .Review of a facility policy titled Fall Response and Management, revised 08/21/2026, showed; The facility is committed to ensuring that residents are provided with an environment free from accident hazards and that residents receive appropriate supervision and assistive devices to minimize fall risk, while promoting resident autonomy and dignity. The facility will provide each resident with appropriate assessment and interventions to prevent falls and minimize complications if a fall occurs.Procedures:5. Fall incident(s) will be evaluated to determine probable causal factors, including but not limited to environmental, medical, supervision and/or assistive device need.8. Fall incident(s), Resident assessment(s), intervention(s), and notification(s) will be documented in the clinical record.Findings included.<RESIDENT 1>Resident 1 re-admitted to the facility on [DATE] with diagnoses including falls and left femur fracture. According to the admission Minimum Data Set (MDS - an assessment tool) assessment, dated 03/14/2026, showed the resident had moderate cognitive impairment. Resident 1 was independent with walking with a front wheeled walker(FWW), bed mobility, and transfers.Review of the facilities reporting log dated March 2026 documented the resident had a fall with fracture on 03/31/2026 at 5:15 PM.Review of an incident investigation dated 03/31/2026 documented Resident 1 rolled out of bed and sustained a non-displaced humeral neck fracture (a broken upper arm bone just below the shoulder joint not requiring surgery) to their left arm.Review of a progress note titled Skilled Daily Progress Note dated 04/01/2026 at 4PM, Staff D, Licensed Practical Nurse (LPN), documented Resident 1 returned from the hospital with a sling to their left arm and instructions not to move their left arm until further notice. Review of Resident 1's electronic medical record (EMR) showed documentation from an orthopedic appointment dated 04/09/2026 that Resident 1 was to wear a sling to their left arm, and was non-weight bearing to their left arm. Review of Resident 1's physician orders showed an order dated 04/08/2026 for use of a sling to their right upper extremity (RUE) at all times, discontinued on 04/13/2026. An order dated 04/13/2026 showed the resident was to have an arm sling on RUE at all times and non-weight bearing for RUE document every shift. Review of Resident 1's physician orders did not show use of a sling to their left arm and non-weight bearing to left arm.Review of Resident 1's Treatment Administration Record (TAR) dated April 2026 showed the resident was to have a sling on their RUE at all times beginning 4/8/2026 and discontinued on 04/13/2026. The TAR showed the resident was to have an arm sling on RUE at all times, non-weight bearing to RUE beginning 4/13/2026.In observations and interview on 04/13/2026 at 2:19 PM Resident 1 was observed lying in bed with a sling to their left arm. Resident 1 stated they fell and broke their left arm, and their left arm was put in a sling at the hospital. In an observation on 04/14/2026 at 11:59 AM Resident 1 was observed wearing a sling to their left arm.In an interview on 04/14/2026 at 11:48 AM, Staff E, Licensed Practical Nurse, stated the provider would be notified and orders would be given for monitoring skin issues until resolved and to monitor use of splints and braces. Staff F stated for braces nurses would monitor circulation and skin under the brace. Staff F stated monitoring of skin issues, slings and braces would be documented on the TAR.In an interview and record review on 04/14/2026 at 1PM, with Staff G, Registered Nurse (RN), Nurse Manager, stated the Resident 1 sustained a left arm fracture from a fall on 03/31/2026. Staff I stated that if a resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had a sling the nurse would get an order from the provider and the sling would be monitored every shift on the TAR. Staff I reviewed the resident record and stated orders for monitoring of the sling were not initiated until 4/8/2026 and were entered for the right upper extremity (RUE) which is the incorrect arm. Staff I stated new orders were initiated for monitoring of the sling and non-weight bearing to RUE on 04/13/2026 which was the incorrect arm, and stated monitoring should have been for the left upper extremity (LUE).<RESIDENT 2>Resident 2 admitted to the facility on [DATE] with diagnoses including fall, muscle weakness, unsteadiness on feet, and need for assistance with personal care. Review of the admission MDS, dated [DATE], showed the resident had severe cognitive impairment. Resident 2 was independent with bed mobility, dressing, transfers and toileting with FWW.Review of the facilities reporting log dated March 2026 showed Resident 2 had a fall with fracture on 03/05/2026 at 11:20 AM. Review of Resident 2's left shoulder Xray results dated 03/03/2026 at 5:55 PM, showed the resident had a possible non-displaced humeral neck fracture to their left arm.Review of a facility investigation dated 03/02/2026 at 8:15 PM, showed Resident 2 had a fall and was found on the floor holding their left arm. The investigation summary did not show the resident sustained a fracture to their left arm.In an interview and record review on 04/14/2026 at 3:19 PM Staff B stated if a resident sustains a fall with a fracture, the fracture should be included in the investigation summary. Staff B acknowledged the fracture was not included in the investigation summary and the date and time of the fall were documented incorrectly on the March 2026 reporting log.<RESIDENT 3>Resident 3 admitted to the facility on [DATE], with diagnoses including dementia, need for assistance with personal care, muscle weakness, and unsteadiness on feet. Review of the Quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment. Review of the facilities reporting log dated March 2026 showed the resident had a fall with fracture on 04/2/2026 at 12:30 AM and did not show documentation of the resident's laceration injury. Review of a hospital document titled After Visit Summary, dated 04/02/2026 at 3:56 AM, showed Resident 3 had a broken nose and a laceration with sutures to their forehead. Review of Resident 3's physician orders did not show an order to monitor the laceration to the resident's forehead.Review of Resident 3's TAR did not show monitoring of the laceration to the resident's forehead. In an interview and record review on 04/14/2026 at 1PM, Staff F, RN, Nurse Manager, reviewed Resident 3's EMR and acknowledged Resident 1 did not have orders to monitor the laceration to their forehead and the laceration was not being monitored on the TAR. <RESIDENT 4>Resident 4 admitted to the facility on [DATE] with diagnoses including stroke, falls, hemiplegia (paralysis) and hemiparesis (partial weakness) of right side, muscle weakness, and anxiety. Review of the Quarterly MDS, dated [DATE], showed the resident had severe cognitive impairment.Review of the facilities reporting log dated March 2026 showed the resident had a fall with fracture on 03/07/2026 at 6:20 PM. The reporting log did not show documentation of a laceration to the resident's forehead.Review of Resident 4's hospital document titled After Visit Summary dated 03/07/2026 at 11:16 PM showed a fracture to the fifth metacarpal (left finger), keep the left hand in the splint and a laceration to the forehead with sutures.Review of Resident 4's medical record showed documentation of an Orthopedic office visit progress note, dated 03/11/2026, showed the resident was placed into an ulnar gutter brace (a splint to immobilize 4th and 5th fingers) to left hand and was to remain non-weightbearing but can work on gentle range of motion as tolerated. Weight bearing as tolerated through their elbow.Review of Resident 4's physician orders did not show monitoring of the brace to the resident's left wrist until 03/31/2026 and showed an order for non-weight bearing on right wrist (resident to wear ulnar brace), ok to do gentle range of motion as tolerated, dated 03/18/2026. There were no orders for monitoring of bruising to the face or monitoring of laceration to forehead.Review of Resident 4's TAR dated March 2026 through April 13,2026 did not show documentation for monitoring of the brace to the residents left wrist until 03/31/2026 and did not show monitoring of the laceration to the resident's forehead or monitoring of bruising to the resident's face.In observations on 04/09/2026 at 2:22 PM, and 04/14/2026 at 12:08PM Resident 4 was observed wearing a brace to their left hand.In an interview and record review on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/14/2026 at 1PM, Staff G, stated monitoring of Resident 4's laceration and bruising to their face should be documented on the TAR and acknowledged there was no physician order or monitoring on the TAR. Staff I stated the fracture, brace, and non-weight bearing was documented for the incorrect hand. In an interview on 04/14/2026 at 3:19 PM Staff B stated monitoring for skin injuries, slings, braces, and weigh bearing status should have orders for monitoring by the nurses on the MAR or TAR and would be monitored every shift until resolved.Reference WAC 388-97-1060 (3)(g)