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	02/27/2026

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

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' with fluid restrictions had fluid intake monitoring to avoid fluid overload for 3 of 3 sampled residents (Residents 94, 100, and 111) when reviewed for nutrition. This failure placed residents at risk of fluid overload, avoidable discomfort, and a diminished quality of life. Findings included .Resident 94 Review of the electronic health record (EHR) showed Resident 94 admitted to the facility on [DATE] with diagnoses to include heart failure, right ankle pain and dysphagia (difficulty swallowing). Resident 94 was able to make needs known. Observation on 02/23/2026 at 11:51 AM and 02/24/2026 at 10:06 AM showed Resident 94 lying in bed with a water pitcher within reach on the bedside table. Review of a provider's order, dated 02/19/2026, showed Resident 94 had a fluid restriction of 2000 milliliters per 24 hours to be split between nursing and dietary. Review of Resident 94's Medication Administration Record (MAR) from 02/19/2026 through 02/24/2026 did not show totals of all fluids provided by both dietary and nursing on each shift to ensure Resident 94's provider ordered fluid restriction had been followed. During an interview on 02/24/2026 at 12:20 PM, Staff M, Certified Nursing Assistant (CNA), stated they were assigned to Resident 94 and provided them with a full pitcher of water. Staff M stated they were unaware Resident 94 was on a fluid restriction. Resident 100 Review of the EHR showed Resident 100 admitted to the facility on [DATE] with diagnoses to include heart failure, kidney disease and edema (swelling caused by fluid). Resident 100 was able to make needs known. Observation on 02/24/2026 at 1:00 PM showed Resident 100 had a full water pitcher on their bedside table. Review of a provider's order, dated 01/27/2026, showed Resident 100 had a fluid restriction of 2000 milliliters per 24 hours to be split between nursing and dietary. Review of Resident 100's MAR from 02/01/2026 through 02/24/2026 did not show totals of all fluids provided by both dietary and nursing on each shift to ensure Resident 100's provider ordered fluid restriction had been followed. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/2026 at 1:36 PM, Resident 100 stated they were unaware they were on a fluid restriction. Resident 100 stated they were receiving a full water pitcher at bedside until yesterday evening. During an interview on 02/26/2026 at 9:57 AM, Staff H, Resident Care Manager, stated residents on fluid restrictions should not have a water pitcher at bedside. Staff H stated the expectation was that staff were educated on fluid restrictions and the provider's order was followed to document the total amount consumed from nursing and dietary. During an interview on 02/26/2026 at 11:59 AM, Staff B, Director of Nursing Services (DNS), stated the MAR did not show totals of fluid that were provided, to include all of nursing, dietary, and fluid independently consumed in a 24-hour period. Staff B stated the lack of fluid restriction monitoring and documentation did not meet their expectations. Resident 111 Review of the EHR showed Resident 111 admitted to the facility on [DATE] with diagnoses to include end stage renal disease (ESRD, the final, permanent stage of kidney failure where function drops below 10–15%), dependance on renal dialysis (the life-sustaining requirement for regular, long-term, or permanent artificial filtration of blood due to ESRD), and diabetes (too much sugar in the blood). Resident 111 was able to make needs known. Review of provider's orders showed a fluid restriction of 1200 milliliters (ml) in 24 hours, dated 02/17/2026, with the kitchen providing 720 ml (breakfast 240 ml, lunch 240 ml, and dinner 240 ml) and nursing staff providing 480 ml (day 180 ml, evening 180 ml, and night 120 ml). Review of the MAR for February 2026 showed monitoring of Resident 111's fluid provided by nursing staff but did not show tracking of fluid provided by the kitchen or daily totaling of all fluids consumed. Observation of Resident 111's door showed a blue cup sign. During an interview on 02/25/2026 at 1:44 PM, Staff R, CNA, stated there was signage to indicate a resident was on a fluid restriction, to include a hummingbird (nectar thick liquid) and bee (honey thick liquid) signs. Staff R stated those were the only fluid restriction signs. Staff R stated they were unsure what the blue cup sign on Resident 111's door indicated. During a follow-up interview on 02/25/2026 at 1:49 PM, Staff R, CNA, stated they asked the nurse and the blue cup sign indicated Resident 111 was on a fluid restriction. During an interview on 02/25/2026 at 1:52 PM, Staff S, CNA, stated they were aware of a resident's fluid restriction because it was in the care plan and a blue cup sign would be placed on their door. Staff S stated there were no residents on a fluid restriction in their area (which included Resident 111's room). Staff S, after viewing Resident 111's blue cup sign, stated they were previously unaware of Resident 111's fluid restriction. During an interview on 02/25/2026 at 1:56 PM, Staff T, Registered Nurse, stated they were aware of fluid restrictions because it would be in the care plan and a blue cup would be placed on their door. Staff T stated if a resident had a fluid restriction nursing staff should record all fluid intake in the MAR and it should be totaled daily to ensure a resident had not exceeded their fluid intake. Staff T (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident 111's MAR did not include totaling of fluids consumed. Reference WAC 388-97-1060(3)(i)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement Abuse Prohibition policies and procedures including but not limited to identification, investigation, protection and reporting for 1 of 3 sampled residents (Resident 1) when reviewed for abuse. These failures placed residents at risk for unidentified abuse, neglect, and/or injury. Findings included .The facility Abuse, Neglect and Exploitation policies, revised October 2022, showed It is the policy of the facility that all allegations of abuse, neglect.are promptly and thoroughly investigated. Complaints and grievances will be investigated as outlined. The facility will ensure all residents are protected from physical and psychosocial harm during and after the investigation.In response to the allegations the facility will ensure that alleged violations are reported within 24 hours to the Administrator and other officials in accordance with State law through established procedures. Review of the electronic health record (EHR) showed Resident 1 readmitted to the facility on [DATE] with diagnoses to include chronic kidney disease, anxiety and Parkinson's disease (movement disorder of the nervous system). Resident 1 was able to make needs known. Review of the Resident Council meeting minutes dated 11/28/2025 showed a complaint that Resident 1 informed staff they needed a brief change. Staff stated they would inform another Certified Nursing Assistant (CNA). Resident 1 was not attended to in a timely fashion. Review of a grievance form dated 11/28/2025 showed, Night shift slamming doors and disruptive and night shift staff are not managing their scheduled time effectively in regard to brief changes. The grievance was signed by Staff L, Activities Director. Review of the facility's Documentation of Follow-Up showed all night shift nursing assistants were provided in-service education related to Leaving residents who do not have the ability to make their needs known without a brief change for multiple hours. Review of the provided documentation did not show evidence of an interview with Residents 1 to determine if there was an outcome to the residents and if neglect had occurred or evidence of interviews with residents or staff. During an interview on 02/25/2026 at 3:51 PM, Resident 1 stated they informed a CNA at 10 PM that they had a bowel movement (BM) and required a brief change. The CNA turned off the call light and stated they would inform the CNA assigned to Resident 1. The assigned CNA responded approximately 3 hours later at 1 AM. During an interview on 02/26/2026 at 8:45 AM, Staff L, Activity Director, stated after writing the grievance they believed the incident was an allegation of neglect and reported the incident to Staff A, Administrator, who was also the Abuse Coordinator. Staff L stated, A resident sitting in their BM for 3 hours seems like neglect to me. As a mandated reporter I was informed to report those concerns to Staff A. During an interview on 02/26/2026 at 11:50 AM, Staff K, CNA, stated if a resident reported not having a brief change for several hours after requesting it they would assist the resident and then report it to the nurse for staff neglecting to provide care to the resident. During an interview on 02/26/2026 at 11:52 AM, Staff H, Resident Care Manager, stated when a resident reported they did not receive timely care, the staff member should notify management and complete grievance due to the allegation of neglect. Staff H stated three hours was an unacceptable amount of time to wait. During an interview on 02/25/2026 at 12:54 PM, Staff A, Administrator, stated they interviewed Resident 1 and staff were provided education as a resolution to the concern. During an interview on 02/26/2026 at 12:03 PM, Staff B, Director of Nursing Services, stated they were unaware of the situation until yesterday. Staff B stated an investigation to include interviews, a skin assessment, social services evaluation and determining if there was an allegation of neglect should have been completed. Staff B stated the lack of investigation did not meet their expectations. Reference WAC 388-97-0640(6)(a)(b)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the minimum data set assessment (MDS) accurately reflected the status for 2 of 19 sampled residents (Residents 11 and 8) when reviewed for accuracy of assessments. Failure to accurately reflect Resident 11's hospice status and Resident 8's pressure ulcer/skin injury status placed the residents at risk for unmet care, inaccurate medical record data, and a diminished quality of life.Findings included. Resident 11Review of the electronic health record (EHR) showed Resident 11 readmitted to the facility on [DATE] with diagnoses of dementia (a decline in mental abilities, severe enough to interfere with daily life), chronic obstructive pulmonary disease (restricted airflow making it difficult to breathe), and anxiety disorder. Resident 11 usually was able to make needs known. Review of the EHR showed Resident 11 had an active focused care plan for terminal prognosis, (a medical assessment that an incurable, irreversible, or progressive disease is expected to end in death, often within six months or less) initiated on 10/07/2025, showed Resident 11 received hospice services (end of life care and services) with interventions being implemented. Review showed hospice care services were being provided and documented per the active provider's order for hospice. Review of the quarterly MDS dated [DATE] showed it was coded No for hospice services. During an interview on 02/26/2026 at 12:47 PM, Staff D, MDS Coordinator (MDSC), stated Resident 11 was receiving hospice services and the 01/08/2026 quarterly MDS was coded No, and should have been coded, Yes. Staff D stated the MDS needed to be modified. During an interview on 02/26/2026 at 12:51 PM, Staff B, Director of Nursing Services (DNS), stated Resident 11's quarterly MDS dated [DATE] was inaccurately coded for hospice and did not meet their expectations. Resident 8 Review of the EHR showed Resident 8 admitted to the facility on [DATE] with diagnoses of dementia, stage 4 pressure ulcer (the most severe form of skin and tissue damage caused by long-term pressure), and anemia (lack of healthy red blood cells reducing oxygen supply to the body). Resident 8 was unable to communicate needs. Review of the quarterly modification MDS dated [DATE] showed Resident 8 had a stage 4 pressure ulcer (PU). Review of the EHR showed Resident 8 had an active provider's order dated 06/30/2025 to provide daily treatment to a stage 4 PU to the left lower back area. Review showed the treatment was provided per the provider's order. Review of the quarterly MDS dated [DATE] showed Resident 8 had a stage 3 PU (wound that exposed fatty tissue, not as deep as a stage 4) and not a stated 4 PU. During an interview on 02/26/2026 at 1:14 PM, Staff E, MDSC, stated Resident 8 had a stage 4 PU; however, the quarterly MDS dated [DATE] was coded for a stage 3 PU and should have been coded for a stage 4 PU. Staff E stated the MDS needed to be modified. During an interview on 02/26/2026 at 1:35 PM, Staff B, DNS, stated Resident 8's quarterly MDS dated [DATE] was inaccurately coded for a stage 4 PU and this did not meet their expectations. Reference WAC 388-97 -1000 (1)(b)(4)(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nonpharmacological interventions (NPI) prior to the use of as needed pain medications for 1 of 6 sampled residents (Resident 7) when reviewed for pain management. This failure placed the residents at risk of receiving unneeded medications and a diminished quality of life. Findings included .Review of the electronic health record (EHR) showed Resident 7 readmitted on [DATE] with diagnoses to include left foot pain, diabetes (too much sugar in the blood) and peripheral vascular disease (condition that restricts blood flow). Resident 7 was able to make needs known. Review of Resident 7's medication list showed a provider's order dated 01/27/2026 for oxycodone (a narcotic opioid pain medication) every four hours as needed (PRN) for pain.Review of Resident 7's February 2026 MAR showed oxycodone administered 20 out of 28 days. There was no documentation NPI was offered/provided prior to the administration of the oxycodone. During an interview on 02/26/2026 at 10:03 AM, Staff C, Resident Care Manager, stated nursing staff should have offered ice and repositioning prior to administering the as needed pain medication. Staff C stated the expectation was to document Resident 7's pain level and the interventions attempted and make sure the appropriate PRN medication was given for the pain level. During an interview on 02/26/2026 at 11:58 AM, Staff B, Director of Nursing Services, stated the expectation was when an order for a PRN pain medication was entered into the EHR staff should have also indicated an area on the MAR to document that a NPI was offered and if it met the resident's needs. Reference WAC 388-97-1060(1), -1620(2)(b)(i)(ii)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to consistently maintain the medication refrigerator temperature log in 1 of 3 medication rooms (Transitional Care Unit/TCU), to ensure resident's were assessed to self-administer medications for 1 of 1 sampled residents (Resident 6), and 2 of 6 medication/treatments carts (TCU treatment and TCU medication carts) , when reviewed for medication storage. These failures placed the residents at risk of receiving compromised or ineffective medications, drug diversion, and potential loss of medications/treatments. Findings included .Medication Refrigerator Observation on 02/25/2026 at 10:44 AM with Staff C, Resident Care Manager (RCM), of the medication room refrigerator located in the Transitional Care Unit (TCU) medication room showed various liquid medications. Medications included a vial of a medication solution used to detect tuberculosis (TB, a serious illness that mainly affects the lungs), a box of an Arexvy vial kit (vaccine used to prevent lower respiratory tract disease), and a box of influenza vaccine (used to protect against the influenza virus during flu season) with six single-dose, prefilled syringes. The freezer had several ice packs that were frozen solid. Attached to the refrigerator door was the February 2026 Medication Refrigerator/Freezer Temperature Log. Review of the February 2026 Medication Refrigerator/Freezer Temperature Log from 02/01/2026 – 02/25/2026 showed refrigerator parameters were between 36 – 46 Fahrenheit (F, temperature scale) and the freezer parameters were between -4 - 14 F. The log showed multiple missing documented temperatures, temperatures documented outside of parameters for both the refrigerator and freezer, and multiple times the temperatures were documented one time a day. The section of the form that showed Notes/Corrections Made, had documentation that was illegible/writing not readable which was documented on 02/04/2026, 02/19/2026, and 02/24/2026; however, there were multiple times there was no documentation for temperatures out of parameters in that section of the form. During an interview on 02/25/2026 at 10:44 AM, Staff C, RCM, stated the February 2026 medication refrigerator/freezer temperature log in the TCU medication room had missing temperatures and temperatures logged outside of temperature parameters. Staff C stated the temperatures were not consistently being documented twice a day and should have been because there were vaccines being stored in the refrigerator. During an interview on 02/25/2026 at 11:53 AM, after reviewing the TCU medication room's February 2026 Medication Refrigerator/Freezer Temperature Log, Staff B, Director of Nursing Services (DNS), stated there were gaps/holes in the documentation and temperatures were not consistently being monitored twice a day as required. Staff B stated there were temperatures logged outside of parameters as low as 30 F for the refrigerator and below -4 for the freezer. Staff B stated the writing noted in the notes/corrections made, section of the form was hard to read and unclear what was documented. Staff B stated this did not meet their expectations. Medication at Bedside Review of the electronic health record showed Resident 6 admitted to the facility on [DATE] with (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses to include epilepsy (a disorder marked by sudden recurrent episodes of loss of consciousness, or convulsions, associated with abnormal electrical activity in the brain), diabetes (too much sugar in the blood), and kidney disease. Resident 6 was able to make needs known. Observation on 02/23/2026 at 10:32 AM showed Resident 6 in bed with two pill cups with medications on the bedside table with no facility staff present. Observation showed Resident 6 consumed both pill cups' medication during an interview. Review of a Medication Self-Administration Review assessment, dated 11/20/2025, showed Resident 6 was assessed to be able to self-administer medicated eye drops, but not any pill medications. Review of the care plan, initiated 07/08/2024, showed Resident 6 was assessed to be able to self-administer medicated eye drops, but not any pill medications. During an interview on 02/27/2026 at 9:23 AM, Staff Q, Registered Nurse, stated residents were allowed to self-administer medications if they were assessed to be competent and kept them in a locked box. Staff Q stated Resident 6 was not assessed to be able to self-administer any medications. During an interview on 02/27/2026 at 10:51 AM, Staff B, DNS, stated residents should be assessed prior to self-administering medications and medications should not be left at bedside without this assessment. Staff B stated Resident 6's medications at bedside did not meet expectations. Medication Storage Observation on 02/23/2026 at 12:20 PM showed a treatment cart on Transition Care Unit (TCU) unlocked and no staff were around. During an interview on 02/23/2026 at 12:21 PM, Staff P, Licensed Practical Nurse, stated the treatment cart should have been locked. Observation on 02/25/2026 at 10:31 AM showed a medication cart on TCU left unlocked with no staff round. During an interview on 02/25/2026 at 10:33 AM, Staff O, Staff Development Coordinator, stated the cart should have been locked. During an interview on 02/25/2026 at 1:03 PM, Staff B, Director of Nursing Services, stated the treatment and medication carts should be locked at all times when not attended by licensed nurses, and having the treatment and medication cart unlocked on TCU unit did not meet expectations. Reference WAC 388-97-1300(2), -2340

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food in accordance with preferences for 1 of 1 sampled resident (Resident 94) when reviewed for preferences. This failure placed residents at risk for reduced nutritional intake and a diminished quality of life. Findings included.Review of the electronic health record (EHR) showed Resident 94 admitted on [DATE] with diagnoses to include congestive heart failure, right ankle pain and dysphagia (difficulty swallowing). Resident 94 was able to make needs known. During an interview on 02/23/2026 at 1:04 PM, Resident 94 stated they had spoken to the dietician and discussed receiving smaller portion size. Resident 94 stated they were still getting large meal portions and at times felt overwhelmed with the amount of food. Observation on 02/24/2026 at 8:42 AM showed Resident 94's meal tray card had Regular Texture, heart health, no salt packet, fluid restriction 1500 ml. There were no preferences listed. Review of a Registered Dietician progress note dated 01/23/2026 showed Add small portions to meals per resident request. Review of Resident 94's EHR showed a 01/21/2026 provider's order for Heart healthy (cardiac) diet, regular texture, thin consistency, no salt packets, small portions with meals. During an interview on 02/24/2026 at 12:42 PM, Staff F, Dietary Manager, stated they must have missed transferring information to the resident's meal card related to the portion sizes. Reference WAC 388-97-1140(6)

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to post the location of the survey results and place the binder in identifiable location. This failure prevented residents, family members and visitors from exercising their right to review past survey results and the facility's plans of correction to evaluate the quality of care provided by the facility. Findings included .During an interview with Resident Council on 02/25/2026 at 3:45 PM, Residents 1, 10, and 16 stated they were not aware of the location of the state survey inspections. Observation on 02/25/2026 at 4:15 PM showed the state inspection binder was located at the front reception desk, lying on its side. The desk height was higher than a tabletop, which made it difficult for an individual in a wheelchair to view the title located on the top of the binder. There was no signage posted that identified that the binder was there. During an interview on 02/25/2026 at 4:15 PM, Staff G, Receptionist, stated there was no signage posted showing where the survey binder could be located. During an interview on 02/25/2026 at 4:18 PM, Staff A, Administrator (ADM), stated the facility previously had a sign posted but it was taken down during a remodel. Staff A stated the lack of signage did not meet expectations. Reference WAC 388-97-0480