STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505465	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Josephine Caring Community	9901 272nd Place Northwest Stanwood, WA 98292

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure resident choices/preferences regarding their bathing schedule were honored for 3 of 4 sampled residents (Residents 2, 3, and 4) reviewed for choices. These failures placed the residents at risk for decreased cleanliness, increased risk of infection and diminished quality of life. Findings included .<RESIDENT 2>Resident 2 admitted to the facility on [DATE] with diagnosis to include a stroke with right side hemiplegia (paralysis to one side of the body) and hemiparesis (a condition that causes weakness or partial paralysis on one side of the body). Review of the quarterly Minimum Data Set (MDS - an assessment tool) assessment, dated 12/08/2025, documented the resident was moderately impaired in decision making skills, dependent with showers/bathing and shower transfers. Review of Resident 2's Preference care plan, with a target date of 03/05/2026, documented the resident preferred to take a shower two times a week before breakfast. Review of Resident 2's November 2025 Documentation Survey Report v2 (v2 report), documented the resident received a shower on 11/03/2025, refused on 11/06/2025, received a shower on 11/11/2025 (seven days in between showers), 11/14/2025, 11/19/2025, refused on 11/21/2025, and received a shower on 11/25/2025. There was no documentation regarding if the resident was offered a shower after they refused on 11/06/2025. Review of Resident 2's December 2025 v2 report, documented the resident received a shower on 12/05/2025 (eight days since their last shower), 12/08/2025, 12/09/2025 (nine days since their last shower), and 12/23/2025. Review of Resident 2's v2 report, dated 01/01/2026 to 01/22/2026, documented the resident received a shower on 01/02/2026 (10 days since their last shower), 01/06/2026, 01/15/2026 (nine days since their last shower, refused a shower on 01/14/2026), and received a shower on 01/21/2026 (six days since their last shower). In an interview and observation on 01/21/2026 at 12:35 PM, Resident 2 was lying on their back slightly turned to the rights side. The resident was dressed in a hospital gown and their hair was disheveled. Observation on 01/21/2026 at 12:57 PM and 2:55 PM, Resident 2 was lying in bed, their hair was disheveled. Observation on 01/22/2026 at 9:30 AM, 10:10 AM, 12:00 PM, 2:02 PM, and 3:07 PM, Resident 2 was lying in bed, hair disheveled, and in a hospital gown. <RESIDENT 3>Resident 3 was a long-term care resident. Review of Resident 3's Quarterly MDS assessment, dated 11/26/2025, documented the resident had no cognitive impairment and was dependent on staff for showers. Review of Resident 3's Resident Preferences care plan, revised on 07/07/2021, documented the resident preferred to take a shower twice a week. Review of Resident 3's November 2025 v2 report, documented received a shower on 11/06/2025 and on 11/13/2025 (six days between showers). The resident received showers per their preference 11/13/2025. Review of point of care Nursing Assistant Certified (NAC) documentation from 12/21/2025 to 12/31/2025, documented Resident 3 received a shower on 12/25/2025 and 12/30/2025. Review of Resident 3's January 1 through 21, 2026 v2 report, documented the resident received a received a shower on 01/05/2026, 01/13/2026 (seven days in between showers), and as of 01/22/226, it had been 8 (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	days since the resident was last showered. In an interview and observation on 01/22/2026 at 8:50 AM, Resident 3 was dressed, sitting in their wheelchair in their room. Resident 3 stated they preferred to be showered twice a week, and they barely get one a week. <RESIDENT 4>Resident 4 was a long-term care resident. Review of Resident 4's Annual MDS assessment, dated 01/13/2026, documented the resident was able to make their needs known, and required substantial assistance from staff for bathing. Review of Resident 4's Preference care plan, revised on 07/25/2025, documented the resident preferred to a shower twice a week. In an interview on 01/21/2026 at 12:03 PM, Resident 4 was sitting in their room sitting in a wheelchair. When asked if they were bathed per their preferences, Resident 4 stated no. The resident stated they were bathed on Tuesday's and Friday's. Resident 4 stated it had been eight days since their last shower. The resident stated that last week they went to a doctor's appointment and their family member told them they smelled like urine. Resident 4 stated, this was embarrassing, I can only do so much from a wheelchair. Review of Resident 3's December 2025 v2 report, documented the resident received a shower on 12/02/2025, 12/09/2025 (six days since their last shower), 12/17/2025 (seven days since their last shower), 12/23/2025 (five days since last shower), 12/26/2025 and 12/30/2025. Review of Resident 3's January 1 through 22, 2026 v2 report, documented the resident received a shower on 01/06/2026 (six days since last shower), 01/13/2026 (six days since last shower) and 01/22/2026 (eight days since their last shower). <INTERVIEWS>In an interview on 01/21/2026 at 10:00 AM, Staff F, NAC/shower aid, stated the Kardex (a guide used by the NAC to help direct the residents individualized care) should obtain information on what day and time of day a resident preferred their shower. Staff F stated Monday through Friday they have a shower sheet they documented the residents' weight and when a shower was done. This shower sheet was turned into Staff C, Licensed Practical Nurse/Assistant Director of Nursing. Staff F stated they documented in the resident's electronic medical record (EMR) when a shower was completed. If a resident refused, Staff F stated they reported the refusal to the Licensed Nurse (LN) and documented the refusal in the EMR. In an interview on 01/22/2026 at 9:19 AM, Staff H, NAC, stated the shower NAC showered the residents. If the shower NAC could not complete the resident's shower, they would attempt to provide the shower and documented this information in the resident's EMR. In an interview on 01/22/2026 at 9:46 AM, Staff I, NAC, stated there was a shower NAC on each section of the facility. Staff I stated they occasionally would be directed to shower a resident. Staff I stated showers were documented in the resident's EMR. Staff I stated if a resident refused care, this would be documented in the EMR and reported to the LN. In an interview on 01/22/2026 at 11:33 AM, Staff D, LPN/Nurse Manager, stated a resident's shower preferences were obtained upon admission and as needed. This information included the type of bathing (shower, bath, or bed bath) and how often the resident preferred to be bathed. This information was placed on the resident's care plan. The expectation was when a shower was completed, the NAC documented the information in the resident's EMR. When a resident refused, the NAC reported the refusal to the LN and documented the refusal in the EMR. A joint interview was conducted on 01/22/2026 at 12:14 PM with Staff B, Registered Nurse (RN)/Director of Nursing Services (DNS), and Staff C. Staff C stated that residents were asked what their bathing preferences were upon admission (which included the type of and frequency of being bathed) and was placed on the resident's care plan. Staff C stated there were usually four shower NAC's working five days a week. Staff B stated the expectation was the shower NAC documented when a shower was completed in the resident's EMR, and if they refused the LN was notified and the refusal was documented in the EMR. Reference WAC 388-97-0180(2)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure quality of care and services was provided for 2 of 3 sampled residents (Residents 1 and 2) reviewed for skin, positioning, and assistance with meals. These failures placed residents at risk of medical complications and a diminished quality of life. Findings included .<RESIDENT 1>Resident 1 re-admitted to the facility on [DATE] with diagnoses to include Parkinson's Disease (a disorder of the nervous system affecting movement), Cerebellar ataxia (damage to the brain causing poor coordination and balance problems), Dementia (affects memory), and Muscle Weakness. Review of quarterly Minimum Data Set (MDS-an assessment tool) assessment, dated 12/23/2025, the resident had no cognitive impairment. In a joint interview on 01/21/2026 at 12:37 PM, with Resident 1 and (Collateral Contact) CC1, Resident 1 stated they had talked to CC1 on 01/18/2026 and reported the rash to her toes and feet had worsened and was painful. Resident 1 stated that staff do not clean their feet prior to applying the ointment for the rash. CC1 stated during a visit with Resident 1 on 01/18/2026, when observing the resident's toes and feet they were red, discolored with skin breakdown. Review of Resident 1's skin care plan, undated, documented the resident had chronic dermatitis to lower extremities. on 1/19/2026 the skin care plan reflected a fungal rash to bilateral toes. Review of Resident 1's physician orders showed an order for Triamcinolone Acetonide External Ointment 0.1 % (Triamcinolone Acetonide (Topical)), apply to affected area topically two times a day for rash, dated 07/13/2025 and discontinued 01/20/2026. The order did not indicate where to apply the ointment or how long the ointment should be used. Review of Resident 1's Medication Administration Record (MAR) dated October 2025, November 2025, December 2025, and January 1st through 21st 2026, did not show monitoring of skin issue to feet/toes or cleaning of skin prior to application of ointment to the resident's feet/toes. Review of Resident 1's Treatment Administration Record (TAR) dated October 2025, November 2025, December 2025, and January 1st through 21st 2026, did not show monitoring of skin issues to feet/toes, or cleaning of skin prior to application of ointment of the resident's feet/toes. In an interview and observation on 01/21/2026 at 3:31 PM Staff E, Licensed Practical Nurse (LPN), stated Resident 1 had a rash to their feet/toes, had an ointment that was applied to their toes/feet, and their feet had not been cleaned prior to applying the ointment until 01/20/2026. Observation of Resident 1's feet showed the resident's toes were red with some areas of lighter skin on the top of the toes with moisture between the 2nd and 3rd toes on the right foot, a crusted yellowish flakey skin across the bottom of the toes on the top of both feet, and a red rash to the inner ankle area of the right foot. In an interview and record review on 01/22/2026 at 12:31 PM, Staff D, LPN/Nurse Manager, stated while working on 01/19/2026 Resident 1 had reported that their toes were red and uncomfortable and they were afraid they would lose her toes. Staff D stated they observed the resident's feet and their toes were red and there was a crusty area at the bottom of the toes at the top of the foot, the doctor was notified. Staff D stated the resident was being treated for a stasis dermatitis rash to their feet. Staff D stated skin issues would have been monitored when the ointment was applied and if a change was identified the nurse would make a note. Staff D reviewed the resident's electronic medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record (EMR) and stated the Triamcinolone Acetonide External Ointment instructions showed to apply to affected area, the ointment was for itching and would be applied to the skin area that the resident said was itching. Staff D stated the ointment was being applied to both of the resident's feet. Staff D stated if the resident's feet were to be cleaned prior to administration of the ointment it would have been included in the order. In an interview and record review on 01/22/2026 at 2:30PM, Staff B, Registered Nurse/Director of Nursing, when asked if treatment orders would have an end date, stated treatment orders would usually include application site and have an end date. Staff B reviewed the resident's Triamcinolone Acetonide External Ointment order and acknowledged there was not a specific application site or end date for use. When asked if skin would be cleaned prior to application of an ointment Staff B stated not necessarily. When asked what the expectation was for documenting description of skin issue and monitoring of skin issues, Staff B stated they were looking for information. When asked how skin treatments were monitored and evaluated for effectiveness, Staff B stated they were looking for information. No further information was provided. <RESIDENT 2>Resident 2 admitted to the facility on [DATE] with diagnosis to include a stroke with right side hemiplegia (paralysis to one side of the body) and hemiparesis (a condition that causes weakness or partial paralysis on one side of the body). Review of the quarterly MDS assessment, dated 12/08/2025, documented the resident was moderately impaired in decision making skills, required substantial/maximal assistance to turn side to side in bed, required supervision or touching assistance with meals, was at risk for developing pressure ulcers (PU's – also known as a pressure injury, was a localized injury to the skin and/or underlying tissue caused by prolonged pressure), and was dependent with dressing needs. Review of Resident 2's care plan titled, Resident Status in Bilateral Activities of Daily Living and Functional Mobility, dated 08/02/2025, documented the resident required substantial/ maximal assistance with two people for bed mobility. The resident was able to feed themselves after set up assistance and required occasional monitoring and cueing. Review of Resident 2's at risk for developing pressure injuries (PI's), dated 01/13/2026, documented the resident current open PI's to include their right outer ankle and left heel. Staff were directed to float (elevate the heels off a surface to prevent PI's) the resident's heels when in bed as they allowed. In an interview and observation on 01/21/2026 at 12:35 PM, Resident 2 was lying on their back slightly turned to the rights side, their lower legs were uncovered, and their heels were lying directly on the surface of the bed. There was an untouched lunch meal tray observed on the over the bed table. The resident could not accurately answer interview questions. In an observation on 01/21/2026 at 12:57 PM, Resident 2 was lying supine in bed, feet were covered and an unidentified staff member was standing on the left side of the bed observed assisting them with their meal. In an observation on 01/21/2026 at 2:55 PM, Resident 2 was lying on their right side, with the head of the bed elevated, the resident was positioned down in the bed with their torso leaning back towards the left edge of the bed, their knees were hanging over the right side of the mattress edge. Their lower legs were observed positioned bent back at the knee with the left leg resting on the right leg, and the right outer ankle was lying directly on the mattress. In an interview on 01/22/2026 at 9:19 AM, Staff H, NAC, stated they knew how to care for a resident by reviewing their Kardex (a guide used by the nursing assistant to help direct the residents individualized care) that was handing inside of their closet. If they had any further questions, they would ask the Licensed Nurse (LN). When there was a change to the residents' Kardex this was communicated to the care staff by a typed in-service that the staff read and signed. In an interview on 01/22/2026 at 9:37 AM, Staff L, NAC, stated that they knew how to care for a resident by the Kardex inside of their closet. If there were changes to their care plan this was communicated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to them by either the LN or the nurse manager. In an interview on 01/22/2026 at 9:46 AM, Staff I, NAC, was asked how they knew how to provide care to each resident and meet each resident's specific needs. Staff I stated refer to the Kardex in the EMR. In an observation on 01/22/2026 at 10:10 AM, Resident 2 was lying in bed, lower legs uncovered with a pillow observed under their calves, their right foot was lying on the pillow, and their left heel was lying directly on the surface of the bed. In an observation on 01/22/2026 at 12:00 PM, Resident 2 was lying on their back, both feet/heels were observed directly lying on the surface of the bed. There was a full lunch tray sitting uncovered on the overbed table and was within reach. There were no staff members present. In an observation on 01/22/2026 at 2:02 PM, Resident 2 was observed in the same position with an untouched lunch tray, and no staff member was present. In an observation and interview on 01/22/2026 at 3:07 PM, Resident 2 was lying in bed in the same position, with an untouched lunch tray. There were no staff present. Resident was asked if they had eaten lunch and replied yes. In an observation and interview on 01/22/2026 at 3:11 PM, Staff K, NAC, was in the hallway. When asked when lunch was usually served, Staff K stated around noon. Staff K was informed Resident 2 had an uneaten lunch tray present in their room. In an interview on 01/22/2026 at 3:13 PM, Staff J, LPN/Nurse Manager, was informed Resident 2 had their untouched lunch tray on their bedside table. Staff J stated that it had been a long time and would take care of it immediately. Reference WAC 388-97-1060 (1), 2 (b), (c), 3 (b), (h), (j)(viii)