

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Madison Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. Based on interview, observation and record review the facility failed to periodically inform the residents of their rights after the resident was admitted to the facility. This failure had the potential to diminish the residents' quality of life. Findings included .According to the facility policy titled Resident Rights, dated 2025, documented, the resident has the right to be informed of his or her rights and of rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. In the Resident Council interview on 06/22/2026 at 12:45 PM the residents in attendance (11, 14, 15, 58 and 63) were asked if the staff talked about and reviewed the rights of the residents. Resident 58 stated staff had not talked to them about resident's rights. Resident 63 stated they remembered reading resident rights in their admission packet but that was four years ago. The rest of the residents stated no. Review of Resident Council minutes from April to May 2026 did not show documented evidence that residents' rights were reviewed. In an observation on 06/23/2026 at 8:30 AM, there were no postings about resident's rights in the facility. In an interview on 06/24/2026 at 10:45 AM, Staff M, Activities Director, stated that they had been the Activities Director for a year. Staff M stated they had never discussed resident's rights in their resident council meetings in the last year. When asked why there were no postings of residents' rights in the facility, Staff M later stated they used to be posted in the dining room but was taken off when they did some construction work. In an interview on 06/26/2026 at 11:47 AM, Staff A, Administrator stated that they provide resident rights on admission and were supposed go over them during resident council meetings. Staff A added that they used to have residents' rights posted in the dining room but was taken down during construction and staff did not put it back. No WAC reference.		

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 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. Based on observation, interview and record review, the facility failed to ensure dining rooms included enough space for residents to dine, and for residents to enter and exit a dining room without having to move other residents in 1 of 1 dining rooms. This failure created risk for the inability of staff to respond quickly in an emergency situation, and risk for decreased quality of life for residents unable to dine with their peers. Findings included .In an observation on 06/22/2026 at 8:18 AM, the facility was observed to have one room designated for dining. The room included one refrigerator and one section of upper and lower cabinets. There was one table in the back left corner facing a wall with one resident sitting facing the wall. There were three other square tables in the room. A total of seven residents were in the room for breakfast. All seven residents were in wheelchairs. One resident wheelchair blocked the doorway, and there was no space to walk between the two center tables without moving residents. There was visible table space at tables for 10 residents. The posted facility census on 06/22/2026 was 53 residents. In an observation and interview in the facility dining room on 06/25/2026 at 11:37 AM, residents were beginning to arrive for lunch and Resident 61 stated the dining room got really crowded especially with wheelchairs. Resident 61 stated sometimes there were 10 residents in there and they would run out of room, so if you weren't there early then you just had to eat in your room. Resident 70 was observed to self-propel into the room and over to the corner table that faced the wall. Resident 70 stated they were not crazy about facing the wall but liked to sit alone. Resident 70 stated the problem was that when they were done eating, they had to wait to leave because they couldn't get out past the other resident's wheelchairs blocking the way and stated they wanted there to be a pathway that stayed open. In an observation and interview on 06/25/2026 at 11:48 AM, Staff L, Maintenance Director, was observed measuring rooms, and stated the dining room measured 24 feet by 14 feet. Staff L stated there were usually about eight residents in the dining room. Staff L stated if all 50 (or so) residents wanted to eat in there, that would be an issue. In an interview on 06/25/2026 at 1:54 PM, Staff A, Administrator, stated the prior larger dining room had been converted to the therapy gym and was aware of the small size of the current resident dining room. Staff A stated there was not enough space in the current dining room for more than about 10 residents and stated the facility needed to make a plan for more dining space. Reference WAC 388-97-2760(1)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a psychotropic medication consent for 4 of 6 residents (Residents 3, 16, 72, and 77) reviewed for psychotropic medications (medication that affects the mind, altering mood, thoughts, perceptions, or behavior). This failure placed residents at risk of receiving medications without being informed of the possible risks, or side effects, and a decreased quality of life. Findings included .According to the facility policy titled, Use of Psychotropic Medication(s), dated 2025, the facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care and the resident had the right to accept or decline treatment. RESIDENT 72> Resident 72 was admitted to the facility on [DATE] with diagnosis to include depression. Review of Resident 72's provider's order documented Mirtazapine (an antidepressant) for depression, dated 06/14/2026. Review Resident 72's Medication Administration Record (MAR) for June 2026 documented Mirtazapine was given daily since 06/14/2026. Review of Resident 72's progress note did not document any discussion with resident about starting Mirtazapine. Review of psychotropic medication consents in Resident 72's electronic chart did not show a consent for the Mirtazapine. In an interview on 06/26/2026 at 10:06 AM, Staff I, Resident Care Manager (RCM), stated prior to administering psychotropic medications the licensed nurse was required to obtain consent from the resident or the resident's representative. Staff I could not provide the consent for Resident 72's Mirtazapine medication. Staff I stated they had a new provider for behavioral health and they had placed an order for the Mirtazapine and failed to notify the nursing staff of the new order. <RESIDENT 3> Resident 3 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder (mental health condition characterized by significant mood swings) and depression. Review of Resident 3's provider orders documented lamotrigine (mood stabilizing medication) was ordered for bipolar disorder twice daily on 05/12/2026. Review of Resident 3's MAR dated May 2026 and June 2026, documented they received lamotrigine twice daily. (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's Electronic Medical Record (EMR) showed no consent had been completed for the use of lamotrigine. <RESIDENT 16> Resident 16 was admitted to the facility on [DATE] with diagnoses to include major depressive disorder, anxiety disorder, and bipolar disorder. Review of Resident 16's provider's orders documented olanzapine (antipsychotic medication used to manage psychosis, which includes hallucinations, delusions, paranoia, and disordered thinking) was ordered for depression and bipolar disorder twice daily on 04/02/2026. Review of Resident 16's MAR's dated April 2026, May 2026 and June 2026 documented they received olanzapine twice daily. Review of Resident 16's EMR showed no consent had been completed for the use of olanzapine. <RESIDENT 77> Resident 77 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder, and panic disorder. Review of Resident 77's provider's orders documented lamotrigine was ordered for bipolar disorder twice daily on 05/18/2026. Review of Resident 77's MAR's dated May 2026 and June 2026 documented they received lamotrigine twice daily. Review of Resident 77's EMR showed no consent had been completed for the use of lamotrigine. In an interview on 06/26/2026 at 8:43 AM, Staff G, Licensed Practical Nurse, stated they did not obtain psychotropic medication consents, and the facility Resident Care Managers obtained consents for psychotropic medications. In a joint interview on 06/26/2026 at 9:54 AM, Staff H, RCM and Staff I, stated they were responsible for reviewing risks and benefits of the psychotropic medications with the resident or the resident's responsible party and have a consent signed before the medication was given. Staff H and Staff I confirmed Residents 3, 16, and 72 did not have psychotropic medication consents completed. In an interview on 06/26/2026 at 11:00 AM, Staff B, Director of Nursing Services, stated their expectation was a psychotropic medication consent was completed before psychotropic medications were administered. Refer to WAC 388-97-0260		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident MDS (Minimum Data Set, a required assessment tool) assessments were transmitted as required and within the required timeframes for 3 of 5 residents (Residents 4, 14 and 50) reviewed. This failure had the potential to affect facility CMI (Case Mix Index) and facility payments. Findings included . According to the Resident Assessment Instrument (RAI) Manual, Chapter 2, MDS Discharge Assessments must be electronically transmitted within 14 days of the event that triggered the form. Quarterly MDS Assessments must be electronically transmitted within 14 calendar days of the completion date. <Resident 4> Review of Resident 4's MDS assessment records documented their Discharge MDS dated [DATE] was created and assessment data was collected. The MDS remained in completed status and had not been transmitted within 14 days. <Resident 14> Review of Resident 14's MDS assessment records documented a Quarterly MDS assessment had been created and showed a status of accepted dated 05/13/2026 in the facility system, however the MDS reference date was not until 05/15/2026. The assessment was not included in the validation report of transmitted assessments for the time period. <Resident 50> Review of Resident 50's MDS assessment records documented their Discharge MDS dated [DATE] was created and assessment data was collected. The MDS remained in completed status and had not been transmitted within 14 days. In an interview on 06/23/2026 at 12:35 PM, Staff J, Registered Nurse, MDS Nurse, stated they completed the MDS assessments but were not doing the transmissions. Staff J stated all discharges were supposed to be transmitted. Staff J reviewed Resident 14's quarterly MDS data and stated that the dates made no sense. Staff J confirmed Resident 4 and 50's Discharge Assessments and Resident 14's quarterly MDS had not been transmitted within 14 days as required. In an interview on 06/23/2026 at 12:58 PM, Staff B, Director of Nursing (DNS) stated they used a 3rd party software system for transmission, and they had not been able to view the information and transmissions. Staff B stated the system should not have marked an assessment as accepted if it was not in a transmission batch and the validation reports should have been reviewed to ensure all assessments had been transmitted and accepted. Reference WAC 388-97-1000 (5)(e)(ii,iii)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Minimum Data Set (MDS-an assessment tool) were accurate for 3 of 15 residents (Residents 34, 56 and 72) reviewed for resident assessment. The failure to accurately complete MDS assessments resulted in lack of triggering and completion of Care Area Assessments (CAA -triggered by MDS responses which indicates additional assessments for specific care areas), lack of comprehensive care plan development, inaccurate facility payment, and diminished quality of life. Findings included . <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), depression and metabolic encephalopathy (a problem in the brain that is caused by a chemical imbalance in the blood). <VISION> Review of Resident 72's admission MDS assessment dated [DATE] under section B for vision, documented that the resident's vision was adequate with no glasses. In an interview on 06/24/2026 at 2:38 PM, Resident 72 stated they could not see things up close and they used eyeglasses to help them read. Review of Resident 72's care plan documented that resident had impaired visual function due to advanced age. The care plan intervention initiated on 05/07/2026 documented the resident wore glasses and requested assist with glasses. <PAIN> Review of Resident 72's MDS section J for pain documented that non-medication interventions were provided. Review of Resident 72's June 2026 Medication Administration Record (MAR) and progress notes (print date) 06/23/2026, reviewed there was no documentation that non-medication interventions were provided for the resident prior to giving pain medication. Review of Resident 72's care plan did not show any documentation of non-medication interventions for pain. Review of Resident 72's CAA for pain and the characteristics of the pain, frequency and intensity of pain, non-verbal indicators of pain were all blank. There was no resident/representative input regarding pain. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<ANTIPSYCHOTIC MEDICATION> Review of Resident 72's MDS section N documented that the resident received antipsychotic (medication that alters brain chemistry to reduce symptoms such as hallucinations, delusions or disordered thinking) medication but under section N it was marked that resident did not receive any antipsychotic medications. Review of Resident 72's CAA for psychotropic (medication that alters brain function, affecting a person's mood, thoughts, feelings or behaviors) drug use, revealed there was no documentation on any specific behaviors the resident exhibited or any specific adverse side effects. There was no input from the resident or their representative regarding psychotropic drug use. Review of Resident 72's care plan had no documentation regarding psychotropic drug use. In an interview on 06/25/2026 at 2:06 PM, Staff J, Registered Nurse, MDS Nurse stated their process for gathering information for the MDS was interviewing the resident and reviewing notes in the resident's chart. Staff J stated the Resident Care Managers (RCM) were the ones that did initial pain assessment and they reviewed the notes the RCM documented to code for the pain section of the MDS. When asked their process in filling out the CAA, Staff J stated that they were supposed to answer the questions on the CAA's that got triggered but had not been answering them prior to this month. Staff J looked at Resident 72's MDS, under vision, it documented that resident's vision was adequate, but care plan showed Resident 72 had impaired vision. Staff J was unable to answer why the care plan and MDS contradicted. Staff J was not able to provide evidence the resident had adequate vision. For non-medication intervention, Staff J stated they were unable to find evidence that staff provided non-medication intervention to the resident. Regarding psychotropic medication, Staff J stated they made a mistake in answering the question and they should have marked yes since the resident received antipsychotic medications. Staff J was unable to explain why the CAA's for pain and psychotropic sections were not answered for Resident 72. Staff J stated it's mostly the RCMs that updated the care plan. Staff J was unable to explain why psychotropic drug use was not in Resident 72's care plan. Staff J stated they would be updating the MDS for Resident 72. <RESIDENT 56> Resident 56 admitted [DATE]. Review of the Nursing admission assessment dated [DATE] documented the resident had missing and broken teeth. A baseline care plan was initiated related to oral/dental problems. In an observation and interview on 06/23/2026 at 9:24 AM, Resident 56 stated their teeth were terrible. Resident 56 opened their mouth and pointed to their lower jaw with visible tooth fragments and missing teeth. Resident 56 said their teeth had been in bad shape for a long time and said they had been seen by someone here at the facility who told them they needed them all pulled. Resident 56 stated they had to avoid certain foods and if they bit down wrong they sometimes got a sharp shooting pain. Resident 56 had not been told about any further follow up. Review of the admission MDS dated [DATE] documented no for abnormal mouth tissue, obvious or (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	likely cavity or broken natural teeth, inflamed or bleeding gum tissue. As a result of the negative MDS responses, no CAA for Dental was triggered or completed, and the comprehensive care plan was not revised. In an interview on 06/25/2026 at 11:25 AM, Staff J stated they were doing their own physical assessments of residents, observed their mouth and interviewed the residents when doing the MDS and stated they must have missed Resident 56's mouth issues, and should complete correction. Staff J stated they did review the other nursing assessments but completed their own assessments as well. Staff J stated they did the Care Area Assessments that triggered but the Resident Care Managers did the care plans. <RESIDENT 34> Resident 34 was readmitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD-a progressive lung disease which blocks airflow and makes breathing difficult). Review of the admission MDS assessment dated [DATE], coded Resident 34 as having COPD with shortness of breath or trouble breathing when lying flat. This assessment coding placed the resident into a special high nursing category, which resulted in a higher reimbursement rate. Review of Resident 34's Electronic Health Record (EHR), showed no clinical documentation supporting the coding the resident experienced shortness of breath or trouble breathing when lying flat during the assessment coding window. In an interview on 06/24/2026 at 12:15 PM, Staff J stated there should be supporting clinical documentation to code the resident as having shortness of breath or trouble breathing when lying flat. Staff B confirmed they could not find any such documentation to validate the assessment coding. Reference WAC 388-97-1000 (1)(b)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 the Pre-admission Screening and Resident Review (PASRR- assessment/a federal requirement for Medicaid-certified nursing facilities to ensure individuals, especially those with mental illness, seeking admission are appropriately placed and receive necessary services) level I were referred for a PASRR level II and followed up on for 6 of 7 residents (Residents 2, 3, 30, 56, 72, and 77) reviewed for PASRR. This failure placed residents at risk of unmet mental health services and a diminished quality of life. Findings included .<RESIDENT 56> Resident 56 admitted on [DATE] with diagnoses which included substance abuse, mood and anxiety disorders. Review of Resident 56's level I PASSR dated [DATE], identified mood disorder, anxiety disorder and substance abuse disorder and identified a level II evaluation was required. A Notice of Determination was noted in the record dated [DATE], which identified that Resident 56 had been in the skilled nursing facility for greater than 30 days and required level II evaluation. Review of Resident 56's medical record revealed no level II evaluation had been completed since their admission. In an interview on [DATE] at 10:25 AM, Staff C, Social Services Director, stated Resident 56 required a level II PASSR evaluation and stated they received the Notice of Determination but nothing else at this time. Staff C confirmed no level II had been completed for Resident 56 and had no evidence of communication or attempts to follow up with the PASSR coordinator regarding Resident 56. <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). Review of Resident 72's PASRR documented the resident met the criteria of 30-day exemption. However, the date of the PASRR was [DATE] which expired prior to the resident's admission to the facility. Review of Resident 72's electronic chart did not have any other PASRR on file. In an interview on [DATE] at 11:42 AM, Staff S, admission Marketing Director, stated that they reviewed the PASRR prior to accepting the resident to their facility. They reviewed the accuracy of the PASRR. If they had a 30-day exemption Staff S notified the Social Worker to follow up. If they were not exempted, then they needed the notice of determination prior to accepting residents to their facility. Staff S reviewed Resident 72's PASRR and stated they missed the date. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<RESIDENT 30> Resident 30 readmitted to the facility on [DATE] with diagnoses to include bipolar disorder (a mental health condition that caused extreme shifts in mood, energy, activity levels, and concentration). Review of Resident 30's updated Level I PASRR, dated [DATE], showed Resident 30 had indicators of a Serious Mental Illness and a level II evaluation was required. Review of Resident 30's Electronic Health Record (EHR) showed no Level II PASRR was completed prior to the resident being admitted in the facility. In an interview on [DATE] at 2:50 PM, Staff C confirmed Resident 30 required a Level II PASRR but there was not one in their EHR. In an interview on [DATE] at 11:13 AM, Staff A, Administrator, stated the expectation was to obtain Level II required PASRR prior to admission. <RESIDENT 2> Resident 2 was admitted to the facility on [DATE] with diagnoses to include major depressive disorder, and generalized anxiety disorder. Review of Resident 2's PASRR level I, dated [DATE], documented the PASRR level II was not indicated due to 30 days hospital exemption and a PASRR level II must be completed if a scheduled discharge in 30 days did not occur. Review of Resident 2's progress note dated [DATE] at 8:55 AM, Staff C documented they faxed the PASRR level I to the PASRR level II evaluator. <RESIDENT 3> Resident 3 was admitted to the facility on [DATE] with diagnoses to include bipolar and depression. Review of Resident 3's PASRR level I, dated [DATE], documented a PASRR level II evaluation referral was required. Review of Resident 3's EHR showed the PASRR level I was faxed to the PASRR level II evaluator on [DATE]. Review of Resident 3's progress notes dated [DATE] through [DATE] showed no documentation related to PASRR level II follow up. <RESIDENT 77> Resident 77 was admitted to the facility on [DATE] with diagnoses to include bipolar disorder, and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 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. They did not know why elopement risk was not in the resident's care plan. <PSYCHOTROPIC MEDICATIONS> (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<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 &ndash; 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. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 77's MAR and TAR, dated June 2026, did not include non-pharmacological interventions for pain management. 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. (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 06/23/2026 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 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)		

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Centers for Medicare & Medicaid Services

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure there was eight consecutive hours of Registered Nurse (RN) coverage each day. Failure to have adequate RN coverage placed residents at risk for inadequate assessment of medical conditions which could cause their health to decline. Review of the 30-day staffing pattern form, dated 05/23/2026 - 06/22/2206, documented six of the 31 days did not have eight consecutive hours of RN coverage. During an interview on 06/25/2026 10:06 AM, Staff B, Director of Nursing services, stated they were aware that they did not meet the requirement for RN coverage as they did not have enough RNs on staff. Refer to WAC 388-97-1080 (8)		

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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. Based on observation and interview, the facility failed to ensure dietary staff were following USDA Food Code requirements for hair restraints in 1 of 1 facility kitchens. Failure of staff with facial hair to wear beard restraints created the potential for physical and biological contamination of facility food. Findings included .In an observation through the kitchen door on 06/22/2026 at 8:00 AM, one cook and two other kitchen staff were observed in the food area plating breakfast items. Both the cook and one of the two dietary staff were observed with beards and neither were wearing beard coverings. In an observation and interview on 06/24/2026 at 11:52 AM, Staff K, Dietary Manager, and Staff O, Dietary Aid were observed with facial hair and without beard coverings in the food service areas. Staff O stated they believed they were not required to wear beard restraints because their facial hair was not over an inch long. Staff O further stated they did not have a supply of beard restraints due to the belief they were not required. Staff O stated they would have to order beard coverings. In an interview on 06/25/2026 at 1:49 PM, Staff A, Administrator stated any kitchen staff with facial hair needed to wear a beard cover and stated they had provided reminders recently about this. Staff A was not aware that beard restraints had not been ordered or available in the kitchen due to misinformation about their requirement. This is a repeat deficiency from SOD dated 07/21/2025. Reference WAC 388-97-1100 (3)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 that Enhanced Barrier Precautions (EBP -infection control intervention designed to reduce transmission of multidrug-resistant organisms requiring staff to wear gowns and gloves during high-contact resident care activities) were observed for 2 of 3 residents (Resident 6 and 76) sampled for medication administration and 1 of 1 resident (Resident 47) observed during a Hoyer lift (an assistive medical device used to safely transfer residents between a bed to wheelchair) transfer. These failures placed residents at risk of infection and diminished quality of life. Findings included .According to facility policy titled: Enhanced Barrier Precautions, dated 2025, documented EBP will be used during care of feeding tubes and central lines, and high contact care activities such as transferring. <MEDICATION ADMINISTRATION><RESIDENT 6>Resident 6 was admitted to the facility on [DATE]. Resident 6 has a feeding tube. In an observation on 06/22/2026 at 8:51 AM, prior to entering Resident 6's room, there was an EBP sign posted at the door. In an observation and interview on 06/22/2026 at 8:51 AM, Staff P, Licensed Practical Nurse administered medication to Resident 6 via feeding tube (medical device inserted directly through the abdomen into the stomach). Staff P did not wear a gown. Staff P stated the EBP sign that was posted at the door was for Resident 6 because of their feeding tube. Staff P stated they should have worn a gown when they were giving medications to the resident. <RESIDENT 76>Resident 76 was admitted to the facility on [DATE]. Resident 76 has a central line. In an observation on 06/24/2026 at 4:06 PM, prior to entering the Resident 76's room, there was an EBP sign posted at the door. In an observation and interview on 06/24/2026 at 4:06 PM, Staff N, Registered Nurse, flushed and connected the intravenous (IV) medication for Resident 76 without wearing a gown. Staff N stated the EBP sign that was posted at the door was for Resident 76. Staff N added they should have worn a gown prior to administering Resident 76's IV medication. <HOYER LIFT>Resident 47 was admitted to the facility on [DATE]. Resident has a feeding tube.In an observation on 06/22/2026 at 11:13 AM, prior to entering Resident 47's room, there was an EBP sign posted at the door. In an observation and interview on 06/22/2026 at 11:13 AM, Staff Q, Nursing Assistant Certified (NAC) and Staff R, NAC, transferred Resident 47 from their bed to their wheelchair using the Hoyer lift. Neither staff were wearing gowns. Asked both staff what the EBP sign that was posted on resident's door and Staff Q stated it meant they were to wear a gown when changing briefs or cleaning the resident. Staff Q then added that they should have worn a gown when they transferred the resident to their wheelchair.In an interview on 06/25/2026 at 10:05 AM, Staff D, Infection Control Nurse, reported they do rounds, on the spot checks and audits and if they notice a staff member not following precautions signs, they will provide an education for that staff right away. Staff D was unable to explain why the staff did not follow the precaution signs.In an interview on 06/26/2026 at 11:40 AM, Staff B, Director of Nursing Services, stated staff were able to verbalize that they were to wear gowns and gloves when providing high-contact care to residents on EBP but unable to explain why the staff did not follow the precaution signs. Refer to WAC 388-97-1320(1)(a)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to timely complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS-an assessment tool) for 1 of 2 residents (Resident 53), reviewed for SCSA. This failure placed the residents at risk for delayed care planning, unmet care needs, and diminished quality of life. Findings included .Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1, dated October 2025, showed that an SCSA is a comprehensive assessment that must be completed when the Interdisciplinary Team determines a resident meets the significant change guidelines for a major decline or improvement in status that impacts more than one area of health status, and the condition is not expected to return to baseline within two weeks. Resident 53 was admitted to the facility on [DATE].Review of a quarterly MDS dated [DATE], coded Resident 53 with no pressure ulcer, no skin treatment, rejecting care one to three days, and required dependent assistance for toilet transfers.Review of a dietary progress note dated 04/15/2026, documented Resident 53 had an 8.1% weight loss over 180 days.Review of a progress note dated 04/23/2026 at 9:38 PM, documented Resident 53 had dysphagia (difficulty of swallowing) and ate less than 50% of meals.Review of a dietary progress note dated 05/06/2026, documented Resident 53 had an 11.2% weight loss over 180 days.Review of a skin observation dated 05/22/2026 at 11:44 AM, showed Resident 53 had developed two pressure ulcers.Review of an initial wound consultant progress note, dated 05/27/2026 at 07:07 AM, documented per discussion with nursing staff and Director of Nursing, the resident had significant decline in function, weight loss, increased weakness, a decline in getting out of bed, and refusal of position changes over the past several months.Review of a quarterly MDS dated [DATE], coded Resident 53 with stage three pressure ulcers with pressure ulcer care, holding food in mouth/cheeks or residual food in mouth after meals, and toilet transfers were coded as not applicable.Review of Resident 53's Electronic Health Record (EHR), showed there was no completed comprehensive SCSA after Resident 53 sustained a decline in status that impacted multiple areas of their health status.In an interview on 06/24/2026 at 1:47 PM, Staff B, Director of Nursing, stated Resident 53 developed facility-acquired pressure ulcers after declining ADLs (Activities of Daily Living), exhibiting poor nutritional intake, experiencing weight loss, and refusing to transfer. Staff B stated Resident 53's condition was not expected to return to baseline within two weeks. Staff B confirmed and stated they expected an SCSA would have been completed following this multi-system decline. Reference WAC 388-97-1000 (3)(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 observation, interview and record review, the facility failed to ensure professional standards were met for 1 of 1 resident (Resident 76) sampled for intravenous (IV-into the vein) medication administration. The failure to have a physician's order for the IV flush (injecting a sterile solution to clear medications, prevent blood clots and verify the line is working) placed resident at risk for complications included blockage of line and adverse outcomes. Findings included . According to the facility policy titled Intravenous Therapy, dated 2025, the policy documented to utilize a 10 milliliter (ml) syringe of normal saline to inject and confirm patency of vascular access device per protocol. Resident 76 was admitted to the facility on [DATE] with diagnoses to include pyogenic arthritis (serious, painful bacterial infection of joint space). In an observation on 06/24/2026 at 4:06 PM, Staff N, Registered Nurse flushed Resident 76's central line (long flexible tube inserted into a large vein from the chest with the tip near the heart, use to give IV antibiotics) with 5 ml of normal saline then started an IV antibiotics infusion for the resident. Record review of Resident 76's physician's orders with a print date of 06/24/2026 did not show an IV flush order. In an interview on 06/24/2026 at 4:40 PM, Staff N, stated they must have an order for IV flushes, and they were supposed to flush before and after the IV antibiotics were infused. Staff N could not find the order for the IV flush for Resident 76. Staff N stated that the night before, an IV nurse needed to be paged to the facility to clear Resident 76's central line for blockage. In an interview on 06/26/2026 at 7:18 AM, Staff B, Director of Nursing Services stated it's an expectation to have an order for IV flushes and they were unsure as to why Resident 76 did not have an order. Reference WAC 388-97-1620(2)(b)(ii)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received proper assistive devices to maintain their hearing abilities for 1 of 2 residents (Resident 30) reviewed for hearing services. This failure placed the resident at risk for declined communication and decreased quality of life. Findings included .Review of the facility policy titled, Hearing and Vision Services, copyright date 2026, documented employees would assist the resident with the use of any devices or adaptive equipment needed to maintain hearing. Resident 30 was readmitted to the facility on [DATE]. In an interview and observation on 06/22/2026 at 8:34 AM, Resident 30 stated they could not hear when asked questions and they needed their hearing aids. It was observed the resident was not wearing hearing aids. In an observation on 06/22/2026 at 1:34 PM, Resident 30 was observed not wearing hearing aids. In an interview and observation on 06/23/2026 at 8:56 AM, Resident 30 stated they needed their hearing aids. It was observed that the resident was not wearing hearing aids. In an interview on 06/23/2026 at 1:28 PM, Staff Q, Nursing Assistant Certified (NAC), stated Resident 30 had hearing impairment and did not have hearing aids. Staff Q stated they simply increased their speaking volume and spoke closely into the resident's left ear since their left side had better hearing. In an interview and observation on 06/23/2026 at 1:41 PM, Staff T, NAC, stated they had not seen Resident 30 wore hearing aids. Staff U, Licensed Practice Nurse (LPN), joined the conversation and stated they had just placed the hearing aids on the resident. Together with Staff T present, Resident 30 stated the hearing aids did not work and they still could not hear. In an observation on 06/24/2026 at 8:55 AM, Resident 30 was observed not wearing hearing aids. In an interview and observation on 06/24/2026 at 8:58 AM, Staff V, LPN, stated Resident 30's hearing aids did not work because they could not be charged, and noted that one aid was missing. Staff V stated the hearing aids stopped working recently and the missing aid was reported yesterday. It was observed that the hearing aids case was kept in the medication cart; there was no charger with the case, and only one hearing aid was in. Review of Resident 30's care plan, initiated 11/25/2023, documented the resident wore bilateral hearing aids. Review of Resident 30's June 2026 Medication Administration Record (MAR) documented an order to provide bilateral hearing aids in the morning and remove them at night, effective since 08/25/2025. The MAR further documented a code 9 indicating Other/See Progress Notes on the night of 06/06/2026 and the morning of 06/22/2026. Review of Resident 30's progress notes on 06/06/2026 and 06/22/2026, revealed no documentation corresponding to the code 9. In an interview on 06/24/2026 at 1:36 PM, Staff V stated they documented a code 9 on 06/22/2026 because the hearing aids were not working .In an interview on 06/25/2026 at 9:46 AM, Staff I, LPN/Resident Care Manager, stated they documented a code 9 on 06/06/2026 because Resident 30 had not been wearing the hearing aids since that morning. In an interview on 06/26/2026 at 12:31 PM, Staff B, Director of Nursing, stated they expected the nurse to apply the hearing aids for the resident and replace the missing the hearing aid. Reference WAC 388-97-1060(3)(a)		

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NAME OF PROVIDER OR SUPPLIER Madison Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dialysis communication documents were filled out after the resident had their dialysis appointments and returned to the facility for 1 of 1 resident (Resident 77) reviewed for dialysis. This failure placed Resident 77 at risk of inadequate or lack of assessment and documentation upon arrival back at the facility, undetected dialysis complications, and a decreased quality of life. Findings included .Review of the facility provided policy "Hemodialysis," with an implementation date of 06/10/2026 documented the facility would assure that each resident received care and services for the provision of hemodialysis consistent with professional standards of practice. The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments The nurse would monitor and document the status of the resident's access site upon return from the dialysis treatment Resident 77 was admitted to the facility on [DATE] with diagnoses to include end stage renal disease and severe chronic kidney disease. Review of Resident 77's care plan documented they required dialysis three days per week on Mondays, Wednesdays and Fridays at the dialysis clinic. Review of Resident 77's pre and post dialysis assessments dated 06/10/2026, 06/12/2026, 06/17/2026, 06/19/2026, 06/24/2026, and 06/26/2026 did not have post dialysis assessment documentation. In an interview on 06/26/2026 at 8:46 AM, Staff G, Licensed Practical Nurse, stated they did not have an assessment or form to complete after the resident returned from the dialysis clinic. In an interview on 06/26/2026 at 9:54 AM, Staff I, Resident Care Manager, stated the nurse should document on the post dialysis assessment form when they returned from a dialysis treatment and confirmed the documentation was not completed. In an interview on 06/26/2026 at 11:00 AM, Staff B, Director of Nursing Services, stated they had issues with dialysis documentation and were in the process of finding a solution, possibly a different form to complete. Staff B stated their expectation was the post dialysis assessment and documentation would be completed. Reference WAC: 388-97-1900(1)(6)(a-c)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Madison Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 routine and emergency dental services were provided for 1 of 1 resident (Resident 56) reviewed for dental services. This failure had the potential to result in infection, pain and decreased quality of life. Findings included . Resident 56 admitted [DATE]. Review of the Nursing admission assessment dated [DATE] documented the resident had missing and broken teeth. A baseline care plan was initiated related to oral/dental problems. In an observation and interview on 06/23/2026 at 9:24 AM, Resident 56 stated their teeth were terrible. Resident 56 opened their mouth and pointed to their lower jaw with visible tooth fragments and missing teeth. Resident 56 said their teeth had been in bad shape for a long time and said they had been seen by someone here at the facility who told them they needed them all pulled. Resident 56 stated they had a prior dentist and was able to state the name and place of their community dental office. Resident 56 stated they had to avoid certain foods and if they bit down wrong they sometimes got a sharp shooting pain. Resident 56 had not been told about any further follow up and voiced anxiety about the whole process. Review of a dental hygienist visit note dated 05/14/2026 included instructions to refer to a dentist for lower root tip extractions and full upper denture. Further review of the record found no evidence of any follow up related to the dental hygienist visit and recommendations. In a joint interview on 06/23/2026 at 2:49 PM, Staff H, Resident Care Manager, stated Resident 56 did have broken teeth and it was recommended that they pull them. Staff I, Resident Care Manager, stated Resident 56's family member also wanted them to be seen by a dentist. Staff J added that there were no dental appointments scheduled, stating that Resident 56 had been unsure about wanting their teeth pulled and may refuse the appointment due to anxiety. Staff J stated they had not spoken to Resident 56 about their teeth lately and had not been been aware Resident 56 was having complaints about their diet or that they had tooth pain. Staff J had not reached out to the prior dental office for information stating they did not know about them. Reference WAC 388-97-1060(3)(vii)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505463	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Madison Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 (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 06/22/2026, 06/23/2026, 06/24/2026, 06/25/2026 and 06/26/2026 the rooms 107, 108, 110, 302, 305, 306 and 307 had two beds for each room. In an interview on 06/26/2026 at 11:30 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. Reference WAC 388-97-2440(1)		