STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caroline Kline Galland Home	7500 Seward Park Avenue South Seattle, WA 98118

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interviews and record reviews the facility failed to ensure resident concerns were dealt with timely, verbal grievances were identified as such, resident rights were promoted periodically as required, and residents were provided the opportunity to make a grievance anonymously for 1 of 1 Resident Council groups reviewed. These failures placed residents at risk for unmet needs, frustration, untimely resolution of grievances, and a diminished quality of life.Findings included.<Policy>According to the facility policy titled, Resident and Family Grievances, dated 2026, a resident or family member may voice a grievance to staff. The policy showed the Administrator was the Grievance Official. The policy showed verbal or written complaints were acceptable forms of communicating grievances. The policy showed resident grievances could be communicated to any staff and the grievance would be documented on a grievance form and communicated with the grievance official.<Resident Council>Review of the facility's September 2025 through February 2026 Resident Council minute notes showed no resident concerns documented. The September 2025 through February 2026 Resident Council minute notes showed Administrator attendance at each Resident council meeting. Review of the facilities November 2025 through February 2026 grievance log showed no Resident Council concerns logged.In an interview on 02/27/2026 at 11:37 AM Residents 123, 186, and 59 stated food concerns were expressed at every resident council meeting, so the facility started a food committee meeting due to all the food concerns expressed but still there was no resolution. Residents 123 and 59 stated the frequency of cooked carrots being served was a repeated concern and the Director of Culinary Services and the Administrator stated they would investigate it, but no resolution was communicated to them regarding the concern. Resident 123 stated they expressed their preference not to be served tomato-based foods due to their diagnosis of rheumatoid arthritis and should avoid nightshades (family of flowering plants to include tomatoes). Resident 123 stated they expressed their preference to the Culinary Director and were told the facility could not accommodate their preference. Resident 186 stated the Activities Director attended all resident council meetings, and they relied on them to document all concerns brought up in the meetings. Resident 186 stated the Administrator attended all the meetings along with a guest speaker, a staff member from different departments each month. Resident 186 stated staff always attended Resident Council meetings, but they preferred the Activity Director to attend to assist in documenting the concerns brought up in the meeting because they were unable to write all the concerns down.In an interview on 03/04/2026 at 12:12 PM Staff G (Activities Director) stated food concerns were reported at every Resident Council meeting by several residents, including the frequent cooked carrots being served, so the facility created an extra Food Committee meeting as of September 2025. Staff G stated the food committee would meet every three months and the concerns would go to Staff F (Assistant Administrator). Saff G stated they took notes about the Resident Council agenda and stated the Administrator always attended Resident Council and would address the resident concerns brought up in Resident Council meetings.In an interview on 03/04/2026 at 12:24 PM Staff F stated they managed Resident Council and grievances and kept the Resident Council minutes binder. Staff F stated they only submitted resident concerns brought to resident council as a grievance after the concern was repeated. Staff F stated if concerns were not resolved in a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Caroline Kline Galland Home		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 Seward Park Avenue South Seattle, WA 98118	

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reasonable amount of time staff should submit a grievance. Staff F did not define what a reasonable amount of time was. Staff F stated Resident 123 expressed concern about not wanting tomatoes due to their diagnosis of rheumatoid arthritis but understood the concern as Resident 123 did not want any residents with arthritis to receive tomatoes. Staff F stated the Director of Culinary explained to Resident 123 at that time they would have to change the whole facility menu and that was not possible. Staff F stated they did not accommodate Resident 123's preference for no tomatoes but should have. Staff H (Dietician) joined the interview and stated Resident 123 expressed a preference of no tomatoes in several conversations but did not express it as an allergy so it was not included in Resident 123's food profile but should be added as it was the residents' preference. Staff F stated the Administrator must attend Resident Council per new regulation.Reference: WAC 388-97-0920(1-6).

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review the facility failed to accurately assess 4 of 4 residents (Residents 59, 68, 123, & 186) reviewed for restraints. Failure to ensure resident assessments were completed accurately on the Minimum Data Set (MDS- an assessment tool) placed residents at risk for unidentified and/or unmet care needs, and diminished quality of life.Findings included.<Resident 59>According to the 11/20/2025 Quarterly MDS Resident 59 had no memory impairment. The MDS showed Resident 59 had diagnoses of autoimmune disorder and depression. The MDS showed no restraints used for Resident 59.During observations on 02/27/2026 at 11:37 AM and 03/03/2026 at 1:19 PM showed Resident 59 with a seat belt latched, holding them in their wheelchair.<Resident 68>According to the 02/02/2026 Quarterly MDS Resident 68 had no memory impairment. The MDS showed Resident 68 had diagnoses of spinal stenosis at the cervical region (narrowing of the spinal canal causing pain, numbness, and weakness), anxiety and depression. The MDS showed no restraints used for Resident 68.Observation on 03/03/2026 at 1:53 PM showed Resident 68 up in wheelchair with seat belt latched, holding them in the chair.<Resident 123>According to the 02/03/2026 Annual MDS Resident 123 had no memory impairment. The MDS showed Resident 123 had diagnoses of arthritis and below the knee amputation. The MDS showed no restraints used for Resident 123.Observation and interview on 03/02/2026 at 9:42 AM showed Resident 123 up in wheelchair with seat belt latched, holding them in. Resident 123 stated they received the wheelchair from the facility April 2025 with the seat belt already on it. In an interview at this time Resident 123 stated staff had not discussed the seat belt with them.<Resident 186>According to the 12/24/2025 Quarterly MDS Resident 186 had severe memory impairment. The MDS showed Resident 186 had diagnoses of dementia, below the knee amputation, diabetes (unstable blood sugar), and pressure sores. The MDS showed no restraints used for Resident 186.During an observation and interview on 03/03/2026 at 1:19 PM Resident 186 was up in wheelchair with seat belt latched, holding them in. Resident 186 stated staff assisted them in securing the seat belt and getting them into their wheelchair but had not discussed the seat belt with them.In an interview on 03/04/2026 at 8:12 AM Staff B (Director of Nursing) stated they expected staff to accurately complete assessments upon admission, quarterly, and as needed for seat belt use. Staff B stated they expected staff to accurately assess and identify restraints on the MDS. Staff B reviewed Residents 59, 68, 123, and 186 records and stated there was no documentation regarding the seat belt use for the residents. Staff B stated Residents 59, 68, 123, and 186 seat belts were not accurately assessed on their MDS's under restraints but should be.Refer to F656 Develop/Implement Comprehensive Care Plans.Refer to F689 Free of Accident Hazards/Supervision/Devices.Reference: WAC 388-97-1000(1)(b).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, and interview the facility failed to conduct resident and/or resident representative involved care conferences within seven days of each quarterly assessment for 4 of 7 residents (Residents 54, 68, 36, & 123) and failed to ensure resident Care Plans (CP) were updated as needed for 3 of 7 residents (Residents 190, 123 & 4) reviewed for care planning. These failures placed residents at risk for inconsistent and/or inadequate care and treatment, unmet care needs, unnecessary care, frustration, other negative health outcomes, and a diminished quality of care. Findings included .<Facility Policy>Review of the facility's 01/2025 policy titled, Care Plan Conference, showed residents and/or their representatives would be offered a care conference at the time of care plan review or as needed.Review of the facility's 04/2025 policy titled, Care Plans-Comprehensive Person-Centered showed that the facility would revise CPs as information about the resident's condition changed and would review the CP at least quarterly.

<Care Conference>

<Resident 54>

According to the 11/28/2025 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 54 admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis (degenerative brain disease), Neurogenic Bladder (loss of bladder control), and Functional Quadriplegia (paralysis). The MDS showed Resident 54 had an indwelling catheter.

In an interview on 02/25/2026 at 1:04 PM Resident 54 stated they did not remember if they ever had a care conference.

In an interview on 03/03/2026 at 1:13 PM Staff K (Director of Social Services) stated Resident 54 last had a care conference on 09/12/2025. Staff K stated they offered care conferences annually and as needed by resident request. Staff K was not able to find any other care conferences for Resident 54 in the last year.

<Resident 68>

According to the 02/02/2026 Quarterly MDS Resident 68 admitted to the facility on [DATE]. The MDS showed Resident 68 had no memory impairment.

Review of Resident 68's health records showed an 08/15/2025 care conference with no other care conferences offered or provided since. Resident 68's health records showed no documentation of care conference offered within seven days of each quarterly assessment.

In an interview on 02/25/2026 at 10:39 AM Resident 68 stated they hadn't had a care conference with their Interdisciplinary Team (IDT – social worker, nursing, rehab department, activities, and dietary department) for about ten months.

<Resident 36>

According to the 03/14/2025 Annual MDS Resident 36 admitted to the facility on [DATE]. The MDS
(continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed Resident 36 had no memory impairment. Review of resident 36's health records showed a 03/14/2025 social services progress note stated Resident 36's Power of Attorney (POA) declined attending a care conference at that time but may schedule at a later time to touch base with the care team. The 03/14/2025 social services progress note showed Resident 36 was able to participate in decision making for their own care. Resident 36's records showed no documentation of a care conference offered to Resident 36 within seven days of quarterly assessments. In an interview on 02/26/2026 at 10:49 AM Resident 36 stated they could not remember having a care conference or being offered one but would want one. <Resident 123> According to the 02/03/2026 Annual MDS Resident 123 admitted to the facility on [DATE]. The MDS showed Resident 123 had no memory impairment. In an interview on 02/26/2026 at 9:25 AM Resident 123 stated they did not remember having a care conference or staff offering them one with their care team. Review of Resident 123's health records showed a 02/03/2026 social services progress note that Resident 123 was offered a care conference for alternate placement options and Resident 123 declined. Resident 123's health records showed no documentation of care conferences offered within seven days of each quarterly assessment. In an interview on 03/03/2026 at 1:01 PM Staff K stated they expected care conferences to be offered and provided upon admission to the facility, annually, after a significant change, and if a resident requested one. Staff K stated the IDT attends care conferences which included nursing, social services, therapy (if the resident was receiving therapy services), provider, activities, and dietary. In an interview on 03/03/2026 at 1:07 PM Staff VV (Social Service Assistant) stated care conference should be upon admission to the facility, quarterly, with a significant change and as needed if the resident or representative requested one. Staff VV reviewed Resident 123's records and stated they were offered a care conference to discuss alternate placement on 02/03/2026. Staff VV stated a care conference should be offered to discuss all aspects of Resident 123's care and any concerns the resident would need to discuss, but it was only documented that staff offered a care conference for alternate placement. Staff VV stated no other care conferences were offered or provided to Resident 123 since 06/2025 but should be quarterly. Staff VV stated it was important to offer and provide care conferences to have the IDT available to answer questions, address concerns, and keep family informed on how the resident was doing. <CP Revision> <Resident 190> According to the 07/11/2025 Significant Change MDS Resident 190 admitted to the facility on [DATE] with diagnoses including Vascular Dementia (degenerative brain disease), Traumatic Brain Injury, and Atrial Fibrillation (abnormal heart rhythm). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a 02/19/2026 Progress Notes Resident 190 was removed from isolation precautions for an Influenza infection. Review of Resident 190's CP on 02/27/2026 showed the care plan for isolation precautions had not been resolved and updated. <Resident 123> Observations on 02/26/2026 at 9:40 AM and 03/02/2026 at 9:42 AM showed Resident 123 moving throughout the facility, in hallways and main dining room in their powered wheelchair. Resident 123's room did not show isolation precaution instructions and Resident 123 was not in isolation to their room. Review of Resident 123's health records showed a 02/17/2026 progress note discontinuing droplet precautions for the resident. Resident 123's revised on 02/18/2026 influenza CP showed an intervention to maintain strict Aerosol/Contact Precaution isolation and all services were to be provided in Resident 123's private room. In an interview on 03/03/2026 at 10:16 AM Staff C (Staff Development) and Staff J (Registered Nurse/Charge Nurse - CN) stated Resident 123 was not on aerosol/contact precautions since 02/17/2026 and was able to leave their room. Staff J stated the CP should be revised and updated upon discontinuation of the aerosol/contact precautions, but it was not. Staff J stated it was important to keep CP's up to date with Resident 123's current care so staff provided the care they needed and for quality of care. In an interview on 03/04/2026 at 8:12 AM Staff B (Director of Nursing) stated they expected CPs to be revised and updated to reflect resident's current care. Staff B reviewed Residents 190 and 123's CPs and stated they should be updated to reflect current resident status but was not. Staff B stated it was important to keep resident CPs up to date to ensure proper care and orders were being carried out. <Resident 4> According to the 12/01/2025 Significant Change MDS, Resident 4 had multiple trauma and fractures, heart failure, falls, and respiratory issues. The MDS showed Resident 4 had impairment with functional limitation in range of motion on right leg. The MDS showed Resident 4 required maximum assistance from staff with bed mobility and transfers and had no rejection of care during the assessment period. Review of Resident 4's February 2026 Physician Orders showed a 02/24/2026 order for Aerosol/Contact Precautions and directed staff to provide all care and services to Resident 4 in their private room during active infection (Specify symptoms or diagnosis.) There were no specific diagnosis or symptoms documented on the physician orders for Resident 4. Observations on 02/25/2026 at 8:57 AM and at 1:35 PM, and on 02/26/2026 at 9:31 AM and 12:17 PM showed an Aerosol/Contact Precautions sign was posted outside Resident 4's room and instructed staff to wear gown, face mask, eye wear, and gloves before going into Resident 4's room. These observations showed Resident 4 was lying in their bed. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/25/2026 at 1:35 PM, Resident 4 stated they only cough at times and did not understand why they were on isolation precautions. Observation on 02/27/2026 at 8:51 AM showed Resident 4 was lying in their bed and there was no more Aerosol/Contact Precaution sign posted outside Resident 4's room. In an interview on 02/27/2026 at 10:21 AM, Resident 4 stated they were very happy because they were not on isolation precautions anymore. Resident 4 stated they could open the door now and see outside in the hallways. On 03/03/2026 at 10:33 AM, a review of the 02/25/2026 revised CP showed Resident 4 was on droplet precautions related to cough and shortness of breath. In an interview on 03/03/2026 at 12:16 PM, Staff P (CN) stated staff should clarify with the provider about diagnoses for the precautions on Resident 4's physician orders. Staff P stated Resident 4 was not on isolation precautions anymore and the CP was not updated. Staff P stated CPs should be accurate and revised timely so staff could provide better care for residents. Reference: WAC 388-97-1020(2)(c)(d), (4)(b)(c)(i-ii)(f), (5)(b).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the following: appropriate delegation of nursing tasks to nonˆlicensed staff; preparation and administration of insulin in accordance with manufacturer instructions; clarification and following of physician orders; and accurate documentation of nursing tasks for 5 of 35 sampled residents (Residents 218, 7, 8, 205, and 206) and 3 supplemental residents (Residents 225, 226, and 171). These failures placed residents at risk for medication errors, delayed treatment, and adverse outcomes.Findings included .<Improper Delegation of Nursing Tasks> <Resident 225> Review of Resident 225's June 2025 Medication Administration Record (MAR) showed a 06/25/2025 physician order to start a chemotherapy drug (strong medication to damage cancer cells and prevent its growth) once a day on Monday, Tuesday, Wednesday and Thursday each week. Review of Resident 225's June and July 2025 MAR showed the following staff administered the chemotherapy drug: Staff QQ (Medication Assistant - Certified (MA-C) on 06/25/2025, 06/26/2025, 06/27/2025, 07/04/2025, 07/05/2025, and 07/06/2025. Staff PP (MA-C) on 07/02/2025. Staff NN (MA-C) on 07/03/2025 Staff RR (MA-C) on 07/07/2025 and 07/08/2025. <Resident 218> Review of Resident 218's October 2025 MAR showed a 10/08/2025 physician order to start a chemotherapy drug once a day. Review of Resident 218's October 2025 MAR showed Staff QQ gave Resident 218 the chemotherapy drug on 10/08/2025, 10/09/2025, 10/13/2025, 10/14/2025, 10/15/2025, 10/16/2025, 10/20/2025, 10/21/2025, 10/22/2025, and 10/23/2025. <Resident 226> Review of Resident 226's December 2025 MAR showed a 12/10/2025 physician order to start a chemotherapy drug twice a day. Review of Resident 225's December 2025 and January 2026 MARs showed the following staff administered the chemotherapy drug: Staff TT (MA-C) on 12/11/2025, 12/15/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/23/2025, 12/25/2025, 12/26/2025, and 12/29/2025. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff OO (MA-C) on 12/13/2025, 12/16/2025, 12/17/2025, 12/27/2025, 12/30/2025, 12/31/2025, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/10/2026, 01/12/2026, 01/13/2026, 01/14/2026, 01/16/2026, 01/18/2026, and 01/19/2026. Staff PP on 12/12/2025, 12/14/2025, 12/28/2025, 01/09/2026, 01/11/2026 and 01/15/2026. Staff RR on 12/22/2025 and 12/24/2025. Staff NN on 01/01/2026. <Resident 171> According to the 12/19/2025 Quarterly Minimum Data Set (MDS – an assessment tool), Resident 171 admitted to the facility on [DATE] and had medically complex diagnoses including prostate cancer (abnormal cell growth inside a male reproductive gland). Review of Resident 171's order summary showed a 05/20/2023 physician order to start a hormone therapy drug to be administered once a day to treat cancer. Review of the February 2026 MAR showed Staff SS (MA-C) gave Resident 171 the drug each day for a total of 22 doses between 02/01/2026 and 02/28/2026. In an interview on 02/27/2026 at 8:44 AM, Staff SS (MA-C) stated they gave the drug to Resident 171 each morning before breakfast for two to three years. Staff SS stated they were aware administration of the drug required special handling including wearing gloves and ensuring the tablets were not broken. Staff SS stated the drug could cause harm to unborn children. In an interview and record review on 03/03/2026 at 10:10 AM, Staff C (Staff Development) provided a copy of the facility's undated Hazardous Drug Handling education module. Staff C stated all licensed nurses completed the training. Review of the course material directed nurses not to allow MA-C's to administer chemotherapy drugs of any kind. In an interview and record review on 03/03/2026 at 10:15 AM, Staff B (Director of Nursing Services) stated the facility used the National Institute for Occupational Safety and Health (NIOSH) List of Hazardous Drugs in Healthcare Settings, 2024 to identify drugs inappropriate for administration by non-licensed nursing staff. Staff B reviewed the records for Resident 226, 218, 225, and 171. Staff B confirmed MA-C's had administered chemotherapy drugs but should not have. Staff B stated the handling of chemotherapy drugs by non-licensed nursing staff could harm staff and residents. Review of the NIOSH List of Hazardous Drugs in Healthcare Settings, 2014 showed the chemotherapy drugs given by MAˆC's to Residents 218 and 225 were listed in Tableˆ1 meaning they could cause cancer in humans and required special handling. The NIOSH list showed the drugs given by MAˆC's to Residents 226 and 171 were listed in Tableˆ2 meaning they could be harmful and cause developmental or reproductive harm. In an interview on 03/04/2026 at 1:35 PM, Staff A (Administrator) stated they expected staff to follow facility training as well as state and federal regulations. <Clarifying/Following Physician Orders> (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 7> According to the 01/09/2026 Annual MDS, Resident 7 admitted to the facility on [DATE] with multiple medically complex conditions including cancer, kidney failure, and lymphedema (chronic swelling in arms or legs due to buildup of lymph fluid related to damaged lymphatic system). Review of Resident 7's February 2026 MAR showed a 09/04/2025 order directing staff to elevate Resident 7's legs while in bed. An additional 09/04/2026 order directed staff to keep quarter side rails up for self-bed mobility. A 10/07/2025 order directed staff to ensure Resident 7 always had shoes on when they were in their wheelchair. The facility staff documented daily on the MAR showing they completed these tasks as ordered. Observations on 02/25/2026 at 11:02 AM, on 02/26/2026 at 1:22 PM, on 03/02/2026 at 9:23 AM showed Resident 7 sat in a recliner in their room and had no bed in their room. These observations showed Resident 7 never had shoes on and Resident 7 stated they could not wear shoes because their feet were very swollen. Resident 7 stated they did not have a bed in their room because they liked to be in a recliner. In an interview on 03/02/2026 at 9:42 AM, Staff P (Charge Nurse) stated Resident 7 did not have a bed in their room per their preference. Staff P reviewed Resident 7's MAR and stated staff should clarify the orders with the provider and discontinue the bed orders. Staff P stated the facility staff should not sign the tasks they did not complete. Staff P stated staff should talk to the resident about not wearing shoes as ordered, document the refusals in Resident 7's record, and notify the provider. In an interview on 03/02/2026 at 10:30 AM, Staff B stated it was their expectation nursing staff clarified the orders with the provider as needed and follow the orders. Staff B stated staff should not sign the tasks they did not complete. <Resident 8> According to the 12/14/2025 Quarterly MDS, Resident 8 was cognitively intact with clear speech, able to make themselves understood, and understand others. The MDS showed Resident 8 received antipsychotic, antidepressant, and pain medications and had no rejection of care during the assessment period. Review of Resident 8's February 2026 physician orders showed an 11/04/2025 order for staff to administer antidepressant medication twice daily for an anxiety disorder and major depressive disorder. Review of Resident 8's record showed Resident 8 signed the consent on 05/20/2024 and again on 06/02/2024 for the antidepressant medication used for pain. Review of an 11/06/2024 provider's progress note showed Resident 8 received the antidepressant medication for chronic pain. In an interview on 03/02/2026 at 10:35 AM, Staff B reviewed Resident 8's record and stated Resident 8 received antidepressant medication for pain. Staff B discussed Resident 8's consent record with Staff Y and stated there was no other consent signed after 06/24/2024. Staff B stated staff should clarify the order with the provider and fix the diagnosis, but they did not. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Caroline Kline Galland Home		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 Seward Park Avenue South Seattle, WA 98118	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<Resident 205> According to the 02/17/2026 admission MDS, Resident 205 had diagnoses including arthritis and low back pain. The MDS showed Resident 205 had almost constant pain frequently affecting their sleep, with an intensity of up to nine on a pain scale of zero to 10, with 10 being the most severe pain. The MDS showed Resident 205 took scheduled and as-needed pain medications, including opioid pain medications and had no cognitive deficits. Review of the February 2026 MAR showed Resident had two different as-needed pain medications: a 02/12/2026 order for a non-opioid pain medication to be administered every eight hours as needed for a pain level between one and six on the zero-to-10 pain scale, and a 02/13/2026 order for an opioid pain medication to be administered every four hours as needed for a pain level between seven and 10. This MAR showed on 02/16/2026 the medication was given for a pain level of five out of 10, and on 02/19/2026, 02/23/2026, and 02/25/2026 for a pain level of six out of 10. In an interview on 03/04/2026 8:37 AM, Staff BB (Assistant Director of Nursing Services, Transitional Care Unit Manager) stated because Resident 205 was alert and oriented, they had the right to request an opioid pain medication outside the parameters ordered by the physician. In an interview on 03/04/2026 11:45 AM, Staff B stated staff should follow the physician's orders and only give medicines according to the parameters listed on the order. Staff B reviewed Resident 205's February 2026 MAR and acknowledged they were given their opioid pain medication outside the physician's parameters. <Insulin Administration> <Resident 206> Review of a July 2023 manufacturer's Instructions for Use of a prefilled insulin pen showed directions to prime (remove the air from the needle and cartridge and ensure the insulin pen was working correctly) before each use. Failure to prime the pen could cause a resident to get too much or too little insulin. Steps for priming the pen included setting the dose to two units (international units – a measurement used for insulin dosing), holding the pen upright, tapping the cartridge to remove air bubbles, and pressing and holding the dose knob (a button at the top of the pen to release the dose) to a slow count of five. Priming should result in insulin being visible at the tip of the needle. Steps to administer the insulin injection included inserting the needle into the skin, pushing the dose knob all the way in, continuing to hold the dose knob in and slowly counting to five before withdrawing the needle. Observation on 02/27/2026 at 12:28 PM showed Staff L (Registered Nurse) preparing Resident 206's insulin pen for administration. Staff L did not prime the insulin pen prior to administration. Staff L inserted the insulin pen needle into Resident 206's skin, pressed and immediately released the dose knob, and held the needle in the skin for a count of five before withdrawing the needle. Observation on 03/04/2026 at 9:49 AM showed Staff M (Registered Nurse) preparing Resident 206's insulin pen for administration. Staff M primed the pen with 0.5 units (international units - a measurement used for insulin dosing) of insulin while holding the pen horizontally. Observation did not show evidence of any insulin ejected from the needle. Staff M removed the needle from the pen and attached a new needle. Staff M proceeded to administer the ordered insulin dose to Resident 206. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/04/2026 at 10:41 AM, Staff C stated they expected nurses to prime insulin pens with two units of insulin prior to each administration and to hold the dose knob down for five-to-ten seconds during injection before withdrawing the needle, to ensure the resident received the correct dose of insulin. REFERENCE: WAC 246-841-589(3)(b), (6)(e), WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i).

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review the facility failed to ensure residents were provided meaningful, life enriching activities for 4 of 4 residents (Residents 213, 215, 217, & 212) reviewed for activities. This failure placed residents at risk for boredom and a diminished quality of life. Findings included <Facility Policy>According to the facility's December 2025 Activity Policy and Procedure, upon admission to the facility, residents would be asked if they wanted to engage in activity while on the rehabilitation or not, and ask what the resident's interest were. The policy showed when residents moved from the Transitional Care unit to a Long Term Care unit, facility staff would complete an initial activity assessment, after which a Care Plan (CP) would be developed. The policy showed staff would document activity participation, goals, and interventions in the CP, quarterly activity notes, quarterly Minimum Data Set (MDS - an assessment tool) preference reviews, and as needed. The policy showed when a resident exercised their right to refuse to participate, it would be reflected in the record.<Resident 213> According to a 02/22/2026 admission Minimum Data Set (MDS - an assessment tool) Resident 213 had a debilitating condition including fractures and heart failure. The MDS showed it was important for Resident 213 to listen to music, have books or newspapers to read and keep up with the news. Review of the 02/18/2026 Activity Deficit and Social Isolation Potential Related to Weakness CP showed staff were to monitor Resident 213's ability to continue with self-directed activities. In an interview and observation on 02/27/2026 at 9:03 AM, Resident 213 stated they needed help with reaching their remote control to turn their television (TV) on and no one came to assist them with turning the TV on. In an interview on 03/02/2026 at 8:55 AM, Resident 213 stated they did not have any activities to do. Observed at the time showed the room did not have their TV on and did not have any books or magazines to read. In an interview on 03/03/2026 at 10:32 AM, Staff G (Activities Director) stated staff should assess residents' activity needs and incorporate residents' interests into their activity CPs. Staff G stated if Resident 213 liked books, the facility had a library, and books could be delivered to bedbound residents. Staff G stated it was important to give Resident 213 activities to foster a sense of belonging and being cared for and to provide an escape for the resident. <Resident 215> According to a 02/06/2026 admission MDS, Resident 215 had a history of fractures, end stage renal (kidney) disease and a neurological condition. The MDS showed Resident 215 had interest in keeping up with the news. Review of the 02/02/2026 Activity Deficit and Social Isolation Potential CP showed the goal was for Resident 215 to express satisfaction with activities both verbally and non-verbally and for staff to monitor for satisfaction through verbal check-ins, observations of body language, facial expressions, positive physical gestures, and vocalizations. Review of the 02/02/2028 and 02/28/2026 activity assessments showed Resident 213 enjoyed watching football. The assessments showed Resident 215 told staff unless they could watch (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	something with comedy, they would be depressed. In an observation and interview on 02/27/2026 at 8:50 AM Resident 215 stated they used their phone to keep busy. Observation at the time showed there was no TV in Resident 215's room and no other activities materials such as books, magazines, or activity supplies for Resident 215 to keep busy with. In an observation and interview on 02/27/2026 at 12:07 PM, Resident 215 stated they needed help using their cellphone when they wanted to listen to something. Observation at the time showed there was no TV in the resident's room, the room was dimly lit, and the blinds were closed. In an interview on 03/02/2026 at 9:34 AM Resident 215 stated they wanted to watch TV. In an observation and interview on 03/02/2026 at 1:46 PM, Resident 215 was observed to scroll through their cellphone and stated at least they had their phone to keep them busy. Observation at the time showed there was no TV in Resident 215's room. In an interview on 03/03/2026 at 10:32 AM Staff G stated for residents who were bed-bound the facility provided one-on-one activities and music. Staff G stated it was important for Resident 215 to have a TV in their room as it was important for maintaining independence and ownership of activities. Staff G was not aware Resident 215 did not have a TV in their room and stated all residents should be provided a TV. In an interview on 03/04/2026 at 10:09 AM Staff B (Director of Nursing) stated Resident 215 should have had a TV in their room for comfort and choice. Staff B stated they were not aware Resident 215 did not have a TV and stated it was standard to have a TV in each room and staff should have reported this to maintenance but did not. <Resident 217> According to the 02/04/2026 admission MDS, Resident 217 had minimal difficulty with hearing, clear speech, understood, and could understand others. This assessment showed Resident 217 required substantial/maximal assistance from staff with bed mobility and transferring to and from their bed to the wheelchair. The MDS showed Resident 217 had cognitive impairment and their favorite activities included listening to music and keeping up with the news. The MDS showed it was very important to Resident 17 to participate in their favorite activities. Review of the 02/04/2026 revised Activity deficit and social isolation. CP showed a goal for Resident 217 to engage in opportunities to listen to music and showed live music occurred on the resident's unit. The CP directed staff to invite the resident to live music opportunities and to take Resident 217 on walks outside for fresh air. Review of a 02/17/2026 Initial Activity Assessment progress note showed Resident 17 preferred spending time with their family and listening to music. The assessment showed Resident 217 had a physical impairment and needed staff invitations/reminders for activities and to be escorted by staff to activities. In an observation and interview on 02/25/2026 at 10:33 AM, Resident 217 was lying in bed and stated they were unaware of the activities the facility offered. Resident 17 stated they felt like they only (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stayed in bed, and did not talk to anyone except the medication nurse. Resident 217 stated they would like to go to activities. Observation on 02/27/2026 at 8:35 AM showed Resident 217 sitting in their wheelchair, watching television, Resident 217 asked when they could go home. Observations on 03/02/2026 at 9:39 AM and on 03/03/2026 at 10:34 AM, Resident 217 stated they were bored. An observation on 03/04/2026 at 9:37 AM showed the activities calendar on the resident's window bench, outside of the resident's reach. Review of Resident 217's February 2026 task documentation records and February 2026 progress notes showed no activity documentation. These records did not show staff offered/invited the resident to activities or if Resident 217 participated in or declined activities. In an interview on 03/04/2026 at 10:51 AM, Staff WW (Certified Nursing Assistant) stated group activities did not occur downstairs on the Transitional Care Unit where Resident 217 resided. Staff WW stated staff gave residents the activity calendar and staff would assist residents upstairs for activities if a resident wanted to go. In an interview on 03/04/2026 at 11:51 AM, Staff XX (Transitional Care Unit Discharge Planner) stated Resident 217 only expressed interest in music. Staff XX stated there was a recent live music event on the unit that Resident 217 did not attend. Staff XX stated it was not staff practice to document resident participation in activities, but documenting would be important. <Resident 212> According to the 12/25/2025 admission MDS, Resident 212 had clear speech, adequate vision with glasses, and could be understood and could understand others in conversation. The MDS showed Resident 212 had a mild cognitive impairment and was unable to transfer out of bed during the assessment look-back period due to medical conditions. The MDS showed it was very important for Resident 212 to keep up with the news, do their favorite activities, and go outside for fresh air when the weather was good. The MDS showed Resident 212 needed tube feeding to meet their nutritional needs. Review of the 12/22/2025 Initial Activity Assessment showed Resident 212 preferred independent activities, and their favorite activity was spending time outdoors in nature. The assessment showed Resident 212 needed assistance to get out of bed. Review of the 12/26/2025 Activity deficit and social isolation potential related to desire to focus on therapies during stay . CP showed Resident 212's goals were to engage in individual activities in room (listening to the local news) and for their activity engagement to be person-centered. This CP included interventions including encouraging family/friend visits, taking Resident 212 for a short walk or ride outside building for fresh air, and monitoring Resident 212's ability to continue with self-directed activities. Review of the 01/27/2026 Initial Activity Assessment showed Resident 212 sometimes enjoyed classical and instrumental music, and their favorite activity was being outdoors in nature. The (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment showed Resident 212 needed prompts and assistance to participate in activities. Review of the activities social services department progress notes showed no notes discussing Resident 212's participation in, interest in, requests for, or refusals of activities except a 12/25/2025 note describing the 12/22/2025 Initial Activity Assessment, and a 01/27/2026 note describing the 01/27/2026 Initial Activity Assessment. In an interview on 02/26/2026 at 9:34 AM, Resident 212 stated they had a concern that they did not have anyone to talk to except when care was provided. Resident 212 stated they got help when they used their call bell but interactions were limited to care provision and exercise times. Resident 212 stated they got bored and stated all television channels available were garbage. Resident 212 stated they were given a weekly activity calendar, but staff never offered to either take them to an activity, take them outside when the weather was good, or bring them something to keep them occupied in their room. Observation of Resident 212's room (located in the 100 Transitional Care Unit - TCU) at the time showed no reading materials available in the room. In an interview on 03/02/2026 at 8:41 AM, Resident 212 expressed frustration that they had a Compact Disc (CD) player but only had a few CDs that they were bored with. Resident 212 expressed frustration that the CD player cord was too short and could not use it while in bed (which was over 16 hours a day while they received their tube feeding). Observation at this time showed a CD player in the windowsill with a cord that did not allow the CD player to be used from the bed. Observation on 03/03/2026 at 10:29 AM showed Resident 212 lying down in bed, awake with no stimulus. Resident 212's CD player was on the windowsill, out of reach. In an interview on 03/04/2026 10:14 AM, Staff F (Assistant Administrator) stated the facility's Activity Director provided group activities on the 300 level of the building and did not document what activities they provided to which residents due to the size of the building. Staff F stated the social services department oversaw the provision of activities for the Transitional Care Units. Staff F stated they monitored residents for changes and would implement changes to their activity CP, if the change lasted. Staff F stated activities participation might be documented in social services progress notes. Staff F stated refusals should be documented but the facility did not document each instance an activity was provided. At that time Staff FF (Assistant Director of Social Work, Transitional Care Unit) stated that while the courtyard nearest Resident 212's room was not available for resident use at that time, there were several other courtyards that would be appropriate for Resident 212 to enjoy getting some fresh air. Staff FF stated Resident 212's walking/exercise program was included on Resident 212's Activity CP but did not know if the resident found this to be a leisure activity, or not. REFERENCE: WAC 388-97-0940(1)(2).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to obtain provider orders, complete safety assessments, and obtain consents for the use of seatbelts for 4 of 4 residents (Residents 59, 68, 123, & 186) reviewed for the use of physical restraints. This failure placed the residents at risk of injury, unmet needs, and diminished quality of life.Findings included.<Policy>According to the facility policy titled, Restraint Free Environment, dated 04/2025, the facility was responsible for the appropriateness of the determination to use a physical restraint. The policy defined a seat belt in a chair, that prevented the resident from rising, was a physical restraint. The policy showed before a resident was physically restrained, the facility would determine the presence of a specific medical symptom that would require the use of the restraint. The policy showed the facility would document how the restraint would treat the medical symptom(s), the length of time the restraint was anticipated to be used, who may apply the restraint, the time and frequency the restraint would be released, determine the type of direct monitoring and supervision that would be provided during the use of the restraint, and obtain a provider order for the restraint. The policy showed the facility would document less restrictive alternatives were attempted but were ineffective, ongoing safety assessments, the Care Plan (CP) would be updated to reflect the use of the restraint, and the facility would obtain resident/representative consent for the use of the physical restraint.<Resident 59>According to the 11/20/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 59 had no memory impairment. The MDS showed Resident 59 had diagnoses of autoimmune disorder and depression. The MDS showed no restraints used for Resident 59.Review of Resident 59's health records on 03/03/2026 showed no documentation of a seatbelt to their wheelchair including no safety assessments, no consent, and no physician order for the seat belt.During observations on 02/27/2026 at 11:37 AM and 03/03/2026 at 1:19 PM showed Resident 59 with a seat belt latched, holding them in their wheelchair.In an interview on 03/03/2026 at 1:19 PM Resident 59 stated they had the powered wheelchair for about four years and it came with the seat belt attached at the time they received the chair from the facility. Resident 59 stated staff had not discussed the seat belt with them.<Resident 68>According to the 02/02/2026 Quarterly MDS Resident 68 had no memory impairment. The MDS showed Resident 68 had diagnoses of spinal stenosis at the cervical region (narrowing of the spinal canal causing pain, numbness, and weakness), anxiety and depression. The MDS showed no restraints used for Resident 68.In an interview on 02/27/2026 at 10:57 AM Resident 68 stated they were unable to use or move their left arm and hand at all and only had use of their right arm. Resident 68 stated they depended on staff to transfer and position them in their wheelchair.Review of Resident 68's health records on 03/03/2026 showed no documentation of a seatbelt to their wheelchair including no safety assessments, no consent, and no physician order for the seat belt.Observation on 03/03/2026 at 1:53 PM showed Resident 68 up in wheelchair with seat belt latched, holding them in the chair.<Resident 123>According to the 02/03/2026 Annual MDS Resident 123 had no memory impairment. The MDS showed Resident 123 had diagnoses of arthritis and below the knee amputation. The MDS showed no restraints used for Resident 123.Review of Resident 123's health records on 03/03/2026 showed no documentation of a seatbelt to their wheelchair including no safety assessments, no consent, and no physician order for the seat belt.Observation and interview on 03/02/2026 at 9:42 AM showed Resident 123 up in wheelchair with seat belt latched, holding them in. Resident 123 stated they received the wheelchair from the facility April 2025 with the seat belt already on it. In an interview at this time Resident 123 stated staff had not discussed the seat belt with them.<Resident 186>According to the 12/24/2025 Quarterly MDS Resident 186 had severe memory impairment. The MDS showed Resident 186 had diagnoses of dementia, below the knee amputation, diabetes (unstable blood sugar), and pressure sores. The MDS showed no restraints used for Resident 186.Review of Resident 186's health records on 03/03/2026 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed no documentation of a seatbelt to their wheelchair including no safety assessments, no consent, and no physician order for the seat belt.During an observation and interview on 03/03/2026 at 1:19 PM Resident 186 was up in wheelchair with seat belt latched, holding them in. Resident 186 stated staff assisted them in securing the seat belt and getting them into their wheelchair but had not discussed the seat belt with them.In an interview on 03/04/2026 at 8:12 AM Staff B (Director of Nursing) stated they expected staff to complete safety assessments upon initiation and then quarterly and as needed for seat belt use. Staff B stated they expected staff to obtain a physician order for seat belt use, obtain consent from the resident, update the Care Plan, and include on the MDS. Staff B reviewed Residents 59, 68, 123, and 186 records and stated there was no documentation regarding the seat belt use for the residents. Staff B reviewed Residents 59, 68, 123, and 186 therapy notes and found no documentation regarding seat belts. Staff B stated Residents 59, 68, 123, and 186 did not have physician orders, consents, safety assessments, and the seat belts were not coded on their MDS's but should be.Refer to F641 Accuracy of Assessments.Refer to F656 Develop/Implement Comprehensive Care Plans.Reference: WAC 388-97-1060(3)(g).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were provided the portion size they were assessed to require for 2 (Residents 7 & 17) of 36 sample residents reviewed and 4 supplementary residents (Residents 224, 22, 202, and 223). This failure placed residents at risk for hunger and weight loss. Findings included. <Facility Policy>According to the facility's revised 02/2026 Nutrition Assessment Policy, within 14 days of admission, the facility would complete a nutritional assessment and implement nutritional interventions as needed with the purpose of restoring or optimizing the resident's nutritional health. <Tray Line/Meal Service>Review of the schedule menu for 03/02/2026 showed the regular entree served that lunch was penne pasta with [NAME] sauce. The menu showed residents who required a mechanically soft altered texture entree would be provided with a mechanically softened version of the same meal. The menu did not show what size portion to provide.Observation of the tray line for lunch service on 03/02/2026 11:04 AM showed Staff O (Cook) preparing to serve entrees onto plates while other culinary services staff were preparing to assemble the other components of each resident's lunch. The main entree that day was penne pasta in a [NAME] sauce. The food to be served was laid out on a steam table to maintain temperature. There was a pan containing regular penne pasta with [NAME] sauce that had a gray scoop for portioning. The mechanically soft pan had the same meal with macaroni used as a substitute for the penne pasta and had a green scoop for portioning.On 03/02/2026 at 11:15 AM the dietary team began putting together lunch trays for the residents. Observation at that time showed the portion size listed for both the regular and mechanically altered entrees was nine ounces on the tray ticket. Observation showed Resident 7, Resident 17, Resident 224, Resident 22, Resident 202, and Resident 223 had tickets indicating they required a nine-ounce serving of the mechanically softened texture preparation of the meal. Resident 7, Resident 17, Resident 224, Resident 22, Resident 202, and Resident 223 and all other residents who were assessed to require a mechanically altered texture meal were served their portion with the green scoop.In an interview on 03/03/2026 at 9:35 AM, Staff T (Dietary Services Manager) stated the dietary staff should follow the orders on residents' tray tickets to ensure they were provided with the nutrition they were assessed to require. Staff T stated the blue scoop used for the mechanically altered texture meals was not the correct size for a nine-ounce portion. Staff T stated the correct serving tools should be used so the portion sizes listed on the residents' tray tickets could be provided but were not and this prevented residents from receiving the correct portions.In an interview on 03/03/2026 10:10 AM, Staff H (Dietician) stated they were not sure which colored scoops represented what portion sizes but stated it was important for residents to be given the size portion they were assessed to require.REFERENCE: WAC 388-97-1160(1)(a)(b).

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NAME OF PROVIDER OR SUPPLIER Caroline Kline Galland Home		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 Seward Park Avenue South Seattle, WA 98118	

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure meals were prepared in sanitary conditions for 1 of 1 main kitchens reviewed, failed to ensure food was reheated in unit kitchens on 2 of 5 units (100 East unit and 200 East unit), and failed to reheat lunch meals for 1 of 2 (Resident 213) resident's that required feeding assistance. These failures placed residents at risk for eating contaminated or unsafe food, foodborne illnesses and food not palatable according to resident's preferences.Findings included .According to the facility's 02/15/2023 Food Safety Requirements policy, food safety practices would be followed throughout the facility, including employee hygienic practices. The policy showed staff would wash their hands according to facility practices and when previously cooked foods were reheated, staff must ensure a temperature of 165 degrees Fahrenheit (F) was reached.<Food temperature> According to a 02/22/2026 admission Minimum Data Set (MDS-an assessment tool), Resident 213 received palliative care (end of life care) and had a debilitating fracture, malnutrition and heart failure. The MDS showed sometimes Resident 213 could be understood or understood by others. Observation and interview on 02/25/2026 at 12:18 PM Resident 213 stated they did not really care for the food at the facility, and the food was usually dry. Observation on 02/27/2026 at 12:15 PM showed Resident 213 stated they were hungry. Observation showed their lunch tray was on the bedside table across the room. Resident 213 stated they were hungry but could not reach their food as their food was left on the other side of the room and covered with a napkin. Observation on 02/27/2026 at 12:33 PM showed staff arrived to assist Resident 213 with their food, asked Resident 213 if they were hungry, and left the room. Observation on 02/27/2026 at 12:52 PM showed caregiver asked Resident 213 if they needed juice before eating, left to obtain juice, and then began to assist Resident 213 with eating after initial observation 40 minutes prior. In an observation and interview on 02/27/2026 at 12:54 PM Staff KK (CNA) stated staff were to put resident's food trays in the room after it was delivered to the unit. Staff KK stated staff then return to residents who were bed-bound and needed feeding assistance after the residents who had one-on-one feeding in the dining room were fed first. Staff KK stated sometimes they put the time on the meal ticket of when the food was placed in their room. Staff KK stated lunch arrived at 11:30 AM and staff were told they were allowed to leave the food out for up to one hour before it needed to be served. Staff KK stated if a resident wanted their food reheated, they could request it at any time. Observation showed Resident 213's meal tray ticket did not have time when their food was delivered to their room. In an interview on 02/27/2026 at 1:01 PM, Staff LL (CNA) stated residents who need feeding assistance and were bed-bound were fed after everyone else was fed first. Staff LL stated they were unsure of how long it took for residents to get fed in their room because it depended on how many residents needed feeding assistance in the dining room. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/27/2026 at 1:07 PM, Staff II (Primary Registered Nurse) stated for residents that needed feeding assistance, the staff should not take the food off the food cart until it's ready to be eaten so food would not get exposed. Staff MM stated the staff fed those that can be brought to the dining room first and then they fed the residents bed-bound in their rooms. Staff MM stated sometimes it could be up to two hours before the food was served to residents once food was brought to the unit. Staff MM stated it was important for dignity and food safety for food to be served at appropriate food temperatures. In an interview on 03/03/2026 at 12:09 PM, Staff H (Dietician) stated food should be served within safety guidelines. Staff H stated for palatability, if food was left out of the food cart, staff should rewarm resident's food before serving. In an interview on 03/04/2026 at 10:33 AM, Staff B (Director of Nursing) stated if a resident was bed-bound, the staff should be educated on not leaving the meal tray in residents' rooms and then serving it without rewarming the food first. Staff B stated food should be warm before feeding residents and all residents had the right to receive food at a warm temperature. <Lunch Preparation> Observation of lunch preparation on 03/02/2026 at 10:06 AM showed Staff O (Cook) preparing [NAME] sauce. Staff O stirred ground meat in in a large skillet with a large spatula while wearing gloves. Staff O stopped stirring and handled some square containers with red lids and took some pots and pans to the dishwasher area. Staff O then removed their gloves and put on a new pair of gloves without washing their hands. After moving a tray, Staff O then changed gloves again and placed a large square pan on a cart and returned to stirring the sauce with the same gloved hands. Staff O then placed a pot on the cart and changed their gloves without washing their hands. Staff O then moved the cart with the pan closer to the skillet with the same gloves and placed some cooked penne pasta in the pan. Staff O still did not wash their hands, and with the same gloves ladled the sauce from the skillet into the holding pan and took a lid for the pan from a rack. At 10:12 AM Staff O with the same gloves and without washing their hands put the pot in sink, picked up some aluminum foil, covered the pan, and moved the cart away. At 10:14 AM Staff O removed the gloves, lifted the black lid of a yellow garbage can and then wiped their hands with paper towels and put on new gloves and then oven gloves. Staff O did not wash their hands. <Unit Kitchens> <100 East Unit Kitchen> Observation of the 100 East unit kitchen on 02/27/2026 at 11:51 AM showed a microwave oven was located on the counter. Above this microwave oven was a sign above the microwave directing all staff and visitors to ensure all food reheated for residents reached 165 F and to sanitize the thermometer. There was no thermometer or anything with which to sanitize a thermometer available in the unit kitchen Observation on 03/02/2026 1:46 PM showed there was still no thermometer available. (continued on next page)

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	505442	A. Building B. Wing	03/04/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 03/03/2026 at 12:23 PM showed there was still no thermometer available. In an interview on 03/03/2026 at 12:27 PM Staff Q (Certified Nursing Assistant – CNA) looked for a thermometer by the microwave oven and stated a thermometer was at one time available on top of the microwave oven but they could not find it. At that time, Staff S (Charge Nurse, Registered Nurse) stated there should be a thermometer by the microwave oven at all times. <200 East Unit Kitchen> Observation on 03/03/2026 12:34 PM of the 200 East unit kitchen near room [ROOM NUMBER] showed Staff R (CNA) reheating a resident's meal in the microwave oven on the counter. There was a sign above the microwave directing all staff and visitors to ensure all food reheated for residents reached 165 F. Staff R did not use the thermometer stored on the side of the microwave to ensure the meal was reheated as directed by the sign and told a nurse the food was for a resident. In an interview at that time, Staff YY (Unit Clerk, Registered Nurse) stated the nursing aide should have followed the reheating directions but did not. In an interview on 03/03/2026 at 9:35 AM, Staff T (Director of Culinary Services) stated the facility nursing department was responsible for overseeing the unit kitchens. Staff T stated washing hands was an important step in food preparation. Staff T stated they expected cooks to wash their hands whenever they were soiled and with glove changes. REFERENCE: WAC 388-97-1100(3), -2980.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to allow 3 (Residents 8, 186, & 123) of 6 residents reviewed for choices, the right to make choices regarding important daily routines including accommodating preferences for the frequency and/or type of bathing and food choices. The facility's failure to accommodate resident choice placed these residents at risk for a diminished quality of life.Findings included .<Bathing> <Resident 8> According to the 12/14/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 8 was cognitively intact with clear speech, able to make self-understood, and understood others. This MDS showed Resident 8 was dependent on staff for shower/bathing needs. According to the revised 12/10/2025 Activities of Daily Living (ADL), Care Plan (CP) Resident 8 required one-person substantial assistance from staff with a weekly shower. In an interview on 02/26/2026 at 10:47 AM, Resident 8 stated the facility staff did not give them a choice how often to shower. Resident 8 stated staff told residents they could receive only one shower every week. Resident 8 stated they would like to shower twice a week. Review of Resident 8's February 2026 bathing records showed Resident 8 received only one shower on 02/27/2026 and no bed bath documented in 28 days. <Resident 186> According to the 01/20/2026 Medicare 5 Day MDS, Resident 186 was cognitively intact with clear speech, able to make self-understood, and understood others. This MDS showed Resident 186 had an impairment in functional range of motion in both their legs. The MDS showed Resident 186 was dependent on staff for shower/bathing needs and had no rejection of care during this assessment period. According to the revised 08/15/2025 ADL CP, Resident 186 required total assistance with bathing from staff. In an interview on 02/26/2026 at 8:57 AM, Resident 186 stated the facility staff did not give them choices how often the resident wanted to take shower. Resident 186 stated they wanted to take shower twice a week, but the facility only provides once a week. Review of Resident 186's February 2026 bathing records showed Resident 186 received three showers in 28 days. In an interview on 03/03/2026 at 8:54 AM, Staff P (Licensed Practical Nurse - Charge Nurse) stated they offered showers to all residents once a week. Staff P stated they had only one shower aide Monday to Friday and no shower aide over the weekends. Staff P stated if residents wanted an extra shower; staff could provide bed baths. Staff P did not provide documentation showing staff offered a choice of bathing to residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<Resident 123> According to the 02/03/2026 Annual MDS Resident 123 admitted to the facility on [DATE] with no memory impairment. The MDS showed Resident 123 had a diagnosis of arthritis. The MDS showed Resident 123 did not receive a therapeutic diet. Review of Resident 123's health records showed 02/26/2026, 01/29/2026, 11/17/2025, 11/03/2025, and 09/11/2025 Nutritional/Dietary notes indicating Resident 123 did not want nightshades (flowering plants with fruits including tomatoes) related to their arthritis. Resident 123's health records showed a regular diet with no food preferences identified/accommodated. In an interview on 02/27/2026 at 11:37 AM Resident 123 stated they expressed their preference not to be served tomato-based foods due to their diagnosis of rheumatoid arthritis which meant they should avoid nightshades but that it was only tomatoes that agitated their arthritis. Resident 123 stated they expressed their preference to the Director of Culinary Services and were told the facility could not accommodate their preference. Resident 123 stated staff did not discuss a resolution for their preference of no tomatoes with them. Resident 123 stated they ordered foods that they thought had no tomatoes, such as navy bean soup, but the facility made the recipes with tomatoes, so they were unable to ensure they did not receive tomatoes. In an interview on 03/04/2026 at 12:24 PM Staff F (Assistant Administrator) stated Resident 123 expressed concern about not wanting tomatoes due to their diagnosis of rheumatoid arthritis. Staff F stated the Director of Culinary explained to Resident 123 at that time they would have to change the whole facility menu and that was not possible. Staff F stated they did not accommodate Resident 123's preference for no tomatoes but should have. Staff H (Dietician) joined the interview and stated Resident 123 expressed a preference of no tomatoes in several conversations but did not express it as an allergy so it was not included in Resident 123's food profile but should be added as it was the residents' preference. REFERENCE: WAC 388-97-0900 (1)-(4).

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to thoroughly investigate a fall for 1 of 7 sampled residents (Resident 190) reviewed for accidents. Facility failure to complete thorough investigations placed residents at risk for further accidents, negative health outcomes, and poor quality of life.Findings included.<Policy>According to the facility policy titled, Fall Policy dated 04/2025, the facility would complete a thorough investigation after each incidence of a resident falling.According to the undated facility neurological assessment protocol, neurological assessments should be implemented immediately in the event of unwitnessed fall or if resident hits their head. Neurologic assessment protocol states that neurological assessments should be completed every 15 minutes for the first hour, every 30 minutes for two hours, every two hours for four hours, then every shift for two days.<Resident 190>According to the 07/11/2025 Significant Change Minimum Data Set (MDS - an assessment tool) Resident 190 admitted to the facility on [DATE] with diagnoses including Vascular Dementia (degenerative brain disease), Traumatic Brain Injury, and an abnormal heart rhythm. The MDS showed Resident 190 had short and long-term memory problems and had two or more falls since admission.Review of Resident 190's 10/20/2025 risk for fall and injury Care Plan (CP) showed Resident 190 was at high risk for fall and injury due to history of falls with interventions to report signs of acute changes to the provider as needed.Review of the facility's fall investigation for Resident 190's fall on 02/27/2025 showed Resident 190 had an unwitnessed fall in their room due to a wheelchair malfunction. Interventions listed in the investigation report showed that Resident 190 was given a new wheelchair and to be monitored with neurological assessments to assess for latent injuries.Review of the facility's fall investigation for Resident 190's fall on 04/17/2025 showed Resident 190 had a non-injury unwitnessed fall in their room when they attempted to self-transfer to the bathroom without assistance. Root cause analysis for Resident 190's 04/17/2025 fall showed conflicting documentation of the fall being witnesses, assisted, and with injury. Statements in the investigation report from staff on duty at the time of the fall showed that Resident 190 had had an unwitnessed non-injury fall. One intervention listed in the investigation report showed that Resident 190 was to have neurological assessments per protocol.Review of facility's fall investigation for Resident 190's fall on 06/02/2025 showed Resident 190 had an unwitnessed non-injury fall when attempting to self-transfer from their wheelchair to their bed. One intervention listed in the investigation report showed that Resident 190 was to have neurological assessments per protocol.In an interview on 03/04/2026 at 9:05 AM Staff B (Director of Nursing) stated for any unwitnessed falls neurological assessments should be completed but they were not for Resident 190's falls on 02/27/2025, 04/17/2025, and 06/02/2025. Staff B stated it was important to thoroughly and accurately complete investigations to rule out abuse and neglect.In an interview on 03/04/2026 at 11:36 AM Staff B stated the contradictory root cause statement in Resident 190's fall was inaccurate.REFERENCE: WAC 388-97-0640(6)(a)(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 a Pre-admission Screening and Resident Review (PASRR - a process to determine if a potential nursing home resident had mental health/intellectual disability needs which required further assessment/treatment) assessment was accurate to reflect the residents' mental health conditions for 2 of 6 residents (Resident 190 & 52) reviewed for PASRR. This failure placed residents at risk of not receiving timely and necessary services to meet their mental health needs.Findings included.<Policy>Review of the facility's 11/2025 PASRR policy showed the facility would refer any resident who exhibited a newly evident mental disorder or related condition to the state mental health authority for a Level II resident review.<Resident 190> According to the 07/11/2025 Significant Change Minimum Data Set (MDS – an assessment tool) Resident 190 admitted to the facility on [DATE] with diagnoses including Vascular Dementia (a degenerative brain disease), Traumatic Brain Injury, and an abnormal heart rhythm. The MDS showed Resident 190 had diagnoses including Anxiety and Dementia with psychotic disturbances. Review of Resident 190's records show that they received a new diagnosis of Anxiety on 05/22/2025. In an interview on 03/03/2026 at 1:13 PM Staff K (Director of Social Services) stated resident PASRRs were reviewed when a new mental health diagnosis was added to the residents' plan of care. Staff K stated a PASRR review did not occur for Resident 190 on 05/22/2025 for their new Serious Mental Illness (SMI) indicator of anxiety. Staff K stated Resident 190 should have been referred for a Level II PASRR. <Resident 52> According to the 12/22/2025 Annual MDS Resident 52 had moderate memory impairment and had diagnoses of schizophrenia (a chronic mental disorder disrupting thought processes and causing hallucinations), depression, and anxiety disorder. The MDS showed Resident 52 received Antipsychotic (AP) and Antianxiety (AA) medications on a routine basis during the assessment period. The MDS showed Resident 52 had behaviors which significantly affected Resident 52's care and their participation in activities and/or social interactions. Review of Resident 52's Social Services progress notes showed a 12/03/2024 note Resident 52 was referred to behavioral health services related to increase in Resident 52's behaviors. Another 12/10/2024 progress note showed social services updated PASRR I to reflect their SMI and emailed PASRR level II evaluation to PASRR office. Review of the 12/10/2024 updated Level I PASRR showed Resident 52 was identified with SMI indicators which included Schizophrenia, Depression, and anxiety disorder diagnoses, and indicated a Level II PASRR evaluation referral was required for SMI indicators. According to a 12/31/2025 social services progress note, the facility requested documentation from the PASRR assessor for the Level II referral submitted on 12/10/2024, over 12 months later. Review of the February 2026 Medication Administration Record (MAR) showed Resident 52 received routine AP and AA medications every day as ordered related to their diagnoses. The MAR showed (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff monitored Resident 52's behaviors daily as ordered including refusal of care, yelling towards others, hitting and scratching staff. In an interview on 03/02/2026 at 9:08 AM, Staff Y (Social Services) reviewed Resident 52's record and stated they followed up with PASRR evaluator on 12/31/2025 and sent the updated PASRR Level I for Level II evaluation. Staff Y confirmed they did not follow up with the PASRR evaluator for over 12 months, and they should follow up every two to three months. Staff Y stated they should make sure the PASRRs are accurate and sent to PASRR evaluator timely for Level II evaluations so residents would receive timely and necessary services to meet their mental health care needs. REFERENCE: WAC 388-97-1975(7).

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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 observations, interviews, and record review the facility failed to assist residents with Activities of Daily Living (ADLs - personal hygiene, grooming, bathing,) for 2 of 5 residents (Residents 6 & 217) reviewed who were assessed to be dependent on staff for ADLs including oral care, nail care, and bathing. The failure to provide ADL assistance to dependent residents as required left residents at risk for poor hygiene, diminished feelings of self-worth, and other negative health outcomes.Findings included.<Facility Policy>The facility's Activity of Daily Living policy, revised 04/2025, showed the facility would provide the necessary services to maintain good nutrition, grooming, personal, and oral hygiene to the resident who was unable to carry out ADLs independently.<Resident 6> According to the 12/23/2026 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 6 admitted to the facility on [DATE] and had diagnosis of cancer, heart failure, and urinary retention. The MDS showed Resident 6 required one person assistance from staff with personal hygiene, oral care, eating, and toileting, and had no rejection of care during the assessment period. Review of a 01/23/2026 revised ADL Self Care Performance Deficit Care Plan (CP) showed Resident 6 had limited mobility related to weakness and cancer. The CP showed Resident 6 required assistance from staff with oral care, bathing, personal hygiene, and toileting. Observation on 02/26/2026 at 9:13 AM, on 02/27/2026 at 11:02 AM, and on 03/02/2026 at 9:00 AM showed Resident 6 was lying in bed. Their teeth were dirty with debris and had a slight odor. In an interview on 02/27/2026 at 11:03 AM, Resident 6 stated they did not brush their teeth for few days because they did not have a toothbrush. Observations on 02/27/2026 at 11:05 and on 03/02/2026 at 8:45 AM showed Resident 6 had a wash basin in their cabinet in the bathroom. There was toothpaste in the washbasin but there was no toothbrush. In an interview on 03/02/2026 at 9:16 AM, Staff AA (Certified Nursing Assistant - CNA) stated the facility staff assisted residents with morning routine care and provided set up for Resident 6. In an observation at that time, Staff AA checked Resident 6's oral care washbasin and confirmed Resident 6 did not have a toothbrush. Staff AA stated there should be a toothbrush for Resident 6, but there was not. In an interview on 03/03/2026 at 12:24 PM, Staff P (Charge Nurse) stated they expected staff to provide morning care to every resident including oral care, shaving, and dressing as residents allowed, but they did not. <Resident 217> According to the 02/04/2026 admission MDS, Resident 217 had minimal difficulty with hearing, clear speech, understood, and could understand others. The MDS showed Resident 217 had cognitive impairment and did not reject care during the assessment period. The MDS showed Resident 217 had diagnoses including traumatic brain dysfunction, recent fracture, and weakness. Review of Resident 217's 01/29/2026 ADL CP showed no instructions directing staff on what level of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistance the resident required for nail care or when to offer/provide nail care to the resident. In an observation and interview on 02/25/2026 at 10:33 AM, Resident 217 was lying in bed. Their nails to both hands were long and jagged, extending past the nail bed. The middle nail on Resident 217's left hand was broken. Resident 17 stated they did not have fingernail clippers and stated staff did not offer to assist them to trim their nails. Review of Resident 217's February 2026 task documentation showed no documentation staff provided nail care to the resident. This documentation showed staff provided bathing assistance to Resident 217 on 02/25/2026. Review of progress notes from 02/25/2026 to 03/04/2026 showed no documentation indicating Resident 217 refused nail care. In an interview on 02/27/2026 at 9:04 AM, Staff JJ (CNA) stated they primarily provided residents with bathing assistance on the unit. Staff JJ stated nail trimming and shaving were offered on bath days. Staff JJ stated if a resident refused care, they would offer the care the next day and document the refusals. In an interview on 03/04/2026 at 8:21 AM, Staff BB (Assistant Director of Nursing, Transitional Care Unit Manager) stated CNAs offered assistance/provided nail care on bathing days. Staff BB stated if a resident refused, the process was to find out why the resident refused and staff were expected to notify the charge nurse or Staff BB. Staff BB stated refusals should be documented. In an observation and interview on 03/03/2026 at 10:30 AM with Staff M (Registered Nurse), Resident 217 was lying in bed. Their fingernails remained long and broken. Resident 217's right thumbnail extended past the nail bed and half the nail was broken off. Staff M confirmed Resident 217's nails were long. Staff M stated if residents refused nailcare, the CNAs would report the refusal to the nurse. REFERENCE: WAC 388-97-1060(2)(c).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER Caroline Kline Galland Home		STREET ADDRESS, CITY, STATE, ZIP CODE 7500 Seward Park Avenue South Seattle, WA 98118	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were monitored and received the treatment they were assessed to require for 2 of 3 (Residents 3 & 7) residents for edema (swelling) management and blood pressure monitoring. The failure to monitor and implement interventions for edema management and blood pressure management placed residents at risk for decline in medical status, quality of life related to unmet care needs and discomfort. Findings included .<Facility Policy>According to the facility's undated Resident handbook and Family guide, Notification of Changes section in the manual showed the facility would immediately inform the resident, consult with their provider and notify the resident representative whenever there was a significant change in the Resident's physical, mental or psychosocial status, that is, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications.<Resident 3> According to the 12/24/2025 Quarterly Minimum Data Set (MDS-an assessment tool), Resident 3 had medically complex conditions including hypertension, was on dialysis for end stage renal disease and had low blood pressure. Review of the 03/21/2025 Dialysis Care related to End Stage Renal Disease Care Plan (CP) showed staff were to contact Resident 3's providers of a problem immediately and to take vital signs (blood pressure, pulse, respirations and oxygen saturations) before and after dialysis treatment. Observation on 02/26/2026 at 9:18 AM showed Resident 3 was lying in bed, able to answer questions, appeared sleepy and weak, and talked faintly when responding to questions. Observation on 02/27/2026 at 12:36 PM showed Resident 3 was out of the facility. The signage posted outside of Resident 3's door showed staff were to take Resident 3's vital signs every Monday, Wednesday, and Friday before dialysis. Review of March 2026 vital signs record showed Resident 3's blood pressure on 03/02/2026 at 8:14 PM was 107/36 millimeters of mercury (mmHg). A second blood pressure was taken at 8:15 PM and the nurse documented Resident 3's blood pressure was 116/46 mmHg, outside of normal blood pressure parameters. Review of March 2026 progress notes did not show the provider was notified of low blood pressure readings on 03/02/2026. In an interview on 03/03/2026 at 12:00 PM Staff BB (ADNS/TCU Manager) stated Resident 3 was sent out to the hospital after resident went out to a wound care appointment that morning on 03/03/2026. Staff BB stated the wound care office sent Resident 3 to the hospital due to low blood pressure and anemia (low blood in the body). In an interview on 03/04/2026 at 8:54 AM Staff II (Registered Nurse) stated vital signs should be taken by the nurse, sometimes the CNAs will take vital signs but should be reported to the nurse. Staff II stated it was important for the nurse to recheck a low blood pressure and to notify the provider for resident's care. In an interview on 03/04/2026 at 10:50 AM Staff B (Director of Nursing) stated vital signs should be taken before and after dialysis. The nurses should check their blood pressure again, assess the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident for signs and symptoms and report them to the provider. Staff B stated the nurses should have stopped any outing for Resident 3 the next morning because of the low blood pressure and notify the provider but did not. <Resident 7> According to the 01/09/2026 Annual Minimum Data Set (MDS – an assessment tool), Resident 7 admitted to the facility on [DATE] with multiple medically complex conditions including cancer, kidney failure, and lymphedema (chronic swelling in arms or legs due to buildup of lymph fluid related to damaged lymphatic system). The MDS showed Resident 7 had impairment with functional limitation in range of motion on both legs. The MDS showed Resident 7 was dependent on staff for transferring, toileting, lower body dressing and had no rejection of care during the assessment period. Review of the revised 01/26/2026 Activities of Daily Living (ADL) decrease in function related to lymphedema showed no interventions or instructions for staff to follow related to lymphedema. Review of February 2026 Physician Orders showed a 08/24/2025 order directed staff to apply Coban wrap on both legs daily for lymphedema. An additional 09/04/2025 order directed staff to elevate Resident 7's legs while in bed related to lymphedema. Observations on 02/25/2026 at 11:42 AM, on 02/26/2026 at 8:57 AM and at 12:37 PM, on 02/27/2026 at 8:42 AM, and on 03/02/2026 at 1:02 PM showed Resident 7 was sitting in a recliner in their room, both legs and feet swollen, both feet on the floor, and had Coban wrap on. There was no bed in Resident 7's room and Resident 7 stated they liked to sleep in their recliner. Resident 7 stated they could not elevate their feet because they hurt while elevating them. Review of Resident 7's record on 02/27/2026 showed there was no indication the facility staff assessed, monitored the severity and documented the degree of edema (example 2+ or 3+) and/or notified the provider. There was no documentation on Resident 7's record directing staff where to monitor edema and when to notify the provider. An observation and interview on 03/03/2026 at 8:50 AM, Staff GG (Licensed Practical Nurse) assessed the resident with edema on both feet. Staff GG was asked why Resident 7 's feet were not elevated per the Physician Order. Staff GG stated Resident 7 did not like to elevate their feet and they used the remote control for the recliner to not elevate their feet. Staff GG stated they did not notify the provider about refusals and did not document them in Resident 7's record. Staff GG asked this surveyor to talk to the Charge Nurse for more documentation. In an interview on 03/03/2026 at 8:57 AM, Staff P (Charge Nurse) reviewed Resident 7's record and was unable to provide any documentation about Resident 7's refusals to elevate their feet in while sitting in recliner. Staff P stated they did not have a physician order to assess, monitor and document the degree of edema and when to notify the provider. In an interview on 03/03/2026 at 12:58 PM, Staff B (Director of Nursing) visited Resident 7's room with this surveyor and observed Resident 7's lower legs/feet while Resident 7 sat in a recliner. Staff B reviewed Resident 7's record and stated it was important to monitor fluid overload for residents. Staff B stated there was no documentation the facility staff assessed or monitored Resident 7 for edema on lower legs, staff did not follow the physician order and did not notify the provider of Resident 7 refusals for elevating legs. Staff B stated staff should monitor the resident for edema and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document the degree of edema in their record and notify the provider to provide better care for the resident, but they did not. Reference: WAC 388-97-1060 (1).

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caroline Kline Galland Home	7500 Seward Park Avenue South Seattle, WA 98118

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for catheter care for 1 of 4 residents (Resident 54) reviewed for Urinary Catheters (a tube inserted to drain the bladder). This failure placed residents at risk for unmet care needs, diminished quality of life, and poor health outcomes.Findings included.<Facility Policy>According to the undated facility policy titled, Indwelling Catheter Care and Maintenance, the facility would perform routine monitoring of indwelling catheters to ensure that residents receive appropriate catheter care and maintain dignity when indwelling catheters are in use.<Resident 54>According to the 11/28/2025 Quarterly Minimum Data Set (MDS - an assessment tool) Resident 54 admitted to the facility on [DATE] with diagnoses of Multiple Sclerosis (a degenerative brain disease), Neurogenic Bladder (loss of bladder control), and Functional Quadriplegia (paralysis). The MDS showed Resident 54 had an indwelling catheter.Review of 09/25/2025 Progress Note showed Resident 54's catheter was leaking. There was no documented provider notification of Resident 54's catheter leak.Review of 01/07/2026 Physician's Progress Note showed Resident 54's catheter was still leaking and to refer to Urology specialist.Review of Resident 54's alteration in elimination Care Plan (CP) showed they had a urinary catheter due to diagnosed neurogenic bladder. Resident 54's CP showed no interventions to address the catheter leak.Review of 01/21/2026 Physician's Progress Note showed that the provider re-approached the nursing team to schedule Resident 54's urology appointment.Review of 01/28/2026 Physician's Progress Note showed Resident 54's catheter was still leaking Necessitating a Urology appointment, which has not yet been scheduled.In an interview on 02/27/2026 at 1:21 PM Resident 54 stated their catheter had been leaking for multiple months without resolution.In an observation on 03/03/2026 at 11:03 AM Staff U (Certified Nursing Assistant) provided catheter care for Resident 54, during this observation of care the catheter was observed to be leaking.In an interview on 03/03/2026 at 11:52 AM Staff V (Registered Nurse) stated that the catheter had been leaking for approximately two weeks that they knew of. Staff V was not sure if it had been reported to the provider but should have been.In an interview on 03/04/2026 at 8:12 AM Staff B (Director of Nursing) stated that any time a catheter leaked they expected staff to let the provider know. Staff B stated when a provider placed a referral, they expected staff to schedule the appointment timely and document in the residents' medical records. Staff B reviewed Resident 54's records and was unable to provide documentation the urology referral had been addressed or the appointment scheduled.REFERENCE: WAC 388-97-1060(3)(c).

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: provide medically related social services to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being of residents for 1 of 5 residents (Resident 190) reviewed for nutrition; assist residents in obtaining resolution regarding refusals of treatment and care for 1 of 5 residents (Resident 190) reviewed for nutrition. This failure placed residents at risk of unmet social service needs, negative health outcomes, and a diminished quality of life. Findings included .<Policy>According to the facility policy titled, Resident Rights Regarding Treatment and Advanced Directives, revised 2025, the facility would document refusals in the resident's health record, the reason for the refusals, provider/ Interdisciplinary Team (IDT - Social Services, Nursing, Therapy if therapy services are being provided, Dietary, and Activities) notification of the refusal, and resident education of the risks associated with the refusals of care. The policy showed the facility would offer alternative treatments for refusals of care. <Resident 190>According to the 07/11/2025 Significant Change Minimum Data Set (MDS - an assessment tool) Resident 190 admitted to the facility on [DATE] with diagnoses including Vascular Dementia (a degenerative brain disease), Traumatic Brain Injury, and an abnormal heart rhythm. The MDS showed Resident 190 exhibited daily rejections of care. The MDS showed that Resident 190 had worsening behaviors during the assessment period.Review of December 2025 Activities of Daily Living (ADL) documentation showed Resident 190 refused 59 of 93 meals. The December 2025 ADL documentation showed Resident 190 refused 45 of 93 nutritional supplements offered. December 2025 oral care documentation showed Resident 190 refused oral care 15 of 93 times. December 2025 ADL documentation for transfers showed Resident 190 refused 16 of 93 attempts to get out of bed.Review of January 2026 ADL documentation showed Resident 190 refused 66 of 93 meals. The January 2026 ADL documentation showed Resident 190 refused 43 of 93 nutritional supplements offered. The January 2026 oral care documentation showed Resident 190 refused oral care 24 of 93 times. January 2026 ADL documentation for transfers showed Resident 190 refused 22 of 93 attempts to get out of bed.Review of February 2026 ADL documentation showed Resident 190 refused 67 of 84 meals. The February 2026 ADL documentation showed Resident 190 refused 46 of 84 nutritional supplements offered. The February 2026 oral care documentation showed Resident 190 refused oral care 18 of 84 times. February 2026 ADL documentation for transfers showed Resident 190 refused 24 of 84 attempts to get out of bed.Review of Resident 190's Care Plan (CP) on 02/27/2026 showed no CP with measurable goals and/or interventions to address refusals of care.In an interview on 03/03/2026 at 8:47 Staff I (Certified Nursing Assistant - CNA) stated Resident 190 refused to get out of bed or get up for meals.In an interview on 03/03/2026 at 9:50 Staff I stated Resident 190's refusals of care were reported to the charge nurse.In an interview on 03/03/2026 at 11:52 AM with Staff C (Staff Developer) and Staff J (Registered Nurse/Charge Nurse), Staff J stated when CNAs reported refusals, nurses documented the refusals and shared the information during rounds with supervisors and social workers during weekly rounds. Staff C stated that the refusals were documented in the care record and action should be taken when a resident refused care and reported to the provider. Staff C reviewed Resident 190's health records and stated there were no documentation of provider notifications for the December through February 2026 refusals.In an interview on 03/03/2026 at 1:13 PM with Staff K (Director of Social Services) stated the IDT met in informal weekly huddles on the unit to review behaviors, including refusals of care. Staff K stated if refusals were a baseline behavior, they should be documented in the care record, and a care plan was created. Staff K stated that there was no documentation of the IDT huddle or care plan for the December 2025 through February 2026 refusals for Resident 190.In an interview on 03/04/2026 at 9:05 AM Staff B (Director of Nursing) stated they were aware of the refusals of care for Resident 190 and staff should have (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions and different approaches to meet Resident 190's needs that addressed the refusals but did not.Refer to F692 Nutrition/Hydration Status Maintenance.Refer to F791 Routine/Emergency Dental Services in Nursing Facilities.REFERENCE: WAC 388-97-0960(1).

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 of 5 sampled residents (Resident 190) reviewed for nutrition, received necessary treatment and services consistent with professional standards of practice to treat broken or missing teeth and oral/dental pain. This failure placed all other residents at risk for lack of dental services, unmet care needs, negative health outcomes, and a diminished quality of life.Findings included.<Policy> According to the undated facility policy titled Dental Services the facility required staff to assess residents' dental status as part of routine nursing and MDS assessments and make appropriate referrals to facility providers or dental providers.<Resident 190>According to the 07/11/2025 Significant Change Minimum Data Set (MDS - an assessment tool), Resident 190 admitted to the facility on [DATE]. The MDS showed Resident 190 had obvious or likely cavities or broken teeth, and mouth or facial pain. The MDS showed Resident 190 had a diagnosis of Malnutrition.Review of the Nutrition/Dietary Note(s) dated 02/11/2026, 01/07/2026, 10/08/2025, 06/24/2025, 04/10/2025, and 01/09/2025 showed Resident 190 had nutritional risk factors including no upper teeth, poor lower dentition, difficulties chewing and swallowing, and pureed food texture.Review of Resident 190's health records showed a 04/24/2025 Oral Health Problems Care Plan (CP) identified Resident 190 had missing upper natural teeth, possible cavities, difficulty chewing, and poor mouth hygiene due to refusals of oral care. Interventions listed on the CP for Resident 190 instructed staff to coordinate arrangements for dental care. Resident 190's records showed no documentation of a dental referral being made.Observation on 02/25/2026 at 9:15 AM showed Resident 190 lying in bed, able to communicate through grunts/moans, shaking and nodding head yes or no. The observation showed Resident 190 had no upper teeth, broken and missing natural lower teeth.In an interview on 03/03/2026 at 11:52 AM Staff C (Staff Development) reviewed Resident 190's records and stated there were no provider notifications of Resident 190's dental status and no dental referrals were made but staff should have.In an interview on 03/03/2026 at 1:24 PM Staff E (MDS Coordinator) stated that MDS assessed dental needs quarterly. Staff E stated they were expected to notify the charge nurse of dental issues, and the charge nurse would coordinate dental care. Staff E stated that all long-term residents should see the dentist every six months. Staff E was unable to find documentation that Resident 190 had been referred to or offered dental services since admission.In an interview on 03/04/2026 at 8:12 AM Staff B (Director of Nursing) stated they expected charge nurses and MDS nurses to assess and coordinate dental needs for residents. Staff B reviewed Resident 190's health records and was unable to find record of dental exam/referral. Refer to F745 Provision of Medically Related Social Services.Reference: WAC 388-97-1060(1)(3)(j)(vii).

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on observation, interview, and record review the facility failed to: ensure staff followed contact precautions (a type of isolation precaution used to prevent the spread of infections transmitted by direct or indirect contact) for 2 (2 East unit and 1 East unit) of 4 units reviewed for contact precautions; ensure staff used appropriate Personal Protective Equipment (PPE - disposable barriers such as gloves, eyewear and gowns used to prevent exposure to infectious materials) for 1 of 3 residents (Resident 68) and 2 supplemental residents (4 & 142) reviewed for Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the transmission of multidrug-resistant organisms in long-term care settings); and ensure staff used appropriate Hand Hygiene (Staff P & BBB) during wound and catheter care. These failures placed residents and staff at risk for exposure to and development of contagious, communicable infectious diseases.Findings included .<Facility Policy>Review of the facility's 2026 Infection Prevention and Control Manual showed the purpose of the Infection Control Policy was to prevent, control, and investigate the spread of infections among residents and staff within the home. The policy showed any questions regarding policy and procedure should directed to the Infection Preventionist. The policy showed the facility would implement actions in addition to standard precautions based upon the means of transmission (airborne, contact, and droplet) to prevent or control infections. The policy showed staff should wear Personal Protective Equipment (PPE - including gown, gloves, face mask, and eye wear) when directed by precautions signs outside the resident's room. The policy showed the facility would ensure healthcare personnel were educated and trained regarding the appropriate use of PPE prior to caring for a resident. The policy showed when a resident requiring isolation was transported outside of their room for medically necessary purposes, the transporter would discard contaminated PPE before transport and wear clean PPE to handle the resident at the destinationReview of the facility's Hand Hygiene policy revised on 01/05/2026 showed hand hygiene was the single most important procedure for preventing the spread of infections. The policy directed staff to practice hand hygiene before and after direct contact with residents' mucus membranes, non-intact skin, wound care, after toilet use, before delivering food, and before and after using gloves.<EBP>

<Resident 68>

According to the 02/02/2026 Quarterly Minimum Data Set (MDS – an assessment tool) Resident 68 admitted to the facility on [DATE]. The MDS showed Resident 68 had a stage four pressure ulcer (a full thickness open wound with tissue loss, and exposed bone, tendon, or muscle, often include undermining or tunneling of the wound) and a urinary catheter (a tube inserted into the bladder for drainage).

Review of Resident 68's health records showed a 01/18/2026 physician order for EBP.

Resident 68's records showed a 06/09/2025 EBP Care Plan (CP) instructing staff to follow EBP directions for PPE use when wound care, catheter care, and peri care were provided.

Resident 68's records showed a 02/19/2026 Intravenous (IV – tube inserted into a vein) medications due to wound infection CP was in place.

Observation and interview on 02/27/2026 at 10:29 AM showed EBP signage outside of Resident 68's room with a cart stocked with Personal Protective Equipment. Staff UU (Registered Nurse) assisted with turning and positioning Resident 68 during wound care while Staff UU wore their mask under
(continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their nose. Staff UU stated they were expected to properly wear their mask covering their nose and mouth for all resident care areas. Staff UU stated it was important to properly wear PPE to prevent the spread of infection. Observation on 03/02/2026 at 11:41 AM showed Staff BBB (Certified Nursing Assistant – CNA) and Staff U (CNA) providing Resident 68 incontinence care. Staff BBB and Staff U did not wear gowns, and Staff BBB wore their mask below their nose during the care. In an interview on 03/02/2026 at 11:44 AM Staff BBB and Staff U stated they were expected to wear personal protective equipment per the EBP directions including a gown during care for Resident 68 but did not. <Resident 4> Observation on 02/25/2026 at 10:31 AM showed an aerosol contact precautions sign posted outside Resident 4's room [ROOM NUMBER]. This sign directed staff to wear a gown, gloves, face mask, and eye wear before entering room [ROOM NUMBER]. In an interview on 02/25/2026 at 10:40 AM, Staff AAA (Charge Nurse, Licensed Practical Nurse) stated Resident 4 needed aerosol contact precautions related to respiratory issues and staff were to wear appropriate PPE before entering the room and remove the contaminated PPE before leaving the room. Observation on 02/26/2026 at 10:43 AM showed staff entered the room with PPE on, provided care to Resident 4, left the room, and removed and discarded the PPE in a blue trash bin across the hall. Observation on 02/26/2026 at 11:00 AM showed Resident 4 in room [ROOM NUMBER] lied in their bed with the door was closed. There was no trash bin inside Resident 4's room to discard contaminated PPE. In an interview at that time, staff in the hall stated they discarded contaminated PPE in the blue trash bin across the hall. In an interview on 03/03/2026 at 10:21 AM, Staff X (Infection Preventionist) stated there should be a trash bin in each room with precautions for staff to discard contaminated PPE before they left the room. <Resident 142> Observation on 03/03/2026 at 8:35 AM showed an EBP sign posted outside Resident 142's room [ROOM NUMBER] directing staff to wear PPE while providing direct care including urinary catheter (tubing to help the bladder drain urine) care. Staff MM (Charge Nurse, Registered Nurse) entered room [ROOM NUMBER] with no PPE on and provided urinary catheter care. In an interview on 03/03/2026 at 8:42 AM, Staff MM stated they were supposed to wear PPE while providing urinary catheter care to Resident 142, but they did not. <Hand Hygiene> <Staff BBB> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/02/2026 at 11:45 AM showed Staff BBB providing urinary catheter care for Resident 68. Staff BBB washed Resident 68's skin and catheter, put a clean brief on and dressed Resident 68, and covered the resident with their blankets but did not change gloves or perform hand hygiene between washing the resident and dressing them. In an interview on 03/02/2026 at 11:58 AM Staff BBB stated they were expected to change gloves between clean and dirty cares and perform hand hygiene between glove changes but did not. Staff BBB stated it was important to follow the EBP directions to prevent the spread of infection. <Staff P> Observation on 03/03/2026 at 9:40 AM an EBP sign posted outside Resident 166's room [ROOM NUMBER] directing staff to wear PPE including ga own and gloves while providing direct care. Observation on 03/03/2026 at 9:44 AM showed Staff P (Charge Nurse) providing wound care to Resident 186 in their bed. Staff P wore PPE as required during wound care. Staff P removed a contaminated dressing from a lower back wound, cleaned the wound, applied a treatment as ordered, and covered the wound with a clean dressing. Staff P did not change gloves and did not practice hand hygiene in between doing dirty to clean tasks. In an interview on 03/03/2026 at 9:56 AM, Staff P stated they should remove their gloves after removing the contaminated dressing and sanitize their hands before grabbing the clean dressing, but they did not. In an interview on 03/03/2026 at 10:45 AM, Staff X stated their expectation was for staff to change gloves between clean and dirty cares and perform hand hygiene between glove changes to prevent spread of infection. <Contact Precautions> <2 East Unit> Observation on 02/25/2026 at 8:36 AM showed a sign at the entrance of the East 2B Transitional Care Unit indicating the unit had an active Influenza A (a highly contagious, acute respiratory virus) outbreak. The sign showed precautions took effect on 02/23/2026 and showed residents were encouraged to don facemasks when out of their rooms. The sign showed facility staff must wear a mask that securely covered their nose and mouth for resident care. Observation on 03/02/2026 at 12:01 PM showed Staff A (Administrator) walking away from a resident in the group dining area with their face mask pulled below their chin, exposing their mouth and nose. There were residents present in the dining area at that time. <1 East Unit> Observation on 02/26/2026 at 8:35 AM showed a Droplet Contact Precautions sign posted outside room [ROOM NUMBER] in the 1 East unit. This sign directed staff to wear eye protection before entering the room. Underneath the sign was a small cart with reusable face shields and disinfecting wipes. At that time Staff Z (CNA) was observed inside the room providing care to a resident without wearing eye protection. After finishing caring for the resident, Staff Z left room [ROOM NUMBER]. At (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2026
NAME OF PROVIDER OR SUPPLIER: Caroline Kline Galland Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 7500 Seward Park Avenue South Seattle, WA 98118	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that time Staff Z stated they did not put on a face shield as they only provided care for a short while. Staff Z stated they should follow the sign and wear a face shield but did not. In an interview on 03/03/2026 at 10:45 AM, Staff X stated they expected staff to follow the signs posted on resident's doors for EBP/Contact/Aerosol precautions, but they did not. REFERENCE: WAC 388-97-1320 (1)(a)(c).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review the facility failed to establish an infection prevention and control program that included implementation of the Antibiotic (ABO) Stewardship Program to promote appropriate use of ABOs and reduce the risk of unnecessary ABO use for 2 (Resident 10 & 68) of 5 residents reviewed for ABO use. This failure placed residents at risk for potential adverse outcomes associated with the inappropriate and/or unnecessary use of ABOs.Findings included.<Facility Policy>Review of the facility's Infection Surveillance, Antimicrobial Stewardship, and Reporting policy, revised 12/30/2025, showed the infection preventionist would survey community or hospital acquired infections and facility acquired infections on an ongoing basis through bedside observation, clinical chart review and reports, laboratory reports, resident and staff interviews, email communications, and by other means. This policy showed ABO medications would be monitored for appropriate use. The policy showed staff would communicate to the attending medical provider when needed for further documentation to support ABO use, the efficacy of the ABO medication, whether the resident's infectious process was improving/resolving, and if the ABO should be continued.<Resident 68> According to the 02/02/2026 Quarterly Minimum Data Set (MDS - an assessment tool), Resident 68 admitted to the facility on [DATE]. The MDS showed Resident 68 had a stage four pressure ulcer (an open wound with full thickness tissue loss and exposed bone, tendon, or muscle, often including undermining or tunneling of the wound) and a urinary catheter (a tube inserted into the bladder for drainage). Review of Resident 68's health records showed a 02/06/2026 physician order for an ABO medication twice daily for five days for a urinary tract infection. In an interview on 03/02/2026 at 1:30 PM Staff X (Infection Preventionist) stated they reviewed Resident 68's records related to the 02/06/2026 ABO and concluded Resident 68 did not meet the McGeer's (an infection evaluation criteria) or Loebs (infection clinical criteria to help determine when to initiate ABO treatment for urinary tract infections) criteria the facility utilized to ensure they did not administer unnecessary ABOs. Staff X stated the provider prescribed and staff administered the 02/06/2026 antibiotic for Resident 68 but they should not have. Staff X stated the provider should document a note showing why they prescribed the ABO without meeting criteria but did not. Staff X stated it was important to ensure the criteria were assessed and followed as part of the facility's ABO stewardship program to ensure residents were not prescribed unnecessary ABOs. <Resident 10> According to the 11/19/2025 admission MDS, Resident 10 had moderate cognitive impairment. The MDS showed Resident 10 had a serious wound infection, admitted to the facility with three pressure ulcers, and received an ABO medication during the assessment period. Resident 10's revised 02/26/2026 resident is on antibiotic therapy. Care Plan (CP) directed staff to administer ABO medications as ordered and monitor/document side effects and the effectiveness every shift. Record review showed a 12/05/2025 order for ABO medication. This order directed staff to administer the ABO twice daily related to Resident 10's wound infection and directed staff to discontinue the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ABO when the resident's wound vacuum (a medical device that utilizes suction to promote healing in chronic wounds) was discontinued. Record review showed a second 12/05/2025 order for an ABO medication. This order directed staff to administer the ABO twice daily related to Resident 10's wound infection and directed staff to discontinue the ABO when the resident's wound vacuum was discontinued. Review of Resident 10's physician orders showed no active orders directing staff to provide/apply/monitor a wound vacuum. Record review showed staff discontinued Resident 10's wound vacuum on 02/12/2026. Review of a 02/11/2026 nurse progress note showed Resident 10 was seen by the wound team on that day. The progress note showed the wound team provided wound care, discontinued the wound vacuum, and gave new orders to treat Resident 10's wound. Review of a 02/12/2026 nurse progress note showed staff documented Resident 10's wound was improving. The progress note showed staff documented continued use of the wound vacuum was impractical due to the small size of the wound. Review of progress notes from 02/12/2026 to 02/25/2026 showed staff did not document the physician was notified or contacted regarding the discontinuation of the wound vacuum and if the two ABOs should be continued after the wound vacuum was discontinued. Review of a 02/26/2026 nurse progress note showed staff contacted the physician to clarify the use of the two ABO medications after the change in the wound dressing order. Staff documented the wound showed no signs of infection. The progress note showed staff did not request clarification regarding the ABOs until 14 days after the wound vacuum was discontinued. Observation on 02/27/2026 at 12:15 PM showed staff providing wound care to Resident 10. Observation of Resident 10's wound at that time showed a clean, minimal wound. There was no wound vacuum in place. In an interview at that time, Staff HH (MDS Coordinator) stated they were the in-house wound care nurse. Staff HH stated Resident 10 was no longer using the wound vacuum, Resident 10's wound was very minimal, and healing well. In an interview on 03/03/2026 at 9:33 AM, Staff X was asked to provide documentation regarding continuing the ABO medications two weeks after the wound vacuum was discontinued. No further documentation was provided by Staff X. In an interview on 03/03/2026 at 11:54 AM, Staff HH stated the provider wanted to see how Resident 10 did without the wound vacuum before discontinuing the ABO medications. Staff HH was unable to provide documentation showing the continuation of the ABO was discussed with the provider. REFERENCE: WAC 388-97-1320(2)(a-b)(3).