STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505463	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madison Post Acute	2520 Madison Everett, WA 98203

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure development and implementation of comprehensive care plans for 7 of 14 residents (Residents 2, 11, 30, 34, 53, 72 and 77) reviewed for comprehensive care plans. These failures placed residents at risk for unmet care needs, inadequate pain interventions, unnecessary medications, skin issues, accidents, and decreased quality of life. Findings included .According to the facility policy titled Comprehensive Care Plans, dated 2025, documented the comprehensive care plan would describe at a minimum, the following: the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. <ELOPEMENT RISK> <RESIDENT 11> Resident 11 was admitted to the facility on [DATE] with diagnosis to include dementia. Review of the elopement binder at the front desk on 06/23/2026, showed Resident 11 as one of the residents who were at high risk to elope. Review of Resident 11's elopement risk assessment dated [DATE] showed a score of 17 which meant a high risk for elopement. Review of Resident 11's care plan did not document the resident's risk for elopement. In an interview on 06/24/2026 at 2:42 PM, Staff W, Nursing Assistant Certified (NAC) stated that they looked at the resident's care plan and Kardex (quick summary of resident's medical history and daily care plan) if they wanted to know how to care for a resident. In an interview on 06/24/2026 at 2:46 PM, Staff X, Licensed Practical Nurse (LPN) stated that a resident was at risk for elopement if they tried to get out of the facility. They added that there was an elopement binder in the nurse's station that lists residents who were at high risk for elopement. Staff X stated that Resident 11 was on the list because they kept saying they wanted to go home. In a joint interview on 06/26/2026 at 10:10 AM, Staff I, Resident Care Manager (RCM) and Staff H, RCM, Staff I stated they assessed residents on admission to determine if the resident was at risk for elopement. Then they put the resident's name and other information in the elopement binder. Then updated the care plan and include elopement risk. Staff I stated that Resident 11 scored high on admission that's why they added them in the elopement binder, but had not had an actual elopement. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	They did not know why elopement risk was not in the resident's care plan. <PSYCHOTROPIC MEDICATIONS> <RESIDENT 72> Resident 72 was admitted to the facility on [DATE] with diagnosis to include depression and metabolic encephalopathy (a problem in the brain that is caused by a chemical imbalance in the blood). According to the admission MDS dated [DATE], the resident had a moderate cognitive impairment and received antipsychotic (medication that alters brain chemistry to reduce symptoms such as hallucinations, delusions or disordered thinking) and antidepressant medications. Review of Resident 72's physician's order dated 05/07/2026 documented an antipsychotic medication and antidepressant medication were ordered. Review of Resident 72's MAR for May and June of 2026 documented the resident received antipsychotic and antidepressant medications daily. Review of Resident 72's care plan did not show any documentation about resident's antipsychotic and antidepressant medications. There was no documentation of behaviors or monitoring for any adverse side effects. In a joint interview on 06/26/2026 at 10:06 AM, Staff H and Staff I, Staff H stated they included psychotropic (any medication that altered the brain function, affecting a person's mood, thoughts, feelings or behaviors) medications in the care plan for residents receiving psychotropic medications. They included resident's behaviors and listed possible side effects of psychotropic medication. They tried to make the behaviors resident specific. Staff H was unsure why Resident 72 did not have psychotropic medications in their care plan. In an interview on 06/26/2026 at 11:35 AM, Staff B, Director of Nursing Services, stated their expectation when it came to developing a comprehensive care plan was to have it completed before day 21, it had to be accurate and all the information about the resident had to be in the care plan to include elopement risk, non-pharmacological interventions for pain and psychotropic medications. Staff B added that they tried to review care plans during their interdisciplinary Meetings, but it had not been working effectively lately. <PAIN MANAGEMENT> <RESIDENT 72> Resident 72 was admitted to the facility on [DATE] with diagnosis to include rheumatoid arthritis (chronic autoimmune disease where the immune system mistakenly attacks the lining of the joints). According to the admission Minimum Data Set (MDS – an assessment tool) assessment, dated 05/12/2026, resident received scheduled and as needed pain medications and had frequent pain. Review of Resident 72's physician's order dated 05/07/2026, documented a narcotic pain medicine every 6 hours as needed for pain. Review of Resident 72's Medication Administration Record (MAR) for May and June 2026 documented (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident received the pain medication on average two to three times daily. Review of Resident 72's May and June 2026 MAR and Treatment Administration Record (TAR) did not show any non-pharmacological interventions for pain. Review of Resident 72's care plan with a print date of 06/23/2026 showed no documentation of non-pharmacological interventions for pain. <RESIDENT 2> Resident 2 was admitted to the facility on [DATE] with diagnoses to include polyneuropathy, low back pain, and partial amputation of right foot. Review of Resident 2's admission MDS dated [DATE] documented they had moderate pain, chronic low back pain, and neuropathy (nerve pain). Review of Resident 2's pain care plan documented pain related to amputation of 4th and 5th toes of the right foot. The care plan did not address Resident 2's chronic back pain, or neuropathy. Resident 2's care plan was incomplete and did not have specific goals or interventions to address their comprehensive pain management based on their comprehensive assessment. The care plan did not include non-pharmacological interventions for pain management. Review of Resident 2's pain assessment dated [DATE] documented they had frequent moderate pain daily. The pain assessment was not thorough and complete and did not document non-pharmacological interventions for pain management. Review of Resident 2's MAR and TAR dated April 2026, May 2026 and June 2026 did not include non-pharmacological interventions for pain management. <RESIDENT 77> Resident 77 was admitted to the facility on [DATE], readmitted on [DATE] with diagnoses to include osteoarthritis. Review of Resident 77's pain care plan documented unspecified pain, the pain characteristics, or the location the resident experienced pain. The care plan did not include non-pharmacological interventions for pain management. Review of Resident 77's pain assessment, dated 04/10/2026, documented they reported frequent pain, interventions were documented as distraction and repositioning. The pain assessment documented interventions of distraction and repositioning and did not document the effectiveness of those interventions. Review of Resident 77's pain assessment, dated 05/18/2026, documented they reported frequent pain. The pain assessment did not have documentation related to non-pharmacological interventions. Review of Resident 77's MAR and TAR, dated June 2026, did not include non-pharmacological interventions for pain management. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 06/26/2026 at 8:46 AM, Staff G, LPN, stated there were non-pharmacological interventions for pain for any resident who received pain medication. Staff G stated they documented the non-pharmacological interventions on the MAR or TAR. Staff G confirmed Resident 2 , 72 and 77 did not have non-pharmacological interventions on their MAR's or TAR's. In an interview on 06/26/2026 at 9:54 AM, Staff I stated all residents who received pain medications should have non-pharmacological interventions to document before administration of pain medications. Staff I stated the non-pharmacological interventions were the same for all residents. Staff I confirmed Resident 2, 72 and 77 did not have non-pharmacological interventions in their care plan or on their MAR's or TAR's. In an interview on 06/26/2026 at 11:00 AM, Staff B stated their expectation was non-pharmacological interventions would be appropriately documented and attempted before using medications. <RESTORATIVE> <RESIDENT 30> Resident 30 was readmitted to the facility on [DATE]. Review of the facility Restorative Program Binder showed Resident 30 had nursing restorative programs for bilateral upper and lower extremities. Review of Resident 30's Medical Record on 06/23/2026, there was no documentation regarding restorative programs. Review of Resident 30's current care plan, revealed no corresponding focus area, goals or interventions about restorative programs. <RESIDENT 53> Resident 53 was readmitted to the facility on [DATE]. Review of the facility Restorative Program Binder showed Resident 53 had nursing restorative programs for bilateral upper and lower extremities. Review of Resident 53's medical record on 06/23/2026, showed there was no documentation regarding restorative programs. Review of Resident 53's current care plan, revealed no corresponding focus area, goals or interventions about restorative programs. In an interview on 06/23/2026 at 1:54 PM, Staff Y, Director of Rehab, stated Resident 30 and 53 had recommended restorative programs upon discharge from active therapies. In an interview on 06/23/2026 At 2:21PM, Staff Z, NAC, stated they were actively performing Resident 30 and 53's restorative programs but were documenting on papers logs. In an interview on 06/24/2026 at 2:18 PM, Staff B, stated the care plan was supposed to be updated (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to include the resident's restorative programs. <SKIN CONDITION> <RESIDENT 53> Resident 53 was readmitted to the facility on [DATE]. According to the quarterly MDS assessment, dated 06/05/2026, the resident had an unhealed pressure ulcer. Review of Resident 53's June 2026 MAR, documented the resident had an active pressure ulcer and was receiving wound treatment. Review of Resident 53's current care plan on 06/23/2026, revealed no focus area, goals, or interventions regarding pressure ulcer care. <RESIDENT 34> Resident 34 was readmitted to the facility on [DATE]. In an observation on 06/22/2026 at 9:15 AM, Resident 34 was observed wearing an offloading heel boot on the left heel. Review of Resident 34's June 2026 MAR, documented the resident had a left heel pressure ulcer with treatment. Review of a wound consultation progress note dated 06/17/2026, documented a clinical recommendation to offload the left heel using a sage or moon boot. Review of Resident 34's current care plan on 06/23/2026, revealed no interventions regarding heel offloading or application of a specialized boot. In an interview on 06/24/2026 at 1:47 PM, Staff H and Staff I, stated for resident 34, the care plan should include the offloading boot intervention but confirmed it had not been updated. Staff H and Staff I stated Resident 53 had a pressure ulcer and the care plan should have included pressure ulcer interventions. Reference WAC 388-97-1020(1)