STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505499	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottesmore of Life Care	2909 14th Avenue Northwest Gig Harbor, WA 98335

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 an environment that is free from accident hazards by not following their fall protocol, which included bed height placement, fall assessment, and call light within reach for 7 of 12 residents (Residents 2, 4, 5, 6, 7, 8, and 10) reviewed for falls. This failure placed residents at risk of increased falls, significant injury with fall, and a diminished quality of life.Findings included.Review of a facility policy titled Fall Management, dated 03/11/2025, showed a fall risk assessment would be completed upon admission, readmission, quarterly, change in condition, and with any fall, utilizing the fall risk evaluation form. Review of the policy showed a referral to the Lippincott procedures fall management for long term care to assist with fall prevention and management interventions. Review of the Lippincott Nursing Procedures, 8th edition, showed standards of practice for fall prevention in long term care were:-keep the bed in its lowest position so the patient could easily reach the floor when getting out of bed. This position would also reduce the distance to the floor in case the patient would fall.-keep the call light positioned so it would be within the patient's reach at all times.-Respond promptly to the patient's call light to help limit the number of times the patient would get out of bed without help. RESIDENT 1Resident 1 admitted to the facility on [DATE] with diagnoses that included subdural and subarachnoid hemorrhage (a bleed in the brain), history of falling, muscle weakness, difficulty in walking, and restlessness and agitation. The discharge minimum data set (MDS), an assessment tool, dated 01/30/2025, showed Resident 1 was dependent on staff for care.During an interview on 01/05/2026 at 03:15 PM, Collateral Contact (CC) A, family member, said Resident 1 had a fall at an assisted living facility before going to the hospital. CC A said Resident 1 had been on fall precautions while at the hospital. CC A said Resident 1 was discharged from the hospital and admitted to the facility on [DATE]. CC A said Resident 1 fell while at the facility and hit their head only a few hours after arriving there and had to return to the hospital. CC A said Resident 1 could not recover from the fall, was placed on hospice, and sent to a different facility where they eventually passed away. Review of the progress notes, dated 01/30/2025, showed Resident 1 arrived at the facility at approximately 01:00 PM on 01/30/2025 for admission. Review showed upon arrival, Resident 1 was confused.Review of the Fall Risk Evaluation dated 01/30/2025, showed Resident 1 had a fall risk score of 20, indicating a high risk for a fall.Review of a risk management document dated 01/30/2025 at 08:30 PM, showed Resident 1 had a fall from bed. Review showed Resident 1 was observed on the floor next to their bed lying sideways on the ground with their head against the wall and their legs tangled in the bed sheets. Review showed Resident 1 was having a seizure (sudden surge of electrical activity in the brain, leading to changes in awareness, movement, or sensation) after the fall. Record review showed Resident 1 was sent to the hospital for evaluation and treatment at 09:00 PM. Review showed Resident 1 had their bed in low position, bare feet, and was agitated and confused.Review of the care (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sitting in a wheelchair next to their bed, the bed was against the wall on the right side, the call light hanging down the wall, behind the bed and not within reach, and no reacher within reach. Observation showed a star on the door next to Resident 6's name, indicating they were on the falling star protocol.During an interview on 01/09/2026 at 11:20 PM, Resident 6 said they could not reach their call light and did not know where their reacher was. RESIDENT 7Resident 7 admitted to the facility on [DATE] with diagnoses that included adult failure to thrive (loss of weight, appetite, and interest in activities), muscle weakness, repeated falls, and low back pain. The quarterly MDS dated [DATE], showed Resident 7 had moderate cognitive impairment. Review of the progress notes dated 10/03/2025 at 02:37 PM showed Resident 7 had an assisted fall with no injuries.Review of the fall risk evaluation dated 10/03/2026 showed Resident 7 had a fall risk score of 14, indicating a high risk for falls. Observation on 01/08/2026 at 01:40 PM showed Resident 7 in bed. Observation showed the bed was in a high position (waist level).During an interview on 01/09/2026 at 11:57 AM, Resident 7 said they have a fear of falling while in bed. Resident 7 said the staff often leave the bed too high after providing care. Resident 7 said they prefer the bed be at a lower level. RESIDENT 2Resident 2 admitted to the facility on [DATE] with diagnoses that included vascular dementia (a loss of cognitive functioning), adult failure to thrive, muscle weakness, difficulty in walking, and a history of falling. The quarterly MDS, dated [DATE], showed Resident 2 was severely cognitively impaired.Review of the fall risk evaluation dated 11/11/2025 showed Resident 2 had a fall risk score of 16, indicating a high risk for a fall. During an observation on 01/08/2026 at 01:44 PM, showed Resident 2 in bed. Observation showed Resident 2's bed in a high position (waist level). Observation on 01/09/2026 at 11:07 AM showed Resident 2 in bed. Observation showed Resident 2's bed in a high position (waist level). Attempts to interview Resident 2 were not successful due to cognition. RESIDENT 5Resident 5 admitted to the facility on [DATE] with diagnoses that included muscle weakness, difficulty in walking, and chronic pain. The quarterly MDS dated [DATE], showed Resident 5 was cognitively intact.Review of the fall risk evaluation dated 12/06/2025, showed Resident 5 had a fall risk score of 16, indicating a high risk for falls. Observation on 01/08/2026 at 01:39 PM showed Resident 5 in bed. Observation showed the bed was in a high position (waist level). Observation on 01/09/2026 at 11:11 AM showed Resident 5 in bed. Observation showed the bed was in a high position (waist level).During an interview on 01/09/2026 at 11:12 AM, Resident 5 said the staff had left their bed at that height when they left the room after providing care. RESIDENT 8Resident 8 admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (weakness and paralysis on one side of the body), muscle weakness, repeated falls, and unsteadiness on feet. The quarterly MDS, dated [DATE], showed Resident 8 was cognitively intact. Review of the fall risk evaluation, dated 11/20/2025, showed Resident 8 had a fall risk score of 16, indicating a high risk for falls. Observation on 01/08/2026 at 01:45 PM, showed Resident 8 in their bed. Observation showed the bed was in a high position (waist level). Resident 8 did not wish to participate in an interview. RESIDENT 10Resident 10 admitted to the facility on [DATE] with diagnoses that included vascular dementia, epilepsy (reoccurring seizures), and muscle weakness. The quarterly MDS dated [DATE], showed Resident 10 was severely cognitively impaired. Review of the fall risk evaluation dated 10/14/2022 showed Resident 10 had a fall risk score of 12, indicating a high risk of falls. Review of the Electronic Health Record (EHR) showed this fall risk evaluation as the most recent fall assessment. (Review showed the fall risk evaluation was not completed quarterly per policy.)Observation on 01/09/2026 at 11:08 AM showed Resident 10 in bed. Observation showed the bed in high position (waist level).Attempts to interview Resident 10 were unsuccessful.During an interview on 01/09/2026 at 12:38 PM, Staff B, Certified Nursing Assistant (CNA) said, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	if a resident was a high risk for falls, the nurse would let the aide know. Staff B said there would be a star on the door indicating high fall risk. Staff B said the bed would be put in the lowest position, they would keep the door open, and complete frequent checks. Staff B said if a resident was a high fall risk, their bed should not be in a high position, it should be in a low position. During an interview on 01/09/2026 at 12:45 PM, Staff C, CNA said, if a resident was a high fall risk their bed would be put in a low position, they would check on them often, and leave the door open. Staff C said if a resident was a high risk for falls, their bed should not have been high and it should be low for safety.During an interview on 01/09/2026 at 01:12 PM, Staff D, Licensed Practical Nurse (LPN) said, each resident would have a fall risk assessment completed to assess for fall risk. Staff D said if a resident was a fall risk, the interventions would be in the care plan and on the Kardex. Staff D said if a resident was a fall risk, the bed should be low and not at a high level. During an interview on 01/09/2026 at 02:30 PM, Staff E, Resident Care Manager/Registered Nurse (RCM/RN) said, if a resident was identified as being a fall risk, they would be put on the falling star program where they would place a card with a star outside of the door, letting everyone know they were a fall risk. Staff E said more frequent observations would be done. Staff E said the information would be on the Kardex and they would notify nurses and aides. Staff E said the interdisciplinary team would make a decision about placing residents on the falling star program and what interventions would have been put in place. Staff E said not all residents with a high fall risk score were added to the falling star program or have a star on their door. Staff E said if a resident was a high fall risk, their bed should not be in a high position if they are in their bed. Staff E said the call light should be within reach for all residents.During an interview on 01/09/2026 at 02:57 PM, Staff A, Director of Nursing/Registered Nurse (DNS/RN) said not all residents at high risk for falls were put on the falling star program. Staff A said if they were not on the falling star program, but were a high risk for falls, management would communicate interventions in the care plan and Kardex. Staff A said it is their expectation that the bed would not be elevated high at waist level for a resident that was a fall risk. Staff A said it is standard of practice for all beds to be at sitting level or lower. Staff A said it is their expectation that call lights be within reach of all residents, including a fall risk. Reference WAC 388-97-1060(3)(g).