

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505532	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2026
NAME OF PROVIDER OR SUPPLIER Cedar River Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 17420 106th PI SE Renton, WA 98055	
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 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 observations, interviews, and record review the facility failed to ensure physician's orders were followed, failed to ensure medications were available from the pharmacy and failed to notify the provider of not giving medications as ordered for 1 of 5 residents (Resident 1) whose medication regimens were reviewed. The failure to ensure orders were followed and medications were made available, placed residents for unnecessary pain, and other negative health outcomes. Findings included . <Facility Policy>Review of the facility's 01/2025 Medication Ordering and Receiving from the Pharmacy policy showed timely delivery of new orders is required so that medication administration is not delayed.According to the 06/25/2025 admission Minimum Data Set (MDS - an assessment tool) Resident 1 had medically complex diagnoses including orthopedic conditions, pain in right hip, and anxiety. The MDS showed Resident 1 needed after care for orthopedic surgery, pain management and surgical wound care. In an interview and observation on 06/25/2026 at 2:15 PM, Resident 1 stated they just recently admitted to the facility and have been having troubles with nurses getting their medications to them on time or at all. Resident 1 stated when they admitted , they had a pain medication that did not get to them until late and thought the facility should have their medications available when they admitted . Resident 1 stated they had a breathing treatment but had not received it since admission and stated the facility was also not providing their skin treatment care as ordered. Record review showed Resident 1 physician's orders included the following:- a 06/19/2026 order to apply skin cream for a skin infection one time daily. - a 06/19/2026 order to apply external powder medication to affected area twice a day for a rash.-a 06/23/2026 order for a muscle relaxer medication to be given three times daily for pain and to hold for oversedation.- a 06/19/2026 order for long-acting pain medication to be given every 12 hours for moderate to severe pain.-a 06/19/2026 order for an inhaler to be provided through a breathing treatment device twice daily for asthma. Review of the June 2026 Medication Administration Record (MAR) showed on 06/20/2026, 06/21/2026, 06/22/2026, 06/23/2026 and 06/24/2026, the cream for the skin infection was not provided to Resident 1. Review of Resident 1's progress notes from 06/20/2026 through 06/24/2026 showed no documentation of why the cream was not provided to Resident 1 and did not show the provider was notified the skin cream was not given as ordered. Review of the June 2026 MAR showed on 06/23/2026 and 06/24/2026, showed the muscle relaxer medication was not given to Resident 1. Review of Resident 1's progress notes from 06/23/2026 through 06/24/2026 showed no documentation of why the muscle relaxer was not given and showed no documentation the provider was notified the muscle relaxer was not given as ordered. <Medications not available>Review of the June 2026 MAR showed on 06/20/2026 and on 06/21/2026 the external powder for the skin rash was not given to Resident 1. Review of Resident 1's progress notes showed on 06/20/2026 the external powder was not given because they were waiting for the delivery from the pharmacy. Review of the progress notes showed no documentation the provider was notified the external powder was not given as ordered. Review of a 06/20/2026 progress note showed the long-acting pain medication was to be administered at 9:00 PM, however Resident 1 did not receive the medication until 11:30 PM, more than two hours later because the pain medication was not available by the pharmacy. There was no documentation that showed the provider was notified of the late medication administration. Review (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: 505532	Facility ID: 505532 If continuation sheet Page 1 of 2

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of the June 2026 MAR showed the inhaler medication for breathing was not given on 06/19/2026, 06/20/2026, and 06/21/2026. Review of a 06/20/2026 progress note showed the nurse was waiting for the pharmacy to deliver the medication. There was no documentation that showed the provider was notified about Resident 1 not receiving their inhaler medication as ordered. In an interview on 06/25/2026 at 3:00 PM, Staff D (Registered Nurse) stated the skin cream, muscle relaxer, and long-acting medication were not given to Resident 1. Staff D stated these medications showed as pending confirmation and the medications should have been given or the pharmacy and provider should have been called but could not find documentation in the record. Staff F stated the nurses should have documented why the medication was not given as ordered but did not. In an interview on 06/25/2026 at 4:50 PM, Staff C (Resident Care Manager-RCM) stated nurses should provide medications as ordered and were to notify the provider and document when a medication was not provided but did not. In an interview on 06/25/2026 at 5:02 PM, Staff B (Director of Nursing) stated medications should be available and if not, staff were to use the emergency kit or call the pharmacy to get medications as soon as possible. Staff B stated it was important for residents' safety and care to document why medications were not given and to notify the provider of medications not being provided as ordered. REFERENCE: WAC 388-97-1620(2)(b)(i)(ii),(6)(b)(i)(ii).		