

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Marianwood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 Providence Point Drive Southeast Issaquah, WA 98029	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to establish an infection prevention and control program that included developing an antibiotic stewardship program to promote appropriate use of antibiotics and reduce the risk of unnecessary antibiotic use for 2 (Resident 74 & 38) of 3 residents reviewed for unnecessary antibiotics and 2 (September and October 2025) of 3 months of Infection Control (IC) documents reviewed. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate/unnecessary use of antibiotics and placed residents at a greater risk of developing antibiotic resistance. Findings included .<Policy>Review of the revised 06/11/2025, Antibiotic Stewardship facility policy showed the facility would promote appropriate use of antibiotics and reduce the possible adverse side effects with antibiotic use. The policy showed the facility would review new antibiotic orders and criteria for prescribing of antibiotics daily and track measure outcome surveillance related to antibiotic use as part of Quality Assurance Performance Improvement (QAPI) meetings. The facility would consider antibiotic time-out practices that would be considered a stop order for an antibiotic when diagnostic tests or symptoms of the resident do not support the diagnosis of an infection. The Infection Preventionist (IP) would collect, track data, and review findings with the team, and feedback would be given to the physicians on their prescribing patterns.<Resident 74>Review of the 09/08/2025 quarterly Minimum Data Set (MDS, an assessment tool) showed Resident 74 was able to make needs known, had no behaviors and had diagnoses that included loss of motor and sensory function in their lower body due to a spinal cord injury, urinary tract dysfunction that required an indwelling catheter (a tube inserted into the urinary tract to expel urine).Review of September 2025 IC documents showed Resident 74 was started on an antibiotic on 09/09/2025 and on 10/01/2025.Review of Resident 74's UA, collected on 09/01/2025 and reported to the facility on [DATE], showed two organisms present in the urine. Review of a UA collected on 09/30/2025 and reported to the facility on [DATE], showed the UA was contaminated (the sample has multiple bacteria from the skin and results were inaccurate) and would not be processed for Culture and Sensitivity (C & S, identifies the type of bacteria and the antibiotic that would be most effective).Review of physician orders showed a 09/09/2025 order to start Resident 74 on antibiotics for five days and to monitor the resident for signs and symptoms of a Urinary Tract Infection (UTI). Review of physician orders showed a 10/01/2025 order to start Resident 74 on an antibiotic for 14 days.Review of Resident 74's clinical record showed on 09/04/2025 the physician wrote a note directing staff to obtain urinalysis (UA, testing of urine to identify infection) for a one-time episode of a low-grade fever of 99.3 degrees Fahrenheit. A 09/08/2025 physician note showed Resident 74 was seen for UA results that showed organisms present in the urine. The note showed Resident 74 denied systemic symptoms (fever, chills, altered mental status) and the plan would be to wait for the C & S results before starting antibiotics. Review of Resident 74's progress notes from 09/04-09/14/2025 showed no documentation that Resident 74 had or was being monitored for signs and symptoms of a UTI or for adverse side effects related to the antibiotic. Review of Resident 74's clinical record showed a 09/29/2025 physician note that Resident 74 appeared fatigued, had confusion, painful urination, and a low-grade fever. Review of Resident 74's clinical record showed no documentation (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505418	Facility ID: 505418 If continuation sheet Page 1 of 23

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident 74 had or was being monitored for signs and symptoms of a UTI or for adverse side effects related to the antibiotic. In an interview on 11/21/2025 at 9:20 AM, Staff C (Infection Preventionist/Licensed Practical Nurse) stated the facility used McGeer's criteria (standardized definitions used in long term care to identify and count infections consistently) to determine when an infection met the criteria for antibiotic treatment. During an interview on 11/21/2025 at 2:40 PM with Staff B (Director of Nursing) and Staff C, Staff B stated a one-time low-grade fever would not indicate a reason to obtain a UA as one symptom does not meet McGeer's criteria for an infection or antibiotic treatment. Staff B stated a UA usually does not take up to six days to result but after six days with no symptoms Resident 74 did not require antibiotics. Staff B stated they would expect staff to contact the physician as soon as results are received and acknowledged staff waited two days after the UA results were received to notify the doctor. Staff C stated staff should document the symptoms daily, and any potential adverse side effects until the antibiotic was completed. Staff C stated that after the completion of the antibiotic the resident should be assessed to ensure the antibiotic was effective and the infection resolved. Staff B reviewed Resident 74's C & S results and stated a new UA should have been obtained and Resident 74 was sent to the hospital on [DATE], returned with the same antibiotic prescription, and was unable to locate the hospital C & S in the resident's record. Staff B stated the C & S must be obtained to ensure the antibiotic is effective against the organism and that antibiotic time outs should be done to ensure antibiotics are not prescribed unnecessarily. <Resident 38>Review of a 09/22/2025 annual MDS showed Resident 38 was able to make some needs known, had help with decisions, and had medically complex conditions including malnutrition and heart failure. Review of Resident 38's physician orders showed an 11/18/2025 antibiotic order to be given in the muscle every 24 hours for wound infection. Review of Resident 38's clinical record showed an 11/18/2025 physician note that showed the resident was seen for new lab results that showed an elevated white blood cell count, an indication of potential infection. The physician documented that given the resident's declining condition and sacral (tailbone) pressure ulcer a wound culture would be obtained before antibiotics would be started. Review of 11/19/2025 wound culture results showed, specimen requires recollection and a new order in place if results are needed. Review of Resident 38's progress notes showed a 11/20/2025 wound provider note that the wound was assessed as deteriorating. No other documentation was found in the progress notes related to signs or symptoms of the wound infection, inability to process the wound culture, or any adverse side effects to the antibiotic. In an interview on 11/21/2025 at 2:51 PM, Staff C stated they used an infection surveillance form to determine if an infection meets McGeer's criteria and Resident 38's wound infection did not meet the criteria for an antibiotic. Staff C stated there should be documentation in the resident's record monitoring any signs/symptoms of infection, monitoring of adverse side effects of the antibiotic and documentation of provider notification and discussion of Resident 38's wound infection not meeting the criteria. <September and October 2025>Review of the September 2025 IC documents showed no monthly analysis of the number of Community Acquired Infections (CAI) only Healthcare Acquired Infections (HAI), the number of the most prevalent sites or organisms of infection in the facility, no comparison on rates to previous months, trends and actions or plans to reduce IC rates within the facility. Review of the September 2025 IC rate (the percentage of infections per month, per 1000 resident days) showed Staff C documented 32 infections in the month of September at an infection rate of 39.4 %. Review of October 2025 IC documents showed similar findings with no monthly analysis of the number of Community Acquired Infections (CAI) only Healthcare Acquired Infections (HAI), the number of the most prevalent sites or organisms of infection in the facility, no comparison on rates to previous months, trends and actions or plans to reduce IC rates within the facility. Review of the October 2025 IC rate showed Staff C documented 29 infections for the month of October at an infection rate of 35.3%. Review of the total resident days for September 2025, showed a total of 2437. The rate was determined by taking the number of infections divided by the total resident days and times by 1000 to equal a September 2025 monthly IC rate of 13.3 %. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the total resident days for November 2025 showed 2544, for a monthly IC rate at 11.4%. During an interview on 11/21/2025 at 3:10 PM Staff C was asked how the infection control rate was determined. Staff C stated they took the number of infections for the month and divided it by the daily census and times that number by 100 to determine the rate. Staff C was shown the total number of resident days for September 2025 and acknowledged they did not use the right number for total resident days. Staff C stated they did analyze the IC documents monthly to include a narrative, will present the information at QAPI meetings, and would provide those documents. Documents provided showed Staff C completed the monthly summary to include the corrected monthly infection rate indicating the summary was completed after 11/21/2025, and not completed at the end of the month. REFERENCE: WAC 388-97-1320(2)(a)(c).		

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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 implement a system to ensure Advanced Directives (AD) were in place for 3 of 5 residents (Residents 18, 5 & 30) reviewed for ADs. The facility failed to provide information indicating residents were informed, educated, or offered assistance to formulate an AD. This failure placed residents at risk of losing their right to have their stated preferences/decisions honored regarding medical treatment and end-of-life care. Findings included. <Facility Policy> Review of the facility's Advanced Directive and Associated Documentation policy, revised 12/2023, showed the facility staff would provide the resident/family with written information regarding their right to formulate an AD and document in the resident's record, at the time of admission, that the resident/family was provided with AD information. The policy showed a copy of the resident's AD would be obtained and placed in the resident's record. <Resident 18> According to the [DATE] Annual Minimum Data Set (MDS -an assessment tool) Resident 18 admitted to the facility on [DATE] and had severe memory impairment. The MDS showed Resident 18 had diagnoses of Moyamoya disease (a rare condition where the blood vessels supplying the brain become narrowed or blocked) and aphasia (a partial or total loss of the ability to articulate ideas or comprehend spoken or written language, resulting from damage to the brain from injury or disease). Review of the [DATE] AD Care Plan (CP) Resident 18's family was legal next of kin/surrogate decision maker. The CP showed Resident 18 was unable to make decisions for themselves and their primary decision maker was a family member. Review of Resident 18's electronic health records showed a [DATE] Advanced Directive Documentation progress note stating Resident 18's family member was not prepared to take on legal guardianship and declined applying for/obtaining legal guardianship for Resident 18's health care. In an interview on [DATE] at 8:54 AM Resident 18 stated they did not have a Durable Power of Attorney or legal guardian and staff had not discussed ADs with them. In an interview on [DATE] at 1:25 PM Staff D (Social Service Director &ndash; SSD) stated Resident 18's family member was not prepared to spend the money to obtain legal guardianship for Resident 18's health care. Staff D stated they did not obtain a legal court appointed guardianship for a resident if they had a family member that could talk for them. <Resident 5> According to the [DATE] admission MDS, Resident 5 did not have cognitive impairment and had diagnoses including cancer, malnutrition, and required nutrition through a feeding tube surgically placed in the stomach. Review of an [DATE] Social Services Assessment showed Resident 5 did not have an AD. The assessment showed a checkbox resident and/or resident representative have been informed in a manner easily understood of their right to formulate advanced directives. This checkbox was left blank by facility staff. In an interview on [DATE] at 11:20 AM, Staff D stated residents were asked to provide copies of ADs (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upon admission and social service staff would follow up to obtain the documentation. Staff D reviewed Resident 5's records and stated the resident did not have an AD. Staff D stated they did not have documentation to show AD planning or assistance was offered, or documentation showing the resident declined. <Resident 30> According to the [DATE] Quarterly MDS, Resident 30 had some problems with thinking and memory. The MDS showed Resident 30 had diagnoses including history of a brain bleed, cancer, heart and kidney disease, and difficulty expressing speech. Review of Resident 30's record showed the resident had AD paperwork via guardianship. The guardianship paperwork showed it expired on [DATE]. Review of Resident 30's progress notes showed the social services department requested updated guardianship paperwork on [DATE]. The progress notes showed no further documentation regarding obtaining up to date guardianship paperwork. In an interview on [DATE] at 11:15 AM, Staff D stated they called the court to obtain updated guardianship paperwork, and the court was backed up. Staff D stated they were unsure if the facility followed up since [DATE]. No further documentation was provided by the facility. REFERENCE: WAC 388-97-0280(3)(a)(c).		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, interview, and record review, the facility failed to maintain a homelike environment for 4 of 4 units (Units 100, 200, 300 and 400) reviewed. The failure to provide necessary maintenance and repairs in pantry areas and resident rooms for damaged walls, carpets, and furniture left residents at risk for a diminished homelike environment. Findings included .<Facility Policy>According to the facility's October 04, 2016, Resident Rights policy, the facility would provide a safe, clean, comfortable, and homelike environment.<Units 100 and 200 Pantry/Bistro> Observations on 11/18/2025 at 10:52 AM, 11/19/2025 at 8:58 AM, and 11/20/2025 at 8:44 AM of the Bistro area (an area accessible to residents and used as a designated pantry for Units 100 and 200) showed 4 of 4 tables were soiled with dried spill marks and food debris during each observation. During each observation, residents were seen sitting in the bistro area. The refrigerator/freezer was labelled Attn: Staff Access Only and stocked with food and drinks for residents. The combination cable lock across the refrigerator door was broken and the freezer door did not have a lock. The cabinet underneath the sink showed signs of water damage with black patches of mold-like growth and odor. In an interview and observation on 11/20/2025 at 12:45 PM, Staff F (Plant Operations Manager) stated the areas needed to be repaired to prevent possible mold exposure during food and beverage preparation, and to prevent unauthorized access to the refrigerator and freezer. In an interview and observation on 11/20/2025 at 1:35 PM, Staff H (Housekeeping Supervisor) stated the bistro area was assigned to the evening staff to clean each night and needed to be disinfected to provide a safe and clean homelike environment for residents. <Unit 300 Pantry> Observations on 11/18/2025 at 10:12 AM, 11/19/2025 at 8:16 AM, and 11/20/2025 at 8:24 AM of the Unit 300 pantry (a locked room used to store and prepare food and drinks for residents) showed water damage inside the cabinet under the sink with black patches of mold-like growth and odor. In an interview and observation on 11/20/2025 at 12:45 PM, Staff F stated the areas needed to be repaired to prevent possible mold exposure during food and beverage preparation. <Unit 400 Pantry> Observations on 11/18/2025 at 10:41 AM, 11/19/2025 at 8:23 AM, and 11/20/2025 at 8:37 AM of the Unit 400 showed damage to the laminate on the cabinet making it uncleanable, and the wall beneath the hand sanitizer dispenser was damaged and unrepaired. In an interview and observation on 11/20/2025 at 12:45 PM, Staff F stated the areas needed to be repaired to allow for proper cleaning in areas of food and beverage preparation. <Wall damage/Curtain removal> Observations on 11/17/2025 at 11:34 AM, showed staff had removed window dressings from resident (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms 306, 308, 314, 316, 318, 322, 324, 326, 328, 400, 404, 406, 410, 412, 416, 418, 420, 422, and 428, leaving the walls damaged. In an interview and observation on 11/20/2025 at 12:45 PM, Staff F stated the facility removed all window curtains in September 2025 and planned to repair the wall damage when residents were on leave from the facility or the rooms became vacant. Staff F stated it was important to make timely repairs to maintain a homelike environment. Observations on 11/18/2025 at 10:03 AM showed plaster missing from the wall corner near the doorway in Resident #7's room, deep scratches beneath the television, and a carpet stain in the hallway outside the room. In an interview and observation on 11/20/2025 at 12:45 PM, Staff F stated the areas needed to be repaired to maintain a homelike environment. In an interview and observation on 11/20/2025 at 1:35 PM, Staff H stated the carpet needed to be cleaned to ensure a safe and clean homelike environment for residents. Observations on 11/18/2025 01:23 PM showed Resident 13's multiple deep scratches on the walls and their headboard was missing a large piece of laminate exposing the chipboard. In an interview and observation on 11/20/2025 at 12:45 PM, Staff F stated the areas needed to be repaired to allow for proper cleaning and to maintain a homelike environment. In an interview on 11/20/2025 at 1:10 PM, Staff F stated they conduct monthly room~by~room assessments and record concerns in the TELS app (a digital maintenance application) for future repair. After touring the facility, Staff F stated none of the areas of concern had been identified or entered into TELS. Staff F stated they expected staff to report problems promptly through TELS. Staff F stated no other maintenance logs or documentation besides TELS. <Personal Care Supplies> <room [ROOM NUMBER]> Observation of room [ROOM NUMBER]-1 showed the resident's nightstand was covered with personal care supplies. The nightstand contained an opened package of adult briefs with one brief lying outside the package, four packages of personal wipes, all opened, a bottle of lotion that was tipped over, two bottles of skin cleanser, and wound dressings that were not contained. In an interview on 11/20/2025 12:26 PM, Staff K (Resident Care Manager) stated personal care supplies and wound supplies should not be kept on the resident's nightstand and should be kept away in a drawer. <Wall Scrapes> <room [ROOM NUMBER]> Observation on 11/18/2025 at 8:44 AM showed the resident in room [ROOM NUMBER]-2 lying in bed. Long scrapes with the wallpaper peeling and hanging off the wall was observed behind the head of the bed, near the floor. <room [ROOM NUMBER]> Observation on 11/18/2025 at 8:48 AM showed the resident in room [ROOM NUMBER]-1 lying in bed. Long scrapes with the wallpaper peeling and hanging off the wall was observed behind the head of (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the bed. Reference: WAC 388-97-0880, -2040.		

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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 call report to the hospital regarding the resident's status for 6 of 6 residents (Residents 38, 11, 8, 74, 9, & 22) and provide a written transfer notice to 3 of 6 residents (Residents 8, 74, & 9) reviewed for discharge process. Failure to call report to the receiving hospital placed residents at risk of a break in communication and continuity of care. Failure to ensure written notification was provided to the resident/resident representative, in a language and manner they understood, placed residents at risk for not having an opportunity to make informed decisions about their transfer/discharge rights. Findings included .<Policy>According to the facility policy titled, Transfer or Discharge Notice, dated 09/2012, the facility would provide the resident or resident representative the name, address, and telephone number of the state health department agency designated to handle appeals of transfers and discharges. According to the facility policy titled, Transfer or Discharge, Emergency, dated 09/2012, the facility would notify the receiving facility that the transfer was being made.<Resident 38> Review of the 08/20/2025 Discharge Minimum Data Set (MDS &ndash; an assessment tool), Resident 38 was discharged to the hospital with their return anticipated. Review of Resident 38's progress notes from 08/18/2025 to 08/25/2025 showed facility staff did not document a note regarding the resident's transfer to the hospital. There was no note indicating the resident's condition, who was notified of the transfer, or the reason for the transfer to the hospital. Review of an 08/20/2025 eInteract Change in Condition Evaluation assessment showed the assessment was incomplete. The Situation part of the assessment was incomplete showing only the resident seem[ed] different than usual. The second and third page of the assessment included sections for staff to document mental, functional, behavioral, respiratory, heart, abdominal, urine, skin, and pain evaluations. Both pages were blank. The assessment showed staff did not document the provider or family was notified of Resident 38's transfer to the hospital. The assessment showed staff did not document that report was called to the hospital prior to the resident's transfer. <Resident 11> Review of the 08/03/2025 Discharge MDS, Resident 11 discharged with their return anticipated. The 08/28/2025, 09/20/2025, and 10/25/2025 Discharge MDS' showed Resident 11 discharged to the hospital with their return anticipated. Review of Resident 11's progress notes from 08/03/2025 to 10/25/2025 showed staff did not document a report was called to the receiving facility regarding the resident's transfer. Review of Resident 11's eInteract assessments showed staff only completed the assessments for the resident's 08/28/2025 and 10/25/2025 hospitalizations. Staff did not document on the eInteract assessment that hospital staff were called and given report regarding Resident 11's transfers. Staff did not complete eInteract assessment forms for the 08/03/2025 or 09/20/2025 transfers. In an interview on 11/20/2025 at 12:35 PM, Staff K (Resident Care Manager - RCM) stated it was their expectation staff complete a progress note and called the hospital to give report on residents that were being transferred out emergently. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 8> According to the 07/26/2025 admission MDS Resident 8 readmitted to the facility on [DATE] with no memory impairment. Resident 8 had diagnoses of anxiety disorder and depression. Review of Resident 8's health records showed they were transferred out of facility on 07/10/2025 to an acute care hospital. Resident 8's records showed no written transfer notification was provided to Resident 8 and report was not provided to the receiving acute care hospital. In an interview on 11/17/2025 at 1:20 PM Resident 8 stated they had a recent hospitalization. In an interview on 11/19/2025 at 1:39 PM Staff E (RCM) stated they did not provide Resident 8 with a written transfer notification for the 07/10/2025 transfer to the hospital. Staff E stated they did not document report called to the hospital for Resident 8's 07/10/2025 transfer but should have. Staff E stated it was important to provide written transfer notification to the residents or representatives upon transfer to ensure they understood their rights to appeal and to provide reports to receiving hospital to ensure good continuity of care. <Resident 74> According to the 04/02/2025 Annual MDS Resident 74 readmitted to the facility on [DATE] from a short stay hospital transfer. The MDS showed Resident 74 had no memory impairment. Review of Resident 74's health records showed documentation of a 12/31/2024 transfer to an acute care hospital. Resident 74's health records showed no written transfer notification was provided to Resident 74 for the 12/31/2024 transfer to the hospital and report was not provided to the receiving hospital. In an interview on 11/18/2025 at 9:11 AM Resident 74 stated they had a hospitalization at the beginning of the year. In an interview on 11/19/2025 Staff H (Director of Medical Records) reviewed Resident 74's health records stating there was no documentation of the required written transfer notification being provided to the resident. Staff H stated there was no documentation of report called to the receiving hospital for the 12/31/2024 transfer to the hospital but should be. <Resident 9> Review of the 05/18/2025 Discharge MDS, Resident 9 was discharged to the hospital with their return anticipated. Review of Resident 9's progress notes from 05/18/2025 showed they were transferred out of the facility to an acute care hospital for severe abdominal pain. Resident 9's health records showed no written transfer notification was provided, and report was not provided to the receiving acute care hospital. In an interview on 11/17/2025 at 1:43 PM Resident 9 stated they had been hospitalized this year. <Resident 22> (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 08/25/2025 Discharge MDS, Resident 22 was discharged to the hospital with their return anticipated. Review of a 08/25/2025 Nursing Home Transfer or Discharge Notice showed Resident 22 was being transferred to the hospital for kidney stones and was signed by Staff N (Registered Nurse) for the notice being provided to Resident 22. Review of Resident 22's progress notes from 08/25/2025 showed they were transferred out of the facility to an acute care hospital for severe abdomen and groin pain. Staff did not document they called the hospital to give report of Resident 22's status. In an interview on 11/17/2025 at 12:33 PM Resident 22 stated they had recently been hospitalized . In an interview and record review on 11/21/2025 at 12:50 PM, Staff B (Director of Nursing) stated there was no documentation of the required written transfer notification being provided to Resident 9 and no documentation of staff contacting the receiving hospitals during the transfers of Resident 9 or Resident 22. Staff B stated they expected report be given to the receiving hospital to prepare them with the resident's condition and background. Staff B stated they expected staff to document notices and reports in a resident's electronic health record. Reference: WAC 388-97-0120(1)(2)(a-d)(3)(a)(4)(b)(5), 0080, -0140(1)(a-c)(i-iii).		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure Preadmission Screening and Resident Review level II (PASRR -federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care) coordination was completed prior to admission to the facility for 1 of 5 residents (Resident 28) reviewed for PASRR. Failure to ensure PASRR II completion prior to admission placed residents at risks for unmet mental health care needs.Findings included.<Policy>POLICY????????<Resident 28>According to the 10/28/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 28 admitted to the facility on [DATE]. The MDS showed Resident 28 had a diagnosis of Depression.Review of Resident 28's health records showed a 10/20/2025 PASRR I that indicated Resident 28 had a Serious Mental Illness (SMI). The PASRR I showed a level II evaluation was required for SMI. Resident 28's health records showed no PASRR II was completed.In an interview on 11/21/2025 at 1:22 PM Staff O (Social Service) stated the admissions department was expected to obtain the PASRR II determination or invalidation prior to admission to the facility per regulation. Staff O stated there was no documentation of a PASRR II referral being made for Resident 28. Staff O stated they did not receive a PASRR II notice of determination or invalidation prior to Resident 28's admission. Staff O stated it was important to obtain level II PASRR's prior to admission to ensure residents received specialized services that the individual required for optimal mental health needs.In an interview on 11/21/2025 at 1:35 PM Staff Q (admission Coordinator) stated when a resident was referred for a level II PASRR upon screening, they were expected to ensure the PASRR II was completed prior to admission to the facility. Staff Q stated they must have missed Resident 28's incomplete level II [NAME] before admitting them to the facility.Reference: WAC 388-97-1915(4), -1975(7)(8)(10).		

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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 observation, interview, and record review, the facility failed to ensure Care Plans (CP) were updated and/or revised, as needed for 2 of 5 sample residents (Residents 22 & 75) reviewed for CPs, and conduct timely Care Conferences (CC) with the residents Interdisciplinary Team (IDT) present to ensure person-centered care for 2 of 5 sample residents (Resident 75 & 28) who were reviewed for CC's. This failure left residents at risk for unmet care needs, inappropriate care, and other negative health outcomes.<Facility Policy>Review of the Comprehensive Person-Centered Care Planning policy, revised August 2017, showed the facility would provide advance notice for and conduct care planning conferences with each resident and/or their representative and the IDT to both create and review the residents' person-centered care needs and preferences and revise when additions were necessary.<Care Plans> <Resident 22> According to the 09/06/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 22 was admitted to the facility on [DATE] with multiple medically complex conditions including paraplegia (inability to move the lower half of the body), a blood clotting disorder and anxiety disorder. Resident 22 had no impaired memory. In an interview on 11/17/25 at 10:13 AM, Resident 22 stated frustration with their inability to attend recreation activities due to their waist-high compression hose being soiled and not available for use. Observations and interviews on 11/18/2025 2:33 PM, 11/19/2025 9:37 AM, 11/20/2025 09:41 AM and 11/21/2025 10:01 AM showed the compression hose hung at bedside and Resident 22 stated they had not been laundered. Review of a 04/24/2025 physician order showed Resident 22 was to wear waist-high compression stockings when out of bed. Review of Resident 22's comprehensive CP on 04/30/2025 showed Resident 22 had an intervention for compression hose when out of bed. Review of Resident 22's 09/02/2025 CP showed no interventions for waist-high compression stockings or task for laundering of the hose. In an interview on 11/21/2025 at 11:30 PM, Staff I (Certified Nursing Assistant) stated they were aware of Resident 22's need for daily evening handwashing of the compression hose, confirmed it was within their role, and reported completing the task on previous evening shifts. In an interview and record review on 11/21/2025 at 12:50 Staff B (Director of Nursing) stated they were aware of Resident 22's need for the compression hose. Staff B stated the facility transitioned from the old Electronic Health Record (EHR) to the current system on May 1, 2025. After reviewing Resident 22's EHR across both systems, Staff B stated the care plan was not updated accurately and left out the compression hose and their laundering care. Staff B stated they expected CNAs to handwash garments for dependent residents, as needed. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 75> According to the 10/21/2025 admission MDS, Resident 75 had medically complex conditions including heart failure, kidney disease, and diabetes (inability for the body to control blood sugar levels). The MDS showed Resident 75 received a water pill and medications to treat their diabetes during the assessment period. Review of Resident 75's 11/18/2025 order summary showed a 10/17/2025 order directing staff to administer a water pill twice daily for the resident's heart failure. The order summary showed an 11/18/2025, 10/17/2025, and 10/14/2025 order directing staff to administer injectable medications to treat Resident 75's diabetes. Review of Resident 75's 10/14/2025 comprehensive CP showed staff did not initiate a focused CP to address goals and interventions regarding the resident's use of the water pill medication and heart failure. The CP did not include information regarding monitoring the resident's weight or potential adverse reactions of the water pill. The CP showed staff did not initiate a focused care plan to address goals and interventions regarding the resident's diabetes diagnosis or diabetic medication management. There were no directions to staff regarding Resident 75's usual blood sugar levels, monitoring for high or low blood sugars or adverse reactions to their diabetic medications. In an interview on 11/21/2025 at 10:50 AM, Staff K (Resident Care Manager) reviewed Resident 75's CP and confirmed the comprehensive CP did not include information regarding the resident's water pill and heart failure or the resident's diagnosis of diabetes. Staff K stated it was their expectation the CP included information regarding monitoring the water pill and diabetes management. <Care Conferences> <Resident 75> According to the 10/21/2025 admission MDS, Resident 75 admitted to the facility on [DATE] and was not cognitively impaired. In an interview on 11/18/2025 at 1:12 PM, Resident 75 stated they did not have a care conference with the therapy, nursing, or social services department. Resident 75 stated they sort of trickled in one at a time, I like to take notes, and I could not. Resident 75 stated they requested to see the social worker last week and they were still waiting for the social worker to come by their room. Review of Resident 75's comprehensive record on 11/18/2025 showed staff did not hold a CC for the resident. There was no CC assessment or progress note documenting staff offered or arranged a CC for Resident 75. In an interview on 11/19/2025 at 11:24 AM, Staff O (Social Services) stated it was their process to hold CC for newly admitted residents within 7-10 days of their admission. Staff O stated the CC would include family as applicable, social services, therapy staff, and kitchen staff. Staff O confirmed Resident 75 did not have a CC. <Resident 28> According to the 10/28/2025 admission MDS Resident 28 admitted to the facility on [DATE]. The (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS showed Resident 28 had no memory impairment. In an interview on 11/18/2025 at 9:37 AM Resident 28 stated they had not had a CC with her IDT since admission. Resident 28 stated facility staff mentioned a CC with the IDT would be scheduled but it did not happen. Review of Resident 28's health records at this time showed no CC offered or attended. In an interview on 11/20/2025 at 1:26 PM Staff O stated the facility policy was to offer CC's for newly admitted residents within 7-10 days of their admission. Staff O stated the CC would include family as applicable, social services, therapy staff, and kitchen staff. Staff O confirmed Resident 28 did not have a CC. Reference: WAC [PHONE NUMBER](2)(c)(d)(e)(f), (4)(b)(c)(i)(ii)(d-f).		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to ensure physician orders were administered as prescribed for 2 (Residents 9 & 12) of 19 sample residents, failed to obtain physician orders for treatment for 1 (Resident 74) of 19 sample residents, and failed to clarify physician orders for 1 (Resident 30) of 19 sample residents. These failures placed residents at risk for medication errors, delayed treatment, and other negative health outcomes. Findings included .<Administering Physician Orders> <Resident 9> According to the 09/02/2025 Quarterly Minimum Data Set (MDS &ndash; an assessment tool), Resident 9 had heart and lung conditions including heart failure. Review of Resident 9's physician orders showed an 08/18/2025 order for a medication to slow their heart rate and reduce the force of their heart beat, with instructions to hold the medication if the systolic blood pressure (a measure of the pressure inside the arteries when the heart squeezes) was less than 110 mmHg (millimeters of mercury) or heart rate was less than 60 beats per minute. The physician orders showed an 11/18/2025 order directing staff to obtain orthostatic blood pressure (measuring the resident's blood pressure while lying down, sitting, and standing) once per month. Review of Resident 9's September, October, and November 2025 Medication Administration Records (MARs) showed staff failed to hold the medication on 09/03/2025, 09/04/2025, 09/07/2025, 09/21/2025, 10/05/2025, 10/14/2025, 10/16/2025, 10/30/2025, and 11/17/2025 as ordered. On 11/19/2025, Resident 9's orthostatic blood pressure was recorded as 146/73 mmHg for lying, sitting, and standing. <Resident 12> According to the 10/21/2025 Quarterly MDS, Resident 12 had impaired memory, poor nutrition, elevated blood sugar, and a risk for skin injury. Review of Resident 12's physician orders showed a 05/01/2025 order for a medication to soften stool with instructions to hold for loose stools and an 11/18/2025 order to receive orthostatic blood pressures once per month. Review of Resident 12's October and November 2025 Documentation Survey Reports and MARs showed staff documented loose stools and failed to hold the stool softening medication on 10/24/2025, 10/25/2025, 10/26/2025, 10/29/2025, 11/03/2025, 11/06/2025, 11/13/2025, 11/14/2025, 11/17/2025, 11/18/2025, and 11/19/2025. On 11/19/2025, Resident 12's orthostatic blood pressure was recorded as 96/64 mmHg for lying, sitting, and standing. In an interview on 11/20/2025 at 10:51 AM, Staff J (Certified Nursing Assistant) recalled performing one blood pressure measurement for Resident 9 and Resident 12, and both measurements were taken while they were seated. Staff J did not recall how to obtain orthostatic blood pressure measurements. Staff J stated they gave the blood pressure results to Staff G (Licensed Practical Nurse) to enter into the residents' records. In an interview on 11/21/2025 at 12:32 PM, Staff G stated they documented the blood pressure (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results into Resident 9 and Resident 12's medical record without questioning Staff J about the similarities between all three positions. Staff G stated orthostatic blood pressure results would not typically be identical across all three positions for both residents. Staff G stated they did not ask Staff J to clarify how the task was performed prior to documenting the results. In an interview and record review on 11/21/2025 at 1:31 PM, Staff B (Director of Nursing) stated staff failed to hold the medications per the physician orders for Resident 9 and Resident 12. Staff B stated the orthostatic blood pressure results would not typically be identical across all three positions for both residents, and they expected nurses to further assess prior to documenting them. Staff B stated it was important for staff to follow physician orders, complete ordered tasks, confirm competency prior to delegating and correctly record results in the residents' medical records. <Obtaining Physician Orders> <Resident 74> According to the 04/02/2025 Annual MDS Resident 74 had no memory impairment. The MDS showed Resident 74 had diagnoses of Paraplegia (complete paralysis of the lower body) and post-traumatic stress disorder. In an interview on 11/18/2025 at 9:17 AM Resident 74 stated they had a seatbelt in their wheelchair for a long time. Resident 74 stated staff observed them for safety related to use of the seatbelt. Review of Resident 74's health records at this time showed no physician order for the seatbelt to Resident 74's wheelchair. In an interview on 11/21/2025 at 8:55 AM Staff B stated they expected staff to obtain a physician order for restraints used for residents. Staff B reviewed Resident 74's health records and stated there was no physician order for the seatbelt to Resident 74's wheelchair but should be. Staff B stated it was important to obtain a physician order for treatments to ensure staff were aware of treatments in place for the resident and the physician was overseeing and managing care and treatments for the resident. <Clarifying Physician Orders> <Resident 30> According to the 10/27/2025 Quarterly MDS, Resident 30 had mild, cognitive impairment. The MDS showed Resident 30 was always continent of bowel and required substantial/maximal assistance from staff with toileting hygiene. In an interview on 11/17/2025 at 9:33 AM, Resident 30 stated they were constipated at times and they would take prune juice, but the juice was not enough. Resident 30 stated they were currently constipated and requested medicine from the nurse the night before but did not receive the medicine. Review of Resident 30's 10/2025 bowel documentation showed the resident did not have a bowel movement documented for 4 days, 10/07/2025 through 10/10/2025. The documentation showed Resident 30 did not have a bowel movement from 10/18/2025 through 10/21/2025 or from 10/24/2025 through 10/27/2025. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 10/2025 MAR showed a 07/31/2025 order directing staff to administer an as needed medication for bowel management. The order did not specify when staff should administer the medication. The MAR showed staff did not administer the as needed bowel medication when Resident 30 was constipated. Review of Resident 30's 09/2025 bowel documentation showed the resident did not have a bowel movement documented from 09/02/2025 to 09/07/2025, from 09/18/2025 to 09/21/2025, or from 09/26/2025 to 09/30/2025. Review of the 09/2025 MAR showed a 07/31/2025 order directing staff to administer an as needed medication for bowel management. The order did not specify when staff should administer the medication. The MAR showed staff administered the as needed medication on 09/05/2025, 4 days after not having a bowel movement, and on 09/07/2025, 6 days after no bowel movement. The MAR showed staff did not administer the as needed bowel medication between 09/18/2025 to 09/21/2025. The MAR showed staff did administer the bowel medication on 09/30/2025, 5 days after Resident 30 did not have a bowel movement. In an interview on 11/20/2025 at 12:20 PM, Staff K (Resident Care Manager) stated residents had standing orders for bowel protocols. Staff K stated the protocol was to administer an as needed bowel medication on the morning of the 4th day without a bowel movement, if the medication was ineffective, the evening shift was expected to administer an as needed suppository. If the suppository was ineffective, the night shift would administer an enema to the resident. Staff K stated if Resident 30 refused to take the as needed bowel medication, staff were expected to document the refusal and assess Resident 30 for bowel sounds, tenderness, distended abdomen, and notify the provider. Staff K stated staff were expected to write a progress note. Staff K reviewed Resident 30's orders and confirmed the resident did not have a complete bowel protocol ordered and that the resident's orders needed to be clarified. Reference: WAC 388-97-1620(2)(b)(i)(ii)(6)(b)(i).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide assistance with Activities of Daily Living (ADL) for 3 of 5 residents (Residents 22, 38, & 10) reviewed who were dependent on staff for daily cares. The failure to provide assistance with ADLs placed residents at risk for poor hygiene, diminished feeling of self-worth, and a decreased quality of life. Findings included .<Resident 22> According to the 09/06/2025 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 22 was admitted to the facility on [DATE] with multiple medically complex conditions including paraplegia (unable to move both legs), a blood clotting disorder and anxiety disorder. Resident 22 needed staff to perform all effort required to dress their lower extremities and apply footwear. Resident 22 had no impaired memory. In an interview on 11/17/25 at 10:13 AM, Resident 22 stated frustration with their inability to attend recreation activities due to their waist-high compression hose being soiled and not available for use. Resident 22 reported asking the evening aide to handwash and hang-dry the garment and was told it was not their responsibility. Resident 22 stated the compression hose was last washed two weeks prior by a different evening aide. Resident 22 stated frustration about having to frequently negotiate their care needs with staff. Observations and interviews on 11/18/2025 at 2:33 PM, 11/19/2025 at 9:37 AM, 11/20/2025 at 09:41 AM and 11/21/2025 at 10:01 AM showed soiled compression hose hanging at bedside. Resident 22 stated the hose had not been laundered and could not be worn because they were unclear and stretched out from prior use. Review of a 04/24/2025 physician order showed Resident 22 was to wear waist-high compression stockings when out of bed. Review of Resident 22's comprehensive Care Plan (CP) on 04/30/2025 showed Resident 22 had a risk for autonomic dysflexia (a sudden, dangerous rise in blood pressure) requiring waist high compression hose when out of bed. Review of Resident 22's order summary report as of 11/20/2025 did not show an order for waist-high compression stockings. Review of Resident 22's 09/02/2025 CP showed no interventions for waist-high compression stockings or task for laundering. Review of Resident 22's 11/20/2025 Kardex (an at-a-glance snapshot of the resident's care needs available to all staff) showed no interventions for waist-high compression stockings or task for laundering. In an interview on 11/21/2025 at 11:30 PM, Staff I (Certified Nursing Assistant/CNA) stated they were aware of Resident 22's need for daily evening handwashing of the compression hose, confirmed it was within their role, and reported completing the task for Resident 22 when assigned to them on past evening shifts. In an interview and record review on 11/21/2025 at 12:50 Staff B (Director of Nursing) stated they (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were aware of Resident 22's need for the compression hose application prior to transferring from bed to wheelchair. Staff B stated they expected CNAs to handwash garments for dependent residents, as needed. Staff B stated the facility's failure to launder and apply the compression hose limited Resident 22's access to essential ADL support. <Resident 38> According to the 09/22/2025 Annual MDS, Resident 38 was impaired on one side of their body to their upper and lower extremity. The MDS showed Resident 38 was dependent on staff for personal hygiene. In an observation and interview on 11/18/2025 at 1:36 PM, Resident 38's fingernails to both hands extended past the tips of their fingers and there was dark debris noted underneath the nails. Resident 38's spouse was visiting and stated the resident preferred their nails short and clean. A similar observation was made on 11/19/2025 at 8:57 AM. Review of Resident 38's November 2025 bathing documentation showed staff provided a sponge bath to the resident on 11/14/2025 and 11/16/2025. <Resident 10> According to the 10/07/2025 admission MDS, Resident 10 was admitted to the facility on [DATE] with no memory impairment. The MDS showed Resident 10 was dependent on staff to perform all hygiene cares. Review of Resident 10's health records showed a 10/16/2025 ADL CP showed they required moderate assistance from staff for hygiene cares. Observations on 11/18/2025 at 12:46 PM, 11/19/2025 at 8:42 AM and 1:12 PM, 11/20/2025 at 1:40 PM, and 11/21/2025 at 9:48 AM showed Resident 10 lying in bed on their back with their hair not brushed and wearing a hospital gown. In an interview on 11/21/2025 at 8:55 AM Staff B stated they expected staff to offer and assist residents with AM. Staff B stated they expected staff to assist with brushing hair, washing face, brushing teeth, and getting residents dressed and out of bed as part of AM cares. Staff B stated, if a resident refused care, they expected staff to document all refusals and notify the residents care manager. Staff B stated, if staff were unable to complete assigned care, they expected staff to report the issue to management. In an interview on 11/21/2025 at 10:38 AM Staff P (Certified Nursing Assistant) stated they were expected to assist residents assigned to them with brushing hair, washing face, brushing teeth, getting dressed, and up for the day as part of AM cares. Staff P stated Resident 10 did not have any personal clothing except for one pink gown so they were unable to get Resident 10 dressed daily. Staff P stated they had not notified Social Services or the nurse manager that Resident 10 did not have any personal clothing but should have. Staff P stated they did not get Resident 10 out of bed on Tuesday, Thursday, or today (Friday). Staff P stated they were expected to offer AM cares before breakfast but had a lot of heavy care residents that required two-person assistance so they could not finish all tasks for each resident. Staff P stated they had not reported the incomplete tasks to management but should have. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER Marianwood Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 Providence Point Drive Southeast Issaquah, WA 98029	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reference: WAC 388-97-1060(2)(c).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2025
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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 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 ensure medications were stored and labeled in accordance with currently accepted professional standards of practice. The facility failed to: (1) Label medications properly and dispose expired medications timely for 2 of 4 medication carts (Units 100 & 300) reviewed; (2) monitor the medication refrigerator temperature; and (3) secure medications found at the bedside for 1 (Resident 38) of 19 sample residents. These failures placed residents at risk for receiving compromised medications with decreased or no potency, the potential use of unsecured medications, and a decreased quality of life. Findings included . <Facility Policy>Review of the facility policy titled, Storage of Medications, revised April 2007, showed the facility would store all drugs and biologicals in a safe, secure, and orderly manner. The policy showed medications must be labeled accordingly and outdated drugs should be returned to the dispensing pharmacy or destroyed. The policy showed medications requiring refrigeration must be stored in a refrigerator and the nursing staff were responsible for maintaining proper medication storage. The policy showed medications should not be left unattended. <Unit 100 Medication Cart> Observation of the Unit 100 medication cart on 11/20/2025 at 11:03 AM with Staff L (Registered Nurse) showed one full bottle of Aspirin (Non-Steroidal Anti-Inflammatory Drug) expired on 10/2025, one tube of antibiotic skin wound gel expired on 05/30/2025, and one bottle of liquid disinfectant expired on 05/05/2025. In an interview on 11/20/2025 at 11:27 AM, Staff L confirmed the medications observed in the cart were expired. Staff L stated it was important to ensure expired medications were disposed of properly for resident safety. <Unit 300 Medication Cart> Observation of the Unit 300 medication cart on 11/20/2025 at 11:59 AM with Staff M (Licensed Practical Nurse) showed two opened insulin (a blood sugar medication) injection pens; one pen had a mislabeled open and discard dates, and the other pen did not have a discard date. There was one opened steroid inhaler (a respiratory medication) with no open and discard dates listed. There were four bottles of resident-owned nutritional supplements without an expiration date on the label. In an interview on 11/20/2025 at 12:23 PM, Staff B (Director of Nursing) confirmed the medication labeling issues identified in the cart. Staff B stated it was important for the nursing staff to ensure all medications were labeled appropriately with both the open and discard dates per the facility policy to ensure residents were not given expired medications. Staff B stated the resident-owned supplements observed without expiration dates should have been clarified with the provider. Staff B stated they expect the nurse who initially opened the medication to put the label properly for resident safety. < Medication Room Refrigerator> Review of the facility's Temperature Log for Refrigerator form located in the medication room showed the staff should monitor the medication refrigerator temperature and take action if the temperature was out of range (above 46F or below 36F). Observation of the medication room refrigerator on 11/20/2025 at 8:21 AM with Staff L showed there (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were temperature-sensitive medications located inside the refrigerator including insulin injection pens, antianxiety medication vials, suppositories, nasal inhalers, and biological vaccines. Review of the October 2025 refrigerator temperature log from 10/01/2025 until 10/31/2025 showed the temperature was not monitored for 11 days and the refrigerator was not working for two days. Review of the November 2025 refrigerator temperature log from 11/01/2025 until 11/20/2025 showed the temperature was not monitored for 14 days. In an interview on 11/20/2025 at 10:31 AM, Staff B stated the night shift nursing staff was responsible for monitoring the refrigerator temperature in the medication room. Staff B stated it was important to monitor the medication refrigerator temperature to ensure temperature-sensitive medications remained potent, .so the medication's formulation does not get ruined. Staff B reviewed the October 2025 and November 2025 temperature logs and stated the staff should have monitored the refrigerator temperature consistently as expected, but they did not. <Resident 38> Observations on 11/19/2025 at 2:10 PM showed unsecured, medicated wound treatments on Resident 38's nightstand. There were two tubes of medicated honey used to treat open wounds, and four bottles of spray wound cleanser that were accessible to Resident 38. In an interview on 11/20/2025 at 12:26 PM, Staff K (Resident Care Manager) stated the wound care supplies should not have been left on Resident 38's nightstand but should have been contained in the resident's closet. REFERENCE: WAC 388-97-1300(1)(b)(ii)		