STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505434	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynnwood Post Acute Rehabilitation Center	5821 188th Street Southwest Lynnwood, WA 98037

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent physical abuse for 1 of 3 residents (Resident 1), reviewed for abuse investigations. Resident 2 walked over to Resident 1 and placed their hands and pushed inward around Resident 1's neck. This failure placed residents at increased risk of injury, emotional distress, and a diminished quality of life.Findings included .RESIDENT 1Review of the quarterly Minimum Data Set (MDS - a required assessment tool) dated 03/29/2026, showed Resident 1 was admitted to the facility on [DATE] with a diagnosis list that included muscle weakness. The MDS further showed Resident 1 did not have impaired thinking or memory and required assistance for all mobility and transfers.RESIDENT 2Review of the quarterly MDS dated [DATE], showed Resident 2 was admitted to the facility on [DATE] with a diagnosis list that included anxiety (an emotion characterized by feelings of tension and worried thoughts). The MDS further showed the resident did not have impaired thinking or memory and could transfer and walk independently.Review of an incident investigation report dated 05/06/2026, showed Resident 2 shared a room with Resident 1, raised voices were heard coming from their room that escalated into a verbal exchange. The report further showed the assigned nurse entered the room and seen Resident 2 leaving Resident 1's side of the room, returning to their own side of the room. Resident 1 reported that Resident 2 placed their hands around their neck. Resident 2 stated that they did put their hands around Resident 1's neck because of the way Resident 1 treated and spoke to staff. The incident investigation report further showed the residents were placed in separate rooms and Resident 2 was monitored by staff until law enforcement removed Resident 2 from the facility. Resident 1 was assessed for pain/injury, and none were found.In an interview on 05/18/2026 at 2:13 PM, Resident 1 stated, we were just shooting the breeze, like we have done so many times before, I was laying in my bed when Resident 2 got up from their bed and ran over to my side of the room and put both of their hands around my neck, they started choking me. They pressed long enough and hard enough for me to start having trouble breathing. I think Resident 2 heard someone coming to the room, that is when they stopped and started to go back to their side of the room. The law enforcement came and talked to me about it; they took pictures of my neck and showed me the finger prints and red marks around my neck that were caused by them choking me. I did have a little bit of pain for a little while after it happened, but it went away. I could not sleep for about a week. I have no way of protecting myself, I can barely move without help. I would lay awake thinking Resident 2 would come back and finish the job. I was scared because I cannot defend myself against something like that.In an interview on 05/20/26 at 12:59 PM, Staff C, Certified Nursing Assistant (CNA), stated there were different types of abuse, and if a resident went over to another resident and put their hands around their neck and started to choke them, that would be considered physical abuse.In an interview on 05/20/2026 at 1:12 PM, Staff D, CNA, stated that if a resident hit another resident or if a resident went over to another resident and put their hands around their neck and started to choke them, that would be called abuse.In an interview on 05/20/2026 at 1:23 PM Staff E, Licensed Practical Nurse, stated, I was standing at my medication cart in the hall by Resident 1's and Resident 2's room, I heard a lot of commotion and loud voices, so I went to their room. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When I entered the room, I saw Resident 2 leaving from Resident 1's side of the room. Resident 1 told me they were talking with Resident 2, then Resident 2 came over and put their hands around their neck and started to choke them. Staff E stated that Resident 2 stated that they did place their hands around Resident 1's neck. Staff E stated Resident 1 was seen in their bed when they saw Resident 2 walking away from Resident 1's side of the room. Staff E stated Resident 1 was dependent on staff for transfers and mobility and that Resident 2 could walk independently. Staff E further stated that it was physical abuse when Resident 2 went over to Resident 1 and placed their hands around their neck and started to choke them.In an interview on 05/20/2026 at 2:08 PM, Staff B, Director of Nursing Services, stated that when Resident 2 willfully went over to Resident 1 and placed their hands around Resident 1's neck and started to press down [choke them] that was physical abuse.Reference: (WAC) 388-97-0640(1).