STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain essential equipment in safe operating condition. The facility failed to adequately identify fluctuating dishwasher rinse temperatures and ensure maintenance/repairs were successful for one of one facility high temperature dishwasher. They failed to ensure Hoyer lifts (mechanical device that assists with transfer of residents from one surface to another) and sit to stand lifts (mobility device used to help residents who are partially weight bearing from sitting position to a standing position) for one of three halls (3 South) batteries were consistently monitored and repaired for safe operation. These failures placed residents at risk for food borne illness, accidents, and overall decreased quality of life. Findings included . <DISHWASHER> On 5/12/2026 at 10:13 AM, observed the rinse cycle on the high temperature dishwasher and the temperature gauge when running the rinse cycle. The rinse cycle temperature read 178 degrees Fahrenheit (F). The gauge on the dishwasher showed the temperature should be between 180-190 degrees F. In an interview on 05/12/2026 at 10:15 AM, Collateral Contact 5 (CC 5), Kitchen Manager, stated they were contracted to provide food services for the facility. CC 5 stated they had issues with their dishwasher keeping temperature in the past and was unaware of any current issues, maintenance or repairs needed. Observed CC 5 use a thermal pad (temperature pad used to go through the dishwasher cycles and measure the temperature) in the dishwasher and after the final rinse the temperature was 151.5 degrees F. CC 5 stated they would contact the maintenance and have them repair the dishwasher. In a follow up visit to the kitchen on 05/13/2026 at 12:56 PM, observed the dishwasher rinse temperature to be 179 degrees F, observed the dishwasher running an additional three trays of dishes through the dishwasher with the rinse cycle at 170 degrees F. In an interview on 05/13/2026 at 1:00 PM, CC 5 stated they had called maintenance yesterday, they came and found no issues and the dishwasher temperature was within range at 190 degrees F. CC 5 stated they would contact maintenance again. In an additional observation on 05/13/2026 at 1:10 PM the dishwasher rinse temperature was 200 degrees F. In a follow up interview on 05/13/2026 at 1:12 PM CC 5, stated they had called maintenance, and they had turned up the temperature from the boiler room. (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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of work orders from maintenance for the last 15 months (February 2025 through May 2026), documented 14 instances involving the dishwasher functioning and requiring repairs/maintenance. Review of a repair estimate summary, dated 10/13/2025, documented the dishwasher was originally installed 07/11/2017 and required repair for, the unit is not heating well for the final rinse. In an interview on 05/13/2026 at 4:15 PM, Staff F, Director of Dietary Services, stated they had checked the dishwashing rinse temperature on 05/12/2026 and it was running within the temperature range. Staff F stated they were unaware the temperature of the rinse cycle was continuing to fluctuate and at times was not up to temperature. Staff F stated the contracted food service provider would need to coordinate repair of the dishwasher and they would follow up with them. <HOYER LIFT-SIT TO STAND LIFTS> In an interview on 05/13/2026 at 8:50 AM, Resident 22 stated the sit-to-stand machine battery frequently died in the middle of the transfer, and they were left hanging while nursing staff searched the facility for a working battery. In an observation and interview on 05/13/2026 at 1:53PM, Staff DD, Nursing Assistant Certified (NAC), was observed attempting to use multiple batteries on the Hoyer lift, but the machine failed to operate. Staff DD stated that although the battery charging bar indicated the batteries were fully charged, the battery still did not work. Staff DD stated this had occurred frequently for three and four months since they began working at the facility. Observed that the battery status indicator on the machine displayed a full charge, but the lift remained inoperable. In an observation and interview on 05/13/2026 at 2:25 PM, Staff EE, NAC, attempted three different batteries from the charging bases to use on the Hoyer lifting machine, but the machine failed to function. Staff EE stated that staff frequently had to go to different floors of the facility to find a working battery. Staff EE stated that this defective equipment had been an ongoing problem for over one year and had been reported to facility management. In an interview and observation on 05/14/2026 at 10:07 AM, Staff G, Maintenance Assistant, explained that a yellow light on the charging base indicated an active charge, while a green light verified the battery was fully charged and ready to use. Staff G stated the battery docked on charging base number one was ready to use as the green light was on. Staff G explained the machine also had a screen which indicated how much the battery was charged. Staff G inserted this battery into the Hoyer lift; the machine screen indicated a full charge, but the lift failed to operate. During this observation, Resident 46 approached and stated that the lift batteries were always not working. Staff G then attempted to use the same battery on another Hoyer lift machine, and it failed to operate as well. Staff G confirmed the battery was defective rather than the Hoyer machines. Staff G then tested an additional two batteries that displayed full charge indicators on both the wall charging base and the machine screen; both failed to operate the lift. Staff G confirmed that three out of the five facility batteries tested were not functional. Staff G inspected the three defective batteries and identified historical dates on the back: 11/29/2021, 03/10/2020, and 09/15/2016. Staff G stated they were unsure if these represented production or expiration dates and lacked knowledge regarding the lifespan of the battery. Staff G reported that facility administration was aware of the problem but had previously attributed it to poor battery and charging base connections. Staff G confirmed these three specific batteries were fully charged but entirely nonfunctional. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In a group interview on 05/14/2026 at 2:40 PM, Resident 22 expressed concern regarding when the facility would replace the lift batteries. Resident 22 stated they had been left hanging up in the air in the middle of a transfer when the machine's battery died, forcing the nurse to run all over the places to different floors for a working battery. Resident 46, Resident 39 and Resident 7 stated the same machine failure had happened on them as well, leaving them halfway in the air due to dead batteries. Resident 46 and Resident 39 stated this equipment concern had been brought up to the Resident Council meetings several times. Resident 45 nodded their head in agreement. In an interview on 05/15/2026 at 1:19 PM, Staff A, Administrator, stated they received periodic complaints regarding the Hoyer lifts and staff had recently reported battery failures. Staff A stated they were unsure if the maintenance department had figured out the battery's problem and stated the facility had begun renting a Hoyer lift the previous week. In a follow-up interview on 05/18/2026 at 9:03 AM, Staff G stated they had reported to Staff A about two to three months ago that the batteries required replacement. Staff G stated the nonfunctional batteries should be removed from the charging station. On 05/18/2026 at 11:03 AM, Resident 22 approached the surveyor and reported they had been stuck in the air again during sit to stand transfers on 05/16/2026 and 05/17/2026. Resident 22 stated they were very worried about using the sit to stand lift and was sure something would happen or someone would get hurt if there was no change. Refer to WAC 388-97-2100 (1)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a follow up response to concerns voiced by 1 of 1 resident groups (Resident Council). The failure to respond to the Resident Council about their concerns left the issues unresolved and resulted in the Resident Council process being ineffective at improving resident quality of life. Findings included .Review of the facility policy titled, Resident Council Meetings, revised date 01/2026, documented the facility shall act upon concerns of the Council and communicate the decision to the Council. Review of the facility policy titled, Resident and Family Grievances, revised date [DATE], documented that grievances could be voiced via verbal complaints during resident council meetings. The policy documented the staff member receiving the grievance would record the nature and specifics of the grievance on the designated form and take any immediate actions needed. The policy showed all staff should make prompt efforts to resolve the grievance. In a group interview on [DATE] at 2:40 PM, Resident 2 and Resident 7 stated that some nursing assistants talked very loudly in the hallways at night and noted this was a consistent concern. Resident 45 nodded their head to acknowledge agreement. Resident 2 stated they frequently received other residents' clothes from the laundry department. Resident 35 stated they received Resident 7's clothes, and Resident 22 stated they received Resident 35's clothes. Resident 7 and Resident 35 stated this laundry concern was brought up during Resident Council meetings, but no change occurred. During the same group interview, Resident 22 asked when the batteries for the Hoyer lift (machine that lifts persons from one surface to another) would be replaced, stating they had been left hanging up in the air in the middle of a transfer when the machine's battery died. Resident 46, Resident 39 and Resident 7 stated the same machine failure had happened on them as well, leaving them halfway in the air due to dead batteries. Resident 46 and Resident 39 stated this equipment concern had been brought up to the Resident Council meetings several times. Resident 45 nodded their head to acknowledge agreementReview of Resident Council Meeting minutes for [DATE] documented there was a concern regarding staff talking loudly in the hallways. There was no documentation of resolution or facility follow-up on the minutes. Review of the Grievance Resolution Log for [DATE] showed no documentation or resolution to the noted concerns from Resident Council from [DATE].Review of Resident Council Meeting Minutes for [DATE] documented there was a concern regarding staff talking in different languages in the hallways and laughing loudly. There was no documentation of resolution or facility follow-up on the minutes. Review of the Grievance Resolution Log for [DATE] showed no documentation or resolution to the noted concerns from Resident Council from [DATE].Review of Resident Council Meeting Minutes for [DATE] documented there were concerns regarding staff talking in different languages in the hall, and laundry/clothes being returned to the incorrect rooms with bleach stains. There was no documentation of resolution or follow-up on the minutes. Review of the Grievance Resolution Log for [DATE] showed no documentation or resolution to the noted concerns from Resident Council from [DATE].Review of Resident Council Meeting Minutes from [DATE] to [DATE], show no documentation about concern regarding the Hoyer lift. In an interview on [DATE] at 10:11AM, Staff X, Director of Activity, stated they filled out grievance forms for the Resident Council's concerns and passed them to the Director of Nursing and the Administrator. Staff X stated they were not following up with the outcomes. In an interview on [DATE] at 9:34 AM, Staff Y, Laundry, stated they were not aware of the concern from the resident council meeting regarding the clothes being returned to the wrong residents.In an interview on [DATE] at 1:03 PM, Staff A, Administrator, stated that the facility did not log group concerns from Resident Council meetings into the formal Grievance Log, nor did they file official grievance reports. Staff A stated the facility had conducted in-service trainings regarding staff talking loudly in the hallways and would provide documentation of the training.In a follow-up interview on [DATE] at 12:07 PM, Staff A stated they were unable to find any in-service training records (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	corresponding to the concerns about staff talking in the hallways, nor any training or resolution documentation related to clothes being returned to the wrong residents.Reference WAC 388-97-0920

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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. Based on interview and record review, the facility failed to provide instructions upon discharge, evaluate the need for home health support or equipment needs, and make arrangements for home medications to ensure a safe discharge for 1 of 2 residents (Resident 88) reviewed for discharge to the community and failed to provide appropriate notifications in writing to the resident/representative and the ombudsman (neutral resident advocate) for 3 of 4 residents (Residents 9, 11, and 88) reviewed for discharge process. These failures placed residents at risk of an unsafe discharge, risk of medical complications, and risk of not being informed of their rights regarding the transfer/discharge process.Findings included.<RESIDENT 88>Review of a progress note, dated 03/26/2026, showed Resident 88 discharged home Against Medical Advice (AMA). The note did not document any instructions that were provided or document any services or equipment needs for Resident 88. Review of Resident 88's Electronic Medical Record (EMR) showed no record of a discharge summary, discharge instructions or Notice of Transfer form.During an interview on 05/14/2026 at 11:42 AM, Staff D, social service assistant, stated when a resident was discharged , they ordered services and equipment and provided the Notice of Transfer form to the resident. Staff D stated that if a resident left AMA, the facility sets up services and provided instructions the same as a regular discharge. Staff D stated Resident 88 discharged without any notice, so they had not set up any services. Staff D stated they had not contacted Resident 88 after discharge to offer services.During a joint interview on 05/14/2026 at 3:35 PM with Staff C, Assistant Director of Nursing Services, and Staff B, Director of Nursing Services; Staff C stated that services and discharge instructions were provided for residents that left AMA. Staff B reviewed Resident 88's EMR and stated there was no documentation that any instructions were provided or that any services were set up for Resident 88 upon discharge.During a follow up interview on 05/14/2026 at 3:43 PM, Staff C reported they contacted the nurse that was working when Resident 88 was discharged and they could not remember what information had been provided to the resident upon discharge.During an interview on 05/14/2026 at 3:45 PM, Staff A, Administrator, stated social services kept the completed Notice of Transfer forms and they would provide a copy for Resident 88.In a follow up interview on 05/14/2026 at 4:32 PM, Staff A reported that the social service staff had not been providing Notice of transfer forms for residents that left AMA. <RESIDENT 11>Review of a progress note dated 05/02/2026 at 7:20 AM, showed Resident 11 was transferred to the hospital.Review of Resident 11's EMR showed no record of a Notice of Transfer form being provided to the resident or resident's representative. <RESIDENT 9>Review of a progress note dated 04/24/2026 at 3:51 PM, showed Resident 9 was sent to the hospital Emergency room.Review of the progress notes from 04/24/2026 through 05/01/2026 showed Resident 9 did not return from the hospital and their significant other picked up all personal belongings.Review of Resident 9's EMR showed no record of a Notice of Transfer form being provided to the resident or resident's representative.During a joint interview on 05/14/2026 at 3:45 PM, with Staff B and Staff A, Staff B stated the facility staff should be including the Notice of Transfer form with the transfer instructions. Staff A stated they would follow up with social services.In a follow up interview on 05/14/2026 at 4:32 PM, Staff A reported that they could not find any Notice of transfer forms for Resident 11 or Resident 9. Staff A reported that the facility staff had not been providing notices to residents that were transferred to the hospital. Refer to WAC 388-97-0080 (5),(7) & 388-97-0120 (5)(b)(i)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure expired medications were discarded in one of two medication room refrigerators and sharps containers emptied after reaching the full line, temperatures were documented and monitored for vaccines located in one of two medication room vaccine refrigerators, and failed ensure medications were secured and not accessible to the public or residents for one of one residents (Resident 93) whose medications were at their bedside. These failures place all residents at risk for receiving compromised and/or ineffective medications and medical solutions, which potentially result to the residents not receiving the therapeutic effect of the medications, and or possibly experience adverse side effects.Findings included . Review of the facility policy titled, Storage of Medication Requiring Refrigeration, reviewed documented the facility would assure proper and safe to prevent storage of medications requiring refrigeration and the potential alteration of medication by exposure to improper temperature controls by monitoring temperature daily to ensure proper temperature control and documented on the temperature log located outside of the refrigerator provide safe and effective storage of medications through proper temperature controls consistent with professional standards of practice. According to the facility policy titled Bedside Medication Storage dated 01/2023 documented, a written order for the bedside storage of medication is present in the resident's medical record. According to the Center for Disease Control and Prevention (CDC), The Epidemiology and Prevention of Vaccine-Preventable Diseases also known as the Pink Book, Chapter 5 documented if temperatures could not be recorded digitally, they should be checked and recorded a minimum of two times each workday. In an observation on 05/14/2026 at 9:13 AM of the sixth-floor medication room, the vaccine refrigerator contained vials of flu vaccine. Review of the temperature logs for: -05/01/2026 through 05/14/2026 documented temperatures/initials recorded for AM Temp and PM Temp were blank. -04/01/2026 through 04/30/2026 documented temperatures/initials missing for AM Temp for 04/01/2026 and 04/10/2026 and missing temperatures/initials for PM Temp for the entire month except for 04/01/2026. -03/01/2026 through 03/30/2026 documented missing temperatures/initials for AM Temp on 03/17/2026 and PM Temp for 03/04, 03/05, 03/08, 03/09, 03/11, 3/18, 3/19. 3/20 and 3/23 through 3/30/2026. In an observation on 05/14/2026 at 9:13 AM observed the refrigerator in the medication room contained a bottle of liquid Amoxicillin and Clavulanate Potassium for Oral Suspension 400 milligrams/57mg per 5 milliliters (an antibiotic) with a filled date of 05/01/2026 and expiration date of 05/11/2026 on the pharmacy label. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 05/14/2026 at 9:13 AM observed the sharps container located on the wall adjacent to the vaccine refrigerator filled past the full line. The container was hanging in an unlocked wall mount. In an interview on 05/14/2026 11:07 AM Staff V, Licensed Practical Nurse/Nurse Manager stated the refrigerator temperatures for vaccines should be checked and documented twice daily and would be completing education with the nursing staff. Staff V stated that the nurses at night were responsible for maintaining the medication room and refrigerator to ensure expired medications and products were disposed of as required. <MEDICATIONS AT BEDSIDE> <RESIDENT 93> Resident 93 was admitted to the facility on [DATE]. In an observation and interview on 05/12/2026 at 2:28 PM, Resident 93's overbed table had 2 nasal sprays – Fluticasone Nasal Spray (over the counter medication (OTC) to treat allergy) and Ipratropium Bromide (prescription medication to treat allergy) and 2 tubes of Triamcinolone Cream 0.5% (a prescription medication to treat skin problems). The resident stated they administered the nasal sprays once a day and used the cream for itchiness. In an observation and interview on 05/13/2026 at 8:17 AM, Resident 93 stated the nurse took their nose sprays. Observed Vicks VapoRub container (OTC medication to treat congestion) and Systane eyedrops (OTC eye lubricant) by their windowsill. Resident stated they use the Vicks for stuffy nose and the eyedrops for dry eyes. In an observation on 05/14/2026 at 9:26 AM, Resident 93 was eating their breakfast and observed Vicks VapoRub, Systane eyedrops, 3 different brands of OTC antifungal creams, and 2 tubes of Triamcinolone creams on their over bed table. Record review of Resident 93's order summary with a print date of 05/13/2026 did not contain an order that the resident may keep medications at bedside. In an interview on 05/14/2026 at 10:44 AM, Staff M, Licensed Practical Nurse stated that any medications and creams such as antifungal creams were not supposed to be at resident's bedside. Staff M stated they saw the creams on Resident 93's bedside and will take them out of the resident's room. Reference WAC 388-97-1300 (2)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to allow residents to make choices about daily routines for 1 of 2 residents (Resident 12) reviewed for choices. The facility's failure to accommodate resident choices placed residents at risk for a diminished quality of life.Findings included. Resident 12 was admitted to the facility on [DATE]. According to the admission minimum data set assessment (MDS-an assessment of care needs), dated 12/30/2025, the resident was cognitively intact.<FOOD>In an interview on 05/12/2026 at 10:46 AM, Resident 12 reported experiencing weight loss because the facility repeatedly provided food items they disliked. The resident stated they disliked pineapple but the facility provided pineapple in the fruit cup. The resident further stated they did not like chicken but almost every meal contained chicken. Resident 12 stated the facility should have been aware of these preferences. In an interview on 05/13/2026 at 3:04 PM, Staff I, Nursing Assistant Certified (NAC), reported Resident 12 disliked chicken and certain green vegetables. In an observation and interview on 05/14/2026 at 12:36 PM, Staff J, NAC was observed assisting Resident 12 with lunch. The beef on the lunch tray was observed to be approximately 10 percent consumed. When asked if they liked beef, Resident 12 stated, No. Staff J stated that Resident 12 disliked chicken and most beef dishes. Staff J further stated that Resident 12 disliked pineapple, but the kitchen occasionally provided it anyway, even though the resident's meal tray card documented no pineapple. Staff J stated the dietary manager needed to be informed to update the resident's food preferences.Review of Resident 12's lunch tray card on 05/14/2026 documented Resident 12 disliked pineapple, but not other food restrictions or dislikes. The tray card showed an order for health shake (high protein drink), but this was manually crossed out with the word out written next to it.In an observation and interview on 05/15/2026 at 9:23 AM, Staff K, NAC, was observed assisting Resident 12 with breakfast. Resident 12 consumed all of the eggs and almost all of the sausages but left the oatmeal untouched. Resident 12 stated they liked eggs and sausages but disliked oatmeal. Resident 12 reiterated that they disliked chicken and beef, but the facility always provided those items. Staff K stated that Resident 12 disliked oatmeal and refused to eat it. Staff K reported the resident also disliked pineapple but the kitchen still served to Resident 12. Staff K stated they had never seen the resident eat steaks (beef) or diced chicken and noted it was challenging for the resident because the kitchen frequently served chicken and beef for lunch. Staff K stated that Resident 12 did not like the available substitutes and would usually finish the rest of the meal, leaving them with no protein source. Staff K stated they had reported the resident's preferences to the nurse.In an observation and interview on 05/15/2026 at 1:06 PM, Staff K was observed assisting Resident 12 with lunch. Staff K stated that the resident did not like chicken or the ordered health shakes. The chicken inside a hot pie was observed to be almost untouched, and the health shake remained unopened. Staff K stated the resident preferred chocolate milk over the health shake, and Resident 12 nodded their head in agreement.In a follow-up interview and observation on 05/15/2026 at 1:37 PM, Resident 12 stated they did not like chicken and had only eaten a couple of bites. The resident stated they did not like the health shake and chose not to drink it. The lunch tray was observed in the dietary cart with the chicken left in the bowl and the health shake untouched.In a phone interview on 05/16/2026 at 3:51PM, Collateral Contact 3 (CC3), spouse of Resident 12, stated that the resident used to eat all types of meat before suffering a stroke, but no longer did. CC3 stated that Resident 12 disliked chicken and fish due to their textures, and ate a very limited amount of beef, specifically disliking hamburgers. CC3 confirmed they had seen pineapple served to the resident despite the resident's strong dislike for it.Review of Resident 12's diet order, dated 04/28/2026, documented that the resident required a high-protein diet.Review of Resident 12's body weight record showed that the resident's weight decreased from 205.1 pounds on 12/23/2025 to 182 pounds on (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/05/2026, which was a loss of 23.1 pounds and 11.26 percent weight decline in less than six months.Review of a facility form titled, FOOD PREFERENCES RECORD FORM, date 12/23/2025, documented yes for all types of meat and listed no foods under the dislikes section. The form failed to indicate what type of milk Resident 12 preferred.Review of Resident 12's Electronic Health Record (EHR) showed that no further food preferences assessments were conducted after the initial admission date.Review of Resident 12's physician order summary documented an order dated 04/04/2026 to offer a health shake once per day due to reduced meal intake.In a joint interview on 05/15/2026 at 10:49 AM with Staff F, Director of Dietary, and Staff H, Dietitian, Staff F stated they had not spoken with Resident 12 about food preferences since the initial admission assessment. Staff F stated that if the tray card indicated the resident disliked pineapple, the kitchen should not have provided it. Staff H stated they had recently updated the tray card to reflect that Resident 12 disliked pineapple and liked cottage cheese. Both Staff F and Staff H stated they were unaware that the resident disliked chicken, beef, or any other items. Staff H stated that Staff F regularly attended resident care conferences to provide opportunities for updating food preferences.Review of the care conference records dated 12/29/2025 and 01/16/2026, showed no documentation about diet or food preferences discussed in the meetings. Review of the care conference record dated 03/09/2026 showed that Staff F did not sign the attendance log. In a follow-up interview on 05/18/2026 at 9:23 AM, Staff F confirmed they did not attend Resident 12's last care conference on 03/09/2026.In an interview on 05/15/2026 at 12:47 PM, Staff B, DNS (Director of Nursing), stated the expectation was for nursing staff to communicate directly with the dietary manager to update resident food preferences.In an interview on 05/15/2026 at 1:19 PM, Staff A, Administrator, stated they expect food preferences to be updated during scheduled care conferences. <Bed Time>In an interview on 05/12/2026 at 10:46 AM, Resident 12 stated they did not get enough sleep at night and was always getting disturbed by staff which made them sleepy and tired during the day. In an interview on 05/14/2026 at 9:39 AM, Resident 12 stated they were awakened in the early morning and middle of the night for medications, vital signs check (blood pressure, heart rate, amount of oxygen percentage in the blood, and temperature), and care of urinary device. Resident 12 stated they had told the staff about not wanting to be awakened at night, but no changes were made.Review of a facility psychosocial assessment and history, dated 12/24/2025 at 10:58 AM, documented Resident 12 complained about not getting enough sleep because staff were bugging them every two hours.Review of the Grievance Resolution Log for December 2025 showed no documentation or resolution to the concern about being awakened at night for Resident 12. Review of a facility form titled, [NAME] AT PACIFIC, dated 12/23/2025, under section of preferences, documented Resident 12 preferred to wake up at 11AM. Review of a quarterly MDS assessment dated [DATE], documented it was very important for the resident to choose their own bedtime routine. Review of Resident 12's Medication Administration Record from 05/01/2026- 05/13/2026 showed a physician order for a thyroid medication scheduled to be administered daily at 6AM. Review of Resident 12's V2 Survey Report (documentation of care provided) from 05/01/2026 to 05/13/2026 documented the night shift staff routinely drained the resident's urinary device at 12 AM (midnight) and 5 AM. In an interview on 05/14/2026 at 10:05 AM, Staff Z, NAC, stated that facility routine required staff to check residents' vital signs at the beginning of every shift at 6AM, 2 PM and 10PM. In an interview on 05/18/2026 at 10:47 PM, Staff D, Social Service Assistant, confirmed that no facility grievance had been generated regarding the sleeping concerns documented on the initial 12/24/2025 psychosocial assessment, and was not sure if any adjustment had been made to Resident 12's night-time care routine. In an interview on 05/18/2026 at 11:37 AM, Staff E, Registered Nurse/Nurse Manager, stated staff generally discuss resident preferences during care conferences. Staff E acknowledged that Resident 12's personal preferences were not being followed. In an interview on 05/18/2026 at 12:01 PM, Staff A, Administrator, stated that if a resident requested not to be awakened at night, the facility expectation was for the nurse manager to update the care plan, rearrange tasks, and adjust (continued on next page)

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	505404	A. Building B. Wing	05/18/2026

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Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication administration time to accommodate the resident's choices. Reference WAC 388-97-0900 (1)

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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 observation, record review and interviews, the facility failed to ensure that 1out of 5 residents (Resident 84) reviewed for Preadmission Screening and Resident Review (PASRR - a federally required screening of all individuals for Intellectual Disability or Related Condition and a Serious Mental Illness prior to admission) process. The facility failed to incorporate PASRR Level II recommendations into the comprehensive care plan and failed to implement individualized activities to meet the resident's specialized behavioral health needs. This failure placed the resident at risk for psychological decline, unmet psychosocial needs, and lack of specialized services. Findings included. Review of the facility policy titled, Resident Assessment -Coordination with PASARR (PASRR) Program, revised date 04/2025, documented any recommendations included specialized services, from a PASARR level II determination and/or PASARR evaluation report would be incorporated into the resident's assessment, care planning, and transitions of care. Resident 84 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (a mental health condition characterized by extreme, cyclical shifts in mood, energy, and activity levels). Review of Resident 84's PASRR Level II Initial Psychiatric Evaluation Summary, dated 08/14/2025, documented under the sections of Recommendations for Nursing Facility and Activities that Resident 84 had specific specialized preferences for artwork including drawing, painting and Play-Doh. Review of Resident 84's care plan, initiated on 07/03/2025, showed no interventions that Resident 84 did artwork for activity. In an interview on 05/15/2026 at 9:43 AM, Staff AA, Activity Assistant, confirmed that Resident 84 was not provided with individualized artwork activities. In an interview on 05/15/2026 at 9:53 AM, Resident 84 stated they really liked artwork, painting, drawing and Play-Doh, but there was not much in the facility. The resident stated they needed more supplies and assistance to set up. In an interview on 05/15/2026 at 10:11 AM, Staff X, Director of Activity, confirmed that Resident 84 did not have individualized art activities structured and did not engage in drawing, painting or Play-Doh. Staff X stated the resident attended general group ceramics occasionally and stated they were unaware that Resident 84 had specific PASRR activity recommendations or documented preferences. In an interview on 05/15/2026 at 12:13 PM, Staff D, Social Service Assistant, stated they forwarded PASRR Level II evaluations to other departments via email upon receipt. Staff D stated PASRR Level II recommendations should be implemented into the resident's care plan. Refer to WAC 388-97-1975(8)(10)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the State PASRR (Pre-admission Screening and Resident Review-an assessment used to identify residents with Serious Mental Illness [SMI] or intellectual disabilities (ID) were not inappropriately placed in a nursing facility for long term care) Coordinator after a significant change in behavior status for 1 of 5 residents (Resident 40) reviewed for PASRR. This failure placed the resident at risk for unmet mental health services necessary to obtain the resident's highest level of psychosocial well-being and a diminished quality of life.Findings included.Resident 40 was initially admitted on [DATE] and most recently readmitted on [DATE].Review of Resident 40's Level 1 PASRR, dated 11/11/2024, showed no indicators of SMI or ID.Review of Resident 40's diagnosis list showed dementia with psychotic disturbance (decline in mental ability that often includes visual hallucinations or paranoid beliefs) was added on 08/13/2025.Review of Resident 40's quetiapine (medication to treat paranoia and/or hallucinations) physician order history showed medication was initiated on 08/28/2025.Review of the minimum data set (an assessment tool), dated 03/09/2026, documented that Resident 40's current behavior status was worse compared to the prior assessment.Review of Resident 40's electronic medical record (EMR) showed no record of an updated Level 1 PASRR.During an interview and record review on 05/14/2026 at 12:11 PM, Staff D, Social Service Assistant, stated if a resident had a change in behavior status or had a new diagnosis added for a mental health condition, a new Level 1 PASSR should be done. Staff D reviewed Resident 40's EMR and reported an updated Level 1 PASSR was not completed when they had a new diagnosis of dementia with psychotic disturbance and medication for that condition had been started. Refer to WAC 388-97-1975(9)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure oral hygiene was performed for 1 of 1 resident (Resident 41) reviewed for Activities of Daily Living (ADLs). This failure placed the resident at risk for poor oral hygiene, dental complications, decreased self-esteem, and diminished quality of life.Findings included . Review of the facility policy titled, Activities of Daily Living (ADL's), reviewed 3/2026 documented, the facility would ensure residents would receive the care and services to include oral care based on their choices and comprehensive care plan. A resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.Resident 41 was admitted to the facility on [DATE] with diagnoses to include stroke with an affected right side and removal of brain tumor.Review of Resident 41's care plan dated 04/10/2026 documented they were totally dependent on staff for oral care.Review of Resident 41's V2 Documentation Report (Nursing Assistant charting) for 05/01 through 05/17/2026 documented NA (Not Applicable) during evening shift on 05/03, 05/04, 05/07, 05/08, 05/09, 05/13, 05/14/2026 (total of 7 out of 18 opportunities on evening shift).In an interview on 05/12/2026 at 11:05 AM Resident 41 stated they were not always offered to brush their teeth. Resident 41 stated their preference was to brush their teeth twice daily and this was their routine at home prior to being hospitalized . Resident 41 stated they observed a toothbrush and toothpaste in a basin located above the sink in their room.In an interview on 05/14/2026 at 11:39 AM Resident 41 stated they had not had their teeth brushed since the night before last and had not been offered.In an interview on 05/18/2026 9:19 AM Resident 41 stated they had not brushed their teeth or been offered to for several days. Resident 41 stated they had eaten breakfast already and had not been offered to have their teeth brushed.In an interview on 05/18/2026 at 9:27 AM Staff W, Nursing Assistant Certified (NAC), stated oral care for residents was expected to be done at least once a shift, usually after meals. Staff W stated they encouraged Resident 41 to brush their teeth, required set up, and at times encouraged them to use mouthwash versus brushing their teeth. Staff W stated they had not offered Resident 41 oral care that day. Staff W stated they were unaware of Resident 41's routine prior to their admission regarding oral care and relied on information provided in the care plan.Reference WAC 388-97-1060(2)(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure quality of care were met for 1 of 2 residents (Resident 12) reviewed for vision, and 1 of 5 residents (Resident 84) reviewed for unnecessary medication review. The facility failed to place essential items including the call light and television remote control within the resident's unaffected vision field; failed to ensure physician-ordered parameters were followed for blood pressure medication administration. These failures placed the residents at risk for medication errors, unmet needs, and decreased quality of life. Findings included . <Resident 12>Resident 12 was admitted to the facility on [DATE] with diagnoses to included right side hemiplegia (paralysis of one side) and hemiparesis (weakness of one side) following cerebral infarction (stroke). According to the admission minimum data set assessment (MDS-an assessment of care needs), dated 12/30/2025, the resident was cognitively intact.In an interview and observation on 05/12/2026 at 10:46 AM, Resident 12 stated their left eye was blind and could not see items placed on their left side. Observed the resident's call light was placed beside their left upper arm; the television remote control was on the bedside table; and both the bedside table and the nightstand situated at the left side of the bed within the resident's left blind side. In an interview and observation on 05/13/2026 at 1:27 PM, Resident 12 asked the surveyor where their call light was located. Observed the call light lying on the bed to the resident's left. The resident reiterated that they could not see the call light when placed on their left side. Review of the initial admission nursing assessment dated [DATE] at 3:48 PM, documented Resident 12 had impaired vision due to left eye blindness. Review of Resident 12's care plan, initiated on 12/30/2025, documented the resident had impaired visual function related to left eye blindness. However, there was no corresponded intervention directing staff to position the call light and other essential items within the resident's unaffected right visual side. Review of Resident 12's admission MDS assessment, dated 12/30/2025, in visual function care area assessment, showed no documentation about left eye blindness, any contributing risk factors to the care, or clinical rationale to guide care planning. In an interview on 05/14/2026 at 12:36PM, Staff J, Nursing Assistant Certified, confirmed Resident 12 could not see their left side due to left eye blindness. Staff J stated they should place the call light, television remote control and other essential items on the resident's right side. In an interview on 05/15/2026 at 11:45 AM, Staff E, Nurse Manager, confirmed Resident 12 had an impairment of their left visual field and the care plan lacked instructions to position the call light and essential items on the right side. In an interview on 05/15/2026 at 12:47 PM, Staff B, Director of Nursing, stated that staff were expected to place all essential items, especially the call light, within the resident's unaffected visual field; and the intervention should have been documented in the care plan. <RESIDENT 84>Resident 84 was admitted to the facility on [DATE] with diagnoses to include high blood pressure.Review of Resident 84's from 05/01/2026 to 05/13/2026 MAR, showed a physician order for a blood pressure medication to be given twice a day. The order directed nurses to hold the medication for a heart rate below 60 beats per minute (bpm). However, the medication was administered when the resident's heart rate was below 60 bpm on the morning of 05/03/2026. Review of Resident 84's April 2026 MAR, showed the medication was administered when the resident's heart rate was below 60 bpm on the mornings of 04/17/2026, 04/18/2026, 04/25/2026, 04/26/2026, and the evenings of 04/13/2026 and0 4/25/2026. In a record review and interview on 05/15/2026 at 12:03 PM, Staff E, Nurse Manager, stated the nurse needed to follow the order instruction and hold the medication when the heart rate was below 60 bpm. In a record review and interview on 05/15/2026 at 12:47 PM, Staff B, Director of Nursing, stated the expectation was to follow the provider's order, to read the parameter, and to hold the medication if the parameter was out of range. Refer to WAC 388-97-1060(1)(3)(k)

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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 a call light (a device to request help as needed) within reach for one of one resident (Resident 20) reviewed for call light accessibility and failed to ensure one of two residents (Resident 41) were comprehensively assessed and interventions implemented to prevent an avoidable fall with injury. These failures placed residents at risk for accidents, avoidable falls, and diminished quality of life.Findings included . Review of the facility policy titled, Call Lights: Accessibility and Timely Response revised 3/2026 documented their policy included the call system would be accessible to residents while in their bed or other sleeping accommodations within the resident's room.Review of the facility policy titled, Fall Risk Assessment revised 3/2026 documented it was the facility's policy to provide an environment free from accident hazards over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. A fall risk assessment would be completed at admission to identify, evaluate, and analyze environmental hazards and individual risk, including the need for supervision. <RESIDENT 20>Resident 20 were admitted to the facility on [DATE] with diagnoses to include stroke affecting their left side.Review of Resident 20's Kardex (derived from the care plan with resident specific information/directions to provide care) as of 05/14/2026, documented under safety, to ensure their call light was within reach and encourage them to use if for assistance.In a continuous observation starting on 05/14/2026 at 10:30 AM Resident 20 was lying in their bed, their door open and their call light on the floor on the left side of their bed. At 10:36 AM Collateral Contact 1 (CC 1), provider for Resident 20, entered their room and then exited the room at 10:39 AM. In a brief interview with CC1, they stated they were the provider for Resident 20 and could not complete a visit as they wanted them to return tomorrow. CC 1 stated they did not observe Resident 20's call light on the floor. CC 1 left the area after the interview and did not reenter Resident 20's room. At 10:51 AM Staff S, Registered Nurse, and Staff T, Nursing Assistant Certified, walked past Resident 20's room while their call light remained on the floor. At 10:56 AM Staff U, Certified Occupational Therapy Assistant, knocked on Resident 20's door and explained they would be removing a piece of equipment from their bathroom. Observed Staff U remove and clean an over the toilet commode in Resident 20's doorway until 11:02 AM. At 11:23 AM Staff V, Licensed Practical Nurse (LPN)/Nurse Manager, entered Resident 20's room and informed them they were closing their door for a fire drill and closed their door. Staff V returned at 11:36 AM and opened Resident 20's door and picked up their call light from the floor and provided it to them. In an interview at 11:36 AM Staff V stated they were unaware Resident 20's call light was on the floor until they reentered their room after the fire drill.<RESIDENT 41>Resident 41 was admitted to the facility on [DATE] with diagnoses to include stroke with an affected right side and removal of brain tumor.In an interview on 05/12/2026 at 10:46 AM Resident 41 stated they had a fall while in the facility from rolling out of bed and suffered an abrasion to their head. Resident 41 stated they had been in a smaller bed and since the fall was placed in a larger bed. In an observation at 10:46 AM, Resident 41 was lying in a bariatric bed with bolsters to define the border of the mattress and fall mats on each side of their bed. Resident 41 stated they were left hand dominant.Review of Resident 41's hospital physical and occupational therapy (PT, OT) notes dated 04/04/2026, showed they were a fall risk and their bed was in the lowest position for safety.Review of Resident 41's hospital speech and language evaluation dated 04/01/2026 documented they were left hand dominant.Review of Resident 41's facility fall risk assessment dated [DATE], scored a 14, and documented they were a high fall risk. The assessment and accompanying progress note failed to fully identify, evaluate, and analyze environmental hazards and individual risk for Resident 41. Review of Resident 41's admission Care Area Assessment (used to create care plan) dated 04/21/2026 documented they were at risk for falls related to their incontinence. There was no input documented (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from family or residents and they were noted to have decreased balance, dependence on staff for assistance, and if they were to fall placed them at risk for further decline.Review of Resident 41's care plan for falls dated 04/10/2026 documented they were to have their call light within reach, assist them in keeping frequently used items in reach, ensure appropriate footwear when in their wheelchair, and their room close to the nurse's station for increased visibility.Review of Resident 41's PT notes dated 04/23/2026 documented they required maximum assistance from two staff for bed mobility.In an interview on 05/14/2026 at 3:30 PM Collateral Contact 2 (CC 2) stated they had been concerned about Resident 41's positioning in their bed and a week prior to the fall and had spoken to staff about positioning them in the middle of the bed. CC 2 stated they had asked about bed rails at the time and were told they were not allowed to use them.Review of the incident report dated 04/23/2026 documented Resident 41 rolled out of their bed onto the left side, hit their head and sustained an abrasion at 7:30 PM. The root cause analysis documented Resident 41 had been having involuntary movements which caused the fall. The witness statement by the aide that was assigned to and found Resident 41 documented they had repositioned them on their side and changed their brief prior to the fall at 6:15 PM. Interventions implemented after the fall included a bariatric mattress with perimeter (to have increased surface area to move), bed in lowest position, bolsters to define the sides of the mattress, and fall mats on each side of the bed. The investigation failed to determine which side Resident 41 was positioned and no other witness statements were included even though they required two-person assistance.Review of a grievance dated 04/17/2026 documented CC 2 had filled out a grievance regarding an observed transfer of Resident 41 from their wheelchair to their bed and the position in which Resident 41's was left, their head was pressed up against the headboard of the bed.Review of progress notes from 04/10/2026 through 05/12/2026 showed no documentation of involuntary movements as described in the incident report.In an interview on 05/18/2026 at 11:12 AM Staff V, LPN/ Nurse Manager stated they were not part of the investigation or admission process for Resident 41 and had no knowledge of the details related to their fall. Staff V deferred to Staff B, Director of Nursing Services.In an interview on 05/18/2026 at 12:22 PM and 2:51 PM Staff B stated they did not know which side Resident 41 was repositioned to prior to their fall, had consulted with the provider and there was no notation of involuntary movements or treatments for it, all residents were at risk for falls, Resident 41 was right hand dominant and was repositioned prior to their fall.Reference WAC 388-97-1060(3)(g)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 2 sampled residents (Resident 44) reviewed for use and care of a catheter (a flexible tube inserted into the bladder to drain urine), received appropriate care and services, to minimize the risk of associated urinary tract infections. This failure placed residents at risk for discomfort, loss of dignity, continued urinary tract infections and other health complications.Findings included . Review of the facility policy titled, Catheter Care, reviewed 03/2026 documented the facility would ensure residents with indwelling catheters received appropriate catheter care. Resident 44 admitted to the facility on [DATE] with diagnoses to include acute prostatitis (severe bacterial infection in the prostate gland) and urine retention (inability to completely empty the bladder).Review of Resident 44's care plan, dated 04/29/2026, documented they had a catheter related to urinary retention with the goal for them not to have any catheter related trauma.Review of Resident 44's progress notes, dated 04/29/2026, through 05/12/2026 documented the following:-On 05/08/2026 a urine sample was collected to check urine osmolality (laboratory test that provides information on how well the kidneys are functioning).-On 5/11/2026 they were found to have blood-tinged urine in their catheter bag.-On 5/12/2026 they were found to have a fever; a urine sample was collected and sent to the laboratory.-On 05/13/2026 they were found to have a urinary tract infection (UTI) and was started on antibiotics.On 5/13/2026 at 10:40 AM Resident 44 was observed in their room, sitting upright in their wheelchair, the catheter tubing on the floor, and was dragging across the floor as they moved themselves in the wheelchair.In an interview on 05/13/2026 at 10:40 AM Resident 44 stated they had just been tested for a UTI and had fever yesterday.On 05/18/2026 at 10:50 AM, observed Resident 44 sitting upright in their wheelchair, with their catheter tubing resting on top of their left wheelchair wheel.In an interview on 05/18/2026 at 10:50 PM Resident 44 stated their catheter bag had recently been covered with the privacy bag, the catheter bag had often been left on the floor throughout their stay, and described a situation from a few nights prior that a staff had emptied the catheter bag, which was full, and overfilled the urinal causing urine to spill all over the floor, catheter bag and tubing.On 05/18/2026 at 10:54 AM, observed Staff BB, Nursing Assistant Certified, empty Resident 44's catheter. Staff BB was observed to unhook the catheter tubing from the wheelchair, take the catheter bag out of the privacy bag, and place it on the floor. Observed Staff BB place the urinal on its side, on the floor, open the catheter spout (without use of a surface disinfectant), and empty the contents of the catheter into the urinal. Staff BB then closed the spout (without the use of a surface disinfectant) on the catheter bag and place it into the privacy bag then they hung it back on the wheelchair.In an interview on 5/18/2026 at 11:00 AM, Staff BB stated space was limited and thus the reason for them to place the catheter bag on the floor. Staff BB stated it was difficult because Resident 44 was sitting in the wheelchair and if they were in their bed they could have used the bed frame to hold the catheter bag. When asked about using a disinfectant to clean the catheter bag spout before or after emptying the contents, Staff BB stated they do use a disinfectant sometimes, but not always.In an interview on 05/18/2026 at 11:08 AM Staff V, Licensed Practical Nurse/Nurse Manager stated the expectation of catheter care was for it to be completed every shift, the spout of the catheter bag to be disinfected, and the catheter tubing and catheter bag should never be on the ground.Reference WAC 388-97-1060(3)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505404	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure 1 of 1 resident (Resident 55) reviewed for respiratory care received their physician ordered Continuous Positive Airway Pressure machine (CPAP -a machine that sends a steady flow of pressurized air into the nose and mouth to keep the airways open and helps you breath normally while sleeping). This failed practice placed the residents at risk of respiratory distress, lack of restful sleep and diminished quality of life.Findings included. According to facility policy titled Noninvasive Ventilation (CPAP, BiPAP, AVAPS, Trilogy) with revised date of 07/2025 documented, document use of the machine, resident's tolerance, any skin, respiratory or other changes and response(s).Resident 55 was admitted to the facility on [DATE] with diagnosis to include obstructive sleep apnea (disruption of breathing during sleep due to airway blockages).Review of Resident 55's physician orders documented CPAP to be on at bedtime and off in the morning, and to cleanse mask with mild soap and water, air dry every day. Order was dated 04/21/2026.In an observation and interview on 05/14/2026 at 12:10 PM, Resident 55's CPAP machine was not at their bedside. The resident stated that their CPAP was at their daughter's home and was not using it.Review of Resident 55's April and May 2026 Medication Administration Record and Treatment Administration Record (TAR) had no documentation of the order to put the CPAP on at bedtime and off in the morning however, cleaning of the CPAP mask daily was in the TAR, and it was signed daily by Licensed Nurses.In an interview on 05/14/2026 at 12:25 PM, Staff L, Certified Nursing Assistant, stated they had not seen a CPAP machine in Resident 55's room.In an interview on 05/14/2026 at 12:25 PM, Staff M, Licensed Practical Nurse stated that they had not seen the CPAP machine in Resident 55's room. Showed Staff M the May 2026 TAR that staff had been signing that they were cleaning the CPAP mask daily. Staff M looked at the TAR and responded, oh God and walked away. In an observation and interview on 05/14/2026 at 12:31 PM, Staff N, Social Services Assistant, stated Resident 55's CPAP machine was in their room. Observed Staff N looked inside the bedside table cabinet and then looked in the drawer by resident's closet and pulled out a plastic bag that had the resident's CPAP machine. Resident 55 stated they did not know that it was in there and had not been using their CPAP machine.In an interview on 05/14/2026 at 2:23 PM, Staff O, Resident Care Manager stated Resident 55's daughter took the CPAP machine home, and they were not aware that the daughter brought it back. They added that the resident had history of refusing to use the CPAP machine. Staff O could not provide documentation of resident's refusal to use the CPAP machine and documentation that staff had offered the resident to use the CPAP machine.Review of Resident 55 admission Minimum Data Set (MDS-an assessment tool) dated 04/28/2026 documented the resident used CPAP.In an interview on 05/18/2026 at 11:15 AM, Staff P, MDS Nurse, stated they could not find documentation that Resident 55 used their CPAP machine during the look back period and they will modify the MDS to reflect that. Refer to WAC 388-97-1060 (3)(j)(vi)

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	505404	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany at Pacific	916 Pacific Avenue 3rd-5th Floors Everett, WA 98201

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social services and to advocate for 1 of 4 cognitively impaired residents (Resident 81) reviewed for advanced directives. The facility failed to advocate and educate the resident of legal options for an advanced directive and failed to identify other family that may be an alternative decision maker per state law which placed the resident at risk of not having their rights and wishes honored.Findings included.Resident 81 admitted to the facility on [DATE] with diagnoses to include fall with wedge compression fracture (spinal break where the front part the vertebrae collapse while the back remains intact) of the upper/middle back.Review of Resident 81's care plan dated 05/08/2026 documented they were primary language was Mandarin.Review of Resident 81's admission documents dated 05/01/2026, to include advanced directive options/information, showed they were all signed by their Collateral Contact 4 (CC 4) as Resident Surrogate.Review of Resident 81's preferences dated 04/30/2026 showed they were completed and signed by CC 4.In an interview on 05/15/2026 at 9:50 AM CC 4, Resident 81's daughter stated they had a brother and no other siblings, CC 4 stated Resident 81 had no power of attorney, no spouse, and had relied on them to make decisions for them as needed. CC 4 stated Resident 81 was cognitively intact and was able to make decisions, however they were used for translation needs.Review of Resident 81's progress notes dated 05/04/2026 documented an interpreter was used to conduct the brief interview for mental status (assessment used to determine memory loss) and scored 11/15 indicative of moderate cognitive impairment.In an interview on 05/15/2026 at 10:24 AM Staff CC, Social Services Director, stated they were aware Resident 81 had a son but did not have their contact information. Staff CC reported CC 4 and Resident 81 had lived together for many years and CC 4 had been wanting to take care of everything themselves, and Resident 81 had been a little confused.In review of Resident 81's progress notes dated 04/30/2026 through 5/12/2026 documented no discussions with Resident 81 about advanced directives, their preferences, or they had any other family members.Reference WAC 388-97-0960

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	505404	A. Building B. Wing	05/18/2026

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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 ensure speech therapy services were provided for 1 of 2 residents (Resident 91) reviewed for specialized rehabilitative services. This failure prevented residents from attaining and maintaining their highest practicable level of physical, functional and psycho-social well-being.Findings included.Resident 91 was admitted to the facility on [DATE] with diagnoses to include stroke. According to the admission Minimum Data Set (an assessment tool) dated 05/14/2026, the resident had intact cognition.In an interview on 05/12/2026 at 9:52 AM, Resident 91 stated they had not seen a speech therapist since they were admitted to the facility. According to the resident, they had to wait for the speech therapist to evaluate them first before they could upgrade the diet texture of their meals.Review of Resident 91's orders documented Speech Therapy evaluation and treatment for swallow and cognitive evaluation, order date 05/07/2026.Review of Resident 91's therapy service log matrix report with a print date of 05/13/2026 had no documentation of minutes for speech therapy.In an interview on 05/13/2026 at 1:12 PM, Staff Q, Resident Care Manager, stated when they received an order for a resident to see a speech therapist, the resident would normally be seen within 24-48 hours after the order was placed in resident's chart. Staff Q could not provide notes that Resident 91 was seen by speech therapist.In an interview on 05/14/2026 at 8:47 AM, Staff R, Rehab Director, stated after verifying the therapy (Physical Therapy/Occupational Therapy/Speech Therapy) order, they schedule the therapist to see the resident within 24-48 hours. Staff R confirmed that Resident 91 was not seen by speech therapist within 24-48 hours after the order was placed. Staff R stated they had no available speech therapist at that time. Staff R stated they did not inform the provider about the delay with speech therapist evaluating Resident 91. Refer to WAC 388-97-1280(1)(a)