STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505417	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades of St Anne	3540 Northeast 110th Street Seattle, WA 98125

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to initiate non-pharmacological interventions for pain management prior to the administration of pain medication for 1 of 2 residents (Resident 1), reviewed for pain management. In addition, the facility failed to adequately monitor adverse side effects of pain medication for Resident 1. These failures placed the resident at risk for unnecessary medications, incomplete pain control and unrecognized adverse side effects. Findings included . Review of the admission Minimum Data Set (a required assessment) dated 02/14/2025 showed Resident 1 was admitted to the facility on [DATE] with a diagnosis that included a fracture [break] in the lower back with lower back pain. Review of the February 2025 and March 2025 Medication Administration Record (MAR) showed Resident 1 had physician orders dated 02/08/2025 for Methocarbamol (medication used to relieve pain) 500 milligrams (mg-a unit of measurement) every six hours as needed and was administered the medication on 02/09/2025, 02/10/2025, 02/11/2025, 02/17/2025, 02/18/2025, 02/20/2025, 02/27/2025, 03/01/2025, 03/02/2025, 03/03/2025, 03/04/2025, 03/06/2025, 03/08/2025, 03/09/2025 and on 03/14/2025. Further review of the February 2025 and March 2025 MAR showed Resident 1 had the following physician orders dated 02/08/2025: - Oxycodone (narcotic medication used to relieve pain) 5 mg, give one, tablet every six hours as needed for pain rated on a scale of 1-5 and was administered the medication on 02/08/2025, 03/01/2025, 03/02/2025 and 03/03/2025. - Oxycodone 5 mg give two tablets every six hours as needed for pain rated on a scale of 6-10 and was administered to Resident 1 on 02/09/2025, 02/10/2025, 02/11/2025, 02/12/2025, 02/13/2025, 02/22/2025, 02/23/2025, 02/24/2025, 02/27/2025, 03/02/2025, 03/03/2025, 03/04/2025 and on 03/05/2025. - Non-pharmacological interventions used before as needed pain medication by number: 1. Reposition for comfort, 2. Massage, 3. Involve in activity4. Provide a quite setting with reduced stimuli as needed. 5. Relaxation technique, 6. Music, 7. Remove from area, 8. Direction/distraction, 9. Toilet, 10. Walk, 11. Provide food/drink, 12. Educate (d), 13. One on one, 14. Other. (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional review of February 2025 or March 2025 MAR did not show nonpharmacological interventions were offered or implemented prior to administering the as needed pain medications for Resident 1. In an interview on 04/16/2025 at 3:12 PM Staff D, Registered Nurse (RN) stated, I would try repositioning with pillows or other nonpharmacological interventions before I gave a pain medication that was not scheduled to be given. In an interview on 04/16/2025 at 3:28 PM, Staff E, RN, stated that the interventions should be tried before as needed pain medication was administered to the resident. In an interview on 04/16/2025 at 4:10 PM, Staff B, Director of Nursing, stated that their expectation was that nonpharmacological interventions should have been offered to Resident 1 prior to as needed pain medication being administered. Staff A, Administrator, was present when Staff B was being interviewed, Staff A then stated they did not see where any documented interventions were offered to Resident 1 on February 2025 and/or March 2025 MAR's prior to the as needed pain medication administrations. Reference (WAC) 388-97-1060 (1)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35787 Based on interview and record review, the facility failed to ensure adequate monitoring was conducted for use of antipsychotic (medication used to treat mental disorders) for 1 of 2 residents (Resident 1), reviewed for unnecessary medications. This failure placed the residents at risk for receiving unnecessary medications, unrecognized adverse side effects, and related complications. Review of the admission Minimum Data Set (a required assessment) dated 02/14/2025 showed Resident 1 was admitted to the facility on [DATE] with diagnosis that included a delirium (a sudden change in a person's mental state, often characterized by confusion, disorientation, and difficulty thinking clearly). Review of the February 2025 and March 2025 Medication Administration Record (MAR) showed a physician order dated 02/08/2025 for Quetiapine (an antipsychotic medication used to treat mental disorder) 25 milligrams (mg-a unit of measurement) one tablet at bedtime and another physician order dated 02/11/2025 for Quetiapine 25 mg one time a day. Further review of February 2025 and March 2025 MAR showed the following: -An antipsychotic medication-monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, low blood pressure, dark urine, yellow skin, upset stomach, fatigue, drooling, tremors, disturbed walk, increased agitation, restlessness, involuntary movement of mouth or tongue. Document Y if side effects were observed and N if no side effects were observed, monitor every shift. -Check marks were documented for the day, evening and night shifts and did not reflect if side effects were observed or if side effects were not observed. In an interview on 04/16/2025 at 3:14 PM Staff D, Registered Nurse (RN), stated, the check marks on the February and March 2025 MAR's did not show if Resident 1 had side effects to the antipsychotic medication, that a Y for yes, or a N for no and should have been documented. In an interview on 04/16/2025 at 3:30 PM, Staff E, RN, stated they thought it was a yes or no system to reflect if side effects were observed or not and that the current system that used check marks needed clarification because it was not clear if side effects had been observed or not. In an interview on 04/16/2025 at 4:30 PM, Staff B, Director of Nursing Services, stated the check marks did not identify if Resident 1 had side effects to the antipsychotic medication, that a Y or an N should have been documented to adequately indicate if the resident had side effects to the medication or not. Reference: (WAC) 388-97-1060 (3)(k)(i)(4)

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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. 35787 Based on observation, interview, and record review, the facility failed to ensure staff followed use of Personal Protection Equipment (PPE - use of gown, gloves, respirator/N95 mask and face shield/goggles) in accordance with the Centers for Disease Control guidelines when caring for residents with known COVID-19 (highly contagious respiratory disease) infection for 1 of 2 residents (Resident 2), reviewed for infection control. This failure placed the residents, staff, and visitors at risk for COVID-19 infection and related complications. Findings included . Record review of a progress note dated 03/28/2025 showed Resident 2 tested positive for COVID-19 on 03/28/2025. Observation on 03/31/2025 at 1:01 PM, showed signage that Resident 2 was on aerosol precautions (a type of isolation used for infections spread through the air) and contact precautions (a set of safety measures used to prevent the spread of infectious diseases through direct or indirect contact with a resident or their environment). The sign showed that everyone must use a respirator/N95 mask, wear eye protection, gown and glove at the door. Staff D, Registered Nurse, knocked on Resident 2's door, entered the room and did not put on the appropriate PPE before entering Resident 2's room. In an interview on 03/31/2025 at 1:06 PM, Staff D stated Resident 2 tested positive for COVID-19 a few days ago. Staff D further stated they should have worn a respirator/N95 mask, eye protection, gloves and a gown before they entered the room because Resident 2 tested positive for COVID-19. An interview on 03/31/2025 at 1:16 PM, Staff C, Interim Administrator, stated Staff D was required to wear a respirator/N95 mask, eye protection, gloves and a gown in all the residents' rooms that were positive for COVID-19. Interview on 04/16/2025 at 4:30 PM Staff B, Director of Nursing Services/Infection Preventionist, stated their expectation was for staff to wear a respirator/N95 mask, eye protection, gloves and a gown in Resident 2's room, and all other resident rooms that tested positive for COVID-19. Reference: (WAC) 388-97-1320 (2)(a)