STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505533	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Everett Transitional Care Services	916 Pacific Avenue Everett, WA 98201

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent an accident for 1 of 1 sampled resident (Resident 1) reviewed for burns. Resident 1 experienced harm when facility staff heated food and then failed to ensure safe temperatures prior to serving the resident, resulting in second degree burns. The facility failed to report to the appropriate state agencies at the time of the incident. This failure also placed other residents at risk of serious injury and a diminished quality of life. Findings included.Review of a facility policy titled Microwave Reheating Guidelines updated 10/01/2022 showed; Policy Statement: Foods and fluids heated in the microwave are served to residents at safe temperatures- 7. Temperature is taken prior to service to the residents. Hot beverages and hot foods are served to residents at less than or greater than 145 degrees. <RESIDENT 1>Resident 1 was re-admitted to the facility on [DATE] with diagnoses to include Rheumatoid arthritis, diabetes, kidney disease dependent on dialysis, pain in the left and right shoulder, chronic pain, and abnormalities of gait and mobility, below the knee left and right amputations, and lack of coordination. According to the Minimum Data Set (MDS- an assessment tool) assessment dated [DATE], documented Resident 1 had no cognitive impairment.Review of Resident 1's electronic medical record (EMR) showed the resident is dependent on 2 staff for transfers with a mechanical lift, dependent on 1 staff for bed mobility, toileting, and dressing, and required set up assistance for meals and could feed themself.Review of the facilities State reporting log dated February 2026 showed documentation that Resident 1 sustained a burn on 02/26/2026 at 12:00 AM. In an interview on 05/13/2026 at 4:27 PM, Staff C stated an investigation had not been completed. Review of a progress note dated 02/26/2026 at 2:02 AM documented the Resident 1 had spilled a bowl of hot soup onto themself. Upon arrival, this LN observed the resident lying on his right-side shouting in pain. A skin assessment was performed and there was a great area of redness that covered the left groin area, the lower left abdomen, the left hip, and a portion of the left lower back. There were 4 dime sized blisters that had formed in various areas. Documentation showed first aid was provided and pain medication was administered.Review of a wound consultant progress note dated 03/04/2026 at 10:18 AM showed Resident 1 had a circumferential second degree burn on their left lower leg, mainly on the thigh, some blisters partially open and draining, some blisters are intact, some epidermis (outer layer of skin) already gone. Wound measurement was documented as 15 centimeters (cm) by 58 cm by 0.1 cm. Documentation showed given the large area of the burn and comorbidities (medical conditions that coexist alongside a primary diagnosis, affecting health, treatment, and prognosis), orders were given for antibiotic ointment to prevent infection as the resident was at high risk.Review of Resident 1's Medication Administration Record (MAR) dated February 2026 showed the resident was administered as needed pain medication on 02/26/2026 at 12:40 AM, for a documented pain level of 10.Review of Resident 1's EMR did not show a skin check or pain evaluation completed for the burn incident on 02/26/2026.Review of Resident 1's Kardex and care plan for eating, was revised on 03/02/2026 showed staff to allow food/liquids to cool before placing in reach and ensure resident is covered with a towel/apron when necessary. Ensure resident is positioned in upright position as tolerated.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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	of Resident 1's Care Plan showed a focus initiated on 03/23/2026 that Resident 1 had burn wounds, placing them at risk for infection, pain, impaired skin integrity, and delayed healing. Review of Resident 1's physician orders did not show wound care orders from 04/14/2026 through 04/17/2026. Resident 1's burn wound was resolved on 05/06/2026.Review of Resident 1's MAR and Treatment Administration Record dated April 2026 did not show documentation of wound care provided from 04/14/2026 through 04/17/2026.In an interview on 05/13/2026 at 2:54 PM, Resident 1 stated on 02/26/2026, an NAC had heated up a bowl of soup and placed the bowl at the edge of the bedside table and left the room to get a towel for their lap. The resident stated they started to eat the soup and their hand twitched and the bowel fell and spilled on them. The resident stated the soup was hot and they were yelling for help. The resident stated the hot soup caused burns to their left upper leg and left hip to the edge of their left buttock.In an interview and observation on 05/13/2026 at 3:10 PM, Staff D, Certified Nursing Assistant, stated the Kardex provides information about how to care for residents. Staff D stated that staff can heat food for residents and staff should check the temperature and not serve to the resident until the temperature is between 135 to 145 degrees, there is a thermometer next to the microwave. Staff D stated temperatures for food heated for residents are not documented. This writer observed a thermometer next to the microwave in the fifth-floor nourishment room.In an interview on 05/13/2026 at 4:27 PM, Staff C, Registered Nurse (RN), Director of Clinical Operations (DCO) stated an investigation was not completed and there were no statements from staff. Staff C stated they were gathering information and were attempting to contact and obtain statements from staff.In an interview on 05/14/2026 at 10:21 AM, Staff E, RN, stated staff can heat food for residents but it cannot be served if the temperature is above 145 degrees. Staff E stated nurse managers enter wound care orders, update care plans and complete incident investigations.In an interview on 05/14/2026 at 10:56 AM, Staff F, Dietary Manager, stated staff can heat food for residents and they should follow directions for the food item but staff should temp the food and should not serve to residents until the temperature is between 135 to 145 degrees. Staff F stated there had been binders on the fourth and fifth floors with instructions for heating food, but they were unable to find them. Staff F stated staff were educated but they do not remember the date and cannot find documentation.In an interview and record review on 5/15/2026 at 1:15 PM, Staff G, RN, Nurse Manager, stated the nurse managers and the Director of Nursing (DNS) complete incident investigations. Staff G stated they did not complete an investigation or interview staff for Resident 1's burn. Staff G reviewed Resident 1's EMR and acknowledged there were no wound care orders for Resident 1 from 04/14/2026 through 04/17/2026. Review of a statement dated 02/25/2026 and obtained on 05/14/2026, Staff H, Certified Nursing Assistant, documented Resident 1 had asked them to make noodles. Staff H stated they made the noodles and gave them to the resident and told the resident to be careful because the noodles were hot. Staff H documented they went to get the resident a towel to use as a clothing protector and the resident had spilled the noodles, was hurt and had pain. Review of a statement dated 05/14/2026 at 3:15 PM, Staff C documented an interview with Staff H who stated they heated Resident 1's soup according to the directions and allowed it to sit for one minute prior to serving to the resident. Staff H stated staff had previously offered to add ice to the residents soup, but the resident declined so staff stopped offering.In a joint interview and record review on 5/15/2026 at 12:15 PM, with Staff A, Administrator, Staff B, RN, DNS, and Staff C, RN, DCO, Staff C stated during an interview with Staff H, Staff H could not recall if they had temped Resident 1's soup prior to serving to the resident. Staff C stated heated food should be temped prior to serving residents. Staff A stated food and beverages cannot be served unless the temperature is between 135 to 145 degrees. Staff C stated that an investigation was not completed and confirmed there were no wound care orders for the resident from 4/14/2026 through 4/17/2026. Staff C stated resident care plans should be updated immediately for changes to residents skin and acknowledged that the residents care plan for burn wounds was not initiated until 3/23/2026.Reference WAC 388-97-1060(3)(g)