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	07/08/2025

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services in a dignified manner for 1 of 4 residents (Resident 5), reviewed for dignity. The failure to ensure staff to resident interaction occurred in a respectful and dignified manner placed the resident at risk for diminished self-worth, self-esteem, and feelings of embarrassment.Findings included .Review of the facility's policy titled, Quality of Life-Dignity, revised in August 2009, showed that Residents shall be treated with dignity and respect at all times. It further showed that Verbal staff-to-staff communication.shall be conducted outside the hearing range of residents and the public.Observation on 07/01/2025 at 8:43 AM, showed Staff N, Registered Nurse, enter Resident 5's room and when exiting, Staff N stated in the hallway, he's [he is] pooping. Further observation showed Staff N entered room [ROOM NUMBER], to tell the Certified Nursing Assistant (CNA) inside the room, that [Resident 5's name] is pooping and they said this in front of the resident in room [ROOM NUMBER].In an interview on 07/01/2025 at 9:49 AM, Staff N stated that it was not appropriate to speak about resident's bowel movements in the hallway or in front of another resident. When asked if it was appropriate to say about Resident 5, he's pooping in the hallway, Staff N stated, no. When asked if it was appropriate to say to a CNA in a room with another resident in in it, [Resident 5's name] is pooping, Staff N, stated, no.In an interview on 07/08/2025 at 9:44 AM, Staff C, Resident Care Manager, stated that they expected staff to provide dignity to residents, which included not saying things about residents in front of other residents. When asked if they expected staff to say he's pooping in the hallway or [Resident 5's name] is pooping in front of another resident, Staff C stated, no.In an interview on 07/08/2025 at 5:41 PM, Staff B, Director of Nursing, stated that they expected staff to treat residents with dignity, including not saying resident information in public. When asked if they expected staff to say he's pooping in the hallway, Staff B stated, ideally, no. When asked if they expected staff to say, [Resident 5's name] is pooping in front of another resident, Staff B stated, no.Reference: WAC 388-97-0180 (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure evaluation and assessment for safe administration of medications were conducted for 1 of 2 residents (Resident 50), reviewed for self-administration of medications. This failure placed the resident at risk for inaccurate and unsafe medication administration, adverse side effects, medical complications, and a diminished quality of life. Findings included .Review of the facility's policy titled, Self Administration of Medications, revised in May 2016, showed that if the resident desires to participate in self-administration, the interdisciplinary team will assess the resident's ability to self-administer medications. The residents' cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. If the interdisciplinary team determines that this resident is unable to carry out this responsibility.the interdisciplinary team may withdraw this right. The policy further showed that, if the resident is a candidate for self-administration of medications, a physician's order will be obtained.Review of a face sheet printed on 07/01/2025, showed Resident 50 admitted to the facility on [DATE] with a diagnosis that included asthma (a condition that affects the airways in the lungs).Review of the physician orders printed on 07/01/2025, showed Resident 50 was prescribed Albuterol Sulfate (medication used to open the airways to increase air flow to the lungs) inhaler (portable device for administering a drug which is to be breathed in) as needed for shortness of breath. Further review of the physician orders showed Resident 50 was prescribed Biotene (brand name) moisturizing oral spray as needed for dry mouth.Review of Resident 50's assessments from 02/25/2025 to 07/01/2025 showed no documentation that Resident 50 had an assessment for self-administration of medications.Observations on 06/30/2025 at 10:03 AM and on 07/01/2025 at 9:04 AM, showed Resident 50 had one Albuterol Sulfate inhaler and one Biotene oral spray on top of their bedside table within their reach. Resident 50 stated they used their inhaler for asthma and their oral spray for dry mouth as needed.In an interview and joint observation on 07/07/2025 at 11:33 AM, Staff O, Licensed Practical Nurse, stated that for residents who wanted to do self-administration of medications, they would do an assessment to make sure they were safe and then obtain a physician's order. A joint observation showed Resident 50 had a Biotene oral spray and an Albuterol Sulfate inhaler sitting on top of their bedside table. Staff O stated that Resident 50 should not have had medications at bedside.In an interview and joint record review on 07/08/2025 at 3:00 PM, Staff C, Resident Care Manager, stated that if a resident wanted to self-administer their medications, they would do an assessment and then get a physician's order. A joint record review of Resident 50's assessments showed Resident 50 did not have an assessment for self-administration of medications before 07/02/2025. Staff C stated that Resident 50 should have had a self-administration assessment before having their medications at bedside.In an interview on 07/08/2025 at 4:30 PM, Staff B, Director of Nursing, stated that they expected Resident 50 to have an assessment for self-administration of medications done prior to Resident 50 being able to self-administer their medications.Reference: (WAC) 388-97-0440, 1060(3)(l).

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on interview and record review, the facility failed to ensure the survey binder included the recertification and complaint survey results that resulted in citations for 2 of 3 years (2024 & 2025), reviewed for availability of survey reports. This failure prevented residents, residents' representatives and visitors from exercising their right to review past survey results and the facility's plan of corrections.Findings included . Review of the Survey Binder, on 07/02/2025 at 2:50 PM and on 07/03/2025 at 10:48 AM, showed that the binder did not contain the recertification and complaint surveys that resulted in citations during the three preceding years. Further review showed the recertification survey results and the associated plan of corrections dated 07/22/2024 and complaint survey results and the associated plans of corrections dated 08/16/2024 and 03/19/2025 were not included in the survey binder.In an interview and joint record review on 07/03/2025 at 11:22 AM, Staff A, Administrator, stated that they were responsible for updating the Survey Binder. Staff A further stated that they had been in the facility for the last two years and that when they get a survey and complaint results, they will add them to the binder. A joint record review of the Survey Binder, showed that it did not contain the recertification survey results and associated plan of corrections dated 07/22/2024 and complaint survey results and associated plans of corrections dated 08/16/2024 and 03/19/2025. Staff A stated they should have been included in the Survey Binder.Reference: (WAC) 388-97-0480 (1) (a-c) (2) (a-b) (4).

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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. Based on interview and record review, the facility failed to ensure an advance directive (a written instruction, such as a living will or Durable Power of Attorney [DPOA] 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]) was obtained for 1 of 2 residents (Resident 37), reviewed for advance directives. This failure placed the resident and/or their representative 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 and Associated Documentation, revised in December 2023, showed that an advance directive was A written instruction that relates to the provision of health care when the individual is incapacitated, such as a Living Will, Durable Power of Attorney for Health Care or the Natural Death Act. These documents allow the individual to identify choices related to their medical treatment or designate someone to make treatment choices for them should they lose decision making capacity themselves.Review of the Advance Directive care plan, printed on 07/02/2025, showed that Resident 37 had an advance directive DPOA.Review of Resident 37's electronic health record under the miscellaneous tab reviewed on 07/01/2025, showed documentation that Resident 37 had a financial DPOA on file and did not show that there was a copy of Resident 37's advance directive.In an interview and joint record review on 07/02/2025 at 10:57, Staff S, Social Services Director, stated that the facility would ask residents at admission if they had an advance directive and would ask for a copy to have in the resident's medical records. When asked if a financial DPOA directed a resident's health care choices/wishes, Staff S stated, no, but some DPOA paperwork would show healthcare decisions. A joint record review of page 21 of Resident 37's DPOA paperwork on file, showed documentation that any healthcare decisions would defer to the attorney-in-fact named in my Durable Power of Attorney for Healthcare. In a follow-up interview at 12:06 PM, Staff S stated that they reached out to Resident 37's representative to see if they have a specific health care directive, and if not, I will provide them with one.In an interview and joint record review on 07/08/2025 at 12:56 PM, Staff A, Administrator, stated that there were two types of DPOAs, one is for financial, and one is for healthcare. Staff A stated that if a resident said they had an advance directive, then there should be a copy in the resident's medical record. A joint record review of Resident 37's DPOA paperwork, showed it was a financial DPOA. Staff A stated that the DPOA paperwork on file for Resident 37 was not an advance directive.Reference: (WAC) 388-97-0280 (3)(a)(d).

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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 a notice before transfer/discharge to the resident and their representative describing the reason for transfer in writing for 1 of 1 resident (Resident 43), reviewed for hospitalization. This failure placed the resident at risk for not having an opportunity to make an informed decision about transfers and discharge.Findings included .Review of the electronic clinical record (progress notes and miscellaneous/documents tab) showed Resident 43 was transferred to the hospital on [DATE]. Resident 43's clinical record showed a Nursing Home Transfer or Discharge Notice, dated 06/17/2025, stating the reason for resident transfer/discharge was necessary for their welfare and their needs could not be met at the facility. The notice showed it was provided to Resident 43's representative verbally stating, out of town. Verbal agreement. Further review of Resident 43's clinical record showed no documentation that Resident 43 and their representative had been provided with written notification of transfer to the hospital.A joint record review and interview on 07/08/2025 at 2:49 PM, with Staff C, Resident Care Manager, showed a Nursing Home Transfer or Discharge Notice, dated 06/17/2025, that was provided verbally to Resident 43's representative. Staff C stated that they expected to provide the notice in writing to the residents or representatives. Staff C stated their process was to fill out the Nursing Home Transfer or Discharge Notice form and send it with the resident and keep a copy. Staff C stated that they spoke with Resident 43's representative who was out of town and not in the facility to sign the notice. Staff C further stated that the notice was provided in Resident 43's discharge packet to the hospital. When asked if they had any documentation to support that the notice was provided, Staff C stated that there was not and that they normally did not document that.On 07/08/2025 at 4:56 PM, Staff B, Director of Nursing, stated their process was to provide the notice of transfer/discharge in writing by sending it with the resident and keeping a copy. When asked if they expected supporting documentation to show that the notice was provided to Resident 43 and their representative, Staff B stated, I'm [I am] telling you that's [that is] what we do, not everything needs a policy.Reference: (WAC) 388-97-0120 (2) (a-c)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure resident assessments were completed accurately for 2 of 10 residents (Residents 23 & 46), reviewed for Minimum Data Set (MDS-an assessment tool). The failure to ensure accurate assessments were coded on the MDS regarding medication use and dialysis (a process of removing excess water and toxins from the blood in people whose kidneys [organs that filter blood, remove waste and balance fluids in the body] can no longer perform these functions) placed the residents at risk for unidentified and/or unmet care needs, and a 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 1.19.1, dated October 2024, 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). MEDICATION USERESIDENT 23Review of quarterly MDS dated [DATE], showed Resident 23 was marked for insulin (medication that lowers the level of glucose [a type of sugar] in the blood) injections and orders for insulin in Section N (Medications - under N0350A and N0350B). Review of the physician orders printed on 07/01/2025, showed Resident 23 was not prescribed insulin injections. Review of May 2025 Medication Administration Record (MAR) showed Resident 23 did not receive insulin injections during the look-back-period (05/02/2025 to 05/08/2025). In an interview and joint record review on 07/08/2025 at 10:47 AM, Staff E, MDS Coordinator, stated they would follow the RAI Manual for MDS accuracy. A joint record review of Resident 23's quarterly MDS dated [DATE] showed that insulin injections and orders for insulin were marked in Section N0350A and N0350B. Another joint record review of Resident 23’s May 2025 MAR and physician orders showed that Resident 23 did not receive insulin injections or was prescribed insulin injections. Staff E stated Resident 23 should not have been marked for insulin injections and orders for insulin in Section N0350A and N0350B. Staff E further stated Resident 23’s MDS was not accurate. In an interview on 7/08/2025 at 4:30 PM, Staff B, Director of Nursing, stated that they expected the MDS to be completed accurately for Resident 23. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DIALYSISRESIDENT 46Review of the physician orders printed on 06/30/2025, showed that Resident 46 went for dialysis on Tuesday, Thursday, and Saturday. Review of the comprehensive care plan printed on 06/30/2025, showed that Resident 46 received dialysis for renal (kidney) failure. Review of the quarterly MDS dated [DATE], showed Resident 46 was not marked for dialysis in Section O (Special Treatments/Procedures). In an interview and joint record review on 07/07/2025 at 1:58 PM, Staff E stated that they used the RAI manual to complete the MDS and that it should be accurate. A joint record review of Resident 46’s physician orders showed that Resident 46 went for dialysis on Tuesday, Thursday, and Saturday. Staff E stated that they would expect the MDS to be marked for dialysis. Another joint record review of the quarterly MDS, dated Reference: (WAC) 388-97-1000 (1)(b) .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Preadmission Screening and Resident Review (PASARR-an assessment used to identify people referred to nursing facilities with Serious Mental Illness [SMI], Intellectual Disabilities [ID]; or related conditions are not inappropriately placed in nursing homes for long-term care) Level I form was completed accurately and Level II PASARR referrals were made for 1 of 6 residents (Resident 108), reviewed for PASARR screening. These failures placed the resident at risk of not receiving the appropriate care and services for their needs and/or lacking access to specialized services for individuals with identified mental health diagnoses or disabilities.Findings included .Review of the facility's policy titled, PASRR screening for Serious Mental Illness/Intellectual Disability, revised on 07/03/2025, showed that It is the policy of this facility to establish a PASRR process to.screen for possible serious mental disorders, intellectual disabilities, and related conditions through the PASRR process. It further showed that The initial pre-screening (PASRR level I) should be completed prior to admission to facility. A Negative Level I requires no further action. A positive Level I Screen (PASRR indicates that individual requires a PASRR Level II Referral) necessitates an in-depth evaluation of the individual by the state-designated authority (PASRR Level II).Review of a face sheet printed on 07/03/20205 showed Resident 108 admitted to the facility on [DATE] with diagnoses that included anxiety disorder (having excessive/persistent worry and fear). Review of Resident 108's Level I PASARR dated 06/17/2025, showed the diagnosis of anxiety disorder was not marked in Section IA (SMI). Further review showed that Section IV (4- Service Needs and Assessor Data) was marked for No level II evaluation indicated.A joint record review and interview on 07/03/2025 at 3:06 PM with Staff G, Social Services Assistant, showed Resident 108 had diagnosis of anxiety on their diagnosis list. An additional joint record review showed that anxiety disorder was not marked on Resident 108's Level I PASARR in Section IA. Staff G stated that Resident 108's Level I PASARR should have included their diagnosis of anxiety disorder. Staff G further stated that a Level II PASARR referral should have been sent to the PASARR coordinator for Resident 108.In an interview on 07/08/2025 at 12:49 PM, Staff A, Administrator, stated that they expected the PASARR form to be accurate, which included marking any SMI diagnoses that a resident had. When asked when a resident's PASRR should be referred for Level II evaluation, Staff A, stated, I'm [I am] not sure.Reference: (WAC) 388-97-1975(1).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 care plans for 4 of 10 residents (Residents 22, 7, 2 & 5) reviewed for comprehensive care plans. The failure to develop and/or follow care plans for conducting an assessment, medication use, and splint usage placed the residents at risk of not receiving needed care, decline in condition, and a diminished quality of life. Findings included . Review of the facility’s policy titled, “Comprehensive Person-Centered Care Planning,” revised in August 2017, showed that the facility interdisciplinary team would develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a residents’ medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. ASSESSMENTRESIDENT 22Review of the comprehensive care plan printed on 07/02/2025 showed that the psychotropic (drugs that affects how the brain works, and causes changes in mood, awareness, thoughts, feelings or behavior) medication care plan had an intervention that Resident 22 would have an Abnormal Involuntary Movement Scale (AIMS-a 12-item observer-rated scale developed to assess the severity of tardive dyskinesia [TD-a movement disorder that can develop due to use of antipsychotic [mind altering] medications, typically not reversible]) and follow its progression over time) assessment completed. Review of the electronic medical records (miscellaneous/documents and assessments tabs) from 06/05/2025 to 07/01/2025 did not show that an AIMS assessment was completed for quetiapine (an antipsychotic) medication use for Resident 22. Review of the June 2025 Medication Administration Record (MAR) showed Resident 22 had an order for quetiapine 25 milligrams (unit of measurement) tablet once a day for Lewy Body Dementia (progressive form of dementia [memory loss] that affects a person's ability to think, reason, and process information). In an interview and joint record review on 07/08/2025 at 11:45 AM, Staff C, Resident Care Manager, stated that AIMS assessments were completed upon resident’s admission to the facility or prior to resident’s starting antipsychotic medication, and then quarterly. A joint record review of the June 2025 MAR showed Resident 22 had an order for quetiapine. Staff C stated that Resident 22 started the quetiapine on 06/06/2025. A joint record review of Resident 22’s psychotropic care plan showed an AIMS assessment should be done. A joint record review of assessments tab did not show that an AIMS assessment was completed. Staff C stated that Resident 22 did not have an AIMS assessment and that there should have been one completed on admission. A joint record review and interview on 07/08/2025 at 5:13 PM with Staff B, Director of Nursing, showed that Resident 22 did not have an AIMS assessment. Staff B stated that Resident 22’s care plan had an intervention for AIMS assessment to be completed and that they should have had one completed upon admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MEDICATION USERESIDENT 7Review of the May 2025 to July 2025 MAR showed Resident 7 had orders for a diuretic (medication that reduces fluid buildup in the body and increases urine output) and anticoagulant (medication that prevents or reduces blood clot [mass that forms when blood hardens from a liquid to a solid] daily, dated 05/22/2025. Review of the admission Minimum Data Set (MDS - an assessment tool) dated 05/28/2025 showed Resident 7 were marked for anticoagulant use in Section N0415E and diuretic use in Section N0415G. Review of the comprehensive care plan printed on 07/01/2025 did not show Resident 7 had a care plan for diuretic and anticoagulant use. During an interview and joint record review on 07/08/2025 at 11:49 AM, Staff C stated that resident’s use of diuretic and anticoagulant medications should be in care plan. A joint record review of Resident 7’s comprehensive care plan did not show a care plan for diuretic and anticoagulant use. Staff C stated that Resident 7 should have had care plans for diuretic and anticoagulant use. In an interview on 07/08/2025 at 5:15 PM, Staff B stated they expected a care plan for residents taking diuretic and anticoagulant medications. Staff B further stated that Resident 7 had no care plan for diuretic and anticoagulant use and that they should have. RESIDENT 2Review of Resident 2’s face sheet printed on 07/01/2025, showed they were admitted to the facility on [DATE] with a diagnosis that included diabetes (a condition that affects the level of sugar in the blood). Review of the physician’s orders printed on 07/01/2025, showed Resident 2 was prescribed insulin (medication that lowers the level of glucose [a type of sugar] in the blood) injection routinely since 03/26/2025. Review of the comprehensive care plan printed on 07/01/2025, showed Resident 2 had no care plan for diabetes or insulin. In an interview and joint record review on 07/07/2025 at 10:56 AM, Staff O, Licensed Practical Nurse, stated Resident 2 had a diagnosis of diabetes and received insulin injections. A joint record review of Resident 2’s comprehensive care plan showed no care plan for diabetes and insulin. Staff O stated they did not see a diabetes or insulin care plan for Resident 2 and that there should have been. In an interview and joint record review on 07/08/2025 at 3:00 PM, Staff C stated Resident 2 had diabetes and insulin injection orders. A joint record review of Resident 2’s comprehensive care plan showed a diabetes care plan was started on 07/08/2025. Staff C stated that Resident 2 should have had a diabetes care plan prior to 07/08/2025. In an interview on 07/08/2025 at 4:30 PM, Staff B stated that they expected Resident 2’s diabetes care plan to have been implemented (prior to 07/08/2025). RESIDENT 5Review of the annual MDS dated [DATE] showed Resident 5 had impairment on both sides of their upper and lower extremities. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility’s document titled, “Occupational Therapy Evaluation and Plan of Treatment,” dated 04/03/2025, showed that Resident 5 had a diagnosis of “contracture [a permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joints to shorten and become very stiff] of muscle, right upper arm.” Review of the limited physical mobility care plan printed on 06/30/2025, showed an intervention for Resident 5 for “Right elbow extension and right resting hand orthotic [splint] for 6-8 [six to eight] hours daily during the day.” Multiple observations on 06/30/2025 at 9:50 AM and at 1:39 PM, on 07/01/2025 at 9:22 AM, on 07/02/2025 at 9:23 AM and at 11:45 AM, on 07/03/2025 at 10:13 AM and at 1:53 PM, and on 07/07/2025 at 9:32 AM and at 12:09 PM, showed Resident 5 was not wearing the right hand/elbow splint. In an interview and joint record review on 07/07/2025 at 12:14 PM, Staff U, Certified Nursing Assistant (CNA), stated that aides were responsible for putting on splints for residents and “we chart when we put them on.” A joint record review of the Kardex (CNA care plan) showed an intervention for Resident 5, “Right elbow extension and right resting hand orthotic for 6-8 hours daily during the day. ” A joint observation showed that Resident 5 did not have any splints on their right hand or elbow. Staff U stated they would look for the splint and put it on the resident. In an interview and joint record review on 07/07/2025 at 2:07 PM, Staff L, Registered Nurse, stated that “the morning shift, the aide usually,” was responsible for placing splints for Resident 5. A joint record review of the limited physical mobility care plan, showed an intervention for Resident 5, “Right elbow extension and right resting hand orthotic for 6-8 hours daily during the day.” Staff L stated that “I don’t [do not] see the splint on evening shift” and “I don’t see the splint in the afternoon when I start at two [2:00 PM].” Staff L stated that the care plan should have been followed. In an interview and joint record review on 07/08/2025 at 9:44 AM, Staff C stated that they expected staff to follow resident care plans. Staff C stated that “therapy” was responsible for putting a care plan in place for splint use and “nursing staff [was] responsible for carrying it [placing splints] out.” A joint record review of the limited physical mobility care plan, showed an intervention for Resident 5 for, “Right elbow extension and right resting hand orthotic for 6-8 hours daily during the day.” Staff C stated that they expected staff to be placing the splint for Resident 5. In an interview and joint record review on 07/08/2025 at 5:41 PM, Staff B stated that they expected staff to follow resident care plans. A joint record review of the limited physical mobility care plan, showed an intervention for Resident 5, “Right elbow extension and right resting hand orthotic for 6-8 hours daily during the day.” Staff B stated that they expected staff to apply splints for Resident 5 if the care plan said to do so. Reference: (WAC) 388-97-1020(1), (2)(a)(b) .

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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. Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with accepted professional standards of practice for 1 of 6 residents (Residents 109), reviewed for respiratory care. The failure to obtain accurate oxygen orders placed the residents at risk of respiratory related complications and a diminished quality of life.Findings included .Review of the facility's policy titled, Oxygen Administration, revised in February 2023, showed that It is the policy of this facility that oxygen therapy is administered, as ordered by the physician or as an emergency measure until the order can be obtained. It further showed that the first step for oxygen administration was obtain appropriate physician's order.Review of Resident 109's physician orders showed an order for Oxygen via mask at 3-4 [three to four] LPM [Liters per minute-a unit of measurement] continuously.Observations on 06/30/2025 at 9:01 AM, on 07/01/2025 at 1:55 PM, and on 07/02/2025 at 8:28 AM, showed Resident 109 was receiving six LPM of oxygen via nasal cannula (flexible tubing that sits inside the nostrils and delivers oxygen) that was connected to an oxygen concentrator.In an interview and joint record review on 07/02/2025 at 2:44 PM, Staff L, Registered Nurse, stated that they expected a physician order for oxygen use. Staff L stated that Resident 109 was on six liters of oxygen. A joint record review of Resident 109's physician orders showed an order for Oxygen via mask at 3-4 LPM continuously. Staff L stated, it's not updated and he had a change of condition, now it's [it is] six liters via nasal cannula. A joint observation showed Resident 109 was receiving six LPM of oxygen via nasal cannula. Staff L stated that the order should be for six liters of oxygen.In an interview on 07/08/2025 at 9:44 AM, Staff C, Resident Care Manager, stated that they expected a physician order for oxygen use. A joint record review of Resident 109's physician orders showed a new order for oxygen 3-10 liters, started on 07/02/2025. Staff C stated that prior to that it was three to four liters via mask, that was the order that he came from the hospital with. Staff C further stated that the nurse should have clarified the order if there was a change and that the order should match what the resident was receiving.In an interview on 07/08/2025 at 5:41 PM, Staff B, Director of Nursing, stated that they expected a physician's order for oxygen use and that the order should match what a resident was receiving. Staff B stated that Resident 109's order should have been changed to reflect what Resident 109 was receiving and now I changed it [the oxygen order].Reference: (WAC) 388-97-1060 (3)(j)(vi).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure appropriate pharmacy services for medication administration and/or disposal for 4 of 6 residents (Residents 40, 6, 162, & 36), reviewed for medication administration and storage. The failure to follow physician's orders and disposal of controlled substances (a drug or other substance that is tightly controlled as it may be abused or cause addiction) placed the residents at risk for medication errors, negative outcomes, and a diminished quality of life. Findings included . Review of the facility’s policy titled, “Administration Procedures for all Medications,” dated May 2022, showed the facility policy was, “To administer medications in a safe and effective manner.” The policy further showed staff should review the five rights three times; prior to removing the medication from the cart/drawer check the Medication Administration Record (MAR) for the order, and checking prior to removing the medication from the container, and after the dose has been prepared. Review of the facility’s policy titled, “Vials, Ampules, and Pens of Injectable Medications, ” dated May 2022, showed, “Vials, ampules, and pens of injectable medications are used in accordance with the manufacturer’s recommendations or the provider pharmacy’s directions for storage, use, and disposal.” Review of the online manufacturer’s recommendations document titled, “Instructions for use Insulin Lispro [rapid-acting form of insulin [a hormone/medication] widely used to manage high blood sugar in individuals with diabetes (chronic disease where the body does not produce enough insulin or cannot properly use the insulin it produces, leading to high blood sugar levels)] …,” revised July 2023, showed, the insulin pen should be primed before each injection and that priming the pen meant removing air from the needle and cartridge. The document further showed if priming did not occur before each injection, the resident could receive too much or too little insulin. MEDICATION ADMINISTRATION RESIDENT 40 Review of Resident 40’s physician orders printed on 07/01/2025, showed an order for Docusate Sodium (medication for constipation [a problem with passing stool]) oral capsule 100 milligrams (mg- a unit of measurement), to give two capsules by mouth two times a day for constipation. The physician orders further showed an order for Magnesium Oxide (a mineral supplement) oral tablet 400 mg, to give two tablets by mouth one time a day for low magnesium level. Observation and interview on 07/01/2025 at 7:54 AM, showed Staff Q, Registered Nurse (RN), poured in a medication cup two Docusate Sodium 100 mg tablets (instead of thecapsules) and one Magnesium Oxide 400 mg tablet (instead of the two tablets) as ordered for Resident 40. Staff Q walked inside Resident 40’s room and stated they were ready to give these medications to Resident 40. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A joint record review and interview on 07/01/2025 at 8:02 AM, with Staff Q, showed an order for two Docusate Sodium 100 mg capsules, and two Magnesium Oxide 400 mg tablets. Staff Q stated that prior to administering the medication they should check to see if they have the right medication, dose, route, and would follow the physician order. Staff Q stated that they did not have Docusate Sodium 100 mg capsules in supply and that they used tablets. Staff Q stated that if a medication was not in supply, they should notify the facility and the provider. Staff Q further stated they should have given two Magnesium Oxide 400 mg tablets instead of one. RESIDENT 6 Review of Resident 6’s physician orders printed on 07/01/2025, showed an order for Aspirin (used to lower the risk of heart attack, stroke [blockage of blood supply to the brain], or blood clot [a mass that forms when blood hardens from a liquid to a solid]) Low Strength oral tablet Chewable 81 mg. Observation and interview on 07/01/2025 at 8:56 AM, showed Staff N, RN, 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 6. Staff N walked inside Resident 6’s room and stated they were ready to give the medication to Resident 6. A joint record review and interview on 07/01/2025 at 8:56 AM with Staff N, showed Resident 6 had a physician order for a chewable Aspirin 81 mg tablet. Staff N stated that prior to medication administration they should check to ensure they had the right resident, medication, route, dose, and time. Staff N stated that they were expected to follow the physician orders. Staff N further stated they prepared an enteric coated aspirin for Resident 6, and they should have given a chewable aspirin tablet. On 07/08/2025 at 9:44 AM, Staff C, Resident Care Manager, stated that prior to administering medication staff should check the rights of medication including right medication, resident, dose, time, and route. Staff C stated Staff Q should have rechecked the orders for Resident 40 and given two tablets instead of one [Magnesium Oxide 400 mg tablet], and that Staff Q should have obtained an order for Docusate Sodium tablets as the facility no longer had Docusate Sodium capsules. Staff C further stated Staff N should have given Resident 6 the “correct form” of the medication (Aspirin 81 mg chewable tablet). RESIDENT 162 Review of Resident 162’s physician orders printed on 07/01/2025, showed an order for Humalog Solution (a brand, Insulin Lispro) to inject per sliding scale (a method of adjusting insulin dosage based on blood glucose levels) before meals and at bedtime. Observation and interview on 07/01/2025 at 11:19 AM, showed Staff C, prepared Resident 162 four units of lispro insulin without priming the pen. Staff C walked inside Resident 162’s room and stated they were ready to give Resident 162 their insulin. Staff C stated they did not prime the insulin pen. Staff C further stated the insulin pen needed to be primed to “make sure the insulin is ready to administer,” and to “make sure I don’t [do not] allow air to go in.” In a phone interview on 07/07/2025 at 9:08 AM, Staff V, Pharmacist, stated that an insulin pen should be primed two units per prime, and that this was important to make sure the resident received the full dose, and to remove any air bubbles. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/08/2025 at 4:56 PM, Staff B, Director of Nursing, stated they would expect nursing staff to check all the medication rights. Staff B stated nursing staff were not supposed to make errors and that they needed to follow the physician orders. Staff B further stated they expected staff to follow their medication administration policy, and that if the policy said to follow manufacturer recommendations, they would expect their staff to do so. CONTROLLED SUBSTANCE DISPOSALRESIDENT 36Review of the facility’s policy titled, “Controlled Substance Disposal,” dated May 2022, showed that “The director of nursing, in collaboration with the consultant pharmacist, is responsible for the facility’s compliance with federal and state laws and regulations in the handling of controlled medications.” It showed that controlled medications were “destroyed in the presence of two licensed nurses” and that “Disposition is documented on the individual controlled substance accountability record/book.” It further showed that the information entered on the “individual controlled substance accountability record/book” included “signatures of witnesses.” A joint observation and interview on 07/03/2025 at 1:35 PM with Staff R, Licensed Practical Nurse (LPN), showed the controlled substance book for the Sound Medication Cart, a page for Resident 36’s oxycodone (a controlled pain medication) 5 (five) milligrams (a unit of measurement) had been discontinued, and 35 tablets of oxycodone were destroyed on 06/30/2025. It further showed one witness signature to the destruction of oxycodone. Staff R stated that there was one signature and could not tell whose signature it was, and the second witness line/space was blank. In an interview on 07/08/2025 at 9:44 AM, Staff C stated that the process to dispose of controlled substances was that either two RNs or one RN and one LPN would witness the destruction and “both of them would sign the narcotic [controlled substance] book.” Staff C further stated that the controlled medication book should “be signed by two witnesses.” In an interview on 07/08/2025 at 5:41 PM, Staff B stated that controlled substances were disposed of “always by two witnesses.” Staff B stated that they had “failed to sign that page” for the destruction of Resident 36’s oxycodone. When asked if the controlled medication log had been signed by two witnesses, Staff B stated, “no.” Reference: (WAC) 388-97- 1300 (1)(b)(i)(c)(ii)(3)(a)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure adequate monitoring was conducted for use of insulin (medication that lowers the level of glucose [a type of sugar] in the blood) and/or diuretic (medication that reduces fluid buildup in the body and increases urine output) for 3 of 5 residents (Residents 2, 23 & 7), reviewed for unnecessary medications. This failure placed the residents at risk for unmet care needs, related complications, and a diminished quality of life.Findings included . Review for the facility’s policy titled, “Administration Procedures for all Medications,” dated May 2022, showed that medications were administered in a safe and effective manner. The policy further showed, “monitor for side effects or adverse drug reactions immediately after administration and throughout each shift.” INSULIN USERESIDENT 2Review of Resident 2’s face sheet printed on 07/01/2025, showed they were admitted to the facility on [DATE] with diagnosis that included diabetes (a condition that affects the level of sugar in the blood). Review of the physician’s orders printed on 07/01/2025, showed Resident 2 was prescribed insulin injections routinely. The physician’s orders further showed no monitoring for hypoglycemia (low blood sugar) and/or hyperglycemia (high blood sugar). Review of Resident 2’s June 2025 and July 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not show that Resident 2 was being monitored for hypoglycemia and/or hyperglycemia. Review of Resident 2’s comprehensive care plan printed on 07/01/2025 did not show a care plan for diabetes. In an interview and joint record review on 07/07/2025 at 10:56 AM, Staff O, Licensed Practical Nurse, stated residents who had a diagnosis of diabetes and were receiving insulin would be monitored for their blood sugar levels and would be checked for hypoglycemia and hyperglycemia. A joint record review of Resident 2’s physician’s orders and the June 2025 to July 2025 MAR/TAR showed they were receiving insulin and there was no documentation to show that Resident 2 was being monitored for hypoglycemia and hyperglycemia. Staff O stated they did not see that Resident 2 was monitored for hypoglycemia and hyperglycemia. In an interview and joint record review on 07/08/2025 at 3:00 PM, Staff C, Resident Care Manager, stated for residents who had diabetes and received insulin, would be monitored for hypoglycemia and hyperglycemia. A joint record review of Resident 2’s physician’s orders showed there was no documentation to show that Resident 2 was being monitored for hypoglycemia and hyperglycemia. Staff C stated that Resident 2 should have been monitored for hypoglycemia and hyperglycemia. In an interview on 07/08/2025 at 4:30 PM, Staff B, Director of Nursing, stated that they expected Resident 2 to have been monitored for hypoglycemia and hyperglycemia. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DIURETIC USERESIDENT 23Review of the physician’s orders printed on 07/01/2025, showed Resident 23 was prescribed Torsemide (diuretic medication) 30 milligrams (mg-unit of mass) by mouth two times a day for edema (or swelling-the build-up of fluid in the body’s tissue). Review of the June 2025 to July 2025 MAR and TAR printed on 07/01/2025, did not show that Resident 23 was being monitored for adverse side effects of diuretic use and/or edema. Review of a care plan printed on 07/01/2025, showed Resident 23’s focus care plan indicated a potential for fluid deficits related to daily diuretic therapy with interventions to “Administer medications as ordered. Monitor/document for side effects and effectiveness.” In an interview and joint record review on 07/07/2025 at 10:45 AM, Staff O stated for residents who were receiving diuretic medication for edema, they would monitor their vital signs, fluid intake/output, hydration status, laboratory and edema. A joint record review of Resident 23’s physician’s orders and June 2025 to July 2025 MAR and TAR did not show Resident 23 was being monitored for adverse side effects related to diuretic use and/or edema. Staff O stated Resident 23 was not monitored for edema. In an interview and joint record review on 07/08/2025 at 3:00 PM, Staff C stated residents who were receiving diuretic medication for edema would be monitored for adverse side effects, vital signs, laboratory, and edema. A joint record review of Resident 23’s orders and care plan did not show Resident 23 was monitored for diuretic adverse side effects and/or edema. Staff C stated that Resident 23 should have been monitored for diuretic adverse side effects and/or edema. In an interview on 07/08/2025 at 4:30 PM, Staff B stated that for residents taking diuretics there would not be an order for monitoring edema or adverse side effects, and that the monitoring would be in the care plan. A joint record review of Resident 23’s comprehensive care plan showed no monitoring for edema. Staff B stated that Resident 23 was not monitored for edema in the care plan and they monitor for dehydration (a condition caused by the loss of too much fluid from the body – a diuretic adverse side effect). “I would be more worried about them [resident] becoming dehydrated.” RESIDENT 7Review of a face sheet printed on 07/01/2025 showed Resident 7 admitted to the facility on [DATE]. Review of the physician orders printed on 06/30/2025 showed Resident 7 had an order for furosemide (diuretic medication) 40 mg tablet. “Give 0.5 [half] tablet” once a day for congestive heart failure (long-term condition in which the heart is unable to pump enough blood to meet the body’s need). Review of the May 2025 through July 2025 MARs did not show Resident 7 was being monitored for adverse side effects related to their diuretic medication. Review of the comprehensive care plan printed on 07/01/2025 did not show Resident 7 had a care plan for use of their diuretic medication and/or that they were being monitored for adverse side effects related to their diuretic medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and joint record review on 07/08/2025 at 11:51 AM, Staff C stated that residents taking diuretics were monitored for adverse side effects. A joint record review of Resident 7’s physician orders and comprehensive care plan did not show Resident 7 was being monitored for adverse side effects related to diuretic use. In an interview and joint record review on 07/08/2025 at 5:17 PM, Staff B stated that residents taking diuretics were monitored for dehydration in their care plan. A joint record review of the comprehensive care plan did not show that Resident 7 had a care plan for use of diuretic medication and/or that Resident 7 was being monitored for adverse side effects to their diuretic medication use. Staff B stated that Resident 7 should have a diuretic use care plan that included monitoring for dehydration. Reference: (WAC) 388-97-1060 (3)(k)(i) (4) .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 25 medications for 2 of 5 residents (Residents 40 & 6), observed during medication administration resulted in a medication error rate of 12%. 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 .Review of the facility's policy titled, Administration Procedures for all Medications, dated May 2022, showed the facility policy was, To administer medications in a safe and effective manner. The policy further showed staff should review the five rights three times; prior to removing the medication from the cart/drawer check the Medication Administration Record (MAR) for the order, and checking prior to removing the medication from the container, and after the dose has been prepared.RESIDENT 40 Review of Resident 40's physician orders printed on 07/01/2025, showed an order for Docusate Sodium (medication for constipation [is a problem with passing stool]) oral capsule 100 milligrams (mg- a unit of measurement), to give two capsules by mouth two times a day for constipation. The physician orders further showed an order for Magnesium Oxide (a mineral supplement) oral tablet 400 mg, to give two tablets by mouth one time a day for low magnesium level.Observation and interview on 07/01/2025 at 7:54 AM, showed Staff Q, Registered Nurse (RN), poured in a medication cup two Docusate Sodium 100 mg tablets (instead of the capsules) and one Magnesium Oxide 400 mg tablet instead of the two tablets as ordered for Resident 40. Staff Q walked inside Resident 40's room and stated they were ready to give these medications to Resident 40.In a joint record review and interview on 07/01/2025 at 8:02 AM, with Staff Q, showed an order for two Docusate Sodium 100 mg capsules, and two Magnesium Oxide 400 mg tablets. Staff Q stated that prior to administering the medication they should check to see if they have the right medication, dose, route, and would follow the physician order. Staff Q stated that they did not have Docusate Sodium 100 mg capsules in supply and that they used tablets. Staff Q stated that if a medication was not in supply, they should notify the facility and the provider. Staff Q further stated they should have given two Magnesium Oxide 400 mg tablets instead of one. RESIDENT 6Review of Resident 6's physician orders printed on 07/01/2025, showed an order for Aspirin (used to lower the risk of heart attack, stroke [blockage of blood supply to the brain], or blood clot [a mass that forms when blood hardens from a liquid to a solid]) Low Strength oral tablet Chewable 81 mg. Observation and interview on 07/01/2025 at 8:56 AM, showed Staff N, RN, 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 6. Staff N walked inside Resident 6's room and stated they were ready to give the medication to Resident 6.A joint record review and interview on 07/01/2025 at 8:56 AM with Staff N, showed Resident 6 had a physician order for a chewable Aspirin 81 mg tablet. Staff N stated that prior to medication administration they should check to ensure they had the right resident, medication, route, dose, and time. Staff N stated that they were expected to follow the physician orders. Staff N further stated they prepared an enteric coated aspirin for Resident 6, and they should have given a chewable aspirin tablet.On 07/08/2025 at 9:44 AM, Staff C, Resident Care Manager, stated that prior to administering medication staff should check the rights of medication including right medication, resident, dose, time, and route. Staff C stated Staff Q should have rechecked the orders for Resident 40 and given two tablets instead of one [Magnesium Oxide 400 mg tablet], and that Staff Q should have obtained an order for Docusate Sodium tablets as the facility no longer had Docusate Sodium capsules. Staff C further stated Staff N should have given Resident 6 the correct form of the medication (Aspirin 81 mg chewable tablet).On 07/08/2025 at 4:56 PM, Staff B, Director of Nursing, stated they would expect nursing staff to check all the medication rights. Staff B further stated nursing staff were not supposed to make errors and that they needed to follow the physician orders.Reference: (WAC) 388-97-1060 (3)(k)(ii).

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	505434	A. Building B. Wing	07/08/2025

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to appropriately label and/or dispose expired medications in accordance with current accepted professional standards for 2 of 3 medication carts (Sound Medication Cart & [NAME] Medication Cart) and for 1 of 1 Medication Storage Room, reviewed for medication storage and labeling. In addition, the facility failed to properly store drugs or biologicals (diverse group of medicines made from natural sources) for 1 of 2 residents (Resident 50). These failures placed the residents at risk for receiving compromised and ineffective medications. Findings included . Review of the facility’s policy titled, “Medication Storage in the Facility,” dated May 2022, showed that “Medications and biologicals are stored safely, securely, and properly, following manufacturer’s recommendations or those of the supplier.” It showed that “Certain medications or package types, such as…multiple dose injectable vials, ophthalmics [medications for the eyes] …require an expiration date shorter than the manufacturer’s expiration date to insure medication purity and potency.” It further showed that “All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining.” SOUND MEDICATION [NAME] joint observation and interview on 07/03/2025 at 1:35 PM with Staff R, Licensed Practical Nurse (LPN), showed an opened bottle of atropine sulphate (an ophthalmic medication) with an opened date of 06/02/2025. When asked how long atropine sulphate was good for after opening, Staff R stated, “I’m [I am] not sure. I can check.” In a follow-up interview at 2:38 PM, Staff R stated, “It’s [it is] good for twenty-eight days once it was opened.” A joint observation showed that the atropine sulphate was opened on 06/02/2025. Staff R stated that they “should have been discarded” on 06/30/2025. In an interview on 07/08/2025 at 5:41 PM, Staff B, Director of Nursing, stated that they expected ophthalmic medications to have an “open date” and a “discard date.” When asked about the atropine sulphate that was opened on 06/02/2025, Staff B stated that it should have been discarded on 06/30/2025. BAKER MEDICATION [NAME] joint observation and interview on 07/03/2025 at 10:18 AM with Staff O, LPN, showed a blister pack (plastic packaging that holds medications) containing eight tablets of oxycodone (a medication for pain) with an expiration date of 01/07/2025. Staff O stated that the “medication must be discontinued” and “it should be disposed of.” Staff O further stated that there should not be expired medications in the medication cart. In an interview on 07/08/2025 at 5:41 PM, Staff B stated that they expected expired medications to be “destroyed” and to “get rid of them.” When asked about the expired oxycodone, Staff B stated, “[nursing] should’ve [should have] destroyed it.” (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MEDICATION STORAGE ROOM A joint observation and interview on 07/02/2025 at 1:10 PM with Staff D, Resident Care Manager, showed an opened multi-dose vial of Tubersol (a skin test to help diagnose Tuberculosis [a potentially serious bacterial infection that mainly affects the lungs]) that did not have an opened date on it in the refrigerator. Staff D stated that it was multi-dose vial and that “no, it does not” have an open date on it. Staff D further stated that “anything that we break a seal on or open has to be dated with a date on it.” In an interview on 07/08/2025 at 5:41 PM, Staff B stated that they expected staff to “put on an opened date” when opening a multi-dose vial. RESIDENT 50Review of Resident 50’s face sheet printed on 07/01/2025, showed they were admitted to the facility on [DATE] with a diagnosis that included asthma (a condition that affects the airways in the lungs). Review of a physician orders printed on 07/01/2025, showed Resident 50 was prescribed Albuterol Sulfate (an inhaler [portable device for administering a drug which is to be breathed in] used to open the airways to increase air flow to the lungs) inhaler as needed for shortness of breath. Further review of the physician orders showed Resident 50 was prescribed Biotene (brand name) oral spray as needed for dry mouth. Observations on 06/30/2025 at 10:03 AM and on 07/01/2025 at 9:04 AM, showed Resident 50 had one Albuterol Sulfate inhaler and one Biotene oral spray on top of their bedside table within reach. Resident 50 stated they used their inhaler for asthma and their oral spray for dry mouth as needed. In an interview and joint observation on 07/07/2025 at 11:33 AM, Staff O stated that residents who were on self-administration of medications kept their medications at bedside and needed to be kept in a locked drawer. “It [medications] should be kept safe so it can’t [cannot] be used or taken from [by] someone else.” A joint observation showed Resident 50 had one Biotene oral spray and one Albuterol Sulfate inhaler sitting on top of their bedside table. Staff O stated that the medications should be kept in a locked drawer when not in use. In an interview on 07/08/2025 at 3:00 PM, Staff C, RCM, stated that if a resident wanted to self-administer their medications and keep the medication at bedside, the medication would be locked in the bedside table and/or locked drawer/box. In an interview on 07/08/2025 at 4:30 PM, Staff B stated that Resident 50’s inhaler and oral spray should have been in a locked drawer. Reference: (WAC) 388-97-1300 (2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Enhanced Barrier Precautions (EBP-precaution to protect residents from multidrug-resistant organism [a germ that is resistant to medications that treat infections]) practices were followed for 1 of 4 residents (Resident 39) and failed to discard a laboratory sample for 1 of 1 discharged resident (Resident 164), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications.Findings included .Review of the facility's policy titled, IPCP [Infection Prevention & Control Program] Standard and Transmission Based Precautions, revised in October 2022, showed EBP precautions indicated to use gown and gloves during high-contact resident care activities. The policy further showed that high-contact resident care activities included dressing, bathing/showering, transferring, providing hygiene, changing briefs or assisting with toileting. Additionally, the policy indicated that EBP was used for infection or colonization with MDROs [Multidrug Resistant Organisms) that included Extended-Spectrum Beta-Lactamase (ESBL bacteria - a type of antibiotic [medication that treats infections] resistance mechanism that allows bacteria to resist the effects of certain antibiotics that can lead to serious infections that are difficult to treat) producing bacteria.Review of the undated signage/posting titled, Enhanced Barrier Precautions, showed it instructed staff to wear gown and gloves for high-contact resident care activities that included dressing, bathing/showering, transferring, changing linens, providing hygiene, and changing briefs or assisting with toileting.EBPRESIDENT 39Review of the nursing progress notes dated 06/10/2025 showed Resident 39 was placed on EBP precautions related to history of ESBL.Review of Resident 39's physician orders printed on 07/03/2025 showed an order dated 06/10/2025 for ENHANCED BARRIER PRECAUTIONS: PPE [Personal Protective Equipment - gowns and gloves] required for high resident contact care activities. Indication: Hx [history of] ESBL.Observation on 07/03/2025 at 9:07 AM showed Staff J, Certified Nursing Assistant (CNA), and Staff K, CNA, entered Resident 39's room with a Hoyer (mechanical lifting device) lift without wearing their gowns. Further observation showed Resident 39's room had an EBP signage outside the room that instructed staff to wear gown and gloves or high-contact resident care activities that included dressing, bathing/showering, transferring, changing linens, providing hygiene, and changing briefs or assisting with toileting. At 9:17 AM, Staff J and Staff K came out of the room pushing Resident 39 in their wheelchair.In an interview on 07/03/2025 at 9:30 AM, Staff J and Staff K stated that they helped Resident 39 with changing their briefs and clothes, washed their face, brushed their teeth and transferred them from bed to their wheelchair using the Hoyer lift. Staff J and Staff K stated that they were not wearing their gown when providing care [high-contact resident activities) for Resident 39. Staff J stated, no gown is needed for [Resident 39], and that a gown was needed for providing care to Resident 39's roommate. Staff J stated that Resident 39 did not have EBP precautions. Staff J further stated that they would use gown and gloves to provide care for residents on EBP precautions when assisting with dressing toileting, changing briefs, and transfers.In an interview and joint record review on 07/07/2025 at 12:15 PM, Staff L, Registered Nurse (RN), stated that residents on EBP precautions would have an EBP signage outside their room. Staff L stated that Resident 39 did not have EBP precautions and that it was Resident 39's roommate who was on EBP precautions. A joint record review of the physician orders showed Resident 39 had orders for EBP precautions. Staff L stated that Resident 39 had a history of ESBL and was not on EBP precautions. At 12:20 PM, Staff L stated that they spoke with Staff C, Infection Preventionist, and they said that Resident 39 was on EBP precautions. Staff L further stated that both staff [Staff J and Staff K] that provided care for Resident 39 should have worn their gown [during high-contact resident care activities].In an interview and joint record review on 07/07/2025 at 12:37 PM, Staff C stated that staff should follow EBP guidance/signage and CDC guidelines. A joint record review of Resident 39's physician orders showed an order for EBP precautions. Staff C stated that Resident 39 was on EBP precautions, had an order in place, and that they had EBP signage outside their room. Staff C further stated that nursing staff should have worn their gown when helping Resident 39 with dressing toileting, changing briefs, and transfers.In an interview on 07/08/2025 at 5:12 PM, Staff B, Director of Nursing, stated that they expected staff to follow EBP precautions signage. Staff B further stated that both CNAs should have worn their gown when care was provided for Resident 39.URINE LABORATORY SAMPLERESIDENT 164Review of a face sheet printed on 07/01/2025 showed Resident 164 was admitted to the facility on [DATE] and discharged on 05/26/2025 Observations on

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review of room size measurement, two single resident rooms (Rooms 17 & 18) failed to meet the minimum room size requirement of at least 100 square feet (sq ft - unit of measurement) for a single resident room. The failure to ensure residents reside in rooms which met the regulatory requirements for square footage, placed them at risk for living in a physical environment too small to meet their needs.Findings included .Review of an undated and untitled facility provided document showed the following rooms square feet measurements were:-room [ROOM NUMBER]- 93.2 sq ft-room [ROOM NUMBER]- 92 sq ftReview of the facility's census dated 06/30/2025, showed rooms [ROOM NUMBERS] were occupied with residents.RESIDENT 28During an interview and observation on 06/30/2025 at 3:03 PM, Resident 28 stated that their room size did not bother them. Observation showed Resident 28 was in room [ROOM NUMBER] and was not found to be negatively impacted by their room size.RESIDENT 41During an interview and observation on 06/30/2025 at 3:04 PM, Resident 41 stated, I love my room, but I wish it was larger. Observation showed Resident 41 was in room [ROOM NUMBER] and was not found to be negatively impacted by their room size.In an interview and joint record review on 07/07/2025 at 10:59 AM, Staff F, Plan Operations Director, stated there were no changes in square footage for rooms [ROOM NUMBERS] since the last recertification survey. A joint record review showed that room [ROOM NUMBER] was 93.2 sq ft and room [ROOM NUMBER] was 92 sq ft. Staff F stated that the room sizes for rooms [ROOM NUMBERS] had not changed.In an interview on 07/07/2025 at 12:23 PM, Staff A, Administrator, stated that there were no changes in the rooms' square footage since the last recertification survey. Staff A further stated that rooms [ROOM NUMBERS] did not meet the required square footage for single resident rooms according to federal and state regulations.Reference: (WAC) 388-97-2440 (1).