

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Bellevue Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2424 156th Avenue Northeast Bellevue, WA 98007	
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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure dietary needs and preferences were provided for 4 of 5 residents (Residents 3, 4, 5 & 6), reviewed for food preferences. This failure placed residents at risk for dissatisfaction with food, weight loss, and a diminished quality of life. Findings included. Review of the facility's policy titled, Food and Nutrition Services, revised in October 2017, showed, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Reasonable efforts will be made to accommodate resident choices and preferences. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. RESIDENT 3 In an interview on 07/23/2026 at 9:27 AM, Resident 3 expressed their concerns regarding meal accuracy. Resident 3 stated their breakfast menu ticket for that day showed scrambled eggs, bacon, a cinnamon roll, and fruit. However, they were served pancakes and sausages instead. Resident 3 further stated they did not believe the kitchen staff reviewed the menu tickets when preparing food. Observation on 07/23/2026 at 12:00 PM, revealed that the lunch menu posted in the first-floor main dining room listed baked cheese lasagna, capri vegetable blend, garlic bread, frosted gelatin pork cake, milk, and beverages. Observation on 07/23/2026 at 12:01 PM, showed that the first-floor tray carts were delivered to the floor, and staff were observed distributing the trays to residents' rooms. At 12:57 PM, Resident 3 had not yet received their lunch. During a joint observation and interview on 07/23/2026 at 1:07 PM, Staff G, Certified Nursing Assistant (CNA), was observed delivering a lunch tray to Resident 3's room. Observation showed that Resident 3 was served grilled cheese sandwiches and zucchini, and there was no meal ticket on the tray. Staff G stated that Resident 3's lunch had not been sent from the kitchen, requiring them to return to the kitchen to get it. When asked how they verified that this was the correct meal for the resident, Staff G stated, I do not know. Resident 3 was asked if they had requested the lunch menu that was served to them, Resident 3 stated, I did not request or order this. RESIDENT 4A review of Resident 4's breakfast meal ticket titled, Breakfast - day 12 7/24/2026 [07/24/2026] - Fri [Friday] showed that scrambled egg and sausage patty were crossed out on the resident's menu ticket. Further review of the ticket indicated that egg was listed under Resident 4's dislikes. During a joint observation and interview at the facility's kitchen breakfast tray line on 07/24/2026 at 7:44 AM, Staff K, Dietary Aid, was observed placing Resident 4's meal ticket onto a tray containing scrambled eggs. Staff K then placed the tray into a tray cart that was ready for delivery to the unit. When Staff D, Dietary Manager, was asked about Resident 4's meal ticket and the breakfast tray with scrambled eggs, Staff D stated that the scrambled eggs were crossed out on the ticket. Staff D further stated that the resident frequently changes their preference, and stated, I can't (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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	keep up with [Resident 4] likes and dislikes.A review of Resident 4's lunch meal ticket titled, Lunch - day 19 7/30/2026 [07/30/2026] - Thu [Thursday] showed that Orange Glazed Chicken Breast was crossed out on the resident's menu ticket. Further review of the ticket menu indicated that chicken was listed under Resident 4's dislikes.In an interview on 07/30/2026 at 12:20 PM, Resident 4 stated that the facility was not following their food preferences. Resident 4 stated that staff frequently delivered food items they disliked. When asked about the most recent occurrence of this issue, Resident 4 stated, Today they sent me chicken for lunch.A joint observation and interview on 07/30/2026 at 12:24 PM, showed Staff J, CNA, removing a lunch tray from Resident 4's room. Observation showed an untouched chicken breast remaining on the resident's tray. Staff J stated that the chicken breast was crossed out on the meal ticket and listed as dislikes and that Resident 4 should not have received it.RESIDENT 5A review of Resident 5's breakfast meal ticket titled, Breakfast - day 12 7/24/2026 [07/24/2026] - Fri [Friday] showed that Chef's Choice Fruit was listed under the resident's breakfast menu.During a joint observation and interview at the facility's kitchen breakfast tray line on 07/24/2026 at 7:48 AM, Staff K placed Resident 5's tray into a tray cart that was ready for delivery to the unit without adding fruit to the breakfast tray. When asked why Resident 5 was not served fruit, Staff K stated, I do not have fruit for everybody.RESIDENT 6A review of Resident 6's breakfast meal ticket titled, Breakfast - day 12 7/24/2026 [07/24/2026] - Fri [Friday] showed that scrambled egg and bacon were crossed out on the resident's menu ticket. Further review of the ticket indicated that bacon and eggs were clearly listed under Resident 6's dislikes.During a joint observation and interview at the facility's kitchen breakfast tray line on 07/24/2026 at 7:52 AM, Staff L, Dietary Aid, was observed placing Resident 6's meal ticket onto a tray containing scrambled eggs and bacon. Staff L then placed the tray into a tray cart that was ready for delivery to the unit. When the staff was asked regarding Resident 6's meal ticket, Staff L stated that the bacon and scrambled eggs were crossed out on the ticket.In an interview on 07/30/2026 at 11:07 AM, Resident 6 stated that the facility was not following their dietary preferences. Resident 6 stated that they could not eat scrambled eggs and bacon due to their medical condition, but the facility continued to serve them for breakfast. Resident 6 further stated that this had occurred several times.In an interview on 07/23/2026 at 1:26 PM, Staff E, Lead Cook, stated that dietary staff did not follow the meal tickets during the tray line. Staff E further stated that there were multiple concerns within the dietary department and that multiple staff members have expressed these issues to Staff D, who was aware of the concerns.In an interview on 07/24/2026 at 9:02 AM, Staff H, CNA, stated that residents occasionally reported that the meals they received did not match with the items listed on their meal tickets.In an interview on 07/24/2026 at 9:12 AM, Staff I, CNA, stated that there have been several incidents where residents reported they did not receive their meals according to their meal tickets. Staff I further stated that this had occurred multiple times.In an interview on 07/30/2026 at 11:48 AM, Staff D stated that they would expect dietary staff to read the meal tickets, follow the documented preferences, and serve food appropriate for the resident's prescribed diet, texture, and preferences. Staff D stated that if a food item was crossed out on the meal ticket, it meant that the item should not be sent to the residents. Staff D further stated that certain dietary staff required additional training, and that the facility was conducting further education to improve their accuracy.In an interview on 07/30/2026 at 1:55 PM, Staff A, Administrator, stated that they would expect dietary staff to do their best to honor resident preferences and to serve food according to the meal ticket.Reference: (WAC) 388-97-1120 (3)(a).		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to conduct a thorough investigation for 1 of 4 residents (Resident 1), reviewed for incident investigations. This failure placed residents at risk for repeated incidents, inappropriate corrective actions, and unrecognized abuse/neglect. Findings included .Review of the Nursing Home Guidelines, The Purple Book, Sixth Edition, dated October 2015, showed, A thorough investigation is a systematic collection and review of evidence/information that describes and explains an event or a series of events. It seeks to determine if abuse, neglect, abandonment personal and/or financial exploitation or misappropriation of resident property occurred, and how to prevent further occurrences .All incidents require thorough investigation and reporting, as necessary, according to state and federal regulations. All such investigations attempt to determine if such injury or allegation of injury results from abuse or neglect. Review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised in September 2024, showed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Review of the admission record printed on 07/23/2026 showed Resident 1 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (an assessment tool) dated 06/25/2026 showed Resident 1 had intact cognition. Review of the investigation report dated 06/26/2026 showed that Resident 1 and their collateral contact reported an unwitnessed fall. Review of the progress note dated 07/17/2026 showed that Resident 1 left the facility with their collateral contact. Upon return, the collateral contact reported that Resident 1 experienced a fall at their home. Review of the June 2026 and July 2026 incident report log showed no incident was logged for Resident 1's fall incident dated 06/26/2026 or 07/17/2026. In an interview on 07/24/2026 at 10:16 AM, Staff F, Registered Nurse, stated that if a resident self-report a fall incident, a facility investigation would be completed. In an interview on 07/30/2026 at 11:01 AM, Staff C, Charge Nurse, stated that if a resident self-report a fall incident, the resident and any witnesses were interviewed, the attending physician would be notified, the resident would be assessed for injury, and an investigation would be completed. In an interview and joint record review on 07/30/2026 at 11:08 AM, Staff B, Director of Nursing, stated that the purpose of an incident investigation was to determine if the event must be reported to the state, identify the root cause, maintain resident safety, and rule out any abuse or neglect related to the incident. A joint record review of the progress note dated 07/17/2026 showed that Resident 1's collateral contact reported that Resident 1 experienced a fall at their home. Staff B stated that they were unaware of the fall reported on 07/17/2026, noting that this incident should have been investigated. A joint record review of the June 2026 and July 2026 incident log showed no entries for the fall incidents on 06/26/2026 or 07/17/2026. Staff B stated, I do not see these falls on the incident log, and that they should have been recorded. When asked if abuse/neglect was ruled out with Resident 1's fall incident on 07/17/2026, Staff B stated, We do not know because we did not investigate the incident. In an interview on 07/30/2026 at 1:55 PM, Staff A, Administrator, stated that all falls should be investigated. Reference: (WAC) 388-97-0640 (6)(a)(c).		