STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505491	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Everett Center	1919 112th Street Southwest Everett, WA 98204

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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 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 provide written bed hold notice to residents at the time of transfer to the hospital for 3 of 4 sampled residents (Residents 2, 11, 45) reviewed for hospitalization. This failure placed residents at risk for lacking knowledge regarding their right to hold their bed while in the hospital and diminished quality of life.Findings included .<RESIDENT 2> Resident 2 was admitted to the facility on [DATE]. Review of a progress note dated 07/31/2025 at 11:40 PM, documented that the dialysis center called the facility and reported that Resident 2 had been sent to the emergency room. A subsequent progress note showed Resident 2 returned to the facility on [DATE] at 3:24 AM. Review of the bed hold notice showed it was signed by a staff member on 07/31/2025, but no time was documented. The space for the resident or representative section documented refused and was dated 07/31/2025. There was no documentation as to who had refused or the date and time the contact was made. Review of Resident 2’s progress note documented that they were transferred to the hospital on [DATE] at 8:45 PM and was readmitted on [DATE]. Review of the bed hold notice showed it was signed by a staff member on 08/05/2025, but no time was documented. The space for the resident or representative section documented refused and was dated 08/05/2025. There was no documentation as to who had refused or the date and time the contact was made. <RESIDENT 45> Resident 45 was admitted to the facility on [DATE]. According to the 5-day Minimum Data Set (MDS- an assessment tool), dated 08/20/2025, the resident was cognitively intact. Review of a progress note dated 08/02/2025 at 8:18 PM documented Resident 45 was transferred to the hospital. Review of the bed hold notice showed it was signed by a staff member on 08/02/2025 but no time was documented. The space for the resident or representative section documented refused and was dated 08/02/2025. There was no documentation as to who had refused or the date and time the contact was made. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 08/27/2025 at 2:00 PM, Resident 45 denied being offered a bed hold when they were being transferred to the hospital on [DATE]. In an interview on 08/28/2025 at 9:19 AM, Staff G, Registered Nurse, stated that they did not know what a bed hold was, and they had not offered that to residents when they transferred them to the hospital. In an interview on 08/28/2025 at 9:25 AM, Staff D, Director of Social Services, stated that they did not do bed holds and the business office staff were responsible. In an interview on 08/28/2025 at 9:30 AM, Staff E, Business Office Manager, stated that they offered the bed hold notice to the resident if they were being transferred to the hospital. Staff E stated the majority of their residents were not alert and oriented. Staff E stated when they called resident representatives, they frequently were unable to be reached so they would just write “refused” on the notice. Staff E stated that they did not document the time and date or the person they tried to reach on the notice or in the clinical record. In an email interview on 08/29/2025, Collateral Contact 1, Resident 45's family member, documented they had not received a call about a bed hold when the resident was sent to the hospital on [DATE]. <RESIDENT 11> Resident 11 readmitted to the facility on [DATE]. According to the quarterly MDS, dated [DATE], Resident 11 was cognitively impaired. Review of Resident 11’s progress notes from 05/01/2025 to 08/28/2025, documented Resident 11 was transferred to the hospital on [DATE], 06/01/2025, 06/06/2025, 06/08/2025 and 06/17/2025. There was no documentation whether Resident 11’s representative was provided with written information about a bed hold policy or what their decisions were. Review of Resident 11’s bed hold notices, dated 05/05/2025, 06/01/2025, 06/06/2025, 06/08/2025 and 06/17/2025, showed a bed hold was offered and the notice was signed by a staff member. On the portion where the resident or the representative should sign, was documented “Refused”. There was no documentation as to who had Refused or the date and time the contact was made. In an interview on 08/29/2025 at 9:45 AM, Staff E, stated they called and offered the bed hold notices to residents or representatives after residents were transferred to the hospital. Staff E stated they documented “Refused” because they could not reach Resident 11’s representative. Staff E stated they did not document when and who they attempted to contact. Staff E stated they should have documented they could not contact the representative instead of documenting “Refused”. Refer to WAC 388-97-0120 (4)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of insulin (injectable medication that regulates blood sugar) in 3 of 5 medication carts (Carts 3, 5, and 4) when reviewed for medication storage. This failure placed residents at risk of receiving expired medications, ineffective treatment, and a diminished quality of life. Findings included.Review of the facility's policy titled, Insulin Pens, revised on 05/01/2025, showed once insulin pens were opened, they should be clearly labeled and may be stored at room temperature. The License Nurse (LN) was to follow the manufacturer's recommendations for product expiration. Review of Humulin N (an intermediate-actin human insulin) multidose insulin vials and KwikPen (a prefilled insulin pen) manufactures package insert, showed the insulin was good for 31 days once opened and stored at room temperature. Review of NovoLog insulin FlexPen (a prefilled insulin pen) and Novolog multidose insulin vials (a man-made rapid acting insulin) manufactures instructions (www.novolog.com), showed the insulin was good for 28 days once opened and stored at room temperature. Review of Lantus insulin (a long-acting insulin) pens and vials manufacture instructions (www.lantus.com), showed the insulin was good for 28 days once opened and stored at room temperature. Review of Lispro multidose insulin (rapid acting human insulin) vial and KwikPen manufactures package insert, showed the insulin was good for 28 days once opened and stored at room temperature. <MEDICATION CART 3>On 08/24/2025 at 10:23 AM, Medication Cart 3 was observed with Staff L, Licensed Practical Nuse (LPN). The following insulins were observed stored in the medication cart at room temperature:- Resident 38 had an undated Lispro insulin vial and a Humulin N insulin pen dated 06/13/2025.-Resident 63 had an undated NovoLog FlexPen and vial. - Resident 16 had an undated NovoLog FlexPen.- Resident 95 had an undated Lantus SoloSTAR pen (a prefilled insulin pen). In an interview on 08/24/2025 at 10:33 AM, Staff L stated insulin was dated once pulled out of the refrigerator and placed in the medication cart. Staff L stated depending on the type of insulin it was good for 28 or 30 days once removed from the refrigerator. Staff L verified no dates were found on Resident 38, 63, 16, and 95's insulin and Resident 38's insulin was expired. In an interview on 08/24/2025 at 10:45 AM, Staff K, Registered Nurse (RN), stated insulin was dated and good for 28 days when removed from the refrigerator and placed in the medication cart. <MEDICATION CART 5>In an observation on 08/24/2025 at 10:51 AM, Cart 5 was observed with Staff J, LPN. The following insulins were observed stored in the medication cart at room temperature:-Resident 2 had a Lispro insulin pen dated 07/14/2025.- Resident 78 NovoLin N FlexPen dated 07/16/2025. In an interview on 08/24/2025 at 10:58 AM, Staff J stated insulin was good for 28 days once pulled from the refrigerator. Staff J was aware of Resident 2 and 78's expired insulin. <MEDICATION CART 4>In an interview and observation on 08/24/2025 at 11:00 AM, Cart 4 was observed with Staff I, LPN. Resident 74 had a Humalog KwikPen, dated 07/22/2025. When asked Staff I how long insulin was good for when opened and removed from the refrigerator, Staff I stated 28 days. Staff I was aware Resident 74's insulin was expired. On 08/24/2025 at 1:37 PM, Staff B, RN/Director of Nursing Services, was interviewed. Staff B stated the LN was to date any type of insulin when opened, removed from the refrigerator, placed in individual bags, and stored in the medication cart. Their expectation was the LN would check the date of the open insulin prior to administration. Staff B stated depending on the type of insulin, the LN should discard the insulin per the manufacturer's instructions. Refer to WAC 388-97-1300(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and observations the facility failed to maintain accurate and complete medical records and ensure the medical record contained the required information for 1 of 4 residents (Resident 1) reviewed for restorative services, and 1 of 3 residents (Resident 45) reviewed for change of conditions. These failures placed residents at risk for delay in care, unmet care needs, and a diminished quality of life. Findings included .In a review of the facility policy, Health Information: Electronic Medical Records, Forms and Information-Electronic Signatures revised 05/01/2022, documented staff would document resident information electronically and any documentation not converted electronically would be completed manually.Review of the facility policy titled, Restorative Nursing, revised date 08/07/2023, documented restorative nursing program needed to be documented by a licensed nurse in the Care Plan Evaluation progress note. <RESTORATIVE EVALUATION> <Resident 1>Resident 1 readmitted to the facility on [DATE]. According to the comprehensive MDS assessment dated [DATE], the resident received restorative programs. Review of Resident 1's care plan, print date 08/25/2025, documented Resident 1 had restorative programs for passive range of motion. Review of Resident 1's EHR from 01/01/2025 to 08/25/2025, showed there was no documentation of restorative programs evaluations. In an interview on 08/27/2025 at 1:44PM, Staff P, Nursing Assistant Certified/Restorative Aide, stated Resident 1 had a passive range of motion restorative program three times a week.In a joint interview on 08/27/2025 at 2:13 PM with Staff Q, Clinical reimbursement coordinator, and Staff B, Director of Nursing, Staff Q stated they had a restorative review meeting every week with the therapy manager and the restorative aid. Staff Q stated they discussed restorative program plans, goals, progression, and if they needed to modify the restorative programs during the meeting. Staff Q stated they documented the meeting minutes in the binder but there was no documentation of restorative programs evaluations. Staff B stated they would find the binder that contained meeting minutes and restorative programs evaluations. No further information provided. <CHANGE OF CONDITION> <Resident 45>In an email interview with Resident 45's family member, Collateral Contact 1, they reported that there was a delay in carrying out provider orders in the facility. Review of Resident 45's physician order, dated 08/02/2025 at 8:19 AM, documented an order for laboratory tests. This order was confirmed by Staff H, LPN, on 08/02/2025 at 2:35 PM. In a telephone interview on 08/27/2025 at 9:35 AM, Staff H stated that Resident 45 was not feeling well and had some nausea during their shift on 08/02/2025. Staff H reported the provider saw the resident and had put in lab orders and left the facility without talking to them. Staff H stated they tried to call the provider to clarify and confirm the order because the resident was already on antibiotics. Staff H stated they called the provider twice to obtain clarification and that they still wanted the labs drawn. Staff H stated there was an additional delay as they did not have access to order labs electronically. Review of the progress notes dated 08/02/2025 showed no documentation of the series of events as described by Staff H. Reference WAC 388-97-1720 (1)(a)(i)(ii)(iii)(2)(a)(d)(e)(f)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure call lights (an alerting device for staff to assist residents in need) were within reach for 1 of 1 resident (Resident 4), reviewed for accommodation of needs. This failure placed residents at risk for delayed care, potential avoidable accidents, and diminished quality of life.Findings included .Review of the facility policy titled, Call Lights, revise date 07/15/2025, documented each patient would be evaluated for any special accommodations to use the call system and staff would ensure the call light was within reach of the patient. Resident 4 readmitted to the facility on [DATE]. According to the Annual MDS (Minimum Data Set-an assessment tool), dated 06/12/2025, the resident was cognitively intact. In a phone interview on 08/24/2025 at 1:53 PM, Collateral Contact 2 (CC2), a family member of Resident 4, stated Resident 4 could not always reach the call light. CC2 stated Resident 4 could only use their head to activate the call light. CC2 stated the call light frequently was not in place during their visits. Review of Resident 4's Activity of Daily Living care plan, documented interventions for Resident 4 included a soft touch call light, staff to clip the call light to the pillow next to the resident's head, initiated on 08/11/2021. In an observation and interview on 08/25/2025 at 10:49 AM, observed Resident 4's call light lying on top of their abdomen. The call light was a soft touch call light (flat and round call light). When asked how they used the call light, Resident 4 demonstrated by turning their head to the right side. Resident 4 indicated by nodding their head that staff often left their call light on their abdomen. In an interview and observation on 08/25/2025 at 2:00 PM, CC2 stated they visited Resident 4 at 11:30 AM and found the soft touch call light on top of their abdomen. Observed the soft touch call light was changed into a head activated call light system (a triangle shaped call light). CC2 stated Resident 4 used a head activated call light during hospitalization and it was much easier for them to use. In an observation and interview on 08/26/2025 at 8:30 AM, Resident 4's call light was two inches away from their head and face. Resident 4 attempted to turn their head to the right side but could not reach the call light. Resident 4 attempted twice. Resident 4 indicated by shaking their head that they could not reach the call light. In an observation on 08/26/2025 at 9:38 AM and 12:02 PM, observed the call light was too far away from Resident 4's head. In an observation on 08/27/2025 at 9:12 AM, observed the call light was too far from Resident 4's head. Resident 4 turned their head to the right side, but could not reach the call light. In an interview on 08/27/2025 at 9:35 AM, Staff R, Nursing Assistant Certified (NAC), stated Resident 4 was alert, non-verbal, and could not move their limbs. Staff R stated they needed to place the call light close to the resident's head so the resident could activate the call light. In an interview and observation on 08/28/2025 at 10:03 AM, Staff S, NAC, observed Resident 4's call light a few inches away from their head. Resident 4 turned their head but could not reach the call light. Staff S stated the call light was too far from the resident's head and placed the call light closer. Resident 4 demonstrated they were able to reach the call light. Refer to WAC 388-97-0860 (2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that care planned interventions for fall management were in place for 1 of 2 residents (Resident 5) reviewed for falls. This failure placed resident at an increased risk of injury if a fall occurred. Findings included .Resident 5 admitted to the facility on [DATE].Review of a facility report for Resident 5's fall on 06/10/2025, showed that there had been a fall mat on the left side of the bed. The report showed the new intervention was to place a fall mat on the right side of the bed in addition to the other fall mat.Review of Resident 5's Kardex (lists care needs of the resident), dated 08/27/2025, showed Fall mat on the right side of the bed and Fall Matts to floor.During an observation on 08/25/2025 at 10:12 AM, no fall mat was noted on the floor on either side of Resident 5's bed.During observations on 08/26/2025 at 9:35 AM and 08/27/2025 at 10:33 AM, Resident 5 was in bed with no fall mat observed on the floor on either side of the bed.During an interview and observation on 08/27/2025 at 11:09 AM, Staff N, Registered Nurse and Staff O, Nursing Assistant Certified, were in the room providing care to Resident 5. When asked about fall mats at the bedside, both Staff N and Staff O stated they had not seen fall mats in Resident 5's room. Staff O checked the closet and there were no fall mats.During an interview and record review on 08/27/2025 at 11:14 AM, Staff M, Licensed Practical Nurse/interim Resident Care Manager, reviewed the Kardex for Resident 5. Staff M reported Resident 5 was to have fall mats in place at the bedside.During an interview and observation on 08/27/2025 at 11:18 AM, Staff M confirmed the fall mats were not at bedside. Staff M checked the closet and the bathroom and could not locate the fall mats. Refer to WAC 388-97-1060 (3)(g)