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	01/21/2026

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

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to designate a person to serve as the director of food and nutrition services with the proper qualifications. This failure placed all residents at risk of receiving dietary services from staff without the required competencies and skills to carry out food and nutrition services.Findings included.Review of the key personnel list, provided by the facility on 01/13/2026, showed no staff names were listed under the dietary manager.In an interview on 01/13/2026 at 8:06 AM, Staff G, Cook, stated that they had no dietary manager and that they would report directly to Staff A, Administrator. When asked about the last time they had a dietary manager, Staff G stated, I don't [do not] know. In an interview on 01/16/2026 at 3:52 PM, Staff A stated that the facility did not have a dietary manager or a food services director since 12/05/2025. Staff A stated that they were in contact with the corporate resource person and that they had basically taken the role of a dietary manager. Staff A stated that they had a state food safety certificate but no degree in food or nutrition.Reference: (WAC) 388-97-1160(1)(2).

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain food safety and services in accordance with professional standards by:1. Not having food items labeled, dated and/or covered for 1 of 1 Kitchen Refrigerator, 2. Not discarding cups of prune juice after their best-by-dates stored in the Steel Kitchen Rack,3. Not monitoring the dishwashing machine temperature,4. Not monitoring the sanitizing solution for the Three-compartment sink,5. Not maintaining the sanitizing solution within the recommended ppm (parts per million - a unit of measurement for concentration) for 1 of 2 sanitizing buckets,6. Not properly disinfecting the food thermometer for 1 of 1 staff (Staff M),7. Not maintaining milk temperature at 41 degrees Fahrenheit at serving time, 8. Not covering food items during meal tray delivery for 2 of 2 staff (Staff T and Staff I), reviewed for food safety.These failures placed the residents at risk for food borne illness (caused by ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life. Findings included. Review of the facility's policy titled, Food Receiving and Storage, dated 2001, showed, Foods shall be received and stored in a manner that complies with safe food handling practices. PHF [Potentially Hazardous Foods-foods prone to bacterial (organisms that can use illnesses) growth, requiring proper handling and storage to ensure safety] are stored at or below 41 [degrees] F [Fahrenheit]. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded. Review of the facility's undated document with a handwritten title, HPSI [Health and Personal Services, Inc (Incorporated)] Policy + [and] Procedure, showed that concentration in sanitizing buckets would be monitored using test strips regularly. The document showed, Use the provided test strips to test the concentration of the sanitizing solution and record on the sanitizing sink log. If the solution is incorrect, notify the supervisor and DO NOT use until the correct concentration is available and verified. The document further showed, The temperatures of the dish machine will be recorded three times a day.While the dishwasher is running with a rack going through it, the temperature of the wash tank and rinse tank will be recorded. Temperatures will be recorded prior to washing each meals dishes. Review of the undated facility's kitchen signage titled, Sanitizing Bucket Procedures, showed how to prepare a sanitizing bucket which included testing of solution with test strips for proper PPM and the required PPM of 200-400 ppm. Review of the Washington State Retail Food Code dated 03/01/2022, showed, Employees are properly sanitizing.multiuse equipment and utensils before they are reused, through routine monitoring. and exposure time for chemical sanitizing. including the application of sanitizing chemicals by manual swabbing.Contact times must be consistent with those on EPA [Environmental Protection Agency-United States agency safeguarding human health and protecting the environment]-registered label use instructions. KITCHEN REFRIGERATOR-FOOD LABEL/DATINGIn a joint observation and interview on 01/13/2026 at 8:06 AM with Staff G, Cook, showed the refrigerator had a transparent pitcher with a cream-colored mixture inside. The transparent pitcher was unlabeled and undated with a plastic cling wrap cover. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When asked, Staff G stated that the transparent pitcher had a pancake mixture leftover from breakfast. Staff G stated that they were keeping it in case some residents may want it later. Staff G stated that their process was to put a date on food items. When asked why the pancake mixture was not labeled and/or dated, Staff G stated, because I know and I made it [pancake mixture]. Staff G had no response when asked how the other staff would know if the food items were not labeled and/or dated. A concurrent observation showed 11 uncovered, unlabeled and undated glasses with liquid substances in them. When asked, Staff G stated that the liquids in the fridge were five glasses of orange juice, a glass of cranberry juice, two glasses of milk, a glass of peach juice and two glasses of apple juice. Staff G stated that they did not know why the glasses were not covered, unlabeled and/or undated. CUPS OF PRUNE JUICE STORED IN THE KITCHEN STEEL RACKIn a joint observation and interview on 01/13/2026 at 8:35 AM with Staff G showed a steel rack in the kitchen had 54 cups of prune juice with a best by date of 06/29/25 [2025]. Staff G stated, I don't [do not] know why it is [prune juice cups] still here. Staff G further stated that they expected the cups of prune juice to have been thrown away. DISHWASHING MACHINE TEMPERATURE LOGIn an interview and joint record review on 01/15/2026 at 8:59 AM, Staff K, Dietary Aide, stated that they would check the dishwashing machine temperature every Breakfast, Lunch, Dinner, and would write the temperature on the log posted in the kitchen. Staff K showed a document entitled, Dishmachine Temperature Log, dated 1/26 (January 2026). A joint record review of the log showed missing entries for breakfast, lunch, and dinner on the following dates: 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/11/2026, and 01/13/2026. Further record review of the log showed missing entries for dinner on 01/12/2026 and on 01/14/2026. Staff K had no response when asked why there were missing entries in the dishwashing machine temperature log. THREE COMPARTMENT SINK-SANITIZING SOLUTION LOGIn an interview and joint record review on 01/15/2026 at 9:11 AM, Staff K stated that they checked the sanitizing solution every mealtime and that they would write the result in the log posted in the kitchen. A joint record review of the log entitled, Three Compartment Sink log, dated 1/26 (January 2026), showed the log was divided into AM [morning] and PM [afternoon/evening] with missing entries for the following dates: 01/01/2026, 01/02/2026, 01/03/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/10/2026 and 01/11/2026. Staff K had no response when asked why there were missing entries in the three-compartment sink log. SANITIZING SOLUTION BUCKET NEAR THE STOVEIn an interview and joint observation on 01/15/2026 at 9:20 AM, Staff G stated that they test the sanitizing bucket every three hours. A joint observation with Staff G showed the countertop area near the stove was a red bucket with a white, small dish towel inside. Staff G stated that they changed the water this morning. Staff G took a test strip (Hydrion-brand name, used to test ppm) and dipped it in the sanitizing bucket for 10 seconds. A joint observation of the test strip showed 0 ppm as indicated in the test kit color chart. Staff G took another test strip and repeated the process, and it showed 0 ppm as indicated in the test kit color chart. Staff G stated they changed the water that morning. On 01/15/2026 at 9:46 AM, Staff G provided a document entitled, Cloth bucket PPM Record, dated 1/1/26 [01/01/2026]. A joint review of the document with Staff G showed separate columns labeled, 6:00 AM, 9:00 AM, NOON, 3:00 PM and 6:00 PM and an instruction that stated, Check ppm at appropriate time and initial. Further review of the document dated 01/01/2026 showed no initials and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	no entries under the NOON column from 01/01/2026 to 01/14/2026. When asked, Staff G stated they had provided the January 2026 and November 2025 record and that they could not find the December 2025 sanitizing bucket ppm record. USE OF FOOD THERMOMETERAn observation and interview on 01/16/2026 at 11:57 AM, showed Staff M, Cook, used a food thermometer and checked the temperature of hamburger steak patties placed on a metal bowl and then Staff M took a small towel from the sanitizing bucket and wiped off the food thermometer. Staff M immediately proceeded to check the mashed potato and used the same towel to wipe off the food thermometer. When asked, Staff M stated that they had been doing the same process where they would use the towel from the sanitizing bucket to wipe off/sanitize the food thermometer. An observation on 01/16/2026 at 12:29 PM showed Staff A, Administrator, instructed Staff M about using the disposable probe wipes to sanitize the food thermometer. Staff A was heard telling Staff M, We do not use the towel from the sanitizing bucket to clean the [food] thermometer. We use these probe wipes for the food thermometer. In an interview and joint record review on 01/16/2026 at 3:52 PM, Staff A stated that they did not have a dietary manager or a food service director and that they had basically taken the role of a dietary manager. Staff A stated that they expected staff to use probe wipes to sanitize food thermometer. MILK TEMPERATUREOn 01/20/2026 at 11:50 AM, observation during a tray line showed three covered glasses of milk on a plastic tray with some ice cubes. Staff K was observed placing a glass of milk into one of the serving meal trays. Staff K was asked to check for the temperature of the milk, and they used a food thermometer. A joint observation showed the milk temperature was 49 degrees Fahrenheit. Staff K continued with the tray line and did not remove the milk from the tray. Another joint observation and interview on 01/20/2026 at 12:13 PM with Staff N, Cook, showed a glass of milk on a plastic tray with some ice cubes. Staff N was asked to check for the milk temperature. A joint observation showed the milk temperature was 51 degrees Fahrenheit. Staff N stated that 41 degrees Fahrenheit would be the expected temperature for the milk before it would be served to the residents. In an interview on 01/20/2026 at 1:56 PM, Staff F, Corporate Director of Nutrition Services/Registered Dietitian, stated that they provided guidance and served as a resource person for the facility. Staff F stated their expectations that food items in the refrigerator must be covered, labeled, dated by use by date. Staff F stated that food items must be thrown away or discarded and that food should be within the recommended temperature. Staff F further stated, Milk should be at 41 degrees [Fahrenheit] when it reaches the resident. In an interview and joint record review on 01/20/2026 at 3:04 PM, Staff A stated that they expected food items in the refrigerator to be covered, labeled and dated. Staff A stated that they expected staff to remove and toss away food items past their best by dates. A joint record review of the dishwasher temperature log and the three compartment sink log showed missing multiple entries. Staff A stated that they expected staff to monitor and document dishwasher temperature and sanitizing solution's ppm result regularly three times a day. Staff A stated that they expected staff to follow the correct guidelines in testing sanitizing solution and that staff should use the color chart. Staff A further stated that the food temperature must be within the recommended guidelines when served. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	UNCOVERED FOOD ITEMSObservation on 01/13/2026 at 12:17 PM, showed Staff T, Certified Nursing Assistant, was removing a lunch tray from the meal tray-cart parked in front of the kitchen. Further observation showed the dessert bowl on the tray was not covered, and Staff T walked down the hallway with uncovered dessert bowl, entered room [ROOM NUMBER] and delivered the tray to the resident in room [ROOM NUMBER]D. Observation on 01/13/2026 at 12:19 PM showed Staff T was removing another lunch tray from the meal tray-cart parked in front of the kitchen. Further observation showed the dessert bowl on the tray was not covered, and Staff T walked down the hallway with the uncovered dessert bowl, entered room [ROOM NUMBER] and delivered the tray to the resident in room [ROOM NUMBER]D. Observation and interview on 01/13/2026 at 12:21 PM, Staff I, Human Resources, was removing a lunch tray from the meal tray-cart parked in front of the kitchen. Further observation showed the dessert bowl on the tray was not covered, and Staff I walked down the hallway with uncovered dessert bowl, entered room [ROOM NUMBER] and delivered the tray to the resident in room [ROOM NUMBER]W. When asked if the dessert bowl was covered when was it was delivered, Staff I stated, No it was not covered. In an interview on 01/13/2026 at 12:35 PM, Staff T stated that the dessert bowls were not covered when they were delivered to residents in room [ROOM NUMBER]D and 174D. In an interview on 01/21/2026 at 1:36 PM with Staff F and Staff BB, Dietary Manager stated that staff should distribute and serve food under sanitary conditions and all food items on a tray should be covered when carrying a tray and walking down the hallway. In a phone interview on 01/21/2026 at 3:04 PM, Staff A stated that they would expect staff to distribute and serve food under sanitary conditions. Reference: (WAC) 388-97-1100 (3) .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure residents' environment were maintained for 4 of 15 resident rooms (Rooms 159, 161, 170 & 162) and 1 of 1 therapy gym, reviewed for environment. The failure to ensure resident rooms and therapy gym were maintained, air vents were cleaned, baseboard heater cover were in good repair, and lower door frame and walls were repaired, placed the residents at risk for a less than homelike environment and a diminished quality of life.Findings included.AIR VENTroom [ROOM NUMBER]In an interview on 01/15/2026 at 10:04 AM, Resident 47 stated that they were concerned with the air vent in between the two televisions in their room was filthy. Observation of air vent showed dust towards the back of the vent louvers and dark grey discoloration at the top four vent louvers.BASEBOARD HEATERroom [ROOM NUMBER]Observations on 01/13/2026 at 8:48 AM, on 01/14/2026 at 9:00 AM, and on 01/16/2026 at 8:45 AM, showed the baseboard heater covers in room [ROOM NUMBER] were not covering the left side of the heater fins.room [ROOM NUMBER]Observations on 01/13/2026 at 8:52 AM and on 01/14/2026 at 9:05 AM, showed the baseboard heater cover in room [ROOM NUMBER] were not covering the left side of the heater fins.THERAPY GYMObservation on 01/16/2026 at 9:05 AM, showed the baseboard heater in the therapy gym had no cover covering the heater fins.DOOR FRAME AND WALLSroom [ROOM NUMBER]Observations on 01/13/2026 at 8:20 AM, on 01/14/2026 at 8:50 AM, and on 01/16/2026 at 8:40 AM, showed room [ROOM NUMBER] with scrapes and scratches on the lower door frame walls to each side of the bathroom door frame and floor molding.In an interview and joint observation on 01/16/2026 at 3:23 PM, Staff X, Maintenance Director, stated it was their process that they would do daily walk throughs of the building, repair, and repaint the building as they could. Staff X stated they would call a vendor for a repair that could not be done by them. Staff X stated that staff would verbally notify them and would write maintenance issues in logs located at the nurses' station and front desk. A joint observation of room [ROOM NUMBER] showed the air vent between the two televisions had dust and grey discoloration. Staff X stated they could see the dust and grey discoloration and that it should be cleaned. A joint observation of room [ROOM NUMBER] and 170 showed the baseboard heater covers were not covering the left side of the heater fins. A joint observation of the therapy gym showed the baseboard heater fins did not have covering. Staff X stated the baseboard heaters should have been fully covered. A joint observation of room [ROOM NUMBER] showed scrapes and scratches on the lower door frame walls to each side of the bathroom door frame and floor molding. Staff X stated, the damage is more than I can deal with myself. I would have to call a contractor.In a phone interview on 01/21/2026 at 3:03 PM, Staff A, Administrator, stated that they expected the air vent in room [ROOM NUMBER] to have been cleaned, the baseboard heaters in room [ROOM NUMBER], 170, and the therapy gym to have the covers fully covering the heater fins, and the scrapes and scratches on the lower door frame walls on each side of the bathroom door frame and floor molding in room [ROOM NUMBER] to be patched and painted.Reference: (WAC) 388-97-0880 (1)(2).

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	505417	A. Building B. Wing	01/21/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess 6 of 16 residents (Residents 7, 38, 36, 2, 3 & 19), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure resident assessments were completed accurately on the MDS regarding documentation date of gradual dose reduction (GRD-tapering of medication dosage), immunization status and use of anticoagulants (medications used to prevent blood clots) placed the residents at risk for unidentified and/or unmet care needs, and diminished quality of life.Findings included. According to the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed, .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The Observation Period (also known as the Look-back period) is the time-period over which the resident's condition or status is captured by the MDS and ends at 11:59 PM on the day of the Assessment Reference Date (ARD or assessment period). The RAI manual showed, .Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). The RAI manual further showed to follow Centers for Disease Control and Prevention (CDC-a public health agency) guidelines for coding instructions regarding influenza [an infection of the nose, throat, and lungs] vaccination [immunization to prevent influenza] /Pneumococcal Vaccination (to prevent pneumonia [a lung infection]) and that [Up to date] in item [Section] O0300A [Is the resident's Pneumococcal vaccination up to date?] means in accordance with current Advisory Committee on Immunization Practices (ACIP- a committee within CDC) recommendations. GRADUAL DOSE REDUCTIONRESIDENT 7Review of the medication review report printed on 01/14/2026 showed Resident 7 had been prescribed antipsychotic medication (used to treat symptoms of psychosis [mental health condition characterized by a loss of touch with reality]). Review of the annual MDS dated [DATE] showed Resident 7's MDS under Section N0450E (Antipsychotic Medication Review-Date physician documented GDR as clinically contraindicated (refers to a specific situation or condition that makes a medical treatment inadvisable because it may cause harm to the resident) was dated 09/04/2024. Review of Resident 7's progress notes dated 09/25/2025 showed their physician's mental evaluation and documentation of GDR as not clinically indicated at this time. In an interview and joint record review on 01/20/2026 at 4:13 PM, Staff D, Admission/MDS Nurse, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that they followed the RAI manual in coding MDS. A joint record review of Resident 7's annual MDS showed Section N0450E was dated 09-04-2024. When asked if there were additional documentations after 09/04/2024 about Resident 7's GDR as clinically contraindicated, Staff D stated that there was a progress note dated 09/25/2025. A joint record review of that progress note showed Resident 7's physician's mental evaluation and documentation of GDR as not clinically indicated for Resident 7. Staff D stated that they should have documented 09/25/2025 in Section N0450E of Resident 7's annual MDS. IMMUNIZATION STATUSRESIDENT 38Review of Resident 38's quarterly MDS dated [DATE] showed Section O0250C- Influenza Vaccine was marked as received outside of this facility. Review of Resident 38's Electronic Health Record (EHR) did not show documentation that they received their influenza vaccine for the current influenza season. Review of Resident 38's immunization record showed that they refused the 2025/2026 trivalent (a type of) influenza vaccine with a confirmation date of 10/20/2025. A joint record review and interview on 01/20/2026 at 4:25 PM with Staff D showed Resident 38's quarterly MDS revealed they received their influenza vaccine outside of the facility. When asked to show documentation or records related to Resident 38's influenza immunization, Staff D stated that they would further review Resident 38's EHR and would provide information about Resident 38's influenza vaccination. In a follow-up interview on 01/21/2026 at 9:07 AM, Staff D stated that they did not see documentation that would support their MDS coding related to Resident 38's influenza vaccine status. Staff D further stated that it was an inaccurate MDS coding and that it would be modified. RESIDENT 36Review of Resident 36's face sheet printed on 01/20/2026 showed their birthdate of 04/20/1950. Review of Section O0300A in the annual MDS dated [DATE] showed Resident 36's pneumococcal vaccination was coded as up to date. Review of Resident 36's immunization record showed they received their initial dose of pneumococcal vaccine [PPSV23] on 10/19/2004 when they were [AGE] years old and another type of pneumococcal vaccine [PCV13] on 02/19/2019. Further review of the immunization record did not show Resident 36 received the recommended pneumococcal vaccine [PCV20 or PCV21] to be considered up to date per CDC guidelines. An interview and joint record review on 01/21/2026 at 9:09 AM, Staff D stated that a resident to be considered up to date with their pneumococcal vaccination should have received the recommended pneumococcal vaccines. A joint record review of Resident 36's immunization record showed they received two pneumococcal vaccines in which one of those were received before they were [AGE] years old. Staff D stated that Resident 36's pneumococcal vaccination was not up to date and that their MDS coding was inaccurate. RESIDENT 2Review of Resident 2's admission MDS dated [DATE] showed Section O0250C (influenza vaccine) was coded as offered and declined. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the EHR did not show documentation that Resident 2 was offered and declined the influenza vaccine on or prior to their admission MDS assessment date. A joint record review and phone interview on 01/21/2026 at 1:03 PM with Staff B, Director of Nursing Services and Staff C, Regional [NAME] President for Operations, showed Resident 2's admission MDS Section O0250C was coded offered and declined. Staff B stated that it's [it is] inaccurate coding. USE OF ANTICOAGULANTRESIDENT 3Review of the admission MDS dated [DATE] showed Resident 3's MDS under Section N0415 (High-Risk Drug Classes: Use of Indication) was marked for anticoagulant use during this assessment period. Review of the October 2025 Medication Administration Record (MAR) showed Resident 3 did not receive an anticoagulant medication during the 7-day look back period. In a joint record review and interview on 01/20/2026 at 4:04 PM with Staff D showed an anticoagulant was coded in Resident 3's admission MDS dated [DATE]. A joint record review of Resident 3's October 2025 MAR did not show an anticoagulant use during the 7-day look period. Staff D stated that Resident 3's MDS was not coded accurately. In a phone interview on 01/21/2026 at 12:04 PM with Staff B and Staff C, Staff B stated that they followed the RAI manual in coding the MDS. Staff B stated that they expected MDS to be coded accurately to reflect residents' status. RESIDENT 19Review of the admission record printed on 01/20/2026 showed that Resident 19 was admitted to the facility on [DATE]. Review of the quarterly MDS dated [DATE] showed Resident 19's was marked for an anticoagulant use during the assessment period. Review of the November 2025 and December 2025 MAR showed Resident 19 was not receiving an anticoagulant medication during the assessment period. In an interview and joint record review on 01/21/2026 at 9:26 AM, Staff D stated that they would follow the RAI manual and review the resident's medical records to complete MDS assessments. A joint record review of Resident 19's quarterly MDS dated [DATE] showed Resident 19's was receiving an anticoagulant medication during the assessment period. A joint record review of the November 2025 and December 2025 MAR showed Resident 19 was not receiving an anticoagulant medication during the assessment period. Staff D stated that Resident 19 was not on anticoagulant during the MDS assessment period and the MDS would be modified. In a phone interview on 01/21/2026 at 12:04 PM, Staff B stated that the facility would use the RAI manual as guidance for MDS coding, and that they expected MDS assessments to be completed accurately. Reference: (WAC) 388-97-1000 (1)(b) .

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	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing information included the facility name and the actual hours worked by registered and licensed nursing staff directly responsible for resident care per shift for 6 of 6 days (01/13/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/20/2026 & 01/21/2026), reviewed for sufficient and competent nurse staffing. The failure to post a complete and accurate nurse staffing form daily prevented the residents, resident representatives, and visitors from exercising their rights to know the actual nursing staff hours worked in the facility.Findings included .Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, revised in August 2022, showed that the information recorded on the Daily Posting of Nursing Staff form shall include the name of the facility and the actual time worked during that shift.Observations on 01/13/2026 at 2:09 PM, on 01/14/2026 at 12:44 PM, on 01/15/2026 at 2:11 PM, on 01/16/2026 at 3:26 PM, on 01/20/2026 at 2:56 PM and on 01/21/2026 at 10:00 AM, showed the facility's document titled, Daily Posting of Nursing Staff did not include the facility name and the actual hours nursing staff worked for the shift.In a phone interview on 01/21/2026 at 10:59 AM, Staff B, Director of Nursing Services stated that the facility completed the Daily Posting of Nursing Staff form daily and the actual hours were entered the following day. Staff B stated that the form should include the facility's name and that the actual hours should have been added each time the form was posted.In a phone interview on 01/21/2026 at 3:04 PM, Staff A, Administrator, stated that their expectation was for the Daily Posting of Nursing Staff form to be prepared and posted daily with the total number of staff and the estimated hours for each shift. Staff A stated that the actual hours worked were added to the form the following day. When asked whether they would expect the facility name to appear on the Daily Posting of Nursing Staff form, Staff A stated, No, I would not expect the facility name to appear on the form.No associated WAC.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate was less than five percent (%). The failure to properly administer 3 of 28 medications for 4 of 5 residents (Residents 35, 10, 12 & 31), observed during medication administration resulted in a medication error rate of 10.7%. This failure placed the residents at risk for not receiving the correct form, dose, and/or receiving less than the intended therapeutic effects of physician ordered medications and possible adverse effects.Findings included.RESIDENT 35According to the manufacturer's administration instruction revised in December 2024, Metoprolol succinate (a medication used to treat high blood pressure, chest pain, and heart failure) Extended Release (ER - designed to release active ingredients slowly into the body, rather than all at once) should be taken whole tablet and should not be crushed.Review of Resident 35's January 2026 Medication Administration Record (MAR) showed an order, Metoprolol Succinate 25 MG [milligram - unit of measurement] ER . Give 1 tablet by mouth one time a day for HTN [Hypertension - high blood pressure].Observation on 01/16/2026 at 8:28 AM, showed Staff Q, Registered Nurse, poured Resident 35's morning medication including Metoprolol Succinate 25 MG ER in a medication cup. Further observation showed Staff Q crushed Metoprolol Succinate 25 MG ER with the resident's other morning medications, mixed it with applesauce, and walked to Resident 35's room to administer the medication.In a joint record review and interview on 01/16/2026 at 8:41 AM with Staff Q, showed the January 2026 MAR revealed that Resident 35 had an order for Metoprolol Succinate 25 MG ER. Staff Q stated they crushed the medication due to Resident 35's swallowing difficulty.RESIDENT 10Review of Resident 10's January 2026 MAR showed an order, Aspirin [used to reduce pain, fever, swelling, and inflammation. It also acts as a blood thinner] 81 Oral Tablet Chewable.Give 1 tablet by mouth one time a day.Observation on 01/16/2026 at 8:45 AM, showed Staff Q was pouring Resident 10's morning medications. Staff Q poured an Aspirin Enteric Coated (designed to dissolve in the small intestine, potentially reducing stomach irritation) 81 mg tablet in a medication cup instead of the chewable form as ordered for Resident 10 and walked to Resident 10's room and administered the medication.In a joint record review and interview on 01/16/2026 at 8:48 AM with Staff Q, showed the January 2026 MAR revealed that Resident 10 had an order for Aspirin 81 Oral (by mouth) Tablet Chewable. Staff Q stated they did not have the chewable tablet in the medication cart. Staff Q further stated that the chewable tablet should have been administered.RESIDENT 12Review of Resident 12's January 2026 MAR showed an order, guaiFENesin [Guaifenesin] Oral Syrup [a drug that thins and loosens thick mucus in the chest and throat, making it easier to cough up phlegm] . Give 10 ml (milliliter - unit of measurement) by mouth four times a day for cough.Observation on 01/16/2026 at 10:16 AM, showed Staff R, Licensed Practical Nurse, poured 10 ml of Tussin DM (brand name - a medicine for cold symptoms, combining a cough suppressant [stop or reduce], Dextromethorphan [a drug used to temporarily relieve dry, hacking coughs caused by colds or flu]) and Guaifenesin in a medication cup instead of the Guaifenesin oral syrup as ordered. Further observation showed Staff R walked to Resident 12's room, attempted to administer the medication, and was stopped prior to administering the medication to Resident 12.In a joint record review and interview on 01/16/2026 at 10:23 AM with Staff R, showed the January 2026 MAR revealed that Resident 12 had an order for guaiFENesin Oral Syrup. Staff R stated, We do not carry Guaifenesin syrup. Staff R further stated they should have administered the actual medication as ordered, followed the physician order, and stated, I will call the doctor.RESIDENT 31Review of the quarterly Minimum Data Set (an assessment tool) dated 12/19/2025 showed Resident 31 had intact cognition.Review of Resident 31's January 2026 MAR showed an order, Fluticasone Propionate Nasal Suspension [medicine used to treat allergy symptoms] 50 MCG [microgram - unit of measurement]/ACT [actuation] . 1 spray in both nostrils [are the two external openings of the nose that lead to the nasal cavity] two times a day for allergies unsupervised self-administration.Observation on 01/20/2026 at 8:11 AM, showed Staff S, Registered (continued on next page)

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	505417	A. Building B. Wing	01/21/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse, poured Resident 31's morning medication and administered the medication. The Fluticasone Propionate Nasal spray was not included in the resident's morning medication administration.In a joint record review and interview on 01/20/2026 at 8:58 AM with Staff S, showed the January 2026 MAR revealed that Resident 31 had an order for Fluticasone Propionate Nasal Suspension 50 MCG. Further review of the MAR showed the medication was marked as, U-SA [unsupervised self-administration] for this morning. When Staff S was asked how they knew if the resident self-administered the medication, Staff S stated that the medication did not show up on their Electronic Medication Administration Record (EMAR) to be administered. Staff S asked Resident 31 if they self-administered the nasal spray, Resident 31 stated that they were out of their nasal spray three days ago. Staff S stated that the EMAR self-marked as if the medication was administered and did not show in the morning schedule. In a phone interview on 01/21/2026 at 12:48 PM, Staff B, Director of Nursing Services, stated that they would expect nursing staff to follow the physician order, the medication administration rights, and professional standards.Reference: (WAC) 388-97-1060 (3)(k)(ii).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Infection Prevention and Control Program (IPCP) policies and procedures were reviewed annually as required. In addition, the facility failed to ensure Transmission Based Precautions (TBP-specialized infection control measures used to prevent the spread of specific infections) were followed by 3 of 5 staff (Staff J, O & V), reviewed for infection control. The failure to change the face mask after exiting a TBP room, use of eye protection (face shield or goggles) before entering a TBP room and perform hand hygiene, placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included. According to Centers for Disease Control and Prevention (CDC-a public health agency) online publication titled, CDC's Core Infection Preventions and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024 showed that facility shall Provide written infection prevention policies and procedures that are available, current, and based on evidence-based guidelines. Review of the facility's policy titled, Infections-Clinical Protocol, revised in March 2018, showed, The physician or provider and staff will identify infection transmission risks and (in conjunction with the Infection Preventionist) will implement relevant precautions. Review of the facility's policy titled, Influenza [an infection of the nose, throat, and lungs], Prevention and Control of Seasonal, revised in March 2022, showed that one of the key aspects of infection control included review of TBP, appropriate use of personal protective equipment (PPE-gowns, gloves, masks, face shield/goggles) and hand hygiene. The policy further showed that droplet precautions (a TBP, measures taken to prevent spread of germs transmitted when a person coughs, sneezes, talks or breaths) were implemented for residents with suspected or confirmed influenza. IPCP ANNUAL REVIEW Review of the IPCP policies and procedures showed that they have not been reviewed at least annually. The following policies were last revised and/or dated below: -Antibiotic Stewardship was revised in December 2016 -Infection Surveillance was revised in September 2017 -Legionella (a type of waterborne organisms that can cause disease) Surveillance and Detection was revised in September 2022 -Influenza Vaccine (used to prevent influenza and Pneumococcal Vaccine (used to prevent lung infection) was revised March 2022 -Coronavirus Disease (COVID 19-a viral illness that causes fever, difficulty breathing or possibly death) Vaccination was revised in May 2023. In a telephone interview and joint record review on 01/21/2026 at 1:03 PM with Staff B, Director of (continued on next page)

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	505417	A. Building B. Wing	01/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Services/Infection Preventionist and Staff C, Regional [NAME] President for Operations, stated that they reviewed IPCP policies annually and that they talked about it in Quality Assurance and Performance Improvement (QAPI-a data driven and proactive approach to quality improvement) meetings. When asked, Staff B and Staff C stated that they would provide documentation of their IPCP annual review. On 01/21/2026 at 4:48 PM, no documentation regarding IPCP annual review was provided by the facility. TBP STAFF J Observation on 01/16/2026 at 8:43 AM, showed Staff J, Restorative Aide, had a face mask and wore a disposable gown, goggles and gloves and entered room [ROOM NUMBER] (a droplet precaution room). Another observation on 01/16/2026 at 8:47 AM, showed Staff J exited room [ROOM NUMBER] with their face mask on and walked towards the hallway to a room where they placed soiled linens in a covered bin. In an interview on 01/16/2026 at 8:49 AM, Staff J stated that they responded to the call light and provided a blanket to Resident 38 in room [ROOM NUMBER]. Staff J stated that Resident 38 was on droplet precaution due to influenza symptoms. When asked about donning (putting on) and removing PPE, Staff J stated that they did not change their face mask when they exited room [ROOM NUMBER]. Staff J further stated they were expected to remove and changed their face mask but I did not [change my face mask]. STAFF O Observation on 01/20/2026 at 8:09 AM, showed Staff O, Certified Nursing Assistant, delivered a breakfast tray meal to Resident 29 in room [ROOM NUMBER] who was on droplet precaution. Staff O had a face mask and did not have a face shield or goggles when they entered the room. Further observation showed Staff O was adjusting Resident 29's bed and was leaning over Resident 29 who could be heard coughing. Staff O then exited the room and went towards the nursing station and took a cup of coffee as requested by Resident 29. Staff O did not remove and/or change their face mask. In an interview on 01/20/2026 at 8:13 AM, Staff O stated that they knew about droplet precautions and stated, I should have put it [face shield] on. When further asked about their expectation regarding PPE, Staff O stated, I should have changed my mask and wear my face shield for residents on droplet precautions. In a phone interview on 01/21/2026 at 1:03 PM, Staff B stated that they expected staff to follow droplet precautions which included use of face shield or goggles. Staff B further stated that they expected staff to remove and/or change their face mask upon exit of rooms on droplet precautions. STAFF VObservations on 01/14/2026 at 10:46 AM, on 01/15/2026 at 2:32 PM, and on 01/20/2026 at 11:34 AM, showed droplet precaution signage was posted outside Resident 38's Room (room [ROOM NUMBER]). The droplet precaution signage instructed staff to clean their hands, including before (continued on next page)

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	505417	A. Building B. Wing	01/21/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entering and when leaving the room. It further instructed staff to make sure their eyes, nose, and mouth are fully covered before room entry and to remove face protection before room exit. Observation on 01/20/2026 at 8:37 AM, showed Staff V, Laundry Staff, delivering care supplies to residents' rooms. Staff V was observed wearing a mask and was not wearing a face shield or goggles and entered room [ROOM NUMBER] to deliver care supplies. Staff V did not change their face mask upon exiting room [ROOM NUMBER]. Staff V was then observed entering room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] to drop off care supplies. Staff V did not perform hand hygiene before entering and/or after exiting the rooms. In an interview on 01/20/2026 at 8:51 AM, Staff V stated that they were required to wear a face shield when they were entering room [ROOM NUMBER]. Staff V stated that they should have removed their mask before leaving room [ROOM NUMBER] and wore a new one before entering the next rooms. Staff V further stated that they should have performed hand hygiene before entering and after exiting each room. In a phone interview on 01/21/2026 at 10:59 AM, Staff B stated that staff were expected to follow all infection control protocols when providing care/dropping supplies to residents on droplet precautions. Staff B further stated that Staff V should have followed the dropletˆprecaution signage instructions posted outside Resident 118's room. Reference: (WAC) 388-97-1320 (1)(a)(c),1780(2)(c)(d) .

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	505417	A. Building B. Wing	01/21/2026

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure the resident was evaluated, assessed, and care planned for self-administration of medications for 1 of 1 resident (Resident 23), reviewed for self-administration of medications. This failure placed the residents at risk for medication errors, adverse reactions, and related complications.Findings included.Review of the facility's policy titled, Self-Administration of Medications, revised in February 2021, showed that the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do. The policy further stated, If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status.Review of Resident 23's electronic health record (EHR - assessments and progress notes), physician orders, and care plan printed on 01/15/2026 did not show documentation for assessment or evaluation, physician order, or care plan related to self-administration of medications.Observation on 01/13/2026 at 11:18 AM and on 01/15/2026 at 10:11 AM, showed that Resident 23 had two prescription tubes of Lidocaine (pain medication) cream 2% (percent) in individual box with instructions to apply topically (on the skin) as needed to fistula (a surgical connection made between an artery and vein to receive dialysis [medical treatment that filters waste and excess fluid from the blood]) for pain and one prescription bottle of Ammonium Lactate (lotion/cream used to treat dry, scaly, itchy skin conditions) 12% apply to dry skin topically two times a day on their bedside table.In an interview on 01/15/2026 at 10:11 AM, Resident 23 stated that they did not apply the Lidocaine cream, the nurse at the facility and at the dialysis center put the Lidocaine cream on them. Resident 23 stated that they would apply the Ammonium Lactate lotion themselves to their arms, feet, and legs. Resident 23 further stated that they would keep both the Lidocaine cream and Ammonium Lactate lotion on the bedside table.In an interview and joint observation on 01/15/2026 at 12:49 PM, Staff S, Registered Nurse, stated that if a resident wants to self-administer their medications, they would assess the resident's cognition and check the assessment in the computer and monitor the resident when they take the medications. A joint observation of Resident 23's room showed one prescription tube of Lidocaine cream 2% and one prescription bottle of Ammonium Lactate 12% on their bedside table. Staff S stated they would check if Resident 23 was able to self-administer their medications. A joint record review of Resident 23's January 2026 medication administration record, physician orders, and assessments showed no documentation for self-administration of medications. Staff S stated they did not see in the records that Resident 23 could self-administer their medications and that there should be a self-administration of medications assessment.In a joint phone interview and record review on 01/21/2026 at 12:17 PM with Staff B, Director of Nursing Services, and Staff C, Regional [NAME] President of Operations, Staff B stated that they expected residents who want to self-administer their own medications would have an assessment, physician order, and care plan. A joint record review of Resident 23's EHR did not show an assessment, physician order, or care plan for self-administration of medications. Staff B stated that they expected Resident 23 to have a self-administration of medications assessment, physician order, and care plan.Reference: (WAC) 388-97-0440, 1060(3)(l).

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	505417	A. Building B. Wing	01/21/2026

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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** Based on interview and record review, the facility failed to provide information regarding advance directive (a written instruction, such as a living will or Durable Power of Attorney for health care [a document delegating to an agent the authority to make health care decisions in case the individual delegating the authority subsequently becomes incapable to do so]) for 1 of 3 residents (Resident 3), reviewed for advance directives. This failure placed the resident at risk for losing their right to have their preferences honored to receive or refuse/discontinue care according to their choice.Findings included.Review of the facility's policy titled, Advance Directives, revised in September 2022, showed that the resident has the right to formulate an advance directive. The policy further showed that upon admission of a resident, the facility would inquire about existence of any written advance directive and that a written information about formulation of an advance directive would be provided to the resident.Review of the face sheet printed on 01/14/2026 showed Resident 3 was admitted to the facility on [DATE].Review of Resident 3's Electronic Health Record (EHR) did not show documentation that an advance directive had been discussed and/or Resident 3 had been provided information about advance directive.In an interview on 01/14/2026 at 9:00 AM, Resident 3 stated that they knew about what an advance directive is but I don't [do not] remember it being discussed.In an interview and joint record review on 01/15/2026 at 1:41 PM, Staff E, Social Worker, stated that their process was to discuss advance directives upon admission of residents, during care conferences and as needed. Staff E stated that they had informed Resident 3 about the advance directives and that most of the conversation was on the phone. A joint record review of Resident 3's EHR did not show documentation that an advance directives were discussed with Resident 3.In a follow-up interview on 01/16/2026 at 3:21 PM, Staff E stated, There is no documentation to support that the advance directive was discussed with [Resident 3].In an interview on 01/20/2026 at 2:54 PM, Staff A, Administrator, stated that if a resident do not [have an advance directives], we educate them.we should continue to document our efforts that we are asking for the advance directives. Staff A stated, I don't [do not] see any documentation that an advance directive was discussed or offered to [Resident 3]. Staff A further stated that it should have been discussed with Resident 3.Reference: (WAC) 388-97-0280 (3)(a)(c).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure report of an incident was thoroughly investigated for 1 of 2 residents (Resident 8), reviewed for accidents. The failure to investigate a fall incident placed the resident at risk for unidentified neglect or mistreatment and a diminished quality of life.Findings included.Review of the Nursing Home Guidelines, The Purple Book, dated October 2015 (sixth edition) showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment, personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences.Review of the facility's policy titled, Accidents and Incidents-Investigating and Reporting, revised in July 2017, showed, The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.Review of a face sheet printed on 01/14/2026 showed Resident 8 was admitted to the facility on [DATE].Review of the admission Minimum Data Set (MDS-an assessment tool) dated 11/28/2025 showed Resident 8 had intact cognition.In an interview on 01/13/2026 at 10:10 AM, Resident 8 stated that they went out for an appointment through a medical transport service. Resident 8 stated that they had an incident that happened last week [on] Thursday [01/08/2026]. [I] hit the ground. The driver pushed me up the ramp but then the wheelchair rolled back and I hit the ground. Resident 8 stated that they had informed a therapist about the incident when they returned to the facility after their appointment. Resident 8 further stated that they were sent out to the hospital for further evaluation on 01/08/2026.Review of Resident 8's Electronic Health Record (EHR) showed a therapy progress notes [documented by Staff U, Physical Therapy Assistant], dated 01/08/2026, showed Resident 8 had a fall when they went out for an appointment. Further review of Resident 8's EHR did not show other documentations related to a fall incident on 01/08/2026.Review of the facility's January 2026 Incident log did not show Resident 8's fall incident on 01/08/2026.In a follow-up interview on 01/20/2026 at 8:27 AM, Resident 8 stated that they had told other people about the incident on 01/08/2026 but I don't [do not] remember their names, but there is one person who always comes to the kitchen. I think she supervises them, I told her.In an interview on 01/20/2026 at 2:41 PM, Staff U stated that they provided Resident 8 physical therapy. Staff U stated that on 01/08/2026 Resident 8 complained about neck pain and informed them about the fall incident. Staff U stated that they documented it on their therapy notes and that Staff Y, Director of Rehabilitation, was present when Staff U was talking with Resident 8.In an interview on 01/20/2026 at 2:48 PM, Staff Y stated, I spoke with nursing.It may have been [Staff D, Admission/MDS Coordinator] and [Staff D] also works at the same time on the floor. I told them what happened to [Resident 8] and that [Resident 8's] wheelchair tipped over.In an interview on 01/20/2026 at 3:55 PM, Staff D stated that [Resident 8] told me about it on the 8th [01/08/2026]. The van was on a hill, and the ramp was kind of slanted and when the driver pushed the wheelchair, the wheelchair tilted. Staff D stated, I let [Staff B, Director of Nursing Services] know about it right after I have spoken to [Resident 8]. I informed [Staff B] verbally. Staff D further stated that Resident 8 was sent out to an acute care hospital for evaluation. When asked if there was an investigation about Resident 8's incident, Staff D stated, Not to my knowledge.In a phone interview on 01/21/2026 at 10:59 AM, Staff B stated that Staff D informed them about Resident 8's incident. Staff B stated that they did not do an investigation because [Resident 8] did not say that [they] had a fall. [They] said [their] wheelchair tipped. Staff B stated that they were expected to investigate accidents and/or incidents. Staff B further stated, I should have done more of an investigation about it.Reference: (WAC) 388-97-0640 (6)(a).

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	01/21/2026

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide bed hold and/or transfer notices to the residents and/or their representatives in writing for 2 of 2 residents (Residents 25 & 32), reviewed for hospitalization. These failures placed the residents at risk of not having an opportunity to make an informed decision about their transfers.Findings included. Review of the facility's policy titled, Bed-Hold and Returns, revised in October 2022, showed, All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). The policy further showed, Residents, regardless of payer source, are provided written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet); b. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). Review of the facility's policy titled, Transfer or Discharge Notice, revised in March 2021, showed that under certain circumstances such as when the safety or health of individuals in the facility would be endangered, when a resident's condition allows for a more immediate transfer or discharge, or when urgent medical needs require it the notice must be provided as soon as practicable but prior to the transfer or discharge. The policy further showed that residents and their representatives must be notified in writing of the specific reason for the transfer or discharge, the effective date, and the location to which the resident will be transferred or discharged . RESIDENT 25Review of a discharge Minimum Data Set (MDS- an assessment tool) dated 12/05/2025 showed Resident 25 had an unplanned discharge to a Short Term General Hospital. Review of a nursing progress note dated 12/05/2025 showed that Resident 25 discharged to the hospital on [DATE] for further evaluation. Further review of the note did not show a bed hold and/or written transfer notice was provided to Resident 25. In an interview and joint record review on 01/15/2026 at 9:14 AM, Staff E, Social Services Director, stated that the facility's process was that after a resident transferred to the hospital, the facility would provide the bed hold notice. Staff E stated that the bed hold notice was not provided to Resident 25 and/or their representative. A joint record review of Resident 25's Electronic Health Record (EHR) did not show that a bed hold notice was provided to Resident 25 and/or their representative. Staff E stated that the bed hold notice should have been provided to Resident 25 and/or their representative and documented in the resident's EHR. When asked whether a written notice explaining the reason for the transfer was provided to Resident 25 and/or their representative, Staff E stated that the communication was only verbal and that no written notice was given. In a phone interview on 01/21/2026 at 10:59 AM, Staff B, Director of Nursing Services (DNS), stated that their expectation was that an assessment was completed, communication had occurred with the provider, the family, and the hospital. Staff B further stated that the eINTERACT Transfer Form (an electronic guide tool completed during resident change of condition) should be completed and provided to residents for every transfer, and that a bedˆhold notice must be given to the resident and/or their representative. Staff B stated that the eINTERACT form should have been completed and a copy was provided to Resident 25 and/or their representative. Staff B further stated that a bedˆhold notice (continued on next page)

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	505417	A. Building B. Wing	01/21/2026

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should also have been provided to Resident 25 and/or their representative. RESIDENT 32Review of Resident 32's EHR in the progress notes, discharge MDS, and miscellaneous/documents tab, showed Resident 32 was transferred to the hospital on [DATE]. Resident 32's EHR showed no written notification of transfer/discharge was provided to Resident 32 and/or their representative. In an interview and joint record review on 01/20/2026 at 11:29 AM, Staff D, Admission/MDS coordinator, stated that transfer/discharge process included provider notification, provider order, completion of eINTERACT Transfer Form, family notification, transportation communication, completion of progress note, and DNS notification. A joint record review of Resident 32's EHR showed no written notification of transfer/discharge was provided to Resident 32 and/or their representative. Further joint record review showed an eINTERACT Transfer Form that was incomplete and blank. Staff D stated the transfer form was not done. In an interview on 01/20/2026 at 11:46 AM, Staff E stated that there was no written notice of transfer/discharge provided to Resident 32 and/or their representative. In a phone interview and joint record review on 01/21/2026 at 12:17 PM with Staff B and Staff C, Regional [NAME] President for Operations, Staff B stated the eINTERACT Transfer Form was the written notification form given to the resident and/or their representative. A joint record review of Resident 32's EHR showed an incomplete/blank eINTERACT Transfer Form. Staff C stated that the eINTERACT Transfer Form was not complete for Resident 32. Staff B stated that the eINTERACT Transfer Form should have been completed and copy provided to Resident 32 and/or their representative when they were discharged /transferred to the hospital. Reference: (WAC) 388-97-0120 (2) (a-c) (4) .

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	505417	A. Building B. Wing	01/21/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and/or implement a care plan for 3 of 15 residents (Residents 2, 15 & 36), reviewed for comprehensive care plans. The failure to develop and/or implement care plans for pressure ulcer (bed sore), anticoagulant (blood thinner), diuretics (water pills-medications that make kidneys produce more urine) and dementia (memory loss) placed the residents at risk for unmet care needs and a diminished quality of life.Findings included. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, showed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS [Minimum Data Set – an assessment tool] assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. RESIDENT 2Review of the admission record printed on 01/15/2026 showed that Resident 2 was admitted to the facility on [DATE]. Review of the annual MDS dated [DATE] showed Resident 2 was severely impaired with cognition. Further review the assessment showed Resident 2 was receiving an anticoagulant medication during the assessment period. Review of the October 2025, November 2025, December 2025, and January 2025 Medication Administration Record (MAR) showed Resident 2 was receiving an anticoagulant and diuretic medications. Review of the weekly wound observation tool dated 12/03/2025 showed Resident 2 developed a facility acquired pressure ulcer wound on their left heel. Observation on 01/16/2026 at 3:36 PM, showed Staff D, Admission/MDS Coordinator and Staff P, Registered Nurse (RN), were providing wound treatment for Resident 2's left heel pressure ulcer. Staff P stated Resident 2's left heel wound was a pressure ulcer. Review of Resident 2's comprehensive care plan printed on 01/16/2025 showed that there was no care plans developed for Resident 2's pressure ulcer wound, anticoagulant or diuretic medications. In an interview and joint record review on 01/21/2026 at 10:46 AM, Staff D stated that the comprehensive care plan would be completed upon MDS completion and would be updated when there was a change in the resident's condition. A joint record review of Resident 2's comprehensive care plan printed on 01/16/2025 showed that there was no care plan developed for Resident 2's pressure ulcer wound, anticoagulant or diuretic medications. Staff D stated that there was no care plan initiated for Resident 2's pressure ulcer, anticoagulant or diuretic medications and it should have been. In a phone interview and joint record review on 01/21/2026 at 12:17 PM with Staff B, Director of Nursing Services, and Staff C, Regional [NAME] President for Operations, Staff B stated that care (continued on next page)

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	505417	A. Building B. Wing	01/21/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan would be initiated for residents with pressure ulcer wound and residents receiving anticoagulant or diuretic medications. A joint record review of Resident 2's comprehensive care plan showed there were no care plans for pressure ulcer, anticoagulant and diuretic medications. Staff B stated that care plans for Resident 2's pressure ulcer wound, anticoagulant and diuretic medications should have been initiated. RESIDENT 15Review of the provider order summary report and the January 2025 MAR printed on 01/14/2026 showed that Resident 15 was prescribed and given Torsemide (diuretic) for congestive heart failure (condition where the heart's inability to pump blood effectively). Review of a comprehensive care plan printed on 01/14/2026 showed that Resident 15 had no care plan for diuretic medication. In an interview and joint record review on 01/21/2026 at 10:58 AM, Staff D stated that they would update the care plan to reflect any new concerns, issues, or changes. A joint record review of Resident 15's comprehensive care plan showed that Resident 15 had no care plan for diuretic medication. Staff D stated they did not see a care plan for diuretic medication and that there should be. A joint record review and phone interview on 01/21/2026 at 12:17 PM with Staff B and Staff C, showed there was no diuretic care plan for Resident 15. Staff B stated that there was no diuretic medication care plan for Resident 15 and that they expected there to be.RESIDENT 36Review of the admission record printed on 01/14/2026 showed that Resident 36 was re-admitted to the facility on [DATE] with a diagnosis that included dementia. Review of a comprehensive care plan printed on 01/13/2026 showed that Resident 36 had no care plan for dementia. In an interview and joint record review on 01/20/2026 at 3:11 PM with Staff AA, RN, stated that Resident 36 had dementia. A joint record review of Resident 36's electronic health record (diagnosis and care plan) showed Resident 36 had a diagnosis of dementia and no care plan for it. Staff AA stated there was an impaired cognitive function care plan but no separate dementia care plan. A joint record review and phone interview on 01/21/2026 at 12:17 PM with Staff B and Staff C, showed there was no dementia care plan for Resident 36. Staff B stated, there was no care plan specifically for dementia but there are other care plans that included the interventions for dementia care. Reference: (WAC) 388-97-1020(1), (2)(a)(b) .

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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** Based on interview and record review, the facility failed to ensure a care conference or care plan meeting was conducted for 1 of 1 resident (Resident 3), reviewed for care planning. This failure placed the resident at risk for unidentified and unmet care needs, and a diminished quality of life.Findings included. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, showed, Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care. The policy further stated, The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. Review of a face sheet printed on 01/14/2026 showed Resident 3 was admitted to the facility on [DATE]. In an interview on 01/13/2026 at 9:16 AM, Resident 3 stated that they did not remember participating in a care conference/care plan meeting. Review of Resident 3's Electronic Health Record (EHR-social services progress notes) dated 10/15/2025 showed a care conference was scheduled for 10/17/2025. Further review of the EHR did not show documentation that a care conference took place or Resident 3 had participated and/or refused to participate in the care conference/care plan meeting. In an interview and joint record review on 01/16/2026 at 3:29 PM, Staff E, Social Services Director (SW), stated that they scheduled care conferences/care plan meetings and would send invites to the Interdisciplinary Team (IDT) composed of the SW, therapist, doctors, nurses, the resident and/or their representatives. Staff E stated that they informed residents and/or their representatives in person, on the phone or email.depends on the person [resident]. Staff E stated that care conferences were documented and it [documentation] could be anybody or anyone attending the care conferences. A joint record review of Resident 3's EHR did not show IDT documentation regarding care conferences or if Resident 3 had participated or refused participation in the care planning process. Staff E stated they would follow up with Staff D, Admission/Minimum Data Set (MDS) Nurse, who was also involved with the care planning process. In an interview and joint record review on 01/21/2026 at 10:23 AM, Staff D stated that they developed care plans during the MDS (an assessment tool) process and upon a resident's admission to the facility. Staff D stated that they involved the resident and/or their representative in developing the care plan. When asked how they involved the resident and/or their representative in the care planning process, Staff D stated that they would conduct care plan meeting with the IDT and ask the resident and/or their representative to attend. A joint record review of Resident 3's EHR did not show a care plan meeting was conducted or that Resident 3 had been involved or refused to participate in the care plan meeting. Staff D stated, I don't [do not] see anything [care conferences/care plan meetings] in the record. No proof of it that I can find. In a phone interview and joint record review on 01/21/2026 at 12:17 PM with Staff B, Director of Nursing Services, and Staff C, Regional [NAME] President for Operations, Staff B stated that they involved the resident and/or their representative and the IDT in care planning process. Staff B stated that the SW would inform residents about care conferences schedule and that the IDT would receive calendar/email invites about upcoming care conferences. Staff B stated that they expected residents were involved in the care planning process. A joint record review of Resident 3's EHR showed a care conference scheduled for 10/17/2025. Further joint record review did not show documentation that a care conference was conducted or that Resident 3 had participated or refused in the care conference/care plan meeting. Staff C stated, I search by progress notes.but I do not see anything. I personally could not find one that would show that there was a care conference held. Reference: (WAC) 388-97-1020 (2)(e)(f).

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	505417	A. Building B. Wing	01/21/2026

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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 interview and record review, the facility failed to provide necessary services to maintain personal hygiene for 1 of 1 resident (Resident 6), reviewed for Activities of Daily Living (ADL). The failure to provide bath/shower for a resident who was dependent on staff for assistance placed the resident at risk for poor hygiene, unmet care needs and a diminished quality of life. Findings included.Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised in March 2018, showed, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Review the admission record printed on 01/20/2026 showed that Resident 6 was admitted to the facility on [DATE] with diagnosis that included generalized muscle weakness.Review of the quarterly Minimum Data Set (an assessment tool) dated 12/23/2025 showed Resident 6 had intact cognition and was dependent on staff for shower/bathing. Further review of the assessment showed that Resident 6's shower/bathing was important for them.In an interview on 01/13/2026 at 10:05 AM, Resident 6 stated they were not receiving bed bath consistently. Resident 6 further stated that there were times they went without a bed bath for two and a half weeks.Review of Resident 6's Kardex (care guide) printed on 01/20/2026 showed, BATHING: Requires dependent assistance with showering, offer bed bath if [Resident 6] chooses not to shower and notify the nurse .Bathing/Shower- Tues [Tuesday] and Sat [Saturday] Day.In an interview and joint record review on 01/21/2026 at 11:17 AM with Staff T, Certified Nursing Assistant, stated that Resident 6 was dependent with bathing. A joint record review of the undated shower schedule showed the resident was scheduled to have shower/bath every Tuesdays and Saturdays. Staff T stated if a resident refused shower/bath they would offer in another time and if they continued to refuse, they would document refusal and notify the Director of Nursing Services (DNS).Review of the November 2025 Documentation Survey Report showed that Resident 6's scheduled bathing/shower on 11/06/2025, 11/15/2025, and 11/23/2025 were blank or documented as, Activity itself did not occur.Review of the December 2025 Documentation Survey Report showed that Resident 6's scheduled bathing/shower on 12/02/2025, 12/06/2025, 12/09/2025, 12/13/2025, 12/23/2025, 12/27/2025, and 12/30/2025 were blank or documented as, Activity itself did not occur.Review of the January 2025 Documentation Survey Report showed that Resident 6's scheduled bathing/shower on 01/10/2026 and 01/13/2026 were documented as, Activity itself did not occur.Review of the progress notes from 11/01/2025 to 01/21/2025 showed no documentation that Resident 6 refused showers/bathing.In a phone interview and joint record review on 01/21/2026 at 12:03 PM with Staff B, DNS and Staff C, Regional [NAME] President for Operations, Staff B stated that staff were expected to provide shower/bath for residents as scheduled. A joint record review of Resident 6's Electronic Health Record under Task for 30 days look back period showed the resident's scheduled shower/bath documented as Activity itself did not occur on 12/27/2025, 12/30/2025, 01/10/2026, and 01/13/2026. Staff B stated if the resident refused shower, it should have been documented as a refusal and should have not been documented as, Activity itself did not occur.Reference: (WAC) 388-97-1060 (2)(c).

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	505417	A. Building B. Wing	01/21/2026

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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. Based on observation and interview, the facility failed to ensure the Oxygen Storage Room door electronic keypad lock was functioning for 1 of 1 oxygen storage room, reviewed for accident hazards. This failure placed residents at risk of accidents, injuries and a diminished quality of life.Findings included .Observations on 01/13/2026 at 2:58 PM, on 01/14/2026 at 8:29 AM, on 01/16/2026 at 3:51 PM, and on 01/20/2026 at 8:43 AM, showed the door to the oxygen storage room to be unlocked and accessible without inputting the code into the electronic keypad lock.In an interview and joint observation on 01/20/2026 at 9:42 AM, Staff W, Certified Nursing Assistant, stated that the doors with the electronic keypad locks were locked so the residents did not have access to those rooms and to prevent them from getting hurt. A joint observation of the oxygen storage room showed the door was unlocked and accessible without inputting the code into the electronic keypad lock. Staff W stated the door should have been locked due to residents could get hurt from the oxygen tanks.In an interview and joint observation on 01/20/2026 at 11:07 AM, Staff X, Maintenance Director, stated the doors with the electronic keypad locks were locked for safety. A joint observation of the oxygen storage room showed the door was unlocked and accessible without inputting the code into the electronic keypad lock. Staff X stated the door should have been locked and not accessible to residents and/or not qualified people due to the safety of oxygen tanks, oxygen liquid refill, and explosion risks.In a phone interview on 01/21/2026 at 3:03 PM, Staff A, Administrator, stated the oxygen storage room electronic keypad lock should have been functioning and should have been locked.Reference: (WAC) 388-97-1060(3)(g).

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	505417	A. Building B. Wing	01/21/2026

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure enteral nutrition (the delivery of nutrients through a tube feeding [TF - a method of delivering liquid nutrients, fluids, and medication directly into the stomach or small intestine through a flexible tube]) was administered in accordance with physician's orders and professional standards of practice for 1 of 1 resident (Resident 2), reviewed for TF. The failure to follow the physician's orders on the amount of formula to administer, document the amount of formula and water flush administered, and label, with date, and time TF formula bottle and water flush bag placed the resident at risk for unmet nutrition need, adverse health outcomes, and related complications.Findings included .Review of the facility policy titled, Enteral Nutrition, revised in November 2018, showed, Adequate nutritional support through enteral nutrition is provided to residents as ordered.Review of the admission record printed on 01/15/2026 showed that Resident 2 was admitted to the facility on [DATE].Review of the annual Minimum Data Set (an assessment tool) dated 10/15/2025 showed Resident 2 was severely impaired with cognition and dependent on staff with all aspects of care. Further review the assessment showed Resident 2 did not eat or drink and was receiving all nutrition and water through the TF.Review of Resident 2's TF physician order with start date of 12/12/2025, showed the resident had an order for, Osmolite 1.2 CAL [a type of TF formula] administer via Pump 85 ML [milliliter - unit of measurement] per hour. 60 ML water flushes every hour.Observation on 01/13/2026 at 8:27 AM, showed Resident 2 was receiving TF formula Osmolite 1.2 CAL running 75 ML per hour (10 ML less than what was ordered). Further observation showed both the TF formula bottle and water flush bag were not labeled or dated.Observation on 01/14/2026 at 8:07 AM, showed Resident 2 was receiving TF formula Osmolite 1.2 CAL running 75 ML per hour (10 ML less than what was ordered).Record review of the comprehensive care plan printed on 01/16/2026 showed Resident 2 had a TF care plan to, Provide enteral feeding as ordered. Record intake on MAR [Medication Administration Record].Review of Resident 2's MAR and Treatment Administration Record [TAR] for November 2025, December 2025, and January 2026 did not show records of the total amount of formula or water flush provided daily.In an interview and joint record review on 01/21/2026 at 9:09 AM, Staff Q, Registered Nurse, stated that they would follow Resident 2's TF physician order. Joint record review of Resident 2's January 2026 MAR and TAR showed there was no documentation of the total amount of TF formula or water flush provided daily. Staff Q stated they were not documenting the total amount of TF formula or water flush administered at end of their shift.Observation on 01/21/2026 at 9:13 AM, showed Resident 2 was receiving TF formula Osmolite 1.2 CAL running 75 ML per hour. Further observations showed both the TF formula bottle and water flush bag were not labeled or dated.In a joint observation and interview on 01/21/2026 9:17 AM with Staff Q showed Resident 2 was receiving TF formula and both the TF formula bottle and water flush bag were not labeled or dated. Staff Q stated that the formula bottle and the water flush bag were started by night shift and they were not labeled or dated. Staff Q further stated that it should have been labeled and dated.In a joint phone interview and record review on 01/21/2026 at 12:38 PM with Staff B, Director of Nursing Services, and Staff C, Regional [NAME] President for Operations, Staff B stated that staff were expected to label the TF formula and the water flush bag with date and time, follow the TF physician order, and to document the amount of formula and water flush infused during the shift. A joint record review of Resident 2's January 2026 MAR/TAR did not show records of the total amount of TF formula or water flush. Staff B stated that they expected that the total amount of formula infused and water flush provided were documented each shift. Reference: (WAC) 388-97-1060 (3)(f).

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	01/21/2026

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

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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 properly store the Continuous Positive Airway Pressure (CPAP - a therapy that pumps air into the lungs through the nose or nose and mouth that keeps the airway open) mask when not in use and have a proper physician order in place for 1 of 3 residents (Resident 19), reviewed for respiratory care. This failure placed the resident at risk for unmet care needs, respiratory infections, and related complications.Findings included .Review of the facility policy titled, CPAP/BiPAP [Bilevel Positive Airway Pressure - breathing support device that delivers two pressure levels] Support, revised in March 2015, directed staff to document the CPAP settings in the resident's medical record.Review of the admission record printed on 01/20/2026 showed Resident 19 was admitted to the facility on [DATE] with diagnosis that included obstructive sleep apnea (a sleep disorder that is marked by pauses in breathing of 10 seconds or more during sleep and causes unrestful sleep).Review of the quarterly Minimum Data Set (an assessment tool) dated 12/03/2025 showed Resident 19 had intact cognition. The assessment further showed Resident 19 had obstructive sleep apnea.Review of the January 2026 Treatment Administration Record showed that Resident 19 had an order, CPAP assist to set up and take off daily two times a day with a start date of 09/05/2024.Review of the comprehensive care plan printed on 01/14/2026 showed Resident 19 had altered respiratory status/difficulty breathing related to sleep apnea and an intervention, CPAP SETTINGS: Per orders as tolerated.Review of the order summary report active as of 01/21/2026 did not show an order for Resident 19's CPAP settings.Observations on 01/13/2026 at 8:26 AM, on 01/14/2026 at 9:08 AM, on 01/15/2026 at 7:59 AM, and on 01/20/2026 at 7:57 AM showed Resident 19's CPAP machine was sitting on the resident's nightstand, and the CPAP nasal mask was not covered and sitting in the Resident's nightstand drawer with Resident 19's other personal items.In an interview on 01/20/2026 at 1:58 PM, Resident 19 stated that they did not know their CPAP settings. Resident 19 further stated that their CPAP nasal mask would always be stored in their nightstand drawer when not in use.In an interview and observation on 01/20/2026 at 2:07 PM, Staff D, Admission/MDS Coordinator, stated that CPAP mask would be stored in a bag when not in use. When asked Resident 19's CPAP setting order, Staff D stated, I do not see the setting of the CPAP in the resident's orders. A joint observation showed Resident 19's CPAP nasal mask was not covered and sitting on the resident's bed.In a phone interview and joint record review on 01/21/2026 at 12:14 PM with Staff B, Director of Nursing Services, and Staff C, Regional [NAME] President for Operations, Staff B stated that CPAP nasal mask would be stored in a bag and labeled when not in use. A joint record review of Resident 19's active physician order as of 01/21/2026 did not show CPAP setting order. Staff B stated that CPAP setting order should have been entered in the resident's medical record.Reference: (WAC) 388-97-1060 (3)(j)(vi).

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	505417	A. Building B. Wing	01/21/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to properly store biologicals (diverse group of medicines made from natural sources) in accordance with Centers for Disease Control and Prevention (CDC) guidelines and accepted professional standards for 1 of 1 medication refrigerator (Medication Room Refrigerator), reviewed for medication storage. In addition, the facility failed to properly store drugs for 1 of 1 resident (Resident 23). These failures placed the residents at risk for receiving compromised and ineffective medications/biological and medication errors.Finding included. Review of the facility's policy titled, Medication Labeling and Storage, revised in February 2023, showed, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. MEDICATION ROOM REFRIGERATORAccording to the CDC's guideline titled, Vaccine Storage and Handling, dated 03/19/2024, showed, Keep your storage units and vaccines within the appropriate temperature ranges. Check and record storage unit min [minimum]/max [maximum] temperatures at the start of each workday. If your device does not display min/max temperatures, then check and record current temperature a minimum of 2 [two] times (at start and end of workday). In a joint observation on 01/21/2026 at 9:39 AM with Staff D, Admission/Minimum Data Set Coordinator, showed there were two vials of Pneumonia (a lung infection) vaccination stored in the facility's medication room refrigerator. Review of the facility's medication room refrigerator temperature log for January 2026 showed that the refrigerator's temperature was checked once a day in AM. The log had a written direction that stated, Temps [Temperatures] need to be taken twice daily when vaccines are present. Further review of the temperature log showed it was checked once a day during AM from 01/01/2026 to 01/19/2026 except on 01/13/2026. In a phone interview and joint record review on 01/21/2026 at 12:56 PM with Staff B, Director of Nursing Services, and Staff C, Regional [NAME] President for Operations, Staff B stated that they expected medication refrigerator temperature to be checked twice a day. A joint record review of the facility's medication refrigerator temperature log for January 2026 showed that the temperature was checked once a day during AM only. Staff B stated that the refrigerator temperature should have been checked twice a day. RESIDENT 23Review of the facility's policy titled, Self-Administration of Medications, revised in February 2021, showed, Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident request them. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. Review of Resident 23's electronic health record (assessments and progress notes), provider orders and care plan printed on 01/15/2026 showed no resident assessment or evaluation for (continued on next page)

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	505417	A. Building B. Wing	01/21/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administration of medications, no provider orders, and no care plan for self-administration of medications. Observation on 01/13/2026 at 11:18 AM and on 01/15/2026 at 10:11 AM, showed that Resident 23 had two prescription tubes of Lidocaine (pain medication) cream 2% (percent) in individual box with instructions to apply topically as needed to fistula (a surgical connection made between an artery and vein to receive dialysis [medical treatment that filters waste and excess fluid from the blood]) for pain and one prescription bottle of Ammonium Lactate (lotion/cream used to treat dry, scaly, itchy skin conditions) 12% apply to dry skin topically two times a day on their bedside table. A joint observation on 01/15/2026 at 12:49 PM with Staff S, Registered Nurse, showed Resident 23's room had one prescription tube of Lidocaine cream 2% and one prescription bottle of Ammonium Lactate 12% on their bedside table. Staff S stated they would check if Resident 23 was able to self-administer their medications. Staff S stated they did not see in the records that Resident 23 could self-administer their medications. Staff S further stated the Lidocaine cream and Ammonium Lactate lotion should not be on the bedside table. In a phone interview on 01/21/2026 at 12:17 PM with Staff B stated that Resident 23's Lidocaine cream and Ammonium Lactate lotion should have been stored in a locked box with key or in a place where they could lock it up. Reference: (WAC) 388-97-1300 (2) .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to employ sufficient staff that were adequately trained to properly perform kitchen sanitization practices (sanitizing buckets) and safely carry out functions of meal preparation (use of food thermometer) for 2 of 4 dietary staff (Staff L & Staff M), reviewed for food safety. These failures placed the residents at risk for food-borne illnesses (caused by ingestion of contaminated food or beverages) and a diminished quality of life.Findings included. Review of the Washington State Retail Food Code dated 03/01/2022, showed, Employees are properly sanitizing.multiuse equipment and utensils before they are reused, through routine monitoring.including the application of sanitizing chemicals by manual swabbing.Contact times must be consistent with those on EPA [Environmental Protection Agency-United States agency safeguarding human health and protecting the environment]-registered label use instructions. The policy further showed, Concentration of the sanitizing solution must be accurately determined by using a test kit [the strip is dipped in the sanitizing solution and compared the result with the color chart that indicates ppm range] or other device. Review of the undated facility's kitchen signage titled, Sanitizing Bucket Procedures, showed how to prepare a sanitizing bucket which included testing of solution with test strips for proper PPM (parts per million - unit of measure for concentration) and the required PPM of 200-400 ppm. SANITIZING BUCKETSTAFF LReview of the facility's staffing list showed Staff L, Dietary Aide, was hired on 11/16/2020. In an interview and joint observation on 01/16/2026 at 10:59 AM, Staff L stated that they test the sanitizing bucket three times a day and log the result in the form posted in the kitchen. When asked, Staff L took a test strip (used for measuring sanitizer ppm) and dipped it in the sanitizing bucket. Staff L stated, it is 200 [ppm without comparing it to the color chart]. A joint observation of the test strip showed a shade of green. When asked how they could tell that the test strip indicated 200 ppm, Staff L stated, because it is green. My manager told me that if it is green, that is 200 [ppm]. Staff L further stated that they had not used a color chart (indicating ppm range by color) to show the result of the test. STAFF MReview of the facility's staffing list showed Staff M, Cook, was hired on 12/23/2025. In an interview and joint observation on 01/16/2026 at 11:07 AM, Staff M stated that they prepared the sanitizing bucket in the morning. When asked where they took the water to fill in the sanitizing bucket, Staff M pointed to the three-compartment sink across the kitchen and showed the grey hose attached to a compartment with a connected plastic tubing attached to a container labeled Broad Range Quaternary Sanitizer [disinfectant to kill germs]. Staff M proceeded to take a test strip and dipped it in the sanitizing bucket. A joint observation showed the test strip turned pale green. Staff M stated, that is good [ppm range]. When asked how they could know that the sanitizing solution was good to use as disinfectant, Staff M stated, I just know because the color change. I don't [do not] know about the color chart. USE OF FOOD THERMOMETERObservation on 01/16/2026 at 10:28 AM showed Staff M wiping the kitchen countertops with a towel from the sanitizing bucket. Observation and interview on 01/16/2026 at 11:57 AM, showed Staff M used a food thermometer to check the temperature of hamburger steak patties on a metal bowl and then Staff M took a small towel from the sanitizing bucket and wiped off the food thermometer. Staff M immediately proceeded to check the mashed potatoes and used the same towel to wipe off the food thermometer. When asked, Staff M stated that they had been doing the same process where they would use the towel from the sanitizing bucket to wipe off/sanitize the food thermometer. Staff M stated that they removed the used towel from the sanitizing bucket and replaced with a new towel. When asked, Staff M stated that they did not change the water solution from the sanitizing bucket when they replaced the towel. Observation on 01/16/2026 at 12:29 PM, showed Staff A, Administrator, instructed Staff M about using the disposable probe wipes to sanitize the food thermometer. Staff A was heard telling Staff M, We do not use the towel from the sanitizing bucket to clean the [food] thermometer. We use these probe wipes (continued on next page)

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	505417	A. Building B. Wing	01/21/2026

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the food thermometer. On 01/16/2026 at 3:05 PM, Staff A handed in a three-page form titled, Skills Performance Check List. Review of the forms showed a first set of column labeled, Cook: Competency Skills Check with different skills listed below and another two separate columns labeled MET and NOT MET. Further review of the forms showed they were blank, undated, and did not show the employee and/or the evaluator signature as presented on the form. In an interview and joint record review on 01/16/2026 at 3:52 PM, Staff A stated that they did not have a dietary manager or a food service director and that they had basically taken the role of a dietary manager. Staff A stated that they talked to staff about sanitizing bucket and how to check and use the test strips. Staff A stated that there was no actual demonstration but just [a] review. And they [staff] trained with a seasoned [NAME] [Staff G). Staff A stated that they conducted orientation training and competencies skill checks for Staff M. A joint record review of the three-paged forms titled, Skills Performance Check list, showed that they were blank and unsigned. Staff A stated that the forms were used for Staff M. Further joint record review of the forms did not show if Staff M had met or not met the competencies skills. When asked, Staff A stated that the competencies were discussed with Staff M. When asked why they were blank and not signed, Staff A stated they verbally discussed the competencies with Staff M but did not complete the paperwork. Staff A stated that they did not have documentation to show Staff M had completed the skills checklist. Staff A further stated that they expected kitchen staff to follow procedures regarding proper testing of sanitizing bucket and using probe wipes to sanitize food thermometer between checking of food temperature. Reference: (WAC) 388-97-1160.

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	505417	A. Building B. Wing	01/21/2026

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the pneumococcal vaccine (used to prevent pneumonia [a lung infection]) were up to date and offered to 2 of 5 residents (Residents 2 & 36), reviewed for pneumococcal immunizations. This failure placed the residents at risk for acquiring, transmitting, and/or experiencing potentially avoidable complications from pneumococcal disease.Findings included. Review of the facility's policy titled, Pneumococcal Vaccine, revised in March 2022, showed, All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility.The policy further showed that Administration of the pneumococcal vaccines is made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations. According to CDC's official website publication titled, Adult Immunization Schedule Notes, dated 10/07/2025, showed an adult who had previously received both PCV [Pneumococcal Conjugate Vaccine-a type of vaccine]13 and PPSV [Pneumococcal Polysaccharide Vaccine- a type of vaccine]23 but NO PPSV23 was received at age [AGE] years or older will have one dose PCV20 or one dose PCV21 at least 5 [five] years after the last pneumococcal vaccine dose. RESIDENT 2Review of a face sheet printed on 01/20/2026 showed Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Electronic Health Record (EHR) did not show immunization record for pneumococcal vaccine. Further review of the EHR did not show Resident 2 was offered the pneumococcal vaccine. RESIDENT 36Review of Resident 36's face sheet printed on 01/20/2026 showed their birthdate of 04/20/1950. Review of Resident 36's immunization record showed they received their PPV23 on 10/19/2004 when they were [AGE] years old and their PCV13 on 02/19/2019. Further review of the immunization record did not show Resident 36 was offered or received the recommended one dose PCV20 or one dose PCV21 at least 5 years after their last pneumococcal vaccine dose in 2019. In a joint phone interview and record review on 01/21/2026 at 1:03 PM with Staff B, Director of Nursing Services, and Staff C, Regional [NAME] President for Operations, Staff B stated that they offered pneumococcal vaccines to their residents annually and that they followed the CDC immunization guidelines A joint record review of Resident 2's EHR did not show immunization record for pneumococcal vaccine or if the pneumococcal vaccine was offered to Resident 2. Further joint record review of the EHR did not show Resident 36 was offered or received the recommended dose of PCV20 or one dose PCV21 at least 5 years after their last pneumococcal vaccine dose in 2019. Staff B stated that Resident 36's pneumococcal immunization was not up to date. Staff C stated that they did not see Resident 2's pneumococcal immunization record and Resident 36's PCV20 or PCV21 record in the EHR. Reference: (WAC) 388-97-1340 (2).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to provide documentation about COVID-19 (a viral illness that causes fever, difficulty breathing or possibly death) vaccination status for 1 of 1 staff (Staff H), reviewed for COVID-19 immunizations. This failure placed staff and residents at risk of exposure to illness from COVID-19.Findings included. Review of the facility's policy titled, Coronavirus Disease (COVID-19)-Vaccination of Staff, revised in May 2023, showed that staff would provide documentation of their vaccination and that the infection preventionist maintains a tracking worksheet of staff members and their vaccination status. The policy further showed that the facility would maintain documentation related to staff COVID-19 vaccination status. Review of the facility's staff list showed Staff H, Certified Nursing Assistant, was hired on 11/03/2025. In an interview on 01/16/2026 at 9:27 AM, Staff H stated that they received their COVID-19 vaccination in another state. Staff H further stated that they provided a copy of their vaccination status to the facility. In a phone interview on 01/21/2026 at 1:03 PM with Staff B, Director of Nursing Services and Staff C, Regional [NAME] President for Operations, Staff B stated that they would keep COVID-19 vaccination records for their staff. When asked about Staff H's COVID-19 vaccination status, Staff B stated that they were not in the facility at the moment, and that the Human Resources (HR) had Staff H's vaccination record. Staff C stated that the HR staff was not in the building and that they would look into HR office for Staff H's vaccination record. On 01/21/2026 at 4:48 PM, no information or documentation regarding Staff H's COVID-19 vaccination status was provided. Reference: (WAC) 388-97-1620(2)(b)(i)(ii).