STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505527	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Post Acute	21008 76th Avenue West Edmonds, WA 98026

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure foods were handled appropriately in accordance with professional standards of food safety for 1 of 2 Freezers (Kitchen Freezer), 2 of 3 Refrigerators (Kitchen Walk-in Refrigerator & Olympic Dining Room Refrigerator), 1 of 2 Dry Storage Room (Kitchen Mini Storage), and 1 of 3 Staff (Staff M), reviewed for food services. The failure to label, cover, and discard food items past the use by date and perform hand hygiene placed the residents at risk for foodborne illness (caused by the ingestion of contaminated food or beverages), cross contamination, and a diminished quality of life.Findings included.Review of the facility's policy titled, Dietary: Food Storage, revised on 07/25/2024, showed, Leftover food items are stored in appropriate containers so that the interior temperature of the food chills quickly to ˆ [less than or equal to] 41 F [degrees Fahrenheit-temperature scale]. They are covered, labeled, and dated. The policy showed, Non-corrosive [refers to materials, liquids, or substances that do not cause damage] containers with tight-fitting lids should be used to store non-perishable food items.Opened food items in dry storage should be stored in a closed container to prevent contamination.All stored items should have an expiration date or a purchase/delivery date. The policy further showed, To ensure food is rotated properly, food without a product date shall be dated on delivery.Review of the facility's policy titled, Resident Food from Outside Source, dated on 08/01/2024, showed, Refrigerated food items from an outside source is stored in a container with the following information on it: Date product was received, Name of product type (i.e. [example], meat casserole, cookies, salad), Resident name and room number. The policy showed, Refrigerated foods that are unlabeled or undated, when noted, is discarded. The policy further showed, Refrigerated products are discarded on the following schedule: Commercially prepared products, in their original containers, is used before the manufacturer's expiration or use by date.Review of the facility's policy titled, Hand Hygiene, revised on 12/15/2021, showed, Hand hygiene is the primary means of preventing the transmission of infection and should be performed as soon as possible after hands become contaminated and frequently during the working day. The following is a list of some situations that require hand hygiene:.b) When hands are visibly soiled (hand hygiene with soap and water);.f) Before and after eating or handling food (hand hygiene with soap and water);.u) After removing gloves or aprons; and/or before applying; .KITCHEN FREEZERObservation of the Kitchen Freezer on 03/17/2026 at 8:45 AM, showed one uncovered/unlabeled rectangular tray and one uncovered/unlabeled round tray of an unknown food item.In an interview and joint observation on 03/17/2026 at 8:47 AM, Staff G, Assistant Dietary Manager, stated that they labeled food items in the kitchen. Staff G stated that leftover food was good for three days and prepped food was good for seven days. Staff G stated that it would be labeled with the name of the food item, the preparation date and the use by date. Staff G stated that they would expect food items to be labeled and that the food item should be covered unless it was hot food that was cooling down. A joint observation of the Kitchen Freezer showed one uncovered/unlabeled rectangular tray and one uncovered/unlabeled round tray of an unknown food item. Staff G stated that it was left over cake from yesterday [03/16/2026] and that it should have (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	been covered/labeled. KITCHEN WALK-IN REFRIGERATORObservation of the Kitchen Walk-in Refrigerator on 03/17/2026 at 8:33 AM, showed the following:-One uncovered and unlabeled tray that contained five plates of an unknown dessert.-One uncovered and unlabeled tray that contained an unknown dessert in small bowls. -One half full uncovered and unlabeled tray that contained an unknown dessert. -One full unlabeled metal tray that contained an unknown dessert covered in plastic wrap. -Three unlabeled sandwiches wrapped in plastic wrap.In a joint observation and interview on 03/17/2026 at 8:55 AM with Staff G showed threeunlabeled sandwiches. Staff G stated that it should been labeled. Further observation showed one uncovered and unlabeled tray that contained five plates of an unknown dessert, one uncovered and unlabeled tray that contained an unknown dessert in small bowls, one half full uncovered and unlabeled tray that contained an unknown dessert and one full unlabeled metal tray that contained an unknown dessert covered in plastic wrap. Staff G stated that the metal tray contained banana bread that was from yesterday [03/16/2026] and that it should have been labeled. Staff G stated that the other trays were [NAME] Cheesecake for today's (03/17/2026) dessert. Staff G further stated that they should have been covered and labeled.In a follow up observation of the Kitchen Walk-in Refrigerator on 03/20/2026 at 8:46 AM, showed the following:-One full uncovered metal tray labeled Jello with UB [use by] 03/20/26 [03/20/2026]. -One unlabeled and uncovered metal tray that contained an unknown food item. -One unlabeled metal tray that contained an unknown dessert in small bowls and one bowl of mixed salad greens.In a joint observation and interview on 03/20/2026 at 9:28 AM with Staff G showed one unlabeled and uncovered metal tray that contained an unknown food item and one unlabeled metal tray that contained an unknown dessert in small bowls and one bowl of mixed salad greens. Staff G stated that the metal tray contained cake that was made yesterday and that it should have been labeled. Staff G stated that the metal tray with small bowls were leftover dessert from yesterday [03/19/2026] and that it should have been labeled. Further joint observation showed one full uncovered metal tray labeled Jello with UB 03/20/26. Staff G stated that the Jello should have been covered. OLYMPIC DINING ROOM REFRIGERATORObservation of the Olympic Dining Room Refrigerator on 03/20/2026 at 2:38 PM showed the following items:-One container of organic lemonade with please enjoy by 03/11/2026 labeled for room [ROOM NUMBER].-One unopened container of salsa labeled [resident's first name] dated 02/11/2026. In an interview and joint observation on 03/20/2026 at 3:13 PM, Staff G stated that the dietary aides maintained the unit refrigerators. A joint observation of the Olympic Dining Room Refrigerator showed one container of organic lemonade with please enjoy by 03/11/2026 and one unopened container of salsa dated 02/11/2026. Staff G stated that they should have been discarded and that if it's [it is] out of date, it's out of regulations.KITCHEN MINI STORAGE Observation of the Kitchen Mini Storage on 03/20/2026 at 8:38 AM, showed the following:-One opened container of whole celery seed with best by date of 03/05/25 [03/05/2025].-One opened container of poultry seasoning with no use by or expiration date. -One opened container of granulated garlic with no use by or expiration date. -One opened container of parsley flakes with no use by or expiration date. -One opened container of steak seasoning with no use by or expiration date.-One opened container of whole basil leaves with no use by or expiration date.-One opened container of whole bay leaves with no use by or expiration date.-One opened container of coarse ground black pepper with no use by or expiration date.-One opened container of whole thyme leaves with no use by or expiration date.-One opened container of salt with no use by or expiration date.-One opened container of Beef base with the lid not fully closed.In an interview and joint observation on 03/20/2026 at 9:18 AM, Staff G stated that they expected food items to be labeled with an expiration or use by date. Staff G stated that they reused some of the spice containers and that dietary staff would label them with the use by date. Staff G stated that food items past the use by or expiration date would be discarded. A joint observation of the Kitchen Mini Storage showed one opened container of whole celery seed with a best by date of 03/05/25. Staff G stated that it should have been thrown away. Further joint observation showed an opened container of poultry seasoning, granulated garlic, parsley flakes, steak (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	seasoning, whole basil leaves, whole bay leaves, coarse ground black pepper, whole thyme leaves and salt with no use by or expiration date. Staff G stated that they should have had a used by date and that anything that had been opened should have had a use by date. A joint observation showed an opened container of Beef base with the lid not fully closed. Staff G stated that the lid should have been closed. FOOD HANDLING/HAND HYGIENESTAFF MObservation and interview on 03/20/2026 at 10:51 AM, showed Staff M, Cook, was in the preparation station pureeing beef stroganoff in a blender with gloves on. When Staff M was done, they took their used equipment to the dishwasher, placed it on a dishwashing tray and ran the dishwasher. Staff M removed their gloves and waited by the dishwasher to finish. Staff M did not perform hand hygiene after removing their gloves. When the dishwasher was done, Staff M took the clean equipment back to the preparation station. Staff M applied gloves and poured carrots into a blender and pureed it. When Staff M was done, they poured the pureed carrots into a metal container and added a thickening agent. Staff M then placed the container of pureed carrots inside the steamer. Staff M removed their gloves and pushed a cart full of used kitchen equipment to the dishwashing station. Staff M did not perform hand hygiene. Staff M placed carrots into a food processor. When Staff M was done, they poured the minced carrots into a metal container and then took all the equipment they had used to the dishwashing station. Staff M went back to the preparation station, took a rag from a red bucket and wiped down the preparation table. When Staff M was done, they placed the rag back into the red bucket, took the metal container of minced carrots, placed it inside the steamer and performed hand hygiene. In an interview on 03/20/2026 at 11:08 AM, Staff M stated that they would perform hand hygiene when they went from dirty to clean and between glove use. Staff M further stated that they should have performed hand hygiene when going from dirty to clean task and when they removed their gloves. In an interview on 03/20/2026 at 2:31 PM, Staff G stated that staff were to perform hand hygiene when they entered the kitchen, before preparing food, after handling dirty dishes/garbage and between glove use. Staff G stated that Staff M should have performed hand hygiene between glove use, when handling food, and after doing dirty dishes. In an interview on 03/24/2026 at 3:11 PM, Staff C, Infection Preventionist, stated that they would expect dietary staff to perform hand hygiene when entering the kitchen, handling food/spills and when their hands were visibly dirty. Staff C further stated they would expect dietary staff to perform hand hygiene from a dirty to clean task and between glove use. In an interview on 03/25/2026 at 9:16 AM, Staff A, Administrator, stated that they would expect staff to follow their food storage/labeling and hand-washing policy.Reference: (WAC) 388-97-1100 (3).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and/or consistently implement care plans for 4 of 16 residents (Residents 11, 24, 4 & 8), reviewed for comprehensive care plans. The failure to develop a care plan for dementia (loss of memory and cognitive functioning that impairs day-to-day life) and implement care plans for call lights, hearing aids and dining assistance placed the residents at risk for unmet care needs and a diminished quality of life. Findings included . Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised in March 2022, showed, A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. It further showed, A comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team (IDT), with input from the resident, and his/her family or legal representative. The Comprehensive person-centered care plan should be developed within the seven (7) days of the completion of the required MDS [Minimum Data Set-an assessment tool] assessment. (Admission, Annual, or significant change in status), and should be completed within 21 days of admission. RESIDENT 11Review of the admission MDS dated [DATE] showed Resident 11 was readmitted to the facility on [DATE] and had a diagnosis of dementia with other behavior disturbance. Further review of the MDS showed that the question, Will Cognitive Loss/Dementia-Functional Status be addressed in the care plan? was marked yes. Review of the comprehensive care plan printed on 03/19/2026 showed no person-centered care plan with resident specific interventions that addressed Resident 11's dementia. In an interview on 03/24/2026 at 10:19 AM, Staff J, Certified Nursing Assistant (CNA), stated that they looked at the resident's care plan on how to care for them. Staff J stated that Resident 11 had dementia, that they were sometimes confused and had behaviors. In an interview on 03/24/2026 at 10:25 AM, Staff D, Resident Care Manager (RCM), stated that they expected residents with dementia to have a person-centered care plan with specific interventions. Staff D further stated that Resident 11 had dementia and that they would have expected them to have had a dementia care plan. In an interview on 03/25/2026 at 9:09 AM, Staff N, MDS Coordinator, stated that if the question, Will Cognitive Loss/Dementia-Functional Status be addressed in the care plan? was marked, yes in the MDS, they would have expected a care plan addressing the resident's cognitive loss/dementia. A joint record review of Resident 11's annual MDS dated [DATE] showed that the question, Will Cognitive Loss/Dementia-Functional Status be addressed in the care plan? was marked yes. A joint record review of Resident 11's comprehensive care plan showed that the resident had a cognitive impairment care plan that was initiated on 03/24/2026. When asked if there should have been a care plan prior to 03/24/2026, Staff N stated, yes and that they did not see any dementia/cognitive loss care plan that was initiated prior to 03/24/2026. In an interview on 03/25/2026 at 10:51 AM, Staff B, Regional Director of Clinical Services, stated that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they would have expected residents with dementia to have a person-centered care plan with specific interventions and that Resident 11 should have had a care plan. RESIDENT 24Review of a face sheet printed on 03/25/2026 showed that Resident 24 was readmitted to the facility on [DATE]. Review of Resident 24's risk for falls care plan intervention initiated on 11/10/2023 showed, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observations on 03/18/2026 at 9:08 AM, on 03/23/2026 at 9:26 AM and on 03/25/2026 at 8:12 AM, showed Resident 24 lying in bed. Their call light was wrapped around the call light port on the wall and was not within Resident 24's reach. In an interview and joint observation on 03/25/2026 at 8:29 AM, Staff O, CNA, stated that they looked at the care plan on how to care for residents and that they followed the care plan. A joint observation showed that Resident 24's call light was wrapped around the call light port on the wall and was not within their reach. When asked if Resident 24's call light should be within reach, Staff O stated, Always no matter what, that's [that is] unreachable for them. In an interview and joint record review on 03/25/2026 at 8:35 AM, Staff I, Registered Nurse (RN), stated that they expected the CNAs to follow the residents' care plan and that they would expect the resident's call light to be within reach. A joint record review of Resident 24's care plan showed, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Staff I stated that Resident 24 did not use their call light. In an interview on 03/25/2026 at 8:43 AM, Staff D stated that they expected staff to follow the residents' care plan and that they had access to the Kardex (care guide for CNAs). Staff D stated that they expected the resident's call light to be placed within reach. When asked if Resident 24 used their call light, Staff D stated yes, I believe so. Staff D further stated that they would have expected staff to follow Resident 24's care plan and expected their call light to be within reach. In an interview on 03/25/2026 at 10:48 AM, Staff B stated that they expected staff to follow the resident's care plan and expected the resident's call light to be placed within reach. RESIDENT 4Review of the admission MDS, dated [DATE], showed that Resident 4 used hearing aids. Review of Resident 4's hearing care plan, revised on 01/05/2026, showed the intervention to apply hearing aid to both ears. It further showed, Ensure hearing aid or other hearing appliance is in place and in working order. Observation on 03/19/2026 at 11:58 AM showed Resident 4 was not wearing their hearing aids. Resident 4 stated I have some and that they were unsure where the hearing aids were and it had been quite a while since they had used them. In another observation on 03/20/2026 at 10:26 AM showed Resident 4 was not wearing their hearing aids. In an interview, joint record review, and joint observation on 03/23/2026 at 9:25 AM, Staff L, CNA, stated that they would help residents that needed assistance for placing their hearing aids. Staff L (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that Resident 4 was hard of hearing and I haven't [have not] seen a hearing aid. Staff L stated that they would follow resident's care plans. A joint record review of Resident 4's hearing care plan, showed the intervention to apply hearing aid to both ears. It further showed, Ensure hearing aid or other hearing appliance is in place and in working order. Staff L stated that they had never done it [applied hearing aids] for her. A joint observation showed that Resident 4 was not wearing any hearing aids. Staff L stated that Resident 4 was not wearing any hearing aids and that they did not see any hearing aids in their room. In an interview, joint record review, and joint observation on 03/23/2026 at 9:40 AM, Staff H, Licensed Practical Nurse, stated that they followed resident care plans. A joint record review of Resident 4's hearing care plan, showed the intervention to apply hearing aid to both ears. It further showed, Ensure hearing aid or other hearing appliance is in place and in working order. Staff H stated that they did not know if Resident 4 used hearing aids and that she hears me. A joint observation showed Resident 4 was not wearing their hearing aids. Staff H found hearing aids in the top drawer of Resident 4's nightstand and asked Resident 4 if they wanted to use the hearing aids. Resident 4 stated yes. Staff H placed the left hearing aid in Resident 4's ear and asked Resident 4 if they could hear them. Resident 4 stated yes and that they wanted to use both hearing aids. Staff H told Resident 4 that the right hearing aid was broken and stated that they would let Resident 4's family know. In an interview and joint record review on 03/25/2026 at 9:25 AM, Staff F, RCM, stated that if a resident used hearing aids they expected staff to offer them daily. Staff F stated that even if it seemed like a resident could hear without the hearing aids that they expected staff to still offer the hearing aids. Staff F stated that they expected staff to follow resident's care plans. A joint record review of Resident 4's hearing care plan, showed the intervention to apply hearing aid to both ears. It further showed, Ensure hearing aid or other hearing appliance is in place and in working order. Staff F stated that they expected staff to offer Resident 4 their hearing aids. In an interview on 03/25/2026 at 11:49 AM, Staff B stated that if residents had hearing aids they expected staff to offer them every day. Staff B stated that if a resident needed help to place the hearing aids, they expected staff to help them. Staff B further stated that they expected staff to follow resident's care plans and if it said to place hearing aids for a resident, they expected staff to do so. RESIDENT 8Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised in March 2018, showed, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition. The policy further showed that the appropriate care and services would be provided to residents in accordance with their plan of care including dining. Review of Resident 8's ADL care plan revised on 02/28/2026, showed an intervention for Eating: 1:1 [one to one] Feeding Assist. Observation on 03/23/2026 at 8:30 AM, showed Staff S, CNA, assisted Resident 8 set up their breakfast tray on their bedside table. At 8:32 AM, Staff S was no longer in Resident 8's room and Resident 8 was eating unsupervised. At 8:46 AM, Resident 8 was lying in bed with their eyes closed and their breakfast in front of them. At 9:02 AM, Staff S returned to Resident 8's room, woke them up and asked them if they were done with their meal and took the tray out of the room. In an interview and joint record review on 03/23/2026 at 9:10 AM, Staff S stated that they would (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	check the residents' Kardex or care plan to see how much assistance a resident needed with their ADLs. Staff S stated that they were expected to follow the care plan. Staff S stated that Resident 8 could feed themselves, but she needs to be supervised, or sometimes needs to be fed, and that if the resident was unable to do it, they would assist them. Staff S stated that a 1:1 feeding assist meant that they would have to stay with the resident for the entirety of the meal to assist them. A joint record review of Resident 8's Kardex showed they were a 1:1 feeding assist. Staff S stated that Resident 8 did need assistance with feeding at times because they fell asleep or were unable to feed themselves. On 03/25/2026 at 8:12 AM, Staff R, RN, stated that staff were expected to follow the resident's care plan. On 03/25/2026 at 8:33 AM, Staff F stated that they would expect staff to follow the residents' care plan. Staff F further stated that Resident 8 was a 1:1 feeding assist as they had struggled with meal intake since admission and would have expected staff to stay with them during their meal. On 03/25/2026 at 10:06 AM, Staff B stated that they expected staff to follow a resident's care plan. Reference: (WAC) 388-97-1020 (1)(2)(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory services were provided according to professional standards of practice for 3 of 4 residents (Residents 39, 21 & 83), reviewed for respiratory care. The failure to follow physician orders for oxygen (O2) therapy and to properly store O2 equipment placed the residents at risk for respiratory infections and related complications.Findings included .Review of the facility's policy titled, Respiratory Treatment, revised on 06/22/2022, showed, The licensed nurse is responsible to check residents O2 therapy each shift to validate that the regulator is set for the appropriate liter flow.When oxygen is not in use, the cannula [NC-flexible tubing with a prong (one of two small, curved plastic or silicone tips) that sits inside the nose and delivers O2] (mask) and tubing is to be stored in a bag. The policy showed that the administration of other types of respiratory treatments such as Continuous Positive Airway Pressure (CPAP- a device that keeps the airways open during sleep) are completed per physician's order and manufacturer recommendation of equipment operations. The policy further showed, Use the manufacturer guidelines to develop cleaning and care maintenance treatment orders.Place mask and tubing in bag after it has dried. If not stored in a bag, the mask is cleaned prior to each use to prevent any contamination. In addition, the policy showed that should an oxygen mask and CPAP mask be noted on the floor, the mask is cleaned prior to placement on the resident.RESIDENT 39Review of a face sheet printed on 03/18/2026 showed that Resident 39 readmitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (a progressive lung disease that causes air flow blockage and breathing-related problems).Review of the quarterly Minimum Data Set (MDS-an assessment tool) dated 02/06/2026, showed that Resident 39 received O2 therapy.Review of Resident 39's physician orders showed an order for continuous O2 at three liters (a unit of measurement) a minute (3 L/min) via NC every shift for O2 use related to acute respiratory failure with hypoxia (a condition where the lungs cannot deliver enough O2 to the blood, leading to dangerously low O2 levels in the body) with a start date of 05/16/2025.Observation on 03/18/2026 at 1:43 PM, showed Resident 39 was lying in bed with one prong inside their right nostril (nose) and the other prong was outside of their nostril. Resident 39's O2 tubing was not plugged onto the O2 concentrator and that the O2 concentrator was set at 1.5 L/min. At 1:49 PM, Staff J, Certified Nursing Assistant (CNA), entered the resident's room and gave them water. Staff J applied gloves, assisted the resident and left the room. Staff J did not adjust Resident 39's NC and did not plug their O2 tubing onto the O2 concentrator.On 03/18/2026 at 1:57 PM, Resident 39 stated that they had to use O2 all the time.Observation on 03/18/2026 at 2:15 PM, showed Staff K, CNA, entered Resident 39's room and asked Resident 39 if there was anything they could help them with. Resident 39 stated they did not need help and Staff K left the resident's room. Staff K did not adjust Resident 39's NC and did not plug their O2 tubing onto the O2 concentrator.In an interview and joint observation on 03/18/2026 at 2:28 PM, Staff K stated that they checked the residents' Kardex (care guide for CNAs) and care plan when caring for residents. Staff K stated that when caring for resident receiving oxygen, they made sure that the resident was connected to the O2 concentrator and that the NC was applied and working properly. Staff K stated that they would check when they entered the resident's room to see if the resident was wearing their NC and that the O2 concentrator was turned on. Staff K stated that they would ask the resident if they could feel the O2. Staff K stated that they would store the NC in a bag and would place it inside the drawer of the resident's bedside table when not in use. Staff K stated that they made sure that it was not on the floor. When asked who ensured that the resident was receiving the correct O2 level, Staff K stated the nurse. A joint observation showed that Resident 39's O2 tubing was not plugged onto the O2 concentrator and that they had one prong inside their right nostril and the other prong was outside of their nostril. Staff K stated, It [O2 tubing] has to be connected [to the O2 concentrator] and that Resident 39's NC needed to be adjusted.In an interview, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Post Acute	21008 76th Avenue West Edmonds, WA 98026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	joint record review and joint observation on 03/18/2026 at 2:49 PM, Staff I, Registered Nurse, stated that they would change the residents NC if it was visibly soiled or if it fell on the floor and that they would place it in a plastic bag when not in use. Staff I stated that nurses ensured that residents received the right O2 and that we follow the order. A joint record review of Resident 39's physician orders showed an order for continuous O2 at 3 L/min. Staff I stated that they checked the resident's O2 every shift, when the residents' had trouble breathing and as needed. A joint observation of Resident 39's O2 concentrator showed that it was set at 2.5 L/min. Staff I stated that it should have been at 3 L/min and that it should have been connected to the O2 concentrator at all times. Staff I further stated that staff should have adjusted Resident 39's NC if they noticed that it was not applied properly. RESIDENT 21Review of the admission MDS dated [DATE] showed that Resident 21 was admitted to the facility on [DATE] and had a diagnosis of acute and chronic respiratory failure with hypercapnia (the inability of the respiratory system to maintain normal gas exchange, leading to elevated carbon dioxide [helps maintain the body's acid-base balance] levels in the blood. Further review of the MDS showed that Resident 21 received O2 therapy.Review of Resident 21's March 2026 Medication Administration Record showed an order for continuous O2 at 2 L/min via NC every shift for O2 use with a start date of 03/06/2026.Observation on 03/17/2026 at 2:29 PM showed that Resident 21's NC was hung on top of their night stand drawer and was not stored in a bag. Observation on 03/18/2026 at 2:21 PM showed Resident 21's NC was lying on top of their night stand and was not stored in a bag.In a joint observation and interview on 03/18/2026 at 2:32 PM with Staff K showed that Resident 21's NC was lying on the floor. Staff K stated that it should not have been on the floor and that it should have been stored in a bag.RESIDENT 83Review of the admission MDS dated [DATE] showed that Resident 83 was admitted to the facility on [DATE] and had a diagnosis of obstructive sleep apnea (a condition in which breathing stops involuntarily for brief periods of time during sleep). Further review of the MDS showed that Resident 83 used a CPAP.Review of Resident 83's respiratory care plan showed an intervention for CPAP on at 9:00 PM and off at 7:00 AM dated 03/18/2026.Observation on 03/17/2026 at 10:54 AM showed that Resident 83's CPAP mask was lying on top of their night stand and that it was not stored in bag. Resident 83 stated that staff did not store their CPAP mask in a bag.Observation on 03/18/2026 at 10:09 AM showed that Resident 83's CPAP mask was inside the top drawer of their night stand and was not stored in a bag. Resident 83 stated that a staff had placed it there.Observation on 03/23/2026 at 9:15 AM showed that Resident 83's CPAP mask was lying on top of their night stand and was not stored in a bag. In an interview and joint observation on 03/23/2026 at 10:30 AM, Staff H, Licensed Practical Nurse, stated that they would clean the CPAP mask, let it dry and store it in a plastic bag when not in use. A joint observation showed that Resident 83's CPAP mask was lying on top of their night stand and was not stored in a bag. Staff H stated that Resident 83's CPAP mask should have been stored in a bag.In an interview on 03/23/2026 at 1:08 PM, Staff E, Resident Care Manager (RCM), stated that if a resident was on continuous O2, staff were to ensure that the NC was properly in place and stored in a plastic bag when not in use to prevent contamination. Staff E further stated that the CPAP mask would be stored in a bag when not in use. Staff D, RCM, stated that the NC should be stored in a bag when not in use and if it was found on the floor, they would replace it with a new one. Staff E stated that they would expect Resident 39 to receive the right O2 liter and would expect the CNA or nursing staff to ensure their O2 tubing was plugged. Staff E stated that they would expect staff to adjust Resident 39's NC and notify the nurse. Staff E further stated that they would expect Resident 83's CPAP mask to be stored in a bag when not in use.In an interview on 03/25/2026 at 10:35 AM, Staff B, Regional Director of Clinical Services, stated that respiratory equipment should be stored in a plastic bag when not in use. Staff B stated that Resident 21's NC should have been stored in a plastic bag and that if it was on the floor, staff should have replaced it. Staff B stated that if staff noticed that Resident 39's O2 tubing was not plugged onto the O2 concentrator, they would expect the CNA to alert the nurse that the resident's O2 tubing was unplugged. Staff B stated that they would expect the CNA to adjust the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's NC if it was not applied properly. Staff B further stated that Resident 83's CPAP mask should have been stored in a bag when not in use. Reference: (WAC) 388-97-1060 (3)(j)(vi).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure expired medical supplies and medications were discarded for 2 of 2 medication rooms (East & [NAME] Medication Room), and for 2 of 4 medication carts (Cart 3 & Cart 1). In addition, the facility failed to store medications properly for 1 of 2 unit refrigerators (Snohomish Den Refrigerator), reviewed for medication storage and labeling. These failures placed the residents at risk of receiving compromised and ineffective medications, and unauthorized access to medications.Findings included . Review of the facility's policy titled, Medication Storage, dated in January 2023, showed, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The policy further showed that outdated, contaminated, discontinued, or deteriorated medications were immediately removed from stock and disposed of according to procedures for medication disposal. EAST MEDICATION ROOMIn a joint observation and interview on 03/20/2026 at 9:41 AM with Staff F, Resident Care Manager, showed three Medline (brand name) Safety Syringes (a tube with a needle used to inject medications in the body) with an expiration date of 03/04/2026 and one syringe with an expiration date of 02/03/2026. Staff F stated that the syringes expired and should not have been in the medication storage room. In another joint observation of the refrigerator showed four boxes of Actemra (prescription medicine that treats inflammatory conditions) for Resident 9 with an expiration date of January 2026. Staff F stated that Resident 9 was a current resident and that the expired medication should not be in the refrigerator. WEST MEDICATION ROOMIn a joint observation and interview on 03/20/2026 at 10:19 AM with Staff U, Registered Nurse (RN), showed a Tresiba insulin degludec pen (medication for high blood sugar) with an open date of 10/26/2025. Staff U stated that it was expired and that the resident who it belonged to had discharged . An additional joint observation showed a flu (contagious respiratory illness) vaccine injection box dated 05/02/2024. Staff U stated that it was expired and would not use it. MEDICATION CART 3In a joint observation and interview on 03/20/2026 at 10:47 AM with Staff T, RN, showed one opened container of Calcium 600 plus D 10 micrograms (a unit of measurement) tablets (supplement) with a best before date of February 2026 and one glargine insulin pen (medication for high blood sugar) with an open date of 02/08/2026. Staff T stated that the best before date for the Calcium supplement had passed and that it had already been a month for the insulin pen. Staff T further stated that both medications should not have been in the medication cart. CART 1In a joint observation and interview on 03/20/2026 at 11:33 AM with Staff I, RN, showed a lispro insulin pen (medication for high blood sugar) for Resident 74 with an open date of 02/18/2026. Staff I stated that it had been more than 28 days and would discard it. In a phone interview on 03/25/2026 at 9:14 AM with Staff BB, Consultant Pharmacist, stated that lispro and glargine insulin pens were good for 28 days after opening and the Tresiba insulin degludec pen was good for 56 days after opening. Staff BB stated the facility could either destroy the medication in house after that or could send it back to the pharmacy if it was hazardous. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/25/2026 at 10:14 AM, Staff B, Regional Director of Clinical Services, stated that they expected medication to be stored appropriately per guidance, not expired, and secured safely. Staff B further stated they did not expect to have medication from October 2025 in the medication room and that the facility was able to destroy those medications in house and if not would return them to the pharmacy. SNOHOMISH DEN REFRIGERATORObservation of the Snohomish Den Refrigerator on 03/20/2026 at 2:46 PM, showed one opened box of Gel Pack Instant and Reusable Cold or Heat Therapy labeled [room] 218 and one unlabeled flower pill box. In an interview and joint observation on 03/20/2026 at 3:13 PM, Staff G, Assistant Dietary Manager, stated that dietary aides managed the unit refrigerators and that they would not expect non-food items to be stored in the refrigerators. A joint observation of the Snohomish Den Refrigerator showed one opened box of Gel Pack Instant and Reusable Cold or Heat Therapy labeled 218 and one unlabeled flower pill box. Staff G opened the flower pill box and stated that they were pills or vitamins. Staff G stated that they would not have expected them to be stored in the refrigerator. At 3:24 PM, Staff G took the box of Gel Pack Instant and Reusable Cold or Heat Therapy and the flower pill box and showed it to Staff F. Staff F opened the flower pill box and stated that they would not have expected it to be stored in the refrigerator and that we would not utilize that fridge [refrigerator] for medication purposes at all. Staff G further stated that the box of Gel Pack Instant and Reusable Cold or Heat Therapy and the flower pill box should not have been stored in the Snohomish Den Refrigerator. In an interview on 03/25/2026 at 12:24 PM, Staff B stated that they would not expect the residents medications to be stored in the unit refrigerators. Staff B stated that the box of Gel Pack Instant and Reusable Cold or Heat Therapy and the flower pill box should not have been in there. Reference: (WAC) 388-97-1300 (2) .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure there were sufficient dietary support to serve meals on time for 1 of 1 kitchen, reviewed for food service. This failure placed the residents at risk of delayed mealtimes, frustration, and a diminished quality of life. Findings included . Review of the facility's policy titled, Food and Nutrition Services, revised in October 2017, showed, Meals and/or nutritional supplements will be provided within 45 minutes of either resident request or scheduled meal time, and in accordance with the resident's medication requirements. Review of the Dining Meal Times posted outside the kitchen showed that lunch in the dining room was from 11:00 AM to 12:00 PM and room trays were from 11:30 AM to 12:00 PM. In an observation and interview on 03/20/2026 at 1:15 PM showed Staff M, Cook, prepared the last tray for lunch. Staff M stated that they were done with all the meal trays. When asked what time they would finish the tray line, Staff M stated between 12:30 PM to 12:45 PM and that it depended on the food. When asked if lunch was late, Staff M stated that it was late and that lunch was scheduled to be served from 11:00 AM to 12:00 PM. Staff M stated that meals had to be on time. Staff M further stated that they needed another person to work the kitchen when their assistant was off. A joint record review of the facility's document titled, Dining Meal Times and interview on 03/20/2026 at 2:26 PM with Staff G, Assistant Dietary Manager, showed that breakfast in the dining room was from 7:00 AM to 8:00 AM, breakfast room trays were from 7:30 AM to 8:00 AM, lunch in the dining room was from 11:00 AM to 12:00 PM, lunch room trays were from 11:30 AM to 12:00 PM, dinner in the dining room was from 5:00 PM to 6:00 PM and dinner room trays were from 5:30 PM to 6:00 PM. Staff G stated that meals would be delivered as stated in the meal time schedule. Staff G stated that if lunch was going out at 1:15 PM and the meal time was scheduled for 11:00 AM to 12:00 PM, it was not on time. Staff G stated that there were a cook and a dietary aide doing the tray line and that it was a lot of work for two staff. Staff G further stated that they expected meals to be served on time. In an interview on 03/25/2026 at 9:16 AM, Staff A, Administrator, was asked if they expected staff to provide meals per the facility's scheduled meal times, Staff A stated, generally speaking that's [that is] what we strive for, but things can happen that would cause it to be delayed. Staff A further stated that they would expect to have enough dietary staff to prepare meals on time. Observation on 03/17/2026 at 12:51 PM showed the meal cart was delivered to the 300 hall. At 1:05 PM another meal cart was delivered to the 400/500 hall. In an interview and observation on 03/19/2026 at 12:32 PM, Resident 91 stated that lunch was supposed to come now and stated that they had been waiting for twenty minutes. Observation at 12:57 PM showed Resident 91's meal tray delivered to them. In an interview on 03/20/2026 at 12:58 PM, Staff X, Registered Nurse, stated that lunch trays were usually delivered around 12:00 [PM] to 12:30 [PM]. When asked if the meal trays were here now, Staff X stated, no. Observation on 03/20/2026 at 1:05 PM showed the meal cart was delivered to the 300 hall. At 1:15 (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PM another meal cart was delivered to the 400/500 hall. A joint record review and interview on 03/24/2026 at 9:52 AM with Staff G showed the Dining Meal Times for lunch room trays was scheduled from 11:30 AM to 12:00 PM. Staff G stated that they would expect the meal trays to be delivered to the 400/500 hall from 12:00 PM to 12:15 PM. Staff G stated that it would be helpful to have additional staff in the kitchen. Staff G further stated that the lunch room trays should be delivered between 11:30 AM to 12:00 PM. In an interview at 03/25/2026 at 12:09 PM, Staff A stated that they expected the meal trays to be delivered to residents within the scheduled mealtimes. When asked if they expected lunch meal trays to be delivered as late as 1:15 PM, Staff A stated, no. Reference: (WAC) 388-97-1160 .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Contact Precautions (measures put in place to prevent spread of infection by direct or indirect contact with the resident or environment by staff wearing gown and gloves before entering a resident's room or environment) practices were followed for 2 of 5 (Staff H & V), and failed to ensure hand hygiene/glove use practices were followed for 4 of 6 staff (Staff V, L, H & I), reviewed for infection control. These failures placed the residents, visitors, and staff at an increased risk for infection and related complications. Findings included. Review of the facility's policy titled, Transmission Based Precautions [measures put in place to prevent spread of infection by staff wearing Personal Protective Equipment (PPE-use of gown, gloves, mask and/or face shield) before entering a resident's room or environment], revised in May 2023, showed, It is the policy of this facility to implement Transmission-Based Precautions.for residents known to be, or suspected of being, infected with infectious agents. Review of the Centers for Disease Control Prevention online article titled, Transmission-Based Precautions, dated 04/03/2024, showed, Use Contact Precautions for patients [residents] with known or suspected infections that represent an increased risk for contact transmission. It further showed that putting on PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens [germs that can cause disease]. Review of the facility's policy titled, Hand Hygiene, revised on 12/15/2021, showed, Hand hygiene is the primary means of preventing the transmission of infection and should be performed as soon as possible after hands become contaminated and frequently during the working day. It further showed that hand hygiene is required after removing gloves.and/or before applying. CONTACT PRECAUTIONSSTAFF HObservation on 03/17/2026 at 12:17 PM, showed Staff H, Licensed Practical Nurse, entered Resident 84's room (contact precautions room) without wearing a gown or gloves. Observation on 03/19/2026 at 10:34 AM showed Staff H entered Resident 84's room without wearing a gown or gloves. In an interview and joint observation on 03/19/2026 at 10:43 AM, Staff H stated that they would know if a resident was on contact precautions by the signage at the resident's door, during report, and in a resident's medical records. Staff H stated that they used a gown and gloves when providing care for a resident on contact precautions. When asked if they needed to wear a gown and gloves prior to entering a resident's room on contact precautions, Staff H stated that I use a gown when giving care and I didn't [did not] give care to Resident 84. A joint observation of the signage by Resident 84's door showed that everyone must wear a gown and gloves before room entry. Staff H stated, my mistake. STAFF VObservation on 03/20/2026 at 9:04 AM, showed Staff V, Certified Nursing Assistant (CNA), entered Resident 84's room without wearing a gown and gloves. In an interview on 03/20/2026 at 9:10 AM, Staff V stated that they would look at the sign if a resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was on isolation precautions. Staff V stated that Resident 84 was on contact precautions. Staff V stated that they were unsure when they needed to wear PPE for contact precautions and would ask a nurse. In a follow up interview at 9:20 AM, Staff V stated that they have to wear gown and gloves every time they enter a contact precautions room. When asked if they wore a gown and gloves when they entered Resident 84's room, Staff V stated, no. In an interview on 03/25/2026 at 8:30 AM, Staff C, Infection Preventionist, stated that they expected staff to follow the signage at residents' rooms if they were on contact precautions. Staff C stated that they expected staff to wear a gown and gloves prior to entering a contact precautions room. HAND HYGIENE/GLOVE USESTAFF VObservation on 03/20/2026 at 10:04 AM, showed Staff V wearing gloves while changing Resident 4's brief and providing peri-care (the daily cleansing of the private areas to maintain hygiene and comfort). When they were finished, Staff V touched Resident 4, their blanket, sheets, call light, and their clean brief. Staff V did not change gloves between dirty to clean tasks. In an interview on 03/20/2026 at 10:30 AM, Staff V stated that they would change gloves after changing a resident's brief/providing peri-care and touching clean items. When asked if they had changed their gloves between changing Resident 4's brief/providing peri-care and touching Resident 4, their blanket, sheets, call light, and their clean brief, Staff V stated, I made a mistake. In an interview on 03/25/2026 at 8:30 AM, Staff C stated that they expected staff to change their gloves when going between a clean and dirty area, on the body or in the room. Staff C stated that they would expect staff to change their gloves after changing residents' briefs and before touching the residents and their linens. Staff C further stated that staff should perform hand hygiene between glove changes. In an interview on 03/25/2026 at 11:49 AM, Staff B, Regional Director of Clinical Services, stated that their expectation if a resident was on contact precautions was that staff should read the signage and follow it. Staff B stated that they expected staff to wear a gown and gloves prior to entering a contact precautions room. Staff B further stated that they expected staff to change their gloves between dirty and clean tasks and that they should perform hand hygiene between glove changes. STAFF LObservation on 03/23/2026 at 9:56 AM, showed Staff L, CNA, wearing a gown and gloves. Staff L followed Resident 83 to the bathroom and assisted them to sit on the toilet. Staff L closed the bathroom door, stood outside and waited for Resident 83 to finish. When resident called out for Staff L's help, Staff L entered the bathroom and provided Resident 83 with peri-care. When Resident 83 was done, Resident 83 walked back to bed and Staff L followed Resident 83 from behind. Staff L lifted Resident 83's legs up in bed, gave Resident 83 their call light, bed remote control and repositioned their pillow. Staff L did not remove their gloves and perform hand hygiene from dirty to clean tasks. In an interview on 03/23/2026 at 10:20 AM, Staff L stated that they would perform hand hygiene before and after glove use and from dirty to clean tasks. Staff L further stated that they should have removed their gloves and perform hand hygiene. In an interview on 03/24/2026 at 3:18 PM, Staff B stated that they would have expected Staff L to have removed their gloves and perform hand hygiene especially with peri-care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	STAFF HObservation on 03/23/2026 at 8:30 AM, showed Staff H applied gloves and applied diclofenac external gel (medication for pain) to Resident 89's left knee. When Staff H was done, they removed their gloves and applied new gloves. Staff H applied Resident 89's knee brace and immediately removed It. Staff H informed Resident 89 that they were going to come back and that they wanted the medication on their knee to dry. Staff H did not perform hand hygiene between glove use. In an interview on 03/23/2026 at 9:01 AM, Staff H stated that they would perform hand hygiene before and after giving medications and between glove use. Staff H further stated that they should have performed hand hygiene between glove use. STAFF IObservation on 03/24/2026 at 12:35 PM, showed Staff I, Registered Nurse, applied gloves and wiped the cap of Resident 92's insulin (medication for high blood sugar) with alcohol wipes, and drew the medication with a syringe (a tube with a needle used to inject medications in the body). When Staff I was done, they removed their gloves and locked the medication cart without performing hand hygiene. Staff I knocked on Resident 92's door, applied gloves without performing hand hygiene and administered Resident 92's insulin. In an interview on 03/24/2026 at 12:47 PM, Staff I stated that they would perform hand hygiene before/after giving medications and before/after glove use. Staff I further stated that they should have perform hand hygiene before and after glove use. In an interview on 03/25/2026 at 10:32 AM, Staff C stated that they would have expected staff to perform hand hygiene prior to applying gloves to administer an injection. Staff C further stated that Staff I should have performed hand hygiene prior and between glove use. In an interview on 03/25/2026 at 10:46 AM, Staff B stated that they expected staff to perform hand hygiene from dirty to clean tasks and between glove use. Staff C further stated that they expected Staff H and Staff I to perform hand hygiene between glove use. Reference: (WAC) 388-97-1320 (1)(a)(c) .

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	505527	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Post Acute	21008 76th Avenue West Edmonds, WA 98026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure call lights (an alerting device for staff to assist residents in need) were within reach for 2 of 2 residents (Residents 87 & 24), reviewed for accommodation of needs. This failure placed the residents at risk for delayed care, accidents/falls, and a diminished quality of life. Findings included. Review of the facility's policy titled, Answering the Call Light, revised in October 2010, showed, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. RESIDENT 87Review of the admission Minimum Data Set (an assessment tool), dated 03/18/2026, showed that Resident 87 required substantial/maximal assistance [helper does more than half the effort] for sitting to standing. Observation on 03/17/2026 at 8:58 AM, showed Resident 87 in their bed and their call light laying on the chair next to their bed and was not within reach. Resident 87 stated that they were unsure where their call light was and they were looking around their bed for it. At 9:05 AM, Staff Y, Certified Nursing Assistant (CNA), entered Resident 87's room to speak with the resident and take their meal tray. The call light remained on the chair next to Resident 87's bed and was not within reach. Another observation on 03/18/2026 at 1:20 PM, showed Resident 87 in their bed and their call light on the floor and was not within reach. At 1:34 PM, Staff Y entered Resident 87's room to take their meal tray. When Staff Y left the room, the call light remained on the floor. In an interview and joint observation on 03/18/2026 at 1:48 PM, Staff Y stated that when they left a resident's room, they would check that the call light was within reach. A joint observation of Resident 87's room showed the call light on the floor and not within reach of Resident 87. Staff Y stated, I did not check [the call light] when I picked up the meal tray. In an interview on 03/25/2026 at 9:25 AM, Staff F, Resident Care Manager (RCM), stated that they expected the call light to be within reach of residents and that staff should be checking call light placement prior to leaving the residents' room. In an interview on 03/25/2026 at 11:49 AM, Staff B, Regional Director of Clinical Services, stated that they expected staff to check prior to leaving residents' room that the call light was within reach. RESIDENT 24Review of Resident 24's risk for falls care plan intervention initiated on 11/10/2023 showed, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Observations on 03/18/2026 at 9:08 AM, on 03/23/2026 at 9:26 AM and on 03/25/2026 at 8:12 AM, showed Resident 24 lying in bed. Their call light was wrapped around the call light port on the wall and was not within Resident 24's reach. In a joint observation and interview on 03/25/2026 at 8:29 AM with Staff O, CNA, showed that Resident 24's call light was wrapped around the call light port on the wall and was not within reach. When asked if Resident 24's call light should have been within reach, Staff O stated, Always, no (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matter what, that's [that is] unreachable for him. In an interview on 03/25/2026 at 8:35 AM, Staff I, Registered Nurse, stated that they would expect the resident's call light to be within reach. In an interview on 03/25/2026 at 8:43 AM, Staff D, RCM, stated that they expected call lights to be placed within the resident's reach. When asked if Resident 24 used their call light, Staff D stated, yes, I believe so. Staff D further stated that they would have expected Resident 24's call light to be within reach. In an interview on 03/25/2026 at 10:48 AM, Staff B stated that they expected residents' call lights to be placed within reach. Reference: (WAC) 388-97-0860 (2)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to determine on admission if a resident had an advance directive (a written instruction, such as a living will or durable power of attorney for health care) for 1 of 4 residents (Resident 1), reviewed for advance directives. This failure placed the resident and/or their representative at risk of losing their right to have their preferences honored to receive care according to their choice.Findings included.Review of the facility's policy titled, Advance Directives, reviewed in March 2025, showed, During the admission process, the facility will identify if the resident has an advance directive.if the resident does, a copy will be requested and kept in the resident's medical chart, accessible to the physician and care staff.Resident 1 was admitted to the facility on [DATE].Review of Resident 1's Electronic Health Record (EHR) showed no documentation that the facility identified if Resident 1 had an advance directive.In an interview and joint record review on 03/20/2026 at 2:34 PM, Staff Z, Social Services Director, stated that they would document if a resident had an advance directive in an admission note. I would say if they have one or not. When asked if Resident 1 had an advance directive, Staff AA, Social Worker, stated that they were Resident 1's Social Worker and then began looking through Resident 1's EHR. Staff AA stated that there was no documentation that showed if Resident 1 had an advance directive.In an interview and joint record review on 03/25/2026 at 12:09 PM, Staff A, Administrator, stated that they expected that it would be discussed at admission if a resident had an advance directive. Staff B, Regional Director of Clinical Services, stated that they would expect documentation if a resident had an advance directive or not. A joint record review of Resident 1's EHR showed no documentation that the facility identified if Resident 1 had an advance directive. Staff B stated that there was no documentation that showed that the facility identified if Resident 1 had an advance directive.Reference: (WAC) 388-97-0280 (3)(a).

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a copy of the transfer/discharge notice to the State Long Term Care Ombudsman (an advocate for residents of nursing homes who protect and promote resident rights under federal and state law and regulations) office with the required information for 2 of 4 residents (Residents 8 & 9), reviewed for hospitalizations. This failure placed the residents at risk for not having opportunities to make informed decisions about their transfer.Findings included.Review of the facility's policy titled, Notice of Transfer or Discharge, reviewed in April 2025, showed, The center sends a copy of the notice to the State Long term Care Ombudsman.RESIDENT 8Review of the discharge Minimum Data Set (MDS-an assessment tool), dated 01/15/2026, showed that Resident 8 was admitted to the facility on [DATE] and discharged to an acute hospital on [DATE].RESIDENT 9Review of the discharge MDS dated [DATE], showed that Resident 9 was admitted to the facility on [DATE] and discharged to an acute hospital on [DATE].Review of the discharge MDS dated [DATE], showed that Resident 9 discharged to an acute hospital on [DATE]. On 03/24/2026 at 2:31 PM, Staff P, Medical Records Director, stated they were responsible for notifying the Ombudsman either via fax or email when a resident was hospitalized or discharged from the facility. Staff P stated that they had recently started sending over a copy of the notice of transfer/discharge when they were notified that it was required. Staff P further stated that they had not sent out a copy of the notice of transfer/discharge to the Ombudsman for Resident 8 and Resident 9 and that they should have.On 03/25/2026 at 12:34 PM, Staff A, Administrator, stated that they understood that the regulation was to send a copy of the notice of transfer/discharge to the Ombudsman.Reference: (WAC) 388-97-0120(2)(c)(5).

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS - an assessment tool) was completed for 1 of 16 residents (Resident 8), reviewed for significant change of condition. The failure to complete an SCSA within 14 days of a significant change of condition placed the resident at risk for delayed care planning, unmet care needs, and a diminished quality of life. Findings included .Review of the Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual, (a guide directing staff on how to accurately assess the status of residents) Version 1.20.1 dated October 2025, showed that an SCSA is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team determined that a resident meets the significant change guidelines for either major improvement or decline. The RAI manual showed, A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. Further review of the RAI manual showed that an SCSA would be completed 14 days after determination that a significant change in a resident's status occurred (determination date + [plus] 14 calendar days).Review of the facility's policy titled, Change in a Resident's Condition or Status, revised in February 2021, showed a significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff, impacted more than one area of the resident's health status, required interdisciplinary review and/or revision of the care plan, and was ultimately based on the judgment of the clinical staff and guidelines outlined in the RAI. The policy further showed if a significant change in the resident's physical or mental condition occurred, a comprehensive assessment would be conducted as outlined in the MDS RAI manual.Review of the dietary note dated 12/26/2025 showed Resident 8's current weight was 146.9 pounds (lbs.) and had a significant weight loss of 7.4 percent (%) in 30 days related to variable intake.Review of Resident 8's Nutritional Risk Assessment (Admission/Annual), dated 01/23/2026, showed they readmitted to the facility with a diagnosis of above the knee (right knee) amputation (removal of a limb or extremity). The assessment further showed that Resident 8 had a significant weight loss of 10% x [times] 90 days, partially related to loss of limb and to variable intake.Review of the admission MDS dated [DATE], showed that Resident 8 did not have weight loss. It further showed that Resident 8 had functional limitation in range of motion (limitation that interfered with daily functions or placed the resident at risk of injury in the last seven days) to their lower extremity on one side.Review of the quarterly MDS dated [DATE], showed that Resident 8 did not have weight loss. The MDS further showed Resident 8 had functional limitation in range of motion to both sides of their lower extremities.Review of the document titled, Weight Summary, showed Resident 8 weighed 164.5 lbs. on 10/30/2025 and 136.2 lbs. on 01/29/2026, which indicated a significant weight loss of 17.2% in three months.Review of Resident 8's Activities of Daily Living (ADL) care plan revised on 02/28/2026, showed, Resident has actual decline in ADL and remains at risk and requires assistance related to amputation, pain, recent surgery, weakness.On 03/25/2026 at 8:17 AM, Staff N, MDS Coordinator, stated that they followed the RAI manual. Staff N stated that Resident 8 had a significant weight loss and was not on a physician prescribed weight loss regimen. Staff N further stated that Resident 8 had impairments to both lower extremities and that they should have done an SCSA.On 03/25/2026 at 10:14 AM, Staff B, Regional Director of Clinical Services, stated that they would expect staff to complete an SCSA when it met the requirements in the RAI manual. Staff B stated that if a resident had significant weight loss and a decline in range of motion, they would expect an SCSA to be completed and that it should have been completed for Resident 8.Reference: (WAC) 388-97-1000 (3)(b).

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to provide services to maintain hearing methods to carry out the Activities of Daily Living (ADL) for 1 of 1 resident (Resident 4), reviewed for communication. This failure placed the resident at risk of not being able to hear and/or communicate and a diminished quality of life.Findings included.Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised in March 2018, showed that Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Review of the admission Minimum Data Set (an assessment tool), dated 12/30/2025, showed that Resident 4 used hearing aids.Review of Resident 4's hearing care plan, revised on 01/05/2026, showed the intervention to apply hearing aid to both ears. It further showed, Ensure hearing aid or other hearing appliance is in place and in working order.Observation on 03/19/2026 at 11:58 AM showed Resident 4 was not wearing their hearing aids. Resident 4 stated I have some and that they were unsure where the hearing aids were and it had been quite a while since they had used them.Observation on 03/20/2026 at 10:26 AM showed Resident 4 was not wearing their hearing aids.In an interview and joint observation on 03/23/2026 at 9:25 AM, Staff L, Certified Nursing Assistant, stated that they would help residents that needed assistance for placing their hearing aids. Staff L stated that Resident 4 was hard of hearing and I haven't [have not] seen a hearing aid. A joint observation showed that Resident 4 was not wearing any hearing aids. Staff L stated that Resident 4 was not wearing any hearing aids and that they did not see any hearing aids in their room.In an interview and joint observation on 03/23/2026 at 9:40 AM, Staff H, Licensed Practical Nurse, stated that they did not know if Resident 4 used hearing aids and that she hears me. A joint observation showed Resident 4 was not wearing their hearing aids. Staff H found hearing aids in the top drawer of Resident 4's nightstand and asked Resident 4 if they wanted to use the hearing aids. Resident 4 stated yes. Staff H placed the left hearing aid in Resident 4's ear and asked Resident 4 if they could hear them. Resident 4 stated yes and that they wanted to use both hearing aids. Staff H told Resident 4 that the right hearing aid was broken and stated that they would let Resident 4's representative know.In an interview on 03/25/2026 at 9:25 AM, Staff F, Resident Care Manager, stated that if a resident used hearing aids they expected staff to offer them daily. Staff F further stated that even if it seemed like a resident could hear without their hearing aids that they expected staff to still offer the hearing aids.In an interview on 03/25/2026 at 11:49 AM, Staff B, Regional Director of Clinical Services, stated that if residents had hearing aids they expected staff to offer them every day. Staff B further stated that if a resident needed help to place their hearing aids, they expected staff to help them.Reference: (WAC) 388-97-1060 (2)(b).

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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 feeding assistance was provided for 1 of 1 resident (Resident 8), reviewed for activities of daily living. This failure placed the resident at risk of unmet care needs and a diminished quality of life.Findings included.Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised in March 2018, showed, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition. The policy further showed that the appropriate care and services would be provided to residents in accordance with their plan of care including dining.Review of Resident 8's ADL care plan revised on 02/28/2026, showed an intervention for Eating: 1:1 [one to one] Feeding Assist.Observation on 03/23/2026 at 8:30 AM, showed Staff S, Certified Nursing Assistant, assisted Resident 8 set up their breakfast tray on their bedside table. At 8:32 AM, Staff S was no longer in Resident 8's room and Resident 8 was eating unsupervised. At 8:46 AM, Resident 8 was lying in bed with their eyes closed and their breakfast in front of them. At 9:02 AM, Staff S returned to Resident 8's room, woke them up and asked them if they were done with their meal and took the tray out of the room.In an interview and joint record review on 03/23/2026 at 9:10 AM, Staff S stated that they would check the residents' Kardex (quick reference tool for resident care) or care plan to see how much assistance a resident needed with their ADLs. Staff S stated that they were expected to follow the care plan. Staff S stated that Resident 8 could feed themselves, but she needs to be supervised, or sometimes needs to be fed, and that if the resident was unable to do it, they would assist them. Staff S stated that a 1:1 feeding assist meant that they would have to stay with the resident for the entirety of the meal to assist them. A joint record review of Resident 8's Kardex showed they were a 1:1 feeding assist. Staff S stated that Resident 8 did need assistance with feeding at times because they fell asleep or were unable to feed themselves.On 03/25/2026 at 8:12 AM, Staff R, Registered Nurse, stated that staff was expected to follow the resident's care plan.On 03/25/2026 at 8:33 AM, Staff F, Resident Care Manager, stated that they would expect staff to follow the resident's care plan. Staff F further stated that a 1:1 feeding assist would include assisting the residents eat their meal and providing reminders to eat while being observed. Staff F further stated that Resident 8 was a 1:1 feeding assist as they had struggled with meal intake since admission and would have expected staff to stay with them during their meal.On 03/25/2026 at 10:06 AM, Staff B, Regional Director of Clinical Services, stated that they expected staff to follow a resident's care plan. Staff B further stated that a 1:1 feeding assist meant that staff were actively assisting the residents eat their meal and that it was important for their nutrition.Reference: (WAC) 388-97-1060 (2)(c).

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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 ensure clinical records were complete and accurate for 1 of 4 residents (Resident 13), reviewed for advance directives. This failure placed the resident at risk for medical complications and unmet care needs.Findings included.Review of the facility's policy titled, Advance Directives, reviewed in [DATE], showed a definition for Physician Orders for Life-Sustaining Treatment (POLST) that stated, This document, signed by an authorized health care professional, is a medical order that records residents' treatment wishes so that emergency personnel know what treatments to provide in the event of a medical emergency.Review of Resident 13's POLST form dated [DATE], showed Resident 13's code status (instructions to their medical team about what to do if a resident had no pulse and was not breathing) was Attempt Resuscitation/CPR (Cardiopulmonary Resuscitation-emergency lifesaving procedure performed when the heart stops beating).Review of Resident 13's comprehensive care plan printed on [DATE] showed that Resident 13's code status was Do Not Attempt Resuscitation (DNAR).Review of a Physical Therapy note dated [DATE] showed under Precautions that Resident 13's code status was DNAR.In an interview and joint record review on [DATE] at 12:08 PM, Staff V, Certified Nursing Assistant, stated that they knew what a resident's code status was by checking the resident's care plan. A joint record review of Resident 13's Electronic Health Record (EHR), showed that Resident 13's code status was Attempt Resuscitation/CPR. Another joint record review of Resident 13's comprehensive care plan showed that Resident 13's code status was DNAR. Staff V stated that they are different and that they did not match.In an interview and joint record review on [DATE] at 12:15 PM, Staff U, Registered Nurse, stated that they looked for a resident's code status on the main page of a resident's EHR. A joint record review of Resident 13's EHR showed that Resident 13's code status was Attempt Resuscitation/CPR. Staff U stated that the resident's code status should match everywhere, including the resident's care plan.In an interview on [DATE] at 12:28 PM, Staff F, Resident Care Manager, stated that they expected staff to know what a resident's code status was by looking in a resident's EHR, POLST binder, and a resident's care plan.In an interview and joint record review on [DATE] at 12:34 PM, Staff W, Director of Rehabilitation, stated that a resident's code status was documented under precautions in residents' therapy notes. A joint record review of the Physical Therapy note dated [DATE], showed under Precautions that Resident 13's code status was DNAR. A joint record review of Resident 13's EHR showed that Resident 13's code status was Attempt Resuscitation/CPR. Staff W stated that Resident 13's code status in therapy notes needs to be updated.In an interview on [DATE] at 11:49 AM, Staff B, Regional Director of Clinical Services, stated that they expected a resident's code status to be consistent between what the POLST form stated and a resident's comprehensive care plan. Staff B further stated that they expected resident records to be accurate.In an interview on [DATE] at 12:09 PM, Staff A, Administrator, stated that they expected resident records to be accurate.Reference: (WAC) 388-97-1720 (1)(a)(i)(ii).

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the COVID-19 (a highly transmissible infectious virus that causes respiratory illness and in severe cases can cause difficulty breathing and could result in impairment or death) vaccine was offered and/or provided for 2 of 5 residents (Residents 9 & 32), reviewed for immunizations. This failure placed the residents at risk for contracting the COVID-19 virus and related complications.Findings included.Review of the facility's policy titled, SARS-CoV-2 (COVID-19), dated 08/01/2024, showed, Center residents are offered recommended COVID-19 vaccinations upon admission and as eligible per CDC [Centers for Disease Control and Prevention] recommendations.Review of the CDC online document titled, Staying Up to Date with COVID-19 Vaccines, dated 11/19/2025, recommended a 2025-2026 COVID-19 vaccine for people ages 6 months and older. It further showed that getting the 2025-2026 COVID-19 vaccine is especially important if you.are living in a long-term care facility.RESIDENT 9Resident 9 readmitted to the facility on [DATE].Review of the document titled, Informed Consent-Immunization, signed on 12/29/2025, showed that Resident 9's representative signed the consent form for Resident 9 to receive the COVID-19 vaccine.Review of Resident 9's Electronic Health Record (EHR- medication administration record, progress notes, miscellaneous, and immunizations tab), showed no documentation that Resident 9 received the COVID-19 vaccine.In an interview and joint record review on 03/25/2026 at 8:30 AM, Staff C, Infection Preventionist, stated that they expected the COVID-19 vaccine to be offered to residents upon admission and would look at when to offer per CDC recommendations. Staff C stated that if a resident consented to receive the COVID-19 vaccine they would expect them to receive it. A joint record review of the document titled, Informed Consent-Immunization, signed on 12/29/2025, showed that Resident 9's representative signed the consent form for Resident 9 to receive the COVID-19 vaccine. Staff C stated the document showed that they [Resident 9] wanted the vaccine. A joint record review of Resident 9's EHR showed no documentation that Resident 9 received the COVID-19 vaccine. Staff C stated that there was nothing after 12/29/2025 that showed Resident 9 received the COVID-19 vaccine.In an interview and joint record review on 03/25/2026 at 11:49, Staff B, Regional Director of Clinical Services, stated that if a resident signed a consent to receive the COVID-19 vaccine they would expect it to be given. A joint record review of Resident 9's EHR showed the document titled, Informed Consent-Immunization, signed on 12/29/2025, showed that Resident 9's representative signed the consent form for Resident 9 to receive the COVID-19 vaccine. Staff B stated they would keep looking to find if Resident 9 received the COVID-19 vaccine and if they could not find anything it would be considered not given. No further documentation was provided.RESIDENT 32Resident 32 was admitted to the facility on [DATE].Review of the immunization tab showed that Resident 32 declined the COVID-19 vaccine on 10/18/2023 and on 10/04/2024.Review of Resident 32's EHR showed no documentation that they had been offered the COVID-19 vaccine after they declined on 10/18/2023 and on 10/04/2024.In an interview and joint record review on 03/25/2026 at 8:30 AM, Staff C stated they would expect to offer the COVID-19 vaccine even if a resident had previously declined it. A joint record review of Resident 32's EHR showed the last time Resident 32 was offered the COVID-19 vaccine was on 10/04/2024. Staff C stated, I would expect for her to have been offered since then.In an interview and joint record review on 03/25/2026 at 11:49 AM, Staff B stated that they expected the COVID-19 vaccine to be offered to residents upon admission and if they were long term residents they would offer again. A joint record review of Resident 32's EHR showed the last time Resident 32 was offered the COVID-19 vaccine was on 10/04/2024. Staff B stated, doesn't [does not] look like it was offered in 2025. Staff B stated that it should have been offered in 2025, but we did not.Reference: (WAC) 388-97-1620 (2)(b)(i)(ii).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505527	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Ridge Post Acute	21008 76th Avenue West Edmonds, WA 98026

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 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 interview and record review, the facility failed to ensure the survey result binder included the results for 4 of 4 complaint surveys (03/14/2025, 04/07/2025, 05/14/2025 & 07/10/2025) that resulted in citations since the last annual survey. This failure prevented residents, residents' representatives and visitors from exercising their right to review past survey results and the facility's plan of correction.Findings included.Review of the state inspection survey results binder on 03/25/2026 at 11:45 AM showed that it did not include the results for the complaint surveys and plan of corrections from 03/14/2025, 04/07/2025, 05/14/2025, and 07/10/2025.In an interview and joint record review on 03/25/2026 at 12:09 PM, Staff A, Administrator, stated that they expected the survey results binder to include surveys, complaints, and revisits. A joint record review of the survey binder showed the following complaint survey results and associated plans of corrections were missing for 03/14/2025, 04/07/2025, 05/14/2025, and 07/10/2025. Staff A stated that the results should have been in the survey results binder and available for residents and families.Reference: (WAC) 388-97-0480(1)(b)(c).