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	03/31/2025

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

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47104 Based on interview and record review, the facility failed to ensure residents and/or their representatives were offered the opportunity to participate in care conferences (a collaborative care plan meeting where a resident's care is discussed and coordinated by a team of health care providers, family members and residents) for 3 of 6 sampled residents (Residents 3, 27, and 60) reviewed for participation in care planning. This failure placed residents at risk of not being allowed to be involved and informed about care and services and a diminished quality of life. Findings included . <RESIDENT 27> Resident 27 admitted to the facility on [DATE] with diagnoses to include pneumonia and vascular dementia. According to the resident's Quarterly Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], Resident 27 had moderate cognitive impairment. Review of Resident 27's medical record showed no documentation a quarterly care conference had been completed. <RESIDENT 60> Resident 60 admitted on [DATE]. According to the residents MDS dated [DATE], Resident 60 had no cognitive impairment. Review of a Social Services Progress note dated 11/07/2025 at 2:45 PM, Staff O, Social Services, documented a care conference for Resident 60 was scheduled for 11/12/2025. Review of Resident 60's medical record showed no documentation that a admission care conference had been completed. During an interview and record review on 03/27/25 at 2:32 PM, Staff H, Social Services Assistant acknowledged there was no documentation in the Resident 60's clinical record for the scheduled care conference on 11/12/2025. (continued on next page)

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

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 03/31/2025 at 11:42 AM, Staff A, Administrator, stated there should be a care conference within seventy-two hours of admission. Staff A acknowledged there was no documentation of a care conference for Resident 60 on 11/12/2025. No further information was provided. 51551 <RESIDENT 3> Resident 3 was admitted to the facility on [DATE]. According to the MDS assessment, dated 03/09/2025, the resident was cognitively intact. In an interview on 03/24/2025 at 11:38 AM, Resident 3 stated they had not attended a care conference. Resident 3 stated they were not told of a care plan meeting and were not involved in discussions regarding their person-centered care and not sure what the goal was for their care. Review of Resident 3's Electronic Medical Record during last 12 months, revealed no correlating documentation of any interdisciplinary care plan meeting with the resident or representative to discuss revisions of the care plan or changes in resident specific goals of care. In an interview on 03/27/2025 at 3:03 PM, Staff J, Resident Care Manager/Registered Nurse, stated care planning meetings for long term residents were supposed to be conducted with the resident and/or resident representatives every quarter (3 months). Staff J stated no care conference had been set up for Resident 3 since January 2024. In a record review and interview on 03/28/2025 at 12:11 PM, Staff G, Social Service Director, stated they reach out to residents and/or representatives to set up care plan meetings with the interdisciplinary team. Staff G stated care plan meetings were supposed to be conducted on admission, quarterly, annually, anytime for follow up and when a resident was close to discharge. Staff G stated Resident 3's last care plan meeting was done on 01/05/2024 and they were not aware what happened after that. In an interview on 03/29/2025 at 1:02 PM, Staff F, Assistant Chief Nursing Officer, stated care conferences should be conducted on admission, every quarter, annually, and as needed. Staff F stated they were aware the facility was behind in setting up care conferences and care plan meetings were not occurring with many residents or their representatives quarterly as required. Refer to WAC 388-97-1020 (2)(f)(4)(d)(e)

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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** 47104 Based on interview and record review, the facility failed to obtain and/or offer assistance to residents and/or their representatives to formulate Advance Directives (AD) for 1 of 6 residents (Resident 60) reviewed for ADs. These failures placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care. Findings included . An AD is A written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. <RESIDENT 60> Resident 60 admitted on [DATE]. According to the Admission Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], Resident 60 had no cognitive impairment. Review of Resident 60's medical record document titled Advance Directive Review dated 11/05/2024 documented Resident 60 would like to pursue formulating an AD. Review of Resident 60's medical record showed no documentation regarding whether the resident had formulated an AD or had been provided with information regarding their right to formulate an AD. During an interview on 03/26/2025 at 2:45PM, Staff G, Social Services Director, stated social services is responsible for assisting residents with formulating an AD by providing Power of Attorney (POA) documents and information for a mobile notary. During an interview and record review on 03/27/25 at 02:32 PM, Staff H, Social Services Assistant stated they had not followed up with Resident 60 for AD because they knew the resident did not want anyone involved in their care or finances because the resident was independent. Staff H reviewed the resident's medical record and acknowledged there was no documentation that the resident had been assisted to formulate AD. During an interview and record review on 03/31/2025 at 11:42 AM, Staff A, Administrator, stated if a resident indicated that they wanted to pursue developing an AD, the process should start immediately. Staff A acknowledged there was no documentation that Resident 60 was assisted in formulating an AD. Reference WAC 388-97-0280 (1) (3)(a)(c)(ii)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50725 Based on interview and record review, the facility failed to ensure 4 of 6 residents (Residents 25, 26, 59 and 60) had an accurate Pre-Admission Screening and Resident Review (PASARR) on or before admission to the facility. This failure placed residents at risk for unmet care needs and at risk of not receiving appropriate mental health support/services needed. Findings included . Preadmission Screening and Resident Review (PASARR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings. The intent of this process is to ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability (ID) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting appropriate to their needs. <RESIDENT 26> Resident 26 admitted to the facility on [DATE] with admitting diagnoses to include bipolar disorder (a mental health disorder that causes extreme mood swings that include emotional highs, called mania and lows known as depression), Anxiety Disorder, Vascular Dementia. According to the quarterly Minimum Date Set (MDS - an assessment tool) assessment dated [DATE], the resident had intact cognition. In a record review on 03/26/2025 at 3:00 PM, Resident 26's doctor's orders showed that resident was receiving Olanzapine 5 mg (antipsychotic) by mouth at bedtime for Bipolar Disorder, Klonopin 0.5 mg at bedtime for anxiety, and Sertraline Hydrochloride 25 mg by mouth once a day for depression. In a record review on 03/26/2025, Resident 26's PASSR dated 09/24/2025 was documented in Section A that resident had Serious Mental Illness Indicators, mood disorders, psychotic disorders, anxiety disorders and delusional disorders were all checked. In Section B. Intellectual Disability (is a condition that involves limitations on intelligence, learning and everyday abilities necessary to live independently) Related Condition Indicators questions for number 3, 5, and 9 were marked yes, review of resident's diagnoses and history and physical did not indicate that resident had Intellectual Disability. In Section IV. Service Needs and Assessor Data, Level II evaluation referral required for Serious Mental Illness (SMI) was checked. Further review of resident's electronic record and did not see a Determination letter or PASSR Level II Evaluation Summary for the PASSR dated 09/24/2025. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a joint interview/record review on 03/28/2025 at 2:20 PM, Staff H, Social Worker stated that Resident 26's Level II PASSR Evaluation Summary was recently sent by the PASSR Coordinator, and this was document in the evaluation summary. Review of the PASSR evaluation summary showed that the evaluation date was 07/20/2023 and the referral date was 07/05/2024. Further review showed the PASSR that Staff H sent for evaluation was dated 09/24/2024. When asked why some of the questions in Section B of the PASSR were marked yes, Staff H stated they were not aware of how it was supposed to be filled out. <RESIDENT 59> Resident 59 admitted to the facility on [DATE] with admitting diagnoses to include anxiety disorder, depression, Alzheimer's Disease and is on hospice services. According to the quarterly MDS assessment the resident had severe cognitive impairment. In a record review on 03/27/2025 at 10:15 AM, Resident 59's doctor's order showed that the resident was receiving clonazepam 1 mg three times a day for anxiety disorder. In a record review on 03/28/2025 at 11:00 AM, Resident 59's PASSR form dated 10/31/2024 in Section A. Serious Mental Illness Indicators, it was marked no. In Section B: Intellectual Disability related conditional indicators numbers 3, 6, 8 and 9 had yes marked and residents did not have Intellectual Disability in their history or diagnoses. Section IV. Service Needs and Assessor Data, No Level II evaluation indicated was marked. In additional comments section it documented Patient is at end of life (EOL) and on comfort medications to include Quetiapine, Trazadone, Haldol, Lorazepam In an interview on 03/28/2025 at 2:20 PM, Staff H, SW stated they were not aware that Resident 59's PASSR was not filled out correctly and that they would be filling out another PASSR and would send it to the PASSR Coordinator for an evaluation. 51551 <RESIDENT 25> Resident 25 readmitted to the facility on [DATE] with diagnoses to include bipolar disorder. Review of Resident 25 March 2025 Medication Administration Record (MAR) documented Resident 25 was taking antidepressant every day. Review of Resident 25's most updated Level I PASRR, dated 06/27/2024, documented in Section IA that Resident 25 had serious mental illness indicators included mood disorders and anxiety. Section IV indicated level II evaluation referral required for serious mental illness. Review of Resident 25's entire electronic medical record showed no Level II PASRR was completed prior to the resident being admitted to the facility. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 03/28/2025 at 2:20 PM, Staff H stated that their process regarding PASSR on new admission residents is that the intake worker will receive the PASSR from the hospital or another facility and if the Level II was marked, then the intake person would fax a copy of the PASSR to the PASSR Coordinator and when the resident arrives to the facility they send an email to the PASSR Coordinator and wait for the determination letter or the evaluation summary. As soon as they receive the letter, they update the care plan and scan the letter into the residents' electronic chart. Staff H confirmed that they admit residents even if they don't have the evaluation summary from the PASSR Coordinator. In an interview on 03/31/2025 at 8:56 AM, Staff A, Administrator stated the facility admits residents without the Level II determination letter. 40998 <RESIDENT 60> Resident 60 admitted to the facility on [DATE] with diagnoses to include generalized weakness, opioid dependency, attention deficit hyperactivity disorder, insomnia, and major depressive disorder. Review of the clinical record showed the resident was cognitively intact. Review of Resident 60's clinical record documented a Level I PASRR was completed on 10/28/2024 prior to admission to the facility and it indicated the Level 1 was positive and a Level II was required. Review of a progress note dated 03/16/2025, documented Staff H forwarded the positive PASRR dated 10/28/2024 to the states PASRR coordinator requesting a [NAME] II be completed. During an interview/record review on 03/27/2025 at 2:18 PM, Staff H, stated that they have been employed at the facility for about 3 weeks now and honestly when I came back the PASRR process was a mess. Staff H stated that they forwarded a request to the PASRR coordinator on 03/16/2025, requesting Resident 60 be evaluated for their positive Level I. Staff H stated they felt that services for Resident 60 could have been a little better for them if we would have had a PASRR Level II completed earlier. Reference WAC 388-97-1915(1)(2)(a-c)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51551 Based on observation, interview and record review, the facility failed to review and revise care plans for 3 of 10 sampled residents (Residents 3, 34 and 31) reviewed for care planning. The failure to review and revise care plans by the interdisciplinary team placed residents at risk for unmet care needs, adverse health effects and diminished quality of life. Findings included . Review of the facility policy titled, Care Plans, revised date 10/15/2022, documented care plans are updated with any status change and revised based on changing goals, preferences, and needs of the resident and in response to current interventions. <RESIDENT 3> Resident 3 readmitted to the facility on [DATE] with diagnoses to include shingles zoster without complications. Review of Resident 3's March 2025 Medication Administration Record (MAR) documented Resident 3 was taking antiviral medication for herpes (viral infection) daily since 02/01/2024. Review of Resident 3's care plan, print date 03/27/2025, under the focus of potential skin impairment, documented antiviral medication for suppression therapy of long history of shingles outbreaks. There was no care plan about goals, nor any intervention related to antiviral medication use. In an interview and record review on 03/27/2025 at 2:54 PM, Staff J, Registered Nurse/Resident Care Manager (RN/RCM), stated Resident 3 was taking antiviral medication for long term suppression therapy with no end date and nurses needed to monitor possible side effects. Staff J stated they needed to review and update the care plan. In an interview and record review on 03/28/2025 at 12:50 PM, Staff F, Assistant Chief Nursing Officer (ACNO), stated the care plan of the antiviral medication was only mentioned under skin focus but no goals nor interventions were documented, and they needed to update the care plan. <RESIDENT 34> Resident 34 readmitted to the facility on [DATE] with diagnoses to include cerebral infarction (a condition of brain tissue damage due to blood flow to the brain is blocked). According to the annual Minimum Data Set (MDS-an assessment tool) assessment, dated 03/08/2025, the resident was rarely/never understood, dependent on bed mobility and at risk of developing pressure ulcers. Review of Resident 34's care plan, printed date 03/28/2025, documented Resident 34 had potential for skin alteration. One intervention initiated on 11/25/2022 was to offload heels or use boots when in bed. There were no other interventions for heel protection. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In multiple observations on 03/24/2025, 03/25/2025, 03/26/2025 and 03/27/2025, Resident 34 was not using pressure relieving boots and their heels were not off loaded when in bed. In an interview on 03/27/2025 at 9:43 AM, Staff N, Nursing Assistant Certified (NAC), stated Resident 34 required two persons total assistant for bed mobility and Resident 34 did not use pressure relieving boots. In an interview on 03/28/2025 at 10:00 AM, Staff S, NAC stated Resident 34 required two persons total assist for positioning and the resident had not used pressure relieving boots for a long time because they always kicked their legs and tried to remove the boots. In an interview on 03/28/2025 at 10:26 AM, Staff I, Licensed Practice Nurse, stated Resident 34 bent their knees and moved their legs on the bed so they had blanchable redness on the sides of their feet off and on, not only just their heels. Staff I stated Resident 34 did not use pressure relieving boots at all because they kept rubbing the boots and trying to take them off which caused more friction and redness on the feet. Staff I stated the nurses tried to put pillows to offload pressure when redness was seen on the resident's feet. Staff I stated using boots should be removed from the care plan and the care plan needed to be updated. In an interview and record review on 03/28/2025 at 11:00 AM, Staff T, RN/RCM, stated they were responsible for reviewing and updating the care plans quarterly or when needed. Staff T was not aware Resident 34 did not use pressure relieving boots and stated other interventions included heel protection of putting pillows to elevate heels and applying skin prep. Staff T reviewed the current care plan and using pillows and skin prep were not documented interventions on the resident's care plan. Staff T stated the care plan needed to be updated. In an interview on 03/28/2025 at 12:50 PM, Staff F stated the RCMs were supposed to communicate with nurses to know residents' care conditions and review and revise care plans whenever there was a change. Staff F stated they would update Resident 34's care plan immediately. 50725 <RESIDENT 31> Resident 31 was admitted to the facility on [DATE] with diagnoses to include right below the knee amputation. According to the quarterly MDS assessment dated [DATE], the resident had mildly impaired cognition. In an observation and interview on 03/24/2025 at 3:28 PM, Resident 31 was sitting up in their wheelchair, observed their right leg below the knee amputation. There was a leg prosthesis on the floor in their room, and the resident stated staff were not helping them put it on, so they don't wear their prosthesis. Review of Resident 31's care plan on 03/25/2025, did not show the resident had a prosthesis. The resident care plan documented that the resident was on a Restorative Nursing Program. In an observation on 03/26/2025 at 9:39 AM, Resident 31 was up in their wheelchair but was not wearing their leg prosthesis at the time of the observation. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 03/26/2025 at 3:17 PM, Resident 31 was with a male Restorative Aid in the exercise room and the resident was wearing their prosthesis. Review of Resident 31's physician orders on 03/27/2025 at 2:15 PM, an order documented: When donning (putting on) prosthetic leg: Apply gel cushion liner with logo facing anterior, don 3 ply sock (with green thread), roll/pull suspension sleeve proximal thigh. When the prosthesis is removed, apply prosthetic shrinker to maintain volume. This was dated 07/03/2023. In an interview on 03/27/2025 at 2:20 PM, Staff E, NAC stated that they get resident specific information and how to care for them off the Kardex or care plan and the reports given by the nurse or the NAC that worked with that resident on the prior shift. When asked about Resident 31's prosthesis, they stated that the resident had the prosthesis for a while, but they don't assist the resident in putting it on. They added that the only time the resident wears it was when they go for exercise. In an interview on 03/27/2025 at 2;32 PM, Staff C, Restorative Aid stated that Resident 31 can put their own prosthesis on but needs cuing. Staff C stated they put the resident's prosthesis on prior to going to the gym for exercises. Staff C stated that after the exercise, they assist the resident in doffing (removing) the prosthesis and they inspect their skin on the stump area to make sure there's no sore spots or pressure area developing. In an interview on 03/27/2025 at 3:08 PM, Staff K, RN, stated that Resident 31 only uses their prosthesis when they exercise and does not wear it any other time. In an interview on 03/28/2025 at 11:41 AM, Staff J stated that the RCM's update the care plans when there are new orders, or any concerns that need to be care planned and at a minimum reviewed/updated quarterly. When asked about Resident 31's prosthesis, they stated the resident only wears it during therapy sessions or during their Restorative Program. Staff J stated that there was no current order for staff to put the resident's prosthesis on. Staff J was unable to locate the resident's prosthesis on the care plan. In an interview on 03/28/2925 at 3:37 PM, Staff F, ACNO was unable to show documentation of Resident 31's prosthesis and when they were supposed to wear it. Staff F printed a copy of the resident's care plan, and they added an intervention dated 03/28/2025 that documented: Resident has prosthesis in the room, prefers to wear it during Restorative Therapy. Reference WAC 388-97-1020(2)(c)(d)

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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** 50725 Based on observation, interview and record review, the facility failed to ensure that the resident's environment was free from accident hazards of 1 of 3 residents (Resident 59) reviewed for environmental hazards. These failures placed residents at risk for possible injury and diminished quality of life. Findings included . Resident 59 was admitted to the facility on [DATE] with diagnoses to include Alzheimer's Disease and on hospice care. According to the quarterly Minimum Data Set (MDS - an assessment tool) assessment dated [DATE], the resident had severely impaired cognition. In an observation on 03/24/2025 at 10:34 AM, Resident 59 was in bed with a blanket over their head. The bed was in the lowest position with a scoop mattress (a special type of mattress with raised sides designed to prevent residents from rolling out of bed) on the left side of the bed on the floor and the bed was placed against the wall. Review of Resident 59's physician's orders on 03/28/2025 did not show any orders for the bed to be against the wall. Review of Resident 59's restraint consents on 03/28/2025 did not show any consent signed for the bed against the wall. Review of Resident 59's care plan on 03/28/2025 did not document about their bed being positioned against the wall. In an interview on 03/28/2025 at 2:11 PM, Staff K, Registered Nurse (RN) stated that ever since they started working with Resident 59, their bed has always been against the wall. Staff K stated that having a bed against the wall is not a form of a restraint, because the resident can get out of the bed on the other side. In an interview on 03/28/2025 at 2:13 PM, Staff E, Nursing Assistant Certified (NAC) stated that Resident 59's bed had always been against the wall. In an interview on 03/28/2025 at 3:08 PM, Staff I, Licensed Practical Nurse (LPN) stated the different kinds of restraints that they have used in the facility were wheelchairs that a resident can't get out of on their own like tilt chairs, wheelchairs that have seat belts, scoop mattresses, and beds against the wall due to residents not able to get out of bed on one side. Staff I stated prior to initiating a restraint the resident must be assessed first and it's usually Physical Therapy that assesses/evaluates the resident for device appropriateness, then they would obtain a doctor's order and have the resident or responsible party sign a consent, then update the care plan. Once those steps are done, they apply or implement the restraint, and they would review quarterly to ensure it's still appropriate. (continued on next page)

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	505338	A. Building B. Wing	03/31/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/2025 at 3:27 PM, Staff F, Assistant Chief Nursing Officer stated that examples of restraints they use in the facility were tilt-in-space (a specialized wheelchair that allows the entire seating system to be tilted backwards or forward while maintaining a constant seat-to-back angle), low beds, scoop mattresses and beds against the wall. Asked Staff F their process for starting residents on restraints, Staff F stated the process for initiating restraints is that therapy assesses the resident and the device, they do a restraint assessment, obtain a consent signed by resident if able or their responsible party then update the care plan. Staff F stated that those need to be in place prior to initiating restraints. Staff F stated that they review restraints quarterly. Requested Staff F to provide Resident 59's physician's order, consent and care plan regarding the resident's bed against the wall and they were unable to provide the documents requested. Reference WAC 388-97-1060(3)(g)

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	505338	A. Building B. Wing	03/31/2025

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

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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** 50725 Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 5 residents (Resident 26) selected for medication review. This failure placed Resident 26 at risk for adverse outcome related to receiving insulin when blood sugar was below the blood sugar parameter ordered. Findings included . Resident 26 admitted to the facility on [DATE] with admitting diagnoses to include Type 2 Diabetes Mellitus (DM - a chronic metabolic disorder characterized by persistent high blood sugar). According to the quarterly Minimum Date Set (MDS - an assessment tool) assessment dated [DATE] the resident had intact cognition. In a record review on 03/26/2025, Resident 26's physician's order documented: - Insulin Glargine (long-acting insulin), inject 25 units (U) subcutaneously (SQ - method of administering medication by injecting a drug into the fatty tissue layer beneath the skin) one time a day for DM. Hold for blood sugar (BS) less than (<) 90 and provide snack. Date ordered was 03/13/2025. Review of Resident 26's March 2025 Medication Administration Record (MAR) print date 03/26/2025, showed on March 13, 14, 15 and 16, the resident received 25 U of Insulin Glargine but there were no BSs were recorded/documented on either the MAR or progress notes. On March 17th, there was an initial BS on the MAR which indicated no insulin was needed. On March 18th 19th, 20th, 21st and 22nd, 25 U of Insulin Glargine were given but no BS was recorded/documented on either the MAR or progress note. On March 23rd, there was a VO documented which indicated vitals out of parameter and insulin was not administered. On March 24th and 25th, 25 U of Insulin Glargine was given but no blood sugars were documented. On March 27th, the resident's BS documented was 71 and 25 U of Insulin Glargine was given. Review pf Resident 26's physician orders on 03/26/2025, documented: - Insulin Glargine, inject 25 U SQ one time a day for DM. Hold for BS < 100. Order started on 12/02/2024 and was discontinued date on 03/12/2025. Review of February and March 2025 MAR print date 03/26/2025 showed that Resident 26 received 25 U of Insulin Glargine with BS <100. The following dates were when the resident received insulin outside the BS parameters: On 02/03/2025 at 6:55 am- BS was 82 and 25 units of Insulin Glargine was given. On 02/05/2025 at 6:55 AM- BS was 80 and 25 units of Insulin Glargine was given. On 02/06/2025 at 6:41 AM- BS was 89 and 25 units of Insulin Glargine was given. On 02/07/2025 at 6:44 AM- BS was 65 and 25 units of Insulin Glargine was given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/10/2025 at 6:31 AM- BS was 98 and 25 units of Insulin Glargine was given. On 02/11/2025 at 7:16 AM- BS was 81 and 25 units of Insulin Glargine was given. On 02/13/2025 at 7:09 AM- BS was 89 and 25 units of Insulin Glargine was given. On 02/15/2025 at 7:19 AM- BS was 89 and 25 units of Insulin Glargine was given. On 02/16/2025 at 6:50 AM- BS was 85 and 25 units of Insulin Glargine was given. On 02/17/2025 at 7:09 AM- BS was 89 and 25 units of Insulin Glargine was given. On 02/19/2025 at 7:36 AM- BS was 83 and 25 units of Insulin Glargine was given. On 02/28/2025 at 6:49 AM- BS was 86 and 25 units of Insulin Glargine was given. On 03/01/2025 at 7:20 AM- BS was 88 and 25 units of Insulin Glargine was given. On 03/05/2025 at 7:09 AM- BS was 87 and 25 units of Insulin Glargine was given. On 03/06/2025 at 7:00 AM- BS was 89 and 25 units of Insulin Glargine was given. On 03/07/2025 at 6:54 AM- BS was 91 and 25 units of Insulin Glargine was given. On 03/11/2025 at 7:04 AM- BS was 98 and 25 units of Insulin Glargine was given. On 03/12/2025 at 6:52 AM- BS was 77 and 25 units of Insulin Glargine was given. In an interview on 03/27/2025 at 8:11 AM, Staff K, Registered Nurse (RN) stated that prior to giving insulin they check the blood sugar first and if the blood sugar was low, they hold the insulin. They added that all their assigned residents were all on long-acting insulin and that these residents don't have sliding scale insulin (an insulin therapy that involves using a chart with preestablished insulin doses to maintain blood sugar levels). When asked if Staff K had given Resident 26's insulin, and what was resident's BS level, they said yes, they have given the resident's insulin, and their BS level was 71. Asked Staff K if they could show the surveyor the resident's insulin order, they read the insulin order and after reading it they stated they did not give Resident 26's insulin due to their BS level being 71 which was outside the BS parameters that states hold if BS <90. Reviewed the MAR with Staff K and asked what the check mark with their initial on March 27th indicated and they stated they might have clicked it by mistake, and they did not know how to strike it out. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/27/2025 at 11:41 AM, Staff J, Resident Care Manager (RCM)/RN, stated that their process prior to administering insulin injections was follow what the doctor ordered. Staff J stated that the Chief Nursing Officer (CNO) does the audits. Staff J stated the CNO will have a printout on medication errors, and they discuss those in their daily clinical meeting and the RCM's follow up the same day. Staff J stated that the audits included insulin medications and were based off physicians' orders. Review of Resident 26's March 2025 MARs, Staff J stated that the check mark's on the insulin orders indicated the nurse had administered the insulin, and some that were administered were outside the BS parameters. Staff J stated they were not sure if insulin being outside the parameters and still administered was included in the medication audits conducted by CNO, they would have to ask. In an interview on 03/27/2025 at 2:50 PM, Staff B, CNO, stated that they were made aware of the insulin being administered outside the parameters and that they had started an incident report and an investigation. Staff B stated when they interviewed Staff K, they stated that they had not given insulin outside the parameters, but that it came out as it was given due to Staff K not knowing how to strike it out. However, part of the MAR showed the location of where the licensed nurse injected the insulin and all the BS that were outside the parameter had injection sites documented by Staff K. Staff B stated that they had educated Staff K, and they started an audit of all the insulin orders in the building and placed Resident 26 on alert charting to monitor for any side effects for receiving insulin outside the BS parameters. When asked if this error related to the insulin printed out in their medication error report, Staff B stated it did not because the BS and the insulin were signed so it did not show as a missed dose therefore it did not come out as a medication error. Staff B was asked to provide copies of Staff K's skills checklist for computer charting and insulin administration but was unable to provide that information. In an interview on 03/28/2025 at 1:10 PM, spoke to Collateral Contact 2 (CC2), Advanced Registered Nurse Practitioner (ARNP), they stated that they were not informed that Resident 26 had been receiving insulin outside the ordered BS parameters. Reference WAC 388-97-1060-(k)(iii)(4)

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47104 Based on observation, interview, and record review, the facility failed to ensure 1 of 3 sampled residents (Resident 27), reviewed for dental care, received timely assistance to coordinate appropriate denture services. This failure placed residents at risk for difficulty chewing, diminished quality of life and a loss of dignity. Findings included . <RESIDENT 27> Resident 27 admitted to the facility on [DATE] with diagnoses to include pneumonia and vascular dementia. According to Resident 27's Quarterly Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], the resident had moderate cognitive impairment, and upper and lower dentures. The MDS documentation included: -Section L0200 A was documented No for broken or loose fitting full or partial denture (chipped, cracked, uncleanable, or loose) -Section L0200 F was documented No for mouth or facial pain, discomfort or difficulty chewing. In an interview on 03/25/2025 at 11:37 AM, Collateral Contact (CC) 1 stated Resident 27's dentures were old and broken and missing a tooth on the lower denture. CC1 was not able to state when Resident 27's dentures broke but stated they are missing a tooth on the lower denture. Review of Resident 27's medical record on 03/26/2025 showed no documentation they had or were scheduled to receive a dental appointment. In an interview and observation on 03/28/2025 at 11:42 AM, Resident 27 stated they fell not long ago and broke their dentures. The resident stated when they fell out of bed they hit their head and when their dentures fell out a middle tooth on the bottom broke. This writer observed Resident 27's bottom denture that was missing a tooth on the left side. The resident stated that staff know their dentures are broken and they have discomfort when eating. In an interview on 03/28/2025 at 11:39 AM, Staff Q, Nursing Assistant Certified, stated Resident 27's dentures were old and missing a tooth on the bottom. Staff Q stated the resident had a fall and Staff P saw that the resident's dentures were missing a tooth when they picked them up off the floor. In an interview on 03/28/2025 at 11:55 AM, Staff P, Licensed Practical Nurse (LPN), stated Resident 27 wore lower dentures and did not wear upper dentures. Staff P stated they were unaware that Resident 27's dentures were broken and stated the resident had not complained of broken dentures or difficulty eating. Staff P stated if a resident needed a dental appointment, staff would notify the nurse and they would schedule the appointment. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/28/2025 at 1:10 PM Staff R, LPN, Residential Care Manager, stated they were not aware of Resident 27's broken dentures. Staff R stated the resident had an unwitnessed fall out of bed with no injury on 02/26/2025. Staff R stated they would check and see if the resident was scheduled to see the dentist on the next scheduled visit to the facility. No further information was provided. In an interview on 03/28/2025 at 4:15 PM, Staff F, Registered Nurse, Assistant Chief Nursing Officer, stated the dentist visits the facility quarterly and can make referrals for dentures. Staff F stated the facility will facilitate appointments and transportation for residents with denture referrals. In an interview on 03/31/2025 at 11:55 AM, Staff F stated they were unsure if staff had followed up with Resident 27 to address the broken dentures and stated they would talk to Staff R. Review of an email received from Staff A, on 03/31/2025 at 12:28 PM, showed documentation of a late entry Health Status Note created on 03/31/2025 at 12:12 PM with effective date 03/28/2025 at 12:09 PM, Staff R documented Resident 27 was assessed for oral pain, chewing, or swallow issues related to the missing tooth on their dentures and no issues reported by the resident and Resident 27 was added to the list for dental services. Reference WAC 388-97-1060(1)(3)(j)(vii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51551 Based on observation, interview and record review, the facility failed to ensure facility staff used personal protective equipment (PPE) in accordance with the Centers for Disease Control (CDC) guidelines when caring for 2 of 3 sampled residents (Residents 42 and 10) with enhanced barrier precautions (EBP- infection control practices designed to reduce the spread of multidrug-resistant organisms in nursing homes by focusing on gown and glove use during high-contact resident care activities). These failures placed residents at risk for facility acquired or healthcare-associated infections and related complications and a decreased quality of life. Findings included . <RESIDENT 42> Resident 42 admitted to the facility on [DATE] with diagnoses to include open wound. Review of Resident 43's Minimum Data Set (MDS-an assessment tool) assessment dated [DATE], documented Resident 42 had stage 4 pressure ulcer and moisture associated skin damage. Review of a progress note on 03/27/2025 at 9:46 AM, documented a consulting wound specialist was following up with the wound care. Review of Resident 42's current care plan and Kardex (a tool used to provide directions on how to care for a resident), both documented using enhanced barrier precautions to prevent infection. Gown and gloves were required for high-contact resident care including transferring. Review of EBP signage posted outside of Resident 42's room, transferring was listed as a high contact resident care activity and gowns were required. In an observation and interview on 03/26/2025 at 1:27 PM, Staff N, Nursing Assistant Certified (NAC), did not wear a gown when transferring Resident 42 from bed to wheelchair. Staff N stated Resident 42 was on EBP and they did not need to wear a gown when transferring the resident. Staff N stated the EBP signage posted outside of the doors instructed staff that transferring was a high contact resident care activity, and they needed to wear gowns for transferring. In an interview on 03/28/2025 at 12:00 PM, Staff F, Assistant Director of Nursing (ADON)/Infectious Prevention Nurse (IP Nurse), stated they expect staff to follow EBP when taking care of residents. Staff F stated the instruction of EBP was on the signage posted outside the resident's door and documented in the care plan and Kardex for staff to follow. Staff F stated that gowns were required when transferring EBP residents and they definitely needed to educate the staff that did not wear gowns when transferring EBP residents. 50725 <RESIDENT 10> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 10 admitted to the facility on [DATE] with diagnoses to include Venous Ulcers (wound on the leg caused by abnormal or damaged vein) in the right lower extremity. In an observation and interview on 03/28/2025 at 10:17 AM, Resident 10 had just received a shower and staff were preparing to transfer the resident back to their bed from the shower chair. Staff L, Shower Aid/NAC and Staff M, NAC, donned (put on) gloves and proceeded to transfer the resident back to their bed. Neither staff were observed wearing gowns. They assisted Resident 10 in bed with repositioning, application of deodorant and dressing. Both staff were asked who the EBP sign outside the residents door was for and Staff M stated it was for Resident 10 due to wounds on their leg. Both Staff M and Staff L then stated that the precaution sign was just for the nurses when they perform wound care. Both staff stated that they did not need to wear gowns when they were transferring a resident because they were not touching the wound. In a record review on 03/28/2025 at 1:15 PM, Resident 10's doctor order documented EBP for wounds. Gown and gloves required for high-contact patient care (dressing, bathing, transferring, incontinence or toileting care, dressing, changing linens or device or wound care, dated 10/21/2024. In a joint interview on 03/31/2025 at 11:02 AM, both Staff A, Administrator and Staff F were both aware that staff were not using the proper PPE when entering an EBP room. Staff A stated they plan to continue to monitor, audit and educate the staff and to do one on one coaching with staff. Reference WAC - 388-97-1320(1)(a).