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	02/24/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure resolution of grievances for 2 of 3 residents (Residents 87 and 46) and 1 of 1 resident group reviewed for grievances. Failure to thoroughly investigate, log and provide resolution related to individual and resident group grievances placed residents at risk for recurrent unresolved concerns and decreased quality of life. Findings included . According to the policy titled Grievance/Concern with a revised date of 10/15/2024, documented: Upon receipt of the Grievance/Concern Form, the Administrator or designee will document the grievance/concern on the Grievance Concern Log An appropriate department manager will investigate the grievance and notify the person filing the grievance of a resolution in a timely manner. A written resolution for grievances will be offered and will include a summary statement of the grievance, steps taken to investigate the grievance, summary of the pertinent findings or conclusions regarding the grievance and any corrective action(s) taken or not taken by the Center as a result of the grievance/concern. Review of the resident council minutes for the prior six months showed no documentation for September 2025. Review of the October 2025 minutes, dated 10/28/2025, documented three resident council members in attendance whose names were not included. The minutes documented resident concerns of nursing assistants taking breaks at the same time during important times such as lunch, showers, and recreation. A resident council concern response form dated 10/28/2025, did not include investigation of the stated concerns, only stated educated and trained staff to better ensure residents are not late. The form was not signed by any member of the management team and was not provided to any resident council members. The following month (November 2025) there was a meeting form stating no meeting was conducted. Review of the December 2025 minutes, dated 12/23/2025, stated there were nine residents in attendance. No resident names were listed. The form documented discussion of old business was N/A. The December minutes included numerous group concerns: - Communication failures, lack of care and leadership (unclarified)- Inconsistencies with meal tickets and food - Clothes coming back with a lot of lint - Some issues arising when staff change rotation (unclarified)A resident council response form was included, dated 12/23/2025, which only referenced dietary quality concerns. There was no further clarification of the other concerns listed in the meeting minutes, the form only stated dietary has handled the issue with no signature and no resolutions provided to the council. Review of the January 2026 resident council minutes, dated 01/15/2026, documented five unnamed residents in attendance. Discussion of old business was N/A and there were documented concerns with missing laundry, and some staff need education and customer service assistance, (unclarified). No resolution was provided. Review of the facility log of grievances from October 2025- February 2026 revealed none of the resident council grievances were on the log. In a group interview with eight members of the facility resident group on 02/18/2026 at 11:00 AM, residents were asked questions related to the facility response to the group grievances.- Resident 53 stated there was a problem with getting follow up on things, waits a long time, stated they just forget about it. - Resident 88 stated they had brought up some issues about the food but did not know how they would hear back about the outcome.- (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 18 stated it was an ongoing issue that they bring up problems with call lights and concerns with staff and were told they want to know about our concerns, but in reality, nothing happens and we are never told anything, and the same problems keep happening. Resident 18 stated they think the staff were writing the minutes and then Staff A, Administrator, takes the binder so they never see it. Resident 18 stated there should be plenty of mention about the call lights. Resident 44 was observed nodding yes to agree with Resident 18. - The group stated the primary issue that keeps coming up was the response to call lights and responsiveness of staff, with no follow-up and that should be in the minutes. In an interview on 02/20/2026 at 1:43 PM, Staff A, stated they went to the resident council meetings and followed up with what the residents said. Staff A stated there had been grievances done for call lights and was aware call lights were a recurrent grievance issue but had no further information why the resident council minutes did not capture that from the meetings. Staff A stated they had not been doing individual grievances from the resident council and were doing them as one group grievance on the resident concern form. Staff A stated they believed that was how the residents had wanted it. Staff A was not able to state how they follow up with individual residents from the resident council meetings when the minutes did not include which residents were in attendance and which residents had which specific concerns. In a follow-up interview on 02/23/2026 12:28 PM, Staff A acknowledged that vague concerns noted in the resident council minutes had not been clarified. Staff A stated they had not been providing written follow-up to resident grievances only stated that someone followed up with them. Staff A acknowledged the grievances did not show documentation each specific concern was identified, investigated, that resolution occurred and was provided to the appropriate residents involved. Staff A acknowledged resident council grievances were not being logged and stated they had provided education. <RESIDENT 87>Resident 87 was admitted to the facility on [DATE]. In an interview on 02/18/2026 at 10:02 AM, Resident 87 stated that last Monday (02/16/2026) they waited two hours for assistance with toileting. Resident 87 stated a staff member answered their call light at noon and was told to wait for the next shift to arrive at 2:00 PM. Resident 87 stated she knew she had waited two hours as she remembered looking at the clock when the staff answered the call light. The resident stated they informed a manager on 02/17/2026. Review of Resident 87's Care Team meeting note, dated 02/17/2026 at 1:04 PM, documented resident verbalized waiting for care and that a grievance will be filed. Review of the updated Grievance Log, received on 02/20/2026 at 1:30 PM, did not show a grievance for Resident 87. In an interview at 02/23/2026 at 11:09 AM, Staff C, Registered Nurse /Unit Manager, provided Resident 87's grievance and reported it had been resolved. Review of Resident 87's grievance showed the grievance was filed on 02/18/2026 (one day after resident reported). The grievance did not contain specific details of the resident's concern, it only documented complained of wait time for call light to be answered. There were no details regarding time of day or the length of time the resident waited. The grievance showed the Administrator, Director of Nursing and Nurse Manager will address the grievance, however there was no follow up from the administrator or the Director of Nursing. The form did not rule out abuse or neglect, it did not identify staff involved and the plan showed the facility would educate evening shift NAC's (Nursing Assistants) on call light response time despite the concern occurring on day shift and was related to staff informing Resident 87 to wait two hours for care. In an interview on 02/23/2026 at 12:28 PM, Staff A stated the facility practice was to resolve grievances within three days. Staff A stated if it could not be resolved within three days they would (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow up with the resident. Reviewed the grievance with Staff A. Staff A agreed that the grievance was not complete, was lacking details and resolution was not discussed with the resident until 02/23/2026, which was six days after the resident reported it. <RESIDENT 46>Resident 46 was admitted to the facility on [DATE]. According to the annual Minimum Data Set (MDS-an assessment tool) assessment, dated 01/29/2026, the resident was cognitive intact. In an interview on 02/18/2026 at 10:09 AM, Resident 46 stated yesterday (02/17/2026) evening, they waited one hour for the nursing assistant to answer their call light. The resident stated they were waiting for staff to change their brief. The resident stated they had talked with the administrator about the care concern. On 02/19/2026 at 1:00 PM, review of the grievance report, documented the concern as customer services and call light wait time. There was no documentation about the resident's statement of the details of their call light concern nor whether abuse or neglect was ruled out. There was no documentation that staff involved had provided information. In a record review and interview on 02/23/2026 at 12:28 PM, Staff A reviewed the grievance and stated the information on the grievance report lacked information. Staff A stated they expected staff to investigate the call light concerns with more specific details including specific time, duration, timeline, and staff that were talked with. Reference WAC 388-97-0460 (1)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents' care plans were revised and accurately reflected the resident's care needs for 3 out of 18 sampled residents (Residents 8, 9 and 38) when reviewed for care planning and revision of care plans. This failure placed the residents at risk for unmet care needs, medical complications, inaccurate care plan documentation, and a diminished quality of life. Findings included .Review of the facility policy titled, Person-Centered Care Plan, reviewed 09/15/2025 stated the facility must develop and implement a person-centered plan of care for each resident consistent with measurable objectives and timeframes to meet their needs.the care plan will be reviewed and revised by the interdisciplinary team after each assessment. <RESDIENT 38>Resident 38 admitted to the facility on [DATE] with diagnosis of end stage renal disease with dependence on renal dialysis (life-sustaining treatment that filters toxins, waste, and excess fluid from the blood when kidneys fail). Review of Resident 38's admission Minimum Data Set (MDS – an assessment tool) dated 10/15/2025 showed the resident did not require the use of supplemental oxygen. Review of Resident 38's quarterly MDS assessment dated [DATE], showed the resident now required the use of supplemental oxygen. Review of Resident 38's care plan, print date 02/18/2026 showed no documentation the resident had respiratory deficit, or required the use of oxygen supplementation for breathing. In an interview on 02/18/2026 at 9:33 AM, Staff I, Director of Respiratory Therapy (RT) stated they were not familiar with Resident 38 as they did not have an advanced airway system (referring to all other residents on that unit had a tracheostomy – advanced airway system). In observations of Resident 38 on 02/18/2026 at 9:48, 10:24 AM, 10:40 AM, and 11:02 AM, they were observed to have an oxygen tube to the nares (nasal area), and an oxygen concentrator at bedside running with the settings at 2 liters per minute (Lpm). In an observation of Resident 38 on 02/18/2026 at 11:50 AM, the resident was observed in their wheelchair. They had oxygen tubing to the nares, which was attached to an oxygen tank set at 2Lpm. In an observation on 02/19/2026 at 8:45 AM, 11:02 AM and 1:32 PM, and on 02/20/2026 at 8:53 AM, they were observed to have oxygen tube to the nares, and an oxygen concentrator at bedside running with the settings at 2 liters per minute (Lpm). In an interview on 02/20/2026 at 10:28 AM, Staff J, Registered Nurse (RN) stated they when a resident was on oxygen supplementation, that it would be addressed on the care plan. Staff J stated Resident 38 received oxygen supplementation, as they needed it when they slept and they tended to sleep a lot. In an interview on 02/20/2026 at 12:09 PM, Staff K, Licensed Practical Nurse (LPN)/Nurse Unit Manager stated that any resident that required oxygen supplementation should have physician orders (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and their care plan should reflect that. Staff K stated they were aware that Resident 38 was on oxygen supplementation, as the extra fluid from their kidney disease made it difficult to breathe. Staff K was not aware that Resident 38's care plan had not been updated to reflect they required oxygen supplementation and stated the care plan should have been updated. In an interview on 02/20/2026 at 1:30 PM, Staff B, Director of Nursing Services (DNS) stated when a resident required the use of oxygen supplementation regardless of how it was delivered, it should be reflected in the physician orders and care plan. Staff B stated they had been made aware, Resident 38 did not have their care plan updated to reflect oxygen use and stated it should have been updated. <RESIDENT 8>Resident 8 was admitted to the facility on [DATE] with diagnoses to include panic disorder, generalized anxiety disorder, and major depression disorder. Review of Resident 8's physician orders dated 08/07/2025 – 02/18/2025 documented the resident was prescribed clonazepam (anti-anxiety medication) for anxiety, with several dose changes over the dates reviewed. Review of Resident 8's care plan, print date 02/19/2026, showed no care plan area to address how the facility would monitor for adverse side effects of the anti-anxiety medication. In an interview on 02/20/2026 at 12:09 PM, Staff K, LPN/Unit Nurse Manager stated all residents care plans should document the facility would monitor for any adverse side effects from all medications they are prescribed. Staff K reviewed Resident 8's care plan and agreed the monitoring for adverse side effects for Resident 8's anti-anxiety medication was not included in the care plan. In an interview on 02/20/2026 at 1:30 PM, Staff B, DNS stated any resident that could experience an adverse side effect from a medication they are prescribed should be included in the care plan. Staff B stated Resident 8's adverse side effects for anti-anxiety medication should have been included in their care plan. <RESIDENT 9> Resident 9 admitted [DATE] with diagnoses which included osteoarthritis and impaired gait. Review of the most recent physical therapy discharge summary documentation dated 07/23/2025 showed the resident received physical therapy from 05/19/2025 through 07/23/2025. The discharge summary stated Resident 9 had met their skilled goal of walking 100 feet using a walker and supervision/stand by staff assistance. The discharge recommendations included an ambulation HEP (home exercise program) with nursing staff using a walker, independent strength exercises, and stated 24/7 assistance available as needed. The summary stated the resident's prognosis to maintain current level of function was excellent with consistent staff support. In an interview on 02/18/2026 at 3:18 PM, Resident 9 stated they used to walk around the unit with therapy, but it was stopped. Resident 9 stated they also were not allowed to walk without someone with them and said the nursing staff tell them they do not have time, so they are only walking once in a while and feel they have lost strength. Resident 9 stated they felt frustrated because they were motivated to do more, but nobody was available to help. Record review of the Quarterly Minimum Data Set assessment dated [DATE] documented use of (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walker was no, and walking 10 ft was documented as not attempted. Record review of Resident 9's Care Plan and Task records on 02/20/2026 did not show any documentation of a program or task which included assistance with ambulation or exercises. In an interview on 02/23/2026 at 10:56 AM, Staff C, Registered Nurse, Unit Manager, was asked how recommendations for a home exercise program requiring the supervision or assistance of the nursing staff was implemented and Staff C stated they were not sure. In an interview on 02/23/2026 at 11:21 AM, Staff B, Director of Nursing Services, stated Resident 9 did require staff supervision to ambulate and stated they had seen Resident 9 walk with staff a couple times. Staff B did not have further information related to Resident 9's therapy and provider recommendations or resident goals. Staff B acknowledged there were no care planned interventions or tasks addressing the exercise recommendations, preferences or resident goals. Reference WAC 388-97-1020(5)(b)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received assistance for activities of daily living for 1 of 3 residents (Resident 9) reviewed for activities of daily living. Failure to provide Resident 9 assistance with ambulation per the resident's preferences and therapy recommendations, placed them and other residents at risk for decline in function and decreased quality of life. Findings included .Review of the facility policy titled Activities of Daily Living with a revision date of 05/01/2023, stated that based on the comprehensive assessment and consistent with the resident's needs and choices, the facility must provide the necessary services to improve or maintain the resident's ability and prevent avoidable decline in function. Resident 9 admitted [DATE] with diagnoses which included osteoarthritis and impaired gait. Review of the most recent physical therapy discharge summary documentation dated 07/23/2025 showed the resident received physical therapy from 05/19/2025 through 07/23/2025. The discharge summary stated the resident had met their skilled goal of walking 100 feet using a walker and supervision/stand by staff assistance. The discharge recommendations included an ambulation HEP (Home exercise program) with nursing staff using walker, independent strength exercises, and stated 24/7 assistance available as needed. The summary stated the resident's prognosis to maintain current level of function was excellent with consistent staff support. In an interview on 02/18/2026 at 3:18 PM, Resident 9 stated they used to walk around the unit with therapy but it was stopped after they were doing good. Resident 9 stated they wanted to be able to go to the therapy gym and use the bike, as well as walk around, because they would like to lose weight. Resident 9 stated they were told they could not use the bike in the gym because they weren't on therapy anymore and there was nobody to watch them. Resident 9 stated they also were not allowed to walk without someone with them and said the nursing staff tell them they do not have time, so they are only walking once in a while and feel they have lost strength. Resident 9 stated they felt frustrated because they were motivated to do more but nobody was available to help. Record review of a provider note dated 02/09/2026 included recommendation to encourage restorative exercises as tolerated. Review of a provider note dated 12/18/2025 documented the resident's frustration and negative mood with a desire for more exercise and weight loss, with recommendations which (non-specifically) included exercises. Record review of the Quarterly Minimum Data Set assessment dated [DATE] documented use of walker was no, and walking 10 ft was documented as not attempted. Record review of Resident 9's Care Plan and Task records on 02/20/2026 did not show any documentation of a program or task which included assistance with ambulation or exercises. In an interview on 02/20/2026 at 10:04 AM, Staff E, Occupational Therapist/ Rehab Unit Manager, stated Resident 9 was currently being seen by occupational therapy related to issues with their hand, but had not received physical therapy for a while. Staff E stated Resident 9 had asked about using the bike because they wanted to lose weight and Staff E stated they told them that would not help. Staff E stated Resident 9 was able to do some exercises independently or with the nurses and did not believe the resident was on a restorative program. In an interview on 02/23/2026 at 9:12 AM, Staff D, Certified Nurse Aide/ Restorative Aide, confirmed that Resident 9 was not receiving any restorative nursing services and stated if Resident 9 was doing any walking or exercises, it was with the nursing staff on the floor. In an interview on 02/23/2026 at 10:15 AM, Staff N, Certified Nurse Aide, stated Resident 9 usually got up in their wheelchair, needed someone to be there for them to transfer and was able to tell them what they needed. Staff N stated they were not sure if Resident 9 was set up on any kind of exercises and thinks they did them on their own. When asked how much assistance Resident 9 required for ambulation, Staff N stated they were not sure, because they have never seen Resident 9 walk. In an interview on 02/23/2026 at 10:56 AM, Staff C, Registered Nurse, Unit Manager, was asked how (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendations for a home exercise program requiring the supervision or assistance of the nursing staff was implemented and Staff C stated they were not sure. In an interview on 02/23/2026 at 11:21 AM, Staff B, Director of Nursing Services, stated Resident 9 was independent at wheelchair level and did their own exercises. Staff B stated Resident 9 did require staff supervision to ambulate and stated they had seen Resident 9 walk with staff a couple times. Staff B stated Resident 9 had not had a decline in function. Staff B did not have further information related to Resident 9's stated preference for increased ambulation and exercise related to their weight loss goals or how nursing staff would be aware of the therapy and provider recommendations or resident goals. Staff B acknowledged there were no care planned interventions or tasks addressing the exercise recommendations, preferences or resident goals. Reference WAC 388-97-1060 (2)(a)(ii),(b)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 1 of 2 residents (Resident 16) reviewed for activities had an accurate assessment of recreational care needs and received an ongoing program of activities to meet the individual resident's physical and mental needs. Based on the reasonable person concept, not having adequate recreation and/or sensory stimulation placed the resident at risk for social isolation, lack of stimulation and diminished quality of life.Findings included.Review of a facility policy, titled, Recreation Services Policy and Procedures, dated 08/07/2023, documented all patients who have limited tolerance in group or independent programs will have consistent and individualized recreation opportunities.Resident 16 was admitted to the facility on [DATE]. According to the Minimum Data Set (an assessment tool), dated 02/02/2026, the resident was in a persistent vegetative state (a condition where person cannot speak, interact or show awareness of their surroundings due to a severe brain injury).During observations on 02/18/2026 at 10:27 AM and 2:00 PM, Resident 16 was lying in bed in their room. There was no TV on or music playing.During observations on 02/19/2026 at 8:46 AM, 9:49 AM, 1:09 PM and 4:50 PM, Resident 16 was lying in bed. There was no TV on or music playing. During all observations on this date except at 1:09 PM, no lights were on and the room was dark.During observations on 02/20/2026 at 7:38 AM, 10:21 AM, 12:20 PM and 3:01 PM, Resident 16 was lying in bed. There was no TV on or music playing. During all observations on this date, no lights were on and the room was dark except at 12:20 PM. At 12:20 PM a staff member was checking the equipment in the room and had the light on.Review of Resident 16's recreation assessment, dated 02/03/2026, documented they were usually understood, and it was somewhat important to listen to music and watch TV/movies.Review of Resident 16's care plan focus area documented, it is important that resident has the opportunity to engage in daily routines that are meaningful, relative to their preferences, dated 02/03/2026. There was no goal listed for the focus area. Interventions for Resident 16 included I enjoy watching/listening to TV and I enjoy listening to music and prefer_____. The space was left blank despite a note indicating to specify type of music.Review of Resident 16's recreation participation record, from 01/27/2026 through 02/20/2026 showed activities occurred on 01/29/2026, 02/03/2026, 02/09/2026 and 02/17/2026.During an interview on 02/20/2026 at 12:29 PM, Staff M, Nursing Assistant Certified, reported they worked with Resident 16 two-three times a week. Staff G reported that they had not seen the TV on in the room or heard any music playing in Resident 16's room. Staff G reported they had not seen any family or friends visit since Resident 16 admitted .During an interview on 02/20/2026 at 10:08 AM, Staff H, Recreation Assistant, reported that they were provided with a list of residents that required 1:1 visits that day. Staff H reported residents requiring 1:1 visits were placed on a rotation and would be scheduled once every two weeks. Staff H reported that when they completed a 1:1 visit with a resident in a vegetative state, the visit lasted 10 minutes.On 02/23/2026 at 1:07 PM, a joint interview was held with Staff F, Recreation Director and Staff G, recreation assistant. Staff F reported that a resident's activity participation was the responsibility of all facility staff. Staff F reported that any staff could offer in-room activities (word games, music, movies or art supplies) and open blinds for residents in their rooms. Staff F stated care giving staff was responsible for getting residents up for group activities. Staff F and Staff G both stated they had not been in contact with Resident 16's family since they admitted . Reviewed the recreation activity record and observations of the room being quiet and dark with staff F and Staff G. Staff K stated they did not feel there had been adequate sensory stimulation for Resident 16. Staff B stated care giving staff should have turned on the TV and opened the blinds in the room for Resident 16. Reference WAC 388-97-0940-(1)(2)