

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Briarwood at Timber Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Timber Ridge Way NW Issaquah, WA 98027	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview, and record review the facility failed to ensure food was stored and prepared in accordance with professional standards of safety. The failure to ensure: (1) open foods were labeled and dated, (2) kitchen fan and ice machines were monitored and cleaned, and (3) kitchen garbage/trash receptacles were covered as required placed residents at risk for ingesting expired and/or contaminated food and the development of food-borne illness. Findings included .<Facility Policy>The facility policy titled, Food Receiving and Storage, revised 03/2024, showed foods would be received and stored in a manner that complied with safe food handling practices. The policy showed dry foods that were stored in bins and all foods stored in the refrigerator or freezer would be covered, labeled, and dated (use by date) appropriately. The policy showed food services staff would maintain clean food storage and preparation areas at all times.<Dry Storage>Observation on 12/10/2025 at 8:18 AM with Staff G (Sous Chef) showed six bottles of assorted sauces and cooking condiments and one bottle of chocolate syrup that were open but undated; several bottles had dried-up drips along the sides of the bottle cap. There were two packages of dry cashew and walnuts that were left open and uncovered. In an interview on 12/10/2025 at 8:36 AM, Staff G confirmed the foods observed to be opened, undated, and left uncovered and stated the dietary staff were expected to date opened foods and to cover them for resident safety in preventing foodborne illness.<Walk-In Refrigerator #1>Observation on 12/10/2025 at 8:55 AM showed three kinds of partially cut-up cheeses and one package of soybean paste that were opened and undated. In an interview on 12/10/2025 at 9:05 AM, Staff G stated it was important to label and date cheeses because they were moist, could grow molds, and was dangerous to eat especially if they expired. Staff G stated these items should be labeled and dated after opening, but they were not.<Freezer>Observation on 12/10/2025 at 9:13 AM showed one package of ground meat, one package of frozen pasta tortellini, and one package of freezer-burned salami that were open and undated. There were two slices of individually wrapped steak inside a grocery bag tucked behind the boxes of frozen foods that were unlabeled and undated. In an interview on 12/10/2025 at 9:19 AM, Staff E (Executive Chef) validated the food items observed and stated all opened food items in the freezer must be labeled and dated according to their facility policy. Staff E stated the individually wrapped steaks found inside the grocery bag were for a resident and they should be labeled, but they were not.<Kitchen Fan>Observation and interview on 12/10/2025 at 9:39 AM showed a short, stand-up fan was placed on top of metal table by the dishwasher; it was turned on, dirty, and heavily covered with black dust build-up along the blades and outer mesh cover blowing onto the dishes and utensils there were being air-dried. Staff E turned the fan off and stated it should be cleaned weekly by the kitchen staff for food safety.<Ice Machines>Observation and interview on 12/16/2025 at 10:34 AM showed the two ice machines located in the main kitchen had brownish, dirt build-up inside the upper chamber. Staff E stated they were unsure as to who was responsible for monitoring the machine's cleanliness. Review of the May 2025 - November 2025 Ice Machine Monthly Cleaning Log provided by Staff P (Facility Dietician) showed the protocol that was used in cleaning the ice machine located at the skilled nursing unit. The log outlined the ice machine's cleaning process, the date it was cleaned, and who (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 505518	Facility ID: 505518 If continuation sheet Page 1 of 19

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was the person responsible. In an interview on 12/16/2025 at 10:42 AM, Staff F (Food and Beverage Director) stated there were no monthly cleaning logs for both the ice machines located in the main kitchen, [We] will start doing them moving forward. <Kitchen Trash/Garbage Bins> Observation on 12/10/2025 at 8:48 AM showed five garbage/trash bins were actively used in the kitchen during food preparation; three were round and two were rectangular lined with a black garbage bags and they were all without lids/cover. In an interview on 12/10/2025 at 8:51 AM, Staff G stated the facility was in the process of switching vendors and garbage lids were in order. Staff G stated it was important for trash/garbage bins to have a lid/cover to avoid cross-contamination during food handling and preparation, thus preventing foodborne illness. REFERENCE: WAC 388-97-1100 (3), -2980.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to ensure essential equipment including the dishwasher, walk-in refrigerator, and freezer thermostat (a device that regulated a heating or cooling system to maintain a set temperature) located in the main central kitchen were maintained and kept in safe operating conditions. These failures placed the residents at risk for infection with using improperly sanitized dishes and utensils during meals, consuming foods stored in unsafe temperatures, and the development of foodborne illness. Findings included. <Facility Policy>The facility policy titled, Food Receiving and Storage, revised 03/2024, showed functioning of the refrigeration and food temperatures would be monitored at designated intervals throughout the day by the food and nutrition services manager or designee. The policy showed its monitoring would be documented according to state-specific requirements. The facility policy titled, Sanitization, revised 11/2022, showed dishwashing machines were operated according to the manufacturer's instructions. The policy showed dishwashing machines had preventative maintenance programs in place to monitor the equipment for proper operation. < Manufacturer's Instructions - Dishwasher>According to the 09/2024 CMA High-Temperature Conveyor Dish Machine manufacturer instructions manual provided by the facility, the safe operating temperatures specified for this essential equipment were 150-160 degrees Fahrenheit (F) for the Wash Cycle and 180-195F for the Final Rinse Cycle. <Main Kitchen Dishwasher>Observation and interview on 12/10/2025 at 9:48 AM during an actual run cycle of the main kitchen's dishwashing machine with Staff E (Executive Chef) and the dishwasher-on-duty showed the wash temperature registered at 145 F and the rinse temperature registered at 140 F after the run cycle was completed. Staff E stated the dishwasher was the high-temperature type of dish machine. Observation and interview on 12/10/2025 at 9:54 AM during a second-time actual run cycle of the main kitchen's dishwashing machine with Staff E and Staff H (Lead Cook-Kitchen Staff) showed both the wash and rinse temperatures registered at 148 F after the run cycle was completed and did not reach safe operating temperatures as specified in the manufacturer's instructions. The cleaning test strip indicator placed by Staff E on the test plate showed a gray color which indicated the plate was not cleaned and sanitized properly. Staff E stated Staff H was in charge of monitoring the dishwasher for safe operating temperatures. Review of the December 2025 Kitchen Dishwashing Temperature Log showed there was no monitoring completed on 12/10/2025 to confirm the dishwasher was within safe operating temperatures. In an interview on 12/10/2025 at 9:58 AM, Staff H stated it was important for the dishwasher to run at safe operating temperatures to ensure proper sanitation, .it is how germs and bacteria are killed. residents use these [dishes/utensils] to eat with during their daily meals, so it is necessary that the recommended temperatures are reached when washing to prevent foodborne illness. Review of the 12/11/2025 Preventative Maintenance Summary conducted by a third party service provider showed the dishwasher was malfunctioning as the equipment would not fill or heat. The summary showed repair by another company was advised and that parts needed to be replaced. In an interview on 12/11/2025 at 10:08 AM, Staff E stated they utilized the three-compartment sink (a dishwashing method that used chemicals as the sanitizing agent) for washing the dishes after the dishwasher malfunction was identified. Staff E stated the parts needed to repair the dishwasher were ordered. <Walk-In Refrigerator - Bakery>Review of the December 2025 Daily Temperature Log for the walk-in refrigerator where the desserts were stored before meal service showed the temperature was monitored twice during the day (AM) and in the afternoon (PM), and the kitchen staff were instructed to notify the supervisor if the temperature was over 40 F. The log showed on 12/04/2025, the PM temperature logged was 47 F; on 12/06/2025, 12/07/2025, and 12/08/2025, both the AM and the PM temperatures logged were 42 F; on 12/09/2025, the AM temperature logged was 42 F; and on 12/10/2025, the AM temperature logged was 41 F. Observation on 12/10/2025 at 8:40 AM showed dessert items were brought inside the walk-in refrigerator by a kitchen staff despite a temperature (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reading of 43 F as shown on the thermostat. Inside the refrigerator, ready-to-eat food items and several pans of baked cake were observed stacked up on metal racks. In an interview on 12/10/2025 at 9:08 AM, Staff G (Sous Chef) stated the walk-in refrigerator was broken and should not be in use because the temperature readings, both logged and observed, were above the parameters. Staff G stated there was a work service order sent to check and/or repair the refrigerator. Staff G stated it was important to keep foods stored at the right temperatures to avoid reaching the danger zone (40 F to 140 F- the range where bacteria multiply rapidly, causing foodborne illness). <Freezer Thermostat> Review of the December 2025 Daily Temperature Log for the freezer showed the temperature was monitored twice during the day (AM) and in the afternoon (PM), and the kitchen staff were instructed to notify the supervisor if the temperature was over 0 F. The log showed on 12/01/2025, the AM temperature logged was 2 F; on 12/03/2025, the AM temperature logged was 8 F and the PM temperature logged was 7 F; on 12/04/2025, the PM temperature logged was 1 F; on 12/05/2025, 12/06/2025, 12/07/2025 and 12/08/2025, both the AM and the PM temperatures logged were 6 F; and on 12/09/2025, the PM temperature logged was 3 F. On 12/10/2025 at 9:13 AM, observation of the freezer thermostat located by the wall adjacent to the door with Staff E showed the temperature registered at 2.5 F; the device was observed externally wired from the thermostat box, wedged between the freezer door and the door jam, and was threaded inside the freezer. In an observation and interview on 12/10/2025 at 9:19 AM, Staff E stated, [Freezer] has been opened and is probably defrosting. the temperature should be back to negative in 10 minutes. Staff E went inside the freezer and obtained a small, round thermometer located in one of the top shelf racks; the temperature reading on the thermometer was observed to be 2 F. At 10:01 AM, the freezer thermostat's temperature reading was 2.7 F and remained outside the safe parameters. In an interview on 12/16/2025 at 10:43 AM, Staff E stated it was important to ensure state-specific recommended temperatures were maintained at all times for food safety. Staff E stated the replacement of the freezer thermostat device was in the works but the process to have kitchen equipment replaced was a very slow process. REFERENCE: WAC 388-97-2100.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review the facility failed to develop, implement and/or ensure residents' comprehensive care plans accurately reflected care needs for 2 of 12 (Residents 26 & 15) residents reviewed for care planning. These failures placed residents at risk for unidentified and/or unmet care needs, medical complications and a diminished quality of life. Findings included .<Resident 26>According to the 10/21/2025 admission Minimum Data Set (MDS - an assessment tool), Resident 26 had clear speech, impaired memory, and was assessed to require substantial/maximal assistance from staff with grooming/personal hygiene. Review of the revised 10/20/2025 Activities of Daily Living (ADL) Care Plan (CP) showed Resident 26 needed assistance with their ADLs as they were unable to perform them independently. The CP did not show Resident 26 needed substantial/maximal assistance with their grooming/personal hygiene as assessed in their MDS. On 12/10/2025 at 10:36 AM, Resident 26 was observed with facial hair/stubbles, bushy eyebrows, and long unkempt hair. There were white flakes covering both the shoulders and upper chest portion of Resident 26's shirt. In an interview on 12/16/2025 at 2:31 PM, Staff B (Director of Nursing) reviewed Resident 26's CP and stated the resident's need for grooming assistance should be captured, but it was not. Staff B stated they expected resident CP's to be complete, accurate, and revised accordingly because it was what the staff goes by when providing daily care for residents. <Resident 15>According to the 10/01/2025 Quarterly MDS, Resident 15 had clear speech, impaired memory, and was assessed to require partial/moderate assistance from staff with eating. The MDS showed Resident 15 was dependent on staff for their oral hygiene. An 11/24/2025 dental visit note showed Resident 15 had a lower removable partial denture and the resident needed staff assistance with daily denture removal and cleaning. Review of the revised 01/30/2024 ADL CP showed Resident 15 needed assistance with their ADLs as they were unable to perform them independently due to limited mobility and weakness. The CP did not show Resident 15 required partial/moderate assistance from staff with eating as assessed in their MDS. The CP did not show Resident 15 had a lower partial denture and required staff assistance with putting them in and taking out. On 12/12/2025 at 12:14 PM, Resident 15 was observed receiving one on one eating assistance from Staff J (Certified Nursing Assistant) and the resident was not wearing their lower partial denture; it was observed left in the cup by the sink in Resident 15's room. In an interview on 12/16/2025 at 10:15 AM, Staff B reviewed Resident 15's CP and stated both the level of assistance needed by the resident while eating and their current use of a lower partial denture should be captured in the CP, but they were not. Refer to F677 - ADL Care Provided for Dependent Residents. REFERENCE: WAC 388-97-1020(1), (2)(a)(b).		

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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. Based on observations, interview, and record review the facility failed to ensure Care Plans (CPs) were updated and/or revised as needed to reflect person-centered care for 3 (Resident 3, 14, & 6) of 12 residents whose CPs were reviewed. These failures left residents at risk for inappropriate care, unmet care needs, and other negative health outcomes. Findings included.<Facility Policy> Review of the facility's Care Plans policy, revised 03/2022, showed CPs would be revised as information about the resident and/or the resident's condition changed. <Resident 3> According to the 10/03/2025 Quarterly Minimum Data Set (MDS &ndash; an assessment tool), Resident 3 was able to make their needs known, had memory loss, clear speech, could make themselves understood and usually could understand others. The MDS showed Resident 3 had limited range of motion to one leg, used a walker or wheelchair, and required moderate assistance with toileting, bathing, dressing, and personal hygiene. Observations made on 12/10/2025 at 9:25 AM ,12/11/2025 at 9:32 AM, and 12/15/2025 at 11:15 AM showed Resident 3 in a wheelchair with a hard boot on their left lower leg. In an interview on 12/15/2025 at 8:33 AM with Residents 3's Collateral Contact (CC), the CC stated Resident 3 wore a hard boot to the left lower leg and a regular shoe on the right foot. The CC stated Resident 3 could bear some weight to their left lower leg, but they barely put any weight on it when standing. Review of Resident 3's Pressure Wound CP, revised 05/30/2025, directed staff that the resident could not bear weight to their left lower extremity and to check the left foot every shift while Resident 3 was wearing the boot. The CP did not provide directions to staff on how to manage the hard boot, if staff should remove the boot, for how long, and how often the boot must be worn. During an interview on 12/16/2025 at 10:56 AM, Staff Q (Resident Care Manager) stated Resident 3 was non-weight bearing to their left leg because of the wound on the left foot. Staff Q stated the wound healed about four weeks ago and Resident 3 was now able to bear weight to the left foot. Staff Q stated the CP should be updated and revised to reflect the current weight bearing status for Resident 3 and directions for staff on how to manage the hard boot. <Resident 14> According to the 10/13/2025 Quarterly MDS, Resident 14 had severe cognitive impairment. The MDS showed Resident 14 required substantial/maximal assistance from staff with eating. Observation on 12/11/2025 at 11:30 AM showed Resident 14 seated at a table in the dining room for lunch. Staff served Resident 14 their lunch at 11:38 AM. Resident 14 was looking around at other residents and falling asleep. Staff were not observed to provide cueing or eating assistance to the resident. After continuous observation with no staff intervention, Resident 14 was approached by the surveyor at 11:57 AM. At this time, Staff M (Certified Nursing Assistant) stood up, cut up Resident 14's food, and gave the resident their first bite of lunch. Review of Resident 14's I need help with [activities of daily living] . CP, revised on 08/12/2025, showed the resident only required set up assistance from staff with their meals in the dining room. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CP did not show Resident 14 required substantial/maximal assistance from staff with eating. In an interview on 12/16/2025 at 9:45 AM, Staff B (Director of Nursing) stated they expected Resident 14's CP to be revised and direct staff to provide the level of assistance with eating the resident required. <Resident 6> According to the 10/06/2025 Quarterly MDS, Resident 6 had clear speech, impaired memory, and was assessed to require supervision or touching assistance with walking. The MDS showed Resident 6 had a fall and sustained a major injury during the assessment period. Review of the 08/12/2025 facility incident report showed Resident 6 fell at the parking lot of a restaurant while they were out with their family. The report showed Resident 6 was taken to the hospital and was diagnosed with a mildly displaced left collarbone. An 08/12/2025 nursing progress note showed Resident 6 was discharged from the hospital with an arm sling and had left arm non-weight bearing restrictions. Review of Resident 6's CP showed a 04/09/2025 fall CP indicating Resident 6 was at risk for falls and injuries due to their unsteady gait/balance and weakness. An 08/14/2025 CP intervention listed showed therapy recommended non-weight bearing to the left arm with continuous sling use. An 08/14/2025 fall incident CP outlined Resident 6's actual fall on 08/12/2025 and included a 12/09/2025 CP intervention indicating 25% weight bearing limitation on the resident's left arm. In an observation and interview on 12/11/2025 at 10:49 AM, Resident 6 was observed lying in bed and was not wearing a sling to support their left arm. Resident 6 stated they fell badly a while ago, could not recall exactly when, but was feeling much better. In an observation and interview on 12/11/2025 at 12:33 PM, Resident 6 was walking to their spot at the dining room for lunch; they were not wearing a sling. Resident 6 was using their left arm while eating their meal. When asked if they were supposed to be wearing a sling and not using their left arm, Resident 6 stated they did not need to put the sling on anymore and could now use their left arm but with caution. Review of Resident 6's physician orders showed the resident's left arm non-weight bearing restriction and sling use was discontinued on 09/26/2025. In an interview on 12/16/2025 at 2:31 PM, Staff B stated they expected resident CP's to be complete, accurate, and revised accordingly because it was what the staff goes by when providing care for residents. Staff B reviewed Resident 6's CP and stated the two weight bearing restrictions written in the CP were conflicting. Staff B stated Resident 6's CP should be revised when the sling use was discontinued, but it was not. Refer to F677 &ndash; ADL Care Provided for Dependent Residents. REFERENCE: WAC 388-97-1020(2)(c)(d).		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to ensure non-pharmaceutical interventions were in place, pain medications had parameters for residents receiving multiple pain medications, physician's orders were clarified, and staff followed post dialysis orders for 3 (Residents 8, 3 & 18) of 12 residents whose orders were reviewed. These failures placed residents at risk for ineffective treatments, medication errors, and delayed treatments. Findings included. <Pain Medication Parameters & Non-Pharmaceutical Interventions> <Resident 8> According to the 10/13/2025 Comprehensive Minimum Data Set (MDS - an assessment tool), Resident 8 was able to make their needs known, had memory impairment, had clear speech, was able to understand and be understood by others. The MDS showed Resident 8 had diagnoses including an upper arm fracture, pain, and muscle spasms. The MDS showed Resident 8 was assessed with occasional pain that interfered with therapy activities and activities of daily living. Review of the at risk for pain due to a left arm fracture care plan, revised 10/24/2025, directed staff to offer and administer pain medications according to the physician order. The care plan directed staff to encourage the resident to try different pain relieving measures, such as re-positioning and relaxation therapy. Review of Resident 8's December 2025 Medication Administration Record (MAR) showed a 10/10/2025 physicians order for an Over the Counter (OTC) pain medication to be administered every four hours as needed for pain. The order showed insert pain scale and no pain scale or parameters were observed. An additional physician order, dated 10/28/2025 showed a narcotic pain medication to be administered every six hours as needed for moderate to severe pain. The December 2025 MAR showed Resident 8 received narcotic pain medication on 12/05/2025 and 12/07/2025 for pain 4 out of 10, on a scale of 10. Review of December 2025 Treatment Administration Record (TAR) showed a physician order directing staff to observe for pain and offer non-pharmacological interventions to reduce pain. The TAR showed eight different interventions to offer, numbered one through eight. The TAR did not show what interventions were offered and what interventions were effective. In an observation and interview on 12/11/2025 at 10:24 AM, Resident 8 was observed in bed. Resident 8 stated they had pain to their left shoulder, the fracture was not surgically repaired, and they were anxious about having another fall. During an interview on 12/16/2025 at 10:21 AM Staff Q (Resident Care Manager) stated Resident 8's pain medication orders should have pain parameters in place to direct staff what pain medication to dispense for the pain level. Staff Q stated non-pharmacological interventions attempted and the outcome should be documented on the TAR. <Resident 3> According to the 10/03/2025 Quarterly MDS, Resident 3 was able to make their needs known, had impaired memory, and required staff assistance with toileting, dressing, and bathing. The MDS showed Resident 3 had diagnoses including non-traumatic brain disfunction, dementia, and anxiety. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS showed Resident 3 was assessed with no current pain. Review of a pain care plan, revised 07/25/2025, showed Resident 3 was at risk for pain due to arthritis. The care plan directed staff to assess pain every shift by using a pain scale, to attempt non-pharmacological methods for reducing pain, and to offer and document pain medications. Review of Resident 3's December 2025 MAR showed Resident 3 had a 04/04/2023 physicians order for an OTC pain medication to be administered every four hours as needed for pain. An additional physician's order showed a narcotic pain medication to be administered every four hours for moderate to severe pain. Review of December 2025 TAR showed a physician order directing staff to observe for pain and offer non-pharmacological interventions to reduce pain. The TAR showed eight different interventions to offer, numbered one through eight. The TAR did not show what interventions were offered and what interventions were effective. In an observation and interview on 12/15/2025 at 8:33 AM, Resident 3 was observed sitting in a chair. Resident 3 stated their left foot hurt at times but not frequently. During an interview on 12/16/2025 at 10:21 AM, Staff Q stated when a resident had multiple pain medications prescribed the nurse should administer the OTC medication for pain 1-3 out of 10 and administer the narcotic pain medication for pain 4-10 out of 10 on the pain scale. Staff Q stated there was a pain scale located on the nurses medication cart the nurse could use to assess pain. Review of the pain scale located on the nurses cart showed a pain scale that utilized facial expressions to assess pain for non-verbal residents who could not express their pain. When asked if Resident 3 could verbalize and express their pain, Staff Q stated, yes they could. When asked how the pain scale was determined for Resident 3, Staff Q stated each resident had a pain assessment completed and the results of the pain assessment determined what non-pharmacological interventions would be used. Staff Q stated Resident 3's pain medication orders should have parameters to direct nurses on which medication to administer for the pain level indicated and they would expect nurses to attempt and document non-pharmacological interventions before administering pain medications. In an interview on 12/16/2025 at 10:28 AM, Staff R (Licensed Practical Nurse), stated they did not use the non-verbal pain scale for residents who were able to verbally rate their pain on a scale and able to express pain or discomfort. Staff R stated the pain medication orders should have parameters to direct what pain medication to administer. <Clarifying Physician Orders> <Resident 3> Observations made on 12/10/2025 at 9:25 AM ,12/11/2025 at 9:32 AM, and 12/15/2025 at 8:33 AM and 11:35 AM, showed Resident 3 in a wheelchair with a hard boot on their left lower leg. In an interview on 12/16/2025 at 8:33 AM Resident 4's Collateral Contact (CC) stated Resident 4 could bare weight on their left foot. The CC stated Resident 4 wore the boot due to a wound on the left foot. Review of a 12/13/2025 Kardex (quick access to key resident information used by caregivers) (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed Resident 3 was non weight bearing to the left lower extremity. Review of Resident 3's physician orders, showed an 11/13/2025 order directing staff to assess the resident's left foot condition when wearing the crow boot. The order directed staff to monitor the left foot twice daily for any signs of skin impairment. Review of the physician orders showed no order directing staff if Resident 3 was able bare weight on the left foot, able to take off the boot, for how long, or directions on how to manage the boot during showers. The physician orders showed no order directing staff what to do if the bandage to the left foot was dislodged or soiled, or orders for treatment to the left foot as needed. Review of Resident 3's At risk for skin breakdown care plan, revised 07/25/2025, directed staff to monitor the skin under the left boot for skin impairments. Review of the comprehensive care plan showed no other directions for staff on how to manage the crow boot During an interview on 12/16/2025 at 10:56 AM, Staff Q stated Resident 3 wore a boot to the left foot due to a wound. Staff Q stated Resident 3 was non-weight bearing but now could bare weight on the left foot as the wound healed. Staff Q stated there was not but should be a physician order and a care plan for Resident 3's boot that directed staff on how to manage the boot. Staff Q stated Resident 3's Kardex should reflect their current weight bearing status. <Resident 18> Review of Resident 18's 12/05/2025 admission MDS showed the resident had a diagnosis of kidney disease and received dialysis (life sustaining medical treatment that filtered waste products from the blood when the kidneys failed). Review of Resident 18's 12/09/2025 hemodialysis care plan showed the resident had dialysis three times weekly on Monday, Wednesday, and Friday mornings. Review of Resident 18's 12/2025 TAR showed a 12/05/2025 order directing staff to complete the pre and post dialysis assessment on Mondays, Wednesdays, and Fridays at 7:00 AM. The order included a space where staff documented the resident's vitals before leaving for dialysis. A second 12/05/2025 order directed staff to complete the pre and post dialysis assessment per dialysis schedule on [Monday, Wednesday, Friday every night shift on Tuesday, Thursday, Sunday]. This order showed staff were documenting on the TAR Resident 18's vitals at 11:00 PM the following evening on Tuesdays, Thursdays, and Sundays and showed staff were not assessing the resident's vitals upon their return from dialysis on Mondays, Wednesdays, and Fridays. Observation on Monday, 12/15/2025 at 12:59 PM, showed Resident 18 was back from their dialysis appointment and was lying in bed. In an interview on 12/16/2025 at 9:51 AM, Staff B (Director of Nursing) stated staff were supposed to monitor Resident 18's vital signs upon their return from the dialysis center. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to ensure residents who were dependent on staff for assistance with Activities of Daily Living (ADLs) received the assistance they required for 3 (Residents 14, 26, & 15) of 3 residents and 1 (Resident 3) supplemental resident reviewed for assistance with ADLs. The failure to provide assistance with putting on compression stockings, eating assistance, and grooming/personal hygiene left residents at risk for embarrassment, poor hygiene, and other negative health outcomes. Findings included. <Facility Policy>According to the facility's Activities of Daily Living policy, revised 03/2018, care and services would be provided to residents who were unable to carry out ADLs independently. Staff would provide appropriate support and assistance with hygiene, mobility, using the restroom, dining, and communication. <Resident 3> According to the 10/03/2025 Quarterly Minimum Data Set (MDS &ndash; an assessment tool), Resident 3 was able to make their needs known, had memory loss, and required moderate staff assistance with toileting, bathing, dressing, putting on, and taking off footwear. Review of resident 3's edema (swelling caused by excess fluid) care plan, revised 07/25/2025, showed Resident 3 had swelling in both lower legs. The care plan directed staff to apply knee high compression stockings in the morning and remove the compression stockings at night. Observations on 12/10/2025 at 9:25 AM ,12/11/2025 at 9:32 AM, and 12/15/2025 at 8:33 AM and 11:35 AM showed Resident 3 in a wheelchair with a hard boot on their left lower leg and no compression stockings on their lower legs. In an interview on 12/15/2025 at 8:33 AM, Resident 3's Collateral Contact (CC) stated Resident 3 was not supposed to wear compression stockings because the resident had a wound to their left foot. During an observation and interview on 12/15/2025 at 11:01 AM, Resident 3 was observed sitting in a recliner after having a shower. Staff R (Licensed Practical Nurse) was observed assessing Resident 3's left foot wound, the wound was healed, and Staff R stated they observed swelling to Resident 3's ankles that was pitting (an indentation in the skin after being pushed indicating fluid retention in the lower legs). In an interview on 12/16/2025 at 10:56 AM, Staff Q (Resident Care Manager) stated Resident 3 wore compression stockings for swelling in their lower extremities. Staff Q stated Resident 3's wound healed three to four weeks ago, there was an active physician order, and care plan for compression stockings. Staff Q stated staff should assist Resident 3 with putting on and removing the compression stockings and they expected Resident 3 to be wearing compression stockings as ordered by the physician. <Resident 14> According to the 10/13/2025 Quarterly MDS, Resident 14 had severe cognitive impairment. The MDS showed Resident 14 required substantial/maximal assistance from staff with eating. Review of Resident 14's 05/12/2023 ADL care plan showed the resident required assistance from staff to set their meals up in the dining room. The care plan did not show Resident 14 required substantial/maximal assistance from staff for eating their meals. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/11/2025 at 11:30 AM showed Resident 14 sitting at a table in the dining room with four other residents who were being assisted with their lunch meal. At 11:38 AM, host staff served the resident their lunch. Resident 14 was falling asleep and not touching their lunch. In an interview at 11:57 AM, Staff L (Certified Nursing Assistant - CNA) stated Resident 14 had behaviors and often declined assistance. In a continuous observation from 11:30 AM to 11:57 AM, facility staff did not assist or offer assistance to Resident 14 with their lunch. Observation on 12/12/2025 at 8:45 AM showed Resident 14 at a table with their breakfast tray. No staff were sitting with the resident. Resident 14 was not eating their breakfast and kept falling asleep. Most of Resident 14's breakfast remained on the plate. At 8:48 AM, Staff M (CNA) sitting at a nearby table, began calling for Resident 14 by name, attempting to wake the resident up. Staff M did not get up from the table or go over to Resident 14. At that time, Staff B (Director of Nursing) approached Resident 14 and woke the resident up. Staff M, who was still at another table, called to Resident 14 and stated eat your food from afar. In an interview on 12/15/2025 at 10:46 AM, Staff N (CNA) stated they were very familiar with Resident 14. Staff N stated Resident 14 needed help to eat stating the resident could drink on their own and did well with finger food but needed verbal cueing. Staff N stated We have to tell [them] to eat or [they] get distracted. In an interview on 12/16/2025 at 9:45 AM, Staff B stated Resident 14 used to be more independent with their meals, but staff recently noticed the resident was requiring more help with dining assistance. Staff B acknowledged staff should provide Resident 14 assistance with their meals as the resident required. <Resident 26> According to the 10/21/2025 admission MDS, Resident 26 had clear speech, impaired memory, and was assessed to require substantial/maximal assistance from staff with dressing, grooming, and personal hygiene. Review of the revised 10/20/2025 ADL care plan showed Resident 26 needed assistance with their ADLs including dressing. The care plan showed Resident 26 was unable to perform ADLs independently due to their limited mobility and weakness. The care plan did not show Resident 26 needed substantial/maximal assistance with their grooming/personal hygiene as assessed in their MDS. In an observation and interview on 12/10/2025 at 10:36 AM, Resident 26 was observed with facial hair/stubble, bushy eyebrows, and long unkempt hair. There were white flakes covering both shoulders and upper chest portion of their shirt. Resident 26 stated the staff did not help them with shaving but the resident would like to have assistance. In an observation and interview on 12/12/2025 at 9:07 AM, Resident 26 was sitting up in their room eating breakfast; their facial hair was noted to be more pronounced, and their eyebrows and hair were in the same condition as previously observed. Resident 26 stated they got their haircut from the first floor salon in the facility. Resident 26 stated they would like their eyebrows trimmed and have a haircut but could not do it on their own. In an interview on 12/12/2025 at 9:18 AM, Staff K (Unit Coordinator) stated Resident 26 received their (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last haircut from the first floor salon on 09/11/2025. In an interview on 12/12/2025 at 9:33 AM, Staff I (CNA) stated they used and referred to the care plan when providing ADL care to residents for safety. Staff I stated grooming/personal hygiene for male residents included giving showers, shaving the facial hair, and nail care. Staff I looked at Resident 26 inside their room and confirmed the resident needed grooming/personal hygiene care and their shirt changed. In an interview on 12/16/2025 at 10:26 AM, Staff B stated they expected the nursing staff to provide ADL assistance to residents who were assessed to need them for safety, dignity, and quality of life. <Resident 15> According to the 10/01/2025 Quarterly MDS, Resident 15 had clear speech, impaired memory, and was assessed to require partial/moderate assistance from staff with eating. The MDS showed Resident 15 was dependent on staff for their oral hygiene because the resident did not have the ability to insert and remove their dentures. An 11/24/2025 dental visit note showed Resident 15 had a lower removable partial denture and the resident needed staff assistance with daily denture removal and cleaning. Review of the revised 01/30/2024 ADL care plan showed Resident 15 needed assistance with their ADLs as they were unable to perform them independently due to limited mobility and weakness. The care plan did not show Resident 15 required partial/moderate assistance from staff with eating as assessed in their MDS. The care plan did not show Resident 15 had a partial denture that required staff assistance with putting on and taking off especially during meals. In an observation and interview on 12/12/2025 at 12:14 PM, Resident 15 was observed receiving one on one eating assistance from Staff J (CNA) and was not wearing their lower partial denture; it was observed left in the cup by the sink in Resident 15's room. Staff J stated they were aware Resident 15 had a lower partial denture. When asked if Resident 15 was wearing them, Staff J stated, I think so, I am not sure. Staff I confirmed Resident 15 did not have their denture in while eating. In an interview on 12/16/2025 at 10:15 AM, Staff B stated it was important to ensure residents were properly assisted by the nursing staff with putting their dentures on, especially before eating, so residents could tolerate their diet textures effectively and prevent any unnecessary chewing discomfort. Refer to F656 &ndash; Care Plan Development and Implementation. Refer to F657 - Care Plan Timing and Revision. REFERENCE: WAC 388-97-1060(2)(c).		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review the facility failed to ensure 3 (Resident 5, 8, & 7) of 12 residents reviewed received the necessary care and services in accordance with professional standards of practice. The facility failed to ensure residents with diabetes (disease in which the body fails to control blood sugar levels) received appropriate monitoring and had orders in place for emergent changes in blood sugar levels for 1 (Resident 5) of 1 diabetic residents, failed to implement skin preventative measures for 1 (Resident 8) of 12 residents reviewed, and failed to follow the facility bowel protocol for 1 (Resident 7) of 12 residents reviewed. These failures placed all residents at risk for unmet care needs, uncontrolled diabetes, skin breakdown, prolonged constipation, pain, and a diminished quality of life. Findings included .<Facility Policy>According to the facility Diabetes-Clinical Protocol, policy revised 03/2025 showed residents prescribed insulin would have their blood glucose monitored three to four times daily. The policy showed the facility would monitor the resident's Hemoglobin a1C ((Ha1C)a blood test showing average blood glucose levels over the past three months) on admission and every six months after. The policy showed the staff and the provider would monitor for and manage any episodes of low blood sugar or high blood sugar by following the facility protocol and informing the provider as soon as possible.Review of the undated facility policy titled, Bowel and Bladder Management, showed all residents would be initially assessed for elimination status, including risk factors and care needs as part of the admission nursing assessment and it would be utilized by the staff to guide resident care. The policy showed the bowel management program included dietary interventions, evaluation of bowel movement patterns, and administration of bowel medications as ordered.<Diabetes Management> <Resident 5> Review of Resident 5's 10/17/2025, Quarterly Minimum Data Set (MDS - an assessment tool) showed Resident 5 had clear speech, was able to understand and be understood, and had memory impairment. The MDS showed Resident 5 had medically complex conditions, including diabetes, heart failure, and kidney disease. The MDS showed Resident 5 received insulin (an injectable medication used to treat diabetes) daily, during the look back period of the MDS assessment. Review of Resident 5's diabetes care plan, revised 05/23/2025, directed staff to monitor for signs and symptoms of low or high blood sugar. The care plan directed staff to monitor Resident 5's Ha1C (blood test that measured average blood sugar levels over 2 - 3 months) as ordered by the physician. Review of Resident 5's physician orders showed two orders for insulin and directed staff to hold the insulin if Resident 5's blood sugar was below 70 or greater than 350. The physician orders did not include as needed orders to direct staff how to manage a low or high blood sugar level. No orders were observed for emergency medications, such as glucagon (an injection that treats extremely low blood sugar) for an urgent situation when a resident could not swallow or was unconscious. No physician orders were found to perform Ha1C testing every six months per the facility policy or per Resident 5's care plan interventions. Review of Resident 5's lab results, showed a 04/30/2025 Ha1C blood test with abnormally high results. Review of Resident 5's record showed no follow-up testing or additional Ha1C tests every six months. In an observation and interview on 12/11/2025 12:56 PM Resident 5 stated they had their finger poked five times a day, sometimes their fingers hurt, and they took insulin before every meal and at (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	night. During an interview on 12/16/2025 at 9:30 Am Staff B (Director of Nursing) stated they expected residents with diabetes to have Ha1C testing every six months. Staff B stated Resident 5's Ha1C should be re-tested and an Ha1C lab done at least every six months. Staff B reviewed Resident 5's physician orders and stated they expected a physician order to monitor and manage any episodes of low or high blood sugar levels. <Skin Preventative Measures> <Resident 8> According to 10/13/2025 Comprehensive MDS, Resident 8 was able to make their needs known, had clear speech, was able to understand others, and be understood. The MDS showed Resident 8 had medical diagnoses including an upper arm fracture, pain, anxiety, and muscle spasms. Review of the Skin Conditions section of the MDS showed Resident 8 had no current skin conditions. Review of a 10/27/2025, Braden Scale (an assessment tool used to determine risk for pressure injury) showed staff assessed Resident 8 to be at risk for skin issues due to occasional moisture, their ability to walk severely limited, and potential friction and shearing problems when in bed. Review of the at risk for skin breakdown care plan, dated 10/24/2025, showed a goal to maintain intact skin for Resident 8. The care plan interventions directed staff to educate the resident and representative on multiple factors to maintain skin integrity and directed staff to utilize pressure relieving surfaces. In an observation and interview on 12/11/2025 at 10:24 AM, Resident 8 was observed in bed on their back, with a tray table in front of them. When asked if they had any open wounds, Resident 8 stated they had a mole removed on their left front shin area about a year ago and it was very slow to heal. Resident 8's leg was observed with a dry circular area of scabbed skin and a small opened area. During an interview and observation on 12/15/2025 at 11:25 AM, Staff Q (Resident Care Manager) observed Resident 8's leg and stated they were not sure how the open area got missed on the admission and weekly skin checks. Staff Q was asked to observe Resident 8's heels that were resting on the bed. Staff Q stated the heels were a little red but were blanchable (skin turned white when pressed on and quickly returned to red indicating blood flow to the tissue). Resident 8's heels were observed to be red, soft, dimpled, and mushy. The right heel had a slight discoloration at the center of the heel bone and when Staff Q pressed on the area, Resident 8 winced in pain. In an interview on 12/16/2025 at 12:14 PM, Staff Q stated Resident 8 rarely got out of bed due to their anxiety and fear of falling. Staff Q stated there should be skin preventative measures in place, on the care plan, and the Kardex (quick directions to staff regarding specific resident care) to inform staff of Resident 8's risk and prevent pressure injuries. <Bowel Management> <Resident 7> According to the 10/07/2025 admission MDS, Resident 7 had clear speech, impaired memory, and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	frequent bowel incontinence. The MDS showed Resident 7 was assessed to require substantial/maximal assistance from staff with toileting. Review of Resident 7's active diagnosis list showed a 10/01/2025 diagnosis of unspecified constipation (a condition characterized by difficulty in emptying the bowels, usually associated with hardened feces). The 10/02/2025 bowel care plan showed Resident 7 was at risk for altered bowel elimination and a care plan intervention directed the nursing staff to administer bowel medications per the facility protocol if the resident did not have a bowel movement for two days. The 10/14/2025 pain care plan showed Resident 7 was taking pain medications and the staff were instructed to monitor the resident for side effects including constipation. In an observation and interview on 12/10/2025 at 10:50 AM, Resident 7 was observed bent over crooked in bed; restless and uncomfortable. Resident 7 stated they felt the urge and needed to have a bowel movement, but could not. Resident 7 stated they suffered from constipation and did not have a bowel movement in days but could not exactly recall how many. In an observation and interview on 12/10/2025 at 11:01 AM, Staff O (Registered Nurse) stated Resident 7 had ongoing constipation issues. Staff O went to Resident 7's room, gave the resident the bowel protocol medication, and documented the administration in the Medication Administration Record (MAR). Record review of Resident 7's 11/2025 bowel monitoring log showed the resident had no bowel movement for two days on 11/09/2025 &ndash; 11/11/2025, 11/15/2025 &ndash; 11/17/2025, and 11/22/2025 &ndash; 11/24/2025. Review of Resident 7's progress notes from 11/09/2025 until 11/24/2025 did not show the nursing staff evaluated the resident's bowel movement pattern and the lack thereof or notified the physician for further evaluation and/or treatment. Review of the November 2025 MAR showed Resident 7 received stool bulk-forming medication every two days to help with their bowel movement. The MAR showed the nursing staff did not administer any additional bowel medications per the facility protocol to address and manage Resident 7's lack of bowel movement for two days as care planned. In an interview on 12/16/2025 at 2:09 PM, Staff B stated it was important to follow the facility's bowel protocol because, when residents did not have a bowel movement within 48 hours, it could cause ill-effects such as abdominal pain, vomiting, and loss of appetite. Staff B reviewed Resident 7's MAR and confirmed the facility's bowel protocol was not provided to the resident when needed. Staff B stated they expect the nursing staff to administer bowel medications per the facility protocol and to document the administration in the MAR. REFERENCE: WAC 388-97-1060(1).		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure a licensed pharmacist's monthly Medication Regimen Reviews (MRRs) were completed monthly and recommendations were reviewed and acted upon for 2 (Resident 3 & 5) of 5 residents reviewed for unnecessary medications. This failure placed all residents at risk for delays in necessary medication changes and at risk for adverse side effects. Findings included . <Facility Policy> According to the facility's Medication Regimen Review policy, revised 03/01/2017, the facility would maintain each resident's highest practicable level of functioning by helping them utilize medication appropriately and prevent or minimize adverse consequences related to medication therapy. The pharmacist would provide the facility Director of Nursing and the Medical Director with a written, signed, and dated copy of the report, listing the irregularities found and recommendations for their solutions.<Resident 3>Review of a 10/03/2025 Quarterly Minimum Data Set (MDS - an assessment tool), showed Resident 3 was able to make their needs known, required assistance with decisions, had clear speech, impaired memory, could make self understood, and usually could understand others. The MDS showed Resident 3 had medical diagnoses including non-traumatic brain dysfunction, dementia (progressive memory and cognitive function loss disorder), anxiety, and depression. The MDS showed Resident 3 had indications for use of high risk medications and had received antipsychotics, antidepressants, and anticonvulsants within the last seven days prior to the MDS assessment. Review of Resident 3's medical record showed the facility pharmacist completed an MRR for 10/01/2025-10/31/2025 and made recommendations for medication changes on 10/19/2025. The MMR showed staff did not act upon the recommendations until 17 days later. Similar findings for Resident 3's pharmacist MRR for 11/01/2025-11/30/2025, showed the pharmacist made recommendations on 11/10/2025 that were not implemented by facility staff until 21 days later on 12/01/2025. <Resident 5>Review of a 10/17/2025 Quarterly MDS showed Resident 5 was able to make their needs known, had memory loss, was able to understand and be understood. The MDS showed Resident 5 had medically complex diagnoses including heart failure, high blood pressure, diabetes (inability for their body to regulate blood sugar levels), swelling, and kidney disease. The MDS showed Resident 5 had indications for and received injectable diabetes medications and medications to treat their swelling during the seven day look back period. Review of a facility provided binder showed no indication that Resident 5's MRR occurred for the month of October 2025. Review of Resident 5's medical record showed the facility pharmacist completed an MRR for 09/01/2025-09/30/2025, and made recommendations on 09/13/2025. These recommendations were not acted upon or implemented until 16 days later on 09/29/2025. Similar findings for Resident 5's MMR for 11/01/2025-11/30/2025, showed the pharmacist made recommendations on 11/10/2025 that were not implemented by facility staff until 21 days later on 12/01/2025. During an interview on 12/16/2025 at 9:46 AM, Staff B (Director of Nursing) stated they expected staff to inform the resident representatives of the recommendations before medication changes were made and this could create a delay if the resident representative did not respond timely. Staff B acknowledged the pharmacist recommendations were delayed for Resident 3 and Resident 5, and stated they would expect staff to act upon and implement pharmacist recommendations within a week to ten days. REFERENCE: WAC 388-97-1300(4)(c).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Briarwood at Timber Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Timber Ridge Way NW Issaquah, WA 98027	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to maintain complete and accurate medical records for 2 (Residents 34 & 3) of 12 residents whose records were reviewed. Staff failure to include interdisciplinary team notes from behavior meetings including physician documentation regarding Gradual Dose Reduction (GDR) decisions placed residents at risk for unmet care needs and risk for receiving unnecessary psychotropic medications. Findings included. <Resident 34> Review of Resident 34's 09/24/2025 Annual Minimum Data Set (MDS &ndash; an assessment tool) showed the resident had diagnoses including anxiety and depression. The MDS showed Resident 34 received an antianxiety and antidepressant medications during the assessment period. Review of Resident 34's 12/12/2025 order summary showed a 07/17/2024 physician's order directing staff to administer an antianxiety medication three times per day to the resident. A 09/30/2025 physician's order directed staff to administer an antidepressant medication to Resident 34 every morning. Review of a 10/20/2025 social services progress note showed a summary of Resident 34's psychotropic medications. The note showed a GDR recommendation of Resident 34's antianxiety medication was rejected on 03/24/2025. Review of Resident 34's comprehensive medical records showed no progress notes from a physician documenting the rejection of the GDR, there were no documents scanned in from the physician, or pharmacy recommendations that included documentation from the physician regarding rejection of the GDR for the antianxiety medication that occurred on 03/24/2025 per the 10/20/2025 progress note. In an interview on 12/16/2025 at 10:34 AM, Staff C (Social Services Director) stated the interdisciplinary team completed a Behavior Monitor/Medication Management form when the team discussed potential GDRs or medication changes for residents receiving psychotropic and other high-risk medications. Staff C reviewed their personal files and provided the 03/24/2025 Behavior Monitor/Medication Management form with the physician's signed rationale for why a GDR of Resident 34's antianxiety medication was contraindicated. Staff C stated they missed scanning the document into Resident 34's record but stated the document should be part of the resident's record. In an interview on 12/16/2025 at 11:35 AM, Staff B (Director of Nursing) stated it was their expectation the Behavior Monitor/Medication Management form be scanned in and available in Resident 34's records. <Resident 3> According to a 10/03/2025 Quarterly MDS, Resident 3 was able to make their needs known, had memory loss, and required moderate staff assistance with toileting, bathing, and dressing. The MDS showed Resident 3 had medical diagnoses including non-traumatic brain dysfunction, dementia, anxiety, and depression. The MDS showed Resident 3 received antipsychotic and antidepressant medications during the seven day look back period of the MDS assessment. Review of Resident 3's physicians order's showed a 12/20/2024 order for an [NAME]-depressant (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Briarwood at Timber Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Timber Ridge Way NW Issaquah, WA 98027	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication directing staff to administer daily. A 09/09/2025 physicians order directed staff to administer an anti-psychotic medication to Resident 3 twice daily. Review of Resident 3's anxiety and depression care plan, revised on 07/25/2025, showed Resident 3's anti-depressant GDR was contraindicated and the dose remained the same for the last year since 12/20/2024. Review of the care plan showed Resident 3's anti-psychotic medication GDR was rejected on 11/11/2025. Review of Resident 3's comprehensive medical record showed no progress notes from a physician documenting the rejection of the GDR, there were no documents scanned in from the physician, or pharmacy recommendations that included documentation from the physician regarding rejection of the GDR for the anti-depressant medication or the anti-psychotic medication. In an interview on 12/16/2025 at 1:01 PM, Staff C stated the facility interdisciplinary team discussed Resident 3's medications on 11/11/2025. Staff C printed a Behavior Monitor/Medication Management form from their personal file that showed on 11/11/2025 the physician agreed a GDR for the anti-psychotic medication was not recommended and provided a rationale. The form did not address the physician's rationale for not performing a GDR for the anti-depressant medication in over a year. Staff C stated the behavior monitoring and medication management form should be scanned in and part of the resident's record. REFERENCE: WAC 388-97-1720 (1)(a)(i-iv).		