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	07/21/2025

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

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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 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 observation, interview and record review, the facility failed to have a system in place that ensured grievances were addressed and resolved in response to residents' verbal conveyance of concerns for 1 of 1 Resident Council groups and 1 of 1 sampled resident (Resident 27). The facility failed to track and investigate the concerns which led to residents repeatedly reporting the same care issues without resolution and placed them at risk of unidentified and unmet care needs, and diminished quality of life. Findings Included . Review of the undated facility policy titled Grievance Policy & Procedure, showed all grievance issues would be put into writing and brought to the Grievance Officer and would be addressed in an efficient manner. The administrator would contact the party initiating grievance to discuss and resolve any concerns. <RESIDENT COUNCIL> In an interview with Resident Council representatives on 07/16/2025 at 1:55PM: - * Resident 51 and Resident 47 stated the television (TV) noises, laughter and loud voices from staff at night was a continuous issue and was mentioned a few times during the previous meetings. Resident 51 stated the TV was loud almost every night and the TV headphones provided by the facility were not always accessible and uncomfortable to wear. Resident 47 stated the noise from TV's and the laughing and loud voices from the staff made it very hard to sleep at night. * Resident 12, Resident 50 and Resident 51 stated the food served in the facility was cold every meal every day. Resident 47 stated the concern was brought up in every Resident Council meeting since April of 2025 but there was still no change. Resident 13 stated they talked to the administrator about the food served cold, but the administrator did not say anything. Review of Resident Council meeting minutes, dated 04/23/2025, showed residents stated TVs were too loud at night and suggested the night shift nurses could conduct rounds to turn down the volume. There was no documentation about the cold food concerns. There was no documentation of resolutions for the cold food or noise at night. There were no attached grievance/concern forms related to these resident council concerns. Review of Resident Council meeting minutes, dated 06/04/2025, showed residents were still complaining of TV noise at night and the facility was to provide headphones. Residents also brought up night shift staff were boisterous, laughing and loud. There was no documentation about the cold food concerns. There was no documentation of resolutions for the cold food or noise at night. There were no attached grievance/concern forms related to these resident council concerns. (continued on next page)

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

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident Council meeting minutes, dated 07/02/2025, showed TV noise at night was still a problem and residents suggested that headphones be accessible to night shift staff so they could be provided to residents who were watching TV at night. The minutes did not reflect cold food concerns, but showed the kitchen was working on getting new temperature-controlled carts. There was no documentation of resolutions for the noise at night. There were no attached grievance/concern forms related to these resident council concerns. Review of the facility Grievance Resolution reporting log from January 2025 to June 2025, showed the facility had not logged the Resident Council’s concerns during the meetings, such as loud TVs, staff noise at night or cold food concerns. In an interview on 07/17/2025 at 11:55 AM, Staff P, Activity Director, stated they assisted Resident Council meetings and wrote the meeting minutes. Staff P stated they resolve the concerns themselves or pass the specific concerns to other departments. Staff P stated the concerns from Resident Council meetings were different from grievances and they did not complete the grievance forms or track their concerns. In an interview on 07/17/2025 at 1:47 PM, Staff D, Social Service Director, stated everyone could file a grievance concern form and they were responsible to resolve with residents in five to 10 days. Staff D stated they had not been notified of any concerns or received any grievance forms from Resident Council meetings. In an interview on 07/18/2025 at 10:22 AM, Staff A, Administrator, stated they expected the activity director to complete a grievance form from the voiced concerns from the Resident Council meetings and give copies to other departments’ heads, the social service director who was the Grievance Officer, and the administrator to review. Staff A stated they had not received any grievances from Resident Council meetings. Staff A stated they expected the grievances to be resolved within five to 10 days, and a resolution provided to the residents. Staff A stated the concerns brought up from the Resident Council meetings such as noises at night and food served cold were grievances and should be logged in the grievance log and complete a grievance form. Staff A stated the TV noise at night was an ongoing concern that the facility had been working on since April 2025. Staff A stated staff had been educated on noise levels at night, there was no grievance form related to that. Staff A stated they were aware of the cold food concerns, and they had not purchased the temperature-controlled carts. In a follow-up interview on 07/21/2025 at 10:42 AM, Staff A stated they were not aware of the staff noise at night which was brought up during the Resident Council meeting in June 2025 and there was no follow up documentation. Staff A stated they had not established the Resident Council meeting grievance process with the activity director. <RESIDENT 27> During an interview on 07/15/2025 at 11:17 AM, Resident 27 reported “it sounds like they are having a party out there at night.” During an observation on 07/17/2025 at 6:51AM, a walkie talkie located at the desk at the north nurse’s station was overheard from 10 feet away. The communication heard was loud and sounded like yelling. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/17/2025 at 11:07 AM, Staff B, Director of Nursing, reported they were not aware of any recent noise complaints at night and were not aware of any noise concerns from Resident 27. During an interview on 07/21/2025 at 10:42 AM, Staff A was asked about what follow up was done from the resident council meeting in June 2025 about staff being “boisterous and laughing during the night shift?” Staff A reported that they had not been notified about the concern from the resident council and no follow up had been done until noise concern was reported by surveyor on 07/17/2025. Reference WAC 388-97-0920 (4)(5)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure funds were reimbursed to the resident and/or representative or the state Office of Financial Recovery (OFR) within 30 days of resident discharge or death for 1 of 4 (Resident 57) residents reviewed for trust accounts. This failure caused a delay in reconciling residents accounts within the 30 days requirement. Findings included .Resident 57 was admitted to the facility on [DATE]. According to the nursing progress note, the resident passed away on 04/08/2025. In a record review of the facility's trust transaction history dated 07/15/2025, it was documented that Resident 57 had a balance of $378.67.In an interview on 07/18/2025 at 7:54 AM, Staff C, Business Office Manager, stated that any balances from resident's trust account must be returned to the resident within 30 days after discharge. If a resident passed away, then they were to submit the balance amount to the OFR. Reviewed Resident 57's trust transaction history with Staff C and they stated that have not submitted the funds for the resident as required. Refer to WAC 388-97-0340(5)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide complete and updated Notification of Medicare Non-Coverage (NOMNC - a document informing Medicare beneficiaries that their covered services will be terminated and providing information on their appeal rights) for 4 of 4 sampled residents (Resident 4, 15, 25 and 55) reviewed for liability notice. This failure placed residents and/or their representatives at risk for not fully understanding their Medicare benefits and appeal rights and receiving inadequate information to make appeal decisions. Findings included .Review of the facility policy titled, Notice of Medicare non-coverage Letter (NOMNC), revised date 12/27/2024, showed the facility had to make sure the resident and/or representative understood the purpose and the contents of the notice, the appeal process and the associated time frames so they could make an informed decision on whether to appeal.Review of Center for Medicare and Medicaid Services (CMS) electronic web site (CMS.gov), shows the NOMNC form was last updated January/2025. <RESIDENT 4> Resident 4 admitted to the facility on [DATE]. Review of the NOMNC form signed by Resident 4 on 03/26/2025, documented there was no appeal organization’s name or telephone contact written on the form. The NOMNC form was approved by CMS on 12/31/2011 which was not the latest version. Review of Resident 4’s electronic health record (EHR), showed there was no documentation regarding whether Resident 4, or their representative were provided an explanation of NOMNC form. <RESIDENT 15> Resident 15 admitted to the facility on [DATE]. Review of the NOMNC form signed by Resident 15 on 07/02/2025, documented there was no appeal organization’s name or telephone contact written on the form. The NOMNC form was approved by CMS on 12/31/2011 which was not the latest version. Review of Resident 15’s EHR, there was no documentation regarding whether Resident 15, or their representative were provided an explanation of NOMNC form. <RESIDENT 25> Resident 25 admitted to the facility on [DATE]. Review of the NOMNC signed by Resident 25 or representative on 07/08/2025, documented there was no appeal organization’s name or telephone contact written on the form. The NOMNC form was approved by CMS on 12/31/2011 which was not the latest version. Review of Resident 25’s EHR, showed there was no documentation regarding whether Resident 25, or their representative were provided an explanation of NOMNC form. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a record review and interview on 07/18/2025 at 2:27 PM, Staff D, Social Service Director (SSD), stated they were responsible to issue and explain the NOMNC form to residents and/or representatives. Staff D stated they explained the appeal process and the appeal telephone contact information on the form. Staff D was not aware that the appeal organization’s name and the appeal telephone contact information was not written on the form. Staff D stated the form was not updated and the appeal information should be included within the form. <RESIDENT 55> Resident 55 was admitted to the facility on [DATE]. In a record review on 07/17/2025 at 9:32 AM, Resident 55’s NOMNC form documented there was no appeal organization’s name or telephone contact written on the form. The NOMNC form was approved by CMS on 12/31/2011 which was not the latest version. In an interview on 07172025 at 12:22 PM, Staff D stated that they were not aware that there was a newer version of the NOMNC form. Reference WAC 388-97-0300(1)(e)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to issue a written notice of bed hold (holding or reserving a resident's bed while the resident was absent from the facility), provide a written notice to the resident and/or their representative and the ombudsman (independent and objective individual who investigates complaints against government agencies and other organizations) of a hospital transfer for 3 of 3 residents (Residents 14, 53 and 55) reviewed for hospitalization/discharge. These failures placed the residents at risk for lack of knowledge regarding their rights to a bed hold, monetary consequences, appeal rights, and available advocacy services, and possible unidentified or unmet care needs. Findings included .In a review of the facility policy titled Transfer or Discharge Notices, updated 07/13/2025, showed if a resident was transferred to the hospital a notice of transfer would be provided to the resident and representative as soon as practicable and a notice of facility bed hold and return policies would be provided to the resident and representative within 24 hours of emergency transfer.<RESIDENT 4> Resident 4 re-admitted to the facility on [DATE]. Review of Resident 4’s progress notes from 06/11/2025 to 06/17/2025 showed they were hospitalized on [DATE]. No progress notes were found related to a bed hold being offered or notice of transfer/discharge being provided to Resident 4 or their representative. Review of Resident 4’s Electronic Medical Record (EMR) showed no documents for a bed hold, or a notice of transfer or discharge related to their hospitalization on 06/11/2025. In an interview on 07/17/2025 at 1:38 PM Staff D, Social Services Director, stated they sent a list to the ombudsman monthly only for planned discharges. When asked about the notice of transfer/discharge form, Staff D stated they completed them for planned discharges and deferred to nursing for any hospitalizations. In an interview on 07/17/2025 at 3:02 PM Staff H, Registered Nurse (RN) stated the facility had a hospital packet that was completed to include the bed hold and notice of transfer/discharge when a resident was sent to the hospital. Staff H stated they reviewed the bed hold and the notice of transfer with the resident if they were able and if not then the power of attorney/resident representative would be notified. On 07/17/2025 at 3:08 PM Staff I, Nursing Assistant Certified (NAC)/Unit Secretary provided a blank “Transfer to Hospital Packet”. Staff I stated the nurse would complete the packet and signed documents would be left for medical records to upload into the EMR. The packet included: - Directions to complete the packet, -Blank Bed Hold Policy form, -Blank Nursing Home Transfer or Discharge Notice, -Blank Status Report, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Blank Skilled Nursing Facility Transfer Form. On 07/18/2025 at 8:33 AM, Resident 4's signed Bed Hold and Notice of Transfer/Discharge form from their most recent hospitalization (June 2025) was requested. At 10:30 AM Staff D, provided a signed bed hold policy form for Resident 4 from their hospitalization on 2/5/2025. No other information was provided. On 07/18/2025 at 1:35 PM Staff A, Administrator, stated they were not aware a bed hold and notice for transfer/discharge was not done for Resident 4. Staff A stated a resident being hospitalized should have gotten a notice of transfer/discharge and a bed hold policy form. <Resident 53> Resident 53 was admitted to the facility on [DATE]. In a review of Resident 53’s EMR progress notes documented the resident was sent to the emergency room on [DATE]. The EMR did not show a copy of the notification of transfer to the State Ombudsman. In an interview on 07/18/2025 at 1:03 PM, Staff E, RN stated that they were not aware that they were supposed to notify the State Ombudsman regarding transfers/discharges. In an interview on 07/18/2025 at 1:09 PM, Staff B, Director of Nursing Services (DNS) stated that for a planned discharge, the Social Service Department notified the Ombudsman. Staff B stated for unplanned discharges and hospital transfers, the nurses were expected to complete the notification of transfer/discharge form and then Social Services would fax to the ombudsman. Staff B stated they discovered that they were not doing the correct process. <RESIDENT 55> Resident 55 was admitted to the facility on [DATE] and discharged to an adult family home on [DATE]. In a review of Resident 55’s EMR showed documentation that the resident discharged to an Adult Family home on [DATE]. There were no documents in the resident’s EMR regarding notification of discharge to the State Ombudsman. In an interview on 07/17/2025 at 12:22 PM, Staff D, stated the nursing department completed the transfer/discharge notification form and for planned discharges they completed the notification form and sent it to the State Ombudsman. Staff D stated they sent the notifications once a month. Staff D provided a list of residents that were discharged in the month of May and June, that they had sent monthly to the state ombudsman. Staff D did not provide documentation that the transfer/discharge notification form was sent to the state ombudsman for each of the facility discharges. Refer to WAC 388-97-0120(2)(4)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that 4 of 6 residents (Resident 3, 8, 29 and 30) reviewed for the Preadmission Screening and Resident Review (PASSR - a federally required screening of all individuals for Intellectual Disability (ID) or Related Condition and a Serious Mental Illness (SMI) prior to admission) process. The facility failed to refer the PASSRs for further review and failed to ensure any recommendations were incorporated into the plan of care. These failures placed residents at risk for unidentified mental health care needs, lack of mental health services and diminished quality of life. Findings included.Review of the facility policy titled, PASRR screening for Mental Disorder/Intellectual Disability, showed a positive Level I Screen (PASRR indicates that individual requires a PASRR Level ll Referral) necessitates an in-depth evaluation of the individual by the state-designated authority. PASRR Level ll which must be conducted prior to admission to a nursing facility OR upon identification that the individual may need a level ll PASRR Referral while at the Nursing Facility .if a Level II is indicated the facility must ensure an evaluation is conducted and results of the evaluation are incorporated and developed into the residents' plan of care.<RESIDENT 30> Resident 30 admitted to the facility on [DATE] with diagnoses to include depression. Review of Resident 30’s Level I PASRR dated 11/22/2024, showed Resident 30 had SMI and required a level II evaluation. Review of Resident 30's EHR showed no Level II PASRR was completed prior to the admission to the facility. In an interview on 07/17/2025 at 1:40 PM, Staff D, Social Services Director stated they sent an email to the state PASRR Evaluator recently for Resident 30’s PASRR level II, no documentation of confirmation was provided. In an electronic communication on 07/17/2025 at 2:40 PM Collateral Contact 1 (CC1), state contracted PASRR Evaluator, showed they had not received any information regarding Resident 30 and their PASRR from 11/21/2024. <Resident 29> Resident 29 was admitted to the facility on [DATE] with diagnoses to include major depressive disorder. Review of Resident 29’s records showed a level I PASRR was completed 11/22/2024 and documented a level ll evaluation referral was required for SMI. PASRR level ll was not located in Resident 29’s Electronic Health Record (EHR). During an interview on 07/17/2025, at 9:01 AM, Staff D, stated Resident 29’s PASRR required a level ll evaluation. Staff D could not locate a completed PASRR level ll. <Resident 8> (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 8 was admitted to the facility on [DATE] with diagnoses to include unspecified dementia (memory impairment), anxiety disorder, and depression. Review of Resident 8’s care plan dated 10/30/2023 showed had an invalidated level II Pre-admission Screening and Resident Review (PASRR) completed on 11/27/2023. Review of Resident 8’s progress notes from 11/01/2024 through 07/15/2025 showed no documentation referencing the PASRR and the current status. Review of Resident 8’s EHR showed their level I PASRR was redone on 11/21/2024 and they required a level II evaluation. In an interview on 07/17/2025 at 1:40 PM Staff D, stated they had started a new process in the facility related to PASRR’s. Staff D stated when a resident was admitted to the facility, they would review the PASRR and update the diagnoses if needed and if the resident required a level II, they would send them to the evaluator by email. Staff D stated they had reviewed all the long-term care residents PASRR’s and updated them as needed. Staff D stated they did not review their facility policy and procedure on PASRR’s and had email correspondence with the PASRR evaluator weekly. When asked the status of Resident 8’s PASRR completed 11/21/2024, they stated they had emailed it and were going to send an email to the evaluator this week to follow up. In an electronic communication on 07/17/2025 at 2:40 PM CC1 showed they had not received any information regarding Resident 8 and their PASRR from 11/21/2024. <Resident 3>Resident 3 was admitted to the facility on [DATE] with diagnoses to include depression, and borderline personality disorder (difficulties regulating emotions and impulses). Review of Resident 3’s admission PASRR Level II evaluation dated 12/19/2024 showed the resident had a positive Level I screen and had been referred for a mental health evaluation. The recommendations for the nursing facility were the following: the facility should ensure the resident had a space that was free and clear of obstacles and ensure the resident did not have disruptive roommate. The staff should approach in a calm and compassionate manner, female staff members only due to past trauma from men. Staff should provide care in pairs to ensure that the resident did not split or manipulate the staff. The resident would need a private space for tele-health appointments with their therapist. The resident had great fear of going outside and fearful of grass and dirt. Review of Resident 3’s medical record showed a “Trauma Screening Questionnaire” dated 06/03/2025 that showed the resident had a history of traumatic events in their child and adult life, had been physically or sexually assaulted, felt anxious or depressed, felt their traumatic experiences affected their current way of life, and were uncomfortable around men. In a review of Resident 3’s care plan, print date 07/17/2025, showed none of the recommendations from the Level II evaluation had been incorporated into the plan of care. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation and interview on 07/15/2025 at 10:31 AM, Resident 3 was sitting up in their bed. The room space was small, and lacked adequate space for their mobility device, there were personal items in boxes stacked up against the wall. The resident stated there was no space in their room, and felt boxed in a corner, as there was no access to a window. The resident expressed they had no privacy for appointments and were told they would have to go outside for their telehealth appointments. In an interview on 07/18/2025 at 8:56 AM, Staff X, Nursing Assistant Certified (NAC) stated they rely on the care plan and the Kardex (condensed version of care plan) for assessing what level of care to provide to each resident. In an interview on 07/18/2025 at 9:33 AM, Staff F, Registered Nurse (RN) stated that the management team was usually responsible for updates to the care plans for residents. In an interview on 07/18/2025 at 11:00 AM, Staff D, stated their role as it relates to PASRR was they would review all PASRR’s to ensure they were accurate, and if they required a Level II evaluation, they made the request. Staff D stated when a Level II evaluation was completed, they would review and incorporate any recommendations into the care plan for the resident. Staff D was not aware of the recommendations that had been made for Resident 3 that were included in the Level II evaluation. Staff D was not aware that Resident 3 had a fear of going outside, or a fear of men. Staff D stated the facility had completed a trauma screening for all residents in June 2025 and thought Resident 3 had no trauma. Staff D was shown the results of the Trauma Screen that was done on 06/03/2025, and stated they were not aware of those results. In an interview on 07/18/2025 at 1:05 PM, Staff N, License Practical Nurse (LPN)/Resident Care Manager (RCM) stated the comprehensive care plan was created by the interdisciplinary team, each member contributing to their section. Staff N stated social services were usually responsible for updating residents care plan as it pertained to mental health, and PASRR. In a joint interview on 07/21/2025 at 11:04 AM, Staff A, Administrator and Staff B, Director of Nursing both stated they were unaware that there had been a lack of follow up as it related to PASRR, and that PASRR Level II evaluation recommendations had not been incorporated into the care plan. Refer to WAC 388-97-1975(8)(10)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and/or implement individualized comprehensive care plans for 1 of 2 residents (Resident 27) reviewed for catheter use and 1 of 2 residents (Resident 8) reviewed for dementia care. Failure to develop and implement care plans that were individualized and accurately reflected resident care needs placed residents at risk of unmet care needs and potential negative outcomes.Findings included.Review of an undated facility policy, titled, Comprehensive Person-Centered Care Planning, documented a comprehensive care plan would be developed to meet the residents medical and nursing needs and the IDT (interdisciplinary team) would review and/or revise the care plan after each assessment.<RESIDENT 8> Resident 8 was admitted to the facility on [DATE] with diagnoses to include unspecified dementia (memory impairment), anxiety disorder, and depression. Review of Resident 8’s Brief Interview for Mental Status (BIMS-an assessment to determine cognition) dated 03/10/2025 showed a score of 0/15 which was significant for severe cognitive impairment. In an interview on 07/17/2025 at 9:47 AM Staff M, Nursing Assistant Certified (NAC) stated they had worked with Resident 8 since they admitted . When asked what Resident 8’s dementia looked like for them, Staff M stated they became more confused at different times of the day especially in the evening. Staff M stated Resident 8 could be redirected by engaging in conversation about their daughter and plans for them to visit. Staff M stated they were not aware of any signage in the room to access when Resident 8 started speaking Dutch. Review of Resident 8’s care plan showed they had an alteration in their cognition and/or communication related to their dementia process, depression, and anxiety disorder. Resident 8’s goal was for them to be able to communicate basic needs daily. Interventions included asking yes/no questions, cue and/or reorient and supervise as needed, and monitor/document any changes in their cognitive function. In a separate care plan dated 07/14/2025 for communication, showed Resident 8’s first language was Dutch, and they reverted to speaking Dutch at times. Interventions included to anticipate Resident 8’s needs and to utilize signs provided by their family in Dutch to English translation to cue them when needed. On 07/17/2025 at 9:12 AM observed Resident 8’s room. There were no signs found in Resident 8’s room related to Dutch to English translation as described in the care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/18/2025 at 9:59 AM Staff N, Licensed Practical Nurse (LPN)/Resident Care Manager, stated Resident 8 had been admitted to the facility with psychoactive (mood altering) medications because they were unsettled. Staff N stated Resident 8 was currently doing well and were tapering (gradually reducing) their psychoactive medications. Staff N stated Resident 8 exhibits their dementia by not making a whole lot of sense, visualizing something that is not there, or speaking Dutch. When asked about interventions for Resident 8’s dementia Staff N stated they like to watch television, staff to spend time with them, being around others, small group or reading magazines. Staff N stated they would often spend one on one time with Resident 8 and do a written question and answer activity. Staff N was unaware of the intervention for Dutch to English translation signage. Staff N stated they would need to update the care plan. <RESIDENT 27> Resident 27 admitted to the facility on [DATE]. During an interview on 07/15/2025 at 12:14 PM, Resident 27 stated they have had a urinary catheter (tube inserted into the bladder to drain urine) since admission to the facility but did not know why. Review of Resident 27’s care plan, printed on 07/16/2025, showed Resident 27 had a urinary catheter. The care plan did not show why the catheter was clinically unavoidable, the reason the resident had the catheter, nor what the follow up for the catheter was. During an interview on 07/17/2025 at 10:29 AM, Staff N, reviewed Resident 27’s urinary catheter problem on the care plan and reported the care plan was vague and they would have to follow up as to why the resident still had the catheter. During an interview on 07/18/2025 at 12:53 PM, Staff R, LPN/Minimum Data Set (MDS) Coordinator, reported the care plan should show the residents overall goals and how to take care of the resident. Staff R stated Resident 27’s care plan did not document why the catheter was clinically unavoidable. Refer to WAC 388-97- 1020(1), (2) (a)(b)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure professional standards were met for 2 of 5 residents (Residents 3 and 30) reviewed for unnecessary medication review. The facility failed to recognize and ensure parameters were followed for blood pressure medication administration and bowel constipation protocol for the resident and failed to notify the medical provider when the resident's blood sugar levels were beyond the ordered parameters. These failures placed the residents at risk for adverse outcomes, medication errors, complications, and unmet needs. Findings included . Review of the undated facility policy titled Blood Sugar Parameters stated the facility was to notify the provider for any blood sugar levels below 70 or above 450. Review of the undated facility policy titled House Bowel Protocol stated that milk of magnesium (medication for constipation) was to be given to residents if they had no bowel movement in three days, to give a glycerin suppository (medication for constipation inserted into the rectum) if no bowel movement for four days, and if no results from suppository the facility was to administer a enema (liquid inserted into the rectum). <RESIDENT 30> <BLOOD PRESSURE PARAMETER> Resident 30 admitted to the facility on [DATE] with diagnoses to include heart failure. According to the quarterly Minimum Data Set (MDS-an assessment tool) assessment, dated 07/07/2025, Resident 30 was cognitively intact. Review of Resident 30’s 07/01/2025 - 07/15/2025 Medication Administration Record (MAR), showed Resident 30 had one antihypertensive medication (drugs used to treat high blood pressure) to be given twice a day. The order directed nurses to hold the medications for systolic blood pressure (top number of blood pressure reading) less than 110 or diastolic blood pressure (below number of blood pressure reading) less than 55. There was no blood pressures documented with the administration of the antihypertensive medication on the MAR. Review of Resident 30’s vital signs record, showed blood pressure: 07/01/2025 at 2:45 PM was 94/66mmHg (millimeters of mercury, unit of pressure measurement), 07/03/2025 at 12:28 AM was 105/57mmHg, 07/03/2025 at 10:48 AM was 109/67mmHg. Review of Resident 30’s entire electronic health record (EHR), showed no blood pressure documented from 07/04/2025 to 07/06/2024 and after 07/08/2025. In an interview on 07/18/2025 at 8:46 AM, Staff F, Registered Nurse (RN), stated nurses needed to follow the provider’s order and check the parameter if the order had specific instructions. Staff F stated they were not sure why the blood pressure was not documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a record review and joint interview on 07/18/2025 at 12:36 PM with Staff N, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM), and Staff B, Director of Nursing Services, Staff N stated all nurses needed to follow the order and check blood pressures prior to administering antihypertensive medications. Staff N stated the order needed to be updated and the blood pressure should be documented with the medication in the MAR. Staff N stated the antihypertensive medication should be held on those days with out-of-range parameters. Staff B stated the expectation was to follow the provider’s order, to read the parameter and to hold the medication if the parameter was out of range. <BOWEL MOVEMENT> In an interview on 07/15/2025 at 11:53 AM, Resident 30 stated they had constipation, and had not received any bowel medication. Review of Resident 30’s care plan, print date 07/15/2025, showed the goal of the focus area for constipation was to have a normal bowel movement at least every two to three days, and one of the interventions was to follow the facility’s bowel protocol. Review of Resident 30’s bowel elimination record from 06/19/2025 - 07/18/2025, showed Resident 30 had no bowel movement from 07/01/2025 to 07/05/2025. Review of Resident 30’s MAR dated 07/01/2025 - 07/15/2025, documented MiraLAX powder (laxative powder to relieve constipation) was given on 07/04/2025 (no bowel movement on day four) with ineffective result; Milk of Magnesia suspension to be given for no bowel movement for three days was not administered; Glycerin rectal suppository for constipation If no bowel movement for four days was not administered; Fleet enema rectal insert for constipation if no result from Glycerin suppository was not administered. In an interview on 07/18/2025 at 8:52 AM, Staff F stated they had a bowel movement alert list from the EHR. Staff F stated the list showed residents who had no bowel movement for three days and nurses needed to follow the bowel medication orders and monitored the effectiveness. Staff F stated nurses needed to follow up with the provider if the medication was not effective. In an interview on 07/18/2025 at 12:49 PM, Staff B stated nurses should have started the bowel medication when Resident 30 had no bowel movement on day three and they expected nurses to follow the bowel protocol <RESIDENT 3> Resident 3 was admitted to the facility on [DATE] with diagnoses to include diabetes mellitus (disease where the body cannot regulate sugar levels in the blood). The Quarterly MDS dated [DATE] showed the resident had mild cognitive impairment, and received insulin (medication inserted into the body to help regulate blood sugar levels) injections all seven days of look back period. Review of Resident 3’s physician orders dated 04/21/2025 documented to administer insulin injection per the sliding scale, and if blood sugar levels were above 400, to notify the medical provider. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3’s MAR from 05/01/2025 – 07/17/2025 showed the resident had blood sugars above 400 on 05/03/2025, 06/04/2025, 06/15/2025, 06/27/2025, and 07/09/2025. Review of Resident 3’s progress notes from 05/01/2025 – 07/17/2025, showed no documentation that the physician had been notified that the residents blood sugars had exceeded the ordered parameters. In an interview on 07/18/2025 at 9:33 AM, Staff F, stated they were educated to follow parameters that were listed on the resident orders. Staff F stated if the order specified to notify provider when outside the parameters they were to document in the progress notes. Staff F stated for blood sugar monitoring there should be a note about re-checking the blood sugar as well as a possible new order to administer extra insulin. In a joint interview on 07/18/2025 at 1:05 PM, Staff B, and Staff N, Staff N stated if a resident’s blood sugar was outside the facility parameter or the physician ordered parameters they were to call the provider, and made a progress note in the medical record. Staff B reviewed Resident 3’s blood sugars and agreed they were outside the parameters and the licensed staff should have notified the provider and documented in the medical record. Reference WAC 388-97-1060(3)(k)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care and services were provided in accordance with physician's orders and accepted professional standards of practice for 2 of 2 residents (Resident 49 and 6) reviewed for respiratory care. The facility failed to ensure continuous positive airway pressure (CPAP, a form of non-invasive ventilation therapy used to facilitate breathing) orders were active and in place, to include the prescribed pressure settings, checking, refilling, and cleaning of the humidifier reservoir, and identifying what solution was to be used in the humidifier. Additionally, the facility failed to ensure oxygen (O2) was being administered per physician's orders. These failures placed residents at risk for ineffective breathing, decreased oxygen levels, respiratory infection and other respiratory complications.Findings included.Reviewed of an undated facility policy titled, CPAP Monitoring and Management, documented that CPAP machine settings and the mask tubing and adapter are to be cleaned per physician's orders. Review of an undated facility policy titled, Oxygen Administration, documented the facility will administer oxygen as ordered by the physician.<RESIDENT 6> Resident 6 was admitted to the facility on [DATE] with diagnoses to include anxiety disorder and fibromyalgia (long term and chronic condition that causes pain and tenderness throughout the body). In an observation on 07/15/2025 at 12:08 PM, observed Resident 6 wearing a nasal cannula (device used to deliver supplemental O2 through the nose). In an interview and observation on 07/16/2025 at 11:42 AM, Resident 6 was wearing a nasal cannula, attached to an O2 concentrator, with the setting at 1.5 liters per minute (lpm). When asked about the settings for their O2, Resident 6 stated it should be 2 lpm. In an interview and observation on 07/17/2025 at 9:34 AM, Resident 6 was observed lying in their bed wearing a nasal cannula attached to a running O2 concentrator with settings at 1.5 lpm. When asked if they were getting enough O2, Resident 6 stated they could use more but did not want to ask for it because they thought the facility would start weaning them off the O2. In a review of Resident 6’s Medication Administration Record (MAR) for 07/01/2025 - 07/16/2025 showed an order start date of 05/31/2025 for oxygen at 2 lpm via nasal cannula to keep O2 saturations (level) above 90 percent (%) for shortness of breath as needed. In a review of Resident 6’s vitals (measurement of the body's basic functions) dated 07/07/2025 - 07/16/2025 showed their O2 saturations were checked consistently while the resident was using O2 since admission, all documented saturations were above 90%. In a review of Resident 6’s care plan dated 05/30/2025 showed they had altered respiratory status with difficulty sleeping related to sleep apnea (temporary pause in breathing). Interventions included O2 at 2 lpm as needed to keep their saturations above 90%. In an interview on 07/18/2025 at 10:36 AM Staff N, Licensed Practical Nurse (LPN)/Resident Care Manager (RCM) stated Resident 6 admitted with O2. Staff N was asked how Resident 6’s O2 saturations were assessed, when all vitals were documented during O2 use, Staff N did not answer the question. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/18/2025 at 10:42 AM Staff B, Director of Nursing Services (DNS), stated there was usually a range for the lpm on the orders for O2. Staff B stated they were unaware Resident 6’s settings were at 1.5 lpm. When asked how Resident 6’s O2 was maintained above 90%, Staff B stated they would need to discuss the order with the provider and adjust it accordingly. <RESIDENT 49> On 07/15/2025, at 9:51 AM, it was observed that Resident 49 had a CPAP machine on their nightstand. On 07/15/2025, at 2:43 PM, Resident 49 stated that they wore the CPAP every night and that the staff have never washed it. During an interview on 07/16/2025, at 11:14 AM, Resident 49 stated staff have not been washing the CPAP mask. During an observation and interview on 07/16/2025, at 1:18 PM, visually inspected the CPAP mask and noted visible debris on the mask. On 07/17/2025, at 8:46 AM, visually inspected CPAP mask and noted debris and oily substances. Resident 49 stated the CPAP mask had not been washed the prior day. On 07/16/2025, record review showed that there were no active orders in the medication administration record (MAR) regarding the CPAP for Resident 49. In an interview on 07/17/2025, at 9:48 AM, Staff J, Nursing Assistant Certified (NAC), stated the aides did not provide any care for the CPAP and that the nurse did everything for it. In an interview on 07/17/2025, at 9:54 AM, Staff F, Registered Nurse (RN), reported no orders or instructions regarding the CPAP were in the MAR. In an interview on 07/17/2025, at 2:39 PM, Staff B, stated their expectations for a resident with a CPAP were the orders which would include settings, maintenance, distilled water, and cleaning. Staff B reviewed the clinical record and was not able to locate any active orders for the CPAP. Surveyor observed CPAP mask and tubing with Staff B. Staff B stated that the CPAP mask had not looked like it had been cleaned. Staff B was not able to identify what the debris on the mask was, and they stated they saw some white stuff on there. Refer to WAC 388-97-1060(3)(j)(vi)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure ongoing communication and collaboration with the hemodialysis (medical procedure that uses a machine to filter and clean the blood when the kidneys are failing) center and consistently complete resident's pre and post dialysis assessments for 2 of 2 resident (Residents 4 and 28) reviewed for hemodialysis (HD) services. The failure of inconsistent communication and collaboration between the facility and the dialysis center about what occurred during HD and the inconsistent completion of the pre, and post dialysis assessments placed the residents at risk for unidentified medical complications and other potential/negative health outcomes.Findings included .In a review of the facility policy titled, Dialysis (Renal), Pre- and Post-Care revised 02/2025 showed the policy included ongoing communication and collaboration with the dialysis facility regarding dialysis care and service.<RESIDENT 4> Resident 4 initially admitted to the facility on [DATE] with diagnoses that included diabetes, type two (a condition in which the body does not use insulin correctly or does not produce enough insulin leading to high blood sugar) and end stage kidney disease (kidneys no longer function). Review of Resident 4's care plan dated 02/10/2025, documented the resident required hemodialysis related to renal failure with the goal of having no signs/symptoms of complications from dialysis through the review date of 09/22/2025. Interventions included not to take blood pressure in the right arm, encourage the resident to attend their scheduled dialysis appointments, monitor and report any changes to the physician, and the resident had dialysis on Tuesdays, Thursdays and Saturdays. In an interview on 07/17/2025 at 2:29 PM, Staff O, Licensed Practical Nurse (LPN), stated dialysis communication packets are put together by the night nurse and left for the day nurse on the day of dialysis. Staff O stated when a resident returns from dialysis the paperwork goes to the resident care manager and sometimes the dialysis center would be called to get information if none were sent. In an interview on 07/17/2025 at 2:30 PM, Staff N, LPN/Resident Care Manager (RCM) stated they would locate where the information for pre and post dialysis communication was located. In a follow up interview on 07/17/2025 at 2:53 PM, Staff N, LPN/RCM stated there are User Defined Assessments (UDA) in the resident's electronic medical record (EMR) for pre and post dialysis assessments. Staff N stated a packet was made and sent to dialysis which included a face sheet, medication list, and the UDA- pre dialysis assessment and blank after visit summary (AVS). Staff N stated they had not received any AVS from dialysis for Resident 4. In a review of Resident 4's UDA's for pre and post dialysis assessments documented missing post assessments for 6/24/2025, 06/26/2025, 06/28/2025, 07/01/2025, 07/08/2025 and 07/10/2025. In a review of Resident 4's EMR documented dialysis run sheets (tracking clinical data during dialysis) from the dialysis center for 07/01-07/10/2025 and 07/16-07/19/2025. No other documentation found from the kidney center that Resident 4 attended. <RESIDENT 28> Resident 28 was admitted to the facility on [DATE] with diagnoses to include end stage kidney disease and diabetes mellitus type two. In a review of Resident 28's care plan dated 04/23/2025 documented they required HD related to their end stage kidney disease with the goal of having no complications from dialysis through the review date. Interventions included encouraging Resident 28 to attend their dialysis appointments, monitor labs and report to the doctor as needed. In a review of Resident 28's progress notes dated 04/28/2025 10:14 PM, documented they went to dialysis and did not return; a call was placed to the dialysis center at 10:30 PM and was informed they were sent to the hospital. In a review of Resident 28's order summary as of 04/23/2025, documented they had dialysis at the kidney center on Monday, Wednesday and Friday from 12:15 PM until 4:15 PM. In a review of Resident 28's UDA's for pre and post dialysis communication documentation, none were completed from 04/23/2025 through 05/05/2025. There was no post dialysis assessment done on 07/2/2025 and no pre dialysis assessment completed on 07/08/2025. In an interview on 07/21/2025 at 9:07 AM, Staff B, Director of Nursing Services stated there was a UDA that was completed prior to resident attending dialysis and when they returned. Staff B stated if there were any concerns during dialysis the dialysis center would send a note with the resident. Staff B stated medical records had been contacting the dialysis center weekly to get run sheets and was aware there were some missing. Staff B stated the run sheets contain information about the resident's weight, vitals and if any acute changes. In an interview on 07/21/2025 at 9:27 AM Staff A, Administrator, stated the facility does not have contracts with the dialysis centers used to provide HD to Resident 4 and 28. Staff A stated there was a consent to treat for each of the residents. No other information or documentation received related to Resident 4 or 28.Refer WAC 388-97-1900(1)(2)(a)(b)(5)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the person designated to serve as the Director of Food and Nutrition Services (Staff S) had the required qualifications. This failure placed all residents at risk of receiving dietary services from staff without the required competencies and skills to carry out food and nutrition services.Findings included .In an interview on 07/16/2025 at 9:47 AM, Staff S, Dietary Manager (DM), stated they were not a certified DM. Staff S stated they were enrolled in the educational program to obtain their certification. Staff S stated the facility was using the certification of Staff T, Assistant DM, in place of their certification.In a review of the staff roster, undated, documented Staff S was the culinary director.\In a review of the facility assessment dated [DATE], documented Staff S as the certified dietary manager.In an interview on 07/21/2025 at 11:04 AM, Staff A, Administrator, stated Staff T was the dietary manager last year and thought the facility could use their certification until Staff S was certified.Refer to WAC 388-97-1160 (2)(3)(a)(b)(i)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation, and record review, the facility failed to provide appetizing and palatable food to 3 of 7 residents (Residents 1, 27 and 49) reviewed for food temperature and palatability. This failure placed residents at risk for weight loss, inadequate nutrition, and a diminished quality of life.Findings included .<RESIDENT 27> During an interview on 07/15/2025 at 11:18 AM, Resident 27 reported that the food was not served hot. During an observation and interview on 07/17/2025 at 8:50 AM, Resident 27 had just received their breakfast tray. Resident reported the biscuits and gravy tasted “OK.” Resident 27 stated the food would taste better if it was hot, but it was only warm. There was no heated plate warmer under the resident’s plate. The edge and the bottom of the plate were cool to the touch. During an interview on 07/18/2025 at 12:50 PM, Resident 27 was observed finishing their lunch meal. Resident 27 reported the food was just lukewarm, so they did not eat all of it. There was half of the main entrée left on their plate. Review of the July 2025 Resident council meeting minutes documented the Kitchen was working on getting temperature-controlled carts. <Resident 49> During an interview on 07/15/2025, at 12:37 PM, Resident 49 had their lunch tray and stated that, the food could be hotter. On 07/16/2025, at 8:47 AM, Resident 49 was served their breakfast tray. Observed breakfast sausage on the plate looked over cooked. During an interview on 07/16/2025, at 11:13 AM, when asked how their breakfast was, Resident 49 stated, it was okay, but the sausage was on the dry side. At 1:16 PM, when asked how lunch was, Resident 49 said the kitchen was out of the potato salad that they ordered and were served macaroni salad. Resident stated he sent the macaroni salad back because the noodles were not cooked thoroughly and was unable to chew the hard noodles. On 07/17/2025, at 8:47 AM, Resident 49’s breakfast tray was delivered to them. Resident stated at 8:51 AM that the breakfast was lukewarm. <RESIDENT 1> In an interview on 07/16/2025 at 8:13 AM, Resident 1 stated the food and delivery of the food reminds them of the military. Resident 1 stated they were on small portions and did not really want to have small portions. In an observation on 07/16/2025 at 8:19 AM, observed Resident 1’s breakfast tray to have fried eggs, a sausage patty which was overcooked with visible shriveled and hard edges and a donut. (continued on next page)

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	505463	A. Building B. Wing	07/21/2025

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 07/16/2025 at 8:35 AM, Resident 1 stated the sausage patty was overcooked and they were not able to cut it themselves and had assistance to cut it up before eating it. In an interview on 07/17/2025 at 1:40 PM Resident 1 stated the salmon for lunch was a dry. <TEST TRAY> In an observation of a lunch test tray on 07/17/2025 at 12:37 PM, was the last remaining tray in the final meal cart for lunch. The scheduled meal consisted of salmon, couscous with peppers and mushrooms, asparagus and chicken noodle soup. The alternative was a ham sandwich and macaroni salad. The meal was warm and there was no heated plate warmer. The salmon’s texture was dry, and the salmon skin had to be scrapped off. The soup lacked flavor and was bland, tasted like oil and water. The flavor improved with salt and pepper. The asparagus was overcooked and lukewarm, the tips of the asparagus were crunchy. The macaroni salad tasted like mayonnaise and pasta. <GREIVANCES> Review of a grievance dated 02/06/2025 at 10:00 AM showed a resident found a bread tie in their roast beef sandwich. In an interview on 07/21/2025 at 11:04 AM, Staff A, Administrator stated that they were unaware of the food concerns brought up by the residents and were unaware that the food was not palatable. Refer to WAC 388-97-1100(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, and served under sanitary conditions in one of one facility kitchens, and one of one snack/nourishment refrigerators. The failure to ensure cleanliness of the kitchen, label opened food/beverage items, wash hands, and ensure dishwashing temperature were maintained at the proper temperature. These failures placed all residents at risk for their food to be contaminated, development of food borne illnesses, and consuming spoiled food.Findings included.<CLEANLINESS>On 07/17/2025 at 11:04 AM observed the dishwashing area to have a large hole (approximately 6 -8 inches) in the wall underneath the dishwashing basin. Observed a rusty gallon can (content unknown and not able to be determined), below pipes, underneath the dishwasher appeared to hold up one of the copper pipes. Observed a leak from underneath the handwashing station, which included a pool of discolored liquid directly underneath the sink drainpipe. Observed food debris and remnants and cracker wrappers on the floor in and around the dishwashing area. In an interview on 07/17/2025 at 11:04 AM Staff U, Dietary Aide, stated they had informed every one of the pool of liquid accumulated beneath the handwashing sink. Staff U stated they tried y to do a deep clean in the morning when they arrive and night shift was expected to complete a deep cleaning at night.In an interview on 07/15/2025 Staff V, Maintenance Director, stated there had been a report of cockroaches in the kitchen from kitchen staff. Staff V stated they contacted a pest control company, and the facility was currently on a weekly maintenance plan for pest control.<DISHWASHING STATION>In an observation on 07/15/2025 at 10:00 AM, the dishwashing temperature log showed missing entries for 07/11-07/12/2025. The temperature logged for 07/15/2025 was 127 degrees.In an interview on 07/15/2025 at 10:00 AM Staff S, Culinary Director, stated they had just seen the dishwasher log was missing a few entries.In a follow up visit to the kitchen on 07/17/2025 at 11:04 AM, observed the dishwasher temperature log showed the temperatures recorded for 07/16/2025 for AM at 118 degrees Fahrenheit and for the PM 116 degrees.In an interview on 07/17/2025 at 11:04 AM Staff U, who was operating the dishwasher, stated the dishwasher was a low temperature-chemical dishwasher, and the temperature was to get up to 130 degrees. Staff U stated they run the dishwasher empty a few times to get it up to temperature before running a load of dishes.In an interview on 07/17/2025 at 11:29 AM Staff S stated they were not aware of the temperatures logged on 07/16/2025. Staff S stated the employee working that day was new and English was their second language. Staff U stated they had educated their staff on running the dishwasher a few times empty, to get it to temperature.<FREEZER>In an observation on 07/15/2025 at 9:44 AM, observed a large amount of ice buildup in and around the door of the freezer.In an interview on 07/15/2025 at 9:44 AM, Staff S stated the facility had just completed maintenance on the freezer two to three weeks ago, and the door seals had not been installed and the maintenance director was coordinating the replacement of the seals.In an interview on 07/15/2025 at 10:20 AM Staff V, stated the door seals were not replaced when the freezer unit was replaced and were due to be delivered soon. Staff U stated they were aware the freezer door was icing up.<HAND WASHING>In an observation on 07/17/2025 at 12:09 PM, Staff S prepared a chopped sandwich for a resident's lunch tray. Staff S removed their soiled gloves and placed a new pair of gloves on their hands without completing hand hygiene. Staff S repeated this observation two more times within minutes of each other.<NOURISHMMENT REFRIGERATOR>On 07/16/2025 at 8:29 AM, observed the dining room nourishment refrigerator to contain opened and undated coconut water and vanilla boost shake.<DRY STORAGE>During the initial tour on 07/15/2025 at 9:44 AM the dry storage was observed to contain opened/unlabeled items including three different types of dry cereal and two bags of pasta.In an interview on 07/18/2025 at 1:48 PM, Staff A, Administrator, stated the facility was on the scheduled to replace the dishwasher and complete a deep cleanof the kitchen. Staff A stated they were aware of the need for a deep clean of the dishwashing area but were waiting for the replacement of the dishwasher.Refer to WAC 388-97-1100(3)

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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 were compliant with Infection Prevention and Control Guidelines and standards of practice for 1 of 4 residents (Resident 31) reviewed for transmission-based precautions (TBP), 1 of 4 residents (Resident 27) reviewed for bowel and bladder care, and 1 of 3 nurses (Staff F) reviewed for medication administration. The facility failed to ensure the staff were wearing appropriate personal protective equipment (PPE) in accordance with recommended national standards, failed to ensure staff were compliant with appropriate hand hygiene practices during perineal care (process of cleaning genitals and anal area), and failed to ensure there was a barrier in place during medication administration. These failures placed all residents and staff at risk of potential infection. Findings include . Review of the facility policy titled Enhanced Barrier Precautions (EBP), revised 02/2025, stated EBP was utilized to prevent the spread of potential multi-drug-resistant organisms (MDROs) .EBP was applied when resident had a wound .EBP instructs the staff to use gown and glove for any high contact care provided to the residents, face protection may be used if potential splash exposure .high contact areas include but not limited, to dressing, bathing, toileting, device care, and wound care. Review of facility policy titled Hand Hygiene, revised 02/2025, stated facility staff should ensure the staff are performing hand hygiene effectively as it was one of the most effective measures to prevent the spread of infection based on accepted standards of practice .hand hygiene should be performed if hands are visibly soiled, caring for residents with a known organisms, before and after using the restroom, before and after direct care with a resident, before and after wearing gloves, before and after handling of food, and before and after removing PPE. <ENHANCED BARRIER PRECAUTIONS> Resident 31 admitted to the facility on [DATE] with diagnoses to include fracture of their right lower leg with ankle wound. Review of Resident 31’s care plan dated 04/23/2025, documented they were on EBP related to their wound. In a continuous observation on 07/16/2025 at 1:15 PM, observed a sign on Resident 31’s door alerting staff of their EBP status. There was PPE cart outside Resident 31’s door which contained gloves, gowns, face masks and eye protection. Observed Staff W, Nursing Assistant Certified (NAC) enter Resident 31’s room and asked them if they were done with their meal. At 1:57 PM observed Staff W enter Resident 31’s room without any PPE and closed the door. Staff W exited Resident 31’s room at 2:00 PM without any PPE. In an interview on 07/16/2025 at 2:03 PM Staff W, NAC, stated they had assisted Resident 31 with toileting. In an interview on 07/21/2025 at 8:46 AM Staff L, NAC, stated Resident 31 preferred to use the urinal and at times the commode, but usually the bed pan for bowel movements. When asked if staff should be using PPE when assisting Resident 31 with toileting, Staff L stated because the wound was covered the EBP applied only to nurses but did not know for sure. <PERICARE> (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 07/17/2025 at 7:10 AM, Staff J, NAC, provided perineal care to Resident 27. Staff J cleansed the genital area, removed their gloves, placed their contaminated hand into the box of gloves and then applied new gloves without doing hand hygiene. Staff J cleansed the buttocks area, removed their gloves, reached into the box of gloves and then applied new gloves without doing hand hygiene. During an interview on 07/17/2025 at 7:31 AM, Staff J stated they should have washed their hands or used hand sanitizer each time after removing their gloves. During an interview on 07/18/2025 at 1:30 PM, Staff Q, Infection Preventionist, stated staff should perform hand hygiene each time gloves were removed during perineal care: before starting task, after cleaning the buttocks and when completed with the task. <MEDICATION ADMINISTRATION> During an observation on 07/16/2025 at 11:42 AM, Staff O, Licensed Practical Nurse, used a glucometer (meter that measures sugar levels in the blood) inside a resident’s room. Staff O then brought the contaminated glucometer and the vial of glucometer strips from the room and placed them on top of the medication cart without a barrier. Staff O then used a disinfectant cloth to disinfect the glucometer but did not disinfect the medication cart. During an observation on 07/16/2025 at 11:46 AM, Staff O brought an insulin pen (device that contains insulin that can be injected) into a resident’s room and placed it on the overbed table without a barrier. Staff O applied gloves and then injected the insulin, put the pen back on the overbed table and removed their gloves and did hand hygiene. Staff O then exited the resident’s room and placed the insulin pen on top of the medication cart without a barrier. Staff O then unlocked the medication cart and placed the insulin pen inside without disinfecting the pen. Staff O did not disinfect the medication cart where the insulin pen had been sitting. During an interview on 07/16/2025 at 11:48 AM, Staff O stated used equipment were considered contaminated until they had been disinfected. Staff O reported they should have used a barrier under the insulin pen in the resident’s room and that they should have placed a barrier on top of the cart before placing items that had been used in a resident room. During an interview on 07/18/2025 at 1:30 PM, Staff Q stated the nurse should have used a barrier under the glucometer and insulin pen on the resident’s table and used a barrier before placing the used glucometer on top of the medication cart before it was sanitized. Refer to WAC 388-97-1320(1)(a)(c)(2)(a)(b)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 7 resident rooms (107,108, 110, 302, 305, 306, and 307) measured at least 80 square feet per resident in multiple resident rooms and at least 100 square feet in single resident rooms. Failure to ensure residents reside in rooms which met the regulatory requirements for square footage, placed them at risk for living in a physical environment too small to meet their needs. Findings included .Square footage (sq ft):room [ROOM NUMBER] 142 sq ft,room [ROOM NUMBER] 143 sq ft,room [ROOM NUMBER] 143 sq ft,room [ROOM NUMBER] 154 sq ft,room [ROOM NUMBER] 154 sq ft,room [ROOM NUMBER] 154 sq ft,room [ROOM NUMBER] 153 sq ft.Review of the facilities census showed that rooms 107, 108, 110, 302, 305, 306 and 307 all had two beds in each room. In observations made on 07/15/2025, 07/16/2025, 07/17/2025, 07/18/2025, and 07/21/2025 the rooms 107, 108, 110, 302, 305, 306 and 307 had two beds for each room. In an interview on 07/21/2025 at 11:04 AM, Staff A, Administrator stated they had requested an exemption for rooms 107, 108, 110, 302, 305, 306 and 307 with the state, and had not been granted exemption as of current. Refer to WAC 388-97-2440(1)