

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505470	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026
NAME OF PROVIDER OR SUPPLIER Columbia Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 Phinney Avenue North Seattle, WA 98103	
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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident and their representative of a discharge in writing for 1 of 3 residents (Resident 1), reviewed for discharge process. This failure placed the resident and their representative at risk for not having an opportunity to make an informed decision about the discharge and about their rights to appeal the discharge. Findings included. Review of a face sheet showed Resident 1 admitted to the facility on [DATE] with diagnoses that included dementia (a condition when a person's brain slowly stops working the way it used to) with agitation and anxiety disorders (when worry becomes so strong and frequent that it gets in the way of daily life). Further review showed Resident 1 had a listed representative. Review of Resident 1's progress note, dated 12/25/2025 at 10:54 PM, showed Resident 1 was transferred to the hospital for medical evaluation. Review of Resident 1's document titled, Notice of Transfer or Discharge, dated 12/25/2025, showed Resident 1 was transferred to a hospital and that [Resident 1] refused to sign. Further review did not show documentation of the notice was mailed to Resident 1's representative. Review of Resident 1's nursing progress note, dated 12/26/2025, showed Staff B, Resident Care Manager (RCM), contacted Resident 1 by phone and received verbal confirmation of his preference not to return to the facility from the hospital. Review of Electronic Health Records (EHR) did not show documentation of Resident 1, and their representative was provided with a written notification for his discharge on [DATE]. In an interview on 02/04/2026 at 11:14 AM, Resident 1's representative stated that they were Resident 1's legal decision maker. When asked how the facility notified them of Resident 1's discharge on [DATE], Resident 1's representative stated, They [Facility] only notified me that he was transferred to the hospital, and that If the hospital sent him back, they should have accepted him. In an interview and joint record review on 02/06/2026 at 12:40 PM, Staff D, Medical Records, stated that Resident 1 had a representative and that his representative signed the facility admission paperwork on 12/13/2025. Staff D stated, [Resident 1] said he couldn't [could not sign] and asked for [Resident 1's representative] to sign. A joint record review of Resident 1's EHR did not show documentation of Resident 1, and their representative was provided with a written notification for his discharge on [DATE]. When asked if there were records not included in Resident's EHR, Staff D stated, At the moment, everything is scanned [included in Resident 1's EHR]. In an interview and joint record review on 02/06/2026 at 12:50 PM, Staff C, RCM, stated that the facility's process for notification of transfers and discharges included providing a written notice to the resident and their representative. Staff C stated that Resident 1 was transferred to the hospital on [DATE] and that Resident 1 was discharged when he verbally declined to be returned to the facility on [DATE]. Staff C further stated that Resident 1 had a representative. A joint record review of Resident 1's notice of transfer and discharge, dated 12/25/2025, showed a section titled, Appeal Rights. Further joint record review did not show documentation of the notice was mailed to Resident 1's representative. When asked if</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 505470
		If continuation sheet Page 1 of 2

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1's representative was notified of the transfer and discharge in writing, Staff C stated, I don't [do not] see it, it would show when it was mailed [to Resident 1's representative]. In an interview and joint record review on 02/06/2025 at 1:10 PM, Staff B stated that notices were provided to the resident upon transfer or discharge. A joint record review of Resident 1's progress note dated 12/26/2025 showed Staff B received verbal confirmation from Resident 1 of his preference not returning to the facility. Staff B stated that they did not contact Resident 1's representative to notify them of Resident 1's discharge on [DATE]. When asked if Resident 1's representative received written notification of the discharge and appeal rights, Staff B stated, No, it does not show it was mailed. Staff B stated that the facility's process for discharge notifications was not followed. In an interview on 02/06/2026 at 1:32 PM, Staff A, Director of Nursing, stated that they expected written notifications of resident transfers and discharges would be provided to the resident and their representative. Reference: (WAC) 388-97-0120 (2) (a-c).</p>		